Contraceptive security is a major concern of African faith-based organizations (FBOs), donors and partner organizations supporting services by FBOs. Christian Connections for International Health interviewed representatives from eight countrywide Christian Health Associations (CHAs) at the biennial conference of the African Christian Health Associations Platform (ACHAP) in Accra, Ghana in February 2011. National CHAs in Africa are networks of FBOs, each network having several hundred FBO members. Many CHAs provide 30-50% of the health care in their countries, compared with the public sector, and often work in rural underserved areas with hospitals, clinics, and community health workers. They are well suited to increase access to family planning, and have expressed their desire to do so (CCIH 2008 member survey).

Major findings from interviews

- CHAs in all 8 countries report that their member organizations provide family planning services; these include Zimbabwe, Kenya, Malawi, Sudan, Nigeria, Zambia, Chad and Tanzania
- Family planning commodities are provided for free via a single source (governments) in these eight countries. Commodity supplies are often erratic and with inadequate quantities for FBOs in each country. Stockouts were frequent.
- Some countries have regulatory constraints preventing FBOs from purchasing through private sources. In these countries contraceptives could only be obtained through government sources.
- CHAs and their members were seldom represented at stakeholder/donor meetings where contraceptives and other MCH commodities were discussed.
- FBOs were sometimes included in government forecasting for commodities. More often, inclusion in forecasting did not yield the supplies forecasted for FBOs. FBO systems for tracking and managing FP commodities varied from being weaker than government, to being at par with or stronger than government systems in most countries. CHAs would welcome assistance in training staff and strengthening their systems. They request assistance with management information systems (MIS) as well as logistics and drug management.

Conclusions

Faith-based Organizations (FBOs) are eager and willing to do more in family planning. In many Global South countries, particularly in Africa, FBOs and CHAs have positive views on family planning as an essential component of comprehensive health care. Governments and donors should support CHAs to strengthen contraceptive security through greater participation at stakeholder meetings on family planning commodities, strengthening MIS and data collection systems for monitoring and procuring family planning commodities from established government sources. Doing so will be an important advance for making family planning universally accessible and meeting the MDGs.
Introduction

CCIH is a membership organization which brings together over 140 Christian organizations and health care networks, 35 secular affiliates, and 300+ individuals working in international health in a forum for field-oriented and up-to-date health information, networking, advocacy, resource mobilization, and action on important health topics.

Christian Connections for International Health (CCIH) conducted a member survey\(^2\) in May 2008 to better understand the views and activities of its members, and to advance reproductive health in keeping with member views. The survey verified that its members have positive views on family planning as an essential component of comprehensive health care, documenting that CCIH members are active in 151 countries, have combined annual incomes of over $3.4 billion, and are often self-sustaining – some being present for over 100 years in countries where they serve.

Collectively and individually, these member organizations have tremendous reach and trust that extend deep into local communities, through pastors, women’s and youth groups, outreach as well as through an impressive array of medical clinics, community health outreach programs and state-of-the-art hospitals. Many of these groups have a long history of promotion of healthy lifestyles and preventive health care as a foundational pillar of their Christian beliefs.

More than half of CCIH members surveyed in 2008 provide family planning methods or information. Members, especially those in Africa, see major unmet needs for family planning. In-country FBO networks (CHAs) definitely want to do more to meet these needs, but lack resources. One common shortfall was commodity supplies. In many conversations, many CCIH members pointed to stock-outs and erratic supply systems as a key detriment to programs.

Christian Health Associations (CHAs) are national networks of FBO health facilities and drug supply organizations. They include health facilities of varying scales (hospitals, clinics, dispensaries, primary health care centers, community-based health posts). In many sub-Saharan African countries, CHAs provide a substantial portion of total health services, particularly in rural underserved areas. Together, they have formed an Africa-wide platform known as African Christian Health Associations Platform (ACHAP).

ACHAP currently has 26 member organizations from 21 countries of Africa who provide a significant proportion of the national health services, ranging between 20-50%. 75 participants from Africa, Europe and North America convened to discuss opportunities for strengthening capacity, partnerships and health systems for quality, accessible and sustainable maternal and child health service delivery through the faith-based health networks in Africa.

Methodology

To understand the constraints that FBOs face in procuring, forecasting and ensuring delivery of family planning commodities, CCIH conducted a preliminary information gathering exercise with CHAs at the 2011 Biennial African Christian Health Association Platform conference in Feb 2011. Via in-depth qualitative discussions using guided interview questions (Annex 1), several themes emerged as key concerns. The questionnaire was developed for national networks of Christian Health Associations.

Eight CHA representatives (executive directors or MCH managers) from the following countries were interviewed: Zimbabwe, Kenya, Malawi, Sudan, Nigeria, Zambia, Chad and Tanzania. Other countries that expressed interest but could not participate due to lack of time were Liberia and DR Congo. CCIH also noted many other CHAs from African countries that were represented at the conference (26 in total) but could not follow-up with everyone on site during the conference.

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\(^{*}\)By Devina Patel, with contributions from Douglas Huber & Anne Wilson.

Findings

Service site/programs: All CHAs interviewed stated that member organizations within their network provided family planning. Family planning information and services are offered within comprehensive health programs such as maternal and child health services. Integrated counseling, IEC and clinical services were mentioned as key components of comprehensive package programs. Most CHA member organizations work in rural and remote areas in a range of facilities both – community based and facility based. This makes supply-delivery even more challenging in places of weak infrastructure. CHWs and village health workers were cited are key vehicles of FP service delivery in rural areas. Women often preferred faith-based sites to government sites for as quality of care was cited to be better. As such, demand and need for contraceptives often exceeded supplies.

Procurement procedures – Availability, method mix, funding and family planning commodity sources varied in each country. All CHAs reported that they had no funding for purchasing family planning commodities. They rely on free government sources. Erratic supplies were a major concern with all. Some countries reported having a balanced method-mix, while others reported that government supply systems failed to recognize demand for particular methods. All CHAs worked within the country central, regional and district supply systems for forecasting, estimating demands and reporting.

Storage and Distribution: Some CHA member organizations had access to private (non-governmental) storage units and distribution systems with the capacity (both electronic and human) to manage supplies. Many CHAs had an extensive and impressive network of rural health posts that were linked to district and provincial facilities and ultimately to national secretariats. Distribution was done in the rural areas via community health workers and village health workers. CHA network/systems were often stronger than government networks. Strengthening CHA storage and distribution systems would strengthen the health system of the country.

Stock-outs: Stock-outs and erratic supplies were frequent phenomena. A key reason given was that government priorities meant that often FBO facilities did not receive all they needed and requested. FBOs were sometimes included in national forecasting models; however the national mechanisms to ensure distribution were not always understood or implemented. The shortfalls in supplies also require a strengthening in forecasting and supply-chain systems. All CHAs outlined a few ways they work around this problem, e.g., commodity exchange between member organizations on an ad hoc basis, referral of patients/clients between member organizations, offering alternate family planning methods (if acceptable to patient/client).

MIS: Most CHAs reported that quantification and forecasting systems were in place to determine needs. Some reported that better training in MIS would assist in ensuring that their needs were better fed back into government systems. Better coordination between government and non-governmental organizations (FBOs included) to ensure interaction with the national MIS system for FP is needed.

Country Stakeholder Coordination: With the exception of one CHA, respondents noted that the CHA was not included in stakeholder meetings at national level. Many cited that while FBOs (member organizations of CHAs) provided a large share of the health services in country, there was seldom an invitation to participate and provide a FBO voice when donors and governmental stakeholders gathered to discuss issues of health at national levels.

Policy obstacles that limit FBOs to provide FP services – All CHAs cited that MOH provided FP supplies for free. Several countries mentioned that regulatory constraints prohibited FP commodities being purchased privately: all had to be procured via government sources.

Internal Systematic issues: FBOs were eager for additional assistance for better MIS, management training and contraceptive updates. All welcomed additional training and support for systems to improve contraceptive security.
Discussion

Limitations of this survey include the small sample size of 8 countries. However, the similarity of problems among these eight suggests the findings will apply to others. Every participant that was approached quickly and readily agreed to provide thoughtful information. Many respondents showed initiative to follow up with CCIH and avail themselves during the ACHAP conference. However the capacity to gather more information at the conference was limited by availability of staff time.

Some informants did not have complete information about commodities for their members and were not able to address all questions. However, it should be noted that the 2008 CCIH survey of 67 member organizations included a number of African as well as international supporting FBOs, which noted similar problems and concerns in this area of contraceptive security.

Other commodity information gathered over the past three years by CCIH staff and FP/RH Working Group members have verified that CHAs and member FBOs often need to have additional sources for a wide range of medical supplies to supplement those from their governments. FBOs regularly seek secondary sources through other organizations or donations.

The Mission for Essential Drugs and Supplies (MEDS) in Kenya, (http://www.meds.or.ke/), is an example of a large faith-based drug supply warehouse and distribution system. However, most faith-based drug supply systems do not carry contraceptives, particularly when they are jointly managed by Catholic and Protestant faith communities. Therefore, strengthening CHA and local FBO systems for accessing their governments’ supplies is especially important.

In one country FBOs purchased contraceptives from the social marketing programs. However, this was uncommon as funding for such external purchases is often limited.

Several questions of interest for FBO providers could be explored in the future.

- Voluntary sterilization: What is the scope for this method since in most African countries 20-45% of women represent unmet need by women who want no more children?
- Natural methods: What are current utilization rates? The need for NFM to be better understood, marketed and utilized is great.
- Could private sector channels, in addition to subsidized sales using donated contraceptives, be utilized?
- Purchase of contraceptives by CHAs – what are the barriers and bridges to diversifying commodity supply sourcing streams?
- How can facilitation of better CHA engagement with UNFPA and USAID country offices happen?

Conclusion

CHAs in Africa are strongly interested in strengthening their own supply-chain systems and want a greater role at stakeholder meetings and conversations to address contraceptive security issues. They also affirm the large role that FBOs have in delivering health care in their respective countries. They advocate for multiple sources of family planning commodities and for strengthening systems in supply-chain management.

Acknowledgements

Contributions to the development, implementation and review of the survey were made by Ray Martin, Anne Wilson, Judith Brown, and Douglas Huber of CCIH. Mark Rilling of USAID and Gary Steele of JSI/Deliver made valuable suggestions for survey questions.
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<th>Respondent Name:</th>
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| Programs: | Let’s talk about family planning. Could you tell me a bit about the kinds of programs that your organization runs in family planning?  
- Rural vs. urban  
- Extent of network/reach  
- Facility-based vs. community?  
- How many org in your network?  
- Rough numbers?  
- What FP Commodities? | Responses: |

| Procurement: | Help me understand about the procurement systems for FP in your country. What are the commodities available – please list. Is your organization able to procure contraceptives and related products on a routine basis? | |

| Procurement: | How do the member organizations within your network procure FP commodities? Are you happy with your system or approach? What would you recommend to other member organizations in the approach that you use? | |

| Distribution: | How does the organization efficiently and effectively distribute commodities to its service sites? | |

| Storage & Distribution: | Does the organization currently have a centrally managed logistics and distribution system for distributing medical supplies and information materials to its service sites? Describe. | |

<p>| Stock-outs: | So many people face stock-outs, does your organization ever face stock-outs? How often? Why does this happen? Describe the last time this happened. What are alternate sources of commodities for your organizations? Where does funding for this come from? | |</p>
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<th>5</th>
<th><strong>MIS</strong>: Tell me a bit about the MIS system. It is often so difficult to step back and record things when you are so busy! Could you tell me a bit about what kind and how these service statistics are collected? Who does this in your office? How does this interact with the national MIS system for FP?</th>
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<td>6</td>
<td><strong>Forecasting</strong>: So, how do you know how much you need? How does organization estimate demand for each FP method? Who does this in your office? Access to country coordinating mechanisms?</td>
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<td>7</td>
<td><strong>Capacity</strong>: Who is responsible for FP programs? Procurement and logistics of FP commodities? Are they full-time staff members? How are they trained?</td>
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<td>8</td>
<td><strong>New methods introduction</strong>: Tell me about special mechanisms in place to assess and evaluate new initiatives, i.e. introduction of a method – such natural family planning?</td>
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<td>9</td>
<td><strong>AOB</strong>: What other issues do you foresee need to be addressed to ensure smooth procurement and distribution, and ultimately strong family planning programs to get to where your organization wants to be?</td>
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