Assessment of Drivers of Progress in Increasing Contraceptive use in sub-Saharan Africa

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Case Studies from Eastern and Southern Africa

African Institute for Development Policy (AFIDEP)

December, 2012

AFIDEP African Institute for Development Policy
Bridging Development Research, Policy & Practice

Web: www.afidep.org

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ACKNOWLEDGEMENTS

The following staff at African Institute for Development Policy (AFIDEP) worked on this project and contributed to the writing of this report: Dr Eliya M Zulu, Dr Nyokabi R Musila, Ms Violet I Murunga, Ms Eunice M William, Ms Mallory Sheff.

AFIDEP wish to thank the stakeholders in Ethiopia, Kenya, Malawi, Rwanda, and Tanzania, who participated in this study for taking the time to meet and discuss their programmes and experiences with us.

We would also like to thank the following individuals for technical and logistical support to our study:
In Ethiopia, Ms. Tigest Alemu (Public Health Consultant), Ms. Yeshibet Gebregiorgis (Save the Children) and Ms. Tenagne Kebede (Federal Ministry of Health).
In Rwanda, Dr Agnes Binagwaho (Minister of Health) and Dr Fidele Ngabo (Director, Maternal and Child Health); Dr Paulin Basinga (Senior Program Officer at the Bill and Melinda Gates Foundation, formerly Deputy Director of Research, School of Public Health, National University of Rwanda); and Dr Angel Musabyimana and Dr Jean Paul Semasaka Sengoma (School of Public Health, National University of Rwanda).
In Tanzania, Dr Esther Dungumaro (Institute of Development Studies, University of Dar es Salaam), Ms Phausta Paul and Ms Neema Timothy.

This assessment was jointly funded by the UNFPA Africa Regional Office (UNFPA-ARO), The David and Lucille Packard Foundation, the Joffe Charitable Trust, UK and AFIDEP.

ACRONYMS

ABC	Abstain, Be faithful, use Condoms
ACK	Anglican Church of Kenya
ADB	African Development Bank
AFIDEP	African Institute for Development Policy
AGALI	Adolescent Girls' Advocacy and Leadership Initiative
AIDS	Acquired immune deficiency syndrome
ARBEF	Rwandan Association for the Promotion of Family Welfare
ARH&D	Adolescent Reproductive Health and Development Policy
ARV	Antiretroviral
ASRH	Adolescent Sexual and Reproductive Health
BAKWATA	National Muslim Council of Tanzania
BCC	Behavior Change Communication
BLM	Banja La Mtsogolo
CAMERWA	Centrale d'Achats des Médicaments Essentiels du Rwanda
CBD	Community Based Distribution
CBDA	Community Based Distribution Agents
CBOs	Community Based Organisations
CBRHA	Community Based Reproductive Health Agents
CCHP	Council Comprehensive Health Plan
CDLMIS	Contraceptive Distribution Logistics Management Information System
CFPHS	Community Based Family Planning and HIV and Aids Services
CHAM	Christian Health Association Of Malawi
CHBC	Community Home-Based Care
CHWs	Community Health Workers
C-HMIS	Community Health Management Information System
C-PBF	Community Performance Based Financing
CIP	Capital Investment Plan
CMS	Central Medical Stores
CORHA	Consortium of Reproductive Health Associations
CPR	Contraceptive Prevalence Rate
CRH	Centre for Reproductive Health
CSA	Central Statistical Authority
CSO	Civil Society Organization
DFID	Department for International Development
DHMT	District Health Management Team
DHO	District Health Officers
DHS	Demographic and Health Survey
DIPs	District Implementation Plans
DMPA	Depot medroxyprogesterone acetate
DSW	Deutsche Stiftung Weltbevoelkerung
DRH	Division of Reproductive Health

EC	Emergency Contraceptive
ECLS	Ethiopia Contraceptive Logistics System
EDHS	Ethiopia Demographic and Health Survey
EDPRS	Economic Development and Poverty Reduction Strategy
EHP	Essential Health Package
EHRP	Emergency Human Resource Program
ESDP	Education Sector Development Program
EU	European Union
FBO	Faith-Based Organizations
FDRE	Federal Democratic Republic of Ethiopia
FGAE	Family Guidance Association of Ethiopia
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FHAPCO	Federal HIV/AIDS Program Coordination Office
FHI	Family Health International
FHOK	Family Health Options Kenya
FMOH	Federal Ministry of Health
FP	Family Planning
FPAK	Family Planning Association of Kenya
FPAM	Family Planning Association Of Malawi
FPLM	Family Planning Logistics Management
FPSS	Family Planning Services Support
FPTWG	Family Planning Technical Working Group
FPU	Family Planning Unit
GAMET	Global AIDS Monitoring and Evaluation Team
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFATM	Global Fund to Fight HIV and AIDS, TB and Malaria.
GNP+	Global Network of People Living with HIV
GOK	Government of Kenya
GOM	Government of Malawi
GTP	Growth and Transformation Plan
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (Formerly GTZ)
HAPCO	HIV/AIDS Program Coordination Office
HC	Health Care
HCF	Healthcare And Financing Strategy
HCSS	Health Commodity Supply System
HEP	Health Extension Program
HEW	Health Extension Workers
HHM	HSDP Harmonization Manual
HII	High Impact Intervention
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistants
HMIS	Health Management Information System

HNP	Health, Nutrition and Population
HPP	Health Policy Project
HRH	Human Resources for Health
HSBF	Health Sector Basket Fund
HSDP	Health Sector Development Programme
HSEP	Health Service Extension Programme
HSSP	Health Sector Strategic Plan
HCT	HIV Counselling and Testing
HTSS	Health Technical Support Services
ICPD	International Conference for Population and Development
ICW	International Community of Women Living with HIV/AIDS
IEC	Information Communication and Education
IFHP	The Integrated Family Health Program
IHP	International Health Partnership
IMR	Infant Mortality Rate
IPLS	Integrated Pharmaceutical Logistics System
IPPF	International Planned Parenthood Federation
IPPFAR	The International Planned Parenthood Federation Africa Region
IRH	Integrated Rural Health
ISI	International Statistical Institute
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSI	John Snow Inc.
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package of Health
KCN	Kamuzu College Of Nursing
KCPS	Kenya Contraceptive Prevalence Survey
KFW	German Development Bank
KDHS	Kenya Demographic and Health Survey
KPNPD	Kenya Parliamentary Network for Population and Development
KWFS	Kenya World Fertility Survey
LAPM	Long Acting and Permanent Methods
LATH	Liverpool Associates In Tropical Health
LMIS	Logistics Management Information System
LS	Life Skills
LSTM	Liverpool School Of Tropical Medicine
MAM	Muslim Association of Malawi
MAYAM	Malawi Youth Action Movement
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MGDS	Malawi Growth and Development strategy
MHEN	Malawi Health Equity Network
MKUKUTA	Tanzania National Strategy for Growth and Reduction of Poverty

MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MNCH	Maternal, Neonatal and Child Health
MOE	Ministry of Education
MOFED	Ministry of Finance & Economic Development
MOH	Ministry of Health
MOHSW	Ministry of Health And Social Welfare
MoLG	Ministry of Local Government
MOPH	Ministry of Health and Population
MOU	Memorandum of Understanding
MOWA	Ministry Of Women's Children & Youth Affairs
MP	Member of Parliament
MPoA	Maputo Plan of Action
MPRS	Malawi Poverty Reduction Strategy
MSD	Medical Stores Department
MSH	Management Science for Health
MSI	Marie Stopes International
MSIE	Marie Stopes International Ethiopia
MSK	Marie Stopes Kenya
MST	Marie Stopes Tanzania
MTEF	Medium Term Expenditure Framework
MYWO	Maendeleo ya Wanawake Organization
NAC	National Aids Commission
NACP	National AIDS Control Program
NCAPD	National Coordinating Agency for Population and Development
NCCSS	National Contraceptive Commodity Security Strategy
NCPD	National Council for Population and Development
NEPI	Nursing Education Partnership Initiative
NFPCIP	National Family Planning Costed Implementation Plan
NFPP	National Family Planning Program
NFWCM	National Family Welfare Council of Malawi
NGO	Non-governmental Organization
NHSSP	National Health Sector Strategic Plan
NORAD	Norwegian Agency for Development Cooperation
NPERCHI	National Package of Essential Reproductive and Child Health Interventions
NRHS	National Reproductive Health Strategy
NYCOM	National Youth Council of Malawi
ODA	Official Development Assistance
OJT	On the Job Training
ONAPO	National Office of Population
PAAL	Pharm Access Africa Ltd
PASDEP	A Plan for Accelerated and Sustained Development to End Poverty
PBS	The Protection of Basic Services Programme
PBF	Performance Based Financing

PEPFAR	President's Emergency Plan for Aids Relief
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PMNCH	Partnership for Maternal Newborn and Child Health
PMTCT	Prevention of Mother-to-Child Transmission
POPC	President's Office Planning Commission
PopFP	Population and Family Planning Project
POW	Programme of Work
PPU	Population Planning Unit
PRB	Population Reference Bureau
PSI	Population Services International
PTL	Permanent Tubal Ligation
QMAM	Quadria Muslim Association of Malawi
RALGA	Rwanda Association of Local Government Authorities
RBC	Rwanda Biomedical Center
RCHS	Reproductive and Child Health Section
RH	Reproductive Health
RHLMIS	Reproductive Health Logistics Management Information System
RHU	Reproductive Health Unit
RHTWG	Reproductive Health Technical Working Group
RRI	Rapid Results Initiative
RPRPD	Network of Rwandan Parliamentarians on Population and Development
SADC	Southern Africa Development Community
SBA	Skilled Birth Attendant
SMS	Short Messaging Service
SLA	Service Level Agreements
SRH	Sexual And Reproductive Health
SSA	Sub Saharan Africa
SSD-E	Support for Service Delivery Excellence
STAFH	Support to AIDS and Family Health
STC	Save the Children
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TCPD	Tanzania Council of Population and Development
TFR	Total Fertility Rate
T-MARC	Tanzania Marketing and Communications Project
TORs	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
UMATI	Family Planning Association of Tanzania
UN	United Nations
UNAIDS	Joint United Nations Program on Aids
UNFPA	United Nations Population Fund

UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
VICS	VCT Integrated Study
WAMA	Wanawake na Maendeleo
WDI	World Development Indicators
WFS	World Fertility Surveys
WHO	World Health Organization

EXECUTIVE SUMMARY

Despite the immense health, environmental and economic growth benefits from use of modern family planning (FP) methods, recent estimates published by Guttmacher Institute and UNFPA in June 2012 present that only 17% (36 million) of married women in Sub-Saharan Africa use modern family planning (FP) methods. However, a significantly greater proportion of married women, estimated at 60%, or a staggering 53 million women, are unable to voluntarily space, delay or avoid births through modern FP methods. Despite the generally poor performance in meeting objectives of the International Conference on Population and Development's (ICPD) Program of Action, which established a reproductive health (RH) and FP framework in 1994, and Millennium Development Goal (MDG) MDG target 5b on universal access to RH by 2015, a few countries in sub-Saharan Africa have ignited a new wave of optimism and progress in addressing unmet need for FP.

This report presents the findings from a study conducted by the African Institute for Development Policy (AFIDEP) between October 2011 and June 2012 that examined the specific policy and program reforms that selected progressive countries in Eastern and Southern African countries undertook to achieve noteworthy and unexpected phenomenal progress in increasing contraceptive use over a relatively short period of time (2000 to 2010). Notably, examination of the psychosocial, socioeconomic and cultural factors that played a role in determining demand for children and contraceptive use is beyond the scope of this study.

It is hoped that lessons derived from this assessment will galvanize commitment to FP, and guide efforts to improve effectiveness of intervention programs in the progressive countries, as well as in countries that have not made notable progress in the region, particularly in view of opportunity presented by the growing interest in addressing unmet need for FP among policy makers and partners (donors, civil society, researchers, etc.), as exhibited by the commitments made at the 2012 London Family Planning Summit to support the 69 countries that the World Bank classifies as the world's poorest, for example.

The project objectives were to systematically identify, document and disseminate policy and programmatic drivers of progress in increasing contraceptive use in Ethiopia, Malawi, and Rwanda. Kenya and Tanzania, whose FP programs experienced challenges but have recently improved (2005 to 2010) were also included in the assessment. The collective experience of these countries demonstrates that FP programs can play a central role to enabling couples to access and use effective contraception, which empowers them to determine the timing and number of children they want. This study revealed five key emergent cross-cutting factors that have contributed to the success of FP programs in all the countries, as follows:

1. **Political will and commitment** was found to be to be the most critical enabler of the success of FP programs. Political will is defined as the commitment and support that leaders have and exhibit towards promoting FP. Overall, captivating and sustaining political will, which is a fluid phenomenon, has largely been dependent upon, amongst other considerations, **sustained evidence-informed advocacy** from a number of influential actors (local and international FP advocates). Political will is a key determinant for an enabling policy and program environment, and facilitates a mobilization of resources, which is a factor to successful FP programs in its own right.

2. Effective **mobilization of financial and technical resources** to support implementation of FP programs.

3. A number of health system reforms at different levels and impact contributed to **health systems strengthening** in order to improve the quality and access of FP services and products. These include:

a. health workforce reforms in pre-service and in-service *health worker training* and *taskshifting* to address health worker shortages
b. improved FP commodity *supply chain management*
c. improved service delivery through *integration of SRH with other services* (particularly HIV services)
d. increased access of services through *private-public partnerships*

4. **Taking information and services to the community** in order to address geographical, logistical and financial barriers to access through community health workers, and mobilization of community faith-based, civic and traditional community leaders to carry out public educational campaigns that increased acceptance of FP.

5. Effective **coordination and accountability mechanisms,** including FP and Commodity Security Technical Working Groups, and other fora for joint decision making between government and development partners.

Notably, these factors do not operate in isolation, but rather work synergistically to increase FP uptake. That said, we postulate that the bedrock of running a successful FP program is political will and commitment to FP, which may be attributed to top-level state leadership or within the Ministry or Ministries (in a multisectoral approach), within which FP services are housed. Political will and commitment to FP forms the basis for supportive policies, as well as the systems and structures that need to be put in place in order to ensure that quality FP services and products are accessible by the client. It should also be noted that although the factors are identical, they manifested differently to achieve this common goal based on historical and current contextual circumstances, (including politics, health, culture, social systems, infrastructure, technical and human resource capacity) and sensitivity of population issues and FP.

Findings in Kenya and Tanzania, whose FP programs momentarily stalled, demonstrated that sustained efforts are required from all stakeholders to ensure that funding and technical inputs for improving the quality and access of FP services is maintained. In these two countries, program effort and financial resources shifted to address emergent HIV/AIDS epidemic. In Tanzania, an additional challenge associated with the stalled progress was decentralization of the health sector. Both countries have since gone a long way to address these challenges and revitalize their FP programs.

The study countries provide lessons, which other countries in the region can embrace and learn from, and take strides to examine within their own specific contexts and circumstances, through knowledge transfer and exchange visits, for example.

Inter-country comparisons on the findings of identified factors of progress highlight country-specific dynamics as a crucial factor to how identical factors may play out very differently for increased contraceptive uptake. These contextual circumstances will need defining when formulating appropriate regional/country-level recommendations for countries that are not performing well in terms of contraceptive uptake.

The following general recommendations are derived from the lessons drawn from this assessment:

1. Galvanize political will and commitment for FP at top leadership and all levels of government, as this will increase its profile as a health and development priority, through evidence-informed advocacy.

2. Position the population agenda, which includes access to FP services, at the centre of development planning. This alongside recommendation 1 will ensure a multi-sectoral approach to implementation of population activities.

3. Increase government and external funding for FP commodities and community oriented educational campaigns. Over-reliance on external sources of funding undermines the sustainability of FPPs, as exemplified by the experiences in Kenya and Tanzania.

4. Harmonize FP activities through strong technical and financial coordination and accountability frameworks, including enhancing local technical capacity in program design, evaluation, and research to feed into the accountability systems.

5. Strengthen the capacity of the health system in providing quality FP services by enhancing the health management information system (HMIS); health worker skill base through pre-service and in-service training, performance-based incentives and task shifting; integration of FP with HIV and other reproductive health services; supply chain management; and public-private partnerships through social franchising.

6. Address financial and geographical barriers through sustainable community-based information and service delivery initiatives. Complimenting this effort with empowerment of community-based public health workers and volunteers through task shifting and demedicalization of clinical FP commodities will optimize impact of FPPs.

7. Increase public awareness on the benefits of FP, and simultaneously break cultural, religious and other barriers to FP uptake.

8. Increase access to and utilization of youth-friendly FP and reproductive health services.

Notably, the implementation of these strategies would be diverse across countries, due to differing in-country systems, structures and resources.

INTRODUCTION

The cornerstone of the 1994 International Conference on Population and Development (ICPD) program of action was the resolution to enable women and their partners to have universal access to the information and services they need to make informed and voluntary decisions about their reproduction and accordingly plan the number and timing of their pregnancies. Moreover, the inclusion of universal access to sexual and reproductive health (SRH) services in the global development framework - the Millennium Development Goals (MDGs) - reinforced the ICPD efforts.

Family Planning (FP) has immense health, environmental and economic growth benefits. For instance, it is estimated that in 2008, FP averted 32% of maternal deaths in sub-Saharan Africa (SSA), and that such deaths would decline by a further 29% if all women who want to avoid or delay pregnancy use an effective contraceptive method (Ahmed et al. 2012). FP also helps save the lives of children; spacing births of children by at least two years would reduce deaths of infants by 10% and deaths of children aged 1-5 years by about 20% (Cleland et al. 2012). By reducing unintended pregnancies, FP programs can reduce fertility by an average of about 1.5 children per woman (Ezeh et al. 2012). Sustained decline in fertility helps to reduce child dependency ratios and increase the number of working age people, which can boost investments in human capital and economic productivity if job-creating economic reforms are enacted (Canning and Schultz 2012).

However, despite these known benefits, limited progress has been made in increasing contraceptive use in the region. An estimated 53 million women in SSA who would like to postpone or stop childbearing are not using modern contraceptives (Singh and Darrock 2012). Consequently, SSA exhibits high levels of unintended pregnancies, which contribute to high maternal and child deaths, high fertility and rapid population growth. SSA's population is projected to more than double from 851 million in 2010 to nearly 2 billion in 2050 (United Nations Population Division 2011). This kind of rapid population growth negates socio-economic development and preservation of the environment and natural resources in the region (Mutunga et al. 2012).

Despite the region's general poor performance towards achievement of universal access to family planning envisaged under the 1994 ICPD Program of Action and the MDG Goal 5b, a few countries in Eastern and Southern Africa which have previously had relatively low uptake (namely Ethiopia, Malawi, and Rwanda) have exhibited a new wave of optimism and made good progress in addressing barriers of access to modern contraception over the past decade or so. Use of modern contraceptives increased by 2.7, 2.8, and 7.0, percentage points per year in the past five years in Ethiopia Malawi, and Rwanda, respectively. In Kenya and Tanzania, progress in increasing contraceptive use stalled, but in the past five years this has picked up with annual increases of 1.5 and 1.6 percentage points, respectively (Figures 1 and 2). Lessons on how these countries have achieved such phenomenal progress over a relatively short period of time have not been systematically documented and disseminated.

This report documents policy and program drivers that have propelled the impeccable as well as stalled and seemingly recovered progress in increasing contraceptive use in these countries. Lessons from these countries could galvanize commitment to FP and propel similar progress in other countries in the region. Additionally, the study helps identify key policy and service gaps that need to be addressed for the study countries to achieve universal access to family planning.

Figure 1: Trends in modern contraceptive use in Rwanda, Malawi, Ethiopia, Kenya and Tanzania (around 1990 to around 2010)

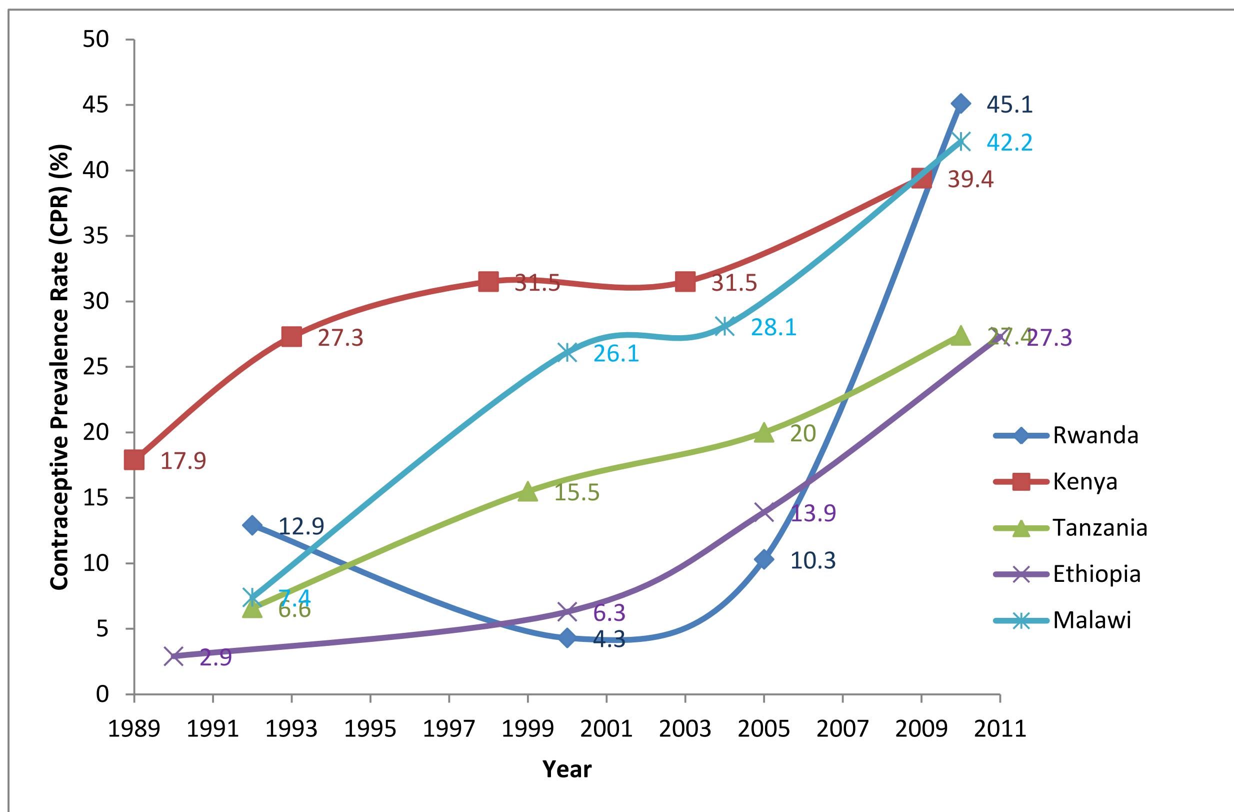
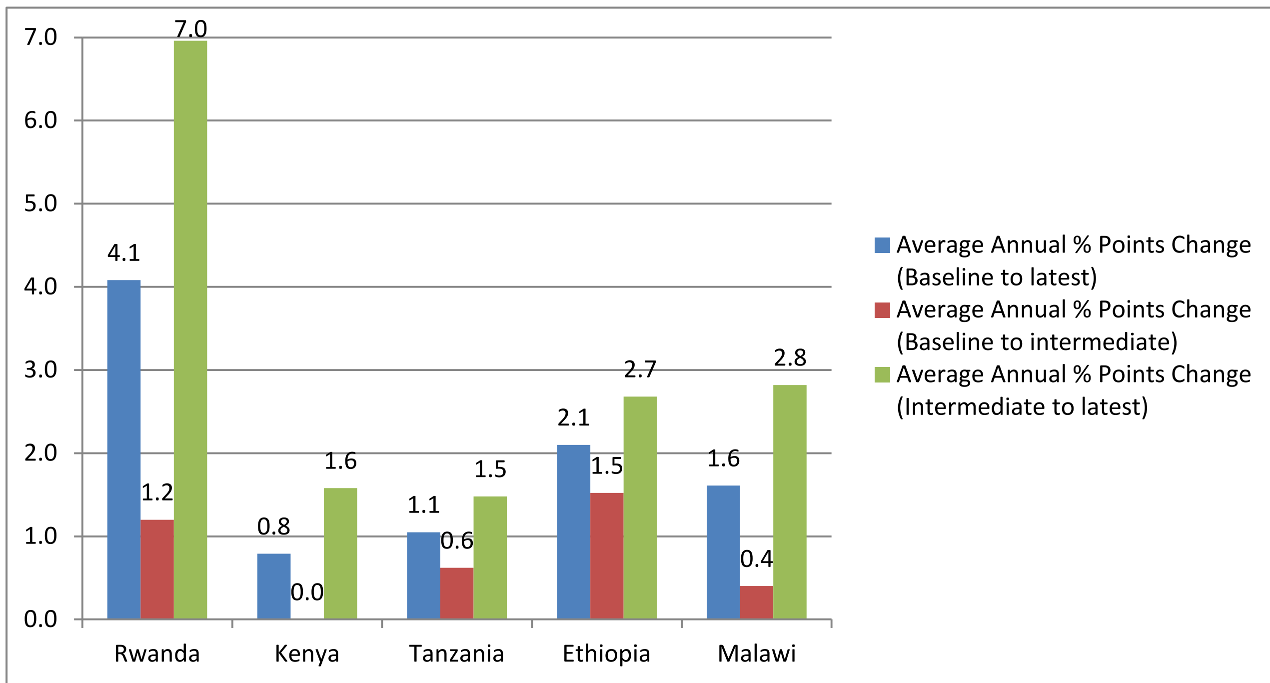


Figure 2: Trends in annual rate of increase of modern contraceptive use in Rwanda, Malawi, Ethiopia, Kenya and Tanzania (around 2000 to around 2010)



PROJECT AIM AND OBJECTIVES

We set out to address the knowledge gaps by systematically examining and documenting the rich experiences and lessons of the success stories, from the reemergence of modern FP uptake in case study countries in East and Southern Africa. It is hoped that lessons learnt will be used to galvanize commitment and support to strengthen FP programs in the region.

The study sought to answer the following questions:

(i) What led to the phenomenal successes in Rwanda, Malawi and Ethiopia?

(ii) What led to the deceleration in modern CPR uptake in Kenya and Tanzania, and further, what led to the recovery in their FP programs in the last 5 years?

(iii) How applicable are country lessons to other less well performing countries in the region?

METHODOLOGY

A triangulation of methods were used to assess the policy, systems and service delivery factors that contributed to the improvements in the FP programs in the 5 study countries. The first component of the study was a review of grey and published literature and policy and program documents in order to understand the nature of policy and program adjustments that the study countries have made to increase contraceptive use over the past two decades (See Appendix 1 for the full list of reviewed policy documents). This included a review of financial resource allocation and expenditure for FP and population issues in the study countries 3. The second component was in-depth key informant interviews with policy makers, development partners, program managers, and civil society stakeholders using a semi-structured tool to gain insights on the factors that played a significant role in the progress of FP programs, as well as explore the challenges experienced, how they were addressed and what measures are being implemented or planned, to ensure sustainability of the recorded progress. (See Appendix 2 for the interview guide)

Key-informants were identified from offices of ministries of health, planning and finance, reproductive health units, non-governmental organizations (NGOs) and civil society organizations (CSOs) involved in RH/FP service delivery and development partners. Interviews were conducted after verbal consent was obtained from all study participants, and interviews were recorded and transcribed. The study team continuously reviewed interview field notes and established specific follow-up questions in subsequent interviews based on key informants' feedback. Further interviewees were identified through snowballing, until data saturation was achieved. Table 1 lists the representation of key informants that took part in the assessment. Notably, fewer interviews were carried out in Kenya. However, the evolution and factors affecting the FP program in Kenya are relatively well documented. (See Appendices 3 to 7 for a comprehensive list of key informants)

Table 1: Key informant representation

Key informants	Rwanda	Malawi	Ethiopia	Tanzania	Kenya
Government – policy makers	11	9	10	11	2
Government – service providers	3	1	-	1	3
Development partners	3	3	5	4	2
International NGOs/private implementers	4	7	11	12	5
Local NGOs/civil society	1	1	2	1	1
Faith-based organizations	1	3	2	2	
Academic institution	-	1	-	1	1
Total	**23**	**25**	**30**	**33**	**14**

In Tanzania, the investigators were invited as non-participatory observers of the Family Planning Technical Working Group (FP TWG) during the field work period. A focus-group discussion was also held with the local FP TWG in Rwanda. Two investigators took elaborate field notes in these fora.

Two investigators conducted a thematic analysis of the field notes and transcripts. Initial descriptive themes were derived according to the interview guide framework and then discussed iteratively among the study team to produce a final set of descriptive themes. Information from literature reviews and emergent descriptive themes were synthesized to identify the key factors that contributed to the successes of the FP programs in the five countries.

FINDINGS

The study revealed that a set of five common and synergistic factors contributed to the success of the FP programs, as depicted in Figure 3. However, they manifested differently in the different countries, based on historical and current contextual circumstances (including political, health, culture, social systems, infrastructure, technical and human resource capacity) and sensitivity of population and FP issues.

The factors are described below:

1. Political will was found to be to be at the centre of the success of the FP programs. Political will is defined as the commitment and support that leaders have and exhibit towards promoting FP. Overall, the origin, manifestation and sustainability of political will is a fluid phenomenon which is largely dependent on, amongst other considerations, sustained evidence-informed advocacy from a number of influential actors (FP advocates).

2. Effective mobilization of financial and technical resources to support implementation of FP programs.

3. A number of health system reforms contributed to health systems strengthening. These include, but are not limited to
   a. health workforce reforms in pre-service and in-service *health worker training* and *task shifting* to address health worker shortages
   b. improved FP commodity *supply chain management*
   c. improved service delivery through *integration of SRH with other services* (particularly HIV services)
   d. increased access of services through *private-public partnerships*

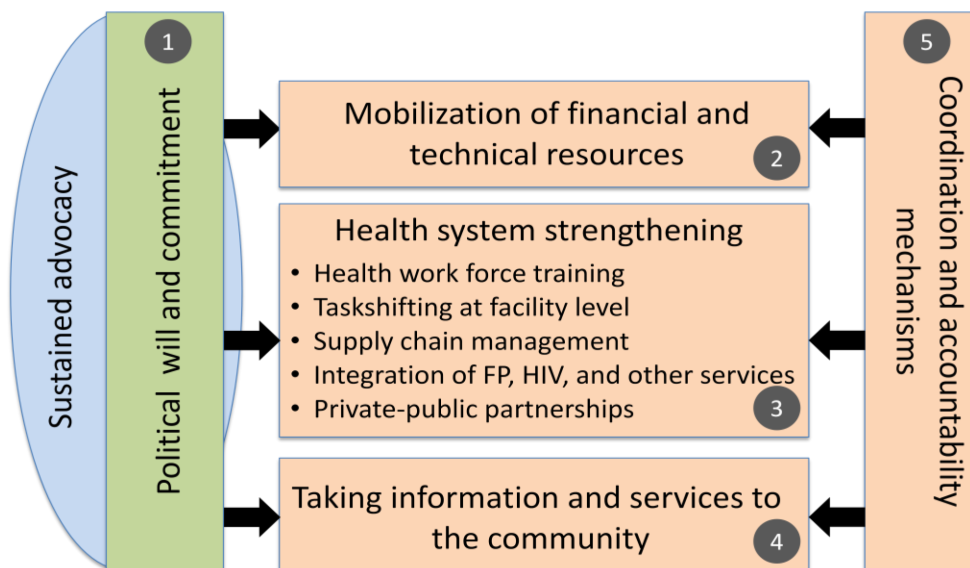
4. Taking information and services to the community in order to address geographical and financial barriers to access.

5. Effective coordination and accountability mechanisms

Although factor 4 (taking information and services to the community) may be strictly categorized as a component of health systems strengthening, it was highlighted in all countries and therefore presented here as a stand-alone factor that merits focused attention.

The relationship between these five factors that contributed to the success of the FP programs is illustrated in Figure 3 below.

Figure 3: Framework describing the policy and programmatic drivers of progress in increasing contraceptive uptake



The drivers of progress of FP programs are discussed on a case-by-case basis using the above framework.

RWANDA

Historical Context of Family Planning in Rwanda

Rwanda is a small, densely populated country. Like many African countries, it has historically had a rapidly growing population, and consequently high population density, high fertility rates and a high dependence ratio, which has been a recurrent concern. Population problems have been a major concern since the colonial times (1900-1962), but the response has varied over time, and prior to the 1994 genocide, various strategies were used to curb high levels of fertility. These included emigration and resettlement to manage the population problem and, later, a gradual interest in family planning programs (May 1996; Tallon 1989). After achieving independence, an emergency development plan (1966-70) was issued. However, the plan underestimated the rate of population growth and failed to put in place measures to address it. The follow-up 1977-81 plan emphasized population as a principal obstacle to development and a policy of reducing growth by spacing births. The plan also promoted research, training, and the delivery of family planning services at all health facilities in Rwanda.

At the end of the 2nd development plan (1981), the National Office of Population (ONAPO) was created to increase awareness of the nation's demographic problems through various types of educational programs and to help the population make informed and responsible family planning decisions. This is when the public sector started participating more effectively in delivery of FP services. The 3rd development plan in 1982-86 was based on the 1978 census which showed a large population size and a higher annual population growth than had been expected (3.7%). The 3rd plan aimed to curb the annual population growth rate by postponing the age at 1st birth and limiting childbearing after age 40. Strategies included passage of needed legislation, making family planning services available, and conducting a vast campaign to make the population aware of demographic problems. The 4th plan (1987-1991) focused on integrating the population policy into planning for economic development. It included a population policy and was based on the need to achieve food self- sufficiency through intensified production and population control. The population policy aimed at reducing the annual population growth rate to 2.0% in 2000, reducing the total fertility rate from 8.5 in 1990 to 4.0 in 2000, and increasing contraceptive prevalence rate (CPR) from 3% in 1987 to 15% in 1991 and 48.4% in 2000. The impetus in developing these goals came from the first application of a model developed by the Futures Group, which was used by ONAPO to understand the links between population and development and to develop projections of population growth and fertility. Other elements of the plan included improving the status of women by legal and other means, territorial management and creation of small rural development centers, public health interventions, and educational and employment initiatives. A community based program was then established to sensitize couples on the problems of demographic growth and the benefits of family planning. Key obstacles that the program sought to address included illiteracy, political and religious opposition, the high infant mortality rate, and the lack of family planning training

By 1992, Rwanda's CPR was still relatively low at 12.9% and barely achieved the target in the 1990 population policy. Following the genocide in 1994, the gains made in the 1980s were reversed with CPR declining to 4.3% in 2000, TFR decreasing from 6.2 to 5.8 children per woman and the population growth rate declining from 3.1% to 1.2% largely due to the human devastation caused by the genocide (Thaxton, 2009). The genocide had resulted in increased poverty, ill-health, and human devastation including displacement of millions of people, a significant reduction in the number of adult men, a large number of orphans, many households without permanent shelter, a reduction in small-scale farming, an increase in the prevalence of AIDS, the loss of human resources and infrastructure, and the emigration of thousands of Rwandans (ibid). Therefore, the impact of the genocide made promotion of FP difficult (Ministry of Health & USAID, 2002). Indeed, the idea of FP was contentious, as demonstrated by the following remark by a key informant:

"*The government was shy to talk about family planning because so many families had lost loved ones.*" – Policy maker

The 2002 census recorded a decline in the population growth rate from 3.1% to 1.2%, however, this was largely as a result of the loss of life and emigration that was experienced during the genocide. Hence, there were still concerns that once the country stabilized, rapid population growth would reemerge as a major impediment to development (Republic of Rwanda, Ministry of Heath 2006). In 2003, under the leadership of the transitional government, ONAPO issued a new National Population Policy which envisaged an integrated approach to addressing population growth by improving health and survival of children and women as incentives for smaller families; providing education and employment; and building an institutional structure that integrates gender, governance, health care, environment, and nutrition (Thaxton 2009). Notably, the policy did not mention FP; the assumption was that improved education and higher levels of wealth would stimulate the demand for and use of contraceptives. Further, in 2003, ONAPO was abolished to avoid duplication of the Health Ministry's own efforts in providing family planning and reproductive health services. ONAPO's scope of work was then transferred to the Ministry of Health and a population desk established at the Ministry of Finance (Solo 2008). Nevertheless, by 2005, Rwanda's CPR had recovered to 10.3% (RDHS, 2005). This initial rise was followed by an unprecedented increase to 45.1% in 2010 at a rate of 4.1 percentage points per year, the highest rate ever in SSA (RDHS, 2010). The total fertility rate (TFR) declined from 6.1 to 4.6 between 2005 and 2010 (Table 2). The population growth rate, which had declined from 3.1% to 1.2% between 1990 and 2002, increased to 2.6% between 2002 and 2012 (Ministry of Finance and Economic Planning, 2005).

The 2010 RDHS estimates show that the most popular FP method is the injectable contraceptives (26.3%), a more than ten-fold increase from 2000 estimates. Unmet need for FP declined to 18.9% in 2010 from 37.9% in 2005 (RDHS 2010). This has been largely attributed to the success of the FP program in meeting a substantial proportion of contraceptive needs.

Table 2: Population, fertility and FP use trends in Rwanda (around 1990 to around 2010)

Year	Population size (millions)	Total fertility rate	Modern Contraceptive Prevalence Rate (%)	Unmet Need for family planning (%)
1992	6.5	6.2	12.9	40.4
2000	8	5.8	4.3	48.8
2005	9.2	6.1	10.3	37.9
2010	10.6	4.6	45.1	38

Data sources: DHS

Population data are from The World Bank, World Development Indicators 2011

The policy, system and service delivery drivers of Rwanda's outstanding progress, as well as challenges in contraceptive uptake in the last 2 decades are described below. Further, the sustainability of these identified drivers is discussed.

Table 3: Chronology of key events related to FP and population policies in Rwanda

Year	Events/Activities	Indicators
1962	Rwanda gained independence from Belgium	
1962	First Family Planning (FP) Program offering modern contraception was established in Butare, Kigali, and Ruhengeri	
1970	Fertility Survey conducted	CPR: TFR: 7.7
1975	UNFPA begins operations in Rwanda	
1977	FP goals to encourage birth spacing also included in five-year plan (1977-1981) for the first time	
1978	Population and housing census conducted	Population: 4 831 527 Density: 191 Growth rate: 3.6%
1981	Prompted by the rise in demographic problems resulting from rapid population growth the National Office of Population (ONAPO) established within the Ministry of Health. Goal was to implement population programs and integrate FP services into all health facilities.	
1983	Fertility survey conducted	CPR:1% TFR: 8.5
1985	A health development strategy based on decentralized management and district-level care is adopted.	
1986	The Association for the Promotion of Family Welfare (*ARBEF*) founded as local member association of International Planned Parenthood Federation (IPPF)	
1990	National Population Policy developed with goals of reducing the population growth rate to 2.0% in 2000, to reduce the total fertility rate from 8.5 in 1990 to 4.0 in 2000, and to increase contraceptive prevalence to 15% in 1991 and 48.4% in 2000	
1991	Population and housing census conducted	Population: 7 157 551 Density: 283 Growth rate: 3.1%
1992	Legal age of marriage increased to 21 years by presidential decree	
1992	Demographic and Health Survey conducted	CPR: 13% TFR: 6.2
1994	Genocide culminating from longstanding ethnic competition and tensions between the minority Tutsi and the majority Hutu people, which resulted in between 500,000 and 1,000,000 deaths	
1999	The government begins to encourage the creation of community-based health insurance schemes/ Mutuelles to promote accessibility of primary health care and community involvement in service delivery.	
2000	Demographic and Health Survey conducted USAID funded program PRIME II assisted the Ministry of Health in building the capacity of primary providers to provide decentralized family planning and reproductive health (FP/RH) services.	CPR: 4% TFR: 5.8
2002	Population and housing census conducted DELIVER Project (implemented by Jon Snow Inc) to improve contraceptive logistics begins Rwandan Parliamentarians' Network for Population and Development (RPRPD) formed	Population: 8,128,553 Density: 321

Year	Events/Activities	Indicators
	PRIME II that provided assistance for prevention of mother-to-child transmission (PMTCT) of HIV services, which included family planning counseling	Growth rate:1.2%
2003	2nd Population Policy issued First National Reproductive Health Policy issued ONAPO closed and its scope of work transferred to the Ministry of Health, and a population desk established at the Ministry of Finance Community health insurance (Mutuelles de santé) introduced. It expanded use of family planning by charging a modest copayment for long-acting and permanent methods.	
2004	PEPFAR funding begins in Rwanda	
2005	Maternal Child Health unit to respond to the issues of higher infant and maternal mortality rates and to the low level of contraceptive use Family Planning Technical Working Group (FPTWG) formed with an aim to improve coordination of FP programs and minimize duplication of effort Twubakane Decentralization and Health Program launched in 12 districts to increase access to and the quality and use of family health services in Rwanda PSI Family Planning program begins, working with private sector and community based distribution RAPID model presented to parliamentarians Scale up of Performance-Based Financing (PBF) in 23 districts National Policy on Condoms approved Government of Rwanda embarks on ambitious territorial and administrative reform to strengthen the decentralized governance and streamline service delivery	CPR: 10% TFR: 6.1
2006	National FP policy and its five-year strategies (2006-2010) produced by MOH District Incentive Funds officially launched to motivate better performance of health facilities through payment for services provided including family planning Performance-based contracts(imihigo) between the president and the 30 district Mayors introduced. They include targets for family planning. Draft Quality Assurance policy developed which includes community-provider partnerships to increase community participation in the planning and management of health care and health care facilities Rwanda Aid policy approved with aim to set clear structures and guidelines for the mobilization and management of external assistance Sector wide approach (SWAP) developed to guide on the priority projects, their implementation, monitoring and evaluation New districts created (the territorial and administrative reform leads to a restructuring that created 30 new districts (previously there were 106 districts)) Initiation of FP secondary posts near Catholic-supported health facilities where clients are referred for modern contraceptive services Capacity Project implemented by IntraHealth International begins support for FP service delivery in 11 districts PSI introduces Confiance, oral contraceptives and three- month injectable	
2007	Government declares FP to be a development priority Line item budget for FP is established Stakeholders organizes a meeting with religious leaders on FP Training of district-level trainers in FP by UNFPA, A draft Law on Family planning developed sponsored by a group of parliamentarians	CPR: 27% TFR: 5.5

Year	Events/Activities	Indicators
2008	Economic Development and Poverty Reduction Strategy, 2008-2012 emphasizes importance of FP and sets target of 70% contraceptive prevalence rate CPR by 2012 and reducing total fertility rate (TFR) to 4.5 children Study tour to Uganda to see community based distribution of DMPA Capacity Project begins on the job training (OJT) for FP in four districts	
2009	FP is repositioned as a national priorty by Preseident Kagame at the Kivu retreat, with senior government and military leaders in attendance Health sector strategic plan July 2009 – June 2012 developed to operationalise the Economic Development and Poverty Reduction Strategy, 2008-2012 in the health sector and to set out a plan for implementation of the policies and programs that had been developed , SWAP is later included in it Development of 3rd population policy in progress (Thaxton 2009)	
2010	Demographic and Health Survey conducted	CPR: 52% TFR: 4.6
2011	Rwanda Family Planning Policy and Family Planning Strategic Plan, both for 2012-2016 developed National Adolescent Sexual & Reproductive Health Policy and Strategic Plan, 2011-2015 developed Scale up of community based distribution of DMPA in three districts Scale up of training of health providers to provide youth friendly SRH services	
2012	Population and housing census conducted	Population: 10,537,222 Density: 416 Growth rate: 2.6%
2013	Private Members Bill in parliament for review - drafted in 2007 and sponsored by a group of parliamentarians seeks to compel the government to ensure there are reproductive health care services at every public health facility	

Adapted from Solo, 2008

1. Political will and commitment: Top level leadership support

A number of drivers have worked in concert to increase contraceptive uptake, particularly in the last 5 years or so. However, what was reiterated by the majority (if not all) of the key informants is that at the central tenet of Rwanda's remarkable progress is the strong support from top level leadership with FP being made a national priority by the President. This explicit adoption of FP as a national priority was the result of persistent advocacy that unequivocally identified Rwanda's rapid population growth as an impediment to the country's socio-economic development. As a result, FP has been prioritised across all government sectors by all levels of leadership, right from the top to bottom level leadership.

His Excellency President Kagame came into power in 2000 as Rwanda's 6th president. Under his leadership, the government spearheaded a pro-poor and pro-development focus with the launch of the country's development blueprint, Vision 2020 in 2000. Vision 2020 has ambitious poverty reduction and economic growth targets in which the health and education sectors are key areas of focus.

The buy-in for prioritization of FP by the President and Prime Minister in 2005 is credited to Dr Jean Damascene Ntawukuriryayo, a renown FP champion in Rwanda who earned the nickname 'Mr Family Planning'. At the time, Dr Ntawukuriryayo, who is currently President of the Senate, was the Minister of Health. Further, in his capacity as President of the Rwandan Parliamentarians' Network on Population and Development (RPRPD), which was established in 2003 as a parliamentary way to implement the ICPD Plan of Action Dr Ntawukuriryayo sought to convince his colleagues and fellow leaders, including Parliamentarians, about the role of FP in supporting sustainable socio-economic development.

"We could not develop into a middle income country without addressing the issue of rapid population growth."– His Excellency President of the Senate

A significant advocacy tool that was presented to Parliamentarians in 2005 was Futures Group's RAPID model which illustrates projections of the social and economic consequences of high fertility and population growth for various sectors including education and health. The importance of providing FP services as a rationale for nationall; development found strong support at the top leadership level of the government.

"After the genocide it wasn't clear that population was a challenge. In the minds of politicians, population is power. It is an economic asset. There was a need to sensitize other politicians and policymakers and to be prudent in policy speech when survivors wanted to get families." – Member of Parliament and FP TWG Member

By 2007, President Kagame was explicitly promoting FP as evidenced by the following excerpt taken from Solo 2008.

"Family planning is priority number one—not just talking about it, but implementing it." - President Paul Kagame, November 2007 (Solo 2008)

The acknowledgement of FP's role in the country's development was sealed in the update of Rwanda's Economic Development Poverty Reduction Strategy (EDPRS) (2008-2012) which guides Rwanda's medium-term development ambitions from 2008-2012. Further, FP was reinforced as a priority on Rwanda's *development* agenda at the 2009 Kivu retreat, a forum where senior government including the President and military leaders converge to dialogue on the country's vision and formulate the activities to support the development process. This event reinforced a common vision of FP prioritization to meet the country's development goals at all levels of leadership, and across different sectors of government .

Paul Kagames explicit promotion of FP, the inclusion of FP as a priority on the development agenda and the multisectoral approach towards its implementation were key strategies that have been attributed to the phenomenal progress in increasing contraceptive use in Rwanda.

Indeed, in her work on the progress in increasing FP in Rwanda, Solo found that citizens of Rwanda may have a high propensity to listen to authority as demonstrated by the following excerpt from her writings (Solo 2008).

"Rwanda is a bit different from other countries as far as coordination—when a decision is taken at the central level it goes quickly to lower levels. That is why we wanted the president to say something."

A statement corroborated by one of our key informant in Rwanda.

1.1. Enabling policy and programme environment

Political will in Rwanda has invariably resulted in an enabling policy environment to improve contraceptive uptake. In the aftermath of the genocide, FP was underemphasized and was even excluded from the 2nd population policy developed in 2003. However the issuance of the National Reproductive Health Policy developed in 2003 still provided an enabling environment for FP service provision especially given that FP was included as one of the six key elements to be addressed. Thereafter, the government formulated the National Family Planning Policy (NFPP) (2006–2010) and required all ministries to develop action plans for addressing population issues in their respective sectors towards a multisectoral approach to improving the quality of and access to family planning (Pandit-Rajani, Sharma, and Muramutsa. 2010). The updated National FP Policy and its'five year strategy (2011-2016) sets out to increase access to a wider range of long term FP methods, including vasectomy.

The inclusion of FP as a target in Rwanda's Economic Development Poverty Reduction Strategy (EDPRS) (2008-2012) indicates a turning point towards prioritization of FP in Rwanda. Population growth is a dominant theme in the poverty reduction strategy, and slowing the rate of population growth through increasing CPR to 70% by 2012 is included as a strategy. Moreover, the indicators and targets for population growth and fertility rates are aligned to the achievement of the MDGs. The latest revision of the population policy (2010), which is still in draft, focuses on meeting the targets set out in the EDPRS by 2014 and includes a costed implementation plan. Further, Rwanda's Health Sector Strategic Plan II (2009-2012) (HSSP II), which operationalizes health sector initiatives, was updated to reflect new priorities in alignment with the EDPRS (2008–2012) (Government of Rwanda, Ministry of Health, 2009).

In 2003, Community health insurance (Mutuelles de santé), which covers basic health services for enrollees, also expanded use of family planning by charging a modest copayment for long-acting and permanent methods (Priya and Humuza, 2010). In 2006, clinical performance-based funding (PBF) was initiated. PBF provides bonus payments to districts and health centers through an assessment of various types of utilization and quality of care including FP. The program consists of a performance-based contract signed by local administrative authorities and is a mechanism that rewards output on various indicators including FP (ibid). In 2008, the Ministry of Health (MOH) introduced a policy on community health workers (CHW) to improve access to and utilization of maternal and child health services (ibid). In 2009, MOH issued guidelines for community-based distribution of injectable contraceptives, the most popular contraceptive method (ibid). Inspired by the success of clinical performance-based funding (PFB), MOH initiated the community PBF (CPBF) as a way to motivate CHW and at the same time introduced a demand-side incentive strategy to increase utilization of maternal and child health services and FP among other key health services (WHO, 2011; Priya, and Humuza, 2010). To increase access to a wider range of long term FP methods the Commodity Security Strategy (2005-2010) was launched. In 2007, to ensure dedicated funds for FP commodities, a line item in the government budget for contraceptives was established.

2. Mobilization of financial and technical resources: coordination of donor and government FP programmes

Crucially, political will in Rwanda has facilitated significant financial and human resource commitment. Given that the health budget has direct implications on funding for RH and FP programs, it is important to note that the government has met and exceeded the Abuja target, with about 17% of the budget allocated to health. As FP is one of the key priorities to be addressed during HSSPII, funding for FP is prioritized in the health sector.

"Budget is not an issue as family planning is a key priority for the government of Rwanda. The government has 17% of the budget allocated to health." – Ministry of Health

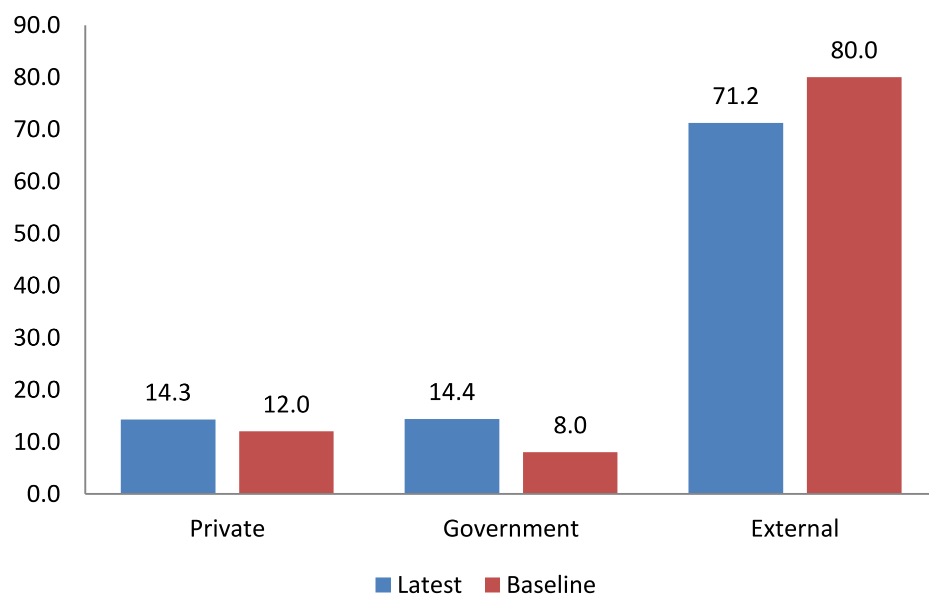
The FP budget has increased tremendously since the early 2000s. Between 2004 and 2007, the budget increased six -fold, rising from 91,231 USD to 5,742,112 USD (Ministry of Health 2009). In 2007, a budget line item for contraceptives was established (Solo J 2008). The inclusion of long-term and permanent FP methods on the essential medicines list also increased the supply of a range of methods at a subsidized cost.

However, the sustainability of funding the FP Program is an apparent challenge, which was disregarded by some key informants. Figure 4 illustrates that between 2002 and 2006 there was a reduction in government input by almost a half to 8% of the RH budget, with a simultaneous increment in development partners/donors input to 80% of the RH budget. A key informant noted that in 2009, about US$ 500,000 was allocated by the government of Rwanda for FP commodities. This reportedly rose to about US$ 650,000 in 2011. In the same year (2011) USA allocated US$ 5 Million to Rwanda, making the government contribution about 13% relative to the USA. In addition to direct funding, development partners also provide off-budget support to a number of FP programs/services.

There is a high cost of implementation of FP programs, including training of pre-service and in-service health workers. Despite this commendable external support for FP, there is concern that overreliance on this external support could potentially jeopardize the sustainability of Rwanda's FP programs and consequently decelerate the recently recorded phenomenal increase in FP uptake. Sustainability of FP services and commodities funding is therefore a pressing issue. However, there is a common view that so long as donors are willing to fund FP programs, Rwanda can prioritize its limited domestically-sourced resources to fund other equally important national priorities, but should funders pull out, the government of Rwanda is ready to step in and provide the needed financial support for the program.

Notably, a number of guiding policies have emerged to maximize funding and increase access to FP services and products, including the Joint Action Work plan which lists RH as a priority area and the health Sector Wide Approach (SWAp), which pools funds from various sources which are allocated based on government priority.

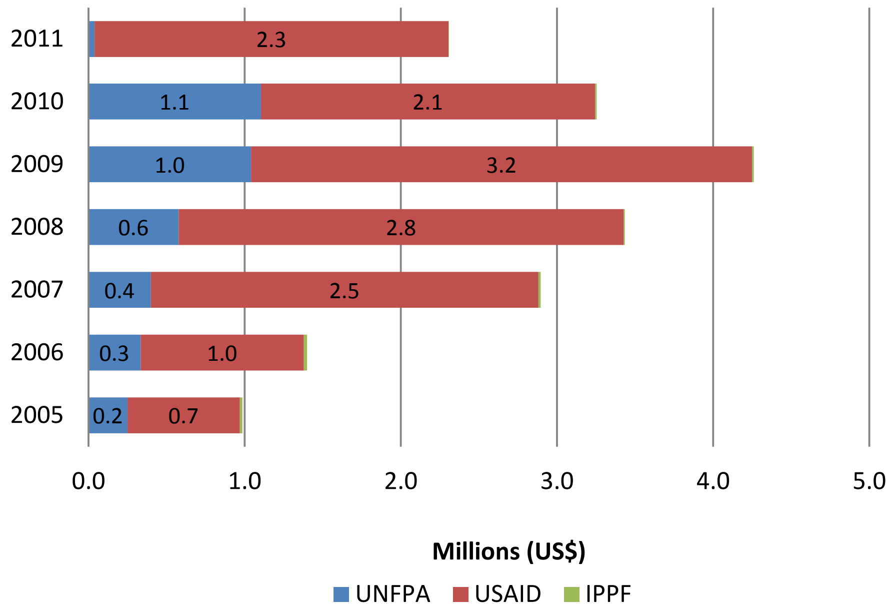
Figure 4: Sources of RH funding, Rwanda



Baseline: Rwanda (2002)
Latest: Rwanda (2006)
Data Source: National Health Accounts

USAID, UNFPA and IPPF have continued to provide major support for contraceptives to Rwanda's public sector (Figure 5). Funding trends reveal that since 2005, the focus has been towards procurement of injectables and implants.

Figure 5: Donor contributions to public sector contraceptives, 2005-2011



Data Source: RHInterchange, April 2012

3. Health system strengthening

The phenomenal increase in FP uptake has not occurred in isolation but rather in a culmination of several initiatives which have contributed to the holistic strengthening of the entire health system in Rwanda and have invariably contributed to increased FP uptake, including improved supply chain management and pre-service and in-service training and are discussed in this section.

3.1. Supply chain management

The increased public awareness on the benefits of FP has created a high demand for FP commodities, making commodity security of great importance. Rwanda's Commodity Security Strategy (2005-2010) and the management of the supply chain by the Logistics Committee, which includes membership from the MOH, donors, NGOs, and private sector organizations ensures increased access to a wider range of long term FP methods.

The FP commodity market in Rwanda is segmented into 3: public, private and social-marketing. FP services and commodities are provided free to the public in government health facilities. The government service, which has partner support, particularly from John Snow Inc. (JSI) (implementers of the USAID DELIVER Project), is coordinated by the Reproductive Health Logistics Committee, which meets quarterly and is chaired by the MOH's Maternal and Child Health director. The Committee coordinates annual quantification exercises to estimate consumption and budget needs for the

next 3 years based on projections from 3 data sources: (i) historic utilization/consumption and estimated need of FP commodities (including FP method mix), (ii) morbidity data from services and (iii) demographic data, and thereafter calculate the required budget. Consumption data is reviewed quarterly to ensure that supplies are adequate.

The main donors for FP commodities are UNFPA, Global Fund, USAID, German GIZ and the Rwandan government. The RBC/Medical procurement and Distribution Division (formerly known as CAMERWA) procures and distributes FP commodities to warehouses in the 30 District Pharmacies. FP commodities are thereafter supplied to health centers and health posts based on requisitions made to the respective District Pharmacies. Notably, the absence, and only in a few instances very low frequencies of stock outs (estimated at <5% at Health Centre level) is a testament to commodity security in Rwanda. One key informant noted that the Rwandan supply chain system is one of the strongest in Africa (USAID DELIVER Personal communication). This has been corroborated in other studies (Kohler, J, Fidele N, Andrew M, Kimberly S, Laurel H, 2012). By 2008, the distribution of family planning commodities reached 96% of health facilities and 92% of district hospitals. Likewise, access to condoms was increased by making them more available in public areas and workplaces, as well as in family planning clinics and health facilities. This is attributed to an efficient Health Management Information System with a 90% reporting rate at health facility level and 100% at district level, and a defined inventory control system that controls maximum and minimum stock levels at central, district and health facility level. The RBC/Medical Procurement and Distribution Division use a logistics management software (SAGE Line 500), which monitors requested and distributed FP commodities at the district level in one tool. Health centers and health posts report consumption data monthly to the district level, which aggregates all data at the central/national level.

"The motto we go by is no family planning product, no family planning program"– Development Partner

In addition to public provision of FP, there are 2 other market segments for FP provision in Rwanda; Population services international (PSI) and the private sectors (clinics and pharmacies). PSI is a social marketing implementer and provides FP products at a cost, but provides generic condoms for free, and branded condoms at a cost. Further, the government has signed an MOU with private institutions (clinics and pharmacies); under this MOU the private institutions provide FP commodities sourced from District pharmacies for free, but charge a user fee.

"There is no wholesaler who imports FP commodities in bulk. All providers including private clinics order them from District Pharmacies for free, and they also report to the District Pharmacy. They give free contraceptives, except they charge consultation fee, for injection, for insertion of the IUD."–USAID DELIVER Project

The decline in unmet need for FP from 38% in 2005 to 19% in 2010 demonstrates the success in meeting a large portion of the contraceptive needs of Rwandans.

3.2. Human resource capacity strengthening

In line with the national prioritization of FP, health worker training programs in Rwanda addresses SRH/FP with pre-service training on SRH/FP having been integrated in the Doctors, Nurses and Pharmacists training curricula. Health workers are further kept up to date through regular in-service training in order to ensure that FP service provision is sustainable.

In 2005, a nationwide rollout of FP training as part of the *Twubakane* program, district-level trainers provided ongoing training, post-training follow-up in long-acting methods and supportive supervision in order to ensure that all Health Centers are able to offer a long-acting methods (IUDs and implants). Prior to 2006, FP clients had to go to district

hospitals to receive long-acting contraceptive methods. The Rwandan MOH was working in collaboration with partners to provide nationwide in-service training to health workers at health facility level on provision of long-acting contraceptive methods (June 2011 to June 2012). The training model took a cascading training-of-trainers approach, which involves training a team of health service providers at national level, who then train a group of providers at district level, who in turn train a group of providers at the community level. The aim is to have two health providers at each facility that can ably provide long term methods, including implants and IUDs. At the time that AFIDEP conducted the key informant interviews in Rwanda, 17 out of 30 districts had been reached.

Since 2010, the MOH in collaboration with partners began training Community Health Workers (CHWs) in community based distribution of family planning commodities (pills, condoms, injectables and standard Days Method). Allowing CHWs to administer injectables, which are the most popular form of contraception (26.3% in 2010) has increased access to a wider range of contraceptives. Nurses can administer all FP commodities except for sterilization methods (vasectomy and tubal ligation). However, high staff turnover presents a significant challenge in the provision of consistent and timely training in accordance with health facility needs.

"All health workers are trained on FP, including pharmacists. But the high staff turnover of health workers is a challenge. When they move, their replacement needs training." – Ministry of Health

3.3. Community Health Insurance

Community health insurance (Mutuelles de santé) is another important enabling factor for expanding use of family planning because it covers basic health services for enrollees and charges a modest copayment for long-acting and permanent methods (other methods are free) (PriyaE and Humuza J, 2010). After a successful pilot between 1999 and 2003, a law was passed in 2007, establishing a national legal framework for mutual health insurance. Health insurance became mandatory for all citizens of Rwanda. Enrollment in community health insurance has grown from 3% of the population in 2003, when the insurance was first introduced, to 92% in 2012 (Kohler et al 2012). A qualitative assessment conducted in 2011 to investigate the impact of mutuelles de santé on family planning uptake revealed that most respondents felt that expansion of health insurance in Rwanda had increased access to and use of health services generally, which resulted in improved attitudes about and use of family planning services (ibid). Further, the strong contraceptive commodity logistics system, with few to no stock-outs in health facilities, was seen as a major contributing factor to women's ability to access family planning services on demand (ibid). Provider engagement and training also contributed to high family planning uptake by preparing health care workers to provide family planning and providing incentives for family planning provision.

3.4. Performance-based financing

Performance-based financing (PBF), were introduced during HSSP I (2005-2009) and the Family Planning Policy Strategy (2006-2010). PBF is an incentive to enhance and maintain quality of care provided by health workers at all levels of the health system. It provides financing to districts and health centers through an assessment of results including family planning indicators. The program consists of a performance-based contract signed between the presidency and district mayors (*Imihigo*) that included an indicator on family planning. The indicator to measure progress in family planning is the number of new users of family planning.

"Targets are based on what the Mayor pledges and hence from needs of the community. MOH has targets and indicators and gives guidelines. We assess the needs of the community" District Administrator

According to the MOH 2008 annual report, the average number of new users per health facility grew from about 18 in 2006, when PBF was started, to 60 by 2008. In 2009, the MOH expanded PBF to the community level to provide an incentive for CHWs to produce and improve results. However, Community PBF does not reward individual CHWs but rather provides financial support to cooperatives established by the CHWs to develop alternative sources of income.

To allay fears of coercion, a USAID-funded assessment was conducted in 2005 and concluded that Rwanda's PBF incentives around family planning do not violate U.S. legislation designed to ensure that family planning is completely voluntary and women are well educated about both risks and benefits of any contraceptive method available (Kohler, J, Fidele N, Andrew M, Kimberly S, Laurel H, 2012). Rwanda's PBF program sets no numerical goals for individual providers, and facility-level goals appeared to be used primarily for planning purposes (ibid). Financial incentives are not based on individual care providers' promotion of family planning or reaching pre-determined targets (ibid). Further, the assessment found no evidence of facilities paying incentives, bribes, or gratuities to patients for use of family planning (ibid). The assessment recommended coordination with the Government of Rwanda (GOR) and other donors to ensure that programs remain voluntary and that voluntarism is emphasized in communications (ibid). Indeed, a key informant from the MOH assured that there are checks in place to ensure no coercion occurs.

3.5. Integration of FP and other services

Since 2007, there has been a drive to integrate FP into other services including HIV, immunization, maternal and child health including post-abortion care in order to expand client access to FP services (Nzabonimpa 2011). A sub-committee of the FPTWG and HIV TWG was created to develop guidelines and tools and oversee implementation (Nzabonimpa 2012). Implementation involves multisectoral participation by social cluster ministries and affiliate institutions and use of FP champions at all levels (ibid). Provincial and district administrators are also continuously sensitized about the importance of integration. The strategy is being implemented using a 3 pronged approach that includes: i) Integration of HIV messages into all MCH documents (policies, protocols, manuals, norms, etc.); ii) Integration of FP indicators into HIV tools; iii) Integration of FP, MCH, HIV, Immunization and Nutrition activities (Nzabonimpa 2011). By 2011, the MOH had trained health service providers in all 30 districts to integrate FP into other services (MOH 2010). An assessment of 5 model sites was carried out in 2011 followed by an evaluation of integration in 10 districts (Nzabonimpa 2012). The assessment found that progress is being hampered by several challenges. In particular, there is need to intensify efforts at community and health facility level. There are financial and human resource constraints. Young people including school going youth and cross generational relationships are difficult to reach. Therefore, the need for continuous advocacy for integration at national, regional and international levels persists.

3.6. Decentralization of FP services

Decentralization began in 2005. The rise in use of modern contraceptives in Rwanda was partly attributed to the *Twubakane* Decentralization and Health Program (2005-2009), which has been a key part of the health system reform process, and aims to ensure increased access of more effective, quality health services at the community level (Muhoza, Rutayisire, and Umubyeyi, 2013). By bringing services closer to the community level, decentralization has encouraged community participation in family planning (ibid). The extension of family planning provision to communities through the direct involvement of community members has also been important for winning the support of men and other family members, in addition to women (ibid). It also permits a strong partnership with religious and traditional leaders, whose support is valuable for the success of the program. For instance, our key informant interviews found that District Mayors in regions with predominantly Catholic health facilities and low contraceptive use (e.g Western Rwanda) are involved in FP advocacy efforts to convince religious leaders to increase support for FP.

4. Taking information and services to the community

4.1. Task shifting and demedicalization of contraceptives

The government addressed limitations in geographical access to FP at the community level by tackling the limited human resource capacity through task shifting and demedicalization of contraceptives. The Community Health Policy developed in 2008, guides community health initiatives in Rwanda. According to the policy, the role of community health is to increase access and health-seeking behavior so that services —go beyond the self-selected population that shows up at the health centres (Priya, and Humuza, 2010). Family planning services are framed in the context of reducing maternal morbidity and mortality, therefore CHWs offer information about child spacing and modern methods of contraception. Community Health Workers (CHWs) were deployed at the village (*Umugundu*) level, Rwanda's lowest administrative region and were initially trained to monitor growth and development in children, provide care for people living with HIV, and to refer patients to the nearest health facility. Each village (100 to 150 households) elects 4 volunteers to act as CHWs. CHWs have 2 supervisors at the higher administrative level (the cell level), who jointly oversee 10 villages. Overall supervision is at the Health Centre level, and at the District level by a Technical Team of supervisors. There were about 60,000 CHWs in 2011, up from 45,000 in 2005 (when decentralization occurred), which was in turn up from 12,000 in 1995.

Prior to 2009, CHWs were permitted to distribute only condoms and pills and provide referrals for other methods including injectables, implants, IUDs and permanent. In 2009, a policy change allowed them to provide injectable contraceptives after a study tour to Uganda. The need to establish the program was prompted by the need to increase access to longer acting methods and in particular the most popular method of contraceptives in Rwanda, the injectables contraceptives, so as to accelerate attainment of the goals in the HSSPII and EDPRS. CHWs provide FP information and services as part of their Preventative Services program, which is 1 of 5 programs (in addition to curative, promotion, community-health management information systems (C-HMIS) & community-performance based financing (C-PBF) and cooperatives). Importantly, CHWs work hand in hand with the local traditional authority, the Village Chief, to increase contraceptive use through community sensitization.

CHWs obtain FP commodities from Health Centres. The FP method, however, must be initiated by a health worker in the Health Centre or Hospital. At the time of writing this report, CHWs were in the first phase of training in 3 districts. The Rwandan government recognizes the impact of CHWs who can administer injectables which are the most popular form of contraception and the MoH therefore plans to expand trained CHWs to 17 districts by June 2012, and scale up nationwide in June 2013. More than 3,000 community health workers have been trained and more than 3,600 clients have received a contraceptive method. 41% of those clients received injectable contraception. The CBD program is evaluated by the FP TWG bi-annually.

In addition, nurses can initiate any new users of oral contraceptives and injectables as well as insert IUDs and implants; doctors previously inserted IUDs and implants (Kohler et al 2012). Doctors conduct for any sterilization procedures (ibid). Some doctors perform "outreach" by visiting health centers for a period to perform sterilization procedures within the health center (visiting providers bring the necessary supplies for the procedure from their home facility) (ibid).

4.2. Demand creation: engagement of community leaders and religious leaders and use of monthly community meetings

In the aftermath of the genocide, the 2000 RDHS revealed a significant decline in contraceptive use. This prompted the MOH to commission a qualitative assessment in 2002 to identify major barriers and opportunities for delivering FP information and services in the country (Ministry of Rwanda and USAID, 2002). A number of reasons emerged for none use of contraceptives including: poverty; socio-cultural and religious influences; inadequate information, counseling and service on family planning; impact of the Genocide. The assessment found that FP would be more acceptable if promoted in the context of improved maternal and child health and quality of life and that opportunities for multisectoral implementation of the FP program existed.

By 2007, efforts to increase awareness of the benefits of contraceptive use appear to have taken root with a recorded more than 6-fold increase in CPR to 27% from the 1992 value. Since prioritization of FP in between 2005 and 2007, an intensive public education campaign was launched which focused on the importance of having fewer children, with longer birth intervals, as an imperative way to reduce national population growth and poverty (Muhoza, Rutayisire, and Umubyeyi, 2013). All key personnel and leaders including local administrators and RALGA members, all public health sector personnel, secondary school teachers, and journalists were trained on these issues ((Muhoza, Rutayisire, and Umubyeyi, 2013; Rwanda Ministry of Health 2006). The Rwandan Parliamentarians' Network on Population and Development (RPRPD), created in 2003, has also played a key role. Various channels used included television and radio, monthly talks after Umuganda, opinion leaders sensitized, etc (Muhoza, Rutayisire, and Umubyeyi, 2013). In addition, the fact that FP services are free in public facilities removed the cost barrier to use.

The MOH works with the Rwanda Association of Local Government Authorities (RALGA) to educate communities about FP. The community service day (*Umuganda*) administered by RALGA to mobilize communities to discuss important community issues is used as a key forum for promoting FP. Community Health Workers (CHWs) attend the meetings on a monthly basis to sensitize communities on health issues including FP issue. Parliamentarians also participate in *Umuganda* fora to communicate with the public on various issues, including FP. Umuganda has also been an important forum for addressing the negative attitudes about contraceptive use that is prevalent among men in Rwanda as well as the widespread preference for large families. In addition, to increase male involvement, the MOH is emphasizing couples counselling even though a woman does not need consent from her husband to obtain contraceptive services (Kohler, J, Fidele N, Andrew M, Kimberly S, Laurel H, 2012).

"*All members of the community 18-65 yrs are supposed to attend the Umuganda. The chair of the Umuganda has data on all residents. All residents are supposed to be registered. Umuganda has a local technical committee. Not perfect just recently institutionalized - 5 months ago. There is a penalty of not more than 5000 francs a day. Community discussions last 3 hours – 2 hours presentations + 1 hour to discuss local issues…..sometimes we have technical issues and because we don't have experts we work closely with the MOH*" District Administrator

Over half of Rwandese people are Catholics and a significant proportion (40% in 2001) of public health facilities in Rwanda is faith-based, majority of which are Catholic (Muhoza, Rutayisire, and Umubyeyi, 2013;). Consequently, FP promotion in Rwanda was strongly opposed in the early years of the program. Therefore, sensitization of religious leaders on FP and development issues has been a crucial component of the strategy for increasing use of contraceptives in Rwanda. Efforts culminated in 2007, with the organization of a major conference that was attended by 250 senior religious leaders (Catholic, Protestant, Anglican, Evangelical and Muslim) and which resulted in a signed common

declaration of support for FP and HIV prevention policies. The two clauses agreed on were that (i) child spacing of 3-5 years apart reduces maternal and child mortality (ii) Contraceptive use should not be opposed (PSI 2012).

RPRPD has also consistently advocated to heads of the Catholic Church, which culminated in the signing of an MOU between the religious leaders and the government in 2009, to support women to plan their families. Whilst Catholic health facilities do not provide modern contraceptives, they serve as an important point of information and referral for those wishing to access them. The government established a series of secondary health posts in areas adjacent to the Catholic health facilities, to provide modern contraceptive methods to community members referred from the Catholic facilities..

"Religious leaders and faith based organizations; churches signed an MOU with government of Rwanda to support women to plan their families" - Ministry of Health

"With the creation of secondary spots, accessibility to FP services has been increased" - Ministry of Health

The establishment of performance incentives in the form of performance contracts between H.E. President Kagame and the 30 District Mayors (locally known as *Imihigo*) in 2006 represents a unique feature of Rwanda's commitment to the FP policy. Health indicators in the performance contracts include use of modern FP methods, therefore making the 30 District Mayors FP champions in their respective districts. An official order from the president requires local authorities to mention reproductive health every time they address their constituencies.

"Mayors discuss about population"- Ministry of Health

"There is political commitment on the country's vision for development and reducing population growth, from top level leadership to the grass roots where one person in the village committee of five people, the Umudugudu, is in charge of family planning promotion. The District Mayor reports directly to the President who chairs the annual evaluation of the Imihigo" – Donor

"*We talk about the dangers of having big families and encourage no more than 3 children. We talk to them about having children they are able to look after and that the country can support. We give practical examples to promote FP*" - District Administrator

Further, a number of key informants highlighted the existence of informal family contracts between families and the local leadership which aims to enhance personal responsibility for FP uptake at the family level. This is therefore a key public sensitization platform on the link between FP and the country's economic and social development as the public is informed about population growth and quality of life by authorities at all levels.

A number of key informants also highlighted Rwanda's unique feature as a post-conflict country that is determined to move forward, and establish itself as a middle income country, with this goal resonating not only across all levels of leadership but also the community at large. There is a view that the common language and culture facilitates a collective effort towards the enactment of this common vision. Further, there is a view that the Rwandese people also have respect for hierarchy and all levels of leadership, such that decisions made at various levels – community, regional and national – are followed. Consequently, the common vision for development and the use of FP as a central tool to development has been embraced nationwide. Futher, community concerns with FP are also considered during development of District plans.

"Community Health Workers and the Village Chief work together. Respect of hierarchy is part of the culture. If the Chief speaks, people listen." –FP TWG Member

"*The population has confidence in leadership*"- District administrator

"Planning is a bottom up approach. It is done through the local administration. At the village level people sit and talk about the issues. As well as at cell level and sector level"- District Administrator

5. Coordination and accountability mechanisms

There are a number of fora to ensure donor coordination including the monthly Development Partner Group meeting, the Sector Wide Approach (SWAp), the Joint Action Development Forum which coordinates development interventions at district level, the Reproductive Health Logistics Committee, the Maternal and Child Health Technical Working Group (TWG), the Adolescent RH TWG etc.

To ensure effective coordination of all government and non-government stakeholders in SRH/FP, the government initiated the FPTWG in 2005. The aim of this forum is to minimize duplication of efforts by creating a platform for multiple stakeholders (government, development partners, NGOs, private sector) to jointly make implementation decisions.

"*Through the FP TWG, MOH shares its action plan with partners. Partners determine how they can assist the MOH to achieve its goals. MOH then covers the gaps*"- Ministry of Health

Rwanda has an Aid Coordination Policy (2006) that guides donor contributions in line with the government's development priorities and agenda. This unique arrangement with Rwanda is agreeable and supported by donors as there is compelling, strong evidence of Rwanda's accountability, governance and progress.

"In Rwanda, every dollar in aid money is accounted for."- Ministry of Health

In fact, there are examples of development partners/implementers who have been asked to leave Rwanda for failing to follow the country's prescribed agenda.

"*Many NGOs who do not align with the government are leaving*" - Ministry of Health

Challenges and long term sustainability for FP uptake in Rwanda

Despite the phenomenal progress made, Rwanda faces a number of challenges moving forwards given the ambitious CPR target yet to be achieved. A point of consideration is financing for FP. Currently, Rwanda's FP program is heavily depended on donor support. However, lessons from Kenya demonstrate how this overreliance can lead to a crippling of the FP program in the likely event donor support substantially diminishes. Rwanda is unique in that it has in place a community health insurance programs with 90% coverage through which users have access to FP and make nominal contributions. The government should consider building on this structure to identify how government and citizens could contribute more in the near term and contribute towards the full cost in a pre-determined time-span. Research shows

that as more couples choose to determine the timing, spacing and number of their children, more will be willing to pay for the service.

"The concern about sustainability [of the FP Program] is short term... When people are convinced, they will want to spend money on FP commodities."– Local NGO

In addition, various programmatic and service delivery challenges need to be addressed to accelerate the progress in Rwanda. Despite ensuring a wide range of contraceptives accessible to people, provision of long acting and permanent methods remains lower than expected predominantly due to lack of practical skills-building during pre-service training. The Ministry is aware of this challenge and is working with the UNFPA and other family planning partners to update the training to include a practical element. A challenge noted by the UNFPA representative is that clinics do not always see sufficient patients requesting long-term methods for each clinician-in-training to receive necessary experience for certification. In the event that clinicians are not able to finish the requisite service delivery during the training program, clinicians can call on District-level trainers to supervise service delivery at their home facilities when a client presents requesting a long-term method. This was not seen as a significant barrier to service delivery, as the District-level trainers are very accessible.

In addition, the increasing numbers of CHWs puts increasing demands on their supervisors who have other roles, thus increasing supervision intervals up from 1 month. CHWs generally have a minimal education (they can read and write), therefore they require adequate training and support, which is expensive. Also CHWs are volunteers, and although there are performance indicators to track and reward their performance through the cooperative system, their low level of education is generally matched with weak financial management skills, which may hamper their motivation. High logistical support to meet CHW needs and strengthen the functionality of cooperatives is therefore a challenge. There have been successful performance incentives such as the gathering that H.E. President Kagame presided over to boost their motivation and underscore their value towards maintaining the health of the nation. Another challenge is that CHWs target adults. Historically it has been taboo for youth to access FP. This CHW program therefore excludes sexually active youth who need FP.

Until 2008, emphasis on youth SRHR was weak. In 2008, the National RH Policy included youth SRHR as one of the strategies but it was not implemented. In 2009, a desk was established in the MOH following a UN meeting that emphasized the need to ensure youth SRHR. Now, the Ministry of Youth has norms and standards for FP, HIV counseling and testing, which have culminated in the provision of youth-friendly services. The Adolescent Sexual Reproductive Health and Rights Policy and National Strategy were finalized in October 2011 pending parliament approval. By then the MOH had also embarked on training health workers to provide services to youth. At the time AFIDEP conducted the study, training had been completed in 25 health facilities with national scale up planned. NGOs specializing in youth friendly service provision such as Population Services International (PSI) are supporting the government. Further, the MOH is closely working with the Ministry of Education who are finalizing a new policy on school health which will include RH. Sexuality education is already provided in schools; the new policy will incorporate RH into the curriculum.

Despite efforts to sensitize men on the benefits of FP, the challenge of negative attitudes about contraceptives among men and preference for larger families still persist. Given that traditionally men in Rwanda are the decision makers in the household, this has an impact on contraceptive use and presents a challenge for married women who would like to use. One of the strategies of the government of Rwanda is to invest in education – *'Free education for all'* – to curb the impact of these beliefs and norms, on the basis that a more educated population is more likely to opt to use FP.

Conclusion

Rwanda represents a success story in Africa. The phenomenal progress seen in Rwanda is a first in SSA. Countries in SSA can take lessons from Rwanda. In addition to explicit top level support for FP, Rwanda has implemented key reforms that have had broad benefits to the health sector including FP service provision. The key programmatic changes that have contributed to the success of the FP program in Rwanda include, the performance based incentives including performance contracts between Mayors and the president to achieve FP goals, community health insurance and secondary posts adjacent to Catholic health facilities have been. The 60,000 CHWs, despite just recently being allowed to provide injectables, have been instrumental in creating demand for all FP methods. The use of the monthly community service meetings (Umuganda) has also been a major contributor to increasing demand and addressing socio-cultural beliefs about FP. To sustain progress, Rwanda needs to improve access and use among young people and men, enhance the capacity of the health system to provide long acting methods as well as consider other financing mechanisms to increase government contributions to the FP program.

MALAWI

Historical Context of Family Planning in Malawi

The journey of SRH and FP in Malawi has been a unique and convoluted one and is only just emerging from major setbacks. FP had been banned in Malawi in the 1960s on the grounds that it was incompatible with Malawian culture, but the ban was later lifted in 1982 with the program named the Child Spacing Program.

Following independence in 1964, President Kamuzu Banda banned family planning in Malawi. Banda believed that the country needed to have a large population to fully realize its agricultural potential and that with improvements in education and literacy Malawians would decide for themselves how many children to have. During the 1970s, the government of Malawi was not interested in either controlling population growth or in modern family planning. Consequently, donor agencies with an interest in population control and family planning became inactive in Malawi until the late 1970s, when the economy of Malawi started to deteriorate. By this time the country did not have adequate agricultural land to absorb the rapidly growing population, evidenced by growing signs of land shortages and environmental degradation. This presented an opportunity for advocacy in population control.

In the early 1980s, Malawian family planning advocates cautiously promoted modern contraception for child spacing, justifying it both in terms of the health of the mother and the health of the child, whilst emphasizing that this was not culturally alien. At the time there was popular interest in child-spacing in Malawi. President Banda was convinced and approved the Child Spacing Program in 1982.

The period 1982-1984 was dedicated to training master trainers as well as training other providers on the job. During the same period, the National Coordinating Committee was established (1983) and a 4 year work plan (1984-1987) was developed to guide implementation of the child spacing activities as well as ensure that donor inputs were properly utilized. In 1984, World Bank and UNFPA sponsored an inter-ministerial orientation seminar on child spacing to encourage multisectoral integration of child spacing activities. In 1987, UNFPA established a Demographic Unit at the University of Malawi to provide MA program in demography and support activities in the area of population including conducting formative research. In 1990 the National Population Planning Unit (PPU) was established and located within the department of Economic Planning and Development, located in the Office of the President and Cabinet. One year later PPU became the Population and Human Resources Development Unit mandated to coordinate, collaborate and monitor all population-related activities in Malawi. Concurrently, the National Family Welfare Council of Malawi (NFWCM) was established, to coordinate, promote and foster the implementation of family planning and subsequently launched the National Family Planning Strategy (1994-1998) to guide FP activities.

In 1992, the Child Spacing program was reoriented towards a broader family planning program to limit family size because of economic reasons which was followed by the development of the National Family Planning Strategy 1994-1998. By that time, Malawi had adopted a multiparty political system, providing an opportunity for discussion of family planning issues from various perspectives. In 1994, the newly elected President Muluzi approved Malawi's first population policy. However, the move came at the hills of the 1994 ICPD conference in Cairo where the international population community had shifted from the neo-Malthusian focus to one that placed gender equity and human rights at the center of reproductive health superseding the traditional view of population control. Even so, this marked the beginning of a new era in the FP programming in Malawi. In his first address to Parliament he announced that family planning was a legitimate strategy for development. Subsequently, parliament approved the first ever budget line for population activities.

After the ICPD 1994, changes in the Malawi family planning program included the formation of the Reproductive Health Unit (RHU) within the Ministry of Health in 1997, and renaming of Child Spacing Program to Malawi Family Planning Program. The reorientation of the Child Spacing program from one focusing on child spacing to one focusing on family welfare as well as adoption of the population policy, are aligned to dramatic improvement in Malawi's modern CPR.

Around the same time, the NFWCM underwent a number of administrative and functional changes. Its name was changed to National Family Planning Council of Malawi in 1997/8. The Council had parastatal status and incorporated public and private organizations that worked in FP. When the Government of Malawi did not commit to funding it, this gave the message that FP was not a development issue for the government, and subsequently, donors (UNFPA, USAID, DFID) pulled out. To keep it functional, the Council was therefore moved to the Reproductive Health Unit (RHU), Ministry of Health and Population (RHU was formed after ICPD 1994). The population docket was later taken to Economic Planning and Development. The FP Council was completely disbanded and dissolved. IPPF supported the launching of Family Planning Association of Malawi, an implementing body with NGO status in 1999. It is an associate member of IPPF, and in the process of accreditation for full membership.

"The increase in contraceptive uptake and high TFR is a paradox. Since 1994 there was a strong campaign that started with child spacing. The National Family Planning Association of Malawi was the government institution that did a lot of sensitization work and sending out of FP commodities. Closing of the association showed the lack of political will, that FP was not a priority for the government. But other organizations like UNFPA were providing FP and contributing to the rising CPR." - Donor

Contraceptive use in Malawi is now trending towards long acting methods. The most popular FP method is injectables (25.8%) with increasing demand for female sterilization. Unmet need for FP remains high at 26.1% (Table 4).

Table 4: Population, fertility and FP use trends in Malawi (around 1990 to around 2010)

Year	Population size (millions)	Total fertility rate	Modern Contraceptive Prevalence Rate (%)	Unmet Need for family planning (%)
1992	9.7	6.7	7.4	36.3
2000	11.2	6.3	26.1	29.7
2004	12.5	6	28.1	27.6
2010	14.9	5.7	42.2	26.1

Data sources: DHS
Population data are from The World Bank, World Development Indicators 2011

Table 5 below gives an overview of the evolution of the family planning and population agenda, policies and programs in Malawi from the late 1960s to the present day.

Table 5: Evolution of the FP and population policies in Malawi

Year	Events/Activities	Key indicators
1969	**FP banned** on the grounds that it was associated with foreigners and incompatible with Malawian culture. Banda the then president also believed Malawi needed a larger population and he viewed	

Year	Events/Activities	Key indicators
	development from the angle of increasing agricultural productivity and preserving cultural traditions.	
Late 1970s	- Malawi Economy struggles - inadequate agricultural land, land shortages and environmental degradation are evident -Early advocates, Malawi medical elites with political ties to Banda - Dr. Chiphangwi and Lucy Kadzamira – begin **advocating for FP** and both recommend a child spacing program in the early years	
1981	After participating in an interdisciplinary conference organized by MOH and funded by UNFPA on child spacing, a **memorandum to the president recommending the introduction of child spacing** is drafted, possibly by Dr. Chiphangwi and Kadzamira	
1982	The **NationalChild Spacing Program is intrdoduced** as an integral part of the MOH's maternal and child health (MCH) programme -The Health Institutional Development project begins training providers in child spacing	
1983	National coordinating committee established to implement **child spacing activities** and formulated a 4 year work plan (1984-1987) to plan and coordinate implementation of child spacing activities and ensure donor inputs are properly utilized	
1982-1984	Early child spacing activities -initial services offered at 2 central hospitals (Blantyre and Liliongwe). By 1984 expanded to 3 district hospitals in Kasungu, Mulanje and Rumphi	
1984	-**Interministerial/sectoral orientation seminar on child spacing** organized to encourage multisectoral integration of child spacing activities- caution and a standardized approach to implementation are emphasized. -**Family Formation Survey** is conducted – shows that women had an average birth interval of about three years similar to recommendation of child spacing program but with traditional rather than modern methods – only 1.1% used modern methods. -First case of HIV is identified	
1987	-Banja La Mtsogolo (BLM) is established with one clinic -GOM launched a development policy plan (1987-1996) with very little reference to child spacing	
1988	1986-1995 National Health Plan supported by World Bank, USAID and UNFPA included expanded aims on community based distribution and social marketing National survey conducted by MOH and Demographic Unit – showing knowledge of modern methods was higher than that of traditional methods despite services being concentrated in urban centers	
1989	A seminar was held In March to look at the policy implications of main findings of Family Formation Survey (FFS) -Seven training sites for child spacing are set up	
1990	-The **National Family Welfare Council of Malawi (NFWCM) was established** by an Act of Parliament to coordinate, promote and foster the implementation of family planning - The **Population Planning Unit(PPU) was established** and located within the Dept of Economic Planning and Development- located in the office of the president and cabinet, Malawi's central policy-making institution	
1991	-PPU became Population and Human Resources Development Unit – mandated to coordinate, collaborate and monitor all population-related activities in Malawi -The **Christian Health Association of Malawi (CHAM) community-based distribution (CBD) projects begin** -Social marketing of condoms begins	
1992	1992 DHS conducted **Child Spacing Policy and Contraceptive Guidelines** (1st edition) are published Support to AIDS and Family Health (STAFH) project begins as a six year project injecting US$45million	CPR: 7.4% TFR: 6.73
1994	-Change of government from one party to multiparty system	

Year	Events/Activities	Key indicators
	-**National Population Policy is launched** with CPR and TFR target of 28% and 5.0 by 2002 respectively -**National Family Planning Strategy 1994-1998 was launched** - still quite cautious promoting family welfare rather than fertility control -**Child Spacing Programme renamed Malawi Family Planning Programme**.	
1995	-**Budget line approved for population activities for the first time** -210 out of 742 sites providing family planning servies up from 2 sites in 1983	
1996	Family Planning Policy and Contraceptive Guidelines (2nd edition) is published - liberalized the circumstances under which contraception could be prescribed - Depo Provera injection made eligible for all women regardless of age, parity and marital status and voluntary surgical contraception for women and men could be performed even for individuals without children	CPR: 14%
1997	-**The Family Health Unit is reformed into the Reproductive Health Unit, and FP became an integrated part of RH services**. Its responsibilities were coordination of integration of RH policies at all levels, develop RH policies, strategies and guidelines, guide implementation of RH, monitor and evaluate RH services -**RH strategy and guidelines developed** to guide implementation of RH programme -STAFH project is ammended and extended until 2001 -Contraceptive Distribution Logistics Management Information System (CDLMIS) is introduced	
1998	-CBD agent training manuals and guidelines are developed -The MoH, in line with the government policy on decentralization (GoM, National Decentralization Policy, 1998) and the Local Government Act in 1999 begins **decentralizing health service delivery to district assemblies**.	
1999	-Population and Family Planning Project (PopFP) tests district-wide CBD of FP (1999-2003) -**Family Planning Association of Malawi (FPAM) is launched** -National health plan 1999-2004 developed -Vision 2020 developed	
2000	2000 DHS conducted Concept of **Essential Health Package (EHP) for health services** to be delivered at no cost was adopted	CPR: 26.1% TFR: 6.3
2001	-BLM expands to 29 clinics -UNFPA and the Dept of Population Service (new name for PPU) formed **multisectoral committee to revise Malawi's population policy to be consistent with ICPD**.	
2002	-Reproductive health policy (2002) implementation of RH is in line with ICPD 1994	
2003	National HIV/AIDS Policy (2003) was developed to i) consolidate efforts of community-based organisations (CBOs), non-governmental organisations (NGOs), faith-based organizations (FBOs) and public and private sector institutions, ii) expand interventions that have great promise and iii) direct the response to new areas of priority	
2003	National Behaviour Change Interventions Strategy for HIV/AIDS and SexualReproductive Health developed to empower Malawians to develop and maintain safer sexual and reproductive health practices in astigma-free and gender transformative environment	
2004	2004 DHS conducted - **Health Sector wide Approach (SWAp) 2004 concept adopted**, MOU was signed with the major development partners and was piloted as a mini-initiative within the national RH programme with good success. -A six-year **Joint Programme of Work (PoW) (2004-2010) details priority health activities that will be undertaken by the MoH**, development partners and selected not-for-profit NGOs , the necessary strategies and resources for programme implementation, which addresses the major causes of death and diseases in Malawi.	CPR : 28.1% TFR: 6.0

Year	Events/Activities	Key indicators
2006	-**Malawi Growth And Development Strategy (MGDS) 2006 – 2011** was developed as an overarching operational strategy for Malawi designed to attain the nation's Vision -**National reproductive health strategy 2006-2010- updated** version of the first RH strategy (1999 – 2004) strategy developed aimed at giving direction and guidance to all stakeholders involved in the planning and delivery of RH services	
2007	-**Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (2007)** developed -**Guidelines for community initiatives for reproductive health (2007)** developed to guide districts on how to work with the community to implement interventions on Reproductive Health in order to reduce maternal and neonatal mortality	
2008	**Community Based Injectable Contraceptive Services Guidelines (2008)** developed to outline the core areas, guiding principles and guidelines for managers in the public sector and NGOs working /supporting community based workers to provide injectable contraceptive at community level	
2009	National HIV Prevention Strategy (2009-2013) developed as part of the implementation process of commitments like Congo Brazzaville Declaration and United Nations Declaration of Commitment on HIV and AIDS	
2010	2010 DHS conducted	CPR: 42.2% TFR: 5.7

1. Political will and commitment: Rejuvenated political will and commitment

The political historical context of family planning in Malawi is central to recognition of the country's phenomenal success in the recent past. Following persistent advocacy, the focus of lifting the ban on family planning in the 1980s with the introduction of the Child Spacing program was to address maternal deaths by increasing birthing intervals. Consequently, there was very little reference to child spacing in the national development policy (1987-1996) and fertility remained high at nearly 7 children per woman. It was not until 1992, when contraceptive use was found to be 7%, that the Child Spacing program was reoriented to promote family planning for limiting family size in order to achieve a better quality of life for families.

The current President (H.E. Joyce Banda) is passionate about safe motherhood and it remains to be seen if she will champion FP beyond safe motherhood as a development tool. At the FP Summit held in London on 11th July, President Joyce Banda announced that Malawi would like to raise the country's CPR to 60% by 2020, particularly focusing on women between the ages of 15 and 24. Additionally, Malawi plans to approve the new National Population Policy by December 2012.

The former First Lady Callista Mutharika was the country's African Union Goodwill Ambassador for Safe Motherhood until May 2012, and reportedly encouraged FP use in that capacity, advocated for girls to stay longer in schools (which has an indirect effect on delayed childbearing), and advocated for births in health facilities. Past administrations have preferred to support FP program as beneficial to maternal and child health and achieving MDG 4 and 5.

In Malawi there has been no visible FP champion who advocates for FP uptake or publicly links FP use to the socio-economic development of the country. The Ministry of Health's *Reproductive Health Unit [*RHU] has therefore been working to promote FP independently of the larger government structure or personalities and has been driver of FP policy and program implementation. Crucially, although top-level leadership has not given explicit support to the family

planning program, it has created an enabling environment for the RHU leadership to implement the family planning program and advance it to the level that it has. Nevertheless, there is need to advocate for political commitment for family planning by demonstrating the broader benefits to the economy and the environment among top level leadership in Malawi.

The challenge is that the RHU needs strengthening in terms of staffing. The RHU Deputy Director is the lead, but it is not a directorate. It is an administrative issue. Also how efficient is the unit in coordinating all the RH players? The high CPR and high TFR indicate a problem. We need quality citizens. " – Local NGO

Despite Malawi's success, there are challenges in the sustainability of its FP Program that is evident in the low level of priority placed on population issues.

Senior Management at the MOH were hesitant to increase the profile of the RHU from being a unit to a directorate, which would translate into more negotiating power for funding the FP Program. Presently, the RHU Deputy Director reports to the Director of Clinical Services who oversees curative, nutrition and SRH services. Further, the Population Unit, which is housed in the Ministry of Planning and Economic Development and has a national mandate in a country with a population of approximately 14 million people, is staffed with only two economists. Relatedly, the revised population policy has been in draft form since 2001 and was only recently committed to being tabled in parliament by the Vice President and Minister for Health, Hon Khumbo Kachali, in July 2012.

"*There is political will to allow FP but their focus has been on safe motherhood. The country is lacking an FP champion to explicitly support FP. There is a need for stronger political will like in the case of HIV/AIDS and safe motherhood in order to sustain the increasing CPR, and further address the high TFR."*- International NGO

"The child spacing campaign never transitioned into child reduction. It was an advocacy strategy that didn't explain the benefits of child reduction." –Donor

In the past five years or so, advocacy efforts promoting the integration of population dynamics into development planning have intensified against Malawi's deteriorating economic and environmental situation. In June 2010, Malawi's new government led by President Joyce Banda endorsed the second installment of the Malawi Growth and Development Strategy (2011-2016) in which population has been included as a standalone sub-theme, for the first time. In essence, FP, the main mode of stabilizing population growth, is being promoted as a tool for accelerating the achievement of all MDG targets. It remains to be seen how this move will translate in terms of resource allocation, programming and related outcomes in 2016.

1.1. Enabling policy and program environment

In the post-ICPD (1994) climate, FP in Malawi became an integrated part of RH services, as guided by a number of policies and strategies, which contributed to the dramatic increase in family planning uptake.. The 1994-1998 National Family Planning Strategy promoted spacing and limiting of births. In 1996, the Guidelines for Contraceptive Distribution liberalized the circumstances under which contraceptives could be prescribed, essentially increasing access to a wider range of modern contraceptives. Injectables, which had been previously only prescribed for married women with 4 children, were now made available for all women regardless of age, parity and marital status. Additionally, surgical contraceptive methods became available for both men and women, including those without children. Malawi's first National RH strategy (1999-2004) was developed in 1999 to guide implementation of the national RH program. In 2000, the National Reproductive Health (RH) policy was launched and emphasized the need to meet the contraceptive requirements of people of Malawi including women, men and youth. The National RH Strategy was updated in 2006 for the period 2006-2010 in which the targets for CPR and TFR were 40% and 4.9 children per woman, respectively. In 2008, another land mark decision came when the Malawi government 'demedicalized' injectable contraceptives allowing their administration by trained community based workers using approved training materials.

The focus of the country's development blueprint, the Malawi Growth and Development Strategy (MGDS) 2006 – 2011 prioritises health and population under the social development theme with a view to achieve poverty reduction. The MGDS is explicit about the need to manage population growth to an annual population growth rate of 1.5%, increasing CPR to 40.6% and reducing fertility to 4 children per woman, in 2011. Other global agreements that Malawi is committed to include the Millennium Development Goals (MDGs) and the Maputo Plan of Action (2007-10) which the country domesticated to track its progress towards achieving universal access to RH against regional targets. To address the persistently high maternal mortality ratios, Malawi launched its Road Map to accelerate attainment of MDGs related to maternal and newborn health in 2005 – of which MDG 5 includes expanding access to and utilization of comprehensive SRH services including family planning.

Malawi's CPR increased from 7% in 1992 to 26% in 2000 and 42% in 2010. Fertility on the other hand, declined marginally from 6.7 in 1992 to 5.7 in 2010.

By 2010, Malawi had achieved its target CPR, albeit with large regional differentials but was far from achieving its fertility and population growth rate targets. According to a key informant, the draft MGDS II (2011-2016) now includes population as a stand-alone sub-theme. This decision was informed by a United Nations (UN) Country Assessment which identified population growth as one of three binding constraints to Malawi attaining its development goals including achieving the MDGs. The other two identified constraints were capacity (human capital) and financial resources.

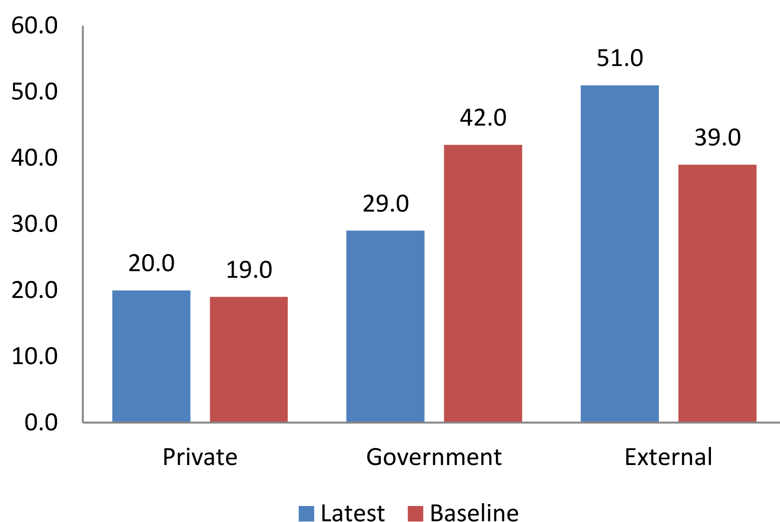
2. Mobilization of financial and technical resources: Innovative, harmonized financing mechanisms and increased investments in infrastructure and systems

Financing for the national family planning program comes predominantly from two sources – the Health Sector Wide Approach (SWAp) (indiscrete funding mechanism) and donors direct funding to programs (discrete funding mechanism). The Health SWAp was launched in 2004 as a basket funding mechanism for health service delivery. It facilitates efficient use of resources by harmonizing funding streams from government and donors, program implementation and reporting, using government systems and processes and based on government health priorities, thereby enhancing efficient use of funds by avoiding duplication of activities.

The 2010 evaluation reported that the Health SWAP improved integration of all RH program components, resulting in an MOU between the government and the major development partners to contribute to it. The major funders of Malawi's health fund pool (SWAp) are DFID, Norway, African Development Bank, Global Fund, GTZ. MOH Directorates plan and budget for their activities and draw funds from the pool. The Joint Programme of Work (POW) developed by the Health SWAp for the period 2004-2010 had two key objectives of: (1) establishing the Essential Health Package (EHP), which was adopted in 2000 as part of the poverty reduction strategy to provide free essential health services, including Maternal and Neonatal Health (MNH) and Family Planning (FP) to the public; (2) implementing the Emergency Human Resource Program (EHRP) (EHRP will be further discussed below in the Human Resources section).

RH activities including FP were therefore incorporated and costed into the POW, although majority of the EHP funds were directed to HIV and AIDs activities. Further, public and private sector FP initiatives rely on other key FP donors who may or may not be contributors to the SWAP, including USAID and UN agencies such as UNFPA, EU, World Bank and WHO. The direct impact of the health SWAP with regards to FP outputs is therefore difficult to assess.
Figure 6 below illustrates National Health Accounts sources of RH funding.

Figure 6: Sources of RH funding in Malawi (%)



Baseline: 2002/03
Latest: 2004/05
Data Source: National Health Accounts

The Annual Work plan of the RHU involves several stakeholders. Government expenditure for RHU was about 21 Million Kwacha in 2009-2010, and this dropped to about 10 Million Kwacha in 2010-2011. The rest of the funds for RHU activities (about 500 Million Kwacha) were from development partners.

"Currently the proportion of the RHU budget for SRH is unknown." – Reproductive Health Unit, MOH

There has been persistent advocacy for FP to be made a budget line item which has finally been successful.

"The [Parliamentary Health] Committee emphasizes the need for FP budget line. The government has allocated twelve to thirteen percent to health. The Abuja target is fifteen per cent. So we are emphasizing the need for FP commodities, and advocating for FP integration within the Ministry of Health." - Parliamentary Health Committee representative

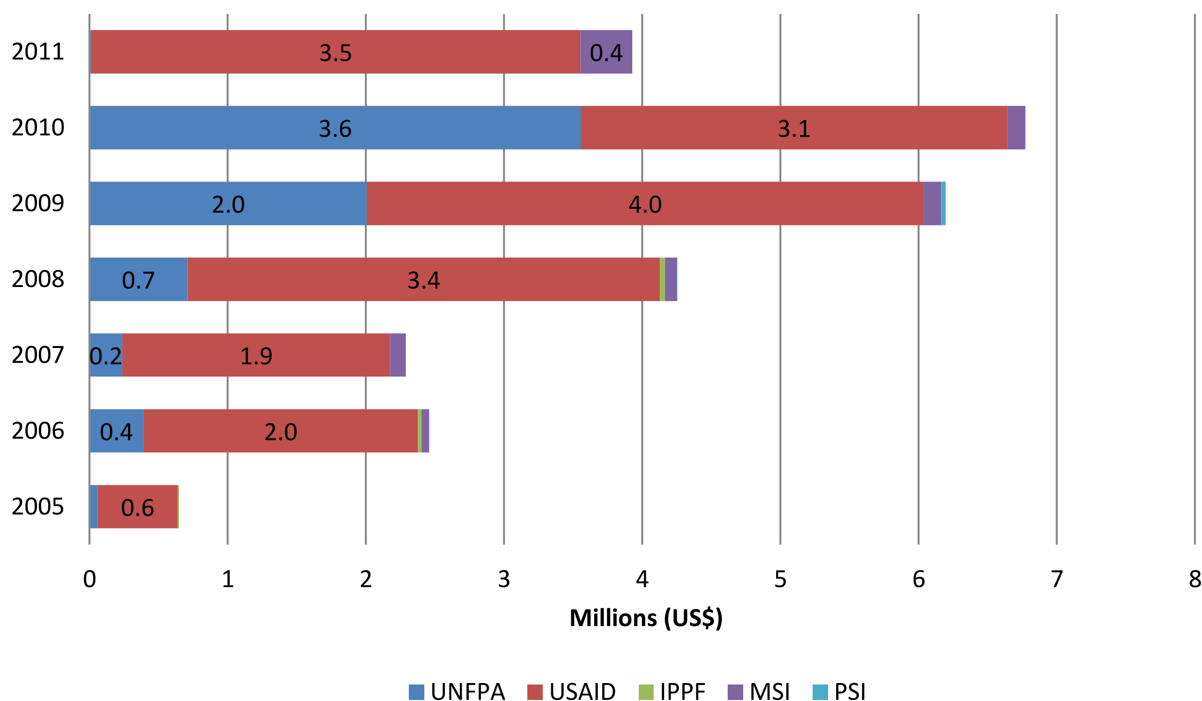
At the London FP Summit (hosted by the Bill and Melinda Gates Foundation and DFID) on 11th July, 2012, H.E. President Banda announced that FP would be a standalone budget line item. In her speech, the President stated that "*Malawi recognizes the role of FP in the growth of the country's economy and in the health of its citizens and the government wishes to embrace family planning to achieve the MDGs*". This may be an early indication of increasing political commitment for family planning as a development issue.

Key development partners contributed 500 Million Kwacha for RHU expenditure in 2010-2011, including financing for FP. Unsurprisingly, a large share of financing for FP for public and private sector rely on key FP donors in and out of SWAP including USAID and UN agencies (UNFPA), EU, World Bank and WHO.

UNFPA activities in Malawi which support the national FP Program include procurement of female condoms and Depo-Provera (long term FP method); funding 5 districts and funding the Christian Health Association of Malawi (CHAM) to train post-graduate mid-wives (in-service training). USAID activities include procurement of Depo-Provera and implants (i.e. Jadelle) and funding implementing agencies such as Management Science for Health (MSH), and Save the Children (STC).

Figure 7 below depicts donor contributions for contraceptives to stock public health facilities between 2005 and 2011.

Figure 7: Donor contributions to public sector contraceptives, 2005-2011



Data Source: RHInterchange, April 2012

In 1994 President Bakili Muluzi decentralized administrative authority to the district level as a poverty reduction strategy. Essentially decentralization brings decision making on health expenditure (including SRH/FP) to the district level, in order to meet specific community needs. However, a number of key informant interviews highlighted that the system is well-intended but falls short in its outputs.

The 1998 Decentralization Policy guided health system reforms (decentralization of health services) articulated in the 1999-2004 National Health Plan in a bid to improve efficiency, equity and quality of health services. Health SWAp funds as well as some donor funds are directly allocated to the District Health Assembly, who plan the budgets for health service delivery in their locality. For example, UNICEF bypasses central government by providing funds directly to the District Health Assembly. In this decentralised system, only health workers' salaries are managed at the central level (MOH).

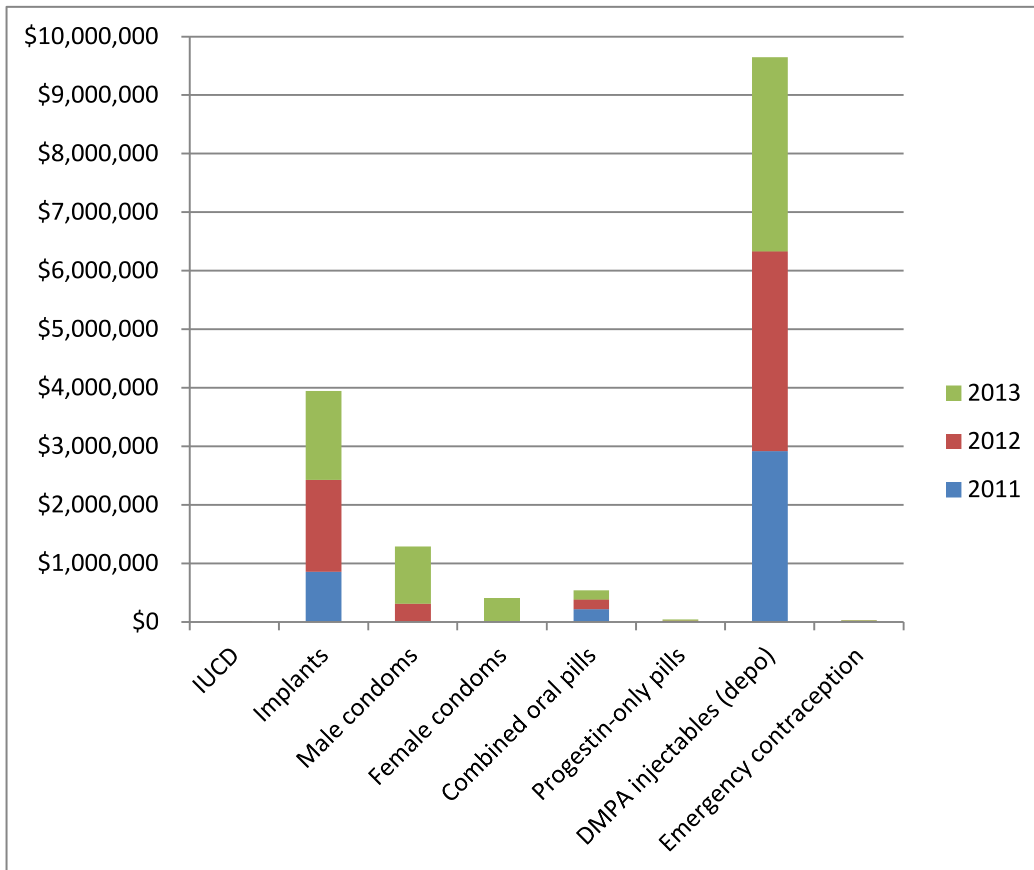
DHOs, who report to the District Commission, control the use of the resources through development and implementation of District Implementation Plans (DIPs) that reflect local priorities. However, a persistent challenge is that DIPs are not adhered to due to limited resources; decentralization essentially depletes district budgets. Decentralization is therefore faulted for deficiencies in commodity security at the District level due to FP not being made a priority in District's expenditure. The impact of this is erratic supplies of FP due to rationing, therefore resulting in increased unmet need for FP and frustration at the community level, as people get sensitized to use FP, resulting in increased demand for FP which is not met. In addition, they are unable to procure according to the demand as Depo Provera, the preferred method, is expensive. Another identified challenge is that resources for equipment in health facilities are low and this has been tabled in SWAp meetings.

"The SWAp argument is that allowing the FP Program to be prioritized will cause other programs to want to be prioritized as well, so they prefer pooling of funds. USAID is committed to the Essential Health Package, which includes FP commodities. The MOH needs capacity building at District level. Other ministries [besides MOH] don't have issues with decentralization." - USAID

DFID provides the largest share of funding for health and in addition, has set aside the largest share of funding for FP. In 2007/8, DFID provided 30% of all donor funds towards health and in 2008/9 this share increased to 36%. In November 2011, DFID committed to provide £25.2 million over five years (2011-2016) to increase the coverage and use of effective FP in Malawi, with a focus on rural, poor, and young women (DFID 2011). Approximately £19 million will be directed to FP service delivery and the remaining £6 million will be spent on contraceptive commodities (ibid). £200,000 is allocated for research and evaluation (ibid).

Between 2011 and 2013, US$ 15.9 million was required to procure contraceptives, with majority of the budget (85%) being allocated to injectables and implants. In 2012, over 50% of the total budget for contraceptives was used to procure injectables and implants, which are in highest demand (Figure 8).

Figure 8: Family planning commodities procurement requirements for Malawi, 2011-2013 (US$) (excluding shipping)



Source: Ministry of Health, The Malawi Government 2011 National Quantification and Supply Planning Report.

The National Reproductive Health Strategy 2006-2010 gives direction and guidance to all stakeholders involved in the planning and delivery of high quality, accessible, affordable and convenient comprehensive RH services, in line with international agreements at ICPD 1994. Its development was informed by a SWOT analysis of the RH program and involved wide stakeholder engagement.

3. Health Systems Strengthening

3.1. Infrastructure investments

There are three levels in the health services provision, namely:

i). primary level - health centres, health posts, dispensaries, and rural or community hospitals
ii). secondary level - district and CHAM hospitals
iii). Tertiary level - central hospitals and one private hospital that provides specialist services.

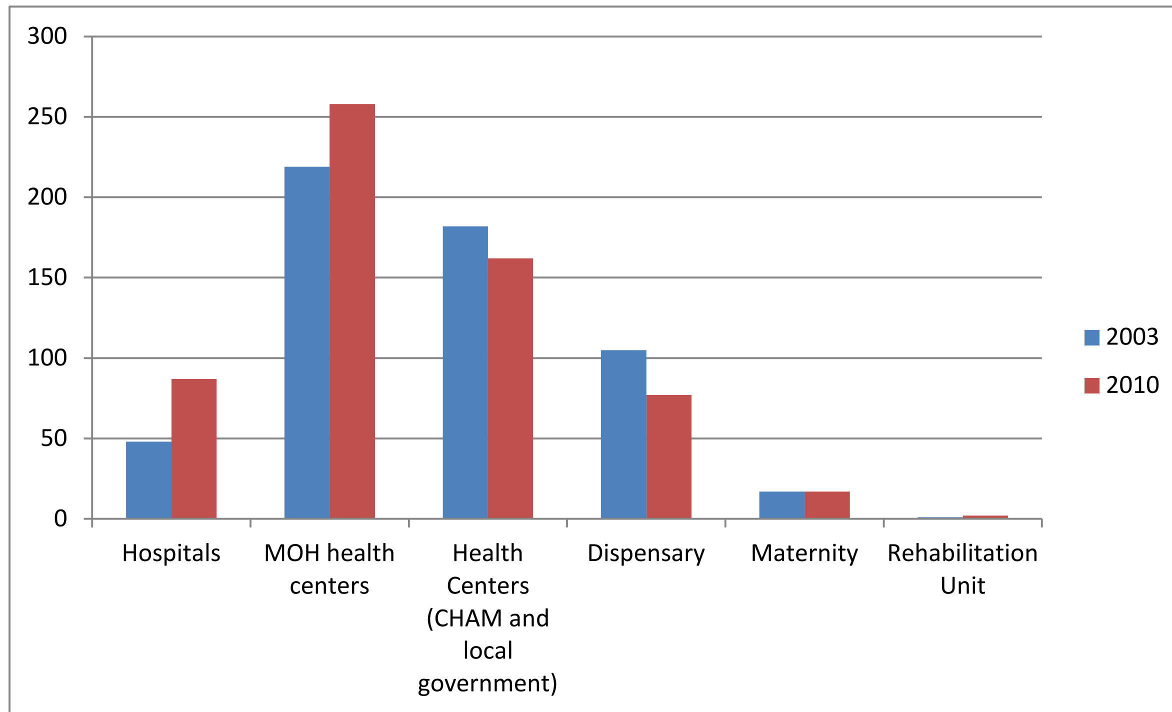
In 2011, about 80% of the population had access to a formal health facility within a 8km radius, which has remained the same for the past decade.

Malawians using modern contraceptives mainly obtain services from the public sector – constituting facilities operated by the Ministry of Health (MoH) (60%), the Christian Health Association of Malawi (CHAM) and other private-not-for-

profit NGOs (36%) and the Ministry of Local Government (MoLG) (1%). The private sector has a very small market share for modern contraceptives. PSI is a key private sector player. CHAM is the key health care provider to the rural community, with majority of CHAM health facilities (90%) located in the rural settings (CHAM Secretariat 2009). FPAM, MSI, FHI and BLM are some of the major players in the NGO sector who support the MOH/RHU in reaching the public especially in rural areas with family planning services. FPAM runs facilities in 5 districts and specializes in providing services to the youth.

Infrastructural development is recognized in the Health SWAp as one of the key challenges to building a sustainable and equitable health care system. The SWAp Infrastructure Pillar was established to secure availability of appropriate facilities to cater for Malawi's health essential service delivery. Between 2003 and 2010 the overall number of health facilities in Malawi increased from 572 to 606, largely due to an increase in the number of health centres owned by MOH (Figure 9). The significant increase in MoH health centres is attributed to some public facilities, mainly maternity units and health posts, being upgraded to health centres in line with the aims of the Program of Work for the Health Sector (PoW) 2004-2006 (MOH 2011).

Figure 9: The number of health facilities in Malawi, 2003 and 2010



Data Source: MOH 2011. Malawi Health Sector Strategic Plan 2011 - 2016

However, evaluation of the SWAp Infrastructure Pillar reveals that progress has been slow in relation to budgetary expenditure and delivery (MOH 2011; MHEN 2009). Nevertheless, the Malawian government recognizes the importance of intensifying progress in infrastructure developments and aims to improve EHP coverage from 74% in 2010/11 to 90% in 2015/16 (MOH 2011).

The MOH has also made other investments to increase access to essential services. MOH signed Service Level Agreements (SLAs) with CHAM facilities in 2003 for the delivery of Maternal and Neonatal Health (MNH) services to increase access to services. Evidence shows that the removal of user fees in CHAM facilities has resulted in a higher number of patients seeking care in these facilities. In addition, the MOH developed and is implementing the EHP Capital Investment Plan (CIP) since 2006, which is aimed at improving geographical access to quality EHP services through rehabilitation, upgrading, and construction of health facilities and provision of necessary equipment. This would also have had a positive impact in FP service delivery.

3.2. Performance-based financing

With a view to sustain the progress in increasing FP uptake and improve utilisation of finances and the governance of the health system, a performance-based financing program (the Maternal and Child Health Program) aimed at helping Malawi achieve MDGs 4 and 5, is in the design phase with OPTIONS and will be implemented over 3 years in 4 districts located in 2 geographical zones (Ntcheu, Mchinji, Dedza in East Central Zone and Balaka in South Eastern zone). Participating facilities will be drawn largely from the public sector with a small number of CHAM facilities.

The program is funded by German Development Bank (KFW) and the Norwegian Agency for Development Cooperation (NORAD), and will build the capacity of the Ministry of Health (including the RHU) in implementing results-based financing approaches to improve maternal and newborn health. This design will focus on 3 core components on both supply side and demand side including: immediate investments in minor infrastructure and equipment for participating facilities; provide financial rewards to facility-based teams at both district level and below and district health management teams; and a conditional cash transfer to women delivering in an approved health facility e.g. providing transport to pregnant women and cash compensation to expectant mothers when they attend antenatal clinics.

3.3. Supply Chain Management

There have been investments in the supply chain management system to enhance commodity security. Central Medical Stores (CMS) is the National Pharmaceutical Warehouse which is tasked with storage of FP commodities and distribution to 3 Regional Stores at pre-determined quantities (South 50%, Central 40% and North 10%). The donor community has played a key role by supporting financing, procurement and national distribution.

The RH Commodity Security Committee is charged with oversight of contraceptive forecasting and quantification activities. The Health Technical Support Services of the MOH compiles consumption data for forecasting. The USAID Deliver Project which is implemented by JSI, supports the government to ensure good data quality through supportive supervision visits that are made to health facilities every 2 months.

The pull system requires district hospitals (in 28 Districts) to make requisitions for FP commodities based on demand (or affordability in this case) to regional medical stores. The district hospitals in turn supply FP commodities to the health centres. Districts can also buy commodities bought using donor funds off budget support. When districts buy from CMS, they pay a 12.5% handling fee in addition to the full cost of the commodities (unsubsidized), totalling 112.5%. When they acquire commodities from donors they pay 5% handling fee. Donors have less overheads/incidental costs as they are delivered for free. Advocacy efforts pushing for the removal of the handling fees were successful in July 2011, leading to the removal of the 12.5% handling fee.

Following forecasting and quantification of country needs, UNFPA, JSI/USAID Deliver and RHU make decisions on procurement, and donors supply FP commodities to CMS. The improved governance has helped mobilize more financing from development partners in Malawi. Their allocated funding to FP commodities has increased due to the increased demand for FP in Malawi. In this regard, they have been a major player in increasing access to contraceptives in Malawi (E.g. previously UNFPA only funded female condoms but now funds other required commodities). The government budget only covers a small proportion of Depo-Provera projected need and condoms. The resource gap is covered by development partners. UNFPA supplies the Districts and USAID supplies community level needs.

For over a decade, Malawi has been working to improve the contraceptive logistics management and this has contributed to increased commodity security thus enhancing FP uptake. Until the late 1990s, there was no standardized logistics system in place and a variety of methods were used at all levels to determine the quantities of contraceptives to order and/or issue (McGregor and Yasmin 1999). As a result there were frequent stock-outs, irregular ordering and lack of inventory control (ibid). In 1997, the Contraceptive Distribution Logistics Management Information System (CDLMIS) was introduced to address these challenges resulting in improved commodity supply. To consolidate the gains made in contraceptive availability, USAID Deliver was introduced in 2000 (USAID 2007). CDLMIS was modified to include drugs for sexually transmitted infections and renamed the Reproductive Health Logistics Management Information System (RHLMIS) (ibid).The system worked well but Malawi’s broader health sector reforms embodied in its five-year health

plan for 1999-2004 sought to move from the vertical logistics system to an integrated logistics system controlled at the district level (ibid). Hence, the DELIVER project (implemented by JSI) assisted MOH in implementing a streamlined distribution system at the district level and an automated logistics management information system for vital health products while helping to maintain availability of contraceptives (ibid).

However, a stall in the operations of CMS arose because of high debts owed by the district health centres. As a result, a parallel logistics system (USAID DELIVER project) was introduced on paper in October 2010 and implemented in December 2010/January 2011. CMS is being transitioned into a Trust and operates in conjunction with USAID's parallel logistics system, a temporary stop-gap measure, while administration changes happen at CMS as part of its recapitalization strategy to make it more efficient and income-generating. It is estimated that it will take 2 years for CMS to transition and be fully functional in its new Trust status.

Challenges in FP commodity security arise from district level planning by the District Health Management Team (DHMT)/ District Health Officers (DHOs), which is hampered by lack of sufficient resources. Even though the districts put forth their costed plans, they are allocated just a proportion of the budget that they need. Hence the DHOs are forced to prioritize their initiatives. Unfortunately curative, as opposed to preventative services such as FP, are prioritized. The need for institution of FP as a budget line item was reiterated by a number of key informants as a solution to this problem. The 2006 quantification estimated a budget requirement of 10 Billion Kwacha. The government approved 2.6 Billion Kwacha. This is not necessarily a reflection that the government does not support FP but rather resource constraints as well as competing priorities. There is also need for advocacy at all levels - central level to lower levels - promoting prioritization of FP.

"Historically donors first introduced FP products to Malawi. The SRH program was funded by DFID and USAID. They procured FP and STI products. There were eight products then procured by donors, especially USAID. They would procure to meet the demand. They wanted to start pulling out and get the government and other partners to take over. The government has limited resources, and put their money in other areas as others like UNFPA stepped in."–Health Technical Support Services, Reproductive Health Unit, MOH

In terms of sustainability, the recapitalization strategy of CMS, with a change of status from a government (MOH) department to a non-profit trust will allow CMS to operate on full cost-recovery basis without public subsidies. CMS will operate like a private company and will be able to hire and fire their own employees (previously they were seconded from other government departments). The running of CMS has historically been very political. The senior accounts personnel were moved a few months ago to other departments and not replaced. Therefore being a trust is good for human resources, although it will take a number of years to see the fruits of these changes. The right people will be employed to deliver the right output.

Of note, the funding of the Trust is not yet clear. There will be a revolving fund from donors. A consignment of about 3 Billion Kwacha funded by DFID, KfW and NORAD has been procured for distribution in the parallel system, to target primary health care. The government will pay CMS for the EHP kit. It is undecided as yet how- it may be a fraction or the full amount. The Trust will need to recover about 4 Billion Kwacha in debts from the districts. The government will top up recapitalization by paying debt in instalments. The payment for the new CMS staff will be very high (relative to current pay).

Sustainability of funding for FP commodities remains a great challenge as government resources are limited. RH commodity security was side-lined in Malawi's SRH strategy in 2006-2010. It has recently been reviewed to incorporate

FP commodity security – in draft form in November 2011. In addition, development partners were withholding funds as the government was not committing funds to FP commodities. Any delays in procurement of FP commodities results in stock outs. However, when the product is available, distribution has not been a problem.

"A major challenge is access, especially when the government procures FP commodities. It's a decentralized system so they deplete the District budget. They don't procure according to demand it is expensive to get Depo [medium term injectable]. Sustainability is a challenge. In 2008 there were problems, there were stock outs of even condoms. Partners were withholding funds as the government was not committing funds. " – Health Technical Support Services, Reproductive Health Unit, MOH

"The problem is acquiring government-procured products, especially Depo [medium term injectable]. The government should have procured cheaper FP [pills and condoms] and donors procure Depo. A box of 10 of Jadelle is very expensive at $23 plus the 112.5% fee."–Health Technical Support Services, Reproductive Health Unit, MOH

Stock-outs of FP commodities has been a persistent issue in Malawi and are attributed to a number of reasons including overreliance on donor funds that were not forthcoming; limited resources and competing health priorities at district level; weak HR capacity for data quality and reporting including recording and reporting consumption data which is crucial for forecasting and quantification. In 2007, the Global Fund committed to purchase 21 million condoms every year for 3 years: 2008, 2009 and 2010. However, the condoms were only received in 2011, and there were reported stock-outs. Pipeline planning had taken the Global Fund commitment into account, and following the 'no-show', they had to rely on other partners. UNFPA procured 4 million condoms which arrived in May 2008. This was well below the average consumption of 24 million condoms per year.

A recurring challenge was the cost of acquiring commodities from CMS (12.5% handling fee in addition to the unsubsidized cost of the commodities) which districts found expensive. Even the lower 5% handling fees on donated commodities was considered expensive. Persistent debates in the Drugs and Medical Supplies TWG from 2009 until early 2011, led to the decision to slash the 12.5% handling fee in July 2011. The issue of cost led to a backlog of bills totaling 3.1 Billion Kwacha unpaid by DHOs who have been supplied with FP commodities. MOH intends to bail out DHOs by paying the bill every year until the bill is settled. The success of CMS trust will result in the increased efficiency of the system as a result of: adequate staff numbers; training staff and; retaining staff.

Moving forward there is need for DHOs to understand the importance of FP, but the challenge is that DHOs have a high turnover. SSD-E will have regular meetings with DHMT to help prioritize FP, and lobby with MOH for FP to be a budget line item. An evidence-based recommendation for policy/practice was highlighted at the July 2011 Community Family Planning Conference held in Nairobi where it was reported that Burundi had not had stock outs for 5 years as a result of FP being established as a budget line item.

Procurement has its own challenges. Logistics of medical supplies is a specialized subject and there is limited HR capacity and some people are not conversant with logistics technical jargon, although logistics started in 1996. Consequently, the quality of the procured FP products may be sub-standard as non-experts are charged with procurement. At district level there is also no money for transport. Therefore the ministry transports commodities directly to health facilities. Storage space is limited but there are plans to expand at the central level then the district level. Sometimes equipment for administration of Depo-Provera such as syringes is also lacking.

Consumption data that feeds into the quantification exercise is of poor quality. HTSSs need to spend more resources on data cleaning or to collect their own data. The parallel system is a push system, and in some instances health workers do not feel obliged to report on donated FP commodities, unaware that consumption history is relevant for the quantification exercise. Also, despite task shifting through HSAs and CBDAs, Nurses and Medical Assistants may not have time to report. In this regard, HSAs were trained in December 2011 to record and report on FP consumption. The government also wants to introduce Pharmacy Assistant cadres to manage the drug stores in health centres (they are at a lower level than Pharmacy Technicians). A Pharmacy course at the College of Health Sciences at the University of Malawi will be introduced to increase the number of Pharmacists in the country.

The national HMIS office brought to light some data collection and quality issues. Supervision of CBDAs is sub optimal because supervisors who are charged with compiling data from the CBDAs do not do so consistently or are not well trained on how to fill out the data aggregation forms. (CBDAs report to HSAs, who then submit data to the health centre.) In addition, the CBDAs do not have sufficient tools for recording data on the ground - they are required to have one book per village but in many cases they use one book for multiple villages. Consequently, the data that feeds into the central level is usually not complete or adequately summarized and disaggregated (per village), therefore forecasting of FP commodity use at District level is problematic due to these inaccuracies. To some extent the FPTWG helps to streamline the data issues in cases where there is delayed reporting from the community level. To address these issues, a number of organizations are piloting technology to support data collection e.g. MSH (Frontline SMS, where reports are sent by mobile phone to districts).
Relatedly, there is a lack of know-how to translate research/knowledge into practice by DHMTs - there is relevant research conducted by the Centre for Reproductive Health on motorcycle ambulance effectiveness, TBAs, teenage pregnancies and abortion.

3.4. Integration of SRH and HIV services

Linkages and integration of SRH and HIV services which has further contributed to increased access and availability of FP services is a recommendation of the Maputo Plan of Action (MPoA) (2007-2010). The RHU and partners are implementing the MPoA through the 2009 Sexual and Reproductive Health and Rights Policy.

The RHU has also received some support from partners to accelerate efforts to integrate SRH and HIV services. The LightHouse Trust, based in Kamuseto Hospital, a recognized World Health Organization Center of Excellence, which provides ARV therapy, has incorporated FP services. Other service providers offering integrated services include BLM and FPAM. UNFPA seconded a Technical Advisor to support the implementation of SRH and HIV services for one year (2008-2009).

In 2010, Malawi was one of the first countries in Africa to implement the Rapid Assessment of Sexual and Reproductive Health and HIV Linkages, a tool developed in 2009 (by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives) to aid countries in assessing the status of bi-directional linkages between SRH and HIV at policy, system and service levels, identify gaps and develop action plans (IPPF, UNAIDS, UNFPA and WHO 2010). The 2010 assessment revealed that on the national level, the two areas operated vertically; however, at facility level there was some integration and multi-skilled human resource (IPPF, UNFPA, WHO and UNAIDS 2011). This implied that integration in Malawi was by default, not by design. Nevertheless, where it is happening the impact is positive.

"There are two distinct phases in the progress of Malawi's CPR. It doubled from seven to fourteen, and then to twenty-three because of the community-based services. Then there was a lag where the CPR only went up to twenty-seven

because funds were injected into HIV. After that it recovered and shot up to forty-two when there was SRH and HIV integration. FP was recognized to have lost momentum in SADC meetings. There were questions about decreasing the number of the HIV epidemic in tandem with FP. The emphasis on MDGs was a strong driver to reposition the focus on FP because also IMR and MMR were decreasing. " –Local NGO

Integrated SRH and HIV services are also being offered at the community level through community outreach activities, in addition to those offered at health facilities. Since 2007, the USAID-funded Community Based Family Planning and HIV and AIDS Services (CFPHS) program implemented by various partners including MSH, PSI, and Futures Group focused on integration and training of Health Surveillance Agents (HSAs) to administer injectables**.** The project also trained CBDAs in provision of short term contraceptives and HIV counseling and testing.

3.5. Improved health worker training: Pre-service and in-service curriculum in RH/FP

The DFID-funded Emergency Human Resource Program (EHRP) was set up in 2004 to address the human resources for health crisis in Malawi using a 2-pronged approach: (i) improving quality of training and (ii) increasing the number of trained health workers. Investments in local training institutes and financial incentives were also provided to health workers/facilities to improve quality of care. The EHRP focuses on retention, deployment, recruitment, training and tutor incentives for 11 priority cadres including doctors, nurses, clinical officers, pharmacies and lab technicians.

In 2005, there was a 52% salary top up for all 11 priority cadres (MOH 2010; GTZ 2008). This resulted in an increase in staffing levels of all health cadres and an increase in the proportion of health centers conforming to the staffing norms for delivery of the EHP in Malawi of 2/2/1 (2 nurses, 2 clinician and 1 Environmental Health Officer) (MOH 2010). An evaluation study by MSH, found that the total numbers of professional health workers increased by 53% in 2009 (DFID and MSH 2010). Additional funds from Global Fund towards the EHRP supported training to scale up the HSA program (lowest paid health worker cadre). Relatedly, the main training body for service providers in Malawi, Christian Health Association of Malawi (CHAM), increased its enrollments from 100 to 396 between 1999 and 2005, nearly achieving its target of 400 by 2005 (CHAM 2005). In 2005, CHAM and the MOH planned to increase enrollment to 500 per year by 2007 (IntraHealth 2006). Anecdotal evidence suggests that by April 2006 enrollment rates had exceeded the 2007 target (ibid). This has also played a significant role in the method mix of contraceptives that is available to the public. There has been increasing demand for implant use which is attributed to the switch from Norplant (which has 5 rods) to Jadelle (which has 2 rods), which is easier for nurses to administer and manage.

"*The fact that Jadelle has less rods makes insertion and removal easier particularly by lower cadre health workers. ....Nurses were trained to insert implants through in-service training."* - Health Technology Support Services, RHU

Malawi has a 65% shortage of nurses and midwives in the public sector. In 2008, the MOH developed a national Health Sector Deployment Policy in order to attract, train and retain health workers and to ensure that they are evenly distributed throughout the country. It was estimated that Malawi needs an additional 50 to 100 educators and 227 clinical nurse instructors to increase the number of students to 2,278 by 2015 in order to improve the quality and responsiveness of nursing and midwifery clinical and classroom education and supervision (PEPFAR).

Since 2010 PEPFAR's Nursing Education Partnership Initiative (NEPI) has deployed resources to support increasing number of trainers and instructors and training of new students through several initiatives including the development of a Masters degree program in Nursing Education, distance learning programs, and competency-based clinical skills

laboratories (PEPFAR). The program is being implemented in several institutions including Kamuzu College of Nursing (KCN), the Malawi College of Health Sciences in Blantyre, Mzuzu University, the Nursing Council of Malawi and the 16 colleges of CHAM (ibid).

Since January 2012, the USAID-funded Capacity-Plus Project implemented by IntraHealth International is working in collaboration with CHAM to strengthen human resource management in affiliated health facilities and creation of policy guidelines.

Improvements in pre-service and in-service training have also contributed to the increased CPR in Malawi. Since 2003, pre-service training on its own was seen to be inadequate, and in-service training was implemented. The pre-service curriculum for Nurses was updated in 2009, and they have now been trained and recently started administering long-term methods (Jadelle, tubal ligation, etc.) at health centre level.

IntraHealth implemented in-service health worker training on long-term FP methods in 2009 (USAID-funded) in 16 districts in CHAM School Nursing Colleges[1]. Further, mentoring of health workers has been a critical component of health worker capacity building. MSc graduates mentor lower cadre health workers based in health centres.

Some HR capacity challenges have been identified. For example with regards to pre-service training, the nursing training institutions, KCN and CHAM, have identified that as much as the government of Malawi has increased pressure on them to train more students, the initiative has created more nurse trainees in health centres, thus resulting in less opportunities for trainees to get practical experience in a variety of different service areas particularly rare cases such as insertion of IUDs and implants. Consequently this has played a significant role in diminishing the nursing pool with integrated skills. Further, deployment is managed by the MOH, and currently the nursing schools have no system of working with the MOH to ensure that students who have had practical experience in FP are placed where they can apply those skills immediately. Of note, there is no system in place to ensure that students who did not get practical experience in one area or another is scheduled for on-the job-training when deployed.

4. Taking information and services to the community

4.1. Demand creation by community leaders

A unique feature in Malawi is concerted action between government, NGO, faith-based and traditional leadership to increase support for family planning among Malawians. This has been as a result of persistent advocacy by national and international players in RH/FP.

Efforts have been successful in mobilizing traditional leadership support for FP. There are Chiefs who have been promoting SRH after undergoing a 1-2 day training/orientation on SRH. Chiefs can make by-laws to reinforce policies and practices. For example, a key informant noted that someone could be made to pay a fine in the form of a chicken if they don't use a Skilled Birth Attendant (SBA), with a view to increase SBA births. There are also by-laws against teenage pregnancies, which are accompanied with community sensitization on family planning. Granted, national roll out of SRH training amongst all traditional authorities would increase the impact.

[1] Christian Health Association of Malawi (CHAM) owns the nursing schools. CHAM is Catholic, Anglican, Presbyterian

Parliamentarians have traditionally considered curative services to be a priority, but this is changing due to recent advocacy efforts by UNFPA. This has led to their buy-in to ensure FP services are offered in health facilities. The recent announcement by the new President that the government will establish a budget line for FP is supportive of this.

Notably, despite the outstanding success in contraceptive uptake, the unavoidably pressing issue in Malawi is the persistently high fertility. Various socio-cultural factors affect FP uptake in Malawi including the cultural expectation for women to have many children; prevalence of early marriage; low education completion rates; and religion.

Information, Education and Communication (IEC) campaigns that link FP and population with development have been instrumental in mobilizing communities and educating them on the benefits of family planning, by promoting culture change in how they view family planning. The Ministry of Economic and Development Planning is also working towards linkages between socio-economic development and FP through a multisectoral initiative chaired by RHU and which brings together various sectors e.g. Finance, Agriculture, etc.

80% of the Malawian population is Christian; of these, majority belong to the Roman Catholic Church and the Church of Central Africa Presbyterian. Muslims constitute approximately 13% of the population. The most effective way of educating religious followers on the benefits of family planning is through their leaders.

The Catholic Church has acknowledged a link between FP and population, and is cognizant of the population pressure. For instance, a program implemented by the Catholic Church called "*Responsible Parenthood*" advocates for the number of children that parents can take care of by linking health, education and land issues.

CHAM provides over 40% of public health services in Malawi, mainly in rural areas, which has implications on access to FP services (US Government Global Health Initiative Strategy 2011). The Catholic Church agreed to offer FP counseling on both modern and natural methods. (The national RH strategy has a provision for the inclusion of natural methods within the FP service package). Staff working in health facilities run by Dioceses are regular health workers salaried by the government and follow government policies, with the exception of providing information and counseling on FP and referring women to public health facilities which offer modern FP methods. However, the RH policy stipulates that women who have just given birth should be furnished with modern FP methods, and CHAM facilities are therefore required to adhere to this.

To address the high birth rates and low contraceptive use rates in Muslim-dominated areas, some significant inroads have been made in terms of gaining the support of Muslim leaders. In 2009, MSH mobilized Muslim leaders for intensive discussions which used a Koran passage to develop messages on the benefits of family planning - *"that a mother should breastfeed her children for two years after birth"* (Global Post 2011). They demonstrated to Muslim leaders that the Koran supported family planning to protect the health of the mother, and protect the health of the child, consequently facilitating the spacing between births for at least two years through breastfeeding. In 2011, the initiative was re-launched to intensify grassroots level uptake of FP messages and services. Notably, use of modern contraceptives is only condoned between married couples, because premarital sex is unacceptable and considered a sin. Hence, Muslim youth do not receive information on contraceptives including condoms.

"For those who are not married, they have no rights unless they are married."- Faith-Based Organization

In 2011, Muslim leaders approved a brochure (in both English and Chichewa) and an advocacy tool that include interpretations of Qur'anic verses and Ahadith as they relate to FP and HIV&AIDS to be used to mobilize increased

awareness and use of family planning among their followers. The tools were jointly developed by the Muslim Association of Malawi (MAM) and Quadria Muslim Association of Malawi (QMAM) and RHU and were based on focus group discussions held in Muslim communities.

4.2. Community outreach: Increased access through task-shifting and demedicalization of FP commodities

Malawi struggles with a serious health work force shortage, with only 33% of the total health workforce required to provide health services (PEPFAR). Access to RH services is worse in rural areas as there is a particularly significant mal-distribution of health personnel which favors urban areas and the secondary and tertiary levels of care (MOH 2006). The phenomenal increase in CPR in Malawi is largely attributed to community-focused initiatives in service provision, which have resulted in increased access through community provision of FP. With 85% of the population living in rural Malawi, innovative community-focused approaches are critical to increasing FP uptake in Malawi in hard-to-reach/marginalized areas.

"Human resource capacity is the biggest challenge. Resources for equipment are also low and have been tabled in SWAp meetings. "– Reproductive Health Unit, MOH

The use of research evidence has been instrumental to policy makers support for FP. Malawi had a CPR of 28.1% in 2004. Of these users of FP, about 18% were users of injectables, but there was a shortage of qualified staff (midwives) to administer this preferred medium term FP method. A user survey conducted by RHU reinforced these DHS data. The user survey found that injectables were the preferred contraceptive method because women feared forgetting to take the pill correctly; women were afraid of their husbands' reaction to using FP; and Depo-Provera is administered every 3 months, which is more convenient. Thereafter, in 2007, the government commissioned a feasibility study to assess the acceptability of community-based distribution of injectables by Health Surveillance Agents (HSAs). The favorable results led to the development of a pilot program designed to improve access to Depo-Provera in rural communities (FHI 2010; USAID 2009). Notably, the National Health Plan (1986-1995) that was launched in 1988 had already emphasized community distribution and social marketing of family planning commodities.

The Malawian government has since made significant strides to increase human resource capacity through task-shifting, and in 2011, Malawi won the Aspen Institute's Resolve Award for its innovative community-based service provision of SRH services alongside Ethiopia's Health Extension Workers and Rwanda's Community Health Workers. Initially, the introduction of community based distribution of injectables using paraprofessionals (demedicalization) was not readily supported by the medical community. However after a period of wide stakeholder consultations, the approach was endorsed (Health Policy Initiative 2008). Further, the Deputy Director of RHU was funded by USAID on a knowledge transfer study tour to Madagascar, and thereafter Malawi adapted the Madagascar Community Health Worker training program into a 5-day training program and developed the Community Based Injectable Contraceptive Service Guidelines in 2008. The guidelines outlined the core areas and guiding principles for managers in the public sector and NGOs to facilitate community-based workers to provide injectable contraceptives at the community level, with the key goal of increasing FP uptake.

"I have found study tours to be the most valuable way to learn"– Reproductive Health Unit, MOH

HSAs who are based in the health centres, are the lowest cadre of government-employed health workers and have been part of the health system since the 1980s. They were initially recruited for specific purposes and are now used in various

programs including HIV counseling and testing (HCT), family planning, health education and community mobilization. Since 2006, HSAs have been given more roles and responsibilities. Previously longer acting methods were only available at the district level, therefore introduction of FP at health centres has increased access to FP services and will be scaled up nationally.

HSAs are O-Level certified and undergo a 10-week training. Each HSA is in charge of 3 to 7 villages. HSAs reside in the communities they serve and form a link between the community and the formal health service delivery. The training was implemented in 2008 by MSH as a pilot in 9 districts (MSH-funded 8 districts, the government funded 1 district- Zomba) (FHI 2010) where 520 HSAs were trained and started to provide Depo-Provera. The pilot was evaluated in 2010 and subsequently the MOH began a national rollout (28 districts in total) with funding from the Partnership for Maternal Newborn and Child Health (PMNCH). There are currently more than 11,000 HSAs in Malawi (1 HSA per 1,000 to 1,300 of the population), an increase from 5000 in the 1980s.

A pending challenge is that HSA training is expensive and the government struggles to keep up with the demand. However, the support of partners has been helpful in easing the burden. Some support for training has been provided by the Global Fund which has contributed to training of 11,000 HSAs. In addition, MSH and other partners (WHO, Adventist Health Services, UNFPA) trained an additional 1,400 HSAs with higher education level (up to form 4 secondary education).

Community-Based Delivery Agents (CBDAs) who are volunteers at the village level (since the early 1990s), offer a critical support to HSAs by increasing awareness about FP (demand creation) and mobilizing members of the community to access FP services, with an emphasis on long acting and permanent methods (LAPM). Between 1999 and 2003, the Malawi Government, with financial support from the World Bank implemented the Learning and Innovation Population and Family Planning Project (PoP/Fp), a community-based FP delivery system in three districts (Kalanda 2010). The objective of the project was to test the feasibility of implementing comprehensive district-wide community-based distribution (CBD) approach to delivery of FP services. CBDAs were found to be effective in increasing knowledge of modern contraceptives and CPR and increasing utilization of public sources of FP (ibid). In 2009, their responsibilities were expanded when USAID through MSH supported MOH to train about 1000 CBDAs to provide integrated FP (pills and condoms) and HIV services (HIV Testing and Counseling) in 8 project districts (USAID 2010). The mid-term evaluation of the project showed that expected outcomes for 2011 would be exceeded with plans to expand the project and train more CBDAs (ibid). In addition to supplying short term methods (the pill, oral contraceptives and condoms), CBDAs also link users to health facilities by providing information and counseling on longer acting methods and referring clients to the HSAs and health centers for long-term FP methods. CBDAs also provide counseling on FP as part of post-abortion care.

Crucially, there is regular supervision of HSAs and CBDAs by health workers at review meetings to discuss data, performance, client issues, etc.

"It was realized in the 1990s that clinic-based services were not sufficient, and we started to provide services to the community through the CBDAs, which led to the rise in CPR. We were able to monitor the impact through segregated data on clinic and community services. This was the turning point for FP in Malawi." –Family Planning Association of Malawi

"The HSAs and CBDAs have created an enabling environment for people to access FP."- International NGO

The MOH continues to strive to strengthen its community-based program. Support for Service Delivery Excellence (SSD-E) is a 5-year USAID-funded project led by JHPIEGO and other partners that began in late 2011. It is designed to reduce fertility and population growth, as well as improve other health conditions included in the EHP. It has a community health systems strengthening focus to optimize service delivery through CBDAs and HSAs.

In addition to government-led efforts, other NGOs are supporting the government in beefing up health worker levels. For instance, the local Marie Stopes International affiliate, Banja la Mtsogolo (BLM) and Family Planning Association of Malawi (FPAM) have clinics throughout the country, and have trained and deployed their own Community Health Workers (CHWs). In addition to offering static services, various organizations (including FPAM, FHI, MSH, BLM, PSI and other service providers) use mobile community outreach to increase awareness and uptake of FP. FPAM also uses the door-to-door approach using CBDAs.

Despite the reported successes of using volunteer CBDAs and also adding FP to the HSAs' traditional responsibilities, the long term sustainability of this strategy was raised severally by a number of key informants as a major concern. Key informants noted that the success that Malawi has demonstrated may be short-lived if a more sustainable model is not put in place. In this regard, several models have been studied. PSI implemented and evaluated a social franchising model where their CBDAs sold FP commodities to clients at a minimal fee (user fee) which CBDAs can keep as their income. This motivated CBDAs without having much impact on demand. Another study evaluated incentives such as bikes, backpacks and umbrellas, and although this motivated the CBDAs, questions about sustainability of the CBDA approach persist. The fact that HSAs are government employees and are not subject to frequent transfers, and they reside in the communities they serve implies that this model may be sustainable. However, because support for HSAs is donor-dependent, District Health Officers should be encouraged to include HSA salaries in their plans to ensure sustainability incase funders pull out.

5. Coordination and accountability mechanisms

Regular coordination of development partners and government efforts in providing RH/FP services is crucial to avoid duplication and thus wastage of resources. The governance structure of development partners in order to maximize aid effectiveness is the SRH Technical Working Group (TWG). The TWG meets quarterly and is chaired by the Ministry of Health (RHU). Membership includes all FP/RH players in government and outside of government: NGOs e.g. *Banja La Mtsogolo* (an affiliate of Marie Stopes International), some government directorates, development partners, UN agencies (WHO, UNFPA), Human Resource Teaching Institutions and regulatory bodies. Further, the SRH TWG has sub-committees which report to the SRH TWG. These include Safe Motherhood, Youth and Adolescent SRH, FP, Cervical Cancer and Commodity Security. The multisectoral SRH Commodity Security sub-committee comprises of donors, regulatory bodies, professional associations, private practitioners and members of Parliament.

Effective coordination between all the players is a challenge, and there have been some reported cases of duplication. A key informant noted that the Procurement TWG should work with the Drugs and Supplies TWG to improve coordination. Further, the Finance TWG should work with the Drugs and Supplies TWG, in order to coordinate their inter-related functions.

Challenges and long term sustainability for FP uptake in Malawi

Despite Malawi's evident success in increasing contraceptive uptake, paradoxically, the country's fertility has marginally declined between 1992 and 2010 by only one child over two decades (TFR 6.7 to 5.7). Consequently, the government's immediate focus is to address high fertility. Early child marriage and low school completion rates have been found to be major contributors this. An analysis presented by AFIDEP at the first National Leaders' Conference on Family Planning, Population and Development held May 2012 in Lilongwe, Malawi, suggests that promoting delayed sexual debut and early marriage through promoting completion of secondary education will lead to a reduction in the TFR (AFIDEP 2012). Advocates are pushing for the government to promote education of girls as a measure to reduce high fertility.

Early marriage remains a major challenge in Malawi. DHS data demonstrates a stall in the last two decades. A study by Ueyema and Yamauchi (2009) suggests a decline in the age at first marriage, and yet a situational analysis on early marriage conducted in 20 districts in 2009 by the National Youth Council of Malawi (NYCOM) demonstrated that women in Malawi have been reported to get married as early as 12 years with some districts as early as 10 years.

USAID's Safe School Program (2003 to 2008) in Malawi which focuses on reducing gender based violence has also been documented to indirectly help girls to avoid child marriage. Some organizations such as Link Community Development and Action AID are using innovative community-based approaches to curb child marriage and other issues affecting the girl child in Malawi. They focus on keeping girls in school through activities led by volunteer women or mother groups and girl clubs. For instance, mother groups established by Link Community Development in all of the schools in their areas of focus in 2010, are comprised of mothers from the school's catchment area. There must be one representative from each village. They participate on a voluntary basis and their main aim is to support girls and strengthen community involvement and communication with the school. The success rate of the Mother Groups is high in helping children remain in school (Link Community Development Scotland 2011).

As recently as 2009, the Malawi National Assembly in its seating between June and July passed a bill to increase the age of entry into marriage from 15 to 16 years. The National Youth Council of Malawi (NYCOM), the coordinating agency on all issues related to adolescents and young people, through technical and financial assistance from UNFPA, led a series of advocacy initiatives to oppose the bill (NYCOM 2009). The Adolescent Girls' Advocacy and Leadership Initiative (AGALI)[2] grantees are also advocating to raise the legal age of marriage in Malawi from 15 to 18 years of age and addressing the harmful traditional practices and socio-economic factors that contribute to the continued prevalence of child marriage throughout Malawi. Notably, President Joyce Banda announced at the 11th July FP Summit in London that Malawi will raise the legal age for marriage to 18 years.

Some key informants also recommended initiatives to address cultural norms such as IEC targeted to mothers-in-law who usually put pressure on women to provide them with many grandchildren, as well as encouraging involvement of men in making decisions about family planning. Even educated male graduates have been found to desire many children. A BLM program reaches men through a workplace program.

The youth population (25 years or under) makes up 65% of the Malawi population. The median age at first sex (about 17 years) has compounded the median age at first marriage (below 18 years) and the fact that over 25% of women 15-19 years have began childbearing (2010 DHS data) which all contribute to a persistently high fertility in Malawi. Therefore youth-friendly services and peer-to-peer education can help prevent unwanted pregnancies and early marriage among other SRH issues. A lot has been done to increase access and uptake of FP by youth. Malawi allows all FP methods for

[2] AGALI implemented by Public Health Institute (PHI) builds the capacity of local and national leaders to develop innovative policy and programmatic solutions to the challenges facing adolescent girls and young women including early child marriage.

youth in the 2000-2004 National HIV/AIDS Strategic Framework, and there is relatively little associated stigma. The importance of addressing youth SRH issues was re-emphasized with the introduction of the National Standards for Youth Friendly Health Services in 2007 after a gap in appropriate services for the youth was identified. Since then, there has been a scale-up in youth-friendly services and programs. Currently, there are 1,640 youth-friendly service sites nationwide, of which 64 are accredited by the MOH (i.e. comply to MOH standards). Health workers are trained in youth-friendly services, and there are also youth CBDAs. Youth-friendly standards are used for monitoring and evaluation of these services.

FPAM has stand-alone Youth Life Centres, which provide youth-friendly SRH information and services. In addition, FPAM runs the Malawi Youth Action Movement (MAYAM) conceptualized by IPPF and aimed at ensuring effective and meaningful youth participation in improving programs, information and services targeted at youth people. The project is being implemented in 7 districts: Lilongwe, Dowa, Kasungu, Salima, Mchinji, Ntcheu and Dedza.

Notably, FP services and commodities are not allowed in Malawian schools, although HIV testing and counseling is conducted in schools, and children starting from standard 5 are taught about FP. This is done through the Life Skills and Sexuality and Reproductive Health Education (LS/SRH) introduced in 2002 in primary and secondary schools to empower pupils, students and teachers on HIV prevention, sex and sexuality. According to an evaluation conducted for the period 2002-2006, there was some reported behavior change as a result of the program. However, lack of teaching materials, poor orientation of teachers on LS/SRH and teaching time are major challenges affecting proper implementation of the program and its impact (Kalanda 2010).

The MOH is also taking steps to addressing Malawi's high fertility through overseas knowledge transfer visits. For example, the RHU Deputy Director went on a study visit to Japan for 1 month to learn from the Japanese Ministry of Health about the primary health care strategy (community visits) they put in place for their TFR to drop from 6 children per woman to 1.

The commitments made at the London Family Planning Summit in July 2012 imply there is fuelled political will and commitment for FP in Malawi. The government's goal "No parenthood before adulthood" has a target CPR of 60% by 2020, with a disproportionate increase in those aged 15 to 24 years. The strategy to achieve this includes strengthening the institutional arrangements to deliver effective policy leadership for population and family planning, establishing a budget line for FP commodities, reforming youth friendly programs and taking them to scale, and increasing community access to long acting and permanent methods.

ETHIOPIA

Historical Context of Family Planning in Ethiopia

Ethiopia is a country with a population of more than 80 million and an annual growth rate of 2.5 percent, resulting in an increase of about 2 million people per year. This high population growth can impede sustainable development, neutralizing any gains in economic growth and expansion of basic health and education services. The country pursues the Federal system of governance whereby nine Regional States and Two City Administrations form a Federal Structure. The Government has introduced a decentralization policy along with the devolvement of the power hitherto concentrated at the upper ladder.

Modern family planning (FP) services in Ethiopia was pioneered by The Family Guidance Association of Ethiopia (FGAE), established in 1966 with funding from Pathfinder International and housed in one room at St. Paul's Hospital in Addis Ababa, notably during the Emperor's time. FGAE remained the sole provider of FP services until about 1980 when the Ministry of Health (MOH) also began providing services (The World Bank 1998). After the1984 census which demonstrated that the country's population was growing rapidly amidst poor maternal and child health indicators, the idea of a national population policy gained credence. Between 1988 and 1991, a capacity building project was held with financial and technical assistance from UNFPA towards the development of a national population policy and the establishment of the Population Planning Unit to support its implementation (ibid). In 1993, recovering from a war and with a new transitional government in place, the country's first population policy was developed.

Following the launch of the population policy, family planning services increased across the country over the period. The impact is demonstrated by improving fertility outcomes. Contraceptive use more than doubled from 2.9% in 1990 to 6.3% in 2000 remaining notably low and fertility declined albeit slowly from 6.4 to 5.9 children per woman. However, in the latter decade, CPR increased rapidly to 27.3% in 2011 translating to a 4-fold increment. Concurrently, fertility dropped by 1 child from 5.9 in 2000 to 4.8 in 2011. Ethiopia now has the second largest population size in Sub-Saharan Africa after Nigeria. Its population has grown 1.5 times from 51.7 million in 1990 to 82.9 million in 2011. The population growth rate declined from 3.4% in 1990 to 2.2% per year in 2011 (Federal Republic of Ethiopia 2007; Federal Republic of Ethiopia 2012).

Contraceptive use in Ethiopia is now trending towards long acting methods. The most popular choice of modern contraceptive shifted from pills in 1990 to injectables in 2011, with growing demand for implants and IUCDs. The unmet need for FP despite declining by 10 percentage points in the last decade remains high at 25.3% in 2011 (Table 6).

Table 6: Population, fertility and FP use trends in Ethiopia (around 1990 to around 2010)

Year	Population size (millions)	Total fertility rate	Modern Contraceptive Prevalence Rate (%)	Unmet Need for family planning (%)
1990	51.7	6.4	2.9	.
2000	65.6	5.9	6.3	35.8
2005	74.3	5.4	13.9	33.8
2011	83	4.8	27.3	25.3

Data sources: DHS

Population data are from The World Bank, World Development Indicators 2011

Table 7 gives an overview of the evolution of the family planning and population agenda, policies and programs in Ethiopia from the late 1960s to the present day.

Table 7: Evolution of the FP and population policies in Ethiopia

Year	Events/Activities	Key indicators
1966	The Family Guidance Association of Ethiopia (FGAE) established -pioneered modern family planning (FP) services in Ethiopia	
1980	The Ministry of Health (MOH) began providing services	
1984	Population and housing census conducted	Population: 39,868,572
1990	1990 EDHS conducted	TFR: 6.4 CPR: 2.9%
1993	The National Population Policy was adopted with two explicit goals to lower the TFR to 4.0 and increase the CPR to 44 percent by the year 2015 The National Health Policy was adopted which emphasized family planning services for the optimal health of the mother, child and family	
1994	Population and housing census conducted The National Office of Population established to implement and oversee the strategies and actions related to the Population Policy National Population Plan of Action developed with objectives and activities for the period between 1994 and 1999 a new healthcare and financing strategy (HCF) was adopted emphasizing various interventions including retention of revenues by health facilities to improve quality and quantity of services	Population: 53,477,265 Growth rate: 2.8%
1995	Ethiopia adopted a constitution that decentralized the government creating nine regional states based on ethnic and national identities. Each region makes sovereign decisions about its budget and freely identifies its activities without being required to have federal government approval. In the health sector, Regional Health Bureaus are at the top of the hierarchy, followed by zonal health departments who supervise the *woreda* health offices	
1996	Guidelines for FP services in Ethiopia adopted to guide stakeholders, expand, and ensure the quality of FP services. In the guideline, the FMOH designated new outlets for FP services in addition to the pre-existing facility-based and outreach FP services Health Sector Development Program (HSDP) formulated to translate the health policy the first phase HSDP I 1996/97-2001/02 launched -introduced a four-tier system for health service delivery, characterized by a primary health care unit (PHCU), comprising one health center and five satellite health posts, and then the district hospital, zonal hospital and specialized hospital	

Year	Events/Activities	Key indicators
2000	2000 EDHS conducted Making Pregnancy Safer Initiative launched- it has four main pillars one of which is Family Planning Work plan for FP Logistics improvement developed in 1997 revised	TFR: 5.5 CPR: 6.3%
2001	Contraceptive inventory and logistics system survey (July) funded by USAID and UNFPA conducted showing stock outs ranging from 30-60% despite adequate supplies in the system.	
2002	HSDP II launched -introduced the concept of a Health Extension Programme (HEP), a community based health care delivery system provided at kebele and household levels with focus on sustained preventive health actions and increased health awareness.	
2003	Accelerated Expansion of Primary Health Care Coverage policy launched The Health Extension Programme (HEP) launched. The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. The package includes FP services.	
2004	MOH Health and health-related indicators published by the MOH in 2004–2005 show a fast-growing population and limited health services Ethiopia Contraceptive Logistics System (ECLS) managed by the government with technical support from USAID DELIVER, a parallel logistics system, developed to improve the contraceptive supply chain	
2005	Dr. Adhanom Tedros is appointed Minister of Health EDHS 2005 conducted HSDP III launched -directly aligned with the health-related MDGs; target for CPR is 60% by 2010. PASDEP 2005/06-2009/10 launched- poverty reduction strategy aiming to attain the goals and targets set in the MDGs at a minimum, health chapter aligned to HSDP III The Revised Abortion Law released includes four legal grounds in which abortion can be made available: rape and incest, lethal congenital malformation, physical health and mental health Code of Conduct by major partners to promote harmonization and alignment of all stakeholders (October)	TFR: 5.4 CPR:13.9%
2006	National Reproductive Health Strategy for 2006-2015 released. Health Commodity Supply System Master Plan released The Protection of Basic Services Programme (PBS) was established - a cooperation of several bi- and multinational development organizations pool of resources	
2007	Population and housing census conducted National Adolescent and Youth Reproductive Health Strategy for 2007-2015 released The federal government allocated a budget line for contraceptives and released US$910,000 Government waived import taxation on contraceptives HSDP Harmonization Manual (HHM) First Edition (April) Global IHP Compact signed (September) to harmonize partner activities	Population: 73,918,505 Growth rate: 2.6%
2008	Ethiopian IHP roadmap launched (February) to harmonize activities Country IHP Compact developed and signed (Aug) - to establish one planning, one budgeting and one reporting system	
2009	Implanon scale up initiative launched which involved training HEWs to insert implanon MDG Joint Financing Agreement developed and signed ("MDG Pool fund") (April) HSDP IV developed using the Joint Assessment of National Strategy Draft HRH Strategic Plan 2009-2020 created still in review process Pharmaceutical Fund and Supply Agency (PFSA) established to manage and administer the Health Commodity Supply System Plan	
2010	IUCD scale up initiative (2011-2013) launched which included training HEWs to give pre and post counseling for IUCD and follow-up care	

Year	Events/Activities	Key indicators
	The federal government released US$919,000 internally generated funds for contraceptives Growth and Transformation Plan (2010/11-2014/15)- poverty reduction strategy follow-up to PASDEP. Target for CPR is 80%. The Integrated Pharmaceutical Logistics System (IPLS) launched – a new integrated commodity supply logistics system. The ECLS and other vertical systems will be phased out.	
2011	EDHS 2011 conducted HSDP IV (2010/11 – 2014/15) launched (June) – emphasizes renewed commitment to the achievement of MDGS; target for CPR is 66% by 2015. The Minister states in its forward that the government of Ethiopia is committed to cover resource gap if resources cannot be mobilized UNFPA nationwide assessment on the availability of Modern Contraceptives and Essential Life Saving medicines in Service Delivery Points in Ethiopia published showing dramatic improvement in commodity security with reduced stock out reports but challenges still exist National Population Plan of Action 2010/11-2014/15 launched - aligned to ICPD, the MDGs, the Beijing Conference on Women, and HSDP IV. Reproductive health is one of 5 focal themes. Target for CPR is 66% The second edition of the National Population IEC/BCC and Advocacy Strategy (2011-2015) with reproductive health as one of the thematic areas of focus	TFR: 4.8 CPR: 27.3%

1. Political Will and Commitment: A desire to achieve development goals

Initially, the Prime Minister Meneles appeared not to be supportive of family planning, but once convinced about its value for Ethiopia's development, he empowered the Federal Ministry of Health (FMOH) to develop and strengthen the family planning programme.

Therefore, the Minister of Health has been at the forefront providing leadership to the family planning programme in Ethiopia. 2005 was a critical year for the FP programme in Ethiopia, marked by the appointment of Dr Tedros Adhanom as Federal Minister of Health. His leadership and ability to rally support from top government officials led to increased financial and technical support from development partners as well as major reforms in the health sector from which the family planning program benefited.

'The current minister of health who is the driving force behind the dramatic increase in contraceptive and was the dramatic driving force at the cabinet level…… the minister has been leading but leading from behind…. there is a lot of wiliness to use contraception, they [women] have demonstrated they were ready, willing and able before the government came on board and now they have a progressive, charismatic minister of health pushing along' – Private implementer

One stakeholder reported that, in 2005, Dr. Adhanom facilitated a major agreement between Ethiopia and USAID to support Ethiopia's FP programme.

Notably, political leaders do not openly promote family planning in the public domain in Ethiopia – although more recently, some parliamentarians have been doing so. Relatedly, family planning is more readily acceptable when promoted for its health benefits, although more recently, family planning is being promoted for its economic benefits among the political leaders. Hence, initially, advocacy messages to increase support for family planning among political leaders focused on highlighting its benefits to maternal and child health.

'The technical group is led by the ministry and the membership is open to all the stakeholders like the donors, implementing partners, professional societies etc and we created interface with the main minister and state ministers they found it very helpful and when they gave us green light we went forward and had schedules for instance convincing parliamentarian, ministers and the prime minister himself how mothers are dying and the strategy is family planning and from there the information went down using different channels' -Ministry of Health

Various policy moves demonstrate political support for FP including: its prioritization in Ethiopia's development plans – PASDEP (2005/06-2009/10, the Growth and Transformation Plan (2010/11-2014/15) and health sector development programme (HSDP) – which are all aligned with the MDGs; its inclusion as one of 16 health packages of the Health Extension Program, a service delivery model created in 2003 to increase access to and utilization of health services in rural Ethiopia; and the creation of a budget line for FP in 2007 with contributions from both national and regional budgets.

'Advocacy for budget allocation for FP commodities was done at both federal and regional levels because Ethiopia has a decentralized government structure and planning is done at woreda (district) level. In all regions, FP is one of the key intervention areas to decrease unmet need for FP and reduce maternal mortality. Hence, implementation is driven from the grassroots level up to the federal level.' – Development partner

Dr. Adhanom, continues to lead the health sector reforms to enhance and expand the HEP to meet its health goals including the country's ambitious CPR targets – the latest of which is to achieve a CPR of 66% by 2015.

Dr. Adhanom presented Ethiopia's commitment for FP at the FP Summit held on 11th July, 2012 in the UK. In his address, he iterated the government's continued commitment to increasing voluntary access and utilization of contraceptives and satisfying the unmet need for FP.

1.1. Enabling policy and program environment

Ethiopia has a strong enabling policy environment in support of FP, and these policies have been developed progressively since the development of the first population policy in 1993. One key informant mentioned that the policy environment has improved to the point that the government relaxed restrictions on mass media distribution of FP messages.

The 1993 population policy was developed following the release of the 1984 census results, which showed that the country was growing at a very rapid rate. The population policy set ambitious targets for CPR (44%) and TFR (4.0) (NOP 1993).The National Population Office was established the following year (1994) to implement and oversee the strategies and actions related to the population policy. In line with decentralization, regional population offices have since been established to facilitate and enhance the participation of the people at the community levels in the implementation of the population policy.

The first *National Health Policy* was also launched in 1993. It emphasized family planning services for the optimal health of the mother, child and family (MOH 1993). In 1996, the Ministry of Health released *Guidelines for Family Planning Services in Ethiopia* to guide health providers and managers, as well as to expand and ensure quality family planning services in the country. Thereafter, the Health Sector Development Programme (HSDP) was launched in 1997, a 20 year strategy to be used as the main medium to translate the health policy in a series of 3 to 5 year plans. In 2005, the first of

the 5-year national development blue print, '*A Plan for Accelerated and Sustained Development to End Poverty*' (PASDEP) 2005/06-2009/10 was released. The follow-up, *the Growth and Transformation Plan* (GTP) 2010/11-2014/15 was released in 2010. The HSDP forms the health chapter of PASDEP and GTP, and all three policies are aligned to the MDGs and incorporate family planning targets. The HSDP III (2005/06-2009/10) and The HSDP IV (2010/11-2014/15), which are the third and final phases of the health sector plan, respectively, aimed to Increase CPR from 25% to 60% and 32% to 66%, respectively. Further HSDP IV aimed to decrease unmet need for FP from 34% to10% by 2015.

The introduction of the HSDP led to the development of a number of supporting policies, strategies and guidelines as well as a number of major reforms, which facilitated the implementation and expansion of the FP program in Ethiopia. Following the implementation of HSDP I (1997/98-2002/03), and the recognition of the need to develop a community based health service delivery model to boost the poor maternal and child health indicators recorded in the 2000 EDHS, the MOH launched the Health Extension Program (HEP) in 2002/03. The HEP was envisioned toensure universal access to primary health care at the village (*Kebele*) level. The HEP is now recognized as the single most important reform in the health sector of Ethiopia that has brought FP services and other essential health services to the '*door step of the community'*. Through the HEP, contraceptive provision was demedicalized which facilitated the reported phenomenal increase in CPR in Ethiopia. The HEP program is continuously being expanded with the launch of the implanon and IUCD scale-up initiatives which aim to increase demand for and use of long acting methods. The HEP program has also been expanded to include a package of care for urban (including targeting in-school youth) and pastoral communities.

Other key policies and strategies that were developed which have facilitated the expansion of FP programs include, The Revised Family Code of 2000, the 2001 policy on free service for all maternal and child health service at the Primary Health Care Unit, the Revised Abortion Law (2005), the National Reproductive Health Strategy (2006), and the National Adolescent and Youth Reproductive Health Strategy (2006). Further, in 2007, the government made two significant decisions which improved the flow of contraceptive supplies and ensured dedicated funds from the federal budget for contraceptives - import tax on contraceptives was waived and a budget line from the federal treasury budget for contraceptives was established. The latest National Population Action policy (2010/11-2014/15) explicitly emphasizes Reproductive health as one of its 5 focal themes and includes a target for CPR (66%). A National Population IEC/BCC and Advocacy Strategy (2011-2015) has been developed to support sensitization efforts.

Of importance, use of research evidence for decision making has improved and has been instrumental in supporting advocacy in Ethiopia to influence policy and program decisions.

'HMIS, data reporting, research and dissemination has improved and many organizations have contributed to this.' - International NGO

Major policy and program decisions including waiver of the import tax on contraceptives, creation of a budget line, revision of the family law on age at marriage and the abortion considered research evidence.

2. Mobilization of financial and technical resources: Sound health and development strategies to guide financing decisions

Ethiopia's total spending for healthcare has increased from US$356 million in 1999/2000 to over US$1.2 billion in 2007/08 (Table 8). Per capita spending on health also grew substantially, nearly tripling from US$5.6 per capita per annum in 1999/2000 to US$16.09 in 2007/08 (Table 8). However, health is still underfinanced with the share of general government spending on health below the Abuja target of at least 15%. According to the WHO National Health

Accounts, in 2010, the share of general government spending on health in 2010 was 13%. More resources need to be made available to the sector to improve the health status of the population which would directly benefit the family planning program.

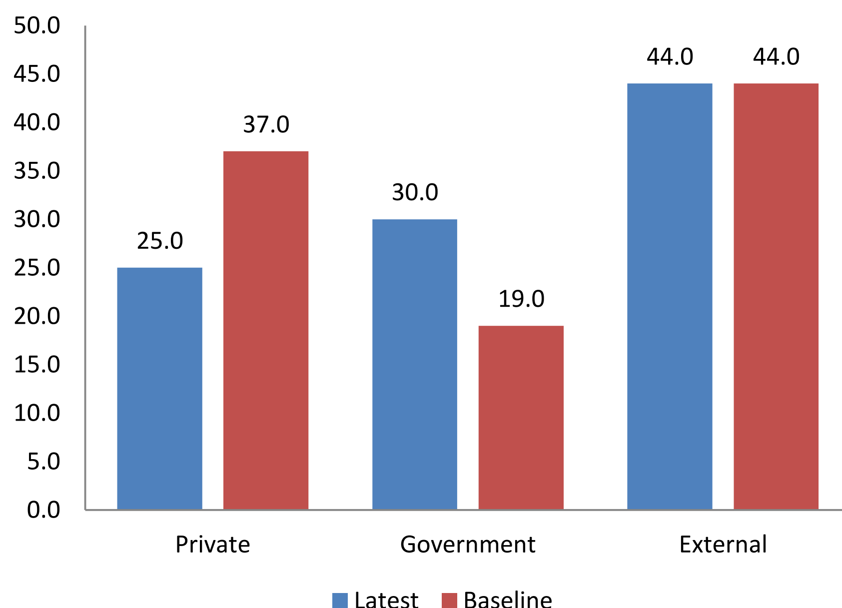
Table 8: Government spending for healthcare (US$)

Health expenditure	**1999/2000[1]**	**2004/05[1,2]**	**2007/08[2]**
Total health expenditure (millions)	356	522	1210
Per capita health expenditure (per capita per annum)	5.6	7.14	16.09
Share of total government spending on health (%)	4.4	5.6	5

Data Source: [1]National Health Accounts, 2004/05; [2] National Health Accounts, 2007/08

Typically, the reproductive health budget covers all reproductive health services including family planning services. A larger share of the funding for reproductive health program in Ethiopia is contributed by donors (44%) relative to government contribution (30%). However government contribution to the program has improved significantly, increasing from 19% in 2005 to 30% in 2008 (Figure 10). This coincided with a decrease in out of pocket expenditure on health.

Figure 10: Sources of RH funding in Ethiopia (%)



Baseline: 2005
Latest: 2008
Data Source: National Health Accounts, 2004/05 & 2007/08

Funding for family planning commodities has also been on an increasing trend (Table 7 and Figure 17). Before 2007, almost all contraceptives had been donated to Ethiopia by major donors (USAID, UNFPA and DFID). In 2007, the government created a budget line for contraceptives enabling better tracking of funds from donors and government towards FP commodities. Treasury started contributing funds albeit a very small share - most of the funds originate from basket funds or pooled funds from donors. Nevertheless, between 2007/08 and 2010, the government contributed

nearly US$ 2 million (Table 7). An added success has been that the regional governments also decided to prioritize family planning with the four major regions also allocating budgets for contraceptives.

'The second major achievement was we didn't limit ourselves to federal level only but we were also advocating at regional government level to start allocating budget for contraceptives which was started by youth and then Amhara regional states and followed by others.' – Local NGO

Currently, there are three financing mechanisms which procure family planning contraceptives and/or fund the health extension program– the Protection of Basic Services (PBS) and the MDG Pool Fund (both indiscrete) and direct funding to programs by donors (discrete). In the past, Ethiopia received funding for its health programs from development partners through budget support to central government (indiscrete) as well as partners funding programs directly (discrete). To fund its ambitious health sector reforms which included the Health Extension Program which was developed to increase access to basic services (including family planning) at the grassroots level, the government took several steps to mobilize partners and harmonize their plans in line with the government's health sector priorities. However, the government's efforts were interrupted following the 2005 elections, when development partners boycotted budget support due to political reasons. Development partners instead decided to pool their funds creating the PBS in 2006 (Pereira 2009), which is managed by the World Bank. Eventually, the government's vision to harmonize donor priorities with the government's priorities was realized with creation of the MDG Pool fund in 2009 (basket funding) managed by the government.

Table 9: Total spending for public sector contraceptives (US$)

Year	Total spending for public sector contraceptives	Total government spending	Internally generated funds	Protecting Basic Services	MDG Pool Fund	% of total spending for public sector contraceptives
2007/08[1]	21,711,864.41	12,810,000.00	910,000.00	11,900,000.00	.	59
2009[2]	29,411,764.71	20,000,000.00	.	20,000,000.00	.	68
2010[2]		14,919,000.00	919,000.00	9,000,000.00	5,000,000.00	
2007/08-2010	51,123,629.11	47,729,000.00	1,829,000.00	40,900,000.00	5,000,000.00	

[1]Data Source: USAID|DELIVER PROJECT Task Order 1. 2010. Measuring Contraceptive Security Indicators in 36 Countries. Arlington, Va.: USAID|DELIVER PROJECT, Task Order 1; [2]FDRE 2011. EDHS 2011 Results: An Unprecedented Increase In CPR

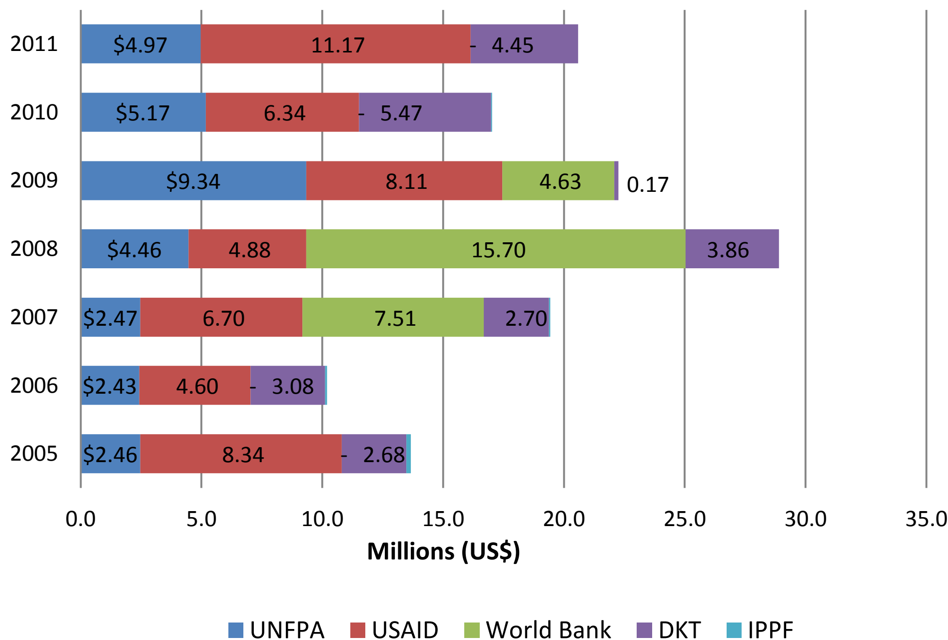
The PBS is a cooperation of several bi- and multinational development organizations (including World Bank, UK, Canada, and Ireland). It aims to pool additional funds to complement the government's spending on basic healthcare which includes essential health commodities and equipment at *woreda* level. PBS committed a total of US$6 billion between 2006-2012, to complement committed funds from the Government of Ethiopia amounting US$4 billion – funds were to be disbursed in two phases. PBS is currently in Phase II (2009-2011) and more than US$1.2 billion has been committed by 12 development partners for the period (The World Bank 2012), an increase from approximately US$1 billion in Phase I (PBS JRIS 2010). PBS contributed US$ 41 million between 2007/08 and 2010 to procuring contraceptives, approximately 3% of total funds spent or committed to the fund so far (Table 9).

The MDG Pool Fund aims to mobilize additional financing for the HSDP focusing on 4 thematic areas including Health Extension Program, Maternal Health, commodity procurement and health system strengthening. Recently the list of contributors is growing with donors such as GAVI Alliance, DFID and WHO contributing to this fund. However, mobilizing donor support has been difficult because donors are nervous about the fact that they are not able to determine and

track use of their funds in the basket (Pereira 2009) – a common view held by development partners in other countries with basket funding mechanisms. The World Bank, for instances, is still considering its options of whether or not to contribute to the fund. Nevertheless, in 2010, the MDG fund contributed US$5 million to procurement contraceptives (Table 9).

According to data from the Reproductive Health Supplies Coalition initiative RHInterchange, which tracks procurement of contraceptives by government and development partners, USAID, UNFPA and DKT (social marketing) have continued to provide major support (on or off budget) for contraceptives to Ethiopia's public sector. Between 2005 and 2009, they funded US$50 million, US$31 million, and US$22 million dollars, respectively, in contraceptives (Figure 11). Between 2005 and 2009, total contributions from these major donors rose from around US$14 million in 2005 to around US$21 million in 2011. Notably, in 2008, World Bank's injected substantial financing for FP commodities relative to USAID, UNFPA and DKT US$29 million. Funding trends reveal that since 2005 to present the focus has been towards procurement of injectables and implants. In the 2011/12 contraceptive forecast, nearly 95% of financial requirements for commodities are for purchasing injectables and implants (Figure 12).

Figure 11: Donor contributions to public sector contraceptives, 2005-2011



Data Source: RHInterchange, April 2012

Another funding mechanism, the H4MNH+, is under development to support maternal and child health and will likely increase financing for the family planning program. Five agencies, UNFPA, UNICEF, WHO, World Bank and USAID, have agreed to develop a joint work plan with targets based on the HSDP IV covering the period 2010/11-2014/15. World Bank is coordinating the group.

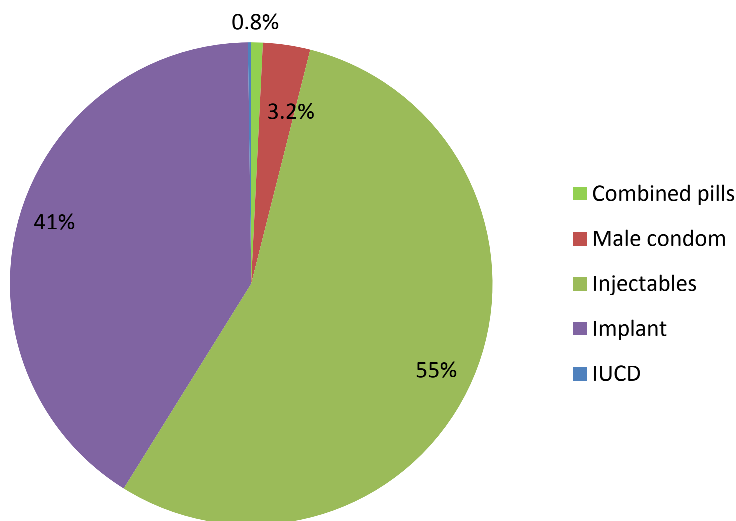
Considering contributions from all financing mechanisms, in 2007/08, the government of Ethiopia contributed nearly 60% of funding for contraceptives, with 5% from internally generated funds and 54% from PBS, while in 2009, the contribution was 68% of the budget from PBS (Table 7). In 2011/12, the estimated national budget for contraceptives

was nearly 35 million (FMOH 2011). The government committed US$930,000 from internally generated fund (including 477,000 and 215,000 from two regions – SNNPR and Amhara) translating to 2.7% of committed funds (ibid).

In addition, on a broader scale but important to the family planning program, the government provides salaries for the existing 33,000 health extension workers who provide family planning services as part of the essential health services package. Various development partners e.g. USAID, the World Bank and DFID also support components of the health extension program and other health systems strengthening initiatives including training and supportive supervision, equipment, health infrastructure and information systems.

'Partners are supporting the training and the pre-service training activities and some of the monitoring and follow-up activities. The health extension workers are salaried by the public sector' –International NGO

Figure 12: Financial requirements for contraceptives, 2011/12



Data Source: Federal Ministry of Health (2011). Ethiopia National Contraceptive Forecast (2011-2013).

3. Health Systems Strengthening

The process of improving the health system with the broader aim of improving access and utilization of services begun in the late 1990's with the introduction of the health sector plan (HSDP) from which the FP program benefited. The reforms included expansion of primary health care coverage; integration of FP and MCH; decentralization of health services so that planning and resource allocation is done at the *woreda* (district) level; human resource strengthening including improvement of pre- and in- service training of health workers in provision of family planning; and infrastructure development.

3.1. Integration of SRH and HIV services

Along with Kenya, Ethiopia has been named a pioneer in integration of SRH and HIV. Since the late 1990s, development partners such as USAID and Pathfinder have been assisting the GoE to develop and implement integrated SRH and HIV policies and programs (Pathfinder International 2011). Following the 2004 Implementing Best Practices (IBP) meeting held in Uganda, which called for integration of FP into VCT and PMTCT, the Federal MOH and Federal HIV/AIDS Program Coordination Office (FHAPCO) established an FP/HIV Integration Technical Working Group (TWG) (ibid). The TWG was mandated to develop and implement an FP/HIV Integration Plan of Action with the following key objectives: increase access to FP information and services in VCT and PMTCT settings to prevent lost opportunities to meet clients' needs; expand FP services to HIV-positive couples to prevent unintended pregnancies. In 2006, a research study on FP/HIV integration, the VCT Integrated Study (VICS) was conducted (ibid). The study findings (published in 2009) revealed that integration of FP benefits a larger target client than those seeking VCT services and provides a setting for repeat visits.

The Integrated Family Health Program (IFHP) implemented by Pathfinder, which has coverage of 40% of the population in Ethiopia, integrates HIV/STI prevention into all community RH service delivery and FP counseling and services in facility-based HIV care and treatment and VCT services (Pathfinder International 2011). In 2011, an evaluation of the program found that the program has had encouraging results in increasing access to and use of contraceptives among HIV positive and negative clients (ibid). The analysis found that the close collaboration between FP/RH and HIV partners to support linkages and synergies has been a major contributor to the success of FP/HIV integration in Ethiopia. Further, FP/HIV integration activities have been facilitated by the fact that they are not implemented as a standalone program. Rather, they exist within the context of a broader program that addresses integrated health services and supports health commodity availability, regular visits by supervisors, and ongoing support for data collection and referral systems. The program is being scaled up with a focus on expanding method mix and promoting use of longer acting methods, strengthening the capacity of health facilities and community health worker to provide integrated RH services, establishing an integrated data collection tools for HIV clients and incorporating FP/HIV integration in in-service and pre-service training of nurses and health officers.

3.2. Expansion of the health infrastructure

Alongside implementing the HEP, the health sector needed to build healthcare infrastructure to support reforms and particularly to increase access in rural areas. There has been tremendous progress in the construction of health posts (HPs) which increased from 76 in 1996/7 to 14,416 in 2010 (Table 10). By 2010, the coverage of health posts and health centers was 89% and 84% respectively with plans to meet 100% coverage (FMOH 2010).

Table 10: Trends of health facility construction

Facility	HSDP I (1996/7)	HSDP II (2003/2004)	HSDP III (2010)
HPs	76	2,899	14,416
HCs	412	519	2689
Hospitals	87	126	195

Data Source: Federal Ministry of Health 2010. Health Sector Development Program IV. 2010/11 – 2014/15. FINAL DRAFT

3.3. Decentralization of the health system

Crucially, with the introduction of the HSDP, the health sector began decentralizing the health system in line with the national decentralization policy of 1995. The third phase of the health sector plan (HSDP III (2004/5-2009/10)) marked

the beginning of the devolution of power to *woreda* (district) based planning process (MOH 2011), an autonomous system which gives significant responsibility to *woredas* (district) for planning and resource allocation. Within each state's health sector, regional health bureaus (RHBs) preside over the zonal health departments that supervise the local health offices (Mbengue and Kelley 2001). The Ministry and the RHBs focus more on policy matters and technical support while *woreda* health offices manage and coordinate the operation of the district health system under their jurisdiction (FMOH 2010).

In 2007/8, the government of Ethiopia implemented a major reform, Business Process Reengineering (BPR), of the health sector which introduced a three-tier health care delivery system: level one is a woreda/district health system comprised of a primary hospital (to cover 60,000-100,000 people), health centres (1/15,000-25,000 population) and their satellite Health Posts (1/3,000-5,000 population) connected to each other by a referral system. The primary hospital, health centre and health posts form a Primary Health Care Unit (PHCU). Level two is a General Hospital covering a population of 1-1.5 million people; and level three is a Specialised Hospital covering a population of 3.5-5 million people (FMOH 2010).The Health Extension Program (HEP) is viewed as the bedrock of the Ethiopia's decentralized health system and serves to increase access to basic services at the village level.

Mechanisms on developing regional and local plans to feed into the country level priorities were further defined in the 2007 Harmonization Plan aimed at streamlining the innumerable plans, budget channels and reporting requirements by different actors in the health sector (FMOH 2007). By the end of HSDP III, all regions, zones and *woredas* had undergone training during the actual planning for the development of HSDP IV annual core plan and had developed HSDP IV *woreda* based Health Sector Annual Core Plan which feed into the regional and national HSDP plans (MOH 2011).

With decentralization, *woreda*'s get a block grant from the central government to plan for deferent sectors including health, education, social services etc. However, this is not adequate to pay for medicines and equipment. This led to a change in the health financing legislation and the initiation of a health financing program enabling public health facilities to retain the collected revenues as additional funds to the governmental (which is much less than the money they generate) (Ageze 2008). The additional funds are earmarked to improve quality and quantity of the service provided at the health facilities (FDRE 1998). The performance report for health care financing up to the end of fiscal year 2008/2009 showed that 73 hospitals and 823 health centres have started retaining revenue (FMOH 2010). Encouragingly, 95% of these units collecting user fees had used the revenue at their level (ibid). From our interview with a key informant, we found out that retaining the funds generated presented an imminent challenge to the health centers and hospitals in relation to additional funds allocated to the health sector from the *woreda*. Health facilities must report the money they generate to the *woreda*. This has resulted in the *woreda's* allocating even less money to the health sector – as they perceived the health sector as having a lot of money. Nevertheless, the change in legislation has led to improvements in health services. But there is still need to convince *woredas* to allocate more resources towards the health sector.

In relation to prioritization of FP at regional level there is regional variation and the need for more advocacy for increased support of FP at this level persists. Nevertheless, in 2009 regional health bureaus of the four major regions - Oromiya, SNNPR, Amhara and Tigray – decided to commit their own funds for contraceptives and even included targets for family planning in their five year health strategies (MOH 2011). Partners are also supporting the devolved system through the PBS funding mechanism and discrete funds preferring this arrangement because they are better able to track how their funds are being used (Pereira 2009). In addition, the national contraceptive forecasting and quantification is based on regional calculations. The new commodity logistics system is also decentralized with regions sending requisitions to zonal hubs and in turn zonal hubs are responsible for obtaining commodities and supplies from

the central stores. However, the system is not without its challenges which are highlighted in different parts of this report.

3.4. Health workforce training

Human resources development is unsurprisingly a priority of Ethiopia's health sector. Ethiopia has lower than the WHO recommended health worker density (0.7 per 1000 population compared to the recommended 2.3) characterized by a particularly large physician shortage. Human resource development was prioritized within Ethiopia's national health policy which emphasizes the expansion of frontline and middle level oriented training with a focus on a team approach to healthcare, supportive supervision, continuous education and career development. A Human Resources for Health (HRH) Strategy is being developed to guide implementation of training of needed health workers and is based on the wider policy framework of the HSDP and MDGs. Nevertheless, there has been some progress to increase and enhance the human resource for provision of healthcare which has directly benefited provision of family planning services. Major initiatives have included expanding the capacity of health workers to provide essential health services which led to the creation of new health cadres based on the principle of task shifting – HEWs and Health Officers.

A major achievement of the health sector human resource development program is the pre- and in-service training and deployment of 33,819 HEWs by 2010. Even so, it only reached 89% of communities, versus the planned target of 100% (FMOH 2010). As part of the implementation, 2,566 HEP supervisors were trained and deployed, achieving 80.2% of the target. This cadre has been attributed to the large increase in contraceptive use and substantial improvements in other key health indicators in Ethiopia during the last decade. With the launch of the implanon scale up initiative in 2009, more than half of the HEWs (17,000) had been trained in implanon insertion procedures by the end of 2011 and plans were in motion to begin training on counselling and follow-up for IUD. These scale-up initiatives are expected to further increase contraceptive use in Ethiopia, particularly the long acting methods. Furthermore, the government plans to train an additional 10,000 HEWs by 2020 to meet the growing health care needs of the country.

Additionally, large scale programs such as the IFHP, funded by USAID and implemented by Pathfinder, support in-service training of nurses and health officers in long acting methods. The IFHP program uses the HEWs to mobilize community members and bring them to the health center overcoming challenges related to having sufficient numbers of clients for facility-based training.

'Within the IFHP program, graduates have to undergo training on LAM. For service based training, there is need for enough number of clients. In the IFHP program, community members are mobilized by HEW to bring them to the health center. In this way, a single training can have up to 500 clients.' –Development partner

There are ongoing efforts to continue augmenting the quality of training of health workers in provision of family planning services. At the time of the interview, the FP Technical Committee was developing a national curriculum for pre-services training of nurses and health officers.

3.5. Public-private partnerships

Since 2001, when the national policy for engagement of the private sector was introduced, there has been a rapid expansion of the private-for-profit and NGO organizations which has augmented the public-private-NGO partnership for health as well as boosted health service coverage and utilisation. Of importance, in relation to family planning services,

many of the NGOs and private sector service providers work with the government through participation on key coordinating and steering committees to assure family planning services are well distributed across the country. By 2007, the GoE had signed into the International Health Partnership (IHP) promoting the One-Plan, One-Budget and One-Report approach at all levels of the health system.

A number of organizations support the government to increase uptake of family planning in the private sector (DKT, MSIE and IPAS). They supply commodities (DKT) to public and private sector or provide a range of contraceptives (through network facilities) including short acting (condoms, pills, emergency contraceptives and injectables) and long acting (implants and IUCD). Population Council and DKT have been instrumental in introducing emergency contraceptives into the market. Population Council generated evidence from a needs assessment in 1997 and found that youth were not using contraceptives. Population Council then assisted the FMOH to mainstream emergency contraceptives (Postino2) into the public sector and building the capacity of health providers to provide counseling. Previously, drug vendors supplied some types of contraceptives. However, the government has been phasing out the drug vendor program for past 6 years following the introduction of the Health Extension Worker program.

Notably, there are still gaps in service coverage, for example, the pastoral communities, young women who have been married and youth in rural areas. To inform improvements in these and other service delivery, access and utilization challenges, health sector systems reforms in the period 2005 to 2010 (HSDP III) resulted in redesigning Research and Technology Transfer as a core process of the FMoH. Consequently, there was a surge in the number of operational studies during that period that covered a wide range of areas: Reproductive health, Child health, Communicable diseases, Public health, and health services (FMOH 2010).

3.6. Supply chain management: Improved forecasting, procurement and distribution

Before 2007, the public sector's health commodities logistics system under Pharmid, the organization responsible for procurement and distribution of public health commodities, had a continuous struggle with lack of a formal system design (DELIVER 2007). In 2004, the FMOH with assistance from development partners designed and developed a parallel logistics system, the Ethiopian Contraceptive Logistics System (ECLS) which was successful in ensuring contraceptive supplies to health facilities and communities. Notably, the FMOH revamped the FP Technical Committee to include a reproductive health commodity security agenda and begun producing an annual contraceptive forecasting, resource *gap* analysis and a quarterly contraceptive stock status report for all regions/cities and their family planning partners in 2004. The process included building the capacity of health facilities in contraceptive quantification and forecasting. The contraceptive stock status report facilitates quarterly planning and tracking of contraceptive stock status nationally. Two types of data are used for quantification and forecasting the National and Regional commodity requirement: demographic trends and issue or distribution data (used as a proxy for consumption data) from the central warehouse to regions for the 3 past years. Service data is not readily available for all regions and is inconsistent and hence is not used in the final analysis. The consumption and demographic forecasts developed by the FP technical committee is evaluated and finalized by each region. The regional forecasts are aggregated into a national forecast and validated against national trends, programs and inventories. Crucially, the ECLS resulted in a large increase in demand for contraceptives in 2005 to the point where DKT, a social marketing organization, was engaged to support the government in supplying the public sector.

Despite the success of the ECLS, the government wanted to integrate the commodity logistics system in line with health sector reform priorities and dissolved Pharmid with the establishment of the Pharmaceutical Fund and Supply Agency

(PFSA), an autonomous agency, in 2007, as well as introduced the Integrated Pharmaceutical Logistics System (IPLS) in 2010. The system is modeled on the existing ARV commodity logistics system, which is considered to be the most robust of the existing vertical commodity supply logistics systems in the country. The system is decentralized and uses a pull system from the service delivery points to the PFSA zonal hubs through to the central medical store which is a change from the Pharmid system that utilized a push system. Crucially, when the health centers prepare their request to the regional hub, the amount of pharmaceuticals to be used by the health posts is considered (there are 5 health posts assigned to each health center). Each month, health posts report to their health centers on available stocks at the post, losses or adjustments and quantity used. The HCs will calculate the need and resupply the HPs with the necessary Pharmaceuticals. The plan is for the system to be the sole procurement and distribution agency for the public sector.

With the establishment of PFSA there have been progressive improvements in the public sector procurement process and subsequently commodity stock-outs have substantially declined in facilities at all levels.

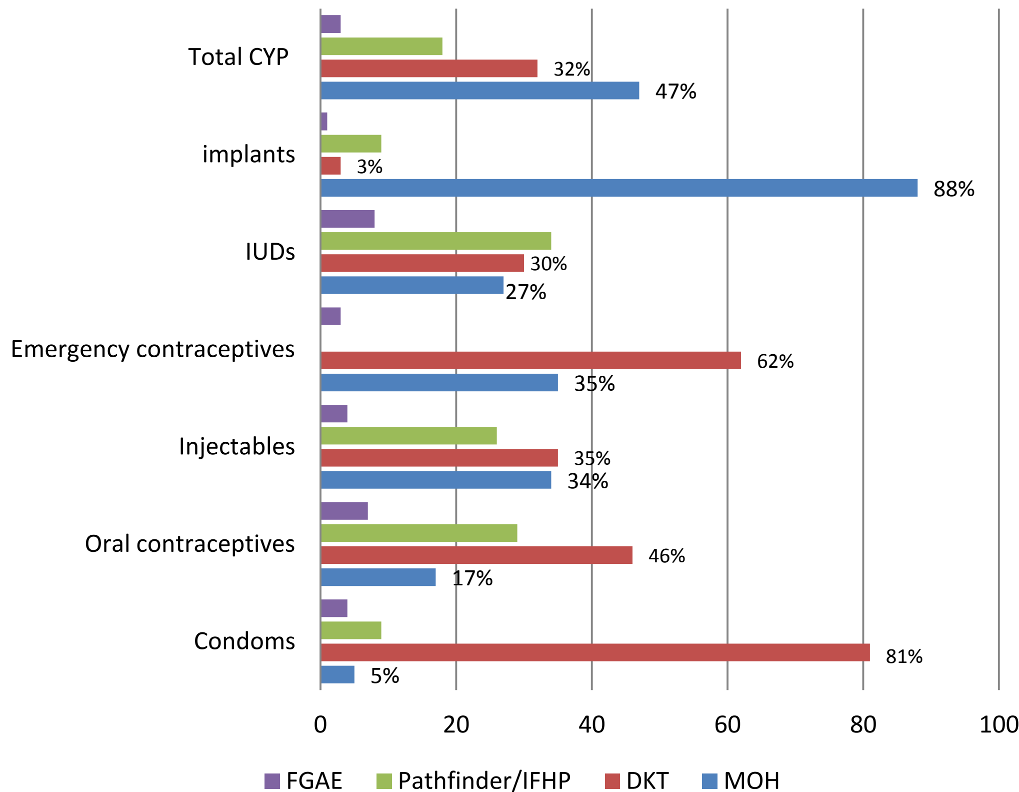
'…commodity stock outs have dramatically reduced in recent years, further ensuring access to contraceptives. UNFPA conducts an annual survey to assess stock-outs – and no stock out reports are being reported for the major three commodities– condoms, pills and injectables and now including long acting methods particularly at secondary facilities - health centers and hospitals at 100%. At primary level no stock-out reports are 95%'- Development partner

The government's decision to waive the import tax on contraceptives in 2007 also improved the flow of contraceptive supplies throughout the country. As a result, stock-out reports have reportedly reduced substantially.

'The first thing is the federal government exempted the tax on contraceptive commodities.'' – Local NGO

Subsequently, DKT contribution of contraceptive supplies to the public sector market has declined due to improvements in the procurement process. In 2002-2003, DKT distributed 61% of total couple years of protection (CYP) which declined to 29% in 2009/10. Cumulatively, over the period 2002-2010, government has contributed nearly half (47%) of the total CYPs while DKT has contributed one-third (32%) of the total CYPs (Figure 13).

Figure 13: Modern contraceptive distribution in the public sector by organization, September 2002-August 2010 (% of the total CYP)



Source: FMOH 2010. MOH annual Health and Health Related Indicators Report
**Does not include private sector supplies (considered to be negligible)*

Notably, the pharmaceutical supply logistics system reform is ongoing and in transition and as a result contraceptive commodities in Ethiopia are distributed through a number logistics systems: the IPLS managed by PFSA; DKT which manages an independent supply chain to private sector but also sends supplies for public sector to PFSA which then go through that system; and the joint JSI/Pathfinder project where commodities are stored at PFSA but distribution is managed by JSI using the Ethiopian Contraceptive Logistics System (ECLS). DKT supplies to the public sector are mostly procured using donor funds such as the World Bank and the UNFPA), USAID (through the Pathfinder/IFHP), DKT and FGAE (the IPPF affiliate.

In terms of ensuring method mix, Ethiopians have access to various types of contraceptives (condoms, pills, emergency contraceptives, injectables, implants, IUCD and permanent methods), mainly through the public sector (procured by both government and NGOs) and some from the private sector. Injectables have been the most popular methods since the 1990s with increasing demand for implants and IUCD as indicated in the recent EDHS (2011). The government's plans show that the current national policy is to increase access and uptake of long acting and permanent methods (implanon, IUCD and sterilization). In 2011/12, nearly 95% of funds committed for contraceptives by government and partners were prioritized for injectables and implants. Private sector is also increasing supplies of long acting and permanent methods.

Despite improvements in the logistics system, there are still challenges to be addressed. The main challenge for the IPLS is the limited human resource, storage and transport capacity at different levels given the big task of integrating all

commodities. Since PFSA is new, it does not have enough storage hubs. PFSA is structured based on geographical proximity rather than regional boundaries so the country needs more than 17 regional hubs and currently there are only 8 under construction. Therefore, until the construction is finalized storage will continue to be a challenge. Logistics and transport for products is also a challenge. There is need for additional vehicles to transport a variety of commodities at one time to service delivery points. The government needs to consider this resource gap and address it either through out-sourcing or developing the capacity in-house. Conscious mapping of the location of hubs relative to service delivery points is critical to ensure effective communication between the *woreda* and zonal hubs. In the HSDP, this was one of the activities identified as necessary to tackle moving forward.

4. Bringing services to the community:

4.1. The health extension program

Following the implementation of the first phase of the health sector plan (HSDP-I) an evaluation of the plan was conducted and revealed that people in rural areas (who make up more than 80% of Ethiopia's population) had poor maternal and child health outcomes (as recorded in the Ethiopia Demographic and Health Survey (EDHS)) because they had poor access to primary care services. At this point the government embarked on a number of reforms under the "Accelerated Expansion of Primary Health Care Coverage" policy, a new health care plan to be delivered through an innovative service delivery model called the health extension program (HEP), that would ensure services at village (*Kebele*) level.

The program involves a one-year training of women aged 18 years selected from the communities in which they reside to provide 16 packages of health services categorized as Family Health, Infectious/communicable diseases, Environmental and Health Education. Family Planning is one of the components in Family Health and included administration of pills, condoms and injectables and referral for long acting and permanent methods. This health cadre is called health extension workers (HEWs) and is the lowest paid cadre in Ethiopia's health system.

One stakeholder interviewed, reported that the HEP was conceptualized by Prime Minister Meles Zenawadi drawing from his experience as a rebel in the war to remove the previous regime from power. While hiding out in the bushes, rebels with minimal training in provision of healthcare provided primary care to ailing rebels.

Still, some stakeholders believe that the HEP was designed using lessons from existing community based programs which utilized young women community based reproductive health agents (CBRHA) to provide RH information and services including condoms, pills and referral to health facilities for all other methods. The women underwent two to three week training and were volunteers who received a token for their services. These programs were mainly implemented by non-governmental organizations providing family planning services in Ethiopia during the 1990s to early 2000s such as Pathfinder International.

'The government drew lessons from the existing FP/RH project which was a Pathfinder project supported by USAID which used volunteers drawn from the community.'- Development partner

'…. the community based reproductive health agencies actually contributed to the increase in demand and also to the increase in the service delivery in relation to specific short acting family planning methods prior to the health extensions program.'- International NGO

The decision for the government to pay the HEWs was born from the need for a sustainable program. HEWs reportedly earn 700 birr per month, an increment from the initial salary of 500 birr per month and just 100 birr less than what entry level nurses employed in the public sector earn per month.

'….when the health extension programs started for us it was considered as big support in terms of community based family planning reproductive health programs because one of our major problems was working with volunteers and sustaining the voluntary work without the inclusion of motivation and all kinds of incentives…..' - International NGO

'The government took lessons but the problem is that they were not salaried. ….HEWs were initially paid 500 birr per month, now they get 700 birr per month. A newly employed nurse gets 800 birr. The commitment of the government is evident in that they are paying salaries for 33,000 HEWs at 700 birr per month.'- Development Partner

Between 2003 and 2011, the GoE trained 33,819 health extension workers (HEWs) and deployed them to 15,000 health posts nationwide translating to 2 HEWs per health post per village and each responsible for a population averaging 5000 people. Hence, it is not hard to see why the HEP is regarded the flagship program for delivering universal primary healthcare in Ethiopia and how as a result there has been a rapid increase in FP uptake during the past 5 years as registered between the 2005 and 2011 EDHSs.

The HEP program has been progressively enhanced to scale-up provision of FP services as well as ensure its sustainability. To meet the high target for CPR (66%) and in particular long acting family planning methods (20%), as indicated in HSDP IV, HEWs were trained to insert implanon, a single rod implant, in 2009 under the government's 'Implanon Scale Up Initiative' and are soon to be trained to provide pre and post counseling and follow-up for IUCD under the government's 'IUCD Scale-Up Initiative' in 2011. The government made the decision to prioritize long acting methods based on evidence showing that the high CPR target can be achieved only if more women opt to use long acting and permanent family planning methods. In addition, to intensify its reach, the program is being enhanced to include household level participation. A number of households have been selected to be mentored by the HEWs into model households to take responsibility of their health and wellbeing including planning their families. The model households will be empowered to influence 5 other families in their village. The government believes that this model will help increase uptake of basic health services including family planning. Model households who have been trained and graduated have reached a cumulative total of 4,061,532 out of an eligible total of 15,850,457 households. This represents only 26% coverage with an additional more than 11 million households to be trained and graduated (FMOH 2010).

Pastoralist people in Ethiopia constitute about 10% of the national population. They remain the most deprived in Ethiopia primarily due to poor infrastructure and lack of skilled service providers in pastoral areas. Use of contraceptives is lowest among pastoral communities (range from 4% in Somali region to 10% in Afar region where they predominantly reside) relative to the rest of Ethiopia (29%). However, most external resources are focusing on regions that carry the majority of the population of Ethiopia which are outside the areas where pastoral communities reside.

The government with support from some development partners such as UNFPA has started making deliberate efforts to focus resources in these communities, but the resources are insufficient, which is hampering progress. FMOH's

Pastoralist Health Promotion and Disease Prevention Directorate focuses attention on addressing the health needs of the pastoral communities (FMOH 2010). The government is currently designing a Health Extension Worker program that fits with the pastoralists culture (ibid). HEWs will be drawn from young men instead of young women. The government found that the rural HEP has not been successful in reaching the pastoralist communities due to its reliance on female HEWs and the mobility of the pastoral communities. Within the pastoral tradition, men are considered more superior to women and women enjoy little independent decision making on most individual and family issues, hence, pastoral communities are more likely to respond to male health workers. .

4.2. Demand creation

While the policies in Ethiopia have highlighted all the benefits of FP (slowing of population growth would facilitate socioeconomic development and environmental sustainability; women and children's health; and general empowerment of women), the main message in educational campaigns has been health benefits although recently, messages are incorporating the benefits of small family size.

Under the Health Extension Program, one of the responsibilities of health extension workers is to mobilize community members to use services through educating them, offering door to door services and making referrals to nearby health centers. Educational campaigns are implemented at national and regional level and use a variety of avenues to deliver messages including media (e.g. Population Media Council TV and radio programs) and community meetings. Leaders are also engaged to influence their followers including politicians, religious leaders, cultural leaders and traditional leaders .

'At the regional level, MOH discussed with Amhara regional health bureau to hold community meetings. The regional health bureaus agreed to support HIV, early marriage, condom and harmful practices. The MOH convinced them to identify gaps and contributions from other actors. There is commitment of the government to improve services and make them available.' - International NGO

Additionally, the FMOH collaborates with other relevant line ministries such as the Ministry of Women, Children and Youth Affairs to sensitize the women and youth about FP and mobilize them to use FP.

Since a large proportion of the Ethiopian population is religious it has been critical to engage religious leaders in order to sensitize the communities about FP. The leaders of major religions in Ethiopia have been engaged in advocacy and sensitization workshops to discuss the population policy, family socioeconomic concerns, harmful traditional practices, and related religious doctrines of the Orthodox Church and Islam. Religious leaders were encouraged and guided on how to incorporate developmental issues such as HIV and AIDS, reproductive health (RH), and gender equity into the daily teachings of the Orthodox Church (Population Council 2012). Once convinced they help educate community members about family planning and in some cases even provide family planning services (Pathfinder International 2006).

'It was not all that opposed but you can imagine we face that opposition when we go to communities but we started it at a higher level every religion had a presentation; Muslims, Christians etc, we reached a consensus and based on their way of communicating to their followers they disseminated the information. The religious leaders their role mainly was to convince their followers to have a small number of family sizes.' -Ministry of Health

Early marriage is prevalent in Ethiopia. Following the revision of the Family Law in 2000, the age of marriage was changed to 18 years and a penal law included. Since then various initiatives are being implemented to curb early child marriage. The Women's Affairs office is located in the office of the Prime Minister demonstrating the high priority the

government places on empowering women. The Ministry of Women, Children and Youth also has a gender program established around 2007. Its mandate is to lead gender mainstreaming in all government sectors. In addition, various development partners (Pathfinder International, Population Council, USAID, UNFPA, PEPFAR and the Adolescent Girls' Advocacy and Leadership Initiative (AGALI)) support, advocate for or implement community based early marriage prevention programs which have been successful in averting some early marriages in areas of great need such as Amhara and Tigray regions, some of which are being scaled up.

5. Coordination and accountability mechanisms

In addition, recognizing the invaluable contribution of the private sector including development partners and non-governmental organizations, the government put in place measures to strengthen partnerships with them and increase aid effectiveness through pooling of financial and technical resources under one plan, one budget and one reporting system. These instruments include the Code of Conduct (2005), HSDP Harmonization Plan (2007) and the Ethiopian IHP+ Compact (2008). Around this time, financial support for FP significantly increased.

Institutional coordination forums have also been strengthened, over the past decade, to streamline the activities of all FP stakeholders in Ethiopia. The FP Technical Working Group (FPTWG) revamped in 2004 is chaired by the FMOH and has been providing strong coordination to development partners supporting the government to implement FP programs in the country. The FPTWG reports to the broader National Reproductive Health Task Force along with TWGs for maternal health, nutrition, STIs/HIV, logistics and adolescent RH. Development partners participating on the FPTWG include UNFPA, USAID, John Snow Inc. (JSI), PACKARD, Futures Group, DFID, World Bank, DKT, Family Guidance of Ethiopia, Pathfinder International, Engender Health, Marie Stopes International Ethiopia and IPAS, to name a few.

The FPTWG is the main planning and coordinating mechanism for the FP program in Ethiopia and has contributed greatly in ensuring that the FP needs of the country are identified and collaboratively addressed with the aim of minimizing duplication and ensuring best use of limited resources. The FMOH assigns partners specific regions for operation and where conflict arises between two or more partners, the FMOH steps in to fairly distribute the regions. The group meets regularly as well as on an ad hoc basis when there is need to address a specific issue such as the development of advocacy initiatives, guidelines, manuals and training curriculums. Since 2004, the committee began contraceptive forecasting and quantification to improve commodity security. The FP Technical Committee has been instrumental in advocating for adequate funding for the FP program and removing barriers to provision of FP services including convincing the government to allocate a budget line for contraceptives and removing import tax on contraceptives, both in 2007.

In line with decentralization, a similar mechanism exists at the regional level. Regional Health Bureaus (RHBs) chair regional FP technical committees and are responsible for coordinating partners and resources, including fund raising and assigning areas of operation, at that level.

At the time of the interviews, concerns were raised over the ad hoc nature that the FP Technical Committee had been meeting in the recent past, attributing it to the recent reorganization of the FMOH. The FP Technical Committee was previously chaired by the Family Health Department. With the reorganization of the FMOH, it is difficult to identify under which Directorate the committee would be housed - the FMOH is now organized into three health Directorates: Urban, Pastoral and Agrarian. The FP program falls under the Urban Directorate. The stakeholders we talked to continue to maintain their value of the committee in sustaining the current momentum of the FP program and felt that the mechanism should continue.

Over the past 5 years or so various health financing coordinating mechanisms which have benefited the family planning program were also created. These are further elaborated in the section on financing.

Challenges and sustainability for FP uptake in Ethiopia

Sustained progress to meeting the contraceptive needs of people in Ethiopia is dependent on efforts to improve a number of challenges. Like in other countries in the region, availability of funding remains a sustainability issue. The government of Ethiopia has made great strides towards ensuring dedicated funding flow for contraceptives by establishing a budget line for contraceptives and mobilizing funding through multiple funding mechanisms (treasury, PBS, MDG pool fund and other discrete funds) for contraceptives. However, there is a funding gap of 50% each year for procuring contraceptives (FP Summit, 2012). Further, the government's contribution from treasury is still relatively small. To ensure that all contraceptive needs of Ethiopians are satisfied, the government needs to find ways of mobilizing additional financing to close the funding gap. A first step could be that the government allocates more funds from treasury towards FP. One thing to note is that as more Ethiopians learn about and decide to use FP, unmet need for FP will likely remain high for some time which has and implication on financing. Contraceptive use in Ethiopia, despite having improved dramatically over the past decade remains quite low in comparison to its neighboring countries. Therefore, sustained advocacy to political and community leaders and educational campaigns are needed to increase the awareness of the benefits of FP particularly in areas with very low contraceptive use. Along with national advocacy, regional and district level advocacy is important because with the devolution of power to the districts, districts are responsible for planning and budgeting for FP and there is need to ensure prioritization of FP at these lower levels.

Breaking socio-cultural practices such as early marriage that promotes early childbearing and stigma related to young people engaging in sex which prevents use of SRH services are of great concern to policy makers in Ethiopia. While various instruments are in place to address these barriers, the progress has been slow. The youthful and rapidly growing population of Ethiopia amidst diminishing resources provides limited opportunity to continue at the current pace. Ethiopia must scale up early marriage prevention programs that have been successful in curbing the practice. Likewise, Ethiopia can scale up successful approaches for reaching all young people with SRH information and services particularly in remote areas, primary and secondary schools and higher learning institutions. Youth centers established at the community level by the government could be an opportunity to incorporate FP information and services. Ethiopia can also learn about innovative approaches being used in Southern Africa and countries such as Kenya and Rwanda to meet the SRH needs of young people. Notably, these efforts must go hand in hand with efforts to increase completion of basic education.

'One of the biggest challenges in the public sector is that majority of the health facilities are not youth friendly. However, some of the NGOs for example MSI and FGAE, have user friendly services and hence many youth go to these centers for services. However, their coverage is not wide and they are mostly situated in the cities serving mostly the urban youth.'- Development partner

Increasing demand for contraceptives means that the health system must have the capacity to respond efficiently. The government of Ethiopia has made impressive progress in improving the health system through strengthening and building infrastructure, strengthening the health information system and training health workers to provide services and use the health information system which have benefited the FP program. However, there are still many challenges to address. Some include the need to improve pre-service training and the logistics system and engage better with the

private sector. Pre-service training of health workers to provide FP remains a challenge which when addressed will substantially reduce the cost of implementing the FP programs. The development of the Ethiopia Contraceptive Logistics System (ECLS) was instrumental in improving the FP commodity supply chain to the public sector in Ethiopia but this was a vertical program put in place in 2004 to address immediate logistic issues at the time. However, Ethiopia has been rolling out an integrated commodity supply chain management system for all commodities over the last year. Ethiopia must make significant investments to address the emerging challenges of the integrated system. Some emerging challenges identified include building required zonal hubs, addressing distribution challenges, updating health facilities with the new information system and training health workers in storage and managing stocks.

Ethiopia's logistic system is an example of a successful public-private partnership where the government has partnered with John Snow, Inc to develop and implement a robust contraceptive logistics system that is aligned to the government priorities. Likewise, the government of Ethiopia needs to find other innovative ways of meeting the contraceptive needs of people through formation of strong partnership with the private sector using a systematic approach as used in Malawi, Kenya and Rwanda.

'It is also a challenge for the government to work with the private sector.' – Private implementer

Conclusion

Ethiopia's rapid increase in contraceptive use over the last decade can be attributed to: political will and commitment of the current Minister of Health; the health extension program which is the bedrock of the health system; and an influx of resources for FP mostly from donors but also commendable contributions from both central and regional budgets. Moving forward, Ethiopia is likely to meet its CPR target of 66% with the successful roll-out of the implanon scale-up and IUCD scale-up initiatives and other strategies such as the model family and pastoral health extension program. However, the need to increase government contribution to the FP program remains a major issue of sustainability.

KENYA

Historical Context of Family Planning in Kenya

Kenya is among the first countries in sub-Saharan Africa to have a successful family planning programme which contributed to the rapidly declining fertility level in the 1980s and 1990s (Mati 2010; Ajayi and Kekovole 1998). Family planning services in Kenya began in the late 1950's in the private sector in Nairobi and Mombasa (Ndegwa et. 2008). Two doctors, Dr Samson N. Mwathi and Dr Meshack Ndisi, are highly credited to have been the local pioneers of family planning in Kenya, and in 1962, they merged the family planning committees of Nairobi and Mombasa to form the Family Planning Association of Kenya (FPAK) (Chimbwete et al 2005). In 1963, the same year Kenya got its independence, FPAK became affiliated to the International Planned Parenthood Federation (IPPF), becoming the first sub-Saharan African Family Planning Association to join IPPF (Mati 2010; Ndegwa et. 2008).

Upon attainment of independence, family planning was not a popular concept with the new government. There were fears that the intention was to weaken Africa for continued Western domination **(**Mati 2010)**.** Even with the 1965 Sessional Paper No. 10, developed through the pioneering efforts of Tom Mboya and Mwai Kibaki, clearly showing preference for the demographic rationale for family planning, there were strong opposing views from Parliament, including banning call to certain contraceptive methods (ibid). Nevertheless, President Mzee Jomo Kenyatta approved the population policy (Family Planning Programme in Kenya) as the first Five-year Development Plan (1966-1970) (Toroitich-Ruto 2011; Robinson and Ross 2007). While the policy recognized the challenge of rapid population growth on development, it did not specify targets for population growth rate and fertility rate, or funds for population reduction possibly because it was not government driven initiative (Robinson and Ross 2007; Chimbwete et al 2005).

In 1967, the Ministry of Health (MOH) established Kenya's Family Planning Programme and issued guidelines to ensure family planning services were provided free in all its facilities (Robinson and Ross 2007). Two circulars on family planning were issued in 1966 and 1967 (ibid). The first was sent to provincial and district medical officers announcing the establishment of the national family planning program. The second stipulated that family planning service providers should be trained and that the services should be offered free of charge. The pronatalist attitude of Kenyans set the tone for the promotion of family planning from the perspective of its benefits to maternal and child health emphasizing child spacing (Chimbwete et al 2005; Thumbi 2002). Two other successive five year development plans were developed between 1970 and 1978, all of which implicitly recognized the importance of the high and increasing rate of population growth for Kenya's economic development (Robinson and Ross 2007).

MOH opened the first family planning centers in Central province in 1968 and later set up the National Welfare Centre (later renamed the Division of Reproductive Health) in 1974 (Toroitich-Ruto 2011). In 1975, a 5 year Government Development Plan was launched and a Maternal and Child Health/Family Planning Programme (MCH/FP) established to improve services to women aged 15-49 years and children below 5 years - the groups proven to be at greatest risk for ill health following an assessment to identify the problems associated with health care in rural areas (ibid). This was followed by the establishment of a comprehensive Integrated Rural Health and Family Planning Programme (IRH/FP) which promoted more cooperation with NGOs and introduced new innovative strategies, such as Primary Health Care (PHC), and demand creation (ibid). The goal of the program was to reduce the population growth rate from 3·3% in 1975 to 3·0% by 1979 (ibid). However, the program was weak and ineffectual failing to meet its targets (Robinson and Ross 2007). Consequently, between 1969 and 1979, the total population grew by just over 40% to more than 15 million people (Ibid). Further, the 1977-78 Kenya World Fertility Survey (KWFS) showed an alarmingly high total fertility rate (TFR) at 8.1 children per woman and a low contraceptive prevalence rate CPR) of 7%.

A defining moment for family planning in Kenya emerged in the 1980's during President Daniel arap Moi's tenure as the second president of Kenya. It has been documented that while President Moi attended an international meeting in China, he was introduced as "the president of the country with the highest fertility in the world". This statement motivated the President to promote an intense nationwide campaign and advocacy for contraceptive use with the support of international donors and other NGOs. This initiated a period of remarkable increase in contraceptive use in Kenya characterized by government leadership, creation of an enabling environment for grassroots and faith based involvement, and support for community-based distribution of services (NCAPD 2010).

Community based distribution of contraceptives (CBD) program was initiated in 1980, with community health workers (CHW) trained to provide information, counseling and quality services for pills and condoms. The CBD program was run by Maendeleo ya Wanawake Organization (MYWO), the Family Planning Association of Kenya (FPAK), Nairobi City Council, Anglican Church of Kenya (ACK), and the MOH. Pathfinder also played a key role in development and implementation of the program. Information Education and Communication (IEC) materials were developed and widely distributed to sensitize people about the benefits of family planning and also to allay the misconceptions that existed about the use of family planning. The CBD programmes helped overcome serious obstacles like women's lack of knowledge that the services were available, and the time and cost constraints they faced in visiting family planning clinics. There was also a lot of advocacy to the public using mass media communication including TV and radio. In 1982, the National Council for Population and Development (NCPD) was established under the Ministry of Health to formulate relevant population policies and strategies and to ensure effective co-ordination of all population related activities in the country. The council was established as a condition by World Bank to continue funding population projects in Kenya- to release the second tranche of the Second Structural Adjustment Loan (Robinson and Ross 2007). NCPD organized the first National Leaders Population Conference in 1984 to rally the support of leaders in the family planning program. This conference also led to the preparation of Population Policy Guidelines, an update of the 1967 population policy. Consequently, the NCPD set up the National Family Planning Programme in 1984 with a strong Information, Education and Communication (IEC) component to increase demand for and utilization of contraceptives.

Development partners were encouraged by the high level of political will and commitment and provided substantial amounts of funding and technical support for the FP programme (Robinson and Ross 2007). The World Bank provided funds for training of nurses to provide family planning methods while EngenderHealth trained medical doctors to provide the surgical methods of family planning. USAID was a key funder of the program and procured most of the commodities especially short and mid acting methods, while Marie Stopes International (MSI), Kenya supplied most long-acting and permanent methods (LAPMs) including sterilization, vasectomy, IUDs and implants. Other NGOs provided services in the government facilities or set up satellite clinics and outreach static sites. Although the government was to provide about 25% of the programme costs, there is no evidence of actual government expenditure for the FP programme. Hence, the programme heavily relied on donor funds. Nevertheless, family planning services were provided free of charge in practically all government hospitals, health centres and clinics.

These concerted efforts to reduce fertility started bearing fruits in 1984 when the Kenya Contraceptive Prevalence Survey (KCPS) showed a reduction in fertility to 7.7 children per woman, and a rise in CPR to 17%. This decline of fertility continued up to 1998 when the Demographic Health Survey (DHS) showed a total fertility of 4.7 children and CPR of 39%. The demographic transition is said to have started in Kenya in 1989 when population growth rate declined to 3.4% in 1989 and further to 2.5% in 1999 (Chimbwete et al 2005 and Thumbi 2002). Fertility had declined to 6.7 (41% decrease since 1978) while contraceptive use had increased to 27% (286% increase since 1978) (KDHS 1989). This was

the largest overall increase in CPR and TFR in sub-Saharan Africa, and thus Kenya is referred as the pioneer of demographic transition in the region.

However, this progress waned in the late 1990's resulting in a stagnation of contraceptive use and an increase in fertility between 1998 and 2003. The 2003 KDHS showed that the contraceptive prevalence rate remained at 39% during that period, while fertility actually increased from 4.7 to 4.9 (Table 11). This period is referred to '*the dark decade in contraceptive uptake in Kenya*'. Unmet need for contraceptive use, which had decreased from 60.3% in 1989 to 23.9% in 1998 (a 60% decrease) increased again to 24.5% in 2003 (Table 11).

In the latest DHS report (2008-09), there is an indication that Kenya is recovering from the stall period. Contraceptive use increased from 39% in 2003 to 45.5% (at a rate of 1.3 percentage points per year) and fertility declined from 4.9 to 4.6. Unmet need for family planning, however, remained the same at around 25%. According to latest DHS reports, Kenya ranks second amongst the five East African Community countries on use of modern contraceptives by married women (Rwanda 45.1% in 2010; Tanzania 27.4%; Burundi 17.7% in 2010; Uganda 17.9% in 2006) (IPPF and AFIDEP 2011). Injectables remains the most popular method being used by married women and increased by 50% from 14.3% in 2003 to 21.6% 2008-09. Use of all other methods remained relatively the same.

Table 11: Population, fertility and FP use trends in Kenya (around 1990 to around 2010)

Year	Population size (millions)	Total fertility rate	Modern Contraceptive Prevalence Rate (%)	Unmet Need for family planning (%)
1993	25.8	5.4	27.3	36.4
1998	29.7	4.9	31.5	23.9
2003	33.8	4.9	31.5	24.5
2008/9	38.5	4.6	39.4	25.6

Data sources: DHS

Population data are from The World Bank, World Development Indicators 2011

Table 12 gives an onverview of the evolution of the family planning and population agenda, policies and programs in Kenya from the late 1960s to the present day.

Table 12: Chronology of key events related to FP and population in Kenya

Year	Events/Activities	Indicators
1955	First private birth control clinic opened in Nairobi	
1956	Second private clinic opened in Mombasa	
1957	Pathfinder Fund assists the Family Planning Committees of Mombasa and Nairobi to merge forming the Family Planning Association of Kenya.	
1963	Family Planning Association of Kenya (FPAK) becomes affiliated to the International Planned Parenthood Federation (IPPF), the first sub-Saharan African Family Planning Association to join IPPF	CPR: TFR:6.8
1965	Sessional Paper No. 10 of 1965 on 'African Socialism' tabled by Ministry of planning; the first effort when population growth was seen as a barrier to socioeconomic development, and the importance of investing in family planning to check population growth	
1966	The population policy entitled 'Family Planning Programme in Kenya' produced in 1965	

	was adopted as the first Five-year Development Plan	
1967	Kenya's Family Planning Programme was established within the Ministry of Health; aimed at reducing high population growth rate and improving welfare of children and women	
1968	Ministry of Health issued guidelines on family planning to all its facilities First family planning centres by MOH opened in Central Province, family planning services were provided free of charge	CPR: TFR:7.8
1974	National Welfare Centre (later renamed the Division of Reproductive Health) was set up in MOH The first world population conference that brought together international governments was held in Bucharest	
1975	Government launched a 5 year Development Plan 1974/78, and established a MCH/FP programme and a comprehensive Integrated Rural Health and Family Planning Programme (IRH/FP). Goal was to reduce the annual rate of natural increase from 3·3% in 1975 to 3·0% by 1979.	
1978	Kenya World Fertility Survey (KWFS) conducted showed high fertility rates Kenyan first president Kenyatta died and Moi took over from him.	CPR=7% TFR=8.1, ,
1979	Population and Housing Census conducted	Population growth rate:3.8%
1980's	The funds provided by world bank were largely used to train nurses to provide information on benefits of family planning and also to provide FP methods	
1980	Policy Guidelines for service providers in family planning developed Community based contraceptive distribution initiated and community health workers trained to provide quality services (Pills and condoms).	
1982	National Council for Population and Development (NCPD) established to formulate relevant population policies and strategies and to ensure effective co-ordination of all population related activities in the country. EngenderHealth begins training doctors in safer, more client-centred surgical sterilization and counseling styles	
1984	First National Leaders Population Conference held followed preparation of Population Policy Guidelines Kenya Contraceptive Prevalence Survey (KCPS) conducted showing a large discrepancy between unmet need for family planning and use of contraceptives. FP IEC materials on the benefits of using FP widely circulated and women educated. The second International Conference on Population held in Mexico City.	CPR: 17% TFR=7.7
1985	Pathfinder develops a comprehensive Community-Based Distribution (CBD) strategy for the government that included the establishment of District Population Officers to work with communities, adopted as the national program. Marie Stopes International (MSI) starts offering services through static clinics and diverse	

	outreach strategies, supplying most long-acting and permanent methods (LAPMs) including sterilization, vasectomy, IUDs and implants	
1987	Serious commitment to the FP programme begins	
1989	Census and demographic health surveys conducted showing declining fertility and increasing contraceptive acceptance	CPR:27% TFR:6.7, Population growth rate:3.4
1992	Introduction of Structural adjustment Programme by the government that introduced cost sharing and user fees in health facilities Transition of political arena from single to multiparty. High levels of corruption and mismanagement of government funds. National focus on democratization of Kenya systems.	
1993	Demographic health survey conducted showing favorable trend of declining fertility and increasing modern contraceptive use.	CPR: 33% TFR:5.4,
1994	International Conference on population and development(ICPD) held in Cairo, Draft National Population Policy Paper developed incorporating the Cairo Programme of Action. Kenya Health Policy Framework developed identifying population growth management as a strategic imperative	
1996	National Reproductive Health Strategy (NRHS) for Kenya 1997-2010 developed to operationalise the reproductive health agenda as recommended by the ICPD NCPD publishes National Population Advocacy and IEC Strategy for Sustainable Development 1996–2010 which flounders when funding from UNFPA was withdrawn in 2002.	
1997	Reproductive Health / Family Planning and Standards for Service Providers launched; an update of 1980 guidelines	
1998	Safe motherhood and Child survival Initiatives launched Demographic health survey conducted showing continued favorable trend for both fertility and contraceptive use. HIV/AIDS declared a national disaster	CPR=39% TFR=4.7,
1999	National Reproductive Health Implementation Plan for the years 1999–2003 developed to guide reproductive health needs in the country National Plan Of Action For The Elimination of Female Genital Mutilation in Kenya, 1999–2019 launched Population and Housing Census conducted	Population growth rate=2.5%
2000	National Population Policy for Sustainable Development, Sessional paper No. 1 of 2000 domesticating the Programme of Action of the ICPD approved	
2001	Kenya adopts the National Population Policy for Sustainable Development in 2000 and developed other related policies and strategies National IUD revitalization strategy launched by MOH together with other partners	

	IUD Task force formed AMKENI Project launched to improve reproductive health service delivery at 97 MOH-supported sites in Coast and Western provinces	
2002	International donor funding for family planning program starts shifting from FP to HIV/AIDS	
2003	Adolescent Reproductive Health and Development Policy (ARH&D) developed to enhance implementation and coordination of programmes that address the reproductive health and development needs of young people Kenya Demographic and Health Survey conducted showing deteriorating indicators with stagnating rates of contraceptive use and slightly increased fertility rates Jadelle approved by the Kenyan government	CPR=39% TFR=4.9,
2004	NCPD becomes a semi-autonomous agency under the Ministry of Planning and Economic Development and changes its name to the National Coordinating Agency for Population and Development (NCAPD) with a new FP/RH and population advocacy mandate Cabinet Memorandum which called for the government to make renewed efforts in family planning tabled by NCAPD in parliament	
2005	Adolescent Reproductive Health and Development Policy: Plan of Action 2005–2015 developed to facilitate the successful implementation of the ARH&D Policy The FP budget for 2005/6 presented to parliament and passed, allocating Kenyan government funds to family planning commodities for the first time- Kshs. 200 million (US$2.62 million).	
2006	Sexual Offences Act No. 3 (Rev. 2007) passed. Mainstreaming Emergency Contraception in Kenya. Kenya Vision 2030 launched, recognizing a well managed population as a critical resource that can help the country achieve its development objectives	
2007	National Reproductive Health Policy developed to enhance the reproductive health status of all Kenyans National Contraceptive Commodity Security Strategy (NCCCS) 2007–2012 developed to address the challenges of CS by focusing on several components, including coordination, commitment, financing, capacity, and client demand and utilization. Population, Urbanization and Housing Section included in the Medium Term Strategic Plan of Vision 2030	
2009	Gender Policy Guidelines developed National Reproductive Health Strategy 2009-2015 developed to improve guidance and alignment for a 'multisectoral' implementation of the NRHP Population and Housing Census conducted	CPR=46% TFR=4.6 Population growth rate:2.9%
2010	National Leaders' Conference on Population and Development held to reach out to leaders about the need to address population growth through family planning and share ideas that will shape a new population policy	

	Constitution of Kenya passed recognizing the right to the highest attainable standard of health for every person, which includes the right to health care services, including reproductive health care. Under the new Kenyan Constitution, women have the right to access safe and legal abortion where the pregnancy presents a danger to their life, and mental or physical health.	
2011	The Acceleration of Maternal, Newborn and Child Survival in Kenya Using High Impact Intervention (HII) also known as the Nakuru meeting held Draft National Population Policy, 2011-2020 developed promoting he repositioning family planning as the best avenue towards reducing population growth rate For the first time, beginning in 2011-2012, the government covers the full cost of contraceptive commodities	
2012	A countrywide birth control campaign launched aimed at reducing population growth from 2.9 to 2.1% Sessional Paper No. 3 of 2012 on Population Policy for National Development launched	

What led to the stall of Kenya's family planning program between 1998 and 2003?

(i) Shift in political commitment to address other emerging national priorities

Since early 1980's, former President Moi is largely credited for being an FP champion which involved him publicly promoting use of contraceptives and mobilizing leaders at all levels of the government to promote family planning uptake [Chimbwete et al 2005 and Thumbi 2002]. His increased attention to addressing family planning was initiated in 1981, upon his return from a meeting in China where he was addressed as the president of the country with the highest fertility rate in the world. The country's total fertility rate had been recorded at 8 children per woman in 1979. President Moi thus publicly advocated for use of contraceptives so as to reduce the country's fertility rate. He used the provincial administration to disseminate messages about the benefits of family planning to the local communities and threatened punitive action for provincial administration who did not promote smaller families in the community.

"I think it was in 1981 when President Moi happened to attend the meeting I think it was in China or somewhere and he was really embarrassed because he was told….that it was the country that was the fastest growing in the world. Around then the children were 8.1 per woman and the doubling time of the population was 17 years. So I think he came with a real momentum and really showed good political good will because if you read that paper that we read over what came, he came with a threat to the civil servants especially. I think it was 4 children or 3 children. I don't really remember."
Academic representative

The political will from the highest level of government and its promotion at all levels of leadership created an enabling environment for donors to invest and expand FP service provision and commodity distribution. The establishment of National Council for Population and Development (NCPD) under the Ministry of Health in 1982, to formulate relevant population policies and strategies and to ensure effective co-ordination of all population related activities in the country signified that family planning was seen as more than just a health issue. Additionally, the first Family Planning Conference held in 1984 helped to further galvanize political support for family planning.

" What led to the success in the 80's and early 90's it is because there were deliberate efforts, through each of the government ministries, it was a whole sector wide approach and then in the Office of the President there was a program that targeted all members of the provincial administration; all the DO's, the chief's who were recruited at that particular time underwent a course at Kenya Institute of Administration and one of the mandatory sessions within that was population and family planning…..Agriculture extension workers were active and where oriented on issues of family planning so whenever they would go to the farms as they talked about the family planning issue." - International NGO representative

However, in the late 1990's, President Moi's attention shifted towards addressing other emergent issues including HIV/AIDS and fighting corruption and human rights abuses claims against a faltering economy.

"HIV showed up, donor funding declined for family planning and political leadership was diverted to other things. We stopped talking about family planning at high level." NGO representative

Concurrently, development assistance for health also prioritized HIV/AIDS which had gained priority at global and national levels. The faltering national economy during this period worsened the situation – in the 1990's the economic performance in GDP was much lower than the population growth rate, reaching its lowest in 2000 when it declined to -0.3%. Meanwhile, many Kenyan politicians who overtly opposed FP became more vocal in promoting pro-birth norms in their communities for political expedience.

"………the politicians went round airing negative messages about family planning, their numbers going down, it could also contribute because there is not any information that is coming out to react to that. Almost the community based distribution died, the program completely went to zero and it was like family planning was not really in existence then". Government representative

(ii) Shift in donor priority and weak national institutionalization of the family planning program

As stated above, towards the late 1990's, HIV/AIDS had become an epidemic and a matter of national priority in Kenya along with many other countries in sub-Saharan Africa. Consequently, there was a major shift in funding from development partners towards addressing HIV/AIDS, which was seen as a crisis by the donor community. Because the FP program was heavily supported by development partners, the shift in donor funding to support HIV/AIDs activities meant that most of the resources that were supporting population activities disappeared (Thumbi 2002; NCAPD 2010). Additionally, the government did not put in place measures to respond to the declining external resources for family planning. Government resources were directed towards supporting HIV/AIDS prevention efforts in the country. Subsequently, this resulted in a stall in the implementation of family planning activities characterized by severe commodity stock outs, decreased access to information and services and decreased demand for contraceptives (Crichton 2008; Ndegwa, Onduso and Casey 2008). Moreover, the few remaining development partners funding FP activities gradually experienced donor fatigue brought on by frustration with poor planning and lack of ownership for family planning in the Ministry of Health (Thumbi 2002).

"….we live in an international environment that has different kinds of players and they are quite invisible but they have the money, really we have the macro influences whereby donors themselves reposition the priorities of money, this is one, and then the priorities of funding for donors or among donors has been influenced by changes in their policy for

example if we look at the American type of donors the changes in their government, the changes in the global health initiatives I mean that is their policy that guides global health priorities it is an automatic statement to where the money is …"- International NGO representative

What led to the recovery of Kenya's FP Program between 2004 and 2009?

1. Rejuvenated Political will and commitment

Following the change in leadership in 2003, from President Moi to President Mwai Kibaki, political will for FP was reignited although not to the level of the 1980s and 1990s. Unlike President Moi, President Kibaki did not publicly advocate for FP. Nevertheless, his government created an enabling environment for promotion of FP by key institutions and FP champions. NCPD which had lost visibility during the period when the FP program collapsed was re-launched in 2004 within Ministry of Planning, National Development and Vision 2030. The re-launch came after the release of the 2003 DHS which showed a stall in CPR at 39% and increase in fertility from 4.7 to 4.9 between the 1998 and 2003. The organization had an expanded mandate of advocacy for population and reproductive health issues and a greater operational flexibility.

"…. within that period, from about 2004 when it was realized that something drastic had to be done, to be able to make the agency more versatile and more committed and addressing issues that are pertinent. So government was requested [a change of status of NCPD to a semi-autonomous]. Because there was a problem of funding and even the use of funds …if you are a government agency it is not easy to use funds because they have to come through the treasury through the PS and therefore you cannot source your own funds. Bt as an agency you can sign documents and agreements with various donors and agree on activities directly without involving high government officials" - Government representative

The operational flexibility enabled the institution to mobilize external funds in addition to recurring funds from treasury and to work with key stakeholders to organize advocacy activities and widespread community awareness campaigns for Family Planning. Of importance, NCPD works hand in hand with the Division of Reproductive Health (DRH), under the Ministry of Health. DRH is the lead government agency responsible for implementing reproductive health services. Hence, advocacy strategies and RH/FP policies are designed collaboratively between the two agencies and their partners.

Since its re-launch, NCPD has provided strong leadership in advocating for increased government support and community demand for family planning services in Kenya including the development of an updated population policy. With strong backing from the former (2002 to 2007) and current Ministers of Planning (Hon. Wycliffe Oparanya since 2008), NCPD advocacy towards increasing attention and resources for population activities in Kenya has been successful. Crucially, sustained advocacy to treasury resulted in the doubling of NCPD's budget in 2011 to 1.2 million US dollars enabling the institution to intensify its advocacy and community sensitization activities, a demonstration of growing government support for population issues.

"Our funding has also increased from the government may be doubling" - Government representative

NCPD gained considerable clout to be able to engage parliamentarians and senior government decision makers in key Ministries (Planning and Health) to strengthen national prioritization of FP. Sustained efforts by NCPD to educate policy makers about the negative effect of rapid population growth on sustainable development and economic growth and the

role of family planning in addressing this challenge led to better understanding and support for family planning. Through its engagement with parliamentarians, NCPD supported the formation and sensitization of two parliamentary groups to focus on increasing support for FP and population matters in the Kenya parliament: Kenya Parliamentarian Network for Population and Development (KPNPD), which is now a full committee in parliament; and Parliamentarians for Family Planning, to lobby for specific issues related to family planning. NCPD worked with international partners such as the Future's Group and Population Reference Bureau (PRB) to develop advocacy tools – *RAPID* (2005) and *ENGAGE* (2011), respectively, which were critical in mobilizing stronger support from key government officials and parliamentarians towards increasing resources for family planning. Advocacy by NCPD in partnership with the two parliamentary groups and other key organizations advocating for FP led to the establishment of a budget line for contraceptive commodities in 2006.

"There was a consulted effort by the ministry of health and the ministry of planning and vision 2030, all rallied together to play a very big advocacy role, of course with partners, which culminated in the establishment of a budget line for contraceptives…". International NGO representative

In 2010, NCPD organized its 2nd National Leader's Conference to promote family planning in the broader development agenda in Kenya (the first one was held over two decades earlier in 1984). More than 1000 decision makers from various Ministries and politicians attended the meeting including the Vice President, Kalonzo Musyoka. The aim of the meeting was to demonstrate the central role of family planning in achieving the development goals of the country emphasizing its impact in various public sectors. The meeting also set the stage for accelerated efforts towards finalizing and approving the new Population Policy. In 2012, NCPD re-launched the national FP campaign aimed at expanding access to FP services nationwide towards achieving the Vision 2030 targets. In recognition of the importance of sustained advocacy, NCPD's plans to expand its advocacy efforts to target county level administrators to ensure prioritization of family planning within county strategic plans and budgets. Additionally, PRB is working with the government to create an advocacy tool for increasing support among decision makers for youth SRH programs – ENGAGE *Youth*.

NCPDs work has been supported by key players in the political arena who publicly advocate for population control and contraceptive use including Hon. Ekwe Ethuro, Chair of the KPNPD, the Minster of Public Health and Sanitation, Ms. Beth Mugo and the Minister for Planning and Development, Mr. Wycliffe Oparanya.

Despite the increase in government commitment there is mixed perception on the level of political will relative to that of the 1980s and 1990s when the FP program was thriving. A number of the stakeholders we interviewed feel that current government commitment pales in comparison to previous commitment mainly because the President is not vocal about family planning.

'In the 80s and 90s they talked about it all the time small family for better health that time. You don't hear that. I would say political will is there but it's not to the level where we had it in the 90s.'- International NGO representation

Still a few believe that the President is fully committed about family planning even though he does not explicitly speak out about the issue. One key stakeholder states that in the early years of his presidency, President Kibaki gave permission for his voice to be used for a media campaign on radio.

Nevertheless, stakeholders agree that political will declined between 1998 and 2003 and has been on the rise since 2004.

Increased political support for population and FP activities has translated to an enabling policy environment for the development of supportive policies and programs. Moreover, family planning is now implemented alongside other health issues within a multisectoral policy framework which includes the Office of the President, Ministry of Public Health and Sanitation, Ministry of Medical Services, Ministry of Planning, ND and V2030, Ministry of Youth Affairs and Sports, Ministry of Gender Affairs and Children, Ministry of Water and Ministry of Environment.

"……The policy frame work within which health and RHFP… is multisectoral very many ministries that all together contribute towards health and reproductive health and family planning in Kenya".
NGO representation

1.1. Enabling policy and program environment

Since the mid-2000s, various health and SRH policies and strategies to guide implementation of RH/FP services have been updated or developed with leadership Ministries of Planning (NCPD) and Health (DRH). The GoK recognized the country's young age structure and the importance of addressing this demographic challenge to optimize achievement of its development objectives. This led to the development of the Adolescent Reproductive Health and Development Policy in 2004 and the plan of action for the policy in 2005. The plan of action aimed to mainstream adolescent health and development issues including increasing access to and utilization of SRH needs in various sectors of government. Furthermore, the Kenya health sector strategic plan (NHSSP) II (2005-2010) developed in 2005 emphasized the achievement of broader international and national goals, the MDGs and Kenya's Economic Recovery Strategy (ERS) -the national development plan. The KHSSP II aimed to 1) strengthen the decentralized health system, introduced in 1984, and the health system's operation within the multisectoral policy framework and 2) to optimize integration of basic health services through the adoption of the Kenya Essential Package of Health (KEPH), which focuses on life-cycle cohorts and health promotion and which includes reproductive health services. KHSSP II also shifted focus from the primary health care (PHC) model to a human rights approach characterized by strong emphasis on community involvement.

Kenya's Vision 2030, launched in 2006, recognized the importance of a well managed population as a critical resource for the country to achieve its development objectives. The strategy included specific targets for increasing contraceptive use from 39% to 70% in 2030. Additionally it prioritized delivery of the KEPH. The first reproductive health (RH) policy developed in 2007 and the National Reproductive Health Strategy (NRHS) 2010 – 2015, for translating the policy, aimed to ensure equitable, efficient, and effective delivery of high-quality reproductive health services throughout the country and broadly, to achieve the MDGs. The NRHS targets included reduction of fertility to 2.1 by 2015, reduction of unmet need for FP by 75% from 24% and to increase CPR among poor women and men by 20 percentage points. The Reproductive Health Communication Strategy 2010-2012 was envisioned to support achievement of the national RH goals as articulated in the national reproductive health policy and NRHS. To ensure uninterrupted and affordable supply of contraceptives to all people that need them the National Contraceptive Commodity Security Strategy (NCCSS) 2007–2012 was developed the same year as the national RH policy. In 2010, the Constitution of Kenya was passed, recognizing that every person has the right to the highest attainable standard of health including reproductive health care.

Most recently in 2012, the national cabinet passed the Sessional Paper No. 3 of 2012 on Population Policy for National Development, which succeeds Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development which guided implementation of population programmes up to 2010. The new policy aims to attain high quality of life for the people of Kenya by managing population growth to a level that can be sustained with the available resources and will guide national population programmes and activities for the next two decades. The Policy identifies rapid population

growth and a youthful population structure as key issues that will pose challenges in the realization of Vision 2030. The policy recognizes that high fertility coupled with high unmet need for family planning over a long period of time, has contributed largely to the observed youthful population structure. The policy has progressive targets for family planning and fertility for 5-year periods from 2010 to 2050. In the near term (by 2015) the policy aims to attain a contraceptive prevalence rate (CPR) of 52% and total fertility rate (TFR) of 4.0 and in the long term (by 2050), CPR of 75% and TFR of 2.1.

2. Financing for FP: Increased domestic and external support

Financing for health in Kenya mirrors many countries in sub-Saharan Africa falling short of the recommended Abuja target of 15% and there is an over-reliance on donor funding. Currently Kenya's government spending on health is 4.6% of the total government budget and has actually declined from 8% in 2001 (Table 13). Nevertheless, total health expenditure has increased by 24 percent, between 2001/02 and 2005/06, from US$ 726 million to US$ 964 million, largely due to the increase in donor spending. Given the high population growth and large youthful population of Kenya, the funding increment may not have a significant impact in addressing the health services requirements of the population. In addition, health budget allocation has continued to skew in favour of tertiary and secondary care facilities, which absorb 70% of health expenditures (Kwamboka et al 2011).

Table 13: Government spending for healthcare (US$)

Health expenditure	2001/2	2005/6	2009/10
Total health expenditure (millions)	1,046	1,389	1,620
Per capita health expenditure (per capita per annum)	33.5	39.0	42.2
Share of total government spending on health (%)	8.0	5.2	4.6

Data Source: National Health Accounts, 2009/10

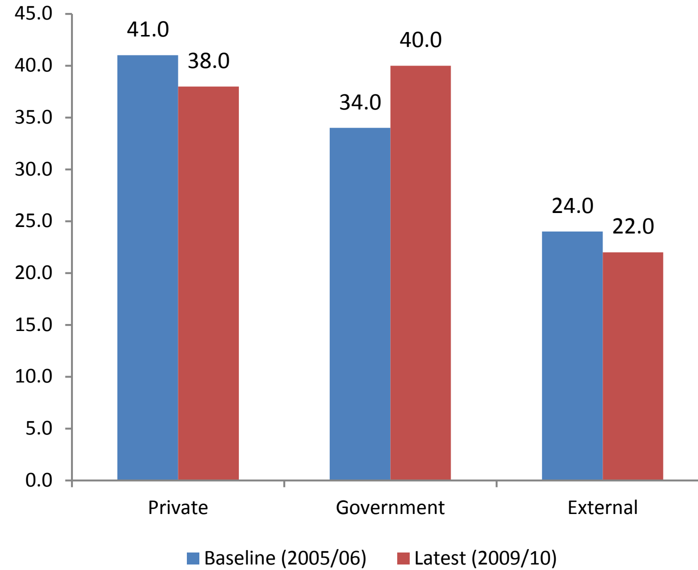
Health financing has implications on funding allocations to RH and FP as budget owners have competing health priorities and tend to prioritize health issues considered to be life threatening. Notably, between 2005 and 2009, public sector funding contribution to RH has increased from 34% in 2004 and 40% in 2009 (Figure 14). Utilization of health funds by community health workers has also increased significantly by 1907% (National Health Accounts, 2009/10). This indicates increased government attention on RH and community based distribution of services.

Historically, the family planning program in Kenya has heavily relied on donor support but this can have serious repercussions. The shift in donor funding priority from funding FP to funding the emergent HIV in the late 1990s, led to a sharp decline in funding for FP for about a decade. In the mid-2000s renewed focus on FP led to more funding flow for FP from both the government and development partners.

"but I think has I have said from about 2005 I think everything has started changing from even from international level, whereby we have had two international conferences on family planning starting with the one in Kampala in 2009 on family planning, and last year we had another conference in Dakar on family planning specifically, so you see that conviction by the international community that FP is a critical ingredient in development, I think that has helped to bring support to the program, international agencies" – Government representative

This renewed focus was ignited by various factors: 1) a shift in global and national priority to integrate HIV and SRH services; 2) increasing recognition by global and national experts of the need to meet the unmet need for FP in order to achieve the MDGs; 3) and increasing recognition by global and national experts of the need to slow the global population growth to ensure sustainable development.

Figure 14: Sources of RH funding, Kenya (%)

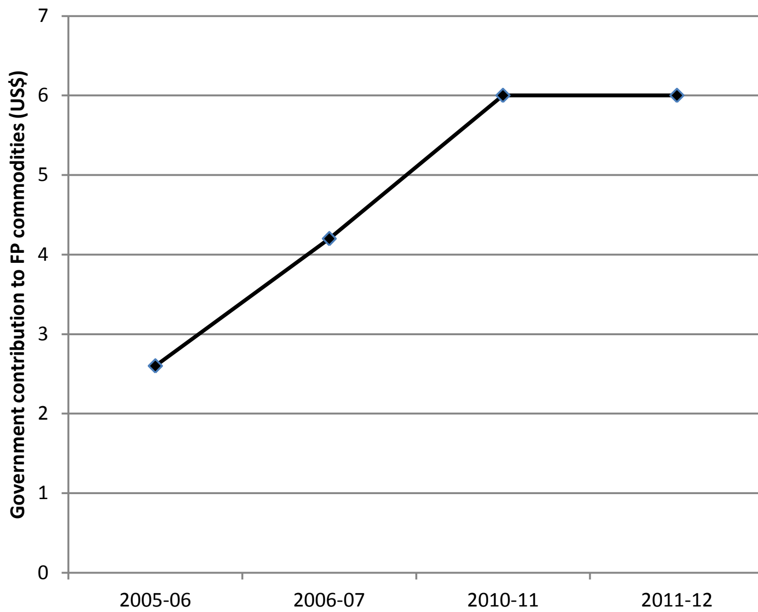


Data Source: National Health Accounts, 2009/10

More funding flow towards SRH services translated to more funding for FP activities which included increased support for advocacy activities to convince the GoK to direct more resources towards the FP program. Consequently, in 2005, the government of Kenya (GoK) established a budget line for family planning commodities. Many of the stakeholders we engaged see the establishment of the budget line as a critical step towards the recovery of the FP program and as an indication of increasing government commitment to the FP program.

"In 2006 when we got the budget line there was also advocacy for family planning by NCPD and others who trained parliamentarians and raised awareness on the benefits of family planning, so much so that a budget line was put in place. It was very important move because we are saying that the government is willing to put in its money which is clearly defined for family planning". Government representative

Figure 15: Government of Kenya budget allocation to family planning commodities (US$, 2006 to 2012)



Source: Author

According to a number of key informants, since the establishment of the budget line, funding contributions for contraceptives from the treasury has been on an increasing trend - from Kshs. 200 million (US$2.62 million) in 2005-06 to more than Ksh 500 million (about US$ 6 million) per year in 2010/11 and 2011/12 (Figure 15). The total annual budget for contraceptives ranges between US$9 to US$12 million depending on the brands of contraceptives procured. Various key stakeholders state that the government is currently contributing 60% of the total budget for contraceptives. The funding gap is filled by development partners. Of note, the level of government funding for FP commodities has stagnated over the last two years, demonstrating that sustained advocacy is crucial if the family planning program is to mobilize additional funds to procure contraceptives.

UNFPA, USAID and KFW are the main donors supporting government to fill the funding gap in the family planning program. UNFPA currently support 30% of the budget (3 million a year), while USAID and KFW cover the remaining 10% (1 million a year). The USAID budget for contraceptives has increased from about $200,000 in 2007 to $2 million in 2010 (USAID 2012). Donors also support other components of FP service delivery. For example, UNFPA also supports implementation of the Community Health Strategy, which is the primary care model being used in Kenya to increase access to basic health services. UNFPA provides funding for training of community health midwives to conduct deliveries and provide various methods of contraceptives including postpartum IUDs and supplies and equipment needed to provide services. UNFPA also supports equipping of health facilities. Other donors who have contributed funds to the program include GIZ (formerly GTZ), IPPF and MSI. Increasing donor commitment to FP over the past 5 years has been demonstrated by increases in resource allocation and technical assistance to FP. In 2010, USAID announced that its funding for FP/RH activities in Kenya would rise to $29 million over a 4 year period – an increase of over $18 million from 2007 (USAID 2012).

One stakeholder interviewed believes that government has the capacity to fully fund the reproductive health budget. Government on the other hand believes that technical assistance and funding to governments should be structured to

strengthen the capacity of governments geared towards institutionalization. Currently, support is occurring in project format and there is need for greater institutionalization of commodity assessments, planning and costing and evaluation.

3. Health systems strengthening

FP services in public facilities are provided free, although in some instances a nominal service charge is requested. The 2008-09 DHS data shows that most people obtained services from public sector (60%), however, private sector also had a relatively large market share (36%). Notably, the proportion of people obtaining services from public sector increased from 53% in 2003 to 60% in 2008. The main health systems strengthening initiatives that have led to the improvement of FP services include public-private partnerships, integration of FP and other SRH services and performance-based financing.

3.1. Public-Private Partnerships

In Kenya, private sector providers (FBO/NGO and private-for-profit) have played a major role in supporting the health sector, where nearly half (47%) of health facilities in Kenya are owned by private providers. Recognizing their role, the NHSSP II (2005-2010) prioritized strengthening public-private partnerships as a strategy to support the government in delivering the KEPH. Relatedly, the NHSSP II prioritized joint planning and a common monitoring system; sharing of resources like information, technology, training and finance; and provision of incentives for improved collaboration articulated within a sector wide approach (SWAP) strategy. Some private providers (FHOK and AMREF) are supplied with family planning commodities by the government and support the government to provide free or low cost family planning services. The private sector has also played a major role in training health workers to provide FP services particularly injectables and long acting and permanent methods.

Notable examples of strategic partnerships between government and the private sector which have contributed to increasing the capacity of the health system to provide RH/FP services over the past 5 or so years include APHIA II (2006-2010) and APHIA *Plus* (2011-2015) (MOH, Pathfinder, FHI, PATH, AMPATH, USAID*);* FHI's *PROGRESS*, a program utilizing mobile technology to deliver messages of FP (DRH, FHOK Marie Stopes Kenya (MSK), and USAID launched in 2008); and *AMUA*, a social franchise focusing on RH/FP and MCH services (MOH, MSK and KFW) launched in 2004; and the RH voucher scheme (MOH and KFW) launched in 2006.

3.2. Integration of FP and other SRH services

In the mid-2000s, there was a global push towards integration of HIV and SRH services with the recognition that HIV infected people were living longer and required access to other health services including FP/RH services. HIV prevalence began to decline from its peak of 13.4 percent in 2000 and continued to decrease steadily to 6.9 percent in 2006 (NASCOP & Ministry of Health 2006). Large-scale USAID funded programs which were reaching a large segment of the population in Kenya with HIV prevention and treatment services were required to integrate FP to meet the unmet need for FP among all women including those living with HIV (USAID 2012).

3.3. Performance-based financing

The government is also working with various partners on a number of innovative solutions to increase access and utilization of RH service; promote community ownership and engagement in their health; strengthen private sector engagement; and increase competition among providers and quality of care. In 2006, an RH voucher program whereby

providers are reimbursed based on the number of services they deliver was launched in four rural districts and two urban informal settlements. The program focuses on safe motherhood (antenatal care, facility-based deliveries, and postnatal care) and long-term modern family planning methods and is engaging both public and private facilities. For voucher distribution, community-based distributors sell safe maternity vouchers to poor pregnant women who are identified using a poverty grading tool. An evaluation of the program found that a voucher scheme in Kenya can increase utilization of assisted deliveries and family planning. By the end of 2011, the program had provided 96,000 facility based deliveries and approximately 27,000 long-term modern family planning methods. In addition, the evaluation found that in contracted clinics, clients were poorer than non-voucher clients, indicating that the program can effectively target the poor. The program is informing the government's long-term plans to establish a National Social Health Insurance Fund.

3.4. Supply chain management

Kenya Medical Supplies Agency (KEMSA) is the government body responsible for FP commodities procurement, warehousing and distribution of commodities. It was created in 2000 after transforming the medical supplies coordinating unit (MSCU) into a parastatal organization, and given mandate to manage the forecasting, procurement, warehousing, distribution and inventory control for essential drugs for the public sector. Before its establishment, parallel logistics systems handling specific vertical supply chains existed, resulting to poor inventory control at the service delivery points and poor reporting for commodities. To help address these challenges, JSI/DELIVER entered into a contract with KEMSA in 2001 but its operations were met with various challenges and as a result, JSI/DELIVER was not able to complete its goal of strengthening KEMSA. Because of these challenges, KEMSA's performance started to decline in July 2007, coming to almost a halt a year later.

KEMSA was restructured in 2008 and four directive were created: 1) warehouse, distribution, quality assurance and technical services; 2) procurement; 3) finance and administration; and 4) legal services. The restructuring resulted to some efficiency in the organization's operations and also interactions with government.

"we have fixed it (KEMSA)……….. we have what we call informed push model, …..initially we (NGO) went and got commodities with the Ministry of Health and distributed ourselves physically in Nairobi, Kisumu and Mombasa, but now we have at least a system in place where they are now supplying them directly to the districts stores and if there is a problem, we go and redistribute". International NGO Represenative

Currently it operates a cash-and-carry pull system for health commodities and commodities are fully supplied based on demand for level 4 and 5 facilities. However, for the level 2 and 3 facilities, the push system is used because they do not have the capacity to quantify the commodities they require. Quantification for each facility is done by the government with help from KEMSA, but once this is done, it becomes the drawing right for each facility (each facility is assigned the value of commodities it can order from KEMSA). The drawing rights are decided based on the consumption of the facilities and the population served.

"Quantification is done by the ministry and also we help them, but once they say that lets say Olkalau district hospital we give them 7 million worth of drugs every time that becomes their drawing right………. They will look at a facility because two facilities might be sitting right next to each other when they are same level but they receive different commodities because it will be based on the population of the area and the consumption of certain products". KEMSA representative

All commodities are initially stored in the KEMSA central warehouse, irrespective of who procured them.

"There are cases where these development partners do their procurement, but bring it here we store and then we distribute. There are those rear cases that they will do their procurement and then will take them straight to the facilities. That is very rear, most of the time if we don't do the procurement for them, they will do it by themselves but they will bring the goods here". KEMSA representative

The government and other partners fund KEMSA to buy commodities which are then distributed to various facilities. However some development partners procure some commodities separately resulting to parallel systems.

"We buy on behalf of the government so, the government gives us funding and from we buy medical commodities for them……. we have a list of health facilities and these goes from general hospitals, district hospitals, sub district hospitals, health centers and dispensaries…….. we do the procurement, we will do the warehousing, we will do the distribution". KEMSA representative

Starting from 2012, KEMSA is operating on a refund basis where funds for commodities (from both government and development partners) are deposited in a consortium account and then KEMSA claims a refund for commodities procured and distributed.

The government provides a list of what commodities are required based on the available money, and procurement is done following the Public procurement Oversight Authority (PPOA). An Enterprise Resource Platform (ERP) program is used for warehousing and consists of several modules; the warehouse module, the distribution module and customer service module. The government then informs facilities to place their orders based on their drawing rights. However the facilities do not get everything they request from KEMSA because the government only gives 65% of the funds requested by KEMSA for procurement of the required commodities. To top up the 35% deficit, facilities use cost-sharing money to purchase commodities from other private pharmacies.

There are two chains of distributing; from KEMSA central stores to District stores then to health centres and dispensaries or from KEMSA central stores to KEMSA regional depots then to districts and health centres and dispensaries. Commodities are distributed to the districts through the family planning logistics management unit of division of reproductive health (DRH). A logistics management information system (LMIS) based on Oracle developed by Deliver is used to determine quantity of FP commodities required. The system collects and organizes district-and-below commodity issues and consumption data for use by decision makers at the division level and MOH division partners have direct access to use of these data for their planning needs. The system utilizes inventory control measures, such as maximum and minimum levels of commodities at facilities, to determine reorder levels and verify reorder quantities. The system also has a timely and accurate commodity request, distribution, and status feedback process. Reporting is done quarterly with facilities submitting quality consumption reports. However, service delivery quarterly reporting is low and thus distribution is based on issues from the district. FP commodity needs are determined using population and consumption based methods. Reporting moves from health centres and dispensaries to districts then to logistics and management unit (LMU/DRH) and finally to KEMSA.

4. Taking information and services to the community

4.1. Demand creation: targeted mass media communication

In relation to increasing uptake of FP services, NCPD has been working in partnership with the Division of Reproductive Health (DRH), under the MOH, to increase demand for services at community level. DRH is the lead agency in Kenya responsible for ensuring availability and access to reproductive health and family planning services. The two entities have scaled up community sensitization activities aimed at decreasing the population growth rate from 2.9% to 2.1%. with emphasis on long-acting methods. Recent service statistics from DRH illustrates that there has been an increase in uptake of implants and IUDs –IUDS and Implants increased from 2000 to 17000 insertions a month (Bashir 2012).

Building from the success of the family planning program in the 1980s and 1990s, family planning messages are being delivered using IEC materials and media including folk media (poetry, puppetry, songs, and dramas), media breakfasts, radio talk shows and TV programs. In 2012, radio and TV promotion of family planning have increased significantly following the re-launch of the family planning campaign in the early part of the year. NCPD and partners have penetrated over 13 media channels (national and community radio stations). The use of community radio stations to increase community awareness about FP has become particularly important since the government endorsed the devolution of powers to the county level in the 2010 Constitution. Additionally, demand creation is targeted and tailored for different audiences [youth, men, rural and urban communities, religious leaders (particularly Muslims and Catholics) and journalists, media producers and media editors], utilizes multiple and/or innovative (mobile technology and social media) approaches, and incorporates information on where to obtain services (strong referral component). Notable examples are the following initiatives - *Tupange* project led by JHIEPIGO, a 5 year urban reproductive health initiative (2010-2014); *The C-Word* led by PSI, targeting youth 15-24 years using radio, social media and sms; *PROGRESS* implemented by FHI, a family planning information service delivered via text message -*Mobile for Reproductive Health or m4RH* and UNFPA's *Catalyzing Action in Kenya: Working with Muslim faith leaders for Family Planning*, targeting religious leaders.

Since health is implemented within a multisectoral policy framework, other line ministries are contributing to increasing awareness of sexual and reproductive health and rights. For instance, through the Ministry of Education, the government introduced Kenya's Free Primary Education Policy in January 2003 which opened up the opportunity for disadvantaged and marginalized girls and boys to attend school. The short- and long-term benefits of the initiatives are far reaching. In the short-term, girls staying in school are less likely to get pregnant at a young age which predisposes them to both health and socio-economic challenges. In the long-term, educated women and men make better decisions about their lives including about the size of family they would like to have which impacts on both family welfare and national development. Likewise, the Ministry of Youth Affairs and Sports established the Department of Youth Development in 2007 which aims to implement various youth development programmes towards achievement of Vision 2030. One of its mandate is to develop youth resource centers across the country where the youth receive RH/ FP information and services among other information and skills.

Despite efforts to increase access to FP services, one of the biggest challenges in Kenya is the huge in-country inequities – some districts have CPRs of 64% while others have 3%! (Bashir, 2012). The government also recognizes the need to reduce pressure on the public sector providing free services to all. Hence, the government is considering market segmentation to identify the poor population segments which will continue to receive free services while the middle class and wealthy population segments transition to paying for services.

5. Coordination and Accountability mechanisms

Institutional coordinating forums set up at NCPD and MOH were strengthened to lead, harmonize and coordinate implementation of the FP programme. The Family Planning Technical Working Group (FPTWG) chaired by the DRH mobilizes and coordinates stakeholders implementing or funding reproductive health programs representing government, non-governmental organizations, private-for-profit and donors. The forum meets on a quarterly basis to develop policies, plan activities and evaluate progress of the FP programme. The commodity security committee established in 2008 which is chaired by DRH and has representation from KEMSA, DFID, USAID, UNFPA, KFW monitors gaps in resources for commodities and obtains government and donor commitments to fill the gaps.

NCPD has also been successful in providing strong multisectoral leadership, coordination and oversight to organizations implementing population activities across the country and aligning non-governmental and donor agencies to its priority. Stakeholders interviewed who are representatives of various entities advocating for greater support for reproductive health and rights programs in Kenya, (FHOK, Pathfinder International, DSW, FHI and MSI), emphasized that their approach is to collaborate with the government. Most perceive this as an ideal and necessary practice because it promotes country ownership which is of particular interest to donors; the US government for instance has been promoting the practice of funding programs that are country owned since 2007. However, one stakeholder cautioned that this has weakened the role of CSOs to ensure government remains accountable.

"Kenya advocacy is always done under one basket, now who is watch dogging NCPD?" International NGO representation

Challenges and sustainability for FP uptake in Kenya

Sustained progress to meeting the contraceptive needs of people in Kenya is dependent on efforts to improve the number of health system challenges identified.

Decentralization of decision-making and the development of a district health system to manage all health activities at the district level started in 1984 were meant to increase access and ownership of health at the community level. This resulted in improved district planning and monitoring capacity; improved financial management and resource utilization; and strengthened general management, leadership and commitment at these levels (MOH 2006). However, the decentralization has not been fully operationalized as a result of MoH's centralized approach to operations and the central's weak internal and administrative linkages with the lower levels. While structures were established at the different levels to manage service provision, they were not adequately equipped with the necessary tools and management skills or empowered to perform these activities. The government recognizes these weaknesses and continues to prioritize strengthening the decentralized system (MOH 2006).

Kenya has struggled with health worker shortage since the early 2000s as a result of poor pay and working conditions in the public health sector (MOH 2006). In the late 1990s when HIV became the focus, training on FP methods and service provision declined, thus affecting provision of FP services. Recognizing its human resources challenges the government made long term commitments by releasing a draft Human Resources for Health Strategic Plan (2006/07–2009/10) as part of the Health Sector Rapid Results Initiative (RRI) and the follow-up Human Resource for Health (HRH) plan 2009-2012 with a costed implementation plan. The government is concurrently strengthening the decentralization of key human resource management and development functions including allocation of training and development budgets for districts and individual health facilities, and handing over responsibility for the use of HR at district level to district administrators (MOH 2006). The government is still grappling with the problem 5 years on. Between 2004 and 2008, a

4% decline in the number of health workers in the public sector was recorded (Africa Health Workforce Observatory 2008).

Although KEMSA was established to ensure an integrated public health commodities procurement, warehousing and distribution system, it has not fully embraced this role and there exits parallel procurement systems especially from donors. The logistics and supply chain has various challenges related to management issues, poor condition of warehousing structures, inadequate finances, human resource capacity, procurement, inventory control and distribution (particularly to level 2 and 3 facilities). These led to difficulty with meeting the demand for contraceptives between 2006 and 2010. The government began addressing some of these challenges by implementing several reforms. In the recent years, the government has been supplying 90% of commodities which has increased access to free FP services. The government also increased the buffer stock from 9 months to 26 months to reduce commodity stock outs. To improve procurement and distribution, KEMSA started conducting 2 year tendering to shorten the procurement process; and FP was incorporated in the essential medicines list enabling FP stocks to be distributed with other medicines. Crucially, the MOH began quantification of contraceptive requirements. Quantification for each facility is done by MOH with support from KEMSA and is based on the consumption of the facilities and the population served and this determines the assigned value of commodities it can order from KEMSA. Still, problems with distribution of commodities to clinics which in turn affects community supplies persist. USAID has been engaged with KEMSA to address this challenge.

In 2005, the government launched the Community Health Strategy in recognition of the need for an alternate service delivery model that would facilitate delivery of basic services (the KEPH within which FP is integrated) at community level. The community health strategy strives to utilize community health extension workers and community health workers to link community members to services, similar to Ethiopia's Health Extension Program. This decision was based on the evaluation of the Primary Health Care model which found that people at the periphery were still not accessing basic health services. However, based on DHS data and stakeholder interviews the community health strategy has not been fully operationalized. A number of stakeholders interviewed stated that the model is being implemented on a small scale and national scale up has not begun. Mirroring stakeholder sentiments, the 2008-09 DHS data shows that more people obtained services from public and private hospitals (23.4% and 19.4%, respectively) relative to dispensaries (19.4%) and health centers (14.5%).

"the mistake we made was that we focused on these higher levels where we have the facilities but it doesn't matter how many service providers you train, it doesn't matter how many of them are youth friendly or whatever it is you have decided them to have FP training ,if in the community people don't know". International NGO representation

Unsurprisingly, community-based distribution of commodities is negligible and has significantly declined since 1993. Until recently, community health workers in most parts of the country were allowed to provide only pills and condoms and refer people to the dispensary and health center for long acting and permanent methods (injectables, implants, IUDs and permanent). Given that currently the preferred contraceptive method is injectables with increasing preference for implants and IUDs this has been a barrier to access for these methods. Results of feasibility studies on provision of injectables by community health workers in Uganda and Kenya, led to a recent approval to use this strategy in underserved areas of Kenya. Prior to this decision, this issue was heavily debated over the past few years. Medical professionals had been resistant to institutionalizing the intervention because of their concerns about the feasibility of ensuring safety of clients using this approach.

Conclusion

Kenya's recovery from the stall in contraceptive use experienced between 1998 and 2003 can be attributed to a number of key factors including: the increase in political will and commitment among leaders at the Ministries Planning and Health within an enabling political environment, from top leadership, to promote FP; an influx of both national and external sources of funding for the FP including the establishment of a budget line for FP commodities; and increase demand creation using mass media particularly radio. With sustained advocacy to increase political will and resource allocation for FP; sustained information, education and communication campaigns; strengthened public-private partnerships; roll-out of the community based distribution of injectables in underserved areas; and scale-up of the RH voucher program within the NHIF framework, Kenya is likely to achieve its CPR target for 2015; 52%.

TANZANIA

Historical Context of Family Planning in Tanzania

Although FP advocacy in Tanzania began prior to independence in 1959, like many African governments, the new African-led Tanzanian government did not appreciate the need for FP due to Tanzania's vast size and need for economic growth after independence was gained in 1961. FP was primarily seen as a European agenda. Early FP advocates (mainly medical doctors and social workers) understood the link between population and development and recognized the critical role of FP in enhancing Tanzania's sustainable development. This group of advocates formed the Family Planning Association of Dar es Salaam in 1959, which was later renamed Family Planning Association of Tanzania (UMATI) to reflect a national agenda. Furthermore, UMATI later became an International Planned Parenthood (IPPF) affiliate.

"They [FP advocates] persisted until we got independence and continued advocating to the Ministry of Health and the government in general, but they were somehow misunderstood. People who saw family planning as a European culture were saying 'we need many people in this country, we still have a big land, why start planning our family?'" – Policymaker, MOHSW

These FP advocates organized a number of advocacy activities targeting politicians including focused meetings with H.E. President Nyerere, who was a Roman Catholic, and therefore unlikely to publically support FP. The Ministry of Health and Social Welfare's (MOHSW) Director of Preventive Services (Dr. Mrisho) also held focused meetings with President Nyerere. The President (Nyerere) was eventually convinced and spoke out publically about the benefits of planning families and is famously quoted stating *"we cannot give birth like rabbits"*. With the country being a one party system, it was easy for the 'child spacing' message to penetrate to the population.

In 1974, the government put in place provisions for maternal and child health clinics to offer FP services. The emphasis of this program was 'child spacing' as a way to safeguard the health of the mothers and children. UMATI was the primary provider of FP services at the time, with a few clinics across the country. The program expanded slowly (contraceptive uptake remained largely unchanged over the 2-decade period of the 1970s and 1908s), with only a few trained providers and limited access due to a weak logistics system. Around the same period, the government put in place a policy aimed at encouraging couples to have small families. The government provided leave allowance for up to four children; those with more than four children were not given allowance for the additional children.

A defining moment in Tanzania's history, which is linked to the global political climate, was the end of the Socialist era in 1984. With the end of the cold war, and imminent dissolution of the Soviet republics, in 1989 the US government became a significant donor to Tanzania, and provided the financial support to establish a National Family Planning Program (NFPP), which was scaled up to all MCH clinics. The NFPP promoted 4 core benefits of FP that are related to health and development – prevention of early pregnancy, spacing, limiting and prevention of early pregnancy. Now that the FP program was taken over by government, UMATI redefined its role to focus on adolescent sexual and reproductive health (ASRH), an emerging challenge in the country.

Owing to the political will and commitment to family planning provided by President Nyerere, the family planning agenda was well integrated into many programs by the time he was succeeded in 1985. However, the program was in its infancy and required more concerted efforts. A World Bank report in 1989 described Tanzania as facing a 'serious population problem'. The Bank recommended a contraceptive solution: *"Over the coming years it will be necessary for*

Government and for donors to concentrate efforts on expanding family planning services and provision of contraceptives throughout the country" (World Bank, 1989).

USAID designed the Family Planning Services Support (FPSS) Project (implemented in 1990–1999), which focused on training, supervision, logistics, and Information Education and Communication (IEC) —and expanded access through community-based distribution (CBD) programs and social marketing. With the momentum of support by political leadership increasing, the MOHSW established the Family Planning Unit within the MOH. The government scaled up training health workers (nurses and clinical officers) in FP and providing management staff (Dr. Calista Simbakalia and Dr. Peter Liwa) with the prerequisite skills to run the program. Dr. Calista Simbakalia, the first head of the Reproductive and Child Health Section (RCHS) is acclaimed for having successfully run the NFPP, in the period before the documented national deceleration in contraceptive use. Her exit, however, was closely timed with the decline of external financial support to the FP program.

"I used to go the Planning Commission every year, and say 'Please can you start also donating even a little bit to show that the ministry, the government is also interested [in supporting RCHS's programs]' but whenever they saw me they would say 'don't even come here'" - Policymaker, MOHSW

The family planning advocacy and sensitization campaign '*Nyota ya kijani*' ('The Green Star') was launched in 1992 by H.E. President Ali Hassan Mwinyi. The national Population Policy which incorporated family planning was launched in the same year. The doubling of the use of contraceptives by married women (6.6% in 1992 to 13.3% in 1996) was attributed to the ubiquitous Green Star campaign.

"Green Star 'Uzazi wa Mpango' [family planning], reached even the villages; actually we reached everywhere. So the donors were very, very happy with the DHS in 1996" – Policymaker, MOHSW

The Community Based Distribution (CBD) program, launched in 1993 and scaled up nationally by 1999, was a major component of the national FP program and accelerated country-wide uptake of FP services by essentially bringing family planning (condoms, pills and referral) to the door step of the community. Village Health Workers (VHWs) also provided oral contraceptives and referral for other methods. There were only 3 radio stations and no TV at the time. Demand creation was therefore mostly through word of mouth. CBD workers travelled on bicycles; every CBD worker had a bicycle which was their main incentive.

"We told them 'this bicycle belongs to you, you can do our work but it is yours'. In most parts of Tanzania once you have a bicycle, it is like having a car; you can hire your bicycle to give people transport....That is how we managed to have the CBDs without really having to pay them. Another incentive we used was to retrain them by giving refresher courses" – Policymaker, MOHSW

The key events relevant to FP policy in Tanzania are presented in Table 14 below.

Table 14: **Key events relevant to SRH/FP and Population policies and program evolution in Tanzania**

Year	Events/Activities	Indicators
1959	Family planning services in Tanzania began – Family Planning Association of Tanzania (UMATI) introduced services at urban clinics. UMATI's roles were (1) to motivate, educate and inform the general public on the need for child spacing,	

Year	Events/Activities	Indicators
	(2) to train both government and non government service providers on child spacing benefits in Family Planning, (3) to procure and distribute contraceptives.	
1961	Tanganyika gained independence	
1964	United Republic of Tanzania was formed by Tanganyika and Zanzibar	
1969	UMATI became an IPPF member	
1973	The National Executive Committee declared its support for the **Family Planning Association of Tanzania (UMATI)** and directed the Government (Ministry of Health) to assist UMATI in the promotion and delivery of child spacing services by using modern FP methods.	
1974	The Government of Tanzania became actively involved in FP service provision as part of a '**child spacing services'** which were integrated into the maternal and child health program in all health facilities in the country. The Family Planning Unit was established Through the 1970s and 1980s, levels of contraceptive use remained unchanged.	
1977	Private-for-profit health services were banned under the Private Hospitals (Regulation) Act	
1982	President Julius K. Nyerere said in a speech to the Nation that: ***"Women in Tanzania are the greatest worker…. One cannot expect these people to give birth every year…… unless Tanzanians are careful, our daughters will be giving birth every year like rabbits".***	
1984-5	President Ali Hassan Mwinyi was elected. Socialist era had come to an end Government started **'National Child Spacing Program'** with support from UNFPA. Other donors in the 1980s included USAID and the International Planned Parenthood Federation (IPPF), which provided support for training, for information, education, and communications (IEC) activities, and for commodities. FP training and information, education and communications are provided by Ministry of Health and Social Welfare (MOHSW) and UMATI	
1987	The Party directed the Government to prepare a Population Policy. A **National Population Committee** was set up in the same year, with a secretariat in the Ministry of Finance, Economic Affairs and Planning.	
1988	Former President Nyerere spoke out publically in support of FP – in this pivotal speech President Nyerere placed family planning on the national agenda UMATI (through IPPF) launched Tanzania's **first Community Based Distribution programs** in Tanzania. By December 1996, CBD programs run by the government, NGOs and faith-based organizations were active in 22 of the 104 districts that make up Tanzania and Zanzibar Island	
1989	The 5-year **National Family Planning Programme (NFPP)** was launched (In light of the economic crisis and structural adjustment reforms, 'the national population programme is mainly financed by multilateral and bilateral assistance' (United Republic of Tanzania (1994) Country Report on Population and Development, International Conference on Population and Development, in Cairo, Egypt, 5th–13th September, Dar es Salaam.) The government established the **Family Planning Unit (FPU)** (later changed to Reproductive and Child Health Section in 1998) to be the overall manager of the NFPP. Government and faith-based organizations joined together to comprise the national program, with UMATI mandated to provide supervision and quality	

Year	Events/Activities	Indicators
	assurance in the public sector. The Reproductive and Child Health Section (RCHS) is not a directorate in its own right (unlike HIV/AIDS). RCHS is a vertical program with separate financing and procurement arrangements from other primary health care programs for some commodities. The RCHS relies on the Medical Stores Department (MSD; see below) for storage and distribution. USAID and other donors provided significant direct support to MOHSW for family planning. To support the NFPP, USAID designed the Family Planning Services Support (FPSS) Project (1990–1999), which focused on the basics—training, supervision, logistics, and IEC—and expanded access through CBD programs and social marketing. The timing of USAID's FPSS project in 1991 coincided with the establishment of the NFPP. FPSS became a nine-year, $30 million project. In addition, large amounts of central funds were made available, and other donor support increased. Concurrent with the money, technical assistance was available in sufficient quality and quantity to support initial NFPP activities. Complementary activities with UNFPA and ODA (clinical and logistical training, and contraceptives) provided some synergy to USAID support. Marie Stopes Tanzania opened and began to provide low-cost FP services A World Bank report describes Tanzania as facing a 'serious population problem'	
1990	National Health Policy launched (FP is not included)	
1991	MOHSW, with USAID support, undertook a **Family Planning Communication Project** to expand the target audience to all men and women of reproductive age (1991 to 1994)	
1992	**National Population Policy** was launched by the Planning Commission. It addressed maternal and child mortality, and indirectly encouraged child spacing. (The NFPP was the implementing arm of the NPP. The NFPP followed the discursive shift from population control to 'improving reproductive health' after the 1994 Cairo Conference) In May 1992, a **new national family planning logo, the Green Star**, (*Uzazi wa Mpango*) was officially launched by President Ali Hassan Mwinyi. New contraceptive methods and services were added — no-scalpel vasectomy and injectables First Tanzania Demographic Health Survey (DHS) was conducted MOHSW established a **FP Community-Based Distribution Unit** MOHSW issued **Family Planning Guidelines and Safe Motherhood Strategy**	**MCPR: 6.6%** **TFR: 6.3** (TDHS I)
1993	National Community Based Distribution Strategy was developed (implemented by government, NGOs and FBOs). The MOHSW launched the **National Community-Based Distribution Program** in four regions (Dodoma, Tabora, Iringa, and Coast), and it was scaled up almost nationally by 1999. MOHSW also developed **National CBD Guidelines** and trained approximately 300 trainers and supervisors. With assistance from NGOs, FBOs, and donors, the government was able to scale up this program almost nationally by the end of the 1990s. MOHSW launched the **first Health Sector Strategy** **Medical Stores Department** was established as a semi-autonomous government department under the MOHSW. (Until 1992, contraceptive ordering was done individually by each donor. Orders were not coordinated by either donors or the government. There were virtually no service delivery or consumption data, and certain items (e.g., oral contraceptives) were overstocked at the central level,	

Year	Events/Activities	Indicators
	with stockouts nationwide at the service-delivery points.)	
1994	ICPD, Cairo **Family Planning Guidelines and Services Standards** issued The MOHSW began a series of **health sector reforms** that eventually included integrating vertical health programs into the general health services and redefining the role of the central MOHSW as facilitator of health services, providing policy leadership and serving in a normative and standard-setting role.	
1995	Norplant implants were introduced by MOHSW and NGOs President Benjamin Mkapa elected in first multiparty elections	
1996	**Long-acting and Permanent Methods (LAPM)** were introduced by private sector Integrated reproductive and child health (IRCH) training was initiated	**MCPR: 13.3%** **TFR: 5.8** (TDHS II)
1997	**Decentralization** for the delivery of basic health services (including family planning) to the district council level. However, FP Uptake is not a Performance Indicator for Decentralized Council Health Plans MOHSW issues **National CBD Guidelines** **First RCH strategic plan** (1997-2001)	
1998	**FPU became the Reproductive and Child Health Section (RCHS). The RCHS program integrated 6 vertical programs, including the FP program. Systemic integration and other reforms diluted family planning's prominence and contributed to a significant loss of momentum.** In-service training in family planning for doctors, clinical officers, midwives, nurses, and nursing assistants was well-established in the early to mid-1990s, but subsequently it was seriously affected by decentralization. A 2006 report stated that there was no current national training strategy for family planning. (ACQUIRE Report. Tanzania Case Study: A Successful Program Loses Momentum A Repositioning Family Planning Case Study. December 2006.) Review and **revision of National Population Policy now included RH** and gender. UMATI shifted to a youth-focused programme after the IPPF Africa Region (IPPFAR) identified UMATI as one of nine FPAs in Africa to be "pioneers" of the post-ICPD paradigm shift. During 1998 IPPFAR also indicated that FPAs in the region needed to carefully re-position themselves in view of enduring "donor fatigue". **Commencement of health SWAp** in order to increase the government's ownership of accessing and managing donor assistance, and making disbursement efficient. The health SWAp is coordinated by the Primary Health Care Secretariat of the MOHSW, and the Health Sector Basket Fund (HSBF, to which a number of bilateral donors contribute) and is managed jointly by the MOHSW and the Ministry of Finance. An annual Comprehensive Health Sector Review is undertaken to establish a common understanding of planned activities, budgeting and financing for the sector, constraints and facilitating factors. Health Sector Reform was implemented in districts in phases; final stage was in 2003.	

Year	Events/Activities	Indicators
1999	**The 1990s were the "golden age" of family planning in Tanzania.** Necessary policies and guidelines were in place; committed national leadership provided vision and strategies; a small group of donors, NGOs and FBOs supported the MOHSW. Tanzania posted one of the **largest annual increase in contraceptive prevalence rate in the East Africa region**. **RCH Facility Survey** was performed **Integration of FP logistics into Medical Stores Department to District level**	**MCPR: 16.9%** **TFR: 5.55**
2000	**Sector-Wide Assistance Program (SWAp)** launched National Package of Essential Reproductive and Child Health Interventions (NPERCHI) were developed as a companion to the National Package of Essential Health Interventions President Mkapa was re-elected	
2001	**National Adolescent Health and Development Strategy** (developed in 2000-2001; in draft form for over 2 years)	
2002	Due to the shift to 'basket funding', The Tanzanian government allocated a budget line for FP commodities. Tanzania was one of the first countries in sub-Saharan Africa to allocate funds for a budget line for contraceptives in its health Medium Term Expenditure Framework (MTEF), in 2002. However, it was not till 2004–2005 that the Government of Tanzania purchased contraceptive commodities. USAID funding/provision of FP commodities to UMATI ended **MOHSW Department of Hospital Services initiated provision of LAPM at all hospitals; all FP methods were now mainstreamed by MOHSW**	
2003	Reproductive and Child Health Strategy (2003-2006) was developed as a follow-on to the Strategy for Reproductive Health and Child Survival (1997-2001) **USAID direct funding to MOHSW RCHS stopped**	
2004	**Contraceptive Security Working Group** chaired by the RCHS with participation from donors and NGOs, was formed to guide forecasting and quantification and prevent stock-outs due to weak infrastructure, poor forecasting, limited government funding, pulling out of donors.	**MCPR: 20%** **TFR: 5.7** (TDHS III, 2004-5)
2005	Reproductive and Child Health Strategy (2005-2010) was updated President Jakaya Kikwete was elected	
2007	**Comprehensive Council Health Planning Guidelines** for decentralization, now with FP uptake as indicator	
2008	President Kikwete launched the **National Road Map To Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania** (2008 – 2015). "One Plan" Operational Target for Family Planning is to **increase Contraceptive Prevalence to 60% by 2015** Re-establishment of the National FP Working Group	
2009/2010 (check)	Pharmaceutical Support Unit managed Tanzania's conversion to the Integrated Logistics System and the related Logistics Management Information System (LMIS), which include contraceptives.	
2010	**National Family Planning Costed Implementation Plan** (2010-2015) launched by Ministry of Health and Social Welfare	
2012	Revision of National Family Planning Guidelines	

What led to the deceleration of Tanzania's FP program in the early 2000's?

The 1990s are referred to as the 'golden age' of FP in Tanzania. The country had one of the largest annual increases in contraceptive prevalence in East Africa, at an average of 1.5 percentage points per annum between 1992 and 1999 (CPR was 16.9% in 1999, up from 6.6% in 1992). Five years later, this laudable progress dropped by almost 3-fold, to 0.6 percentage points per annum (CPR was 20% in 2004/5, up from 16.9% in 1999) (Table 15). In the 2010 DHS report, Tanzania demonstrated a recovery from this deceleration, with an average increase of contraceptive use of 1.5 percentage points per annum (CPR was 27.4% in 2010, up from 20% in 2004/5). Notably, Tanzania ranks third overall in absolute use of modern contraceptives by married women amongst the five East African countries' according to latest DHS reports (Rwanda 45.1% in 2010; Kenya 39.4% in 2009; Tanzania 27.4% in 2010; Burundi 17.7% in 2010; Uganda 17.9% in 2006).

Table 15: Population, fertility and FP use trends Tanzania (around 1990 to around 2010)

Year	Population size (millions)	Total fertility rate	Modern Contraceptive Prevalence Rate (%)	Unmet Need for family planning (%)
1992	27.2	6.3	6.6	30.1
1999	33.4	5.6	16.9	21.8
2004/5	38.8	5.7	20	21.8
2010	44.8	5.4	27.4	25.3

Data sources: DHS

Population data are from The World Bank, World Development Indicators 2011

Three major reasons are attributed to the deceleration of the FP Program between 1999 and 2004/5. Their compounded impact was that access to FP services declined, and consequently the rising CPR lost its momentum.

(i) Shift in donor priorities and emergence of HIV

Due to the heavy reliance on technical and financial donor support for Tanzania's FP Program, the global shift in policies and funding to HIV services in the early 2000s, which was considered to be a larger crisis than FP, had an inevitable impact on funding for FP services. In 2001, President George W Bush reinstated the Global Gag Rule[3], which had been repealed by his predecessor, President Clinton, in 1993. This decline in donor funding coincided with the health system reforms that began in 1998, which integrated FP into broader reproductive health issues (the Family Planning Unit was renamed the Reproductive and Child Health Section). The end result was that FP became less visible. The United States government (USG) was not supportive of promotion of sexual and reproductive health and rights, and as the largest funder of UNFPA, many FP programs had to be significantly scaled down or even shut down when funding to UNFPA was cut. This also affected the advocacy organization UMATI which was financed by a number of USG-funded organizations (USAID, UNFPA, Pathfinder, MSH), and thus shifted its focus to HIV programming. Population Services International (PSI) had started work in Tanzania in 1993 and played an integral role in the success of FP through social marketing of its Salama-branded condom. However, this program collapsed in 2003 due to inconsistent and decreasing funding, as the organization's focus shifted to HIV.

[3] The Global Gag Rule denies foreign organizations receiving U.S. family planning assistance the right to provide legal abortion, counsel or refer for abortion, or lobby for the legalization of abortion in their country. The gag rule was first announced by the Reagan administration at the 1984 United Nations International Conference on Population in Mexico City. (Population Action International)

The Tanzanian government was not ready to fund the national FP Program, and did not make attempts to revive it after the reported decelerated FP uptake in 2004/5. Key informants reported that the hand over process was poor, with the the USG shift in funding being an overnight affair. Consequently, from the early 2000s to 2010, resources for FP commodities decreased markedly.

It has also been stipulated that President Bush's President's Emergency Plan for AIDS Relief (PEPFAR) (2003–2008) and the Global Fund to Fight AIDS, TB and Malaria (GFATM) shifted US priorities and contributed to the decline of the FP program in Tanzania.

The RH program was revived in 2007 by donors. It was initially integrated into the HIV program but became a separate program in 2009.

(ii) Weakened human resource capacity

With the reduced external funding for FP in the 2000s, healthworkers (nurses, midwives, clinical officers) who were trained in provision of FP, moved to work in HIV/AIDs programs.

"The shift in funds meant that the trained personnel who had been working in the ministry of health all started shifting to work in HIV for these large donors." – International NGO

The CBD program, which supported higher cadres of the health workforce, dissolved. USAID and UNICEF supported the financial and managerial aspects of CBD and health worker FP programs heavily in the 1990s, but when the programs were handed over to the Tanzanian government, "*everything went down*." [International NGO]. A key informant noted that new CBDs were not being trained to replace those who were leaving, and by the time the government realized, it was too late.

"In the 90s, commodities were supplied by USAID, but then their policy changed and they stopped supplying, that caused the crisis. Without commodities, demand went down and also the CBDs left because there were not enough resources to keep them in the field." –MOHSW, policy maker

(iii) Premature health system reforms

As part of the health system reforms, health services were decentralized to the District level in 1997. Although this initiative was well intentioned to address community needs by bringing decision-making to the community level, it was actually detrimental for the FP program. Due to the integration of FP with 6 other programs into a broader RCHS program, FP uptake was not an indicator in the Decentralised District Council Health Plans, and FP advocacy was weakened, leading to loss of visibility for FP. This was incredibly detrimental to the program. The health SWAP or 'basket funding' was established in the same time period, and funds were now to be distributed based on government priorities, so FP did not necessarily feature. Additionally, with this new 'basket fund' it was difficult for donors to track how their funds had been used.

What led to the recovery of Tanzania's family planning program between 2004/5 and 2010?

1. Political will and commitment: Repositioning of FP

President Nyerere (who was in office since independence in 1962 until 1985) had a vision for Tanzania's development and understood the need to publicly support FP. However, since President's Nyerere's exit, subsequent incumbents to the current president H.E. Jakaya Kiwete have not publically supported FP like he did, although there have been some recognized champions in the government. FP champions include the Prime Minister, Hon. Mizengo Kayanza Pinda (he is the guardian of UMATI), who directly linked FP with development in a public speech on World Population Day; the former Deputy Minister of Finance (currently Minister of Finance, Zanzibar); Parliamentarians Hon. Jenista Mhagama and Hon. Lydia Mung'ong'o. Although President Kikwete has not come out clearly as a FP champion, he does support maternal, new born and child health (MNCH) as a comprehensive package. Likewise, the First Lady of Tanzania is a MNCH advocate.

"There is no political figure [FP] champion; the President is a safe motherhood champion" –Development partner

"If the country were to be assessed solely on policy frameworks and documentation, then the country would score high, but political will goes beyond that, and the level of commitment to FP is lacking. It is weak." – International NGO

Although the successful impact of advocacy by development partners was attributed to the effective targeting of leaders at various levels, getting the MOHSW on board as the program implementer was critical. UNFPA advocated for the MOHSW to revive the national FP Program over the course of several meetings. At the Ministry level, commitment to the FP Program is very high, particularly from the custodians of the FP Program, the RCHS. A demonstration of this repositioning of FP in Tanzania and renewed government commitment was the attendance of the 2011 Dakar FP Conference by high level officials from MOHSW and Ministry of Finance.

1.1. Enabling policy and program environment

Moving forward, the Government of Tanzania has demonstrated its renewed commitment to FP by integrating it into the national development plans – the development blueprint, Vision 2025, and the National Strategy for Growth and Reduction of Poverty, MKUKUTA I (2005-2010), MKUKUTA II (2010/11-2014/15), and in related sector plans. MKUKUTA is highlighted as the most important map for guiding the country's financing of development projects and has 3 goals: (i) poverty reduction; (ii) improved quality of life and social wellbeing; and (iii) governance and accountability. Tanzania now has target indicators for population growth reduction and total fertility reduction in the 2010 MKUKUTA strategic paper. There is an ambitious target to increase CPR to 60% by 2015, which has been matched with increased funding. MKUKUTA tries to bring access to FP to other development indicators such as education, the labor force, reducing maternal mortality, and child health.

The President's Office Planning Commission (POPC) established by President Kikwete used to be a Ministry but is now a commission with a specific mandate in economic development. POPC is charged with implementation of Vision 2025. Relatedly, POPC is also the custodian of the National Population Policy. Given that FP is integrated within the Population Policy, it demonstrates the country's repositioning of FP at the policy level, and its commitment to prioritising population and health issues in order to attain economic development. Further, RH and FP are included in the draft 5

year Strategic Plan (2011-2016) to implement Vision 2025. At the time AFIDEP carried out key informant interviews in Tanzania, the Strategic Plan was undergoing technical review, prior to its presentation to Cabinet for approval.

There as several policy documents supporting FP but implementation has been poor. Key informants noted that this is however now changing. There are several challenges hampering the achievement of FP targets in Tanzania; these include low human resource capacity and inadequate facilities. A number of policies to support FP uptake are being formulated or have been recently completed. The 1994 Family Planning Policy Guidelines and Standards for Service Delivery and Training are currently being reviewed. The National Population Policy (2006 update), whose aim is to increase awareness and use of contraceptives at the District Council level, is currently being implemented through the Tanzania Council of Population and Development (TCPD) and the National Population Technical Committee (NPTC). The TCPD's membership consists of Permanent Secretaries from various ministries who sit quarterly to address population and development issues. However, the NPTC's Terms of Reference (TORs) were pending cabinet approval in March 2012.

Although the current education policy (yet to be approved by cabinet) does not support provision of FP products to young children, it advocates for targeted education to ensure that girls do not get pregnant at an early age.

2. Mobilization of financial and technical resources: Improved financing and governance mechanisms

There was a realisation by the international community that HIV services cannot be detached from FP services and products, resulting in a global shift in support for FP/RH. International donors such as USAID increased their funding allocation towards FP advocacy and programs, resulting in repositioning of FP in Tanzania. Further, following President Bush's exit in 2009, President Obama's administration lifted the Gag Rule.

"Development partners have come in and are giving resources for family planning." –MOHSW policy maker

There are three funding streams for health services: (i) resources allocated from the Government of Tanzania's revenue; (ii) indirect resources from the Government of Tanzania through development partners who provide financial support to the government either through a basket fund (e.g. UNFPA funds FP commodities through this pool of funds), or direct funding to the government (e.g. USAID and DFID); (iii) Private sector funding through social marketing by NGOs like PSI, Marie Stopes and other private for profit organizations. Due to inadequate financing from government revenue, most FP activities in Tanzania are financed through direct or indirect donor funds. Notably, there are no clear guidelines on how much of the pooled basket fund should be allocated to vertical programs, including RH.

The persistent challenge, therefore, is limited resources for implementation of the national FP program. Tanzania's national health budget, at 8% in 2009/10, is well below the 15% target of the Abuja declaration. In 2009/10, HIV/AIDS, RH and malaria (each is implemented as a vertical program), received the largest share of the meagre government health budget (64%).

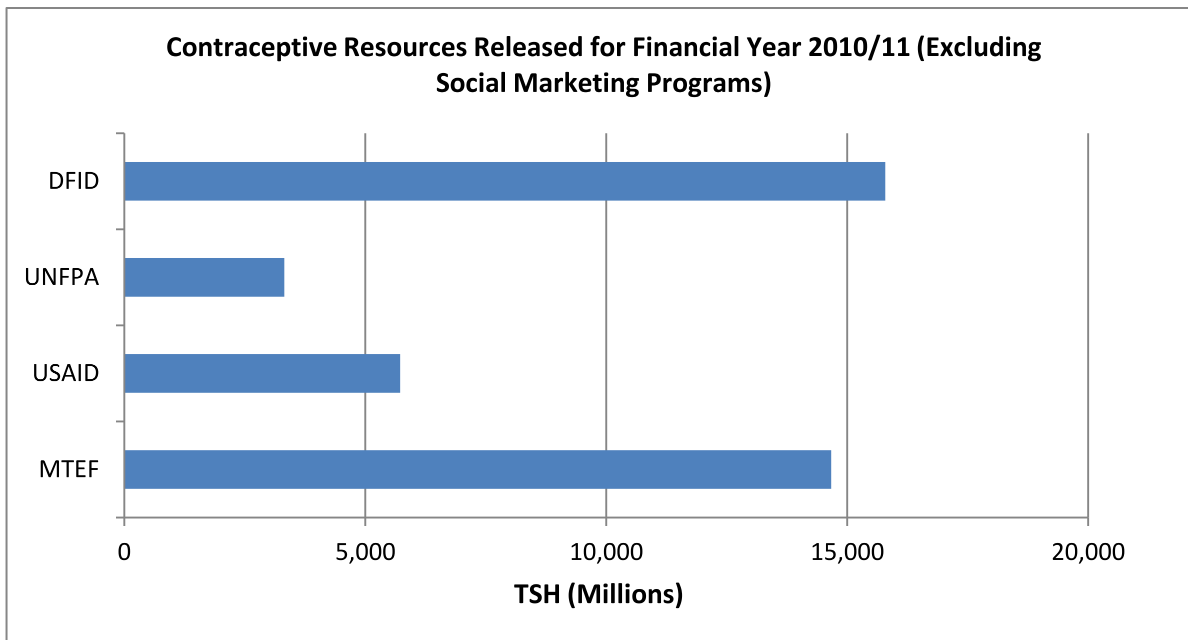
"Political elites are aware of benefits of FP but the challenge is committing to support those services by resource allocation". –MOHSW, policy maker

"The problem is that the program is donor driven. Most of the support comes from outside and the government does some of the activities so as to receive funds from donors but it does not come from their own initiative." –International NGO

A budget line for FP commodities was established in 2000, but it was not until 2004/05 that the government actually purchased FP commodities. Government funds allocated to contraceptives have increased over the years. Likewise, donor support has also been increasing. USAID funding for FP has steadily increased: 2005 (US$ 5M); 2008 (US$ 17M); 2009 (US$ 19M); 2011 (US$ 20M); 2012 (US$ 22M). The 2012 USAID funding is being directed as follows: US$ 5M for contraceptive security; US$ 1M for forecasting and quantification of commodities; US$ 2M for social marketing; US$ 8M for the AQUIRE project which comprises FP integration/PAC/R&D and advocacy; US$ 1.5M for 3 zonal training centres to address the training gap; US$ 0.5M for policy and advocacy.

From 2000/2001, the MOHSW started preparing a rolling three years Medium Term Expenditure Framework (MTEF) to improve budget management and accountability of the Health Sector. Figure 16 below illustrates the funds allocated to purchase FP commodities.

Figure 16: Contraceptive resources released for basket funding in 2010/11

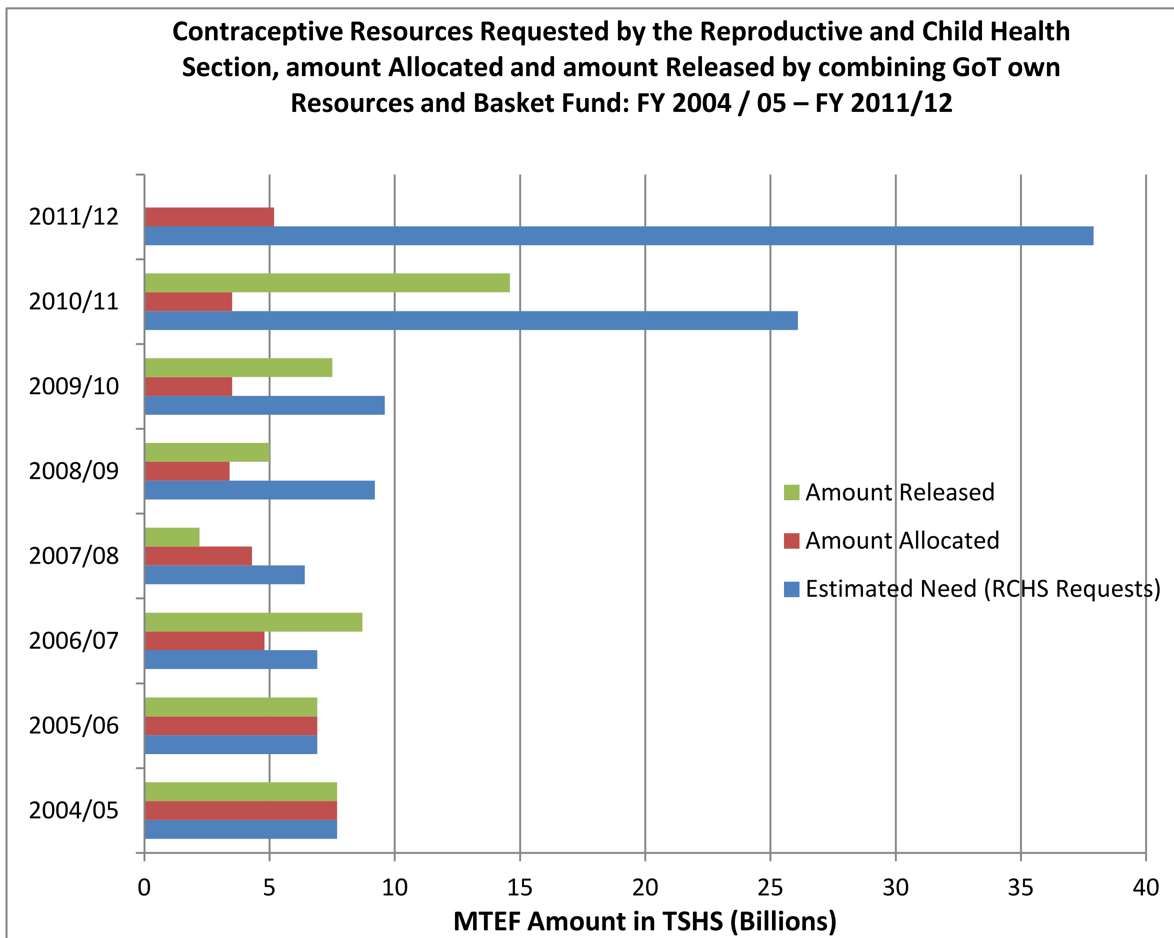


In order to revive government financing for the FP program, in 2009, the MOHSW liaised with development partners (FHI360 served as the secretariat) to develop the National Family Planning Cost and Implementation Plan (NFPCIP) (2010-2015). The CIP addresses six key priorities including contraceptive security, capacity building, service delivery, and monitoring and evaluation, and advocacy, with the aim of raising the national CPR from approximately 30% to 60% by 2015.

The launch of the NFPCIP has facilitated specific quantification of commodities and resources needed by RCHS, as well as tracking expenditure and assessing impact. It is also a useful tool for advocating for and mobilizing resources.

Figure 17 illustrates the tracking of funds requested, allocated and released to the RCHS for commodities. The amount released from basket funds (which includes development partner and government contributions) in 2004/5 and 2005/6 financial years matched the estimated need by RCHS. However, there was a drop in the amount of funds allocated in the 2007/8 budget cycle and a significant drop in released funds. There was a further drop in allocated funds in 2008/9, but there was an upward trend in released funds from 2007/8 to 2010/11. However, this was not close to meeting the steep rise in estimated need by RCHS since 2010/11. This significantly increased need is likely to be due to more accurate estimations, as well as increased demand for more expensive commodities (injectables and LAPMs). Despite significant subsidies (Norplant and Jadelle implants which previously cost US$ 25 and US$ 27 respectively, have been subsidized to US$ 18), more funds are needed to promote access to long acting methods which are relatively more expensive than the short acting methods. Inadequate funding increases the unmet need for FP by limiting the procurement of commodities, in turn limiting the availability of various contraceptive methods (method mix).

Figure 17: Budget tracking for contraceptive resources for the 2004/5 and 2010/11 budget cycle



The current director of RCHS, Dr Neema Rusibamayila, is reportedly very committed and works hard to ensure there are funds available to support RCHS's programs, and has even changed the mind sets of other directors within the MOHSW to support FP.

"*I see a brilliant future because of her [the RCHS Director's] commitment and aggressiveness. The [development] partners are much more ready to support her. When she tells the partners 'this is my problem', they come in and support."* – International NGO

Various partners have successfully engaged with Members of Parliament and Ministerial-level policy makers to advocate for increased budget allocation for FP services and products. In 2007/08, UMATI implemented an advocacy project targeting decision makers including the Minister of Finance to increase budgetary allocations for family planning commodities. The project led to an increase in budget allocation for FP in the 2008/09 financial year. It was a collective effort involving the media, a parliamentary group formed by the initiative, the MOHSW, the Ministry of Finance and central reproductive organizations. The initiative worked to revive family planning champions across different organizations including parliamentarians (Parliamentarian Committee on Social Work).

It is noteworthy that in 2010 there was an FP financing crisis; this had an impact on various aspects of FP programs including commodities and infrastructure. The challenge of FP financing in Tanzania has largely been attributed to the government's overreliance on external funding.

"The problem with financing FP in Tanzania is that almost 80% or 90% of the budget goes directly to FP commodities, and the remainder is kept for capacity building, health systems strengthening etc. As a result of the little funding for the technical aspect of FP, the government becomes too reliant on implementing partners who then take charge of M&E and health systems strengthening." – International NGO

A study by Ifakara Institute and Pathfinder in Shinyanga (which records the lowest CPR and highest TFR) and Dar es Salaam regions showed that majority of RH District funding goes to antenatal care (mainly emergency and delivery services), and only a mere 0.03% of the District budget goes to FP. District-level advocacy is therefore needed to highlight that FP is part of MNCH, with data to demonstrate how FP use contributes to reducing neonatal and infant deaths.

3. Health systems strengthening: Diversified service delivery

3.1. Integration of FP and HIV services

In some instances, integration of SRH with FP previously existed by default due to a stretched health workforce. FP was officially integrated within other RH services (MCH and HIV) in public and private facilities. However, more knowledge is needed to identify the best model of integration, what resources are needed to enhance the system, and what the training needs of health workers are.

Key informants from international NGOs highlighted that they refocused their programs to integrate FP and HIV in RH programs from the mid 2000s. Rapid population growth had persisted in Tanzania despite the emergence of HIV due to the availability of life-prolonging ARVs. Therefore, people living with HIV required contraceptive services, and the prevention of mother to child transmission (PMTCT) program had to be scaled up in 2004.

"The donors saw the need for family planning in the people with HIV that they were dealing with and so they started family planning services… Senior management here saw the gap; that the family planning component was missing…So

they approached the headquarters that they need family planning support to work here and they started supporting us" – International NGO

PMTCT services in Tanzania were initially piloted in 2000 in five zonal facilities and gradually scaled-up in 2004. This scale-up was largely boosted when development partners brought in their support in 2006. According to the National AIDS Control Program (NACP) in Tanzania, the completion of the integration of FP and HIV programs was supported in 2010 through a pilot program operated by FHI360. Currently about 90% of all facilities are providing PMTCT services.

NGOs providing integration of maternal, newborn and child health with HIV/AIDS include Pathfinder, which has SRH integrated with women's rights as a cornerstone of their general rights. Engender Health wants to integrate post abortion care and PMTCT (started in 2007) with FP.

The challenge that has faced integration of services, according to a key informant, is that it was not planned for, but spearheaded by development partners. Structures and guidelines for implementation have therefore been lacking, although Integration Guidelines to integrate service provision for FP, HIV and MCH are imminent. It should be noted that integration of services increases the workload for the limited number of healthworkers, given the human resource crisis in Tanzania.

"*There is no integration [per se] but rather linkages between the MOH, RCHS, HIV and TAC because each has their role but TAC is the national coordinator, and at the facility service level they work together."* –Policy maker

"We [Government agency] have trained the whole country in twenty one regions and more than seven hundred facilities in the revised health care systems and with that there is a component of family planning" – Government technocrat

3.2. Private Public Partnerships

There are a number of PPP to increase access to FP services, for example when there are stock outs at public health facilities. A number of organizations in the private sector offer FP services and products (various short and long acting methods), including Population Services International (PSI), UMATI and Marie Stopes Tanzania (MST). Private sector providers pride themselves in providing higher quality services relative to the public sector.

UMATI offers permanent tubal ligation (PTL) in addition to pills, condoms, injectables, implants and IUCD at its clinics. Exit surveys from UMATI clinics demonstrate that clients enjoy going to UMATI clinics because they have more time to talk with the health worker and they feel that the environment is more caring.

PSI socially markets Salama branded condoms, oral contraceptives and injectables and will soon introduce emergency contraceptives. In the long term, PSI is putting emphasis on implants and IUCD because of their cost effectiveness. PSI products reach the market through various ways: they have access to a network of facilities (privately owned facilities mostly in urban centres that have entered into an MOU with them) and provide FP at a fee for service (the product is free as stated in the RH/FP policy) and also through outreach activities (free services at community level in rural and other marginalised areas). PSI is also implementing a social marketing project jointly with a local organization since 2007 – Tanzania Marketing and Communications Project (T-MARC). The project, Tanzania social marketing project (TSMP), is funded by USAID and markets condoms (male and female) and various types of contraceptives.

MST has its own private health center where they provide family planning services with a focus on LAPM.

The RCHS coordinates all partners together ensuring harmony at work and mutual support between government, development partners and NGOs.

3.3. Youth-friendly services

Demand creation through youth awareness campaigns including the Jiamini FP campaign by Tanzania Capacity and Communication Project and the Green Star need to be synchronised with increased service provision for the youth. There are several challenges including – more funding is needed at all levels; there is still need to dispel cultural beliefs about adolescent and youth sexuality in order to support implementation; there is need for further advocacy with decision makers and policy makers to convince them of the importance of youth and adolescent SRH.

Young people face a number of SRH problems in Tanzania, including early sexual debut, unplanned teenage pregnancy, STIs and HIV/AIDS, unsafe abortion, female genital cutting (FGC), and sexual abuse/violence. The IPPF affiliate UMATI identified a gap in youth access to information and more importantly youth-friendly services to address emerging sexual and RH issues in this age group including unwanted pregnancies, safe abortions, and maternal deaths.

Youth SRH was initially a sensitive issue and not given much focus because it was seen to promote promiscuity. With advocacy led by the RCHS, this has changed. The government's focus on youth intensified only in recent years. After FP services were integrated within RCHS, youth and adolescent SRH was incorporated. Advocacy activities carried out in 2001 by a group of organizations including UMATI, under an initiative of the Ministry of Youth Affairs, was instrumental in bringing to the forefront the youth SRH agenda.

In 2007, UMATI conducted an assessment of youth-friendly services in Tanzania. The assessment revealed that youth-friendly facilities had increased to 30% national coverage. The government has a target to reach 80% coverage through establishing youth-friendly corners within existing health facilities. Having pioneered SRH programs targeting youth, UMATI serves as a resource on youth sexual and reproductive health and rights programs which the RCHS and other organizations can utilize. They have expertise in designing youth-friendly centers and IEC materials.

The RCHS led the development of the Ministry of Health's National Standards for Adolescent Friendly Reproductive Health Services through its Adolescent and Youth Sexual and Reproductive Health (ARH) TWG. Through the ARH TWG, the RCHS and partners also share programmatic information and lessons, track progress as well as come up with strategies to address gaps and emerging challenges.

The Adolescent SRH Policy (2007) makes the case for providing contraceptives to youth. The National Adolescent Reproductive Health Strategy (2010-2015) recognizes that reproductive health services are "a basic human right for all people including adolescents" and thus seeks to address health system responses to adolescent health needs and to provide a platform for linkages with other sectors that deal with young people. In addition, the National Life Skills Education Framework aims to improve knowledge, and promote attitudes and skills, that will facilitate adolescent decision-making on sexual issues. Both strategies need adequate resources, trained health worker and teachers, and a supportive environment that is responsive to the needs of adolescents.

There is an ongoing national advocacy and training to all districts in Tanzania. At the time AFIDEP conducted key informant interviews (March 2012), advocacy had been initiated in 12 regions and was targeted to policy makers, regional coordinators, district officials and faith based organizations. The messages emphasize the need to invest in

adolescent SRH. There have also been increased efforts to train health workers and build youth friendly centers. To increase the reach of youth-friendly services, the country is moving towards creating youth corners within existing health facilities since there are health facilities almost everywhere in the country – to reach its 80% target coverage of youth friendly services. Training of trainers (TOT) of service providers is being conducted at the district level, who in turn should train other providers in their districts.

There are also government-led efforts to increase awareness about RH services among youth. There are a number of organizations supporting the government in educating youth on their sexual and reproductive health and rights and providing services including AMREF, FHI360, MST, UMATI, GIZ, Mema kwa Vijana in Mwanza and DSW.

Facilities with youth-friendly services are being fitted with an identification logo so that youth can easily find them. Service providers are however relatively fewer than organizations doing demand creation. They include UMATI and MST. Additionally, coverage of youth friendly facilities is limited. For instance, UMATI has few clinics in some parts of the country therefore their impact may not be national. M&E tools for youth friendly services which did not exist before the time of key informant interviews were being printed, which demonstrates a commitment towards improving access and utilization of FP among the youth.

3.4. Supply chain management

With a view to improve on efficiency of commodity supply chain management in Tanzania, Medical Stores Department (MSD) was established in 1994 by the Act of Parliament to take over from the government-owned Central Medical Stores. MSD is an autonomous institution within MOHSW that deals with procurement, storage and distribution of medical products. Prior to the health sector review in 1996, the vertical programs were also conducting their own, separate logistical functions to procure, store and distribute medical commodities. These functions were integrated into MSD in order to minimize costs and reduce duplication.

Likewise, in the 1990s, donors such as UNFPA were supplying commodities as part of the support to the family planning program. From about 2005, UNFPA moved from providing direct support of commodities (vertical program) and financial support was integrated into the health system financing mechanism (SWAp). This was to facilitate the government's mobilization of resources from other development partners and manage funds more effectively. There is a lot of reliance on funders such as USAID and UNFPA for funding; they bridge the gap when there are competing priorities with FP commodities for the basket funds.

MST and development partners obtain commodities from government (they go through MSD). The contraceptives logistics system in Tanzania is a pull system; the demand comes from the District health facilities. Commodity forecasting and quantification is coordinated by the Commodity Security Committee which constitutes RCH and various partners (USAID, UNFPA, MST, PSI, to name a few). Reportedly, commodity security at the time of field work in Tanzania was fairly good with sufficient supply to cover the rest of the year and part of next year. Commitment by donors and good coordination of donors and donor funding through the Commodity Security Committee has led to improvement in commodity supply.

John Snow Inc. (JSI), through the USAID DELIVER Project is providing technical assistance to MOHSW/RCHS by leading the quantification exercise due to HR challenges in RCHS, which doesn't have a logistics officer. Since 2010, however, they employed a Doctor and a Pharmacist. JSI supports quantification (based on how many women access the family planning service in the private sectors, couple protection years rate, method mix, method preference, interviews to

make adjustments) and forecasting. The government role with other partners is to solicit funds in order to meet funding gaps for contraceptives at the Contraceptive Working Group of which JSI is the secretariat. After funds are mobilized, a supply plan is prepared with minimum and maximum levels & total supply pipeline for the country (mainland and Zanzibar). The challenges faced are inadequate data from the health facilities, therefore JSI need to do data cleaning and data adjustments. In addition to annual quantification there is also a quarterly review of the supply plan to prevent stock outs.

"In most cases, MSD doesn't experience large stock outs; The Commodity Security Committee are always looking at the data critically. If there are stock outs then you know for sure there are some funding problems. Even so it is uncommon."
– Government technocrat

In order to address sustainability, JSI/USAID Deliver are building capacity at local institutions. There are 2 officers at RCHS. The Pharmacists in the Pharmaceutical Service Section are being trained. Also JSI is in the design phase with MOHSW to develop a Logistics Management Unit. Their mandate will be to conduct nationwide quantifications for all commodities. (Not only for family planning)

PSI participates in the Commodity Security Committee to gain insight of what is happening in the public sector and to inform on its contribution to the private sector. PSI penetration coverage is 80% of PSI outlets for condoms, pills and injectables and 20% for implants and IUDs – mainly because more expertise is required and they are more expensive. In addition, lower level drug dispensing outlets cannot stock these long-acting methods. Through these numbers, PSI is able to forecast demand for its products.

Several challenges exist with commodity security. Obtaining facility level consumption data for use in forecasting has been problematic. Donors contribute to the basket fund in June, making it difficult to project commodity supply for the next year. In addition, despite availability of commodity supplies there are problems with the logistics system and the end user may not receive the product. The procurement process (through MSD) is long, taking between 6 months to a year to procure commodities using basket funds. A coalition of organizations (including UMATI) is advocating for changes in the procurement system.

Integration of systems is required to reduce the workload for health workers and improve accuracy. There are different vertical programs HIV, Malaria, RH (including family planning), TB, etc. therefore not using resources effectively at the facility level. Storage warehouse and distribution at MSD is already integrated. But requisitions need to be done separately for the vertical programs, so given that it is a quarterly reporting system, by the end of the quarter health workers have to fill about five or six R&R forms. Efforts are underway to improve the system – The aim is to have all systems integrated by 2014. The Requisition and Report (R&R) forms which are being used for pulling are being revised.

There is an inadequate supply of popular methods (Depo-Provera, Implanon) as stock outs at central level have been high. The method-mix is inadequate. 18 months ago there was a shortage of injectables and implants (Implanon and Jadelle). Currently, the government is spending a lot more on pills and injectables than on long acting methods. Government is moving towards prioritizing and investing in long acting methods (implants and IUCD) because these are cost effective PSI is promoting long acting methods on the basis that for those who choose the method it has a long life span and hence is very cost effective. PSI outreach teams (10 outreach teams) target certain regions which have low CPR predominantly rural areas and provide long acting methods (IUD and implants). And even in the network facilities PSI is focusing on training in long acting methods in which there is least capacity. The percentage is very low for the youth, the

need for spacing and limiting is very high, and the only way to go is long term. And this will help the country to reach the CPR it needs and also help in achieving the MDGs.

Supportive supervision reports have revealed that distribution is not carried out well. There are 2-way bottlenecks: from MSD zones to health facilities; at R&R by facilities and district level request to zones. Consequently there are frequent stock-outs. Products sometimes stagnate in the zonal warehouses. Sometimes the health facilities delay sending requests to districts (poor planning) so that the order from the districts to the zonal warehouse is also delayed. Sometimes the District Medical Officer (DMO) or the District Management Coordinator (DMC) may complain that the product is not pulling or that they did not get the order placed either in terms of method mix or amount. RCHS was working with UNFPA on logistics pipeline report at the time AFIDEP staff were in the field.

MSD only has the function of procurement, storage and distribution. MSD therefore won't know the status in the field at any one time. The only information they have is the quantities at the central level, what is being distributed to the zone. They don't have facility level data as they don't monitor consumption and stock levels. This is the mandate of region research coordinators of the MOH, who monitor through the facilities' Requisition and Report forms of the pull system.

There are also parallel logistics systems. For instance, PSI buys contraceptives and supplies them to Network facilities (privately owned facilities that have entered into an MOU with PSI) at a fee. PSI deals independently with regulatory, storage, packaging and distribution issues related to the contraceptives they buy. Regional distributors are privately owned companies.

In order to strategically fill the supply gap of public health facilities, Accredited Drug Dispensing Outlets (ADDO) are private retail outlets (drug shops) that have trained staff to provide oral contraceptives; they counsel and then refer women who need other forms of contraceptives (injectables, implants). The training of drug shops staff started in 2001, and it is still on-going. The current number of trained accreditors is 9058 and the number of outlets is 3873. There still remains 5 regions to be trained to have ADDOs: Mwanza, Tabora, Kilimanjaro, Kagera, and Arusha. The drug stores buy their commodities from private suppliers. Even if ADDOs are accredited by the public sector, they are still able to buy from the wholesalers in the private sector.

4. Taking information and services to the community

4.1. Increased acceptance of FP by leaders and demand creation for FP through community engagement

Despite FP being on the development agenda in Tanzania, it is publicly promoted for child spacing – a health, and to a lesser extent, a development issue. A key informant highlighted that many politicians cannot talk about FP publically because people will not vote for them in subsequent elections (a reflection of negative attitudes in the community). Another key informant noted that positive responses to FP advocacy amongst Council members or Parliament is quite slow, but the 'atmosphere' is getting better.

"Family Planning at community level is associated with controlling number of children" – Policymaker.

"Central level leadership and regional level leadership have awareness on the population and development link but politicians resist talking to the public about it" – Policy maker

The reemergence of advocacy efforts in Tanzania has played a big role in mobilizing leaders at various levels to support FP, who can in turn play a role in demand creation by the public. Generally, current advocacy efforts are focused on demonstrating the relationship between FP and broader development goals, as well as the link to maternal health and women's empowerment. The First Lady, Mama Salma Kikwete, advocates for safe motherhood through her foundation *Wanawake Na Maendeleo (*WAMA), a non- governmental, non-profit organization she founded in October 2006.

Parliamentarians are also actively involved in advocacy for FP, and have increased awareness within Parliament and the public. The Parliamentary FP Club (formed in 2011) advocates for FP and was instrumental to the establishment of the budget line for FP commodities. The Parliamentary Social Service Committee legislates and provides budgetary oversight on its priorities (reproductive and child health indicators of the MDGs and pushing the national health budget to be in line with the Abuja declaration). It also has uses the platform of the President's focus on safe motherhood as an opportunity to advocate for maternal and child health (MCH) and FP in order to attain Tanzania's development goals.

Although advocacy for FP has increased amongst some policy makers, many of them still remain impartial and cannot publically advocate for FP. There is therefore a need for more targeted and sustained advocacy to government decision makers at all levels and parliamentarians.

"The sexual reproductive and child health have started this [family planning] champion concept, but to me I don't think that is what we need; we need to convince people at higher level, very high level. They need to first understand themselves and then they can convince others" – Policymaker

Creating demand for FP services and products by addressing cultural and religious barriers has been key to driving contraceptive uptake in Tanzania. There has been focused advocacy to religious leaders, so that they may influence their followers. For example, the POPC and Futures Group, met with the 'Maholamaa' (one of the 15 Muslim Councils in Tanzania), Catholic Fathers and Pastors to advocate for child spacing using natural methods as a way to allow women to take part in economic activities, and to stay healthy. This advocacy aligns itself with teachings from the Quran (Muslim women are taught to breastfeed their children for 2 years and so even if they may not be publicly encouraged to use modern family planning, they are required to space their children by at least 3 years). Consequently, the National Muslim Council of Tanzania (BAKWATA) issued an official clerical statement (Fatwa) in support of spacing using natural methods. Further, some religious leaders openly advocate for FP; two pastors who have undergone vasectomy are renowned FP champions.
Although each Christian denomination has its own dogma on contraception, the Christian Social Security Commission (CSSC) works together with government in policy and advocacy work, and contributes technical, financial and other resources, with all its efforts focused on improving the health of mother and child.

Community sensitization e.g. by the renowned Green Star campaign of the 1990s is credited for significantly contributing to increasing CPR in Tanzania. The emphasis is on *'the importance of having few children so as to meet some of the basic needs'* – Local NGO. There is an ongoing large scale mass media campaign in 2012 to re-launch the Green Star campaign in order to enhance the community's understanding of the link between FP, health and development. There is a distinct focus on a youthful target audience, as well as those living in areas with low CPR such as Kigoma, Tagora, Shinyanga, Mwanza, Mara. UMATI and UNFPA have also implemented similar programs in Shinyanga (in partnership with the local government) to complement these efforts.

“In 1990 there was a clear branding effort on behalf of FP with the Green Star; everybody knew of the Green Star and what it represented, all the way down to the community level. Those who were part of the 40s until the late 90s know about it. Now, there is a need to rebrand or re-energize the brand to target youth that do not know what the Green Star is.” – International NGO

Community sensitization by village health workers, community development officers, social workers and others has been critical to increasing FP awareness. Some organizations (e.g. Marie Stopes Tanzania) have used community-based motivators to sensitize the community about FP and provide referrals to nearby health centers. Other initiatives to increase demand for FP services include PSI’s community outreach program whose aim is to educate women about the benefits of contraceptives through house visits, FHI360’s mobile for reproductive health project (m4RH 2010) which provides information on FP through text messages, and the Jiamini FP radio campaign by the Tanzania Capacity and Communication Project.

“The messaging on use of contraceptives is being sold as spacing for the health of the mother and the child, and that having the number of children one can take care of by using family planning contributes to Tanzania’s development.” – International NGO

Some initiatives target men to support FP. UMATI’s Young Men as Equal Partners Program has been promoting male involvement in FP decision making for the last 7 or 8 years and has contributed to the increased rates of contraceptives uptake. The Champion Program by Engender Health uses media advocacy to change to men’s attitudes on contraceptives.

In line with the long term vision for Tanzania’s development, various efforts have been made to promote awareness of FP issues among young, school-age people. In its policy guidelines, the Ministry of Education (MOE) emphasizes the youth’s right to information on SRH and HIV/AIDS, life skills and human rights. These concepts are taught through: (i) A core curriculum whereby SRH, HIV/AIDS, life skills, and human rights are integrated into core subjects. (In primary school, they are integrated in sciences; in secondary school the 4 topics are integrated in geography, civics, biology and home economics.) (ii) An extra-curriculum using PE education programs, peer education (with members of the community and members of the school), and psycho-social support.

The peer education project PASHA (which is guided by the Ministry of Education Standards for Peer Education) has been running in selected regions since 2003 and is funded by NGOs (Swiss Tropical Institute, USAID, SOLIDA, and GIZ) and focuses on building life skills on various issues including early pregnancy, STI/HIV and abortion. The MOE would like to scale up this program nationally – there has been advocacy to include PATIA in the country’s Mid Term Expenditure Framework, but funds are limited. Further, the MOE supports the Abstain, Be faithful, use Condoms (ABC) approach with more emphasis placed on abstinence. Although MOE policy supports the use of condoms and allows students to be taught how to use them in schools, it does not allow them to be distributed in schools. Condom use is part of the curriculum (you can demonstrate its use in the classroom), but the policy does not allow them to be distributed in schools.

The MOE has also strived to integrate its FP and RH policies with those of other related sectors. For example, it holds regional stakeholders meetings with members from CSOs, MOHSW, gender and community involvement, district officials including the district executive director, district education officers, where they try to sell their ideas of a networking directory for youth SRH services. Integration of SRH issues in addition to HIV is done through the SHANGAZA

star materials with 10 themes that incorporate RH and other topics; they also have life skills booklets. The SHANGAZA star materials are approved by the ministry and thus national.

4.2. Outreach, taskshifting and demedicalization of FP commodities

It is critical that demand creation for FP is met with adequate provision of FP services and products. A number of initiatives have been in place to strengthen the health systems, which have synergistically culminated in improved access to FP services in Tanzania.

Tanzania is experiencing a human resources for health (HRH) crisis, with about 65% vacant posts in the public sector and 80% vacant posts in the private sector. Of the 35% that are filled in the public sector, most are not qualified health care workers. Medical attendants have been known to administer injections in the community, a practice referred to as "task shifting by default".

"There are only 25 family planning service providers per district; and only 7 are fully skilled out of the 25" -International NGO

Some of the strategies employed to enhance access of quality FP service provision include in-service training of Medical Officers by zonal trainers; the expansion of cadre responsibilities to allow Clinical Officers to deliver LAPMs, which was previously only done by Medical Doctors; tool kits and job aids to aid service delivery for FP. A number of NGOs and development partners such as PSI, MST, MSH, GIZ support/facilitate in-service training in specific regions. MSH developed an accreditation program incorporating business skills training and marketing to enhance the provision of FP services in drug shops. Advocacy efforts are also encouraging Districts (which operate in a decentralized health system) to allocate funds to training health workers to provide family planning.

"The permanent and long term methods need specialized service providers who are trained. We've got scarcity of service providers in the rural areas. You find that a nurse assistant or a nurse attendant is in charge of the health facility. You can imagine how can such a person doesn't have time to provide a long term or a permanent method. And even permanent methods need more expertise."- NGO

4.3. Outreach of contraceptive services

Provision of outreach contraceptive services to the community is in recognition of limited access to health services. There are three main approaches to FP service delivery in Tanzania: (i) Daily routine services in facilities whereby every facility provides FP services and products according to its level of jurisdiction (e.g. dispensary level can provide FP methods that are not available at the health center level); (ii) Special service days which were implemented due to heavy workloads and competing priorities during provision of routine services such as emergencies by a stretched workforce. Long acting and permanent methods (LAPMs) are administered on these special service days, by appointment; and (iii) Outreach services or mobile clinics, whereby specialized teams from high level facilities go to the community level – at a health center or dispensary - to provide LAPMs to people who cannot usually access these services.

A number of NGOs in Tanzania, such as FHI360, Engender Health, PSI, MST, Pathfinder, etc. provide free outreach contraceptive services to poor and marginalized communities. Outreach activities are coordinated by the District RH Coordinators (formally called MCH coordinators) in order to avoid duplication by different agencies, and to ensure good

coverage. (The District RH Coordinators report to their respective District Health Management Team). The District RH Coordinators are also responsible for sensitizing the public on the dates that outreach activities will take place. Although outreach services are provided at specified times, they complement the Community-Based Distribution (CBD) program by enhancing access to services. Outreach guidelines are due to be launched by the Ministry of Health in 2012.

Outreach services are typically given in villages/rural areas and peri-urban areas, and have particularly enhanced the provision of long term methods. For example, most MST work is focused on providing LAPMs – IUDs, implants, tubal ligation, vasectomy; this work greatly complements government health workers whose main capacity is in the provision of short acting methods, with limited capacity for provision of long term methods.

"Over 60% of clients for long acting and permanent methods are being reached through outreach services" – International NGO

The CBD Program for FP was launched by the MOHSW in 1993. The role of the CBD program (community health workers, community development workers and village health workers), has been historically critical to Tanzania's success in terms of rate of FP uptake. Of note, the government's CBD program was never scaled-up country-wide during its initial existence (it was only in 18 districts); rather different donors supported its implementation in different regions. Therefore the CBD program faded with declining external support, and the government is currently in the process of reviving it. Key informants noted that the MOHSW wants to re-introduce the Village Health Workers Program with support from UNICEF.

The CBD program's volunteers provide information on all contraceptives methods, dispel myths and rumours, supply limited FP products (pills and condoms only), and make referrals to facilities for other methods. They receive incentives in the form of training, or a small token at meetings, and community recognition for their volunteerism. Some organizations (e.g. MST) do not have CHWs but rather community-based motivators who sensitize the community about FP and provide referrals to nearby health centers.

UNFPA supported the MOHSW to undertake an evaluation of its CBD program through the UN Entrenched Program on Reduction of Maternal and Newborn Mortality. This evaluation identified a number of gaps and made several recommendations for the revival of the CBD program. A rapid assessment of CBD management documents in 2009/2010, however, showed gaps in the implementation of these recommendations. There are now concerted efforts to develop documents to aid supervision and the MOHSW is developing an operational guideline to guide the programming of CBDs. A community package integrating all the services in the community has also been drafted.

The review also showed that the level of education for the CBD workers was low, which caused the MOHSW to pilot a training program for Form 4 leavers, and also paid them salaries. The definition of Community Health Workers (CHWs) is still under discussion. CHWs in Tanzania are not comparable to those in Rwanda, for example. In Tanzania, they have a low level of education (Standard 7), and therefore do not have the mandate to provide prescription only contraceptives or those that require skilled administration e.g. injectables. There is a concern that lower level cadres of health workers create or exacerbate a problem rather than provide a solution due to their low competence levels. The government is therefore equivocally unsupportive of demedicalizing contraceptives. Tanzania is exploring the Ethiopia model whereby Health Extension Workers (CBD workers in Ethiopia), undergo longer training of up to 9 months; a pilot program run by Ifakara Institute is currently in its second intake. GTZ has a comprehensive CBD program being implemented in few districts, where only pills and condoms are redistributed. The CBD workers in this program are Form 4 or 6 leavers,

unlike in the previous program (1990s) which utilized standard 7 leavers or people with no education or volunteers predominantly in the village.

The sustainability of the voluntary CBD program is a matter of concern. At the time AFIDEP spoke to key informants (March 2012), the CBD program was reported to be only active in areas where partners were providing support.

Following research published in late 2011 that demonstrated an association between HIV infection and hormonal contraceptive use (Heffron et al 2012), the debate on demedicalization of contraceptives has intensified. It has been suggested that existing nurses called Reproductive Maternal and Child Health Aids (their new name in the last two years), who have one or two years nursing training are certified to provide MCH services, except provision of LAPMs. PSI is currently training these nurses (in-service training of government employees) to provide LAPMs. Although the MOHSW is flexible about using this particular cadre, it strongly advocates for training of higher skilled providers.

"We are reviewing the Family Planning Guidelines and we asked MOH staff in different regions about the feasibility of CBDs providing injectables. Majority of them said no, and when asked why they said it is because in Tanzania once you start allowing non-skilled personnel to provide injectables, other [non-skilled] people will take advantage and start providing" – Government policy maker

Nevertheless, development partners continue to push for task shifting, most likely because of the positive impact on FP uptake it has had in countries such as Ethiopia, Malawi, Rwanda.

"The challenge is that the government does not allow CBD to issue injectables which are the most preferred method.…There are things that we as an organization and partners would want to see that are happening in task shifting, but the ministry of health say we are not yet ready for that."- International NGO

Several strategies have been explored to support CHWs in their work. For example, FP Mobile Job Aid (initially a component of home-based care for HIV) has now been integrated into FP programs to support CHWs to provide family planning counseling to the community.

Given that getting FP products to the community is a big priority, a Strategic Plan to strengthen CBD services is being formulated.

5. Coordination and accountability mechanisms: Maximizing aid effectiveness

A number of coordination mechanisms are in place to ensure good coordination of the FP program. One of these is the national Family Planning Technical Working Group (FPTWG) (a subcommittee that reports to the Maternal Neonatal and Child Health TWG), which brings together all developing partners and the MOHSW on a monthly basis to discuss implementation activities, funding gaps and other issues. Workplans by the various players are submitted to RCHS on a monthly basis. The RCHS also holds monthly technical meetings. Coordination of donors and donor funding for commodities through the Commodity Security Committee since 2004 has further led to improvement in commodity security.

Challenges and long term sustainability for FP uptake in Tanzania

The aim of decentralization is to bring services to the community level, by allowing decisions to be made at the district level. The government has structures which allow for the community to identify priority issues – Community representatives (they vary from region to region e.g. county councilors and district councilors) reflect community priorities in national plans. Guidelines for decentralization exist since 1997, namely the Council Comprehensive Health Plan (CCHP) to guide devolved decision making. However, when the health system was initially decentralized in 1997, the structures and systems were not in place and so it was a setback for the FP Program. In addition, back in 1997, there was no indicator for FP. Since the 2007 update of the decentralization guidelines, FP uptake is an indicator.

"We did an analysis of the CCHP in 2011. We found that all 40 districts had included an element of family planning." – International NGO

Regardless, a number of challenges exist. Decentralization has been implemented at a slow pace. Hiring of medical and health professionals is decentralized and districts can make the decision as to how many people they hire. This is often a problem, as districts cannot afford to hire the needed health professionals to fill their gaps. Last year, several hundred doctors could therefore not get employment.

Contraceptive use outcomes vary from one region to another. Some regions have low knowledge and awareness and sometimes it is because of poor logistics or psychosocial and cultural issues such as gender disparity. This may be addressed with targeted Information Education Communication (IEC) and Behavior Change Communication (BCC) campaigns.

NGOs also operate on a decentralized platform. Engender Health via their ACQUIRE Tanzania Project (2007) (before this, ACQUIRE Global started in 2002) is decentralized and operate through 4 field offices fully manned by family planning program officers.

With a view to support the FP/RH agenda, FHI360 is working with National Institute for Medical Research *(*NIMRI) to build the local capacity in FP research.

"*They were not conducting family planning research, so we have chipped in and we are working with them. They are now in the process of developing family planning research agenda which will be the first in the country. We are hoping that this research agenda will be a tool to guide us towards to reach our CPR goal of 60% by 2015."*- International NGO

DISCUSSION

The collective experience of these countries demonstrates that Family Planning Programmes (FP Programmes) can play a key role in enabling couples access and use effective contraception, which empowers them to determine the timing and number of births that they would like to have.

The study revealed that six common and synergistic set of factors contributed to the success of the FP Programmes as depicted in Figure 3. However, they manifested differently in achieving this common goal based on historical and current contextual circumstances (including political, health, culture, social systems, infrastructure, technical and human resource capacity) and sensitivity of population issues and family planning.

Below we summarize the key similarities and differences across the five countries on how the set of factors contributed to the success of the family planning programmes. We also summarize the factors that hindered progress in Kenya and Tanzania between the 1990s to 2000s and how the two countries are overcoming the challenges:

Political will and commitment to FP and an enabling environment

Political will, which is initiated and sustained with evidence-based advocacy, has been the most critical factor to FP policy adoption and program implementation. Rwanda stands out with strong leadership by the President who openly supports and promotes family planning as a developmental tool. This has been institutionalized in Rwanda, and traverses all levels of leadership in government. District Mayors and senior leaders in government have performance contracts to hold them accountable to the President for FP uptake. Informal contracts are also encouraged at family level.

In Ethiopia, Malawi, Tanzania and Kenya, political will manifests at the Ministry of Health level (and Ministry of Planning in Kenya). Although neither of the Heads of State of these countries is vocal about supporting FP, there is recognition of the enabling environment to implement the national FP Programmes. Of note, the Ethiopian Ministry of Health is structurally different to the Ministries of Health in Malawi, Kenya and Tanzania, and may explain the difference in level of support at the Ministry level. Whereas, the Ethiopian Ministry of Health is structured on the basis of place of residence (urban, rural and pastoral), the Ministries in the other 3 countries have disease-oriented departments. Another noteworthy point is that advocacy efforts in Ethiopia, Kenya, and Malawi are led by the Ministry responsible for development planning, implying that managing population growth is seen as critical for development planning.

Political will and commitment to FP leads to an enabling environment for development of FP policies and guidelines, and implementation of national FP programs, which are supported by implementing agencies. Top level leadership in many sub-Saharan African countries are keen on advancing development and poverty reduction in their countries. Through sustained evidence-based advocacy, all countries have come to understand the link between FP and development. They have included FP in national development policies and aligned key health sector and national development policy instruments with the MDGs, which emphasizes FP as key to improving maternal health under MDG 5. The close scrutiny on performance of countries towards achieving the MDGs creates a global policy framework in support of FP in all developing countries. However, translation of this prioritization is more apparent in Rwanda, Ethiopia, and Kenya. Further, Rwanda, Ethiopia and Kenya have a multisectoral approach to implementing FP programs demonstrating their understanding of FP as more than a health issue. The explicit institutionalization of FP, with an acknowledged link between population growth and socio-economic development is strongest in Rwanda. Malawi's policy and program guidance for FP has historically been limited to the health sector. However, recently Malawi has started articulating FP within the broader context of development. Therefore, the impact particularly towards reducing fertility which has remained stubbornly high remains to be seen.

Improved mobilization of financial and technical resources

A key consequence of having strong political will and commitment to family planning has been increased mobilization of financial and technical resources to support the design and implementation of programmes. The common feature of the funding situation in all the five countries has been an over-reliance on development partner's financial and technical assistance for design and evaluation of various intervention programs, procurement and distribution of contraceptive commodities, and training of health workers.

The danger of overdependence on donors is well demonstrated by the stalled progress in the Kenyan and Tanzanian FP Programmes, which was occasioned by shifting donor priorities and reduced funding for FP in both countries. Although

the Ethiopian government contributes around half of the required funding towards contraceptive most of it is from basket funds (budget support from external sources). Rwanda's program on the other hand is predominantly funded with external funds on the basis that government resources are best directed to other competing development priorities with less support. In comparison to Ethiopia and Rwanda, the Kenyan government is contributing a much larger share of the budget towards procurement of commodities, around 60%, implying that Kenya has learned from the negative impact to the FP program as a result of the change in donor priorities and funding in the late 1990s.

Health systems strengthening

Various reforms in the health systems of the study countries have contributed to increased access to FP services. These include:

- Decentralization of health services,
- Integration of RH/FP services with other essential health services (e.g. MCH and HIV),
- Task-shifting (i.e. expansion of the pool of health workers able to provide FP and/or integrated health services),
- Infrastructure development,
- Creation of innovative service delivery models (e.g. community based distribution, public-private partnerships, social franchising and performance-based financing).

Decentralization of health services

Transferring decision-making power to the sub-national level means that resource allocation is responsive to the priority health needs of the community. However, it also means that there is need for advocacy at this level to ensure demand is created for FP, and concurrent financial and human resources to meet this created demand for FP including commodities and skilled workers. In Ethiopia, advocacy targeted to the regional governments (at sub-national level) has been successful, and regions have allocated resources from their budgets for FP. Nevertheless, competing health priorities against limited resources remains a challenge in all the study countries, including in Ethiopia. In Malawi, some district health administrators have had to prioritize curative supplies over FP because of limited resources. Limited resources were also responsible for a backlog of debt from health facilities at the Central Medical Stores (the agency in charge of procuring, storing and distributing FP commodities), which led to its eventual restructuring and change in management. A similar challenge was experienced in Kenya that has also led to an overhaul of Kenya Medical Supplies Agency.

Integration of RH/FP services with other essential health services and infrastructure development

In the last decade or so, integration of HIV and maternal and child health (MCH) and sexual and reproductive health (SRH) in all countries has enhanced access to FP services despite existing challenges.

Task-shifting

Increasing the number of trained health care providers who can provide a wider scope of services through task shifting has been extremely beneficial. In Malawi and Rwanda, the Health Surveillance Assistants (HSAs) and Community Health Workers (CHWs) respectively, who are the lowest cadre of government-employed health workers, administer injectable contraceptives. In Ethiopia, the health extension workers can administer injectable contraceptives as well as implants and offer follow-up care to women with IUD. Additionally, health officers can conduct surgical procedures (tubal ligation and vasectomy). In Rwanda, nurses can now insert implants and IUDs which was previously reserved for physicians.

Infrastructure development

Ethiopia and Rwanda have undergone necessary infrastructure expansion to expand services. In Ethiopia, there has been a rapid increase in development of additional health infrastructure at community level (health posts) over the last decade. Rwanda has established secondary posts next to Catholic-run health facilities to enable access to FP services for clients who want to use modern contraceptives.

Innovative service delivery models

In Kenya, Tanzania and Malawi, strong public-private partnerships and social franchising are helping to meet the gaps in public sector health service provision, including access to FP services. In all countries, mobile health services have been instrumental in increasing access to long acting and permanent methods. In Rwanda, the community health insurance program has increase utilization of health services in general, which has contributed to the increased acceptability and uptake of FP services. In addition, implementation of performance based financing has also increased demand for and access to FP services in Kenya (pilot program to be scaled up nationally) and Rwanda.

In all countries, persistent challenges with ensuring access to FP information and services for youth. This has recently been made a priority agenda in Ethiopia, Kenya and Malawi[4] and efforts are underway to meet the need. In Rwanda, a national training of trainers program has been launched to build the capacity of health workers to provide services to young people. Additionally, the government is establishing youth corners within existing health facilities across the country. Kenya uses a multisectoral approach to addressing youth SRH challenges. The Ministry of Health engages the Ministry of Youth Affairs and Sports (MoYA) and the Ministry of Education (MoE) to implement youth focused SRH activities. After years of opposition from religious leaders and concern from parents, Kenya has recently rolled out a national Life skills Education program that now incorporates age-appropriate sexuality education. Efforts are underway to equip existing youth empowerment centers established under Kenya's MoYA to provide SRH information and link youth to services in addition to other youth development activities. Ethiopia's urban health extension workers reach out to urban youth with SRH and HIV information and services. Malawi's high teenage pregnancy rate and high fertility has made addressing youth SRH an urgent matter.

Improved supply chain management

In Ethiopia, Rwanda and Malawi, improved efficiency in supply chain management systems have been central to FP commodity security. Nevertheless, as shown in all the countries, lack of efficient logistics systems and lack of human resource capacity to manage and operate the commodity supply chain can compromise commodity security. A common problem cited is the lack of capacity of health workers at the primary care level to manage stocks and place orders for commodities within the pull system. Another common problem cited is inadequate transportation. In some cases even though contraceptives have been ordered, priority for transportation is given to curative supplies. Adequate warehouses at sub-national level and storage at health facility level are additional challenges that these countries constantly grapple with. Ethiopia is currently transitioning from an efficient parallel system to a new integrated logistics system. It will be interesting to learn about the challenges encountered in relation to contraceptive supplies and how they are overcome. The supply chain management system in Malawi and Kenya, on the other hand, is currently undergoing a major overhaul to improve its efficiency.

Taking information and services to the community and demand creation

At the core of the success of FP Programs in Ethiopia, Malawi, Rwanda and Kenya, is the expansion of service delivery by bringing FP information, services and products to close to the community, which in all cases are predominantly rural.

[4] London Summit on Family Planning. Summaries of Commitments. 21st September 2012.

85% of Ethiopia's population is rural, and FP is one of the essential health services delivered through the successful, nationally implemented Health Extension Program (HEP). The difference between HEP and other community-based service delivery models in Malawi, Rwanda, Tanzania and Kenya is that the health extension workers (equivalent to community health workers (CHWs) in other countries) are the lowest paid health cadre of the health system. Ethiopia's HEW model is therefore more sustainable due to retention of the health extension workers.

In addition, administration of injectable contraceptives by these non-clinically trained volunteer CHWs and lower cadre health workers has increased the availability of methods of contraception. In Ethiopia, health extension workers provide injectables, implants and pre-post care for IUD in addition to pills and condoms. Malawi, Rwanda and Kenya, despite not yet having well established community-based distribution programs are now allowing CHWs to provide injectable contraceptives. Notably, recently Kenya has issued a new policy change, due to questions about health risks associated with this service delivery approach. Malawi and Kenya underwent years of resistance for this policy change from medical professions who are knowledgeable of the potential health risks. Policy change in both cases was informed by feasibility studies and knowledge sharing study tours to countries with successful programs such as Uganda and Mauritius. Notably, the recruitment criteria and training curricula for CHWs vary greatly across these countries. It may be useful to identify optimal components to create a standardized CHW model.

Information, Education and Communication (IEC) campaigns have increased demand for and utilization of FP in Ethiopia, Rwanda, Malawi, Tanzania and Kenya. CHWs have been critical in mobilizing and educating the community. Further, engaging civic, faith-based and traditional leaders to be FP champions in their communities is another key strategy used by all countries. Rwanda has been particularly successful in working with Catholic Church leaders and getting their buy in to allow health service providers in their facilities to provide counseling on modern FP commodities and refer clients to an adjacent health facility specifically by the government built to provide modern FP methods (secondary posts). The Rwandan government also increases demand for contraceptives through monthly community meetings (known as *Umuganda*), which engage community members in discussions on development-focused issues. In Kenya and Ethiopia, innovative use of popular media (e.g. radio, TV), mobile technology and social media are being used as major strategies for increasing demand for FP services. However, with the persistently high levels of teenage pregnancy and related unsafe abortions, the remaining challenge is to reduce stigma associated with provision of FP services to sexually active youth. Recently, Kenya has intensified mass media communication on youth SRH to address this challenge.

Coordination and accountability mechanisms

A key feature of the success that the five countries have witnessed is presence of strong coordination and accountability mechanisms for FP work. Improved financial and technical coordination of public, not-for-profit and private sector health service providers, through the FP and Commodity Security Technical Working Groups has resulted in increased harmonization of the FP financing and coordination of programs in the five countries. Such forums have been critical at both national and sub-national level since the health systems in these countries are decentralized. The basket funding mechanism (which mobilizes development assistance for the health sector based on the government's health sector priorities) has been effective in mobilizing funding for the FP programs in Rwanda, Ethiopia, and Malawi. However, there is still some funding which is allocated directly to programs at community level by development agencies such as USAID and UNFPA. These sources of funding and associated programmes are often not documented and create a challenge in assessing the full impact and gaps of the FP program. Rwanda stands out among the five countries for having a rigorous mechanism for coordinating donor funding. Through insistence that donors should support programmes within the priorities set up by the government, the Rwandese government is able to monitor all donor inputs and ensure that programme areas of highest need are actually prioritized.

Another key role that Commodity Security Technical Working Groups play is to coordinate technical input in the design, monitoring, and evaluation of programmes. In Ethiopia, for example, the FP technical working group has been instrumental in shifting the focus of the programme towards long-lasting methods. These working groups provide a useful platform for building accountability frameworks that will ensure that FP services continue to be managed within the human rights framework agreed upon at the 1994 ICPD. The groups can also hold service providers, governments, and donors accountable to the commitments that they have made through protocols such as the London family Planning summit. A key shortcoming of the frameworks as currently composed is that they do not have civil society representation and the focus is heavily on the supply side of FP Programmes.

Factors Contributing to the Stalled Progress and Repositiong of FP Programs in Kenya and Tanzania

The main cause of the stall in the FP program in Kenya in the late 1990s was the shift in top leadership prioritization of FP, which was compounded by the shift in donor priority and funding. In the late 1990s, when the country's economy was at its worst, HIV was declared a national disaster. Political attention shifted away from FP to address these challenges. At the same time, development assistance shifted to focus to supporting HIV/AIDS prevention and treatment efforts. The shift in development assistance is also blamed for the slow-down in the FP program in Tanzania. Because, development partners heavily financed the FP programs in the two countries, a heavy burden was bestowed upon the two governments, which were unprepared for the responsibility. The resulting stagnation in the FP uptake in Kenya, and retardation in the Tanzania was characterized by a decline in contraceptive commodity security, reduction in the number of trained health workers as they shifted to vertical HIV programs. The community based distribution of FP information and services also collapsed.

Additionally, Tanzania's general slow progress in increasing contraceptive use was as a result of well-intended but premature health service reforms. The FP program was integrated with 6 other programs into a broader health program, which resulted in a loss of visibility for FP, and subsequent decline in prioritization and allocation of government funds.

The repositioning of FP in Kenya and Tanzania by its integration into their development blueprints (Vision 2030 and Vision 2025 respectively), demonstrates the recognition of FP beyond its health benefits, and the importance of managed rapid population growth, as a critical measure for the countries to achieve their development objectives. There was also a concurrent global shift in attention to prioritise RH, as well as sustained evidence-based advocacy to galvanise government commitment to FP.

RECOMMENDATIONS

The following recommendations have been derived from the lessons drawn from assessment of the study countries. As noted above, none of the five sets of factors outlines in Figure 3 operate independently and have had synergistic effects in improving contraceptive uptake in the five countries. Reinforcement of these factors with particular focus on meeting the needs of underserved population will help enhance the impact of FP programmes in increasing use of modern contraceptives in the countries that have made good progress, as well as the ones that are lagging behind.

1. Galvanize political will and commitment for FP at top leadership and all levels of government, as this will increase its profile as a health and development priority, through evidence-based advocacy.

2. Position the population agenda, which includes access to FP services, at the centre of development planning. This alongside recommendation 1 will ensure a multi-sectoral approach to implementation of population activities.

3. Increase government and external funding for FP commodities and community oriented educational campaigns. Over-reliance on external sources of funding undermines the sustainability of FPPs, as exemplified by the experiences in Kenya and Tanzania.

4. Harmonize FP activities through strong technical and financial coordination and accountability frameworks, including enhancing local technical capacity in programme design, evaluation, and research to feed into the accountability systems.

5. Strengthen the capacity of the health system in providing quality FP services by enhancing the health management information system (HMIS); health worker skill base through pre-service and in-service training, performance based incentives and task shifting; integration of FP, HIV and other reproductive health services; supply chain management; and public private partnerships through social franchising.

6. Address financial and geographical barriers through sustainable community-based information and service delivery initiatives. Complementing this effort with empowerment of community-based public health workers and volunteers through task shifting and demedicalization of clinical FP commodities will optimize impact of FPPs.

7. Increase public awareness on the benefits of FP, and simultaneously break cultural, religious and other barriers to FP uptake.

8. Increase access to and utilization of youth-friendly FP and reproductive health services.

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Appendix 1: Reviewed Policies, Strategies and Guidelines

RWANDA

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Appendix 2: In-depth Interview Guide

Background Information

Name of Interviewee	Date of Interview ____/10/2011
Position of Interviewee	Name of Interviewer
Interviewee's Institution	Interviewee's ID No.

Thank you so much for meeting with me today. My name is **[Name]**. The African Institute for Development Policy (AFIDEP), based in Nairobi, Kenya has identified the top performing countries in increasing contraceptive use. **[Country name]** is recognised as one of those top performers and therefore we are conducting a study to identify **drivers of change in sexual and reproductive health (SRH) and population policies and programs in [country].** As part of this study, we are talking to a range stakeholders including policy makers, program managers, donors, civil society organizations in order to gain an in-depth understanding of the status of family planning (FP) / contraceptive use and acceptance, identify key challenges affecting FP uptake, and make recommendations for improving FP uptake in other African countries at policy, system, and service delivery levels. The information obtained will also be used to make recommendations to reinforce FP uptake in **[country name]**.

I have requested an interview with you because we believe that in your position as a**[Position/Job Title]** in the **[Name of Office]**, you will provide useful perspectives and insights on these issues, and I look forward to learning from you today. I have some guiding questions, but want you to feel free to talk about anything <u>you</u> think is important for us to know. I will be taking notes as we talk to be sure I don't miss anything. Is that alright?

Before we get started, I just want to emphasize that everything we talk about today is <u>confidential</u>. No one will have access to the notes I am taking except for those of us working on the project. When we write up our report, we will not use the names of any interviewees so that no one can be identified. Also, if at any point during the interview you would like to stop, or if there are any questions you would rather not answer, just let me know -- that's fine. Is there anything you'd like to ask me at this point? [**Answer any questions regarding the interview**].

1. Context-setting on prioritisation of FP

(i) When did it happen?

(ii) Who led the policy changes?

(iii) What prompted the policy changes? (i.e. why)
Prompt: Was it poverty or population or child mortality or health driven? (is there an impact of child mortality on FP use?)

(iv) What were the challenges experienced when making the policy changes?
Prompt: Was there opposition from certain groups e.g. religious leaders?

(v) How did the policy changes occur? (What was the process?)

2. Policy Framework

(i) What new policies were put in place?

(ii) What was the strategy for implementation of new policies?
Prompt: at a systems/infrastructure level
Prompt: at a service level
(iii) What were the challenges faced with implementation of the new policies?
(iv) What were the identified gaps in the new policies?

3. Funding / Resource allocation

(i) What is the proportion of government funding?
(ii) What measures have been taken to ensure the sustainability of funding for SRH, specifically FP programs?

4. Co-ordination

(i) Is there a recognised link between SRH/FP and population?
(ii) Where does the Population Unit sit? Since when?
(iii) How can you ensure that key messages are common and synergistically relayed by both units?
(iv) Are there programs that integrate SRH and HIV?

5. Health System Strengthening

Supply Chain Management

(i) What is the current status of procurement and supply of FP commodities?
(ii) What changes have been made to meet requirements of new SRH/FP policies?
(iii) How often and how is forecasting for FP needs conducted? Are there reported stock outs? (Assuming there is a monitoring system; e.g. in Lesotho and Ethiopia it is based on annual use patterns)
(iv) Are contraceptives on the Essential Medicines List?

Human Resource Capacity (Public and Non-public)

(v) Are there challenges with staffing to meet SRH/FP needs?
(vi) Are there any changes in pre-service and in-service training?
(vii) Is there task shifting to meet SRH/FP demand?
(viii) Are there restrictions on the care that Community Health Workers can give? (e.g. injectable contraceptives)
(ix) Is there an effect on quality of care with increased FP uptake?

6. Role of Non-Public Organisations (FBOs, CBOs, CSOs, etc)

(i) How have non-public organisations / development partners influenced the policy changes?
(ii) How have non-public organisations / development partners supported the policy changes?

7. Abortion Laws

(i) Have there been changes on abortion restrictions?
(ii) What is the status of post-abortion care?

8. Monitoring and Evaluation

(i) How do you monitor progress/impact of policy changes?
(ii) What systems are in place to monitor the impact of policy changes? (Give indicators)
(iii) What challenges do you face in monitoring?
(iv) How are you addressing these challenges?

9. Contentious issues

(i) What is the attitude towards access for youth to FP?

(ii) What is the status and attitude towards sex education for the youth?

(iii) What is the attitude to FP? Has there been a demedicalisation of contraceptives? (i.e. not medicinal products limited to health workers[5])

10. Concluding remarks

If there is one thing you can name that has really made a difference in this country, that others can learn from, what would it be?

Prompt: it can be a policy, a process, an event, an FP champion, etc.

[5] Linked to question on restrictions on the care that Community Health Workers can give (e.g. injectable contraceptives)

Appendix 3: Key informants Rwanda

	Name	Institution	Position
	Government – Policy makers		
1	Dr Jean Damascene Ntawukuriryayo	Government of Rwanda Senate	President of the Senate
2	Dr Agnes Binagwaho	MOH	Minister of Health
3	Dr Jean de Dieu Ngirabega	MOH	Director General of Clinical services
4	Dr Fidele Ngabo	MOH	Director of Maternal and Child Health
5	Ms Cathy Mugeni	MOH	Coordinator of Community Health
6	Dr Anicet Nzabonimpa	MOH	Integration of PF and HIV in MOH
7	Mr Patrick Mwesigye	MOH	Pharmacy task force
8	Mr Thomas Nsengiyumva	MOH	Officer in charge of FP
9	Dr Daniel Ngamije	MOH	Single Project Implementation Unit
10	Dr Diane Mutamba	MOH	In charge of adolescents and youth health
11	Ms Janinah Gasana Mbabazi	MOE	Education HIV and AIDS Advisor
	Government - Service providers		
12	Mr Jean Claude Tayari	RBC/Medical procurement and Distribution (formerly CAMERWA)	Commercial Director
13	Dr Jules Mushingantahe	MOH	Muhima District Hospital
14	Ms Florence Lyabonyende	MOH	Kimironko Health Center
	Faith-based health facility		
15	Sr Berthilde Uwamariya	MOH	Gikondo Health Center
	Development partners		
16	Dr Maria Mugabo	WHO	In charge of maternal and Child health
17	Dr Friday Nwaigwe	UNICEF	In charge of child health
18	Dr Alphonse Munyakazi	UNFPA	Assistant Representative – SRH
	Local Non-Governmental Organizations		
19	Dr Laurien Nyabienda	ARBEF (Association Rwandaise pour le Bien-Etre Familial)	Executive Director
	International Non-Governmental Organizations and private implementers		
20	Mr Guillaume Bakadi Mukende	Center for Communication Programs, John Hopkins Bloomberg School of Public Health	Technical Advisor
21	Mr Emile Sempabwa	Intrahealth international	Policy and Development Technical Director
22	Ms Robertine Sinabamenye	Project San Francisco	Nurse Counselor
23	Dr Jovith Ndahinyuka	John Snow Inc. (JSI)	Senior MCH/Malaria Logistics Advisor, USAID DELIVER Project

FP TWG (focus group discussion)			
Name of FP TWG Member	**Position in FP TWG**	**FP TWG Member's Institution**	**Position**
Daphrose NYIRASAFARI	Co-chair	UNFPA Rwanda	Reproductive Health and Rights Programme Officer
Guillaume B. SURKENGE	BCC subcommittee	Center for Communication Programs (CCP), Johns Hopkins University	CCP Representative in Rwanda
Agnes MUKAMANA	Member	CARE International	Health and OVC Program Manager
Suzanne MUKAKABANDA	Member	Intrahealth International	RH/FP Program Manager
Emma UMUGABEKAZI	Member	PSI Rwanda	FP Clinical Manager
Eric KAGAME	Member	USAID	MCH Specialist
Jean Marie MBONYINTWALI	Member	Rwandan Parliamentarians' Network on Population and Development (RPRPD)	Program Officer
Jennifer WESSON	Member	FHI 360	Research Director
Paul DIELEMANS	Member	Elizabeth Glaser Pediatric AIDS Foundation	Senior Technical Advisor MCH/FP/RH
Dr Ezechias RWABUHIHI	MP	Rwandan Parliamentarians' Network on Population and Development (RPRPD)	Parliamentarian and former Minister of Health
Liberate KAYITESI	MP	Rwandan Parliamentarians' Network on Population and Development (RPRPD)	Parliamentarian and Secretary General of RPRPD
Roger BAYINGANA	Member	PSF	Study Physician
Robertine SINABAMENYE	Member	PSF	CVCT Coordinator
Emile SEMPABWA	Member	Intrahealth International	Policy & Development Director Hewlett Foundation & Tides Foundation Grants
Anicet NZABONIMPA	Member	MOH	FP-HIV integration program coordinator

Appendix 4: Key informants Malawi

	Name	Organization	Position
	Government - Policy makers		
1	Mrs. Fannie Kachale	Reproductive Health Unit (RHU), MOH	Deputy Director
2	Mr. Danson Kachoro	MOH	Director of Research
3	Hon. Chibungu	Parliamentary Health Committee, National Assembly of Malawi	Chairman
4	Dr. Mwai Mwakoka	National AIDS Commission (NAC)	Policy Officer – Biomedical
5	Dr Ann Phoya	Sector Wide Approach (SWAp), MOH	Head of Sector Wide Approach (SWAp)
6	Mr. Charles Mazinga	MOE	Director for School Health and Nutrition
7	Dr. Kelita Kamoto	Health Technical Support Services, Reproductive Health Unit, MOH	Director
8	Ms. Ivy Zingano	Central Medical Stores, MOH	Controller
9	Mr. Chris Moyo	Health Management Information Systems (HMIS), MOH	Head
	Government - Service providers		
10	Mr. Sam Chirwa	Health Technical Support Services, Reproductive Health Unit, MOH	Senior Logistics Officer
	Faith Based Organizations / religious leaders		
11	Ms. Matilda Maluza	Catholic Health Commission (Episcopal Conference of Malawi)	National Health Secretary
12	Mr. Sheikh Ali Kennedy	Muslim Association of Malawi	Vice Secretary General
13	Ms. Grace Banda	Christian Health Association of Malawi (CHAM)	Head of Health Programs
	Local NGOs		
14	Ms. Effie Pelekamoyo Mr. Mattheus Chatuluka Ms. Tooko Njoloma	Family Planning Association of Malawi (FPAM)	Executive Director Manager, Lilongwe District
	International NGOs and private implementers		
15	Ms. Sandra Mapemba	Population Reference Bureau (PRB)	Country Coordinator, IDEA Project
16	Ms. Olive Mtema	Futures Group/Health Policy Project (HPP)	Senior Policy and Advocacy Advisor
17	Ms. Mala Mabona Mr. Alick Tahuna	Family Health International (FHI) 360	Associate Technical Director Administrative Manager
18	Ms. Caroline Basaka	Population Services International (PSI)	Reproductive Health Program Manager
19	Ms. Desiree Mhango	Liverpool Associates in Tropical Health (LATH)/ Liverpool School of Tropical Medicine (LSTM)	Senior Maternal Health Officer
20	Ms. Linda Edwards	Banja La Mtsogolo (BLM)	Country Director
21	Mrs Veronica Chirwa	John Snow Inc.	USAID Deliver

	Name	Organization	Position
	Development partners		
22	Ms. Harriet Chanzah	World Health Organization	Family Health and Population Officer
23	Mr. Humphreys Shumba	United Nations Population Fund (UNFPA)	National Program Manager - HIV Prevention
24	Ms. Jean Mwandira	United Nations Population Fund (UNFPA)	National Program, Programme Specialist (NPO-RH)
	Academic Institutions		
25	Dr. Malata	Kamuzu College of Nursing (KCN)	Principal

Appendix 5: Key informants Ethiopia

	Name	Organization	Position
	Government - policy makers		
1	Dr. Mengistu Haile Mariame	Ministry of Health	Director
2	Genet Mengistu	Office of Population Ministry of Finance and Economic Development	Director, Population Affairs Directorate
3	Sintayehu Abebe	Ministry of Health	Diredawa Case Team Coordinator and FP Focal Person
4	Sutnan Abdulber	Ministry of Health	Commodity Security Advisor
5	Mideksa Adugna	Minstry of Health	Policy and Planning Officer
6	Abdul Jaleel	Ministry of Health	Resource Mobilization Unit
7	Achamyeleh Alebachew	Federal HAPCO	National Program Officer, Plan, M and E Directorate
8	Dr. Feyesa Regassa	Federal HAPCO	UNFPA Advisor
9	Solomon Belayueh	Ministry of Education	Curriculum Expert
10	Mohammed Abdella Tikuye	Ministry of Education	Resource Mobilization Expert
	Local NGOs/ civil society		
11	Ato Negash Teklu	Population, Health and Environment (PHE) Ethiopia Consortium	Executive Director
12	Holie Folie	Consortium of Reproductive Health Associations (CORHA)	Executive Director
	International Non-Governmental Organizations/ private implementers		
13	Fisseha Mekonnen	Family Guidance Association of Ethiopia (FGAE)	Executive Director
14	Ato Getachew Bekele	Marie Stopes International	Senior Advisor, MSI Global Partnership
15	Dr. Ayeke Debebe Gemechu	Marie Stopes International	Deputy Country Director
16	Saba Kidanemariam	IPAS	Country Director
17	Dr. Yetnayet Asfaw	EngenderHealth	Ethiopia Program Manager
18	Dr. MengistuAsnake	Pathfinder International	Deputy country representative
19	Asha Basnyat Temesegenworkayhu Abner Tewoldeberhan Mekedese Asssefa	FHI 360	Country Director
20	Dr Takle-Abe Mekbib	Population Council	Medical Advisor
21	Andrew Piller	DKT	Director
22	Woineshet Nigatu	JSI	Health Commodity Logistics Advisor, USAID DELIVER Project

	Name	Organization	Position
23	Senait Tibebu	Futures Group	Policy Advisor
	Development Partners		
24	Dr. ZewdituKebede	USAID-Ethiopia	Reproductive Health specialist
25	Michael Tekie	UNFPA Country Office	National Programme Officer
26	Sahlu Haile	The David and Lucile Packard Foundation	Regional Advisor
27	Yemeserach Belayneh	The David and Lucile Packard Foundation	Country Advisor
28	Mieraf Taddesse	World Bank	Project Coordinator, Ethiopian Diaspora Project
	Faith Based Organizations/ religious leaders		
29	Reverend Samson Bekele	Ethiopian Orthodox Tewahedo Church Development and Inter- Church Aid Commission	HIV/AIDS prevention and control department head
30	Mr Nuredin Jemal	Ethiopian Muslim Development Association	Program coordinator

Appendix 6: Key informants Kenya

	Name	Institution	Position
	Government – Policy makers		
1	Mr. George Kichamu	National Council for Population and Development (NCPD)	Deputy Director Communication Advocacy and Public
2	Dr. Samuel Were	Health SWAP Secretariat	Director
	Government - Service providers		
3	Dr. Cecilia Wanjala	Kenya Medical Supplies Agency (KEMSA)	Demand Analysis Officer (Family Planning)
4	Mr. Joshua H. Obell	Kenya Medical Supplies Agency (KEMSA)	Operations Director
5	Dr. Charles Nzioka	Health Management Information System (HMIS)	Head of Health Information System
	Development partners		
6	Barbara Durr	JSI / USAID Deliver	Country Director
7	Dr. Stephen Wanyee	United Nations Population Fund (UNFPA)	Deputy Country Representative
	Local Non-Governmental Organizations		
8	Dr. Richard Muraga	Family Health Options Kenya (FHOK)	Assistant Program Director
	International Non-Governmental Organizations and private implementers		
9	Dr. Solomon Marsden	FHI 360	Associate Director, Reproductive Health Advisor
10	Ms. Caroline Kwamboka	DSW (Deutsche Stiftung Weltbevoelkerung)	International Project Manager
11	Mr. Edwin Mbugua	Marie Stopes Kenya	Program Director
12	Mr. Nelson Keyonzo	JHPIEGO	
13	Ms. Pamela Onduso	Pathfinder International	Program Advisor
	Academic Institutions		
14	Dr Wanjiru Gichuhi	Population Studies and Research Institute (PSRI)	Lecturer

Appendix 7: Key informants Tanzania

	Interviewee	Organization	Position and Department
	Government - policy makers		
1	Dr Cosmas W. Swai	Reproductive and Child Health Section (RCHS), MOHSW	Principal Technical Advisor Contraceptive Security
2	Dr M.D. Kajoka	Reproductive and Child Health Section (RCHS), MOHSW	National Coordinator, PMTCT
3	Dr Rose Wasira	Reproductive and Child Health Section (RCHS), MOHSW	National Family Planning Community Based Coordinator
4	Mrs Imelda Kihaka	Ministry of Education and Vocational Training	Gender Resource Person, Diversity Unit
5	Hon. Mrs Jenista Mhagama	Parliamentary Family Planning Club and Parliamentarians for Safe Motherhood Group	Chairperson
6	Hon. Mrs Sitta / Dr Faustine Ndugulile	Social Services Parliamentary Committee	Chairperson / Vice Chairperson
7	Dr Kalista Simbakalia	Formerly RCHS, Ministry of Health and Social Welfare	First Head of RCHS (now retired)
8	Ms Jesca Masanja	Reproductive and Child Health Section (RCHS), MOHSW	Program Officer, Adolescent and Youth SRH
9	Ms Donita Kilama	National AIDS Commission Program	Acting Head Epidemiology
10	Mr Benedict Raymond Mangulu	Ministry of Education and Vocational Training	Assistant HIV/AIDS /Lifeskills Education Coordinator
11	Anonymous key informant	Presidents Office, Planning Commission	
	Government – service providers		
12	Mr Heri S. Mchunga	Medical Stores Department (MSD)	Acting Director Logistics
	Mr Beatus Msoma	Medical Stores Department (MSD)	Health/Vertical Program Manager
	Local NGOs/ civil society		
13	Mr Simon Mbele	UMATI (FP Association of Tanzania)	Director of Programs
	Mr Stephen Chimele	UMATI	Project Officer for Clinics
	Mr George John Mutasingwa	UMATI	Youth Officer and M&E and Knowledge Management
	International Non-Governmental Organizations/ private implementers		
14	Dr. Edmund Rutta /Dr Suleiman Kimatta	Management Sciences for Health (MSH)	Senior Program Associate for the Strengthening Pharmaceutical Systems (SPS) Program / Senior Technical Advisor
15	Mr Mustafa Kudrati	Pathfinder	Country Representative
16	Ms Feddy Mwanga	Engender Health	Technical Director, ACQUIRE Tanzania Project

17	Ms Dorothy Matoyo	John Snow Inc. (JSI) - USAID Deliver	Deputy Country Director / Chief of Party
18	Mr Gregory Kamugisha	Futures Group	Senior Technical Advisor, Strategic Information (HPI Task Order 5)
19	Mr. Robert Karam	John Hopkins University Centre for Communications Programs (JHU/CCP) Tanzania Limited	Country Representative/Chief of Party TCCP
20	Ms. Halima Shariff	John Hopkins University Centre for Communications Programs (JHU/CCP) Tanzania Limited	Advance Family Planning (AFP) Director
21	Dr Nguke Mwakatundu	Population Services International (PSI)	Reproductive Health Director
22	Ms. Elizabeth Ndakidemi	FHI360	Program Officer - Research Projects
23	Mr. Sammy Masunga	FHI360	Program Officer - Research Projects
24	Ms. Veronica Nkuruzinza	Marie Stopes Tanzania	Outreach Manager
25	Dr Nsiima Mushumba	Marie Stopes Tanzania	Head of Clinical Services
	Development Partners		
26	Mr Tim Manchester	USAID	Senior Family Planning & Reproductive Health Advisor
27	Dr Rutasha Dadi	UNFPA	Assistant Representative
	Dr Rita Noronha	UNFPA	Health Systems Specialist
28	Dr Emmanuel Malangalila	World Bank	Senior Health Specialist, Health Nutrition Population (HNP)- Consultant
	Mr Kristoffer Welsien	World Bank	Assistant to the Country Director
29	Ms Siya A. Mlay	GIZ (German Agency for International Cooperation)	SRHR/HIV/AIDS Technical Advisor
	Faith Based Organizations/ religious leaders		
30	Mohammed Khamis Said/Karim Majaaliwa	National Muslim Council of Tanzania (BAKWATA)	Deputy Secretary General/Director of Administration
31	Ms Josephine Balati	Christian Social Services Commission	Director of Programs and Acting Executive Director
	Academic Institutions		
32	Ms Rose Mgonja	Muhimbili School of Nursing, College of Allied Health Sciences	Nurse Tutor
33		FP TWG	International NGOs, donors