

Ensuring Contraceptive Security within New Development Assistance Mechanisms

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- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Abstract

Contraceptive security exists when people are able to choose, obtain, and use high quality contraceptives and condoms when they want them for family planning and prevention of HIV/AIDS and sexually transmitted infections. In many countries, people rely on the free or subsidized supplies made available by governments and international donor agencies. However, there is a growing financing gap as current levels of government resources and donor support are inadequate to meet increasing demand for contraceptives and condoms. There is concern that recent changes in the way that donors provide foreign aid will adversely affect funding levels for reproductive health commodities.

These changes include the emergence of global funds, movement away from targeted projects toward general budget support, and a new emphasis on poverty reduction. This paper presents findings from a study to examine the impact that two of these new mechanisms in development assistance – sector-wide approaches, or SWAps, and poverty reduction strategy papers, PRSPs – may have on contraceptive security. *PHRplus* conducted a study of three countries and examined in more detail the design and implementation of these mechanisms.

The study sought to determine: 1) whether contraceptive security issues, such as the availability of commodities, strengthened logistics systems, and quality counseling services, were explicitly addressed in the government strategies; and if so, to what extent they were included, 2) whether donor funding levels changed due to the new arrangements and 3) what plans, if any, exist within the SWAp and/or PRSP to finance reproductive health commodities.

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Acronyms

CPR	Contraceptive Prevalence Rate
DANIDA	Danish International Development Agency
DfID	Department for International Development
DHS	Demographic and Health Survey
ESP	Essential Services Package
EU	European Union
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
HIPC	Highly Indebted Poor Country
HPSP	Health and Population Sector Program
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HRD	Human Resources Development
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
I-PRSP	Interim Poverty Reduction Strategy Paper
JICA	Japanese International Cooperation Agency
KfW	<i>Kreditanstalt für Wiederaufbau</i> (German Development Bank)
MCA	Millennium Challenge Account
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MTP	Medium-Term Priority
NGO	Nongovernmental Organization
NHA	National Health Accounts
PBS	Provision of Basic Services
PHR_{plus}	Partners for Health Reform _{plus}
POW	Program of Work
PRSP	Poverty Reduction Strategy Paper

RH	Reproductive Health
SIDA	Swedish International Development and Cooperation Agency
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
WB	World Bank

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Executive Summary

Contraceptive security exists when people are able to choose, obtain, and use high quality contraceptives and condoms when they want them for family planning and prevention of HIV/AIDS and sexually transmitted infections. In many countries, people rely on the free or subsidized supplies made available by governments and international donor agencies. However, there is a growing financing gap as current levels of government resources and donor support are inadequate to meet increasing demand for contraceptives and condoms.

There is concern that changes in the way that donors are providing aid may further affect funding levels for reproductive health commodities. There is a trend away from donor-funded projects toward pooled funding of a single policy and expenditure program defined under a sector-wide approach (SWAp). Beyond SWAps are other changes in development assistance that may impact contraceptive security. These include the emergence of global funds, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunizations, as well as new mechanisms, such as poverty reduction strategies (PSRPs) and the Millennium Challenge Account, that rely on macro-level impact indicators to measure performance and guide disbursement of loans as well as some foreign aid. All of these changes present challenges to governments trying to navigate within the ever-evolving development assistance environment.

In order to assess the impact that two of these new mechanisms in development assistance – SWAps and PRSPs – may have on contraceptive security, Partners for Health Reform*plus* (PHR*plus*) conducted a literature review on experiences in three countries and interviewed key country informants to examine in more detail the design and implementation of these mechanisms. The study sought to determine: 1) whether contraceptive security issues, such as the availability of commodities, strengthened logistics systems, and quality counseling services, were explicitly addressed in the government strategies; and if so, to what extent they were included, 2) whether donor funding levels changed due to the new arrangements, and 3) what plans, if any, exist within the SWAp and/or PRSP to finance reproductive health commodities.

SWAps and PRSPs provide opportunities to bring contraceptive security into the foreground of national priorities. Emphasis on country ownership and broad stakeholder participation provide opportunities to strengthen community inputs and ensure that national priorities are included. The pooling of funds for sector programs can potentially offer security as a country can secure the commitment of more than one donor/partner to support the availability of contraceptives. The SWAp and PRSP development process also creates fertile ground for policy dialogue that could include issues such as logistics and outreach.

However, along with improvements, new financing mechanisms also bring new challenges. Movement away from direct program support towards a macro-level, sector focus may mean that reproductive health (RH) and family planning (FP) programs and their achievements are orphaned. An increased emphasis on fighting poverty means governments must now focus on programs and activities that will achieve poverty reduction goals if they wish to access external funding. Similarly, a global call for reducing disease burden may turn attention away from non-disease interventions such as family planning.

It is important for all participants in the planning, implementation, and monitoring of health programs to be aware of and knowledgeable about the challenges that each change brings so that those challenges can be appropriately addressed. The goal, then, is to ensure that contraceptive security is perceived by governments and development partners as a national good; that it is fundamental to broaden development, poverty reduction, and health objectives; that this commitment to contraceptive security is explicitly addressed in SWAps and PRSPs; and that the commitment is matched by resource allocations.

Key findings from each country include:

Ghana

- ▲ The Ghana SWAp includes strengthening RH as a priority activity but provides very few details on how this objective will be met.
- ▲ Although not specifically addressed in its program of work (POW), Ghana must plan for commodity supplies to achieve its target of doubling its contraceptive prevalence rate by 2006.
- ▲ The PRSP, in line with the SWAp POW, includes population management as part of the strategy by using a two-pronged approach – decentralization of service delivery and institution of a major fertility regulation campaign. However, Ghana has had to prioritize implementation of PRSP programs due to resource constraints.
- ▲ The medium term priority program has no special allocation for population management. Responses from key informant interviews indicate that participation by RH/FP champions' in the SWAp or PRSP processes was not very strong.

Zambia

- ▲ Both PRSP and SWAp strategies mention integrated RH as a health priority, but it is included because FP services are included as part of the basic package of services.
- ▲ Despite the inclusion of integrated RH, no specific budgetary allocation was made and no FP indicators were selected to monitor progress towards meeting the goals laid out in the strategy.
- ▲ Key informants reported that in Zambia it appears that although RH/FP advocates have some opportunity to provide input to the development of SWAP/PRSPs, they have not done so for several reasons: they are largely isolated from these processes and policy discussions in general, are not fully aware of the issues, and have not changed their thinking from vertical to integrated health programs.

Bangladesh

- ▲ Issues concerning contraceptive security are prominent in the Bangladesh SWAp and the I-PRSP plans for subsidized provision of birth control supplies as part of their poverty reduction strategy.
- ▲ Key respondents indicated that it was the nongovernmental organization advocates, in particular, who had limited participation in the processes.

The study found that, when family planning was discussed in PRSPs or SWAps, it was often in broad, more general statements such as strengthening of FP programs or increasing RH/FP education. Without the expressed commitment on the part of donors and governments to make commodities a priority, when there is competition for scarce resources, programs that are not highlighted or addressed may fall by the wayside.

The picture is less clear as to whether the new funding mechanisms have changed or influenced the level of commodities provided by donors. Accurate estimates on global donor financing for RH commodities are difficult to obtain (Mayhew 2002 and United Nations Population Fund [UNFPA] 2001). For some donors it is difficult to separate the amount spent on commodities versus overall RH/FP program support, particularly if they are participating in pooling of funds. Many bank loans are used to finance basic social service programs (such as integrated health and nutrition) that have FP or RH components embedded, making disaggregation of figures difficult (UNFPA 2001). Unfortunately, key informant interviews did not provide any additional insights.

Using the findings from the three-country study as well as the literature review, the following are recommendations that *PHRplus* has developed for all stakeholders – host country governments, donors, program implementers as well as the community – to maximize resources for contraceptives.

- ▲ RH and FP advocates must be knowledgeable of the changing funding environment to ensure visibility of commodities.
- ▲ Information is not enough; RH/FP stakeholders need to be proactive.
- ▲ Be responsive by modifying programs to reflect new objectives and creative in demonstrating how RH/FP priorities and programs meet the funding flows and international demands.
- ▲ Map out how RH/FP programs and services help achieve internationally accepted goals and measures such as the Millennium Development Goals.
- ▲ Link planning and budgeting processes to broader national and international objectives.
- ▲ Improve tracking of donor as well as government expenditures on contraceptives.
- ▲ Encourage private sector participation in development of PRSPs and SWAps.
- ▲ A small amount of good technical assistance to assist implementation will help steer the process.

1. Introduction

Contraceptive security exists when people are able to choose, obtain, and use high quality contraceptives and condoms when they want them for family planning (FP) and prevention of HIV/AIDS and sexually transmitted infections (STIs). In many countries, people rely on the free or subsidized supplies made available by governments and international donor agencies. However, there is a growing financing gap as current levels of government resources and donor support are inadequate to meet increasing demand for contraceptives and condoms.

The United Nations Population Fund's (UNFPA) report *Global Estimates of Contraceptive Commodities and Condoms for STI/HIV Prevention 2000-2015* (2000a) estimates that, by the year 2015, total commodity requirements (for HIV/STI prevention as well as FP) will cost US \$1.8 billion. Its *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2001* (UNFPA 2003) highlights the financial gap in meeting these global requirements. The latter report states that donor support for contraceptives in 2001 was US \$224 million. Although this is a 46 percent increase over the support provided in 2000, support in 2001 met only 36 percent of the year's estimated global contraceptive needs for family planning.

Given that there are three main sources for funding contraceptives – government resources, donors, and individual users – if government budgets and donor contributions do not make up the difference in resource needs, then users will need to do so, through increased out-of-pocket payments. In some cases, the increased cost may make the contraceptives unaffordable.

Additionally, there is concern that recent changes in the way that donors provide foreign aid will adversely affect funding levels for reproductive health (RH) commodities. Global initiatives have emerged from a rising concern that the poorest nations are being overwhelmed by a heavy and ever-increasing burden of disease (Bennett and Fairbank 2003). Global funds, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) and the Global Alliance for Vaccines and Immunizations (GAVI), are mechanisms through which donors can join efforts and funding to address principal causes of the burden of disease. Global partnerships are numerous (see Box 1) and bring new funds to the fight against disease in the developing world.

Box 1: Examples of Global Funds

- ▲ Global Fund to Fight AIDS, TB and Malaria
- ▲ Global Alliance for Vaccines and Immunizations (GAVI)
- ▲ Global Alliance for Improved Nutrition (GAIN)
- ▲ Stop TB Partnership
- ▲ Roll Back Malaria
- ▲ Joint United Nations Program on HIV/AIDS (UNAIDS)
- ▲ International AIDS Vaccine Initiative
- ▲ Global Alliance for TB Drug Development

Source: World Bank 2003

Growing debt in the developing world and increasing recognition that poverty is the underlying cause of poor health has led some donors and lending institutions to focus on the reduction of poverty. For example, the World Bank and the International Monetary Fund (IMF) created the Highly Indebted Poor Country (HIPC) Initiative in 1996; it is the first comprehensive approach to reduce the external debt of the world's poorest, most heavily indebted countries. Closely linked with the HIPC Initiative are Poverty Reduction Strategy Papers (PRSPs), which provide the framework for addressing poverty by country governments.

Another change is a new emphasis on performance measurement, as donors have higher expectations following limited improvements in health status in developing countries after 30 years of foreign aid. Donors are linking aid disbursement to meeting specific performance targets. For example, GAVI disburses funds on a per capita basis for each fully immunized child; the Millennium Challenge Account provides aid to countries that meet and are accountable for certain governing measures (such as just rule and economic freedom).

Within this trend, The Millennium Development Goals (MDGs) have emerged and were agreed to by U.N. member states at the 2000 Millennium Summit. MDGs are a set of measurable targets for reducing world poverty, improving health, and advancing human development. Their commonly accepted framework focuses on development outcomes rather than on inputs to effectively measure national progress towards meeting goals.

All of these new mechanisms present challenges to governments trying to navigate within the ever-evolving development assistance environment.

In order to assess the impact that two of these new mechanisms in development assistance – PRSPs and Sector-Wide Approaches (SWAs) – may have on contraceptive security, Partners for Health Reform *plus* (PHR*plus*) conducted a study in three countries to examine in detail the design and implementation of these mechanisms. The study sought to determine: 1) whether contraceptive security issues, such as the availability of commodities, strengthened logistics systems, and quality counseling services, were explicitly addressed in the government strategies; and if so, to what extent they were included, 2) whether donor funding levels changed due to the new arrangements and 3) what plans, if any, exist within the SWA and/or PRSP to finance RH commodities.

The next section of this paper reviews SWAs and PRSPs and the effect that they may have on contraceptive security issues. The following section presents the findings from the three-country case study. These findings were used to develop recommendations and strategies for using SWAs and PRSPs as vehicles to sustain and increase RH contraceptive financing, as presented in Section 4. Though this study focused on two financing mechanisms (SWAs and PRSPs), the findings and recommendations may apply to other development assistance trends as well.

2. A Closer Look at SWApS and PRSPs

Over the last decade, development assistance has moved away from the traditional direct program support. This change has been driven by 1) dissatisfaction on part of governments and donors with project structure for delivering development assistance, 2) perceived need to improve national budget allocations to better target scarce resources for the poor and underserved, 3) need for national ownership and partnerships, and 4) growing impatience with inability of donors to coordinate their aid and support in a more effective manner (Ireland Aid 2000, Merrick 2002, UNFPA 2000b, and Walt 1999a). In the movement away from project aid, governments must now secure funding for programs that may not mirror what donors are interested in funding. This section looks at two of these new mechanisms – Sector-Wide Approaches and Poverty Reduction Strategy Papers – and discusses some of their implications for contraceptive security.

2.1 Sector-Wide Approach (SWAp)

There is no official definition for a Sector-Wide Approach, as SWAp development takes many forms. However, in keeping with the definition used by many SWAp documents, this paper uses the following: *all significant funding for the sector supports a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector and progressing towards relying on Government procedures for all funds* (Foster, Brown, and Conway, 2000).

“Fragmented donor projects with different and sometimes conflicting agendas lead to large operating costs, duplicated efforts and a significant managerial burden for recipient governments. In addition, individual projects are often not in line with government policy priorities and can exacerbate inequalities through supporting particular regions, or lead to incoherent approaches to development. In this context, SWApS are seen as an opportunity for governments to regain control over their fragmented health sectors, by focusing on government ownership and flexibility” (Seco and Martinez 2001).

The aim of SWApS is to attain sector-specific objectives and to ensure national ownership through partnerships and increased collaboration. All sectoral expenditures follow the agreed-upon sectoral strategies and policies. Through its emphasis on development partners supporting a single sector strategy, a SWAp is meant to reduce aid fragmentation. However, as it is an approach, there is no blueprint for its development.

Given the variability in structure, there are a number of options for financing sector-wide approaches. Governments may have “pooled” or “basket” funding where merged funds for the sector are either by the government or managed by a partner (the World Bank in Bangladesh, for example). Pooled funds may include earmarks for special programs. Outside of pooled funds, parallel funding for activities may (and often does) exist such as donor-funded activities that support the government sector policy but are managed as projects (as is the case with funds from the U.S. Agency for International Development [USAID]). Often, countries have a combination of scenarios at play.

The appealing features of SWAp for governments include increased leadership and control, though not total, over sector programs financed with donor funds. Also, funds pooled for sector

programs are fungible and can be used according to needs determined by governments in consultation with development partners, whereas project aid is relatively inflexible and driven totally by donors managing those funds. For donors, SWAps allow for streamlining of activities and reduce overlap and duplication of efforts. However, there are concerns that have led some donors to shy away from participating in pooling of funds. These concerns include:

- ▲ Losing the ability to attribute expenditures that are part of pooled funding to specific activity areas (making impact hard to measure)
- ▲ Lowering the quality of priority programs if insufficient resources create an environment where these programs are neglected
- ▲ Lack of confidence in government procurement systems to provide necessary commodities
- ▲ Lack of confidence in government financial management systems necessary in accounting for donor funds (perhaps the donors' most important reservation)

There are donors for which pooling of funds is nearly impossible, such as the Japanese International Cooperation Agency (JICA) and USAID, given the requirements imposed by their governments for reporting and accounting for funds.

There are currently about 20 countries with some type of sector-wide approach, and the number is growing. Ghana, Zambia, Pakistan, and Bangladesh have had the longest experiences with SWAps.

2.2 Poverty Reduction Strategies

The World Bank and the International Monetary Fund endorsed a new approach for poverty reduction in the fall of 1999. It is country-owned and detailed in strategy papers that serve as the framework for a country's long-term plan for poverty reduction (within and beyond the development assistance received). Poverty Reduction Strategy Papers 1) present country priorities for reducing poverty and promoting growth across all sectors, 2) outline associated funding needs, 3) are partnership-oriented and participatory in process, and 4) include appropriate targets and indicators to monitor progress.

The PRSP provides the basis for concessional assistance from the World Bank's International Development Association (long-term loans from the Bank at zero interest) as well as debt relief under the Heavily Indebted Poor Country Initiative that provides to eligible countries relief from debt owed to participating multilaterals. National funds, which are thus freed from having to make payment on the loans, are to be applied towards implementation of the activities laid out in the PRSP strategy. PRSPs are written every three years, with progress reports written annually in order to assess progress towards goals. There are no official guidelines for developing PRSPs, but the World Bank has developed some guidance using its experience to date that is compiled in a Poverty Reduction Strategy Sourcebook.

Managing complex policy dialogues with development partners in order to put together an integrated medium-term economic and poverty reduction strategy complete with goals, targets, and a sound monitoring plan is not easy for most countries. As such, the World Bank and the IMF agreed to introduce Interim Poverty Reduction Strategy papers (I-PRSP) to avoid delays in delivering aid. The I-PRSP takes stock of the country's existing strategies to fight poverty and provides a road map for how the country will develop its full PRSP (IMF and World Bank 2003).

As of July 2003, 32 countries have full PRSPs, 21 have I-PRSPs, and others are in process. While PRSPs are a World Bank/IMF initiative, there are other development agencies with poverty reduction focuses, such as U.N. agencies, the Department for International Development (DfID), and the Swedish International Development and Cooperation Agency (SIDA).

2.3 Implications for Contraceptive Security

SWApS and PRSPs provide opportunities to bring contraceptive security into the foreground of national priorities. Emphasis on country ownership and broad stakeholder participation provide opportunities to strengthen community inputs and ensure national priorities are included. The pooling of funds for sector programs can potentially offer security as a country can secure the commitment of more than one donor/partner to support the availability of contraceptives. The SWAp and PRSP development process also creates fertile ground for policy dialogue that could include issues such as logistics and outreach. In terms of monitoring progress towards achieving stated policy objectives, the World Bank has endorsed using contraceptive prevalence rate (CPR) as a necessary indicator to secure funds through PRSPs. Requiring countries to include CPR as indicator for measuring success provides an opportunity for leveraging contraceptive security issues.

However, along with improvements, the new mechanisms' movement away from direct program support toward a macro-level sector focus may jeopardize financing for RH and FP programs. This concern relates not only to SWApS and PRSPs but also applies to the trend towards aid mechanisms that rely on measuring performance more broadly, such as the MDGs. An increased emphasis on poverty means governments must now focus on programs and activities that will achieve poverty reduction goals if they wish to access external funding.

Similarly, a global call for reducing disease burden may turn attention away from non-disease interventions such as family planning.

One of the greatest challenges is providing sufficient time to institutionalize these new arrangements – countries often need a transition period to ensure success. Transitions that occur too quickly can lead to problems. RH/FP advocates and program managers need time and assistance to understand the SWAp and PRSP processes in order to be most effective at ensuring a priority role and continued funding for commodities.

SWAp emphasis on using existing government arrangements for purchasing, which is critical for programs depending on full commodity supply, is yet another challenge. Many countries continue to require technical assistance with logistics systems and therefore will need to ensure that funds for this type of support continue to be available. Past experience in Bangladesh and Zambia shows that problems with government-led procurement systems had negative impact on program performance (Brown 2001; Government of Bangladesh 2000).

A significant challenge for donors is maintaining equal say in strategy discussions regardless of whether they participate in new funding mechanisms. Often donors that do not participate in the mechanism are not invited to meetings that discuss assistance.

Pressure to meet the MDGs may mean that countries prioritize indicators that measure progress toward meeting goals. However, no specific MDG targets exist for sexual and

“SRH stakeholders were not explicitly involved in the design phases because the key SRH donors (USAID and UNFPA) are not currently pooling funds and, therefore, were not considered by the SWAp donors or MOH personnel to be key to the process.”

Key informant, Ghana

reproductive health. The onus is on RH/FP specialists to make the link between their programs and MDG targets such as maternal health, child health, and HIV/AIDS.

It is important for all participants in the planning, implementation, and monitoring of health programs to be aware of and knowledgeable about the challenges of each new change so that the challenges can be appropriately addressed. The goal, then, is to ensure that contraceptive security is perceived by governments and development partners as a national good; that it is fundamental to broaden development, poverty reduction, and health objectives; that this commitment to contraceptive security is explicitly addressed in SWAs and PRSPs; and that the commitment is matched by resource allocations.

3. Three Country Case Studies

3.1 Methodology

3.1.1 Country Selection

A set of criteria was developed for selection of the three countries for the study (see Annex A). Criteria included:

- ▲ Both SWAp and PRSP arrangements undertaken in country
- ▲ Length of experience with funding arrangement
 - △ SWAp: 2+ years of joint planning for health sector policy
 - △ PRSP: Final paper approved (or interim paper in existence for 1+ years)
- ▲ Prior donor involvement in funding contraceptives
- ▲ Availability of data (Demographic and Health Survey [DHS], National Health Accounts, census, other household surveys)
- ▲ USAID presence in country

3.1.2 Data Collection

Data for the study were collected through a review of literature and key informant interviews. The literature review included documents such as country SWAp and PRSP documents, reviews, and donor reports. The literature review was conducted using research databases such as Medline, USAID Development Experience Clearinghouse, the Partners for Health Reform*plus* resource center, the World Bank and donor websites, as well as other electronic databases.

The literature review was supplemented by a series of interviews with informants who were involved (either directly or peripherally) in the development of SWAps and PRSPs in Bangladesh, Zambia, and Ghana. An interview guide was developed in consultation with USAID as well as with Commercial Market Strategies and DELIVER project staff. The final questions are listed in Annex B.

A key informant list was drafted with input from collaborating agencies. Key informants represented a broad range of organizations – bilateral, multilateral, academic, governmental, and non-governmental (see Annex C for list) – and interests – financing, reform, reproductive health, family planning, and logistics.

The interviews were conducted between September and December 2003 by telephone, in person, and via email. The one-on-one discussions were conducted using a semi-structured format that allowed for the flexibility to probe into each participant's statements. It must be noted that because of time constraints on the part of several participants, not every question was covered in each interview.

PHR*plus* examined implementation of SWApS and PRSPs in three countries (Ghana, Zambia, and Bangladesh) to determine whether RH commodities had been explicitly addressed (i.e., as a part of the overall strategy or being specifically monitored to measure progress towards meeting goals), and whether donor assistance had been affected by new arrangements and plans for allocating resources for commodities within the new arrangements.

3.2 Ghana

The Ghana Five Year Health Sector Program of Work (POW) 2002-2006, or Ghana SWAp, is supported by a number of donors either through contributions to the common basket (DfID, Danish International Development Agency [DANIDA], World Bank, Netherland AID, European Union [EU]) or by providing program support outside of the pooled funds (USAID, JICA). The overall goal of the POW is to improve access and equity to essential health care. It also looks to ensure that the health sector plays an essential role in the Poverty Reduction Strategy.

The Health Fund holds the funds pooled by donors to carry out the POW. In 2002, Ghana spent a total of \$117 million (including government funds and external aid) in the health sector. Of that total, \$31 million dollars were pooled in the Health Fund (about 94 percent of external aid) (Institute for Health Sector Development 2003). Not included in SWAp resource planning are global funds such as the Global Fund and GAVI or private sector expenditures.

Although Ghana has encouraged donors to pool funds in the Health Fund, family planning continues to receive earmarked funding both within and outside of pooled funds.

Ghana's PRSP preparation began in 2000 with a series of consultative meetings to initiate the development of the PRSP. The strategy is centered around five pillars: macroeconomic stability, production and employment, human resource development and basic services, special programs for the vulnerable and excluded, and governance. Core teams were formed for each of the five thematic areas and were charged with developing the area, ensuring that the views of average citizens and input from the government and ministries were reflected. Special emphasis was given to civil society and their role in implementing the PRSP strategy.

The health sections of the PRSP fall under the human resource development and basic services component. Within the component, there are five interrelated sectors: education, skills entrepreneurship development, HIV/AIDS, population management, and health. Raised as issues within the latter three sectors are geographical disparities in health outcomes, rapid spread of HIV/AIDS, and limited choices on fertility regulation among poor families.

The total cost of the Ghana PRSP is estimated to be \$5.2 billion, with the majority of the funds (58.5 percent) allocated to Human Resource Development (HRD) and Provision of Basic Services (PBS) (a total of US \$3 billion). Within that component, funding has been allocated as shown in Table 1.

Table 1: Allocation of Ghana's PRSP Funds

Programs/Objectives (HRD and PBS)	US dollars (millions)	% of HRD and PBS	% of PRSP total
Education	782.7	25.7%	15.1%
HIV/AIDS	192.1	6.3%	3.7%
Population management	39.8	1.3%	.8%
Health care	585.2	19.2%	11.3%
Safe water & environmental health	934.3	30.7%	17.9%
Safe shelter	509	16.7%	9.7%
Subtotal (HRD and PBS)	3043.1	100%	58.5%

Source: Government of Ghana 2003

Due to resource and capacity constraints, Ghana prioritized programs within each component for implementation over a three-year period (2003-2005). The total cost for the medium-term priority (MTP) program is estimated to be \$2.5 billion (Government of Ghana, 2003). The largest share of available funding was allocated to Production and Gainful Employment (56 percent) with allocation for the HRD and PBS amounting to \$749 million or 29.8 percent. MTP funding for the HRD and BS component have been broken down as shown in Table 2.

Table 2: Allocation of Ghana's PRSP Funds, Medium Term

Program/Objectives for HRD and PBS under MTP	US Dollars (millions)	% of HRD and PBS	% of MTP total (2.5 million)
Education	281.18	37.5%	11.2%
Model health centers	104	13.8%	4.1%
Phase-out of cash and carry	28	3.7%	1.1%
Health sector program support*	236.63	31.5%	9.5%
Sanitation	90.88	12.1%	3.6%
Promoting women's access to micro-credit	9	1.2%	.3%
Subtotal	749.7	100%	29.8%

Source: Government of Ghana 2003

* Activities listed are health systems performance, addressing communicable diseases, child health, and reproductive health.

Implications for Contraceptive Security

While the POW for the Ghana SWAp includes the strengthening of reproductive health as a priority activity, it provides few details on how this objective will be met other than by including strengthening the delivery of FP services (with special emphasis on integration of STI management and services for men) as a key activity. While the POW does not provide details on implementation, it identifies a range of indicators to monitor progress and evaluate achievements of policies and strategies. For monitoring RH results, Ghana has chosen to include indicators on antenatal care coverage, percent of supervised deliveries, and percent of family planning acceptors. The 1998-2000 DHS reports that 14 percent of married women use modern methods; the target set by the Ghana POW is 40 percent by the year 2006. Although not specifically addressed in the POW, Ghana must

plan for commodity supplies if it hopes to achieve the target of doubling CPR by 2006. Currently, the Ministry of Health's (MOH's) Procurement Unit manages commodities for the POW. However, USAID and UNFPA continue to procure contraceptives as well. Other donors (EU and DfID) procure through international agents using earmarked funds.

The PRSP, in line with the SWAp POW, includes population management as part of the strategy. The PRSP cites a two-pronged approach: decentralization of service delivery and institution of a major fertility regulation campaign. The plan also calls for increasing access to contraceptives via the sale of contraceptives through community agents. Condoms are also explicitly mentioned in the HIV/AIDS section, where intensifying condom promotion (both male and female) is part of the strategy for improved service delivery for HIV/AIDS and STI care.

Ghana chose two FP indicators that depend on access to contraceptive commodities for monitoring achievement of PRSP: use of modern contraceptives and total fertility rate (TFR). A target for female use of modern contraceptives was set at 20 percent, for men at 35 percent; TFR is to be lowered 4.6 in 2000 to 4.2 in 2005.

Of the US \$39.8 million allocated to population management in the Ghana PRSP (Table 1), 67 percent is earmarked for improving the market and distribution system of the service delivery system, 20 percent for a national campaign on fertility regulation, and 12.5 percent to ensure the effective coordination of population management service implementation. However, since Ghana has had to prioritize their programs for the medium term due to resource constraints, these figures are symbolic.

According to the budgets submitted with the medium-term priority program, \$236 million will be spent on supporting the health sector (basically the health sector POW). Unlike the full PRSP (but much like the SWAp), the MTP program has no special allocation for population management. Given that RH activities are considered part of general health sector support, there is room for insertion of FP priorities into activities to be ultimately funded by pooled resources. However, because the MTP program does not fund population management at the level included in the PRSP, it is not clear how these targets will be met.

"Some NGOs and Ministry reproductive health personnel had very little idea how the SWAp was actually developed."
Key informant, Ghana

While FP/RH programs have been given priority in the PRSP, in the actual implementation of the MTP strategy, they have unfortunately not been explicitly included. This may be explained by the level of RH/FP stakeholder involvement.

Responses from key informant interviews indicate that RH/FP champions were not very active in the SWAp or PRSP processes. Ghana's PRSP and SWAp documents state that consultative processes occurred in the development of both strategies. However, what is not as clear is what programs or priorities the participants represented. Key informants reported that that issues related to RH/FP appear to have not been discussed in depth, and RH/FP advocates were only minimally involved in shaping the SWAP, mainly because they were not invited to discussions. Those familiar with PRSP development stated that the PRSP was actually developed by a small group of individuals with little input even from RH/FP program managers in the MOH. This lack of stakeholder involvement may explain why FP/RH programs are not expressed in the implementation strategy outlined by the MTP.

3.3 Zambia

The Zambia SWAp is a result of health reforms that began in 1992 although the Memorandum of Understanding with donors participating in SWAp was not signed until 1999. The priority areas included in the National Health Strategic Plan (2001-2005) for the Zambia SWAp include malaria, HIV/AIDS, Tuberculosis, STIs, integrated reproductive health, and child health.

Zambia's SWAp includes pooled donations into a district "basket," the key intervention level. These funds, which in 2000 totaled \$6.5 million dollars, are released to districts on a quarterly basis. Donors participating in the pooling of funds include UNICEF, DANIDA, SIDA, Ireland Aid, and USAID.¹ The Netherlands, Japan, UK, Canada, and USAID are continuing to provide direct project support, through contributions of equipment and supplies, including contraceptives.

The major objectives of the Zambian PRSP are to promote growth and diversification in production and exports; improve delivery of social services; and incorporate crosscutting policies for HIV/AIDS, gender, and the environment. The resource envelope for the Zambia PRSP has been costed at US \$1.2 billion for the period 2002-2004.

A priority for the health strategy in the PRSP is the financing of a basic health package that includes the following public health issues: malaria, HIV/AIDS, STIs, tuberculosis, integrated RH, child health, and improving control of epidemics and hygiene. Services included as part of the basic package are cost shared, meaning that Zambians contribute some payment for services. However, services that fall outside of the basic health package need 100 percent cost recovery.

As part of the SWAp emphasis on the decentralized level, staff at the district level became responsible for managing and implementing a whole range of primary care activities. A rapid transition period and relatively weak technical capacity to carry out their new responsibilities had serious consequences for areas such as drug ordering and the results were drug shortages and stockouts (Brown 2001; Institute for Health Sector Development 2001). The PRSP is thus making this issue a priority by stating that "there is an immediate need to restructure the procurement system so as to ensure that the purchasing of drugs is done more efficiently."

The largest allocation under the \$1.2 billion Zambian PRSP goes to Roads (19.1 percent). Health receives the second largest allocation (16.7 percent), with the bulk of this provision (\$125 million) going to fund the basic package of services. The PRSP does not provide detail on implementation strategies.

According to the IMF and World Bank's joint staff assessment of the PRSP, Zambia adopted a participatory approach from the beginning. Consultations were carried out in each province and the draft PRSP was presented at a national stakeholder summit. Zambia has also included nongovernmental organization (NGO) and donor representatives on the monitoring and evaluation subcommittee. However, it is important to note that the type of stakeholders involved are not specified (e.g., RH or FP representatives).

¹ Zambia is the only country where USAID is giving funds to the "basket funds".

Implications for Contraceptive Security

“Reproductive health programs are not enough aware of the issues and are by and large isolated from the SWAp process.”
Key informant, Zambia

While the PRSP as well as the SWAp mention integrated reproductive health, there are no details about what this entails or how it will be carried out. Zambia is focusing efforts at the district level through the provision of an essential package of health services. FP services are included as part of integrated reproductive health and, therefore, are part of the basic package.

However, there is no specific line item for FP activities as funds for these services and commodities fall within the more general line item for the basic health package. Similar to Ghana, condoms are specifically included within the HIV/AIDS section of the PRSP (which falls outside of health and has received 7.9 percent of total funds, \$94 million); funding for condom promotion, distribution, and monitoring is \$8 million.

Despite the inclusion of integrated reproductive health as a health priority, no FP indicators such as TFR or CPR were selected to monitor progress towards meeting the goals laid out in the strategy. The indicators selected for the health component of the PRSP are: life expectancy, percent of children under 5 immunized, number of health posts, and number of antenatal care patients.

Key informants reported that it appears that although there is some opportunity for providing input to the development of SWAp/PRSPs, RH/FP advocates have not done so for several reasons: they are largely isolated from these processes and policy discussions in general, are not fully aware of the issues, and have not changed their thinking from vertical to integrated health programs.

3.4 Bangladesh

Bangladesh's Health and Population Sector Program (HPSP) began in 1999 and ended in December 2003. The five-year follow-on is the Health, Nutrition and Population Sector Program. The following information pertains to the former program, as the latter is currently under development.

Over the five years of the HPSP, \$400 million dollars were pooled (roughly 50 percent of donor funds). These funds were contributed mainly by the World Bank, Netherlands, and SIDA, and managed by the Bank in a separate account. Other donors, such as the Canadian International Development Agency, *Kreditanstalt für Wiederaufbau* (or KfW, the German Development Bank), DfID, JICA and the EU participated in the SWAp through earmarked funds for commodities and/or technical support (Merrick, 2002). In addition, USAID, JICA, the Asian Development Bank and the UN agencies supported the SWAp through programs outside of the pool. These funds have been managed by each donor in separate accounts or channeled through other agencies (e.g. NGOs).

The HPSP aimed at improving the health of Bangladeshi women, children and the poor by providing client-focused, better-utilized essential health services. The main thrust of this strategy was the delivery of an essential services package (ESP) within a restructured, decentralized and integrated service delivery system. The ESP emphasized maternal care, control of certain communicable diseases, and child health. The HPSP strategy included phasing out of home visits by health and FP workers and placed them in community clinics that were being established for delivery of the ESP. Similarly, NGOs (including USAID-funded NGOs) discontinued door-to-door provision of contraceptives.

Bangladesh has completed an I-PRSP that was approved in March 2003. As it is an interim strategy, it is mainly a road map for completing the full strategy with fewer details than a full PRSP.

The plan for the full PRSP includes five broad areas: pro-poor economic growth, fostering human development, women's advancement and closing of gender gaps, social protection to the poor, and participatory governance.

A Joint Staff Assessment of the I-PRSP by the World Bank and the IMF found that the consultative process in developing the I-PRSP was quite good in its broad inclusion of nongovernmental and community-level groups. However, reports indicate that neither the health or education sectors were involved in the planning of the poverty reduction strategy in Bangladesh (Foster and Mackintosh, 2001).

Implications for Contraceptive Security

Issues concerning contraceptive security are prominent in the Bangladesh SWAp. This is due to greater importance of the integration of FP services and commodities as part of the essential services package. There is also long history of commitment to population and the provision of contraceptives on the part of the Bangladeshi government. Within the SWAp design, commitment to family planning is indicated through inclusion of CPR as well as discontinuation rates as indicators for monitoring success of the program.

The I-PRSP mentions subsidized provision of birth control supplies as part of their poverty reduction strategy. There is also focus on the provision of FP services through the ESP.

A mid-term review of the HPSP found that the government had achieved changes in the structure and functioning of the health and family infrastructure that has paved the way for a more rational, efficient, and effective system. However, there are also critical areas of concern including the leveling off of the total fertility rate (a key indicator for measuring success). There were also delays in government procurements, which has affected service delivery. In fact, the mid-term review pointed out that only a fraction of the procurement packages had been completed and most were in initial stage of the process. These procurement problems impacted the delivery and uptake of health and population services. However, major obstacles in service delivery were avoided by arrangements made by UNFPA and UNICEF for emergency supplies (contraceptives and drug kits) (Brown, 2001; Ensor, 2002).

Key respondents indicated that it was the NGO advocates, in particular, who had limited participation in the processes. Several respondents mentioned a tension between NGOs and the government, noting that for the most part, NGO presence in discussions was only token. Despite this, it appears that issues related to RH/FP were discussed and that the previous government supported reforms in favor of RH/FP as implemented in the HPSP.

3.5 Discussion

The overall findings for all three countries show that while reproductive health issues are considered in broad strategic priorities, they are less prominent at the more detailed planning or implementation level. When considering whether contraceptives are explicitly addressed, condoms and their promotion are focused on for HIV/AIDS prevention and planning. FP commodities are specifically included only in Bangladesh's PRSP.

This study found that when family planning was discussed in PRSPs or SWAps, it often appeared in general statements such as strengthening of FP programs or increasing RH/FP education. Without the expressed commitment on the part of donors and governments to make commodities a

priority, when there is competition for scarce resources, programs that are not highlighted or addressed may fall by the wayside. Therefore, the onus is on implementers to translate general or broad policies into programmatic objectives for contraceptive security and then link them back to the overall strategy, and on donors to advocate for their inclusion because they are “at the table.”

There were mixed reviews regarding the participation by stakeholders. World Bank mid-term reviews of PRSPs from all three countries found that stakeholder participation was strong. In contrast, most key informants indicated that participation by RH or FP advocates in the SWAp or PRSP design process was minimal. Often advocates were not informed on when or how the process was taking place; those who were involved in the design stages often did not know about the issues in depth.

The picture is less clear as to whether the new funding mechanisms have changed or influenced the level of commodities provided by donors. Accurate estimates on global donor financing for RH commodities are difficult to obtain (Mayhew 2002 and UNFPA 2001). For some donors it is difficult to separate the amount spent on commodities vis à vis overall RH/FP program support, particularly if they are participating in pooling of funds. Many bank loans are used to finance basic social service programs (such as integrated health and nutrition) with RH or FP components embedded within them, making disaggregation of figures difficult (UNFPA 2001). Unfortunately, key informant interviews did not provide any additional insights. However, both key informants as well as the literature review suggest that there is potential for SWAps to reduce commodity spending if commodities are not explicitly planned for in the basket fund. In-depth financial assessments at the country level would be required to determine whether there is sound evidence either way. One key informant, however, pointed out that the SWAp is only an instrument and that the level of commodities ultimately available “probably has more to do with how commodities and those funds are managed.”

What has been shown is that continued reliance on parallel funding to maintain commodity supply does not do much for government leadership of programs. For example, in Ghana where some sexual and reproductive health programs continue to be implemented outside of the SWAp, the government did not initially include condoms as a budget item because it knew USAID and UNFPA would continue to provide them (Mayhew 2002). Reliance on parallel or project funding will also not resolve donor coordination issues, and it maintains the vertical structures that countries are trying to move away from.

While this study sought to determine how contraceptive security is affected by new funding mechanisms, the challenges hold true for most if not all vertical services and priorities. RH/FP stakeholders are not alone in trying to navigate and benefit from new directions in receiving aid. Rather they should leverage and benefit from the each other.

4. The Way Forward

“Building political support requires a strong evidence base, especially when making the case that full financing of reproductive health services should be a high global priority that is a benefit to society as a whole, worthy of investment at a time of intense competition for human and financial resources”

Germain, 2004

The development universe is ever-changing. Those who are ready and prepared with the knowledge and skills to navigate capably through the system will benefit the most; either through increasing or maintaining funds or ensuring inclusion of their priorities. What implications do findings from this study have for RH/FP stakeholders? How can stakeholders ensure that contraceptives and other RH commodities are prioritized?

Participants at a UNFPA workshop on SWApS in 2000 concluded that the integration of reproductive health issues remains problematic. As a result, the following recommendation was made: “all stakeholders who wish to support or be involved in the implementation of a SWAp should join preparatory and planning stages as soon as possible. This is the only way to ensure that issues of interest to them, as well as modalities and instruments for measuring desired change in those issues are factored therein.” Similarly, a study looking at the experiences of integrating vertical programs into SWApS conducted in 2001 found that a key point for ensuring that vertical programs retain their quality and effectiveness depends on their maintaining status as a national priority (Brown, 2001). The same issues hold true for PRSPs.

Using the findings from the three-country study as well as the literature review, PHR*plus* has developed the following recommendations for all stakeholders – host country governments, donors, program implementers, communities – to maximize resources for contraceptives.

- ▲ **Reproductive health and family planning advocates must be knowledgeable of the changing funding environment to ensure visibility of commodities.** Understanding the system will lead to increased and more effective participation by RH/FP advocates and stakeholders in PRSP and SWAp planning. When RH/FP stakeholders understand and speak the language of reformers/donors/policy implementers, they can effectively translate RH/FP goals into poverty reduction or sector goals.
- ▲ **Information is not enough, RH/FP stakeholders need to be proactive.** Have data to demonstrate why continued support for RH/FP programs is important. For example, in Ghana, the education stakeholders did not feel that a one-day meeting, offered and funded by PRSP planners, was sufficient to discuss and prioritize their strategies. They voiced their concerns and paid for another full day of meetings to ensure that their inputs to the process were well informed and designed.

- ▲ **Be responsive by modifying programs to reflect new objectives and creative in demonstrating how RH/FP priorities and programs meet the funding flows and international demands.** Given that poverty reduction strategies place greater emphasis on targeting services to the vulnerable and underserved (often the same groups who have the least access to contraceptives), RH/FP stakeholders can position inclusion of commodities as a means to reduce poverty.
- ▲ **Increase other donor participation in World Bank and the IMF reviews of PRSP and IPRSP progress in countries.** Because the Bank supports and has agreed to work toward the MDGs, they look for links to MDGs in PRSP monitoring and evaluation frameworks. Other donors (such as USAID) could second staff to participate in assessments to provide a greater voice for commodities as well as ensure that their priorities are being addressed in the reviews.
- ▲ **Map out how RH/FP programs and services help achieve internationally accepted goals and measures such as the MDGs.** While the MDGs do not include CPR, TPR, unmet need, or other RH goals, sexual and reproductive health interventions are critical inputs for achieving them – a recent report by the Alan Guttmacher Institute for UNFPA, *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*, makes a strong case for how sexual and reproductive investments make valuable contributions to achieving global goals (Singh et al. 2003). Donors could provide assistance to governments and program planners to link project goals to broader systems goals expressed in SWAps, PRSPs, or MDGs. The findings from this exercise could be shared with governments and provide donors and RH/FP advocates a greater voice in setting priorities.
- ▲ **Place emphasis on tracking subnational indicators that more accurately measure progress among the neediest populations.** Often indicators are set for national levels (overall maternal mortality rate or TFR), which studies have shown are more effective at showing impact among mid- to upper-quintile groups and not the lower and neediest segments of society, such as rural populations and the poor. By tracking RH/FP indicators at the subnational level, there will be strong evidence to show the impact that RH/FP programs can have.
- ▲ **Establish interim indicators by which progress can be measured in the medium term.** Because real impact takes a long time to demonstrate, donors should provide assistance to governments as well as RH/FP stakeholders to develop strong intermediary measures.
- ▲ **Link planning and budgeting processes to broader national and international objectives.** There is a disconnect between national priorities and budget allocations and the filtering of priorities and funds to the local or decentralized level. Often what districts plan and budget for do not meet national, let alone international objectives. Donors and country governments should provide assistance and training so that the planning and budgeting process is grounded in the reality these managers face while linked to the broader national and international objectives.

- ▲ **Improve tracking of donor as well as government expenditures on contraceptives.** UNFPA is attempting to strengthen data collection efforts and has created a database on Donor Support for Reproductive Health Commodities and Logistics. Further work in this area is needed however, as not all donors contribute to the UNFPA database; there also are data quality issues inherent in questionnaire-style reporting. RH subanalyses using the National Health Accounts framework can be a valuable tool in more accurately capturing expenditures on RH commodities and services. *PHRplus* is currently conducting RH NHA in three countries.
- ▲ **Encourage private sector participation in development of PRSP and SWAps.** Ideally SWAps and PRSPs should include the full spectrum of activities within a sector but, in reality, most only capture public sector expenditures (Merrick, 2001). Given the large role that the private sector can play in the provision of contraceptives and FP services, there is a need to consider the sector in these processes.
- ▲ **A small amount of good technical assistance to assist implementation will help steer the process.** DfID is currently providing technical assistance to help program managers change their thinking (from vertical to integrated). USAID as well as other donors can go one step further and provide these managers with the skills to maintain vertical priorities in an integrated environment.

Annex A: PHR*plus*/SO1: Countries that Meet Selection Criteria for Three-country Case Study

PHRplus SO1: Countries that meet selection criteria for three-country case study

Length of experience			Availability of data	Donor involvement in contraceptive funding	In-country presence
Country	SWAp	PRSP			
Bangladesh	Started July 1998	I-PRSP December 2002	<ul style="list-style-type: none"> ▲ DHS 1996-1997; 1999-2000 ▲ National Health Account (NHA) data ▲ National Institute of Population Research and Training, ORC Macro Maternal Health Services and Maternal Mortality Survey 2001 ▲ US Census Bureau, International Programs Center, International Database 2000. 	USAID; KfW; Bangladesh	USAID supports the activities of several US, international, and local contractors, grantees, and agencies in Bangladesh.
Ghana	Memorandum of understanding in 1998	<ul style="list-style-type: none"> ▲ I-PRSP June 2000 ▲ PRSP completed in 2002 	<ul style="list-style-type: none"> ▲ DHS 1988; 1993; 1998; 2002/03 ▲ US Census Bureau, International Programs Center, International Database 2000. ▲ Comprehensive Household Survey 1998/99 ▲ Fifth Ghana Living Standards Survey 2002/03 ▲ Core Welfare Indicators Questionnaire 2002/03 	UNFPA/UNAIDS	<p>USAID supports the activities of several US, international, and local contractors, grantees, and agencies in Ghana.</p> <p>Abt Associates Inc. is present in Ghana.</p>
Kenya		<ul style="list-style-type: none"> ▲ I-PRSP July 2000 ▲ PRSP expected by March 2003 	<ul style="list-style-type: none"> ▲ DHS 1989;1993;1998 ▲ NHA data ▲ Household Survey 2000/01 ▲ US Census Bureau, International Programs Center, International Database 2000. ▲ Ministry of Health, National Council for Population and Development and ORC Macro Kenya Service Provision Assessment Survey 1999. ▲ Poverty Assessment 1996 ▲ Welfare Monitoring Surveys 1994; 1997 ▲ Participatory Poverty Assessment 1996 	USAID is the leading population and health donor; DfID; KfW; UNFPA; International Planned Parenthood Federation (IPPF)	USAID supports the activities of several US, international, and local contractors, grantees, and agencies in Kenya.

Nepal	Agreed upon in 1999	<ul style="list-style-type: none"> ▲ I-PRSP early 2001 ▲ Currently preparing PRSP 	<ul style="list-style-type: none"> ▲ DHS 1996; 2001 preliminary ▲ NHA data ▲ Nepal Living Standard Survey 1996 (Central Bureau of Statistics) ▲ US Census Bureau, International Programs Center, International Database 2000. ▲ Ministry of Health and Macro International, Inc., Nepal Family Health Survey 1996. 	USAID, KfW, UNFPA, DfID	USAID supports the activities of several US, international, and local contractors, grantees, and agencies in Nepal.
Zambia	Began in 1992	<ul style="list-style-type: none"> ▲ I-PRSP July 2000 ▲ PRSP March 2002 	<ul style="list-style-type: none"> ▲ DHS 1992; 1996 ▲ NHA Data ▲ Good quality National Household Expenditure Surveys (1991; 1993; 1996; 1998) ▲ US Census Bureau, International Programs Center, International Database, 2000. 	DfID; IPPF	<p>USAID supports the activities of several US, international, and local contractors, grantees, and agencies in Zambia.</p> <p>Abt Associates Inc. is present in Zambia.</p>

Sources of PRSP documents

Bangladesh I-PRSP: <http://www.sdnbd.org/sdi/issues/poverty/BD-prsp/>

Nepal I-PRSP: <http://www.ndf2002.gov.np/consult/prsp.doc>

Ghana, Kenya, Zambia: www.worldbank.org/poverty

Annex B: Interview Guide

1. Were you involved in the development of the health sector section of the SWAP and/or PRSP in (Ghana/Zambia/Bangladesh)? If not, are you familiar with the process? Is there a defined process for providing comments on the existing PRSP/SWAP? What is it?
2. What donors and stakeholders were involved in the development of the health sector portion of the PRSP? SWAP?
3. In particular, what reproductive health/family planning (RH/FP) program managers were involved (e.g., MOH, NGOs, USAID, UNFPA, IPPF)?
4. What was the degree of their involvement?
5. What do you think were the impediments that prevented (or the factors that facilitated) their involvement in the process? What factors could facilitate their involvement in the future (or in other countries)?
6. To your knowledge, were issues related to RH/FP discussed in the SWAP and/or PRSP process, such as RH/FP service delivery, demand generation, commodity procurement/logistics and/or specific RH/FP indicators (CPR, MMR)?
7. Should commodities be included as a priority in SWAP or PRSP development? Why or why not? If so, how could it be included?
8. Do you feel that the level of commodities provision by donors has been changed either by the PRSP or SWAP? Please explain.
9. Has either the PRSP or SWAP changed or influenced the amount of commodities provided by donors? If so, how (increase/decrease/shifted burden to other donors/government)? If not, does it have the potential to do so? How?
10. Has the government changed its approach or attitude to commodities given the SWAP or PRSP (i.e., if donors reduce commodity support, how does the government respond)?

Annex C: List of Organizations Contacted for Key Informant Interviews

Canadian International Development Agency (CIDA)

Department for International Development (DfID)

U.S. Agency for International Development (USAID)

United Nations Population Fund (UNFPA)

The World Bank

London School of Hygiene and Tropical Medicine

Tulane University

Ghana Health Service

Abt Associates Inc.: *PHRplus* (Ghana and Zambia) and Zambia Integrated Health Project

IntraHealth International: PRIME II project (Bangladesh, Ghana)

John Snow Inc: DELIVER project (Bangladesh, Ghana)

Management Sciences for Health (Zambia)

Population Services International (Zambia)

University Research Co. LLC: NGO Service Delivery Program (Bangladesh)

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