



## Make a Case for Supplies

**Leading Voices in Securing Reproductive Health Supplies: An Advocacy Guide and Toolkit**





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## Introduction

It is both important and urgent that the Reproductive Health Supplies Coalition advocate for ensuring reproductive health (RH) supplies. In today's environment of growing demand for family planning and the imminent phaseout of contraceptive donations in many countries, it is imperative to achieve greater political and financial commitment to support long-term availability of high-quality RH supplies.

If developing countries do not adequately address the growing shortfall in funding for contraceptives, they face the risk of losing 30 years of progress marked by dramatic declines in fertility and significant increases in contraceptive prevalence rates. With inadequate or poor-quality RH supplies, there will be unnecessary adverse effects on the quality of RH care, maternal and RH outcomes, and people's ability to maintain their reproductive health.

Vulnerable populations will experience the most severe consequences of failure to secure adequate RH supplies. As such, advocacy messages must be hard hitting and be designed to **galvanize policymakers into action**, not tomorrow or the day after, but today.

This guide and toolkit offers general information and guidance on advocacy communication that has been useful to many groups interested in advocating for improved RH policy environments.

The general information is complemented by examples and templates of advocacy tools targeted specifically to the aims the Coalition has set forth for securing long-term availability of high-quality RH supplies.

Note that the advocacy templates and experiences referenced in this guide often refer to data on family planning, specifically contraceptives and condoms. This stems from the relative historical depth of information that family planning (FP) researchers have collected around FP versus RH supplies.



In addition, several examples describe successful advocacy for contraceptive security (CS), defined as when every person is able to choose, obtain, and use high-quality contraceptives and services whenever he or she needs them; these examples are derived from recent success stories stemming from projects supported through the United States Agency for International Development (USAID) Contraceptive Security (CS) initiative.

These examples offer illustrative strategic and process lessons that are transferable to the reproductive health (RH) supplies initiatives supported by the Coalition. For instance, information that clearly draws the links among FP/RH supplies and unintended pregnancies, maternal and child mortality and morbidity, abortion rates, and HIV infection among children (through mother-to-child transmission) helps advocates persuade decision-makers that family planning is a worthwhile investment. Recent evidence showing the link between high fertility and poverty is also powerful in building political support for ensuring adequate stocks of RH supplies.

**Whereas the advocacy tool templates presented in this guide are tailored to situations and scenarios that the Coalition and its partners will likely face, there are more permutations of contexts, audiences, and advocacy objectives than the examples and templates can cover.**

**Ultimately, RH supply advocates will have to carefully review and tailor the templates to ensure that they are appropriate and relevant to their respective country contexts.**



The remainder of this guide and toolkit is divided into the following sections:

**The How-to Guide - [Advocacy for Ensuring Reproductive Health Supplies: A Planning Guide](#)** is a brief review of key concepts and points to consider when preparing to launch an advocacy initiative. Even those people familiar with the advocacy process may wish to review this section for several ideas and examples relevant to reproductive health (RH) supplies.

**Section I of the Toolkit - [Advocacy Messages to Support Reproductive Health Supplies Initiatives](#)**, describes five global scenarios that depict different contexts in which the Coalition's country representatives and its partners may find themselves operating while ensuring the availability of RH supplies.

These contexts include situations of limited attention given to FP/RH issues due to competing resource priorities, resulting in high unmet need; countries with high HIV prevalence and diverted attention and funding; countries facing donor phaseout; health systems going through a decentralization process; and situations of high abortion and low fertility rates.

Some Coalition members may find that aspects of each of the contexts apply to their respective country situations. In any case, it may be useful to identify which of the contexts are most relevant.

To expand further on how context shapes advocacy messages, this section includes matrices of the respective contexts and key RH supplies objectives (or "asks"), with recommendations for tailoring the messages depending on context and the particular RH supply objective.

Again, the decisions on how to define and refine the messages are up to the advocate, but knowing the underlying context and ensuring that this is considered in the message is important.

**Section II of the Toolkit - [Advocacy Tools for Ensuring Reproductive Health Supplies: Overview, Templates, and Examples](#)**, includes descriptions of and links to examples or templates for five types of advocacy tools: PowerPoint presentations; policy briefs; fact sheets; talking points/briefing notes; and press releases and media advisories.

The sample templates demonstrate how the different contexts, target audiences, and objectives affect the message.

Recently, various organizations have generated a large body of information related to RH supplies and contraceptive security. This guide includes hyperlinks to many of these resources, which the Coalition maintains in an electronic [Information Bank](#).



The Reproductive Health Supplies Coalition serves as a valued forum, where high-level stakeholder partners are engaged in the issue of reproductive health (RH) supplies shortages. The Coalition's vision is to protect people's health and improve livelihoods by ensuring sustained access to a choice of high-quality RH supplies. To support that vision, the Reproductive Health Supplies Coalition's mission is to ensure that every person is able to obtain and use RH supplies.

As **guiding principles** the Coalition commits itself to achieving a sustained supply of affordable, high-quality reproductive health supplies in low- and middle-income countries.

To this end, the Coalition:

**Understands** that achieving its vision requires:

- public and private resources to optimally serve people's needs for RH supplies, especially the needs of the poorest; and
- utilizing a multi-stakeholder approach to improve RH behaviors. Coalition's membership includes multilateral organizations, bilateral and private foundation donors, low- and moderate-income country governments, civil society, intergovernmental organizations and NGOs, and the private sector.

**Acknowledges** that to be effective the Reproductive Health Supplies Coalition must complement the actions of its individual members; it will therefore

- concentrate on areas where no one partner can work effectively alone to leverage their different comparative strengths;
- commit to strengthening harmonization and coordination of partner activities;
- implement a cooperative, problem-solving approach for developing solutions;
- work by consensus toward common goals.

**Believes** that increased country ownership is fundamental for reproductive health supplies; therefore, it will work through national governments to develop supportive policies, plans, resource commitments, and capacities.

Recognizes the role of both industrialized and developing-country manufacturers for planning, providing, and delivering high-quality RH supplies.

To achieve its mission, the Reproductive Health Supplies Coalition's **goals** are to:

- Improve access to and choice of RH supplies for low- and moderate-income consumers through public, private, and commercial sectors.



- Increase political commitment and financial resources and their more effective use to serve the RH needs of poor and vulnerable populations.
- Strengthen global, regional, and country systems for reliable and predictable supply of high-quality RH supplies.
- Improve coordination and use of global-, regional-, and country-level information, knowledge, best practices, and lessons learned.
- Formulate other strategic responses as needed to address the future demand for RH supplies.

To achieve these goals, the Coalition concentrates on areas in which no one partner can work effectively alone and makes full use of each partner's strengths. This is particularly relevant to its advocacy efforts, whether working at global, national, or local levels; synergies among members and speaking with a collective voice will strengthen its advocacy.



## Acknowledgements

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The authors of this guide and toolkit include (listed alphabetically): Laurette Cucuzza, Anne Jorgensen, Elaine Menotti, Tanvi Pandit-Rajani, and Suneeta Sharma from the USAID | Health Policy Initiative (HPI).

The guide and toolkit were developed with the contributions and assistance of several members of the Coalition's [Resource Mobilization and Advocacy Working Group](#), the [Market Development Approaches Working Group](#), and the [Systems Strengthening Working Group](#).

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Many people contributed to the guide's development. Imelda Zosa-Feranil of the Centre for Development and Population Activities (CEDPA) and others authored HPI's "Contraceptive Security Supplement of Networking for Policy Change: An Advocacy Manual", upon which the advocacy guide and toolkit is based.

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## Abbreviations

<b>AIDS</b>	acquired immune deficiency syndrome
<b>AWARE-RH</b>	Action for West Africa Region-Reproductive Health
<b>CBO</b>	community-based organization
<b>CPR</b>	contraceptive prevalence rate
<b>CS</b>	contraceptive security
<b>CSWG</b>	Contraceptive Security Working Group
<b>DHS</b>	Demographic Health Survey
<b>EDL</b>	Essential Drug List
<b>FP</b>	family planning
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HIV</b>	human immunodeficiency virus
<b>IEC</b>	information, education, and communication
<b>IMR</b>	infant mortality rate
<b>IMSS</b>	Mexican Social Security Institute
<b>IPPF</b>	International Planned Parenthood Federation
<b>JSI</b>	John Snow, Inc.
<b>LAC</b>	Latin America and the Caribbean
<b>LMIS</b>	logistics management information system
<b>MAP</b>	Multisectoral AIDS Program (World Bank)
<b>MCH</b>	maternal and child health
<b>MDG</b>	millennium development goal
<b>MOF</b>	Ministry of Finance
<b>MOH</b>	Ministry of Health
<b>MOHP</b>	Ministry of Health and Population
<b>MOP</b>	Ministry of Planning
<b>MOU</b>	memorandum of understanding
<b>MOY</b>	Ministry of Youth
<b>NGO</b>	nongovernmental organization



- NGO** nongovernmental organization
- PAI** Population Action International
- PEPFAR** President's Emergency Fund for AIDS Relief
- POPCOM** Commission on Population
- PRSP** poverty reduction strategy paper
- REMUPAZ** Red de Mujeres por la Construcción de la Paz
- RH** reproductive health
- SLI** standard of living index
- SPARHCS** Strategic Pathway to Reproductive Health Commodity Security
- SSA** Mexican Secretariat of Health
- STARH** Sustaining Technical Achievements in Reproductive Health/Family Planning
- STG** standard treatment guidelines
- SWAp** sector-wide approach
- UNA** Ugandan Nurses Association
- UNFPA** United Nations Population Fund
- USAID** United States Agency for International Development
- VAT** value-added tax
- WAHO** West African Health Organization
- WHO** World Health Organization



## Why Advocacy?

In **Jordan**, champions from the national Contraceptive Security Working Group (CSWG) successfully persuaded the Cabinet of Ministers to create, and fully fund annually, a line item in the national budget for contraceptives.

In **Paraguay**, even with the existence of a budget line item for contraceptives since 2002, the line item was not consistently or adequately funded. Policy champions for reproductive health and members of the congressional commission on social equity successfully advocated for a law (passed in May 2006) that approves budget appropriations for reproductive health (RH) programs, including the purchase of contraceptive commodities.

However, the mere existence of favorable policies, laws, norms, regulations, and budget allocations is no guarantee that a country will move toward ensuring that its citizens will be able to choose, obtain, and use high-quality and affordable RH supplies.

Without advocates monitoring the policy environment, a government may simply reverse or ignore favorable policies, regulations, and budget commitments.

In fact, policy implementation often proves more difficult than policy enactment.

By undertaking concerted and sustained advocacy, the Coalition and its partners worldwide can effectively influence the nature, scope, and success of policy decisions that will be the foundation for ensuring access to RH supplies.



## Getting Started: Laying the Groundwork for Advocacy Communication

Advocacy communication is only as effective as the underlying advocacy strategy. A winning and persuasive message is one that is consistent with the country context, addresses a clear and felt need by multiple stakeholders, and supports the overall goal and objective of the advocacy effort.

A strategic, evidence-based advocacy campaign that embodies carefully crafted strategies and compels action will have a much greater impact than fragmented, uncoordinated efforts. Thus, laying the groundwork and designing an overall advocacy strategy increases the effectiveness of advocacy communication.

### Planning for effecti

- knowing the context and understanding the underlying issues;
- bringing multisectoral stakeholders together to present and discuss the issues;
- forming an organizing group or committee; and
- engaging nongovernmental organizations (NGOs), civil society, and the private sector.

### Know the Context and Understand the Issues

Every country represented by the Coalition has a different mix of conditions to consider when preparing a reproductive health supplies advocacy initiative. We have identified five general contexts as starting points:

- Low contraceptive prevalence/high fertility rate
- High HIV prevalence
- Health sector decentralization
- Donor phaseout
- High abortion rate/low fertility rate

In some countries facing donor phaseout, health officials may be well aware of an emerging commodity procurement and delivery problem, but they have yet to bring together national stakeholders and craft a plan. In other cases, family planning may be losing attention as national officials cope with the urgent problems associated with HIV. Donor phaseout is not the issue, but fostering an understanding among national leaders of the crucial role that family planning and a reliable flow of commodities plays in the country's response to HIV is paramount.



Alternatively, governments may be decentralizing or undergoing other aspects of health sector reform, and thus, in trying to successfully implement these reforms for the health sector, reproductive health supplies management may not feature predominantly on the government agenda.

Finally, family planning (FP), an integral component of reproductive health, can be a highly controversial issue in many countries. Throughout the world, opposition based on religious beliefs and political philosophy undermines attempts to promote contraceptive use, particularly among adolescents and youth.

Therefore, advocacy related to FP supplies is likely to meet with more hostility and scepticism than advocacy for other RH issues such as maternal health. Making the link between FP supplies and maternal and child health outcomes or development and poverty, alleviation goals is an important tactic. Various approaches to framing and anchoring messages along these lines are presented in [Sections III](#) and [IV](#) of this guide.

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### **Gather information to support advocacy.**

A comprehensive set of questions that reflect different components of reproductive health commodity security can be found in [Appendix A](#). These are described further in [“Strategic Pathway to Reproductive Health Commodity Security \(SPARHCS\): A Tool for Assessment, Planning, and Implementation”](#) (Hare et al., 2004). A compendium of reports that illustrates how the SPARHCS approach has been applied successfully in nine country contexts is included in [Documentation of the Use of the SPARHCS Framework in 9 Countries](#) (POLICY Project, 2006a).

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Depending on the body of information known about the reproductive health (RH) supplies situation in a specific country or the amount of attention that has been paid to it previously, the amount of your “homework” will vary.

If the issues affecting RH supplies are not already well known and documented, advocates can identify issues through key informant interviews with RH stakeholders and a review of relevant documents. The more you know about what is affecting a country’s ability to ensure the availability of high-quality and affordable RH supplies, the more successful you will be in conducting advocacy.

In other words, we must know the issues well enough to make informed decisions and present convincing arguments.

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**You may need to gather information and conduct analysis on the following:**

- Policies, laws, and regulations related to RH issues
- Stakeholder analysis/political mapping
- Financing options
- Resource flow/requirements
- Public and private expenditures on RH products and services
- Projected commodity needs and forecasting
- Unmet need for family planning
- Family planning market segmentation
- Current and potential market niches for the public and private sectors
- Operational barriers
- Client willingness to pay

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To gain a comprehensive understanding of the issues and inform strategies, you could conduct primary data collection or focused analysis of secondary data.

Effective use of reliable, up-to-date information and analysis is an important element of advocacy, policy dialogue, and the planning of activities/efforts. At the planning stage, evidence is used to ensure that resulting policies are well conceived and have a reasonable chance of producing the intended effect.

The information gathered helps planners and policymakers understand the prevailing situation, identify positive and negative factors contributing to the current situation, assess strategic alternatives, and craft policies to resolve existing and potential problems. Building an adequate information base and using it in the policy process is a critical component of evidence-based advocacy and policy formulation.



### Box 1. Country Examples of Evidence Used for Advocacy

An analysis of **16 sub-Saharan African** countries shows that, in all 16 countries, cost savings in meeting five Millennium Development Goals (MDGs) by satisfying unmet need for family planning significantly outweigh the additional costs of family planning. Overall, benefit-cost ratios ranged from 2.03 in Ethiopia to 6.22 in Senegal. These data are being used to help reposition family planning and convince authorities to invest resources in FP programs (HPI, 2006, [Unmet need analysis briefs for 16 countries](#) plus [PowerPoint presentation](#)).

1. In **Romania**, in 2000, the existing supply of free contraceptives was sufficient to meet only 15 percent of the needs of one designated target group. This information helped make arguments for increasing government financing for contraceptive commodities (Dayaratna et al., 2002, [Operational barriers analysis](#)).
2. In **Peru**, from 2000 to 2004, use of modern methods declined by 6 percent among poor women and use of traditional methods increased by 9 percent. During the same period, the proportion of Ministry of Health (MOH) clientele from the poorest and lower-middle quintiles declined by 11 percent. This evidence revealed to the MOH that resource targeting and other efforts were needed to ensure the poorest 40 percent of the population had access to FP products and services (Sharma and Menotti, 2006, [Market segmentation analysis presentation](#)).
3. In **Egypt**, in addition to the health benefits, the LE 2,402 million spent on family planning between 1980 and 2005 was more than offset by the LE 45,838 million estimated cost savings in child health, education, and food subsidies. This analysis reveals the broad-reaching benefits of investing in family planning, in terms of cost savings in public social programs (Moreland, 2006, [Retrospective cost-benefit analysis presentation and brief](#)).
4. In **Jordan**, in 2004, donors financed 26 percent of the FP program, including most of the contraceptives; behavior change communication/information, education, and communication (IEC) campaigns; and research activities. This information helped the government understand and plan for the costs of a fully funded FP program as it planned for donor phaseout (Sharma et al., 2006, [National FP Accounts poster](#)).



## Bring Multisectoral Stakeholders Together

Because reproductive health (RH) issues are so diverse and no one individual or organization can be fully informed on a wide range of issues, RH supplies advocates recognize the importance of bringing multisectoral stakeholders together to present and discuss the issues.

Vital outcomes of this awareness raising are that key stakeholders understand RH supplies needs and that stakeholders have a sense of ownership of the issues and are ready to engage in advocacy, policy dialogue, and planning. Such forums offer excellent opportunities to identify priority issues and “champions” interested in leading any change efforts.

### Box 2. Multisectoral Strategic Planning Process in Egypt

In April 2005, an RH stakeholder presented to key decisionmakers evidence of the critical intersection between the increasing demand for family planning following decades of FP program success in Egypt and impending USAID phaseout. The data was enough to galvanize a multisectoral group of stakeholders to attend a three-day workshop on developing a CS strategic plan, sponsored by the Ministry of Health and Population (MOHP) in Cairo in spring 2005. Specific objectives were to

- identify detailed activities and sub-activities for the priority issues; and
- determine the implementing agencies, timeline, and performance indicators.

Twenty-eight participants from different sectors attended the workshop, including representatives of the MOHP, Egyptian Pharmaceutical Trading Company, Ministry of International Cooperation, Shoura Council, civil society and NGOs, Social Fund for Development, private sector, donors, and technical support agencies. Follow-up planning meetings, policy dialogue, and consistent advocacy successfully enhanced multisectoral commitment. For further information, see the [workshop report](#) and the [formal CS strategic plan](#)—including an advocacy strategy. Finally, in June 2006, the CSWG presented the strategic plan to high-level national decisionmakers. The plan, together with a presentation that vividly shows the impacts of ignoring family planning, galvanized these leaders to approve the plan and include it in the National Reproductive Health Plan. The government has mobilized funds and taken responsibility for implementation (Ministry of Population and National Population Council, 2005; Ministry of Population and National Population Council, 2006).



## Form a Nationally Representative Committee

To coordinate the multisectoral and complex issues associated with ensuring access to high-quality reproductive health (RH) supplies, many country groups have decided that a national representative committee is important not only for coordination but also for gaining support and recognition of the need among high-ranking policy-makers for a concerted national strategy (click on the opposite animation).

Thus, the formation of such a committee is an important initial advocacy objective or “ask.” If a committee already exists, one of the first objectives for this group of committed RH supply advocates is often to press national cabinets of ministers for a funded national strategy to address RH supplies.

In May 2002, **Jordan** initiated an evidence-based multisectoral planning process to move toward achieving contraceptive security in the anticipation of donor phaseout and an alarmingly high population growth rate. Having learned from other countries’ experiences with donor phaseout, Jordan has benefited from starting the contraceptive security (CS) planning process early and including key stakeholders, prior to imminent donor phaseout.

### Box 3. Illustrative Membership in a Nationally Representative Committee

- Ministry of Health
- Ministry of Finance
- Ministry of Religious Affairs
- Ministry of Trade and Commerce
- Other relevant ministries
- District Health Officers
- Social Security Institute
- Research institutions
- Private associations of doctors/nurses/pharmacists/hospitals
- Youth Council
- NGOs working on FP/RH
- International donors and cooperating agencies



The development of a contraceptive security (CS) strategy has involved several interwoven processes: awareness raising among a broad range of stakeholders, building partnerships and support, forming multisectoral planning groups, conducting policy analyses, and mobilizing information for decision-making.

One of Jordan's contraceptive security working group's (CSWG) earliest activities was creating a consensus on the scope of work and next steps for devising the five-year strategic plan for achieving contraceptive security (CS). In particular, early and consistent involvement of the Ministry of Finance in the committee was an important factor in Jordan's ability to make progress on its plan and ensure its funding.

In August 2005, the Higher Population Council met to discuss the final draft of the CS strategy and determine its corresponding financial requirements. At these meetings, the Ministry of Finance reiterated its commitment and plan to provide the needed funds.

As per a [Memorandum of Understanding](#) between the Ministry of Health (MOH) of the Hashemite Kingdom of Jordan and USAID/Jordan, the MOH will allocate increasing amounts of Jordanian Dinar to cover contraceptive purchases for the government's fiscal years 2005 to 2008, assuming full responsibility in 2009 (USAID and the Hashemite Kingdom of Jordan, 2006).

It is incumbent upon reproductive health (RH) supplies advocates to find a place for their issue, particularly in settings where health funding decisions are increasingly affected by the demands that HIV places on the health system and the requirements for national committees to coordinate HIV funds.

For instance, RH proponents might find that forming a working group under the National AIDS Commission or another such body empowered to take national strategic decisions may be the best option for taking advantage of the synergies between ensuring condoms and contraceptives for HIV prevention and ensuring RH supplies.

An example of a presentation that might be used in such a situation can be found in the Templates and Tools section of the Information Bank under [HIV presentation](#).



## Engage NGOs and Civil Society

As with other health and development initiatives, motivating and engaging NGOs and civil society for both planning and advocacy at global and country levels is critical to creating an enabling environment for the reproductive health (RH) supply issue.

Often, RH or health NGO networks are already formed and familiar with advocacy. Once armed with information and engaged in a strategy, NGOs can make great strides in achieving favorable policy change at both national and local levels.

For instance, a women's network in **Turkey**, KIDOG, directed a portion of their advocacy efforts for RH commodities at the highest levels; they successfully advocated with the President of Turkey, and as a result, President Demirel ordered the MOH to mobilize funds for government procurement of contraceptives (POLICY Project/Health Policy Initiative, 2007, [Turkey Case Study](#)).

Civil society and NGOs are also highly effective in mobilizing change at local levels. In **Ukraine**, a country in economic transition with a burgeoning private sector and growing civil society, it was particularly important for the Ministry of Health (MoH) to engage NGOs and private sector allies in the initial planning stages of a national contraceptive security strategy.

The Ukrainian Reproductive Health Network, a group of NGOs involved in advocacy efforts around reproductive health throughout the country, participated in a February 2005 stakeholder meeting to disseminate and discuss the results of an reproductive health commodity security (RHCS) assessment. Following the meeting, the NGOs created a diverse set of contraceptive security (CS) advocacy approaches for their respective oblasts (districts).

By December of that same year, all four advocacy campaigns successfully secured commitment from local administrative officials to increase budgetary obligations to CS efforts, particularly regarding information and access for youth.



For instance, one campaign led to the inclusion of annual training in family planning (FP)/contraceptive security (CS) issues for healthcare workers in Lugansk Oblast. Another campaign led to the provision of free contraceptives to youth in the Donetsk and Poltava oblasts. And, finally, government-funded, NGO-led outreach campaigns on FP/CS in Kharkiv, Zaporozhie, and Donetsk oblasts were realized (POLICY Project, unpublished (a), [workshop agenda](#)).

As the Coalition reaches out to civil society, its members may find that NGOs and other civil society groups are interested and willing to participate in reproductive health (RH) supplies advocacy efforts, but they may need practice on working together as a coalition or network or in building policy advocacy knowledge and skills.

Many organizations worldwide have successfully used the detailed training curriculum, *Networking for Policy Change: An Advocacy Training Manual* ([POLICY Project 1999](#)), to create and train networks in reproductive health advocacy.

Likewise, Coalition members can use this manual and its forthcoming companion resource, *Contraceptive Security Supplement*, to facilitate their capacity-building process. While working with NGOs, Coalition members may also find the need to build knowledge and skills around specific RH supplies issues or the policy processes the Coalition wishes to influence.

For instance, if the aim is to include RH supplies explicitly in the country's poverty reduction strategy paper (PRSP) or sector-wide approach (SWAp), the Coalition may want to bring partner NGOs together for a seminar to increase their understanding of the PRSP or SWAp mechanisms so they can more effectively participate in the effort. Such strategies can be highly effective.

For example, a combination of advocacy, donor pressure, and government efforts led **Uganda's** government to create a budget line item for contraceptives and then allocate US\$650,000 annually from its SWAp funds for contraceptive procurement.



## Engage the Private Commercial Sector

Meeting reproductive health supplies needs requires a comprehensive and integrated approach that finds solutions, beyond the public and NGO sectors, to ensure sustainable access to commodities.

Engaging the commercial and/or private sector in meeting reproductive health supplies needs can be an effective strategy, which involves several steps.

It requires that:

- the public sector create a favorable policy environment that promotes and supports private sector involvement and initiative;
- the public sector recognize and define its niche and target population; and
- both sectors jointly define and agree on appropriate roles and responsibilities for the private sector in meeting RH supplies goals.

In **Bangladesh**, the POLICY and DELIVER projects facilitated the process by holding a first-ever private sector roundtable for family planning (FP) stakeholders in 2005. The roundtable fostered partnership and initiated discussions about operational barriers to increased participation in FP provision, how the public sector could help reduce or eliminate those barriers, and potential opportunities for working with each other and with the public sector.

Note that governments and donors cannot mandate private sector participation. However, by clearly demonstrating the opportunities for private sector involvement in the contraceptive market and by fostering an enabling policy environment, governments and donors can create favorable conditions that induce private providers to expand their participation in the FP/RH market ([see Public-Private collaboration in Pakistan](#)).

This may include actively encouraging the private sector to demonstrate a stated commitment to contraceptive security goals through tangible market initiatives and highlighting that socially responsible behavior by the private sector can improve its social image and attract more business.

Advocacy for reproductive health (RH) supplies and contraceptive security (CS) is typically aimed at country-level decision-makers; however, strategies can be hatched among regional stakeholders who share many of the same interests and issues.



#### Box 4. Public-Private Collaboration in Pakistan

The Government of Pakistan has collaborated with the private sector to help improve the availability and quality of RH care services and products for all segments of the population. In 1996, to ensure that those with limited ability to pay could access private sector RH care services, the government, Social Marketing Pakistan, and Population Services International created the Greenstar Network. Greenstar serves *low-income* individuals with comprehensive, affordable, high-quality RH products and services through its network of clinics and pharmacies ([McBride and Ahmed, 2001](#)). Additionally, Key Social Marketing, a project of the Futures Group since 1996, has been marketing high-quality products to couples who can afford full-price contraceptive products. These products provide the private sector with an opening to meet the need of those who are willing and able to pay commercial prices (Sinioukov, 2005; [www.key.org.pk](http://www.key.org.pk)).

In the case of **Latin America and the Caribbean** (LAC) and **West Africa**, the approach has been to work regionally, not only to ensure that contraceptive security remains an issue of primary importance on national agendas, but also to provide a regional forum for sharing lessons, building capacity, developing strategies, and implementing solutions.

In 2003, USAID, with the POLICY and DELIVER projects, launched a regional initiative to determine how contraceptive security in the LAC region could be more effectively addressed and strengthened in light of the phaseout of contraceptive supply donations.

The initiative's overall goal has been to reveal and compare the common strengths and weaknesses regarding contraceptive security (CS) across eight LAC countries and develop appropriate CS strategies at regional, sub-regional, and national levels.

While, to date, activities have been directed at the country level, the implementation of common activities across the countries has allowed participating countries to learn from each other.

Initial [CS assessment reports](#) for **Bolivia, Honduras, Nicaragua, Paraguay, and Peru** enabled and informed the development of a report on regional recommendations (DELIVER and POLICY Project, 2004).



National CS committees, led by respective ministries of health, have provided critical momentum and leadership. Other activities have included regional and country-level contraceptive procurement option assessments, family planning (FP) market segmentation analyses, preparation of financial and contraceptive commodity projections, and strategic planning.

In 2006, at a regional forum on advocacy for contraceptive security, seven countries shared advocacy experiences, received training on advocacy, and developed CS advocacy action plans.

Likewise, the **West Africa Sub-Regional Initiative for Reproductive Health Commodity Security (RHCS)** was established with the participation of UNFPA, USAID, the World Bank, KfW, John Snow, Inc. (USAID/DELIVER), and Action for West Africa Region/Reproductive Health (AWARE/RH), along with the West African Health Organization (WAHO) and national partners from the sub-region.

The initiative's purpose is to improve the availability of reproductive health (RH) commodities in the sub-region and reduce unmet need for family planning (FP). As countries in the sub-region face common challenges to RHCS, such as limited access to RH commodities, inadequate logistics systems, insufficient commodity financing, and national and operational policy barriers, stakeholders felt that a sub-regional RHCS strategy could be an effective mechanism to address these challenges.

Such an approach would also support implementation of the sub-regional maternal and perinatal health strategic plan. Stakeholders created a sub-regional reproductive health commodity security (RHCS) strategy, which the ministers of health approved at their annual meeting in Abuja, Nigeria, in July 2006.

Implementation is slated to begin in 2007, following efforts to mobilize resources and develop detailed country-level workplans (West African Health Organization, 2006, [minister's declaration](#); and DELIVER, 2006, [RHCS strategy](#)).

Each country, with its own unique set of challenges and opportunities for securing reproductive health (RH) supplies, will require a different RH supplies strategy, and likewise, a unique advocacy strategy.

However, in each country, an advocacy strategy that is informed by data, endorsed by key stakeholders, coordinated at senior levels, has civil society buy-in, engages the private sector, and contributes to an overall strategic plan for securing access to RH supplies will serve as a solid foundation for effective advocacy communication. A summary of the general steps for designing an advocacy strategy is in [Appendix B](#).



## C. Choosing an Advocacy Objective

Ensuring access to reproductive health (RH) supplies encompasses a range of complex issues and thus requires a comprehensive approach with various solutions. RH supplies champions will need to weigh the issues and policy options to select the most important and viable advocacy objectives.

The criteria listed in the worksheet in [Appendix C](#) can help sort out and identify the priorities.

Table 1 "Illustrative RH Supplies Challenges and Desired Policy Actions" summarizes some of the possibilities. The examples represent just a few of the possible solutions; committed stakeholders and advocates often find creative solutions.

### Box 5. Stakeholders Find a Creative Policy Solution to an RH Financing Issue

In Guatemala, stakeholders successfully increased financial resources available for FP/RH—a huge feat in a country that has only recently recognized the importance and value of investing in these health areas. As part of their ongoing campaigns to increase financing for the health sector, and for FP/RH in particular, civil society networks, INSTANCIA Salud/Mujeres and REMUPAZ, held meetings and working sessions with the Congressional Commissions for Health, Women, and Human Rights as well as the Inter-Parliamentary Women's Coalition in Congress to discuss the underfinanced National Reproductive Health Program and present evidence-based advocacy messages. As a result of these concerted efforts, in June 2004, Congress drafted and approved Legislative Decree 21-04, which mandates that 15 percent of the tax on alcoholic beverages—approximately 26 million Quetzales (approximately US\$3,402,340)—will be used for reproductive health, family planning, and alcoholism programs (POLICY Project, unpublished (b), [Establishing an Innovative Source for Funding in Guatemala](#)). A list of other [examples of existing RH commodity or contraceptive security policies](#) is included in the Tools and Templates section of the Information Bank.



## Illustrative RH Supplies Challenges and Desired Policy Actions

Illustrative RH Supplies Challenges	Possible Desired Policy Actions or Outcomes
Lack of understanding of family planning's contribution to other health and development objectives	<ul style="list-style-type: none"> <li>Family planning and RH supplies explicitly addressed in broader country strategies (e.g., PRSPs and SWAps)</li> </ul>
No government commitment to ensure that clients have access to high-quality supplies at all levels of the health system	<ul style="list-style-type: none"> <li>A national strategy for ensuring access to RH supplies approved, financed, and implemented</li> <li>Supply chain strengthening included in the Health Sector Reform Strategy</li> </ul>
Despite high unmet need and declining donations, limited or absent government funding for contraceptives	<ul style="list-style-type: none"> <li>Government creates a funded line-item in the national budget for contraceptives</li> </ul>
MOH budget includes a contraceptive line item, but the MOH has not released funds due to bureaucratic complications	<ul style="list-style-type: none"> <li>Guidelines or policies revised to reduce barriers to funds disbursement</li> </ul>
Stockouts and shortages occurring due to limited coordination among multiple procurement agents, donors, and recipients of RH supplies	<ul style="list-style-type: none"> <li>An active RH Commodity Coordinating Committee created and functioning</li> </ul>
High fertility, low use of modern FP methods among the poor and other vulnerable groups	<ul style="list-style-type: none"> <li>Subsidized contraceptives directed at the poor and most vulnerable</li> <li>Funding for IEC campaigns on reproductive health increased and directed at the poor and most vulnerable</li> </ul>
Public health providers not trained in modern contraceptive technology, safety, and supplies management	<ul style="list-style-type: none"> <li>FP and supply chain management topics integrated into all MOH programs and trainings for public health practitioners</li> </ul>
Expensive contraceptives sold in pharmacies	<ul style="list-style-type: none"> <li>Contraceptives declared essential goods to reduce or eliminate import duties and value-added tax (VAT)</li> </ul>
NGOs cannot receive and distribute government-funded contraceptives even in remote areas where public providers are not present	<ul style="list-style-type: none"> <li>Policies revised to allow NGOs to receive and distribute government-funded contraceptives</li> </ul>



## D. Reaching Decision-makers with effective Advocacy Communication: Informing, Persuading, and Moving to Action.

Decision-makers are bombarded by messages and requests every day. The challenge for the Coalition and its partners is to reach the appropriate decision-makers with effective advocacy messages that capture their attention.

Whether you are trying to reach your primary target audience (decision-makers who have the authority to bring about the desired policy change) or your secondary target audiences (persons who have access to and are able to influence the primary audience (other policy-makers, technical advisors, friends or relatives, the media, religious leaders, etc.), there are several important things to keep in mind.

### What is advocacy communication?

It is any *planned* communication activity that seeks to achieve one of the following communication goals: *inform*, *persuade*, *move to action*, or *maintain relationships and support*.



## Identify the Appropriate Audiences

Advocacy efforts for reproductive health (RH) supplies are typically aimed at a variety of audiences. Target audiences often include political leaders, legislators, officials of national government and/or local government agencies, donors, national and local managers of procurement and logistics systems, the national and local media, religious and traditional leaders and other community influencers, NGOs, commercial sector leaders and business groups, service provider organizations, civic organizations, women's organizations, and groups representing current and potential users.

The target audiences will vary depending on the country context. Important questions to keep in mind are: who has the authority to make the policy decision, and who can help influence the decision-maker? The Minister of Health may be the primary decision-maker for health sector budget allocations and the distribution of contraceptives, whether funded by the government or donated to the government by donors.

Other possibilities may include national officials such as the Minister of Finance and the Minister of Social Protection or local health officials who can assist with issues at the local level. At times, the primary target audience may even include the President or the Prime Minister, particularly if the issue involves interministerial decisions, significant funding allocations, or even linkages with a development initiative espoused by the high-level officials.

In many countries, the Ministry of Finance and the Ministry of Trade and Commerce are primary target audiences for issues related to taxes and import duties. In other instances, advocates need not target the most senior health officials. Critical issues regarding insufficient support for improving logistics management information systems (LMIS) or training on supply chain management may be addressed to and solved by health program managers such as the Reproductive Health Director within the Ministry of Health.

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### Who decides?

Identify which person or decisionmaking body can decide on the policy, program, or funding issues so that your advocacy can be direct, specific, and targeted to those empowered to make decisions.

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## Know your Audience

An advocacy communication strategy follows many of the same principles as an advertising or social marketing campaign. It is essential to thoroughly know your audience and to deliver a concise, consistent message that is tailored to your audience's interests.

In other words, the message communicated to a parents' group about providing family planning (FP) services to adolescents would differ from the message transmitted to officials in the Ministry of Health (MOH) about recurring stockouts. Audience research, particularly qualitative research such as focus group discussions and in-depth interviews, helps identify appropriate messages for various policy audiences.

Having a clear understanding of the audience and the ability to put yourself in the audience's shoes and demonstrate how the audience members will benefit from supporting your cause is a tremendous challenge, but is critical to effective advocacy communication.

The checklist below can assist you in your research.

- **Level of knowledge about the advocacy issue.** Is the audience well informed or does it lack accurate information? How much does the audience know about the importance of ensuring sufficient, high-quality RH supplies?
- **Level of demonstrated support for the issue.** Has the audience actively and/or publicly supported the issue? Rank and describe evidence of support.
- **Level of demonstrated opposition toward the issue.** Has the audience actively and/or publicly opposed the issue? Rank and describe evidence of opposition.
- **Undecided or unknown.** Has the audience failed to declare its position on the issue, or are you uncertain of its position at this time?
- **Potential benefits to the audience.** How might the audience benefit from supporting the RHSC's issue and objective? Might the audience realize political, personal, or professional benefits? Describe any benefits.
- **Find shared values.** Is there a "we" message possible? Might there be a way to frame the issue drawing on values that are important to both the audience and the RHSC?



No matter what level of authority your target audience has, it is important to identify the potential benefits to the target audience from supporting your advocacy objective. In other words, how will each individual in the target audience benefit professionally, politically, or personally from supporting the issue (or conversely, what does each risk)? The answers to these questions should be considered and incorporated into the advocacy messages directed to each member of the target audience.

## Message

Ideally, only one main point should be communicated or, if that is not possible, two or three points at the most. It is better to leave people with a clear idea of one message than to confuse or overwhelm them with too many.

**Box 6. Sample Advocacy Messages** Contraceptive use is low, total fertility rates are high, maternal and infant mortality and morbidity rates are high, and adolescent unintended pregnancy and abortion rates are high. Hospitals, clinics, and community health posts do not have the RH supplies they need to serve their clients; this is because there is insufficient commitment from the MOH to provide high-quality, accessible FP, RH, and MCH supplies and services for our citizens. Skilled RH supply chain management is lacking. Coordination among different levels of health services is lacking. The MOH must fully fund sufficient RH supplies. The Minister of Finance must improve the supply chain management. The Minister of Planning should increase communication and coordination among all levels of health services and RH supply companies. There should be a line item for RH supplies in the MOH budget annually and it should be fully utilized. *Is anyone still reading?*

***...in such a short text, too many general issues and too many requests***

There are insufficient RH supplies to meet the needs of our citizens as demonstrated by a high total fertility rate of 5.8 and contraceptive prevalence rate of only 11 percent. The MOH budget ought to include a line item for RH supplies that is fully funded and utilized based on annual projections.

***...in a short text, one issue and one solution***



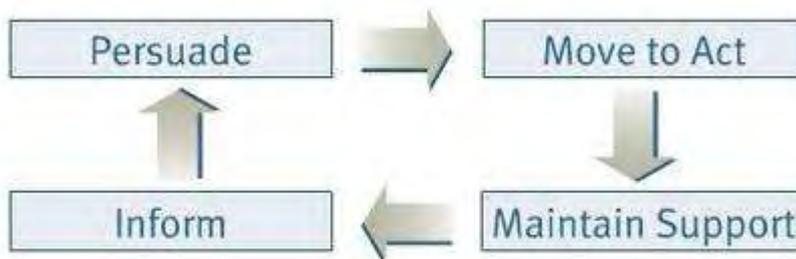
## Choose the Appropriate Level of Communication

Advocacy communication (as well as Information Education and Communication (IEC) campaigns) often focuses on the first level of communication shown in the model on the right, to inform a target audience. To move the audience along to higher stages, audience members need information to develop a thorough understanding of the issue, the situation, and the desired policy change.

Once the audience is informed, the communication strategy moves to achieve the next objective to produce greater impact. That higher level seeks to persuade the audience to feel strongly about the issue and to adopt the desired position.

Once audience understanding and support are achieved, communication moves to the highest level, the point when advocacy messages move the audience to act in support of the issue. Every advocacy communication effort should seek to reach the highest possible level, that is, to move the audience to action.

But an advocate's job is never done! Even after persuading a target audience to act, hard won support can waiver and wane over time, as other priorities compete for limited resources. Thus, maintaining contact with key target audiences, providing updated information and evidence, and advocating for maintained support are important ongoing tasks.





## Describe the Desired Action or the Ask

The message should not only persuade through valid data and sound logic, but should also describe the action the audience is being encouraged to take. What are you asking of your target audience?

The audience members need to fully understand what you want them to do.

- Do you want a colleague to hold a meeting with the Logistics Department within the Ministry of Health to discuss the LMIS?
- Are you asking the Minister of Health to include contraceptives on the Essential Drug List?
- Do you want the Minister of Finance to increase funding for commodities?
- Or, are you preparing a brief to convince the head of the poverty reduction strategy paper (PRSP) committee to clearly specify reproductive health needs of the poor and funding for reproductive health supplies in the upcoming strategy paper?

Whether you are asking a secondary audience to help influence a primary target audience or directly asking a policy-maker to make a policy change, an advocacy message describes the action you would like the particular target audience to take.

The following section outlines different concepts to consider when formulating a persuasive message.

### Pretest the Message

Ideally, messages should be pre-tested with representatives of the target audience to ensure that the message presented is the one received.

For example, when developing an advocacy message directed toward the Minister of Health, it is useful to practice delivering the message to a supportive ministry official as a test run. The ministry official may offer valuable feedback about how the message is interpreted.



*“Trying to run sexual and reproductive health programmes without contraceptives... and other reproductive health commodities is like trying to eradicate smallpox without vaccines. It simply cannot be done.”*

~Steven Sinding, Director-General International Planned Parenthood Federation, 2003

## E. Effective Messages

Think of a message that was particularly effective for you personally. Maybe it was an advertisement or a powerful speech at an annual conference. Why was it memorable for you? There are many different kinds of messages, but effective messages have common characteristics. They are often simple and concise, they use appropriate language tailored to the audience, and the content is consistent with the medium format.

It may help to keep these characteristics in mind when developing and delivering advocacy messages. In addition, it is important to remember that not everyone understands reproductive health (RH) supplies issues or considers them priorities. Thus, messages must be kept simple and precise to inform, persuade, and move audiences to act

Specifically, effective messages result from addressing five important elements:

### Content/Ideas

The content refers to the central idea of the message. What is the main point you want to communicate to your audience? What single idea do you hope the audience will take away from your message? What is your “ask”?

### Language

Language consists of the words you choose for communicating your message. Is the language appropriate for your target audience? Is the language clear or could various audiences interpret it differently? Will the audience understand your abbreviations? Is it necessary to use a local dialect or vernacular to communicate the message?



### When selecting a messenger...

Is the messenger credible to your target audience?

Will the target audience respect the messenger?

Can you include beneficiaries as spokespersons or messengers?

### Messenger / Source

Source refers to the person or people delivering the message.

Think again about a message that was particularly memorable for you. How much of your positive impression was based on your opinion of the person/organization delivering the message?

It is important to select the most appropriate messenger for the target audience; one who is credible and can capture the attention of the audience.

You might select the director's long-time deputy. Or, for example, you might invite a community or religious leader to join you for a high-level meeting with a policy-maker. You might ask a service provider who has to turn away clients who need and want contraceptives because of routine breaks in the supply chain.

Often, advocates can send a powerful and more meaningful message to policy-makers by letting the message come from a member of the affected population.



## Time/Place

When and where will the message be delivered? It is wise to choose a time and place most convenient to your audience.

Your secondary audiences (those who can influence the primary target audience) can help. A trusted technical advisor to the Minister of Finance may know when the minister might be open to or not open to hearing from you about the need for a funded line item for key reproductive health supplies in the national budget.

## Format/Medium

The format or medium is the communication channel you choose for delivering the message.

What is the most compelling format to reach your target audience? Would your audience more likely be reached through face-to-face meetings, briefing packets, presentations, fact sheets, or policy roundtables? Or might your audiences be more likely to take notice of posters, flyers, public rallies, petitions, or press conferences?

Different channels are more effective for certain audiences, and the choice of medium varies for reaching the general public, influencing decision-makers, educating the media, or generating support for the issue among like-minded organizations and alliances.

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### Need templates?

See [Templates and Tools](#) for template [PowerPoint presentations](#) that you can tailor for your country contexts, objectives, and target audiences.

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Factors to consider in selecting the format/medium for your messages are the following:

### **Audience**

Some formats are more effective and more appropriate for specific audiences. For example, high-level policy-makers have little time and many constituents. The message needs to give them the facts and move them to action quickly; also, always leave information for them or their advisors to read later. Effective media for policy-makers include briefing packets or fact sheets, delivered via face-to-face meetings or policy forums. A PowerPoint presentation can be an effective means to open discussion at such a forum.

### **Cost**

Some media require significant resources. Whereas a fact sheet or briefing note can be made using desktop publishing, tapping into mass media such as radio or television can be extremely costly. The Coalition may seek out free or reduced-cost opportunities if the mass media is the medium of choice.

### **Risk**

When going public with an advocacy issue, especially a controversial one related to family planning, risk is always involved. Certain advocacy tactics entail more risk than others. Face-to-face meetings with a known audience may not entail risk, whereas public debates and live forums can turn into "heated" events.

Nevertheless, risk can be minimized through careful planning, selection of speakers, rehearsals, and so forth. Whether you or a surrogate will be delivering the message, a ready list of talking points is always helpful.

### **Visibility**

Your choice of medium can also maximise the ability to make use of a contact or connection to raise the visibility of an event. Perhaps a celebrity or high-ranking public official is willing to pay a site visit to a project or make the opening speech at a meeting. Such an event may provide an excellent opportunity to recruit other decision-makers and promote a particular advocacy objective.

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### **Need templates?**

See [Templates and Tools](#) for template [PowerPoint presentations](#) that you can tailor for your country contexts, objectives, and target audiences.

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After selecting the appropriate format and medium for delivering the advocacy message, the next step (creating the material) can be time consuming.

To assist Coalition partners with preparing different types of advocacy tools, [Section IV](#) includes a series of guides, templates, and suggestions for several types of commonly used advocacy tools:

- PowerPoint presentations,
- policy briefs,
- briefing notes/talking points,
- fact sheets, and
- press releases and media alerts.

## F. Carpe Diem: A One-Minute Message

Sometimes life hands us opportunities. We meet the Minister unexpectedly in the elevator, or a television reporter asks for a live interview during a coffee break at a national forum. A short message to fall back on at any time can help you seize the moment.

A one-minute message includes

- The statement of the issue
- Evidence to support the issue
- An example of the problem
- The desired policy action

*Click on "When Opportunity Knocks" to see an example, using illustrative data.*

Please refer to [Section II](#) for additional examples of short advocacy messages.



### Box 7. One-Minute Message: When Opportunity Knocks

***The Uganda UNFPA representative meets the head of the SWAp Planning Committee at a national donor conference. She knows that the committee will be meeting in the next few weeks to update the strategy...***

**The statement.** Many women in Uganda want to space or limit their births but do not use family planning. To address this unmet need for family planning, contraceptives must be available—reliably—to those individuals who want and need them. Thankfully, Uganda has explicitly addressed the availability of FP/RH commodities in its most recent PRSP. This has resulted in additional resources for the purchase of RH supplies; however, due to multiple financing streams and procurement processes, there are repeated shortages and stockouts.

**The evidence.** Forty percent of health facilities are reporting stockouts of injectables, and 54 percent are reporting rationing of oral contraceptive pills. This has been occurring for the last several years. The latest national demographic health survey revealed that 35 percent of married women in Uganda have an unmet need for family planning. If these needs are not met, approximately 817,000 women and children will die needlessly in the next decade. Stockouts and shortages are compounding the problem.

**Example.** Dr. Bukenya in Ssembabule District told me about having to turn away approximately 40 routine FP clients last week because of a stockout in the regional warehouse due to a delay in purchasing contraceptives with donated funds. This is affecting clinics all over the district. Due to the long distances some women traveled to reach his clinic, he is concerned that they may have lost their trust in him and in his ability to meet their RH needs.

Desired policy action. FP services and supplies should be addressed explicitly in the revised SWAp strategy to pool resources into a common basket to streamline procurement processes



## Toolkit



## I. Advocacy Messages to Support Reproductive Health Supplies Initiatives

Successful advocates know their country's regional or community reproductive health (RH) context and which types of messages are going to be most successful in their respective environments. There are myriad challenges, with specific messages to address them, as each country is unique.

Yet there are some global issues that describe the overall RH context for most countries and can serve as a basis for planning effective advocacy messages.

The following sections describe various scenarios and offer approaches for tailoring the messages to best capture the attention of key groups of target audiences.

### A. Advocacy in Context: Five Global Scenarios for Ensuring Reproductive Health Supplies

Over the last decade, many developing countries have experienced social, economic, and political changes that continue to affect the delivery of healthcare services, including family planning.

For example, in several countries, health sector reform brought decision-making power to subnational levels; private sector opportunities relieved the public sector burden to provide for all; and some donor assistance has shifted from vertical programming to more integrated and sector-wide approaches.

Whether such changes have positively contributed to service delivery largely depends on the context, given that countries are at different stages of the reform process.

The emergence of new financing mechanisms and a changing funding environment for foreign assistance affects how policy-makers make decisions and allocate resources.



## Five Global Scenarios for Ensuring Reproductive Health Supplies

In the last few years, focus has shifted from targeted projects to global initiatives, poverty reduction, the MDGs, and direct budget support.

There is a concern that these recent changes, combined with those experienced over the last decade, are negatively affecting the consistent availability of high-quality family planning (FP)/ reproductive health (RH) supplies.

As a result of the new funding environment, some countries have experienced challenges with forecasting, financing, procuring, and delivering FP/RH supplies in a timely manner. But these changes may also be windows of opportunity for securing reliable funding for FP/RH supplies in the future.

Advocating for increased commitment to FP/RH supplies demands that advocacy messages be appropriately targeted. This not only requires knowing your audience, but understanding the contextual variables that are affecting the availability of products.

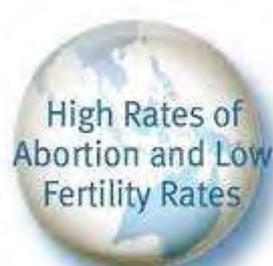
Described in this section are five common scenarios that often provide challenges to ensuring a consistent supply of high-quality FP/RH supplies.

Whether such changes have positively contributed to service delivery largely depends on the context, given that countries are at different stages of the reform process.

The emergence of new financing mechanisms and a changing funding environment for foreign assistance affects how policy-makers make decisions and allocate resources.



## Advocacy in Context: Five Global Scenarios for Ensuring Reproductive Health Supplies



Each scenario is divided into three areas

- a short background on FP commodity challenges;
- links to helpful resources; and
- a “matrix” that lays out illustrative points that advocates can use to create persuasive messages for key target audiences in support of their advocacy objectives.

Please note that depending on the country where you work, the various scenarios discussed below are likely to overlap.

A combination of contextual factors may together contribute to low family planning commitment, so use discretion when determining which scenario(s) is most relevant to your environment.



## B. Scenario 1: High Unmet Need for Family Planning



In most cases, countries with high unmet need for family planning (FP) are also poor and resource-constrained. Political leaders often do not understand that FP is a strong complement to other efforts to reduce poverty or spur development.

### Background

Thus, health systems do not devote sufficient resources to FP, country loan requests do not include strong FP elements, and political leaders do not make public pronouncements that give government officials and lower level politicians the space they need to implement FP programs.

However, through advocacy and coordination, additional resources can be mobilized ([see Securing Increased Government Funding for Contraceptives on the next page](#)).

In West Africa, for example, modern contraceptive use averages about 9 percent. This is also a region with high unmet need, relatively low HIV prevalence, and high maternal and infant mortality rates. In some low-prevalence settings where demand is also low, couples are often unaware of how to access high quality services. Furthermore, services may be nonexistent, where they are most needed at the community level.

An important advocacy goal is to ensure that family planning is a significant part of the country's development strategy. For example, the Poverty Reduction Strategy Paper (PRSP) should include a strong section on FP that includes reference to both policy and programmatic elements. Effective advocacy in this regard may include messages such as the developmental benefits of small families and the cost savings to the social sectors from a smaller population.

A key element of contraceptive security is ensuring that resources are available for purchasing commodities or ensuring the delivery of high-quality services. Effective advocacy should work toward obtaining those resources via allocation of government revenues or donor contributions. In settings where greater political and financial commitment for family planning is needed, advocacy messages should focus on the following points:

- Family planning (FP)/reproductive health (RH) saves lives.
- FP/RH contributes to meeting the following MDGs and with reduced cost: poverty reduction, education, maternal and infant mortality, and clean water and sanitation.



- FP/RH is a sound economic investment and should be included in poverty-reduction strategies.

### Box 1. Securing Increased Government Funding for Contraceptives

Unmet need for family planning remains high in **Togo**. The contraceptive prevalence rate (CPR) is only 25.7%, with modern method use at 9%. This is particularly an issue at a time when donors are reducing their financial contribution to contraceptive commodities. To improve access to contraceptives, the Division of Family Health, within the MOH, in collaboration with multiple stakeholders including the Ministry of Finance (MOF), launched a CS strategic planning process in February 2004 using the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) framework. The MOH advocated with the MOF to create a budget line item for contraceptive commodities. Before the CS strategy was finalized in September 2005, the MOF recognized the significance of the resource gap and declared its intention of creating a line item for contraceptive purchases and in the interim, allocated 50 million CFA Francs (US\$95,000) to the MOH for the purchase of contraceptives (**Alkenbrack and Tossou, Unpublished**).



## Helpful Resources

A brief that documents the successes of the Ghana Family Planning (FP) program over the past 10–20 years and identifies which program interventions led to those successes (Solo et al., 2005a).

A [country report](#) that describes the Ghanaian government's recent application of the RAPID Model to assess options for meeting Millennium Development Goals (MDGs) and Poverty Reduction Strategy Paper (PRSP) goals.

The model continues to be used as an advocacy tool in sensitizing stakeholders, including government, opinion leaders, policy-makers, and decision-makers, on the implications of unmet need for FP and rapid population growth and their socioeconomic consequences (National Population Council and POLICY Project, 2006).

A [conference report](#) that presents the key FP issues in the **West Africa region** and highlights from the conference.

In February 2005, USAID, WHO/AFRO, Advance Africa, AWARE-RH, and the POLICY Project, in collaboration with the GHANA Ministry of Health (MOH), UNFPA, IPPF, and other stakeholders, held a regional conference on "Repositioning Family Planning in West Africa" to discuss the value of FP in the region, in hopes of reviving the interest of donors and governments in reducing unmet need for FP (Dake, 2005).

The Matrix for High Unmet Need can be found in [Appendix D](#).



## C. Scenario 2: High HIV Prevalence



Countries with generalized and emerging HIV epidemics are receiving growing attention from global initiatives, donors, and foundations.

### Background

Numerous HIV-specific initiatives, such as the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR), and World Bank's Multisectoral AIDS Program (MAP), are providing considerable opportunities for addressing the disease.

At the same time, the increasing emphasis on HIV has caused host-country governments to shift human and financial resources away from other health programs, such as family planning (FP) and reproductive health (RH).

Programs that were once integrated are now often operating in parallel, posing a huge challenge for the management of FP supplies.

FP commodities are necessary for both FP and HIV prevention programs. Yet, the management burden to ensure commodity availability often rests upon FP/RH units within ministries of health. How can you, as an FP/RH supply advocate, frame your message around joint responsibility and commitment for contraceptives?

Focus your advocacy messages on one of t

- RH supplies are necessary to achieving HIV-prevention targets (GFATM, PEPFAR, MAP).
- RH supplies are critical because HIV-positive women want access to FP in their care and treatment clinics.
- RH supplies contribute to achieving other health and development targets (e.g., the MDGs).
- Prevention is more cost-effective than treatment, and, therefore, FP is a valuable investment.



## Helpful Resources

Policy Issues in Finance and Planning: [Ensuring Contraceptive Security for HIV-Positive Women](#),” a policy brief discussing the challenges and opportunities in ensuring access to family planning (FP) supplies for HIV-positive women (Hamilton, 2005).

Two case studies that document (a) the successes of FP programs in [Malawi](#) and [Zambia](#), high HIV/AIDS prevalence countries, over the last 15–20 years and (b) identify which program interventions led to those successes (Solo et al., 2005b; Solo et al., 2005c).

A website, created by the Family Planning and HIV/AIDS Integration Partners Working Group, that provides ample material for how to link HIV/AIDS and FP (<http://www.hivandsrh.org/>).

The Matrix for High HIV Prevalence can be found in [Appendix D](#).



## D.Scenario 3: Donor Phase-out of RH commodities



There are many reasons why donors are phasing out Family Planning (FP) programs in specific countries and regions.

### Background

In some cases, donors are choosing to redirect resources to countries with the greatest need because current funding cannot keep up with the global demand for family planning.

And, as mentioned earlier, disease-specific initiatives, such as those for HIV/AIDS and malaria, are gaining more attention and commitment from the global community, diverting resources away from FP programs.

In many cases, countries experiencing phaseout are often those with greater economic and political stability; the expectation in these instances is that governments will take ownership and increase commitment for meeting the healthcare needs of their populations.

As donors phase out donations of or funding for the purchase of FP commodities, sustainability and capacity building for governments are crucial areas of focus. Generally, under the conditions of phaseout of FP assistance, a country gradually increases its financial support for FP services and commodities.

In this process, often governments will initiate the task of contraceptive procurement for the first time and need to put appropriate policies in place to facilitate obtaining the best prices available ([see "Intergovernmental Advocacy to soften regulations around Contraceptive Procurement in Mexico" on the next page](#)).

In addition, governments require capacity building assistance in using data and information to forecast and plan for contraceptive purchases and must mobilize all potential sources of financing to purchase the needed contraceptives.

Where governments cannot afford to provide subsidized family planning (FP) products for all individuals, the private sector may be a viable source of commodities for people who are willing and able to pay.

These settings often have a large number of users and offer interesting opportunities for a whole market approach, where all possible sources of FP service and commodity provision (i.e., NGOs, private clinics, social marketing, pharmacies, social



security, the Ministry of Health (MOH)) are mobilized, which can work to lessen the financial burden of FP provision on the government.

Greater advocacy may be required to create a policy environment that supports a whole market approach. For example, the government might choose to commit to serving poor and other vulnerable populations who cannot afford to pay for family planning.

At the same time, the government can work to ensure that policy and regulatory conditions are favorable to private sector involvement in FP provision, so that private sector can serve those who can afford to pay some or all of the cost of their contraceptives.

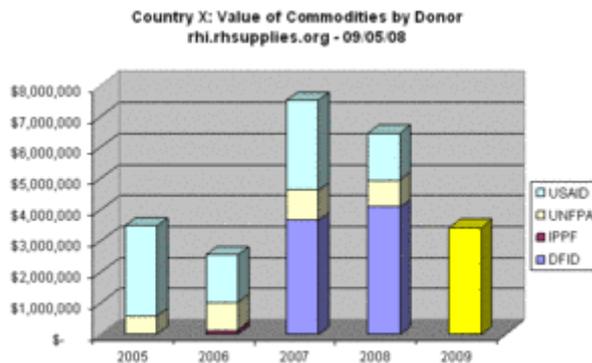
Some ideas for advocating the whole market approach are

- Mobilizing alternative sources of financing to ensure there are sufficient funds to procure contraceptive commodities and carry out other aspects of FP programming (Information, education and communication (IEC) campaigns, training, supervision);
- Building capacity to accurately report, maintain, monitor, and finance the supply chain for FP commodities;
- Developing a timely strategy and phaseout plan among donors and governments; and
- Improving the policy environment to promote private sector growth.



## RHInterchange

In light of potential donor phase out the [RHInterchange](#) provides data on not only historical data but in some cases on future, planned information for donated commodities. In these cases countries can see past and future commodity values by donor to plan for the resources they will need to fill any financing gaps when donors no longer donate commodities. The RHI website can present data graphically including by funding source. The graph below shows funding sources for each year starting in 2005 through 2009. In 2005 the two funding sources were USAID and UNFPA. In 2006 IPPF also procured contraceptives while in 2007 and 2008 DFID was the third financing source.



Data from RHI can also be exported to Excel for manipulation by the user. The user can create his or her own graphs or tables in Excel once data has been downloaded. For instance, the table below are the figures behind the above graph. The graph has been customized to show what the potential funding gap would be in 2009, illustrated by the column in yellow, if USAID were to phase out. It would be in the amount of \$3.4 million dollars in contraceptives. The RHI would be able to provide a breakdown of the methods since USAID provides data on future shipments.

Country X							
	Year						
Donor	2004	2005	2006	2007	2008	2009	Total
DFID				\$3,650,843	\$4,050,967		\$ 7,741,911
IPPF	\$ 36,236	\$ 2,834	\$ 127,153	\$ 7,704			\$ 172,926
UNFPA	\$ 176,160	\$ 578,072	\$ 894,920	\$ 960,003	\$ 881,517		\$ 3,490,671
USAID	\$2,083,526	\$2,882,241	\$1,522,231	\$2,910,266	\$1,497,401	\$3,428,352	\$14,334,539
<b>Total</b>	\$2,294,922	\$3,473,147	\$2,544,304	\$7,529,436	\$6,469,886	\$3,428,352	\$25,740,046



## Funding gap

Historical commodity data is not always easy to obtain and the RHI provides information on what was spent by the three of the major procurers of contraceptives - IPPF, UNFPA, and USAID. The RHI also has data from UNFPA since 2004 when it acted as a procurement agent for another donor or country government. Similarly, the RHI has data since 2006 where Crown Agents acted as a procurement agent on behalf of DfID. Past procurement values in the RHI can be used together with country forecast data to determine if there will be a funding gap. The analysis can allow the MOH and donors to plan for future financing. This can also be done on a regional or global basis by advocacy groups.

## Information from RHI can also be used for coordination and awareness raising

Inbound shipment information can be used to determine if there will be delays to allow stakeholders to make alternate plans to avoid stockouts and redirect shipments. The example below shows the details available in the RHI on inbound shipments to a country. The table below shows the funding source and procuring organization which are USAID in this example. PO Number's are provided to track and identify incoming shipments. Each shipment shows who the recipient will be and the method and product name. It also includes the quantity of the method and cost. The shipment dates and receipt dates are also provided. Because RHI is updated on a regular basis new information on shipment receipt dates or other shipment information will be shown in the RHI as they come in.

### Shipment History example from Bangladesh

Funding Source	USAID
Procuring Organization	USAID
PO Number	80-191
Recipient	Social Marketing Company Bangladesh
Method	Oral - Combined (cycles)
Product	Norgestrel/Ethinyl (Duoform) supplied by WYETH PHARMACEUTICALS
Quantity	2,592,000
Cost	\$643,701
Shipment Date	31-Oct-2008
Receipt Date	31-Dec-2008
Notes	The order has been entered into USAID's order processing system, but has not shipped yet. Both shipment and receipt dates represent estimates.
<b>Shipping Leg Information:</b>	
No shipping legs were found for this shipment.	



Contraceptive Security Committees and others who manage contraceptives can use the RHI to monitor the inbound supply pipeline and understand whether enough supply is coming in to meet projected needs or not. The table below illustrates downloaded data from the RHI showing planned shipment dates and quantities as well as other pertinent information.

Shipment Date	Funding Source	Product	Quantity	Value (\$ US)	Recipient
16-Oct-2008	UNDP	Condoms, male 53mm-Standard, natural colour, straight and parallel sided, reservoir tip, lubricated with silicone. Width: 53mm +/- 2mm. Length: 180mm minimum. Single wall thickness: 0.065 +/- 0.015mm. Tested in accordance with WHO/UNAIDS specification.	3,199,968	96,999	Country X 3rd Party
5-Nov-2008	UNFPA	Condoms, female 2	14,000	9,100	Country X
30-Nov-2008	USAID	IUD Copper T Model TCu380A	2,000	1,279	Academy for Edu Development
30-Nov-2008	USAID	Levonogestrel 36mg [Jadelle]	5,000	114,830	Academy for Edu Development
31-Dec-2008	USAID	DMPA [Depo Provera]	192,000	223,978	Academy for Edu Development
31-Dec-2008	USAID	DMPA [Depo Provera]	45,600	53,195	Academy for Edu Development
31-Jan-2009	USAID	Levonogestrel 36mg [Jadelle]	400	9,048	Academy for Edu Development
28-Feb-2009	USAID	Condom, Male, 52mm No Logo	3,420,000	147,102	Academy for Edu Development
28-Feb-2009	USAID	Condom, Male, 52mm No Logo	540,000	23,227	Academy for Edu Development
28-Feb-2009	USAID	IUD Copper T Model TCu380A	2,000	1,279	Academy for Edu Development
1-May-2009	USAID	Norgestrel/Ethinyl [Duofem]	556,800	196,774	Academy for Edu Development
30-Jun-2009	USAID	IUD Copper T Model TCu380A	3,000	1,916	Academy for Edu Development
30-Jun-2009	USAID	Levonogestrel 36mg [Jadelle]	400	9,186	Academy for Edu Development
31-Aug-2009	USAID	Condom, Male, 52mm Blue/Gold	4,866,000	209,297	Academy for Edu Development
31-Oct-2009	USAID	Condom, Male, 52mm No Logo	540,000	23,227	Academy for Edu Development
31-Oct-2009	USAID	Condom, Male, 52mm No Logo	3,420,000	147,102	Academy for Edu Development
31-Oct-2009	USAID	DMPA [Depo Provera]	45,600	53,195	Academy for Edu Development
31-Oct-2009	USAID	DMPA [Depo Provera]	192,000	223,978	Academy for Edu Development
31-Dec-2009	USAID	IUD Copper T Model TCu380A	3,000	1,916	Academy for Edu Development
31-Dec-2009	USAID	Levonogestrel 36mg [Jadelle]	500	11,483	Academy for Edu Development
31-Jan-2010	USAID	Condom, Male, 52mm Blue/Gold	3,360,000	144,521	Academy for Edu Development
28-Feb-2010	USAID	Norgestrel/Ethinyl [Duofem]	556,800	196,774	Academy for Edu Development



## Helpful Resources

[“Policy Issues in Finance and Planning: Creating Conditions for Greater Private Sector Participation in FP/RH: Benefits for Contraceptive Security,”](#) a policy brief that presents the challenges and opportunities to consider while generating greater public-private partnerships for ensuring access to RH supplies (Sharma and Dayaratna, 2004).

[“The Family Planning Graduation Experience: Lessons for the Future,”](#) a study that details donor phaseout experiences in Brazil, Colombia, Ecuador, Mexico, Morocco, Tunisia, and Turkey and provides a series of recommendations for countries that will eventually face donor phaseout (Cromer, 2004).

[“Lessons Learned from Phaseout of Donor Support in a National Family Planning Program,”](#) a report that discusses Mexico’s experiences and lessons learned (Alkenbrack and Shepherd, 2005).

Matrix for Donor Phaseout of RH Commodities can be found in [Appendix D](#).

**Box 9.** Intergovernmental Advocacy to Soften Regulations Around Contraceptive Procurement in Mexico Historically, the Mexican Secretariat of Health (SSA) was required by law to procure contraceptives domestically in order to protect and preserve local industry. This mechanism resulted in high prices for contraceptives, which meant that the SSA procured a low amount of contraceptives for its investment. Faced with this challenge, in the late 1990s, the SSA successfully lobbied for a regulatory change that now permits the government to procure in the international market, allowing the potential for significant cost savings as well as assurance of high product quality. The Mexican social security institute (IMSS), however, continues to be bound to procuring its contraceptives locally, which it does at high prices. To date IMSS has yet to advocate for a regulatory change to enable them to procure contraceptives in the international market (Alkenbrack and Shepherd, 2005 ; Sarley et al., 2006).



## E. Scenario 4: Health Sector Decentralization



Many countries are currently undergoing or have recently undergone decentralization of the health sector, whereby decision-making and management functions are shifted to lower levels of government (e.g., states, provinces, and municipalities).

### Background

The goals of this decentralization might be to ensure that health services are more responsive to local needs by encouraging community participation; to improve efficiency and equality of health services; and to increase the equity of health services.

In such cases, the decentralization process does not often make clear how RH commodities are to be financed, procured, or managed. Under centralized management, a budget line item for FP supplies may exist; however, at the decentralized level, budget line items for contraceptives often do not exist.

If the procurement of commodities becomes the responsibility of subnational governments, it can be difficult to achieve competitive commodity prices due to a lack of economies of scale.

Central governments do not always take a stewardship approach to assisting lower levels of government with defining new roles and responsibilities and ensuring transfer of technical skills and resources for the management of and decision-making around health services.

Additionally, limited commitment to or awareness of FP/RH issues may exist at local levels. Thus, the challenge under decentralization is to at least maintain the level of capacity that existed under centralized management; this would require explicitly addressing issues related to policy, planning, finance, procurement, and delivery of contraceptives during the decentralization process ([see "Capacity Building at the Decentralized Level for Contraceptive Security Planning and Implementation in Indonesia"](#)).

Also, central to achieving a reliable supply of family planning (FP) products, and often a key part of decentralization strategies, is the undertaking a multisectoral approach that includes community participation.



Advocacy messages at a decentralized level could focus on

- Explicitly addressing FP commodity financing, procurement, and supply systems in the decentralization process and strategy;
- Developing a strategic approach for decentralized planning and implementation of FP/RH programs; and
- Local capacity building for supply chain management, which is essential to avoiding shortages and stockouts of FP/RH supplies.

In this process, often governments will initiate the task of contraceptive procurement for the first time and need to put appropriate policies in place to facilitate obtaining the best prices available ([see Box 9](#)).

In addition, governments require capacity building assistance in using data and information to forecast and plan for contraceptive purchases and must mobilize all potential sources of financing to purchase the needed contraceptives.



## Helpful Resources

[“The Wonders of One Idea: A Philippines Case Study,”](#) describing the experience of a local government unit in the Philippines with creating a funded line item for contraceptives in the context of phaseout (POLICY Project/Health Policy Initiative, 2007).

[“Policy Issues in Finance and Planning: Strengthening Contraceptive Security in Decentralized Settings,”](#) a policy brief that discusses the challenges and opportunities to consider while addressing FP supply issues in decentralized settings (Alkenbrack, 2006).

[“Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean,”](#) a paper that covers the effects of decentralization and other health reforms on contraceptive logistics functions and how to ensure that these issues are considered (Sánchez, 2006).

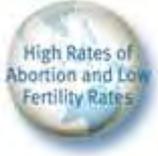
A Matrix for Health Sector Decentralization can be found in [Appendix D](#).

### ***Box 3. Capacity-building at the Decentralized Level for CS Planning and Implementation in Indonesia***

After 30 years of centralized management and implementation, **Indonesia’s** national FP program, BKKBN, was decentralized to over 420 districts and municipalities. BKKBN worked with Sustaining Technical Achievements in Reproductive Health/ Family Planning (STARH) and JSI/DELIVER to produce the Contraceptive Security Toolkit in order to raise awareness about contraceptive security and ensure that contraceptive security stays on the agenda in the context of decentralization. District stakeholders were trained on how to use the tool and in strategic planning. The process also created a mechanism of district-district capacity building and technical assistance. The end result was the development of district-level CS strategies (**Thompson, 2004 unpublished document**).



## F. Scenario 5: High Rates of Abortion, Low Rates of Fertility Background



Among some of the most pressing public health issues are high maternal morbidity and mortality rates due to abortion.

Some countries, within the **Eastern Europe and Eurasia region** in particular, have unusually high abortion rates, often due to high unmet need for modern contraception, which is related to the limited availability of contraceptive commodities.

In these settings, family planning (FP) services may be relatively inaccessible, especially for the poor, causing women to turn to other means to space and limit their births.

The challenge in this environment is increasing political commitment to FP when countries are experiencing declines in population growth.

Policy-makers may be more concerned with how to maintain or increase current fertility rates. However, in cases where unmet need for modern contraceptives is high, demonstrating the link between FP and maternal health is a key aspect to gaining a more favorable policy environment for FP.

Modern contraception has shown to play a significant role in reducing unintended pregnancies and improving birth spacing, which are associated with declining maternal and infant mortality rates. FP/reproductive health (RH) services and commodities must be readily available for women who want to prevent unintended pregnancy.

Expanding women's choice of FP is necessary to improving maternal health and child health.

Hence, advocacy messages should focus on one of the following points:

- Expanding family planning (FP) choice provides women with options to space or limit their births, resulting in improved maternal and child health and reductions in maternal mortality.
- In cases where the private market is flourishing, targeting government subsidies to the poor will help ensure their access to FP commodities and services.
- Where applicable, improvements in maternal and child health will help countries achieve their Millennium Development Goals targets.
- Providing FP is more cost-effective than providing post-abortion care services.



## Helpful Resources

[Mobilizing and Advocating for Targeting in Romania](#): Ensuring that Government-subsidized Contraceptives Reach the Poor, illustrates how advocacy efforts in Romania resulted in free contraceptives for the poor (POLICY Project/Health Policy Initiative, 2007).

A Matrix for High Rates of Abortion, Low Rates of Fertility can be found in [Appendix D](#).



## II. Advocacy Tools for Ensuring Reproductive Health Supplies: Overviews, Templates, Suggestions

As described in [Section II of the How-to Guide](#), there are many different formats and media through which to deliver advocacy messages. Choosing which format to use to support various issues depends on several factors, including the target audience, cost, level of risk, visibility, and time. Some frequently used formats for advocacy include:

- [PowerPoint Presentations](#)
- [Policy Briefs](#)
- [Fact Sheets](#)
- [Talking Points/Briefing Notes](#)
- [Press Releases and Media Alerts](#)

This section provides brief overviews, sample templates, and suggestions for using each of these formats. The templates provided are simply examples.

Coalition partners will find it most effective to tailor and adapt them to their respective contexts, target audiences, and issues. Over time, as the Coalition partners develop country-level materials, it would be helpful to share their tools with other members, accompanied by any lessons learned or suggestions for revisions.

### A. Power Point Presentations Overview

PowerPoint presentations can be a useful tool for communicating with key decision-makers on reproductive health (RH) supplies. As stated throughout this guide, advocacy efforts should be supported by strong evidence and, often, country-specific data is most compelling. For this reason, four PowerPoint templates have been developed to provide realistic and relevant examples to country-level advocates.

Each template illustrates how to tailor an advocacy message based on a specific country, context, “ask,” and target audience.

#### 1. [Systems Strengthening](#)

- Context: a country where family planning (FP) is not a high priority, but attention on maternal health (MH) issues is growing among policy-makers.
- The “ask” or desired outcome: increased resources to strengthen and maintain the supply chain for improved product availability.
- Target audience: Ministry of Health, as a key decision-maker to help achieve the desired outcome.



## 2. Whole-Market Approach (increasing private sector participation)

- Context: a setting where donors are phasing out direct provision of contraceptives.
- The “ask” or desired outcome: an enabling environment for private sector involvement in provision of contraceptives.
- Target audience: Ministry of Health, as a key decision-maker to help achieve the desired outcome.

## 3. Mobilizing Existing Resources

- Context: a country with high HIV prevalence, diverting attention and resources away from family planning (FP).
- The “ask” or desired outcome: Family planning/Reproductive health inclusion into global fund proposals.
- Target audience: the Country Coordinating Mechanism, which is integral to global fund proposal development.

The fourth PowerPoint template, slightly deviates from the above three examples.

Under the USAID-funded POLICY Project and then Task Order 1 of the USAID Health Policy Initiative, 16 country-specific PowerPoint presentations were developed linking family planning to the Millennium Development Goals (MDGs).

These presentations are data-rich and require some experience with quantitative data interpretation. Because these presentations have proven useful in numerous settings, we have adapted one of them to address reproductive health (RH) supplies using a specific context, “ask,” and target audience.

## 4. Addressing Family Planning in National Strategies

- Context: an environment with low contraceptive prevalence rates and high fertility.
- The “ask” or desired outcome: Family Planning/RH inclusion into the poverty reduction strategy paper (PRSP).
- Target audience: PRSP committee, which is key to strategy development.



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## Further resources

In addition to the earlier mentioned templates, the following resources may be helpful for individuals, who would like to generally improve their PowerPoint skills:

For users new to PowerPoint:

- [download.micron.com/pdf/education/workplacewriting/quick\\_reference\\_card.pdf](http://download.micron.com/pdf/education/workplacewriting/quick_reference_card.pdf)
- [academictech.doit.wisc.edu/ORFI/pts/Modules/PTS\\_deliver.htm](http://academictech.doit.wisc.edu/ORFI/pts/Modules/PTS_deliver.htm)
- [www.presentersonline.com/tutorials/powerpoint/](http://www.presentersonline.com/tutorials/powerpoint/)

For presentation and public-speaking skill building:

- [www.presentationhelper.co.uk/Essential\\_Presentation\\_skills.htm](http://www.presentationhelper.co.uk/Essential_Presentation_skills.htm)
- [www.school-for-champions.com/speaking.htm](http://www.school-for-champions.com/speaking.htm)
- [www.cthealthpolicy.org/toolbox/opinion/public\\_speaking.htm](http://www.cthealthpolicy.org/toolbox/opinion/public_speaking.htm)



## B. Policy Brief: Overview\*

For advocacy purposes, policy briefs are generally aimed at high-level policy-makers, who have the power to make decisions. A policy brief outlines a policy issue and the alternative actions and gives the rationale for deciding on a specific policy action for which the Reproductive Health Supplies Coalition is advocating.

Its purpose is to persuade decision-makers that the problem is urgent and there is a critical need to adopt the recommended policy solution, compelling them to act. As such, it is a professional paper rather than an academic one and should be evidence-based, concise, and focused.

The **general structure** of a policy brief is as follows:

- Title of the paper
- Executive summary
- Context and importance of the problem
- Critique of the policy option(s)
- Policy recommendations
- List of supporters of the recommendations
- Appendices and references

### **Title**

The title aims to catch the reader's attention and thus needs to be descriptive, punchy, and relevant.

### **Executive summary**

This short one or two paragraph summary explains the brief's purpose and its recommendations. It should clearly outline the problem, a statement of why the current policy must change, and the Coalition's recommended policy actions.

### **Context and importance of the problem**

This section lays the ground work for your argument and clearly states the problem so as to persuade your audience that the issue is urgent and requires action (e.g., frequent stockouts of reproductive health (RH) supplies at all levels of service delivery result in an increased number of unintended pregnancies, higher levels of maternal and child mortality, and higher rates of abortion).

\* This information was drawn from Young, Eoin and Lisa Quinn. No year. "The Policy Brief." (Retrieved 8/25/06); and Prof. Tsai. 2003. "Guidelines for Writing a Policy Brief." (Retrieved 8/25/06).



Sometimes, the problem is stated as a question that requires a decision (e.g., who should be responsible for ensuring adequate, high-quality Reproductive Health (RH) supplies are available and accessible?). It should then include a brief overview of the main causes of the problem (e.g., the health sector reform strategy does not include RH supplies, and there is no decision-making body responsible for ensuring the availability of RH supplies).

### **Policy options**

This part delineates policy options available to the decision-maker. You may wish to start with what previous or current policy actions, if any, have already been tried to solve the problem. Here you would demonstrate why and how the current (or proposed) policy is not working and emphasize the need and direction for change.

Then it is important to list the possible courses of action, but limit the list to only a few actions so it is focused and not overwhelming. Create bullets of the pros and cons of each course of action for ease of comprehension and priority setting.

### **Policy recommendations**

In this section, the Coalition makes a proposal for a feasible and practical policy solution to the problem. This should include a breakdown of actionable steps or measures to be implemented to achieve the desired policy outcome. You may want to re-emphasize the importance of taking action to close this section.

### **List of supporters**

Including a list of other stakeholders that support the Coalition's recommendations can demonstrate widespread support for your objective.

### **Appendices and references**

Because the policy brief is targeted and concise, you may want to include other supporting documents in appendices. The importance of using evidence to support your argument cannot be overstated, as it grounds your paper in the facts and ensures your recommendations are relevant to the actual situation.

A bibliography is not absolutely necessary but can be put at the end. It may prove more valuable to provide links for further reading to interested policy-makers.



## Templates

In addition to the policy briefs mentioned previously, there are several policy briefs around issues that the Coalition is addressing. They differ from the structure outlined earlier in that they were designed for a global audience not a country-specific audience, and do not include a list of supporters.

If you are designing a policy brief for use in a particular country, you will need to tailor the brief, using relevant data to reflect the existing situation and targeting the specific audience that you want to take action.

### **Policy Aspects of Achieving Contraceptive Security** (Sine and Sharma, 2002)

[www.policyproject.com/pubs/policyissues/PI\\_Eng.pdf](http://www.policyproject.com/pubs/policyissues/PI_Eng.pdf)

[www.policyproject.com/pubs/policyissues/PI\\_Frch.pdf](http://www.policyproject.com/pubs/policyissues/PI_Frch.pdf)

[www.policyproject.com/pubs/policyissues/PI\\_Sph.pdf](http://www.policyproject.com/pubs/policyissues/PI_Sph.pdf)

### **Setting Priorities in Reproductive Health: Lessons Learned** (Butz and Sharma, 2002)

[www.policyproject.com/pubs/policyissues/PI2English.pdf](http://www.policyproject.com/pubs/policyissues/PI2English.pdf)

[www.policyproject.com/pubs/policyissues/PI2French.pdf](http://www.policyproject.com/pubs/policyissues/PI2French.pdf)

[www.policyproject.com/pubs/policyissues/PI2Spanish.pdf](http://www.policyproject.com/pubs/policyissues/PI2Spanish.pdf)

### **Targeting: A Key Element of National Contraceptive Security Planning** (Sine, 2003)

[www.policyproject.com/pubs/policyissues/PF3\\_Eng.pdf](http://www.policyproject.com/pubs/policyissues/PF3_Eng.pdf)

[www.policyproject.com/pubs/policyissues/PF3\\_Fr.pdf](http://www.policyproject.com/pubs/policyissues/PF3_Fr.pdf)

[www.policyproject.com/pubs/policyissues/PF3\\_Sp.pdf](http://www.policyproject.com/pubs/policyissues/PF3_Sp.pdf)



## C. Fact Sheets: Overview

Fact sheets are used for various purposes such as to provide information to journalists, leave with a policy-maker after a face-to-face meeting, or inform the general public.

A good fact sheet conveys in-depth information about a specific topic in a one-to-two page format and breaks down a complicated issue into understandable pieces. Including a few graphs and charts to present supporting data allows for easier comprehension and is visually appealing.

### Examples

The Supply Initiative has developed several excellent fact sheets on relevant issues that can be used by Reproductive Health Supplies Coalition partners for advocacy activities.

- [Why Reproductive Health Supplies Are Crucial to Achieving the Millennium Development Goals](#) (Supply Initiative)
- [Sexual and Reproductive Health Services Undermined by Supply Shortfall](#) (Supply Initiative)
- [Access to Condoms and Contraceptives: Vital for the Prevention of HIV](#) (Supply Initiative)
- [The Importance of the Supply Chain](#) (Supply Initiative)
- [Facilitating Donor Coordination with the RHInterchange](#) (Supply Initiative)

In addition, the POLICY Project, DELIVER, and other partners on the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) activities developed several fact sheets to inform government personnel, civil society, and private sector participants of advocacy trainings, as part of the **Networking for Policy Change: An Advocacy Training Manual, Contraceptive Security Supplement** (POLICY Project/Health Policy Initiative, 2007).

Coalition partners may find the following five fact sheets useful:

- [The RHInterchange Brochure](#);
- [market segmentation analysis](#);
- [private sector involvement](#);
- [target resources](#);
- [procurement of contraceptive commodities](#); and
- [the logistics system](#).

They can be found in the [Information Bank](#) under Tools and Templates.



## D. Talking Points/Briefing Notes: Overview\*

Talking points or briefing notes clearly state the position of the Reproductive Health Supplies Coalition or its partner organizations on a specific issue around reproductive health supplies. The message of this document is: "This is what we think about this issue, and this is what we recommend."

Talking points/briefing notes are written for you or by someone working with you to organize ideas and information to effectively inform your target audience. They are meant to help you or someone who is speaking publicly or writing a letter in support of your advocacy objective.

Talking points are facts and statements that build your argument or make the case for your position. Often talking points provide additional advice to the speaker; for example, how to answer questions or what key points to emphasize. You may want to draft talking points for each Coalition issue and then tailor them for specific target audiences.

Talking points/briefing notes begin with an **introduction of the issue or problem** that needs to be addressed and an explanation of why the Coalition believes it is important. It gives your members or partners the rationale for supporting the Coalition position.

The **main points** are then **listed in bulleted form**, building the argument in a logical sequence of stated facts leading to the Coalition position. The bulleted list may be followed by a **list of potential questions** or **counter arguments** that the target audience could raise and some **prepared answers** for each.

The talking points or briefing notes should conclude with a **few key points to highlight** and/or **specific actions/requests** for the target audience.

\* This chapter is adapted from *International HIV/AIDS Alliance. 2002. Advocacy in Action—A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS. Brighton, UK: International HIV/AIDS Alliance.*



## Templates

Sample talking points addressing issues facing the Coalition working groups are included in the Information Bank. One addresses a need for standard treatment guidelines for a full range of family planning (FP) methods offered in the public sector.

Another addresses [Logistics Management Information System](#) (LMIS) issues. Finally, there are general talking points for the Coalition about the importance of [ensuring RH supplies](#).

Other examples of short messages include

- [private sector participation](#) in the face of donor phaseout,
- [access to contraceptives](#) for HIV positive women,
- [access to FP for poor and rural women](#) in high abortion settings.



## E. Press Releases and Media Advisories: Overview

Communicating through the news media can be an effective way to amplify advocacy messages to target audiences, including members of the public who influence policy-makers critical to achieving change.

Policy-makers are particularly sensitive to mainstream media coverage, which they often view as a window on public opinion of an issue. Generating positive news coverage involves advance planning.

Before beginning any media outreach, you should know the answers to the following questions:

- Which audiences are critical to achieving the change you seek?
- What do they read, listen to, and watch?
- Which messages are essential to convincing that particular audience?
- Who will the audiences be most likely listen to (i.e., who should be your spokespeople and messengers)?
- When will these messages make the most critical impact?
- Are there upcoming, ready-made news opportunities that you can tie your outreach to, including pending legislation, milestones, and commemorations?

Your media outreach will most likely include basic, written materials to communicate your news to reporters and editors:

- A **media advisory** is a one-page announcement of an event, such as a news conference or report launch, to generate media attendance.
- A **press release** announces breaking news and is written like a news story but is never longer than two pages.

**Media advisories** should be no more than one page and include only the basic information: what is the event, who is speaking, when is it, where is it being held, and contact information for more details.

Include information about event visuals if you are targeting photo editors and/or broadcast media.



Basic tips for writing **press releases** include:

### **Write it like a media story.**

- Include all facts necessary for a reporter to write the story in an objective, journalistic style. News stories are traditionally written in the “inverted pyramid” format: the first paragraph includes all the basic facts (who, what, when, why, how), successive paragraphs add additional details including supporting facts and expert quotes, and the final paragraph wraps up the story.

### **Keep it compelling.**

- Include a headline that summarizes the main message in a few words that grab the reporter’s attention. Do not just use facts and figures to convey your story, but “put a face” on the issue through personal stories. Do not use jargon and abbreviations that are not understandable to non-specialists. Use active, not passive, voice.

### **Make it newsworthy.**

- Different news media judge whether something is newsworthy based on varying standards and local practices. However, in general, editors tend to judge something as more newsworthy if an item is timely, has an impact on a lot of people (or prominent people), has a direct impact on the community where the media is based, involves some sort of conflict, is an unexpected outcome, or is related to a topic that is already in the news (has currency).

### **Keep it brief.**

- Most media outlets get hundreds of press releases each day, many of which are never read. Keep the release to one or two pages. Use short paragraphs that are only one or two sentences.

### **Include the basics.**

- Make sure that the release is on letterhead that has the name, Web site, and mailing address of the Reproductive Health Supplies Coalition or member organization. Include the release date and a media contact name, phone number, and e-mail address, someone who will return phone calls quickly and is available after hours. State ‘-more-’ at the bottom of each page, except for the last page where you put a #### sign.
- At the end of the press release, include a sentence or short paragraph that summarizes the mission of the Coalition.



Keep in mind that a press release is only one tool among others that are necessary to generate media interest.

A single press release rarely results in news coverage; it must be followed up by phone calls to reporters to “pitch” the story and provide more information.

Finally, good media coverage is a prized commodity that is built on developing relationships with reporters.

Generating coverage depends on targeting the right reporters who are assigned to cover your issue with regular one-on-one phone calls, briefings, and written materials; organizing special media events and press conferences that can be used to generate news; and inserting your issues into breaking news through letters to the editor and opinion pieces that allow you to communicate your messages directly to target audiences.

Be prepared to respond to “backlash” in the media if coverage of your issue includes misinformation and/or misleading, opposing views.

## Templates

The media examples in the [Information Bank](#) include a fictitious [press release](#) from the International Planned Parenthood Federation (IPPF) Africa Region.

This type of press release would be used to demonstrate high-level support for your advocacy issue and to “create a buzz” around the issue and generate wide-spread public interest. It can also be used as evidence of support with other target audiences to persuade them to join your cause and take action.

There is also a fictitious [sample media advisory](#) from Ethiopia, which would be used to demonstrate the support of leaders for the Coalition’s goals.

For more information about working with the media around contraceptive security, consult the following report: “[Media Advocacy for Contraceptive Security](#): Key Findings from an Asia Regional Workshop.” (Bowman, 2004)



## Appendix A: Most Useful Questions in Identifying CS or RH Commodity Supply Issues

### An Abbreviated SPARHCS Assessment Guide

Assessing contraceptive security is a complicated undertaking. It requires asking questions about the population using or not using family planning (FP) methods, sources, and providers of contraceptive services and supplies, supply systems, coordination, the policy environment, leadership, and the broad socioeconomic and cultural context.

The SPARHCS approach includes a diagnostic guide organized along contraceptive security (CS) components that assists country stakeholders in assessing the current situation, identifying CS challenges, and defining priorities.

Contraceptive security committees and networks can use the information collected for the assessment to (1) create a comprehensive CS strategy to guide program development, financing, and implementation; and (2) select a critical issue and design an advocacy campaign around it.

A team of international and national experts or a team of local experts may undertake a SPARHCS assessment. In either case, the assessment requires the collection and analysis of information obtained from some or all of the following resources.

- Existing studies and reports such as Demographic and Health Surveys, Centers for Disease Control surveys, MOH reports and documents, FP studies, legal and regulatory analyses of the FP environment, the latest census, country projections of FP users (e.g., from POLICY's FamPlan Model), contraceptive procurement tables, past and current data on contraceptive supplies from the [RHI](#) and other country or international information.
- Key informant interviews, focus group discussions, and field visits to supply chain points and service delivery sites.
- A participatory CS issues workshop to identify and analyze CS issues, with participants representing key stakeholder groups (public sector; NGOs; commercial sector; social marketing groups; and civil society groups representing women, the poor, and young people).



Advocates and Contraceptive Security (CS) committees can use other, less structured ways to understand or continuously monitor the policy environment for contraceptive security at the national or local level.

They can find out whether high-level government officials attended the International Conference on Population and Development (ICPD) or related international forums and if they delivered country statements during such events.

They can examine the public statements or speeches of current government officials to determine their stand on modern contraception or contraceptive security. They can also look at the country's or specific area's media coverage of contraceptive security to develop a sense of the media's ability to report accurately on the issues and generate public support for contraceptive security.

It may be useful for network or CS committee members to brainstorm on the availability of information sources as they start analyzing CS.

However the assessment was conducted, a stakeholder forum should be held to present and validate the findings of the CS assessment, particularly if a participatory assessment workshop was not held earlier.

A forum is also important for reaching consensus on the main advocacy issues and for soliciting recommendations for action from ministries, service providers, suppliers, NGOs, and other interested parties.

Even more important, as a participatory process for gaining consensus on the main CS issues and possible policy and program responses, a forum is a crucial step in building broad ownership of and commitment to contraceptive security, especially in countries where family planning is not a priority or continues to be a controversial issue.

## Client Use and Demand

- What are the current and past contraceptive prevalence rates and total fertility rates? Which population groups have the lowest contraceptive prevalence rates? Which groups have the highest fertility rates (e.g., by urban or rural area and region, by level of educational attainment, by income level, and so forth)?
- What are the current and past method mixes? What are the preferred contraceptive methods? Is method use concentrated on short-term methods that require frequent resupply or on long-term and permanent methods?
- What are the current and past contraceptive method sources (public sector, NGO, social marketing, or private provider)?
- What are the current and past levels of unmet need for spacing and for limiting births? Which population groups have high unmet need (e.g., by urban or rural



area and region, by level of educational attainment, by income level, and so forth)? What are the reasons for unmet need (e.g., economic or geographic barriers, religious or ethnic norms, provider skills or biases, fear of side effects, spouse's objections, and so forth)?

- What are the current and past discontinuation rates for specific methods? Why do clients discontinue specific methods (e.g., economic or geographic barriers, stockouts, provider skills or biases, spouse's objections, inability to obtain preferred method, desire to become pregnant, and so forth)?
- What are the projections of total fertility rate, contraceptive prevalence rate, method mix, and levels of unmet need that will be met?

## Service Provider Channels

The following information should be collected from all sectors and sources of services (government, NGO, commercial sector, and social marketing).

- Availability and adequacy of FP commodities and services at all service delivery points.
- Adequacy of providers and their existing knowledge, skills, and attitudes.
- Method choices available at all service delivery points.
- Types of clients (by age, income level, rural or urban location, method choice, and so forth) served by each sector.
- Demand generation: what demand generation efforts does each sector undertake? To which sectors of the population are demand generation efforts addressed? How will demand generation efforts affect future demand for contraceptives and the public and private sector mix?
- Access issues: do all clients who need contraceptives have access to them? What are the barriers to access (e.g., limited method choice, lack of providers, limited FP clinic hours, waiting times, and referral system)? In which service delivery points? In which part of the country?
- What types of clients receive subsidized, free, or donated contraceptives? The nonpoor? Can those who can afford to pay be shifted to the commercial sector? Why?
- How is the contraceptive market divided among sectors and providers (MOH, social security or insurance, pharmacies, NGOs, and other private entities)? Has the market changed over the past 5–10 years? If changes have been dramatic, what are the possible causes?



## Finance and Resources

- Does the government budget include a line item for contraceptive procurement? If so, has the government released the funds and used them to procure contraceptives? How much did the government allocate to the line item in the past 3–5 years?
- What is the current distribution of funding from the government, social security or insurance, NGOs, donors, and households? Which funding sources are likely to increase and which are likely to decrease?
- What are the future resources or financial requirements for contraceptives for government, NGOs, and donors (use projections up to 10 years)?
- Are contraceptive supplies highly dependent on donors? Is the situation likely to change? Do social marketing groups, NGOs, and others depend on government or donor subsidies?
- How adequate is current funding? Is there a funding gap? Is funding expected to increase?
- What cost-recovery systems are in place for the public sector, social marketing programs, NGOs, and the commercial sector? Do policies restrict or regulate fee for service (levels or exemptions)?
- Which contraceptives are locally manufactured?

### For the **commercial sector**

- What is the percentage of total revenue from contraceptive commodities? What are local manufacturers' plans for expanding their production capacity or distribution base? Does the commercial sector demonstrate the willingness and potential to expand its share of the contraceptive market?

### For **NGOs and social marketing programs**

- What is the percentage of total revenue from contraceptive commodities? Do NGOs and social marketing programs plan to expand their FP programs?
- What third-party or health insurance schemes cover family planning? What is the coverage for contraceptive services and commodities? Who are the beneficiaries (employees, families of the employed, the poor, and so forth)?

### For the **government sector**

- Do regulations affect the government budget process (in terms of determining annual funding levels and allocation, degree of flexibility, and required financial management)? Has the government set forth financial management policies (guidelines on retention of fees, management of funds, and local procurement)?



## Forecasting, Procurement, Logistics and Distribution Systems

- Are contraceptive needs forecasted 2–5 years in advance? Are forecasted data used for resource mobilization? For procurement? Which organizations are involved?

### Government procurement

- What percentage of the total contraceptive need does the government procure? Does it rely on donors, grants, loans, or its own funds? Who is responsible for procurement? Is the procurement staff adequately trained? What are the procurement procedures (e.g., international tenders, evaluation of bids, product quality evaluation, supplier background and performance, and lead time to prevent stockouts)? Is the procurement process transparent?
- Were appropriate products procured to address forecasted needs and to ensure quality? Has the government promulgated regulations on client records, referral systems, clients' rights, and so forth?

In any of the programs (government, NGO, social marketing, and commercial)

- are contraceptive products in full supply, or does rationing occur?
- Have stockouts occurred within the last year?
- Have significant amounts of products expired in any program within the last year?
- Which products of which program? Where (warehouse or clinic)? Why?
- What procedures are in place to ensure a high-quality product?



## Policies, Commitment, Coordination and Leadership

Regarding Population and Family Planning Policies:

- What are the government's official population and Family Planning (FP) policies? Overall, do the policies support contraceptive security?
- Do adequate programs and funding support the official population and FP policies?
- Does the government implement the policies or programs?
- Who is responsible for implementing and monitoring population and FP policies?
- Do national leaders support population and FP policies? Does support fluctuate with changes in government? Do current leaders support or oppose the use of government funds for contraceptive security? Who are the government leaders who champion contraceptive security?
- What is the country coordinating mechanism? What stakeholder groups are represented?
- What policies or regulations affect private sector involvement in furthering contraceptive security (e.g., import duties and VATs on contraceptives, provider or product registration and licensing requirements, and limitations on advertisements)? Who are the champions of private sector involvement, and who among them represent the private sector?
- Do policies or practices limit contraceptive access or choice? What operational policies, service delivery guidelines, protocols, norms, and standards pose barriers to accessing contraceptives? For example, only licensed Ob-Gyns may prescribe hormonal contraceptives, or women are required to submit spouse consent forms as a condition of tubal ligation.
- Is it possible to eliminate specific operational barriers? If so, how?
- Have civil society groups mobilized in support of contraceptive security? Do they have the capacity to advocate for contraceptive security? Do civil society organizations involved in advocating for contraceptive security represent all segments of society, especially the poor or disenfranchised?



## Regarding HIV/AIDS

- What is the country's HIV/AIDS policy? Is it linked to the country's population and FP/RH policies?
- Does the HIV/AIDS policy explicitly mention the need to secure adequate supplies of condoms or other commodities?
- Do programs and funding adequately support the HIV/AIDS policy and/or program? Has the government implemented the policy and/or program?
- Do national leaders support the HIV/AIDS policy or program? Do they agree that supporting contraceptive security, especially condom security, can help prevent the spread of HIV?
- Who is responsible for the HIV/AIDS policy? What is the nature of the country coordinating mechanism? What stakeholder groups are represented? Are people living with HIV or AIDS represented?
- Do regulations affect the budget (in terms of a process for determining annual funding levels and allocation, degree of flexibility, and required financial management)?
- Do policies restrict or regulate fee for service (levels or exemptions)?
- Has the government set forth financial management policies (guidelines on retention of fees, management of funds, and local procurement)?

## Context and Environment

- What is the country's incidence of HIV?
- What is the impact of health sector reform (decentralization, integration, financing, private sector involvement) on the country's contraceptive security? Do funding decisions take place at the central or local level? How does the locus of decision-making affect contraceptive funding?
- What is the country's current economic status? What is its per capita income? What percent of the population is poor? Does the government's poverty-reduction strategy address reproductive health and contraceptive security?
- What socioeconomic and cultural factors (education, literacy, religious affiliation, and so forth) affect contraceptive security?
- What are the country's public health priorities? Where does family planning rank as a priority? Does contraceptive security compete for attention and resources with other health challenges (e.g., HIV/AIDS, tuberculosis, malaria, and infant mortality)?



## Appendix B. Designing an Advocacy Strategy

**Define the issue.** Advocacy begins with an issue or problem that requires a policy change.

**Set goal and objectives.** A goal is a general statement of what advocates hope to achieve in the long term (3–5 years). The advocacy objectives describe short-term, specific, measurable achievements that contribute to the advocacy goal. Advocacy objectives should ideally include the following components: policy actor, policy solution, and timeframe/degree of change.

**Identify target audience.** The primary target audience includes the decision-makers who have the authority to bring about the desired policy change. The secondary target audience includes persons who have access to and are able to influence the primary audience. Advocates must identify individuals in the target audience, their positions, and relative power base and then determine whether the various individuals support, oppose, or are neutral to the advocacy issue.

**Build support.** Building a constituency to support the advocacy issue is critical for success. The larger the support base, the greater are the chances of success. Advocates must reach out to create alliances with other NGOs, networks, donors, coalitions, civic groups, professional associations, women's groups, activists, and individuals who support the issue and will work with you to achieve your advocacy goals.

**Develop the message.** Advocacy messages are developed and tailored to specific target audiences in order to frame the issue and persuade the receiver to support the position. There are three important questions to answer when preparing advocacy messages: Who are you trying to reach with the message? What do you want to achieve with the message? What do you want the recipient of the message to do as a result of the message (the action you want taken)?

**Select channels of communication.** Selection of the most appropriate medium for advocacy messages depends on the target audience. The choice of medium varies for reaching the general public, influencing decision-makers, educating the media, generating support for the issue among like-minded organizations/ networks, and so forth. Some of the more common channels of communication for advocacy initiatives include press kits and press releases, press conferences, fact sheets, a public debate, a conference for policy-makers, and so forth.

**Raise funds.** Resources help support the development and dissemination of materials, cover travel to meet with decision-makers and generate support, underwrite meetings or seminars, absorb communication expenses, and so forth. Advocates should develop a fundraising strategy at the outset of the campaign to identify potential contributors of financial and other resources.



**Draft implementation plan.** Advocates should draft an implementation plan to guide its advocacy campaign. The plan should identify activities and tasks, responsible persons/committees, the desired timeframe, and needed resources.

## On-going Activities

**Collect data.** Data collection supports many of the stages of the advocacy process. Advocates should collect and analyze data to identify and select their issue as well as develop advocacy objectives, craft messages, expand their base of support, and influence policy-makers. Data collection is an ongoing activity for the duration of the advocacy campaign.

**Monitor and evaluate.** As with data collection, monitoring and evaluation occur throughout the advocacy process. Before undertaking the advocacy campaign, advocates must determine how it will monitor its implementation plan. In addition, the group should decide how it will evaluate or measure progress and results. In specific terms, what will be different following the completion of the advocacy campaign? How will the group know that the situation has changed?



## Appendix C.

### Worksheet for Identifying Priority Policy Solutions

							Priority ranking
	(Strong, medium, low)	(Identify persons and describe)	(Short, medium, or long)	(Financial or human)	(Existing policy, policy presumed to exist, slow implementation, client demand, procedures)	(Difficult, medium, or easy)	(High, medium, or low)



## Appendix D. Matrices for Different Contexts

### Context: High Unmet Need (General)

The “Ask”	Create and fund budget line item	Form FP/RH committee	Include RH supplies in the Essential Drug List (EDL)	Include FP/RH into PRSPs and SWAp	Develop and fund strategic plan for RH supplies	Create an enabling environment for greater private sector participation	Strengthen and maintain the logistics system for RH supplies
<b>Key Target Audiences</b>	MOF, MOH, donors	MOH, MOF, MOY, MOP, NGOs, FBOs, commercial sector, pharmaceutical companies, civil society, donors	MOH, MOF	MOH, MOF, MOP, donors, MDG committees, PRSP and SWAp committees	FP/RH Committee, MOF	MOH, MOF, MOP, Ministry of Commerce, NGOs, commercial sector, pharmaceutical companies, health provider groups, and media	MOH, MOP, MOF
<b>Evidence-based Arguments</b>	<ul style="list-style-type: none"> <li>• Low CPR and high unmet need for FP</li> <li>• High level of inequality in FP use and demographic and health status between poor and wealthiest (<i>Quintile</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Cross-cutting issue requires a multisectoral approach</li> <li>• Enables strategic approaches to RH supplies issues</li> <li>• Provides a forum to communicate</li> </ul>	<ul style="list-style-type: none"> <li>• Contraceptives are a public health good</li> <li>• Elimination of tax/duty ensures availability of affordable contraceptives</li> <li>• RH is a cost-effective intervention</li> </ul>	<ul style="list-style-type: none"> <li>• Investment in FP/RH contributes to poverty reduction (<i>Gwatkin, <a href="http://www.worldbank.org">www.worldbank.org</a> and RAPID Model application</i>)</li> <li>• Investment in FP/RH</li> </ul>	<ul style="list-style-type: none"> <li>• Need multisectoral and strategic approach to address RH issues and concerns</li> <li>• Fosters communication and improves coordination among donors, ministries, and other sectors</li> </ul>	<ul style="list-style-type: none"> <li>• Private sector already playing an important role, especially in urban areas</li> <li>• Government resources are not enough to serve everyone</li> <li>• Government plays an important role</li> </ul>	<ul style="list-style-type: none"> <li>• Regular maintenance and reporting are needed to respond to changing environment</li> <li>• Builds capacity to accurately report, monitor and finance the supply chain</li> </ul>



	<p><i>analysis)</i></p> <ul style="list-style-type: none"> <li>• High level of donor dependence</li> <li>• Increasing resource gap (with demand increasing, still high population growth, while resources are limited)</li> <li>• Benefits of investing in RH supplies (<i>Egypt FP cost benefit analysis</i>)</li> <li>• Consequences of stockouts/shortages of RH supplies</li> <li>• Government's role in meeting growing needs for FP</li> <li>• No provision of line item or committed funds for FP in the government budget</li> </ul>	<p>and coordinate at national and subnational levels</p> <ul style="list-style-type: none"> <li>• Members can serve as strategic policy champions to keep commitment to FP/RH supplies high on policy agenda</li> <li>• Provides opportunity for the commercial and NGO sectors to participate in policy dialogue and planning</li> <li>• Will generate awareness regarding FP issues and concerns at different levels</li> <li>• Provides a forum for continued monitoring of FP/RH access and quality of services</li> </ul>	<ul style="list-style-type: none"> <li>• EDL should take into account cost-effectiveness of different interventions and supplies</li> <li>• Inclusion of RH in the EDL will improve availability of RH supplies at primary healthcare centers</li> <li>• Ensures availability of highly subsidized or free RH supplies</li> <li>• Benefits of investing in RH supplies are far reaching</li> </ul>	<p>contributes to most of the MDGs (<i>MDG and unmet need analysis</i>)</p> <ul style="list-style-type: none"> <li>• There are significant health gains and cost savings from investing in FP (<i>Egypt FP cost benefit analysis</i>)</li> <li>• Provides larger number of cost-effective interventions and helps with resource allocation decisions</li> <li>• Puts FP in the broader context of healthcare and development</li> <li>• Promotes an integrated approach to address health and development issues</li> </ul>	<ul style="list-style-type: none"> <li>• Helps identify clear goals and develop strategies and action plans</li> <li>• Facilitates the process of estimating the financial resources required to ensure effective implementation</li> <li>• Helps identify potential sources of funding and funding gaps</li> <li>• Identifies appropriate roles for various stakeholders and sectors</li> <li>• Ensures commitment of different stakeholders involved in the planning process</li> <li>• Provides opportunity to incorporate regular monitoring and evaluation to ensure improved planning and implementation</li> </ul>	<p>in creating an enabling environment for greater private sector participation (reducing policy, legal and operational barriers)</p> <ul style="list-style-type: none"> <li>• Government can also create incentives for greater participation of the commercial and NGO sectors</li> <li>• By targeting resources to serve the RH needs of the poor, the government can create opportunity for the private sector to serve those who can afford to pay</li> </ul>	<p>system (<i>share country examples of consequences of inadequate capacity building</i>)</p> <ul style="list-style-type: none"> <li>• People who cannot afford to pay private sector prices suffer the most if stockouts occur in government facilities (<i>Share country examples where poor women started using traditional methods due to frequent stockouts</i>)</li> <li>• Availability of supplies is essential to providing good RH services</li> </ul>
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## Context: High HIV Prevalence Settings

The “Ask”	Mobilize political support for FP	Integrate FP into agenda of HIV/AIDS Coordinating Committee	Include FP/RH into PRSPs, SWAp, and Emergency Plans	Develop a joint strategic plan for RH and HIV/AIDS supplies	Create an enabling environment for greater private sector participation	Remove operational barriers to providing appropriate counseling and methods to HIV-positive women	Integrate delivery of FP and HIV/AIDS supplies and services
<b>Key Target Audiences</b>	Parliamentarians, MOH, MOF, MOP, FBOs, HIV/AIDS Coordinating Committee, PLHIV community, PEPFAR and GFATM implementers in the country, NGOs, civil society groups, media	HIV/AIDS Coordinating Committee, MOH, MOF, MOP, FBOs, PEPFAR and GFATM implementers in the country, NGOs, donors, commercial sector	HIV/AIDS committees, MOH, MOF, donors, PEPFAR and GFATM implementers in the country, PRSP and SWAp committees	MOH, MOF, MOP, HIV/AIDS committees or any relevant sub-groups, donors, NGOs	MOH, MOF, MOP, Ministry of Commerce, NGOs, commercial sector, FBOs, public and private provider associations, media	MOH, MOP, MOF, FBOs, HIV/AIDS Coordinating Committee, FBOs NGOs, media, public and private provider associations	MOH FP and HIV departments, donors, service providers
<b>Evidence-based Arguments</b>	<ul style="list-style-type: none"> <li>Declining financial resources for FP (<i>FP vs. HIV/AIDS funding trend analysis</i>)</li> <li>High unmet</li> </ul>	<ul style="list-style-type: none"> <li>Cross-cutting issue requires multisectoral response</li> <li>Supply chains are integrated, yet programming and funding are</li> </ul>	<ul style="list-style-type: none"> <li>Investment in FP/RH contributes to poverty reduction (<i>Gwatkin, www.worldbank</i>)</li> </ul>	<ul style="list-style-type: none"> <li>Supplies for FP and HIV prevention are often the same—coordination of efforts can lead to economies</li> </ul>	<ul style="list-style-type: none"> <li>HIV/AIDS NGOs can play an important role in FP and vice versa</li> <li>Given the</li> </ul>	<ul style="list-style-type: none"> <li>Adequate and readily available supplies of a full range of methods increase choice and</li> </ul>	<ul style="list-style-type: none"> <li>Access to female controlled FP methods increases women’s ability to protect themselves from HIV</li> <li>Provision of FP information and</li> </ul>



	<p>need for FP</p> <ul style="list-style-type: none"> <li>• Women and men of reproductive age are the key target group for HIV prevention and FP services</li> <li>• Investment in FP/RH contributes to national HIV/AIDS targets</li> <li>• Preventive services (especially FP) are more cost effective than curative interventions</li> <li>• Investment in FP/RH contributes to the MDGs (<i>see series of country MDG briefs</i>)</li> </ul>	<p>often vertical</p> <ul style="list-style-type: none"> <li>• FP is an essential component of HIV prevention, and vice versa</li> <li>• Coordinated funding and oversight are required to ensure effective implementation</li> <li>• Identifying appropriate roles for various stakeholders and sectors can streamline planning and improve access, especially for HIV prevention</li> <li>• Building on existing experience of FP/RH systems rather than maintaining vertical approaches reduces duplication of efforts</li> </ul>	<p>org)</p> <ul style="list-style-type: none"> <li>• Investment in FP/RH contributes to the achievement of the MDGs (<i>see series of country MDG briefs</i>)</li> <li>• Investment in FP/RH contributes to HIV prevention, including PMTCT</li> <li>• Preventive services (i.e., FP) are more cost-effective than curative interventions</li> </ul>	<p>of scale and increased efficiency</p> <ul style="list-style-type: none"> <li>• Integrated planning can avoid over/under projection of commodity needs</li> <li>• Planning should consider comprehensive needs such as condoms for dual protection (HIV and FP)</li> <li>• Joint planning process can lead to better coordination during implementation</li> <li>• Joint planning provides opportunity to jointly monitor and evaluate FP and HIV/AIDS programs and improves implementation</li> </ul>	<p>overextended public sector, a supportive policy environment is needed for greater private sector participation in meeting FP needs</p> <ul style="list-style-type: none"> <li>• Social marketing of contraceptives in non-clinic based settings can minimize stigma-related barriers to access for a broad range of clients, including youth and PLHIV</li> </ul>	<p>access for women</p> <ul style="list-style-type: none"> <li>• Providers need clear guidance in order to expand their ability to provide appropriate counseling and methods to meet FP/RH needs of HIV-positive women</li> <li>• Effective counseling and training curricula that include comprehensive information on contraceptive eligibility criteria and preferred methods in the context of HIV and ARVs are needed to improve quality of care in FP/RH and HIV</li> </ul>	<p>services in HIV/AIDS service contexts supports PMTCT efforts</p> <ul style="list-style-type: none"> <li>• Integrated health services help both FP/RH and HIV/AIDS programs to achieve their goals</li> <li>• Integration of FP and HIV services increases cost-effectiveness of the system</li> <li>• Integration of services reduces stigma related to service delivery sites</li> <li>• Comprehensive services for the same target groups of reproductive age</li> <li>• Helps leverage existing infrastructure and systems; particularly when one system is strong, the other benefits greatly from integration</li> </ul>
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## Appendix D. Context: Donor Phase-out

The “Ask”	MOH funding for RH supplies mobilized	Multisectoral committee for RH supplies formed and meets consistently	-	FP/RH included in health and development agendas	Funded strategic plan for RH supplies drafted	Enabling environment for greater private sector participation created	Sustainable logistics management and information system for RH supplies established
<b>Key Target Audiences</b>	MOF, MOH, Budget Department	MOH, MOF, MOY, MOP, NGOs, commercial sector, donors	MOH, MOP, MOF, Ministry of Rural Development, donors	MOH, MOF, donors, health sector reform, PRSP, and MDG committees	Prime Minister, MOH, MOF, MOP	MOH, MOP, MOF, regulatory bodies, NGOs, commercial sector	MOH, MOP, MOF, Logistics Unit
<b>Evidence-based Arguments</b>	<ul style="list-style-type: none"> <li>• Current extent of donor dependency</li> <li>• Consequences of donor phaseout (over time)</li> <li>• Increasing resource gap (with demand increase and pop growth and declining resources)</li> <li>• Poor are underserved (<i>quintile analysis</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Phaseout will require systematic planning and consideration of multiple factors (<i>show current systems and processes, highlighting need for coordination</i>)</li> <li>• Cross-cutting issue requires multisectoral approach and coordination (<i>show graphically</i>)</li> <li>• Preparation for phaseout transition necessary, i.e., coordination of</li> </ul>	<ul style="list-style-type: none"> <li>• Level of poverty (<i>% below poverty line</i>)</li> <li>• Lower CPR/higher unmet need among the poor vs. other segments (<i>Quintile analysis of DHS data</i>)</li> <li>• Public sector resources are limited and declining</li> <li>• Substantial share of public sector subsidies go to the nonpoor (<i>public sector</i>)</li> </ul>	<ul style="list-style-type: none"> <li>• Increased access to FP/RH improves MCH and health outcomes (<i>MDG and unmet need analysis</i>)</li> <li>• Investment in FP/RH contributes to the MDGs (<i>sub-Saharan Africa MDG and unmet need analysis</i>)</li> <li>• Investment in FP/RH contributes to</li> </ul>	<p>(Preface with the arguments for mobilizing funds)</p> <ul style="list-style-type: none"> <li>• Need strategic approach for donor phaseout (<i>show Jordan and Egypt strategic plans</i>)</li> <li>• Need to phase in other funding as donor funds are phased out</li> </ul>	<ul style="list-style-type: none"> <li>• Private sector already playing an important role</li> <li>• Government cannot serve all with limited resources as donors phase out support</li> <li>• Private sector can help respond to growing market demand and expand consumer choices (<i>show El Salvador public private sector plan</i>)</li> <li>• Redirecting wealthier clients to the private sector</li> </ul>	<ul style="list-style-type: none"> <li>• Heavy reliance on donor financial and technical support for logistics and procurement (<i>show donor roles vs. government roles</i>)</li> <li>• Government must plan to assume full responsibility for government procurement and logistics systems</li> <li>• Lack of appropriate pre-phaseout training</li> </ul>



	<ul style="list-style-type: none"> <li>• Benefits of investing in RH supplies (<i>Egypt FP cost benefit analysis</i>)</li> <li>• Ensure continuity of services</li> <li>• Timing of orders vs. actual need (demonstrates that not just amount of funding but also timing of availability is critical)</li> </ul>	<p>training for procurement and financial management; communicating clear messages about phaseout (<i>show consequences</i>)</p> <ul style="list-style-type: none"> <li>• Members can serve as strategic policy champions to keep commitment to FP/RH supplies high on national agenda (<i>evidence from other countries, i.e., Egypt, Jordan, Madagascar</i>)</li> <li>• Fosters communication and open dialogue among partners</li> <li>• Provides stability in time of uncertainty and change</li> </ul>	<p><i>client profile information from market segmentation analysis</i></p> <ul style="list-style-type: none"> <li>• Private sector prices are too high for poor</li> <li>• Poor, rural areas often expensive to reach and neglected when donors phase out support (<i>Peru, Bangladesh example—show rural urban data by quintile</i>)</li> <li>• Failure to serve the poor has consequences on health outcomes (<i>show inequality in maternal health, IMR, TFR; poor vs. rich</i>)</li> </ul> <p>Target efforts to improve access among the poor have succeeded in other countries (e.g., Guatemala, Kenya, Egypt)</p>	<p>poverty reduction (<i>Gwatkin, www.worldbank.org</i>)</p> <ul style="list-style-type: none"> <li>• Cost benefit of investing in family planning</li> <li>• Coordination is key in a context of donor phaseout—including FP/RH in broader health and development agendas reduces duplication of efforts and confusion; promotes efficiency</li> </ul>	<ul style="list-style-type: none"> <li>• Planning fosters donor coordination during and after phaseout and avoids overstocks (<i>Romania example</i>)</li> <li>• Funding is required to ensure effective implementation of strategic plan (<i>show Jordan MOU between USAID and MOH</i>)</li> <li>• Strategic plan identifies and coordinates appropriate roles for various stakeholders and sectors</li> </ul>	<p>will free up scarce donor and public resources for those who cannot afford to pay (<i>quintile analysis</i>)</p> <ul style="list-style-type: none"> <li>• All sectors need to collaborate to fill the resource gap created by phaseout</li> <li>• Private sector has been successful at reaching the poor (<i>Bangladesh NGOs in rural areas</i>)</li> <li>• Government can create an enabling policy environment for greater private sector participation through reducing legal/regulatory barriers; creating incentives, involving the private sector in planning</li> </ul>	<p>leads to stockouts of RH supplies</p> <ul style="list-style-type: none"> <li>• Need to plan for future LMIS maintenance and updates</li> <li>• Build capacity to accurately report, monitor, and finance the supply chain system (<i>share country example of consequences of inadequate capacity building</i>)</li> <li>• Transition to independent procurement is a challenging aspect of phaseout (<i>LAC region</i>)</li> </ul>
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## Appendix D. Context: Decentralization

The “Ask”	Create a budget line item for FP/RH in subnational budgets	Form FP/RH committees at subnational levels	Develop targeting strategies	Include FP/RH into health sector reform		Increase and coordinate NGO and commercial sector involvement in service delivery	Maintain centralized logistics system for RH supplies
<b>Key Target Audiences</b>	National government (MOH and MOF), subnational government, local health and finance departments, local media	Local representatives from ministries of health, finance, women’s affairs, education, youth, planning, and religion; private providers; NGOs; FBOs; community organizations; parastatals, (e.g., Central Medical Stores)	National government (MOH and MOF), local representatives from ministries of health, finance, women’s affairs, education, youth, planning, and religion; private providers; NGOs; FBOs; community organizations; parastatals, (e.g., Central Medical Stores)	National government (MOH, MOF, and others), subnational government, donors, civil society leaders	FP/RH Subnational Committee, private corporations, multinational companies, and chambers of commerce	MOH, MOP, MOF, NGOs, FBOs, commercial providers, donors	MOH, subnational government, parastatals if relevant, donors



<p><b>Evidence-based Arguments</b></p>	<ul style="list-style-type: none"> <li>• FP/RH is a priority in the region or district</li> <li>• Decentralization on law/policy allows local decisionmakers to decide budget line items and oversight on allocations</li> <li>• Dedicated FP/RH line-item helps local governments improve access to FP/RH services and improve health</li> <li>• Facilitates the process of estimating resource needs and appropriate allocation of resources</li> </ul>	<ul style="list-style-type: none"> <li>• Encourages participation of community leaders, grassroots representatives, and local government implementers from different ministries</li> <li>• Fosters effective coordination to avoid duplication of efforts and promotes efficiency</li> <li>• Helps ensure sustained commitment to RH supplies despite political changes</li> <li>• Establishes effective working relationships among stakeholders</li> <li>• Can foster and</li> </ul>	<ul style="list-style-type: none"> <li>• High-level inequality in health services and outcomes between the poor and wealthiest</li> <li>• High unmet need and use of traditional methods among the poor</li> <li>• High abortion rates among the poor in the region</li> <li>• Limited local government funds means focusing resources on low-income areas or the most in need</li> <li>• Significant regional disparities in resources and wealth</li> <li>• Can effectively target subsidies directly to the</li> </ul>	<ul style="list-style-type: none"> <li>• Keeps FP high on the HSR agenda</li> <li>• Coordination through HSR initiatives avoids duplication of efforts and confusion among implementers</li> <li>• Forecasting and procurement requires training at all levels</li> <li>• Stakeholders at all levels need to understand legal and regulatory requirements of shifting responsibilities to decentralized levels</li> </ul>	<ul style="list-style-type: none"> <li>• Increases access to FP/RH, especially where health insurance does not exist</li> <li>• Increases demand for FP/RH</li> <li>• Decreases burden on public sector to provide FP/RH services for population</li> <li>• Reduces absenteeism and improves productivity as a result of better health</li> <li>• Reduces training and recruiting costs due to decreased turnover of female workers</li> <li>• Invests in</li> </ul>	<ul style="list-style-type: none"> <li>• NGOs often more efficient and effective at reaching poor, rural and remote areas</li> <li>• Market surveys show that those in the middle- and upper-income classes are willing and able to pay for contraceptives</li> <li>• Decreases burden of government to provide for all</li> <li>• Introduces more choice into the market</li> <li>• Minimizes duplication</li> </ul>	<ul style="list-style-type: none"> <li>• Local procurement translates into low-volume procurement and higher unit cost of contraceptives—inefficient use of resources</li> <li>• Fewer opportunities for economies of scale</li> <li>• Quality control can not be effectively enforced at the local level</li> <li>• Inadequate local capacity to accurately report, monitor, and finance</li> </ul>
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	<ul style="list-style-type: none"> <li>• Holds local governments accountable for investing in FP/RH</li> </ul>	<p>strengthen linkage with national committees</p> <ul style="list-style-type: none"> <li>• Facilitates subnational planning processes</li> </ul>	<p>poor and other vulnerable groups</p> <ul style="list-style-type: none"> <li>• Ensures equity in allocation and use of limited government resources</li> </ul> <p>Given greater ease of identifying the poor at local levels, targeting strategies are more easily implemented</p>		<p>prevention over more expensive curative care</p> <ul style="list-style-type: none"> <li>• Attending to primary healthcare needs of employees contributes to improved image and demonstrates socially responsible behavior</li> <li>• Consistent with rising trend toward family-friendly workplace policies</li> </ul>	<p>of efforts and unnecessary competition</p> <ul style="list-style-type: none"> <li>• Improves planning and ensures provision of supplies to diverse socioeconomic groups</li> </ul>	<p>the supply chain system</p>
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## Appendix D. Context: High Abortion/Low TFR

The “Ask”	Create budget line item for the poor in national and subnational budgets	Form FP/RH committee for CS/RH supplies	Simplify exemption mechanisms	Allow family practitioners to provide FP/RH methods	Include RH supplies plan in the national RH strategy	Increase involvement of NGOs	Include contraceptives in health insurance
<b>Key Target Audiences</b>	MOF, MOH	MOH, MOP, MOF, pharmaceutical companies, NGOs, FBOs, commercial sector, donors	MOH, MOP, MOF, civil society, media	MOH, policy development group if in existence, health provider, ObGyns	FP/RH Committee, MOH, MOP, MOF, media	MOH, MOP, MOF, NGOs, FBOs, commercial sector, media	National Health Insurance House, MOH, MOP, MOF, media
<b>Evidence-based Arguments</b>	<ul style="list-style-type: none"> <li>• High rates of unintended pregnancies and abortion among the poor</li> <li>• Poorest 40% of population cannot afford most of the modern methods</li> <li>• The public sector does not target subsidized</li> </ul>	<ul style="list-style-type: none"> <li>• Cross-cutting issue requires multisectoral approach</li> <li>• Generates better understanding of FP issues and concerns</li> <li>• Enables strategic approaches to RH supplies issues</li> <li>• Provides a forum to</li> </ul>	<ul style="list-style-type: none"> <li>• Compared with women in wealthier social classes, the poor tend to be non-users or users of traditional methods and have higher unmet need and more abortions.</li> <li>• Subsidized services and methods are benefiting the</li> </ul>	<ul style="list-style-type: none"> <li>• Despite the existence of a law that allows General Practitioners (GPs) and family doctors to distribute contraceptive s, family doctors generally do not receive contraceptive s for</li> </ul>	<ul style="list-style-type: none"> <li>• Need strategic approach to RH supplies</li> <li>• Inclusion of RH supplies plan into national plans helps ensure funding and implementation</li> <li>• Helps identify appropriate roles for different sectors</li> </ul>	<ul style="list-style-type: none"> <li>• Existence of legal and regulatory barriers to NGO participation in service delivery</li> <li>• NGOs market share is low</li> <li>• NGOs are a popular and potential source of commodities for youth</li> </ul>	<ul style="list-style-type: none"> <li>• Favorable benefit-cost ratio of inclusion of FP into health insurance</li> <li>• Health benefits (fewer abortions, fewer high-risk and unintended pregnancies)</li> <li>• Saves initial</li> </ul>



	<p>contraceptives to the poor</p> <ul style="list-style-type: none"> <li>• Inadequate budgetary provision for operations and supplies at all levels</li> <li>• No separate line item for FP/contraceptives in the local and national level budgets</li> <li>• Inadequate financial autonomy at the decentralized level</li> <li>• High cost of FP due to over medicalization of procedures (<i>especially IUD insertion, surgical procedures</i>)</li> <li>• Common practice of informal payments</li> <li>• High price of contraceptives in the</li> </ul>	<p>communicate at national and subnational levels</p> <ul style="list-style-type: none"> <li>• Supports involvement of civil society and commercial sector in policy formulation and national-level strategic planning</li> <li>• Promotes open dialogue among different sectors</li> <li>• Mobilizes high-level policy support</li> <li>• Provides a forum for improved planning and joint monitoring</li> </ul>	<p>non-poor disproportionately</p> <ul style="list-style-type: none"> <li>• Exemption guidelines apply to multiple target groups</li> <li>• Current means testing mechanisms are cumbersome</li> <li>• Various means testing models have been successfully implemented in different country settings</li> </ul>	<p>distribution</p> <ul style="list-style-type: none"> <li>• High unmet need in rural areas</li> <li>• Inadequate numbers of Ob/Gyns in rural areas</li> <li>• Women go to family practitioners for primary healthcare</li> <li>• Family practitioners are trained and capable of providing good FP counseling and methods</li> </ul>	<ul style="list-style-type: none"> <li>• Puts RH supplies high on policy agenda</li> <li>• Helps ensure periodic monitoring and evaluation</li> <li>• Makes planners and implementers accountable for ensuring supplies as key step to achieving objectives and goals</li> <li>• Ensures ownership and approval of supplies as key part of RH strategy</li> <li>• Places FP supplies in the broader context of RH</li> </ul>	<ul style="list-style-type: none"> <li>• There are well-established NGO networks in the health sector</li> <li>• NGOs work in close collaboration with the MOH</li> <li>• NGOs work in rural and remote areas</li> </ul>	<p>and long-term costs</p> <ul style="list-style-type: none"> <li>• Increases use of contraceptives among insured women</li> <li>• Easy process of including FP in health insurance</li> <li>• Mobilizes employee and government funds for FP</li> <li>• Ensures sustainable financing</li> <li>• Diversifies financing mechanisms for FP</li> </ul>
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	<p>commercial sector</p> <ul style="list-style-type: none"><li>• Pharmaceutical companies influence the types of methods available in the market</li><li>• Market share of NGOs is low</li></ul>						
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## Bibliography

Alkenbrack, S., and C. Shepherd. 2005. Lessons Learned from Phaseout of Donor Support in a National Family Planning Program: The Case of Mexico. Washington, DC: Futures Group, POLICY Project. [Link](#)

Alkenbrack, S. 2006. "Strengthening Contraceptive Security in Decentralized Settings." Policy Issues in Planning and Finance No.6. Washington DC: Futures Group, POLICY Project. [Link](#)

Alkenbrack, S., and J. Tossou. Unpublished. Summary of the Evaluation of the Contraceptive Security Strategic Planning Process in Togo. Washington, DC: Constella Futures, POLICY Project. [Link](#)

Bowman, J. 2004. Media Advocacy for Contraceptive Security: Key Findings from an Asia Regional Workshop. Baltimore, MD: The Health Communication Partnership based at: Johns Hopkins Bloomberg School of Public Health /Center for Communication Programs. [Link](#)

Butz, W., and S. Sharma. 2002. "Setting Priorities in Reproductive Health: Lessons Learned." Policy Issues in Planning and Finance No.2. Washington DC: Futures Group, POLICY Project. [Link](#)

Cromer, C., T. Pandit, J. Robertson, and A. Neiwijk. 2004. The Family Planning Graduation Experience: Lessons for the Future. Washington, DC: LTG Associates Inc. and Social & Scientific Systems, Inc., POPTECH. [Link](#)

Dake, Akunu. 2005. Conference on Repositioning Family Planning in West Africa: Rapporteur-General's Report. Arlington, VA: Advance Africa Project, Management Sciences for Health. [Link](#)

Dayaratna, V., I. Zosa-Feranil, A. Stanescu, L. Marcu, and C. Butu. 2002. Barriers to Implementing Contraceptive Security Policies in Romania. Washington DC: Futures Group, POLICY Project. [Link](#)

DELIVER. 2006. Reproductive Health Commodity Security Strategy for the West Africa Subregion. Arlington, VA: DELIVER. [Link](#)

DELIVER and POLICY Project. 2004. Regional Contraceptive Security Report: Findings and Recommendations. Washington, DC: Futures Group, POLICY Project.

Hamilton, M., 2005. "Ensuring Contraceptive Security for HIV Positive Women." Policy Issues in Planning and Finance No.5. Washington DC: Futures Group, POLICY Project. [Link](#)

Hare, L., C. Hart, S. Scribner, C. Shepherd, T. Pandit (ed.), and A. Bornbusch (ed.).



2004. SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation. Baltimore, MD: Information and Knowledge for Optimal Health (INFO) Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health. [Link](#)

Health Policy Initiative. 2006. Achieving the MDGs: The Contribution to Family Planning. Washington, DC: Constella Futures, USAID | Health Policy Initiative. [Link](#)

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International HIV/AIDS Alliance. 2002. Advocacy in Action—A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS. Brighton, UK: International HIV/AIDS Alliance. [Link](#)

McBride, J., and R. Ahmed. 2001. "Social Franchising as a Strategy for Expanding Access to Reproductive Health Services: A Case Study of the Green Star Service Delivery Network in Pakistan." [Link](#)

Commercial Market Strategies Technical Paper Series. Washington, DC: Deloitte Touche Tohmatsu/Commercial Market Strategies Project.

Ministry of Population and National Population Council. 2005. Contraceptive Security Strategic Plan Workshop Report Cairo, Egypt. Washington DC: Futures Group, POLICY Project. [Link](#)

Ministry of Population and National Population Council. 2006. Contraceptive Security Strategic Plan for Egypt 2006–2010. Washington DC: Constella Futures, USAID | Health Policy Initiative. [Link](#)

Moreland, S. 2006. "Egypt's Population Program: Assessing 25 years of Family Planning." Washington, DC: USAID | Health Policy Initiative. [Link](#)

Moreland, S. 2006. "Egypt's Population Program: Assessing 25 years of Family Planning." PowerPoint presentation. Washington, DC: USAID | Health Policy Initiative. [Link](#)

National Population Council and POLICY Project. 2006. Ghana's Development Agenda and Population Growth: The Unmet Need for Family Planning. Washington, DC: Futures Group, POLICY Project. [Link](#)

POLICY Project/Health Policy Initiative. 2007. Networking for Policy Change: An Advocacy Manual Contraceptive Security Supplement. Washington DC: Constella



Futures, USAID | Health Policy Initiative.

POLICY Project. 2006a. Documentation of the Use of the SPARHCS Framework in 9 Countries ([Bolivia](#), [Egypt](#), [Honduras](#), [Jordan](#), [Madagascar](#), [Nicaragua](#), [Paraguay](#), [Peru](#), [Ukraine](#)). Washington, DC: Futures Group, POLICY Project.

POLICY Project. Unpublished (a). "Contraceptive Security Workshop Agenda." Used in Kyiv, Ukraine. Washington, DC: Futures Group, POLICY Project. [Link](#)

POLICY Project. Unpublished (b). "Establishing an Innovative Source for Funding in Guatemala." Washington, DC: Futures Group, POLICY Project. [Link](#)

POLICY Project. 1999. Networking for Policy Change: An Advocacy Manual. Washington DC: CEDPA, POLICY Project. [Link](#)

Professor Tsai. 2003. "Guidelines for Writing a Policy Brief." (Retrieved August 25, 2006). [Link](#)

Sánchez, A., W. Abramson, N. Olson, and N. Quesada. 2006. Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean: Considerations for Informed Decision Making throughout the Health Reform Process. Arlington, VA: DELIVER. [Link](#)

Sarley, D., V. Dayaratna, W. Abramson, J. Gribble, N. Quesada, N. Olson, and V. Siman Betancourt. 2006. Options for Contraceptive Procurement: Lessons Learned from Latin America and the Caribbean. Arlington, VA: DELIVER; and Washington, DC: USAID | Health Policy Initiative. [Link](#)

Sharma, S., M Rowan, C. Shepherd, and B. Ishaqat. 2006. "Evidence-based Advocacy to Mobilize Financial Resources for FP/RH in Jordan: An Application of National Family Planning Accounts." PowerPoint presentation at APHA Annual Conference in Boston, MA: Constella Futures. [Link](#)

Sharma, S. and V. Dayaratna, 2004. "Creating Conditions for Greater Private Sector Participation in FP/RH: Benefits for Contraceptive Security." Policy Issues in Planning and Finance No.4. Washington, DC: Futures Group, POLICY Project. [Link](#)

Sharma, S., and E. Menotti. 2006. "Changing the Public/Private Market Shares for Family Planning in Peru: What About the Poor?" PowerPoint presentation. International Conference on Global Health in Washington, DC: USAID | Health Policy Initiative. [Link](#)

Sine, J. 2003. "Targeting: A Key Element of National Contraceptive Security Planning." Policy Issues in Planning and Finance No.3. Washington, DC: Futures Group, POLICY Project. [Link](#)



Sine, J., and S. Sharma. 2002. "Policy Aspects of Achieving Contraceptive Security." Policy Issues in Planning and Finance No.1. Washington, DC: Futures Group, POLICY Project.

Sinioukov, A. 2005. Key Social Marketing: Ensuring Greater Spacing, Healthier Families in Pakistan. Washington, DC: Futures Group/Key Social Marketing. [Link](#)

Solo, J., M. Odonkor, J. M. Pile, and J. Wickstrom. 2005a. Repositioning Family Planning—Ghana Case Study: "Give them the power." New York: ACQUIRE Project/EngenderHealth. [Link](#)

Solo, J., R. Jacobstein, and D. Malema. 2005b. Repositioning Family Planning—Malawi Case Study: Choice, Not Chance. New York: ACQUIRE Project/EngenderHealth. [Link](#)

Solo, J., M. Luhanga, and D. Wohlfahrt. 2005c. Repositioning family planning—Zambia Case Study: Ready for Change. New York: ACQUIRE Project/EngenderHealth. [Link](#)

Supply Initiative. No year (a). "Access to Condoms and Contraceptives: Vital for the Prevention of HIV." Washington, DC: Population Action International (PAI). [Link](#)

Supply Initiative. No year (b). "Facilitating Donor Coordination with the RHInterchange." Washington, DC: PAI. [Link](#)

Supply Initiative. No year (c). "Sexual and Reproductive Health Services Undermined by Supply Shortfall." Washington, DC: PAI. [Link](#)

Supply Initiative. No year (d). "The Importance of the Supply Chain." Washington, DC: PAI. [Link](#)

Supply Initiative. No year (e). "Why Reproductive Health Supplies Are Crucial to Achieving the Millennium Development Goals." Washington, DC: PAI.

Thompson, D. 2004. District Planning Tool for Contraceptive Security. STARH, BKKBN, and DELIVER, Unpublished.

USAID and the Hashemite Kingdom of Jordan, 2006. Memorandum of Understanding between the Ministry of Health of the Hashemite Kingdom of Jordan and the United States Agency for International Development. Amman, Jordan: Constella Futures, USAID | Health Policy Initiative. [Link](#)

West African Health Organization. 2006. "The Ordinary Assembly of Health Ministers of the West African Health Organization: Final Communiqué." Abuja, Nigeria: ECOWAS.

Young, E., and L. Quinn. No year. "The Policy Brief." (Retrieved August 25, 2006) [Link](#)



## Additional Resources

Aramati, M., N. DeMetz, S. Arnett, and C. Shepherd. 2006. Using the SPARHCS Approach to Reposition Family Planning in Madagascar: A Success Story. Washington, DC: Futures Group, POLICY Project. [Link](#)

Cardenas, S., and S. Richiedei. 2000. "Participatory Policy Processes in Turkey: A Case Study on the NGO Advocacy Network for Women (KIDOG), 1995–1999." The POLICY Project in Turkey: Overview, Results, and Lessons Learned. Washington DC: Futures Group, POLICY Project. [Link](#)

Marston, C., and J. Cleland. 2003. "Relationships between Contraception and Abortion: A Review of the Evidence." *International Family Planning Perspectives* 29(1): 6–13. [Link](#)

Ministry of Health/Family Health Division. 2005. National Strategic Plan for Securing the Supply of Contraceptive Products in Togo (2006–2010). Lome, Togo: Ministry of Health. [Link](#)

Ministry of Health and POLICY Project. 2004. Jordan: Contraceptive Security Briefing Booklet. Amman, Jordan: Futures Group, POLICY Project.

Ministry of Health and Population and POLICY Project. 2004. Achieving Contraceptive Security in Egypt: Briefing Document. Cairo, Egypt: POLICY/Egypt. [Link](#)

Mitchell, S., and C. Cisek. 2006. Peru Private Sector Assessment: May 15–26, 2006. Bethesda, MD: Abt Associates, Inc/PSP-One.

Moreland, S., N. DeMetz, S. Alkenbrack, K. Smith, H. Abdallah, and J. Durgavich. 2003. An Assessment of Reproductive Health Commodity Security in Madagascar. Washington, DC: Futures Group, POLICY Project.

POLICY Project. 2006. A Decade of Making a Difference: The POLICY Project (1995–2006). Washington, DC: Constella Futures, POLICY Project. [Link](#)

POLICY Project. 2006. Moving in the Right Direction: Results of a Global Survey of Activities and Processes to Meet Contraceptive Commodity Needs. Washington, DC: Futures Group, POLICY Project. [Link](#)

POLICY Project. 2004. POLICY Project Results. Washington DC: Futures Group, POLICY Project.

Quesada, N., C. Salamanca, J. Agudelo, P. Mostajo, V. Dayaratna, L. Patykewich, and A. Karim. 2004. Paraguay: Contraceptive Security Assessment, March 8–19, 2004. Arlington, VA: John Snow, Inc., DELIVER; and Washington, DC: Futures Group, POLICY Project. (also available in Spanish) [Link](#)



Quesada, N., P. Mostajo, C. Salamanca, C. Cisek, L. Patykewich, and A. Karim. 2004. Honduras: Contraceptive Security Assessment, April 26–May 7, 2004. Arlington, VA: John Snow, Inc., DELIVER; and Washington, DC: Futures Group, POLICY Project. [Link](#)

Quijada, C., T. Dmytraczenko, and B. Mensah. 2004. Ensuring Contraceptive Security within New Development Assistance Mechanisms. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Ross, J., and W. Winfrey. 2002. "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate." *International Family Planning Perspectives* 28(3):138–143. [Link](#)

Singh, S., J. Darroch, M. Vlassoff, and J. Nadeau. 2004. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care. New York: Alan Guttmacher Institute and UNFPA. [Link](#)

Taylor, P.A., G. Subiria, C. Cisek, C. Basurto Corvera, and P. Mostajo. 2004. Peru: Contraceptive Security Assessment, September 1–12, 2003. Arlington, VA: John Snow, Inc., DELIVER; and Washington, DC: Futures Group, POLICY Project. [Link](#) (also available in [Spanish](#))

Taylor, P.A., N. Quesada, P. Saenz, K. Garcia, C. Salamanca, P. Mostajo, and V. Dayaratna. 2003. Bolivia: Contraceptive Security Assessment, December 1–12, 2003. Arlington, VA: John Snow, Inc./DELIVER; and Washington, DC: Futures Group, POLICY Project. [Link](#)

Truhan, O. 2005. POLICY Project Contraceptive Security Grants and Results Summary. Kyiv, Ukraine: POLICY Project.

UNFPA. 2004. State of World Population, 2004. The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty. New York: UNFPA. See also <http://www.unfpa.org>.

Vogel, C.G. 2006. "The Changing Face of Foreign Assistance: New Funding Paradigms Offer a Challenge and Opportunity for Family Planning." *Research Commentary* 1(8). Washington, DC: PAI. [Link](#)

WHO, UNFPA, and United Nations Children's Fund. 2004. Maternal Mortality in 2000: Geneva: WHO. [Link](#)

WHO. 1998. Safe Motherhood Fact Sheet. Geneva: WHO.

Zhylka, N. 2005. Contraceptive Security Situation Analysis in Ukraine. Kyiv, Ukraine: Rayevsky Scientific Publishers.

Zosa-Feranil, I. 2003. A Policy Approach Toward Contraceptive Security in Romania. Washington, DC: CEDPA/POLICY Project. [Link](#)