Outlook: Celebrating 20 years of providing reproductive health information worldwide.

OUTLOOK

Ensuring Contraceptive Supply Security

International assistance for family planning has been shrinking at a time when many family planning programs in developing countries are experiencing shortages of contraceptives. A reliable, adequate supply of good-quality contraceptives—such as intrauterine devices (IUDs), oral contraceptives, condoms, emergency contraceptives, and injectables—is a critical component of successful reproductive health programs. It is also a basic requirement for guaranteeing good reproductive health choices to women and men, one of the objectives of the 1994 International Conference on Population and Development (Cairo) Programme of Action. Supplies are the often-unrecognized foundation of reproductive health programs. Yet funding shortages combined with both a surge in contraceptive use and insufficient institutional capacity have made it difficult for many programs in developing countries to establish and maintain a secure supply of contraceptives.

Contraceptive security is achieved when a program is able to forecast, finance, procure, and consistently deliver a sufficient supply and choice of well-made, dependable contraceptives to every person that needs them.[1] This issue of *Outlook* outlines the main causes of shortages. It also highlights the challenges and opportunities faced by program managers, service providers, the commercial sector, donors, and other stakeholders, whose contributions are key to ensuring a ready supply and choice of quality contraceptives. Understanding global and national constraints related to contraceptive supplies should help program managers better plan for supply availability.

Why Is Contraceptive Security Critical?

Without appropriate supplies, reproductive health services are ineffective. As Steven W. Sinding, director-general of International Planned Parenthood Federation (IPPF), recently stated, "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."[2] Lack of access to reliable supplies leaves women vulnerable to unintended pregnancy and births; increased rates of abortions, especially unsafe abortions; higher maternal and infant deaths and disability; and higher rates of sexually transmitted infections, including HIV/AIDS.

Participants at a meeting in Mombasa, Kenya, in November 2001, reported on contraceptive shortages in Ghana, Namibia, Liberia, Zambia, Tanzania, and Kenya. Ghana's Ministry of Health later reported that the funding shortfall for its family planning

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Consequences of Funding Shortfalls

For every $1 million shortfall in contraceptive supply assistance, there are:

- 360,000 unintended pregnancies
- 150,000 induced abortions
- 800 maternal deaths
- 11,000 infant deaths
- 14,000 deaths of children under 5

Source: United Nations Population Fund (UNFPA)[3]

program was US$400,000 below requirements and could grow to nearly $5 million in six years without increased funding commitments, improved logistics support, and other interventions.[4] Many other programs, including ones in Iraq, Morocco, Palestine, Sudan, Yemen, and Nigeria, also have reported various contraceptives being out of stock (stockouts).

The Status of Funding

Shortfalls in funding for contraceptives are determined by comparing the amount needed to pay for contraceptives with the amount that is expected to be available from donors, governments, and individual users. Although estimates of future shortfalls vary widely, the present status of funding is more clear.

The shortfall in global funding from donor nations for contraceptives in 2000 was estimated at US$80 million.[5] In 2001, the shortfall dropped to about $28 million,[6] bolstered by special funding from the Netherlands, the United Kingdom, and Canada—circumstances that are not likely to be repeated. In 2002, UNFPA reported 73 countries with emergency shortfalls in reproductive health supplies (including contraceptives) totaling $150 million. UNFPA was able to provide only $24 million toward these emergency requests.[7]

UNFPA projects that the cost of meeting contraceptive needs will rise from US$572 million to more than $1.2 billion between 2000 and 2015.[3] When condoms for HIV prevention are included, supply costs are projected to rise from $810 million to more than $1.8 billion. The cost of ensuring the quality of services needed to deliver and provide these supplies is projected to increase from $4 billion to $9 billion over this same period.[6]

Assessing Contraceptive Security

A country's supply security often corresponds with its degree of dependence on international assistance. Some countries rely on international agencies for provision of supplies as well as for technical assistance to operate the systems that ensure that supplies reach clients. Other countries, such as Thailand, Morocco, Brazil, China, and India, are relatively self-reliant, although segments of their populations may not have access to products. The vast majority of developing countries count on some outside assistance for funding, supplies, and technical assistance.

A study published in 2001 used 12 indicators to assess contraceptive supply security in 31 countries (see Figure 1, page 3).[8] The indicators were organized into three broad classes: programmatic capacity (logistics), political and economic environment, and needs.

Most of the countries achieved their highest scores on commitment to family planning and to supplies. Few had high overall contraceptive security scores without strong government commitment. Those few have robust commercial sectors and relatively low poverty rates, which together may make government commitment less critical for their family planning programs.

Scores were lowest on programmatic indicators: forecasting, procurement, logistics management information systems, and storage and delivery. This weakness in logistics can, with donor assistance, be significantly improved. However, the countries also scored poorly on indicators related to finance: in-country budget, per capita gross national product, and proportion of the population below the poverty line. These low scores suggest that achieving financial self-reliance may pose the greatest challenge to contraceptive security.

This study suggests that most countries (22 of 31) in the sample have a very weak or weak contraceptive supply security level. Some scores may have improved since the data were originally collected, but the overall picture remains the same. In countries scoring below 50 percent of the maximum attainable score, national programs will likely require full donor support for at least 8 to 10 years to maintain viability. Countries with scores of 30 percent or less will likely require a minimum of 10 to 15 years of assistance. It is crucial that donors and their in-country counterparts understand the work required to create a sustainable program, so that donor withdrawal affirms self-reliance rather than prompting a program crisis.

Causes of Contraceptive Shortages

The factors that have led to contraceptive shortages worldwide include growing demand for contraceptives, shifting foreign aid priorities, lack of in-country capacity, and inadequate coordinating mechanisms at the national and global levels.

Growing demand. Population growth and the young age structures of many countries mean that more couples are interested in using contraceptives than ever before. The population of reproductive age in developing countries is projected to grow by 23 percent between 2000 and 2015.[9]

The success of family planning programs worldwide also has contributed to rising contraceptive demand. In developing countries, the contraceptive prevalence rate (the proportion of all married women aged 15 to 49 years

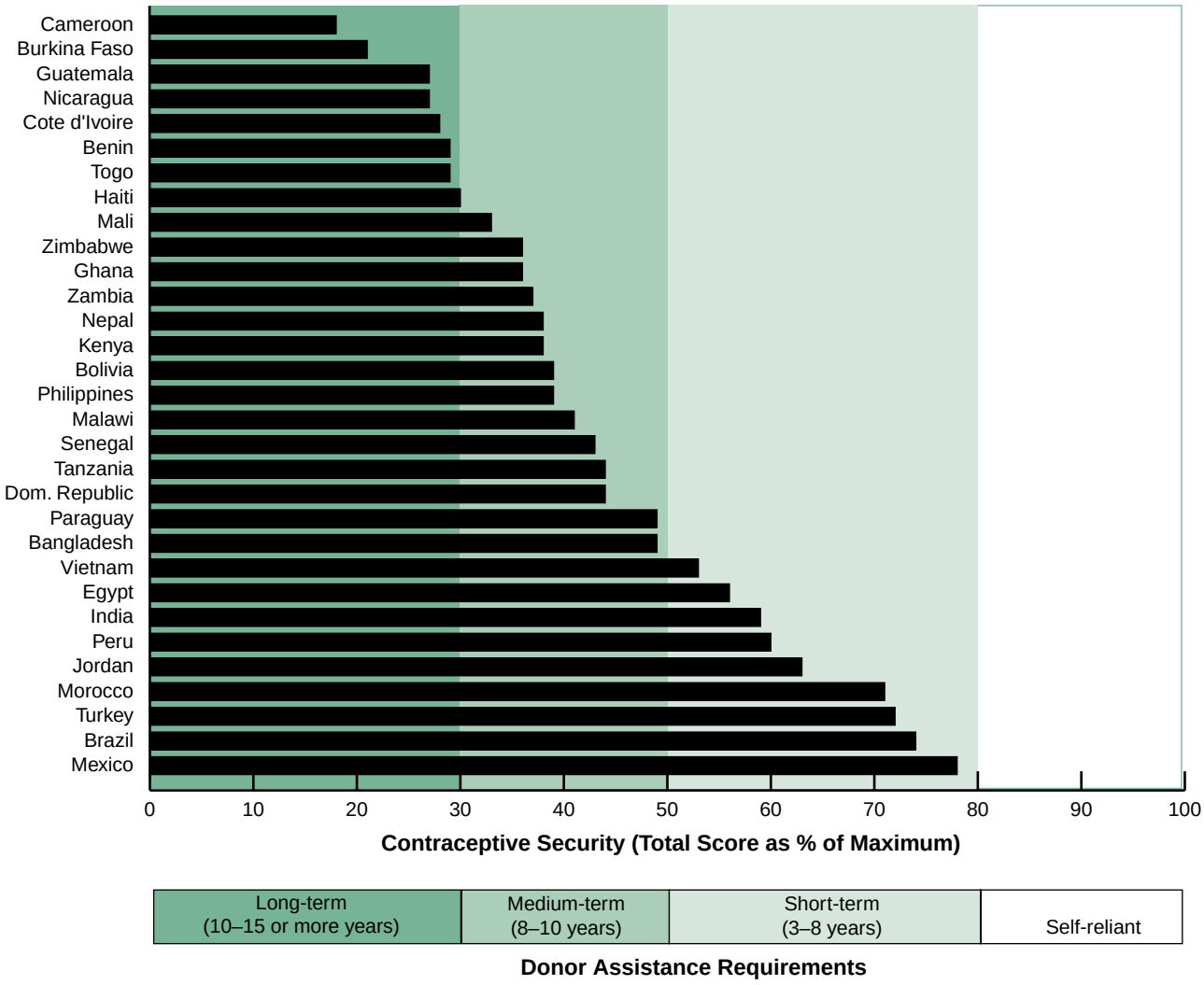
reporting current use of any contraceptive method) has increased from about 10 percent to 60 percent since the 1960s.[9] About nine out of ten contraceptive users now rely on modern methods. There is expected to be a 40 percent increase in developing-country contraceptive need over the next 15 years;[5] for countries that depend on donors for supplies, the projected increase is 79 percent.[10]

Changing donor environment. Donors are not supplying the contraceptives needed to meet increasing demand. More and more, they are stressing sustainability and increased self-reliance through capacity-building, private sector initiatives, and other means. As recently as 1996, donors covered about 41 percent of contraceptive costs globally; governments and other in-country sectors accounted for the remainder. In 2001, donor support accounted for only about 26 percent of the total.[7]

Lack of capacity at the national and local levels. Over the past 20 years, reproductive health programs have become increasingly complex. Supplies have expanded from a few contraceptives provided by a limited number of donors to a broad range of products provided through multiple sources. Ensuring that good-quality supplies reach clients requires effective logistics, regulatory, and quality assurance systems. Yet, in many countries, the systems and approaches needed to plan for, coordinate, and manage supplies are insufficient. Resulting problems include stockouts, shipment delays, and oversupply of certain contraceptives. Donor assistance often is needed to build the capacity to overcome these problems and achieve contraceptive security.

Inadequate coordinating systems. Strong systems for coordinating national and global supply efforts and

Figure 1. Contraceptive security status for 31 countries based on 12 selected indicators (2001).



Source: Finkle, Hutchings, and Vail, 2001.[8]

Requirements of Contraceptive Security

Adequate funding alone will not guarantee contraceptive security. The capacity to ensure that supplies reach the men and women who need and want them is crucial, as are an array of policy, political, and economic factors.

Capacity. Contraceptive supply security requires a minimum set of institutional capacities.

Logistics. Programs need the capacity to estimate current and future contraceptive requirements, procure required contraceptives, track and manage inventories at all levels of the supply chain, and store and deliver products to the individuals seeking services, when and where needed. Efficient logistics management systems can often prevent temporary stockouts and shortages of supplies.

Financial sustainability. Budgetary cycles, international procurement processes, and supply-chain time requirements dictate that funding be reliable and predictable a minimum of three to five years into the future. For most countries, sustainability requires taking advantage of financing options that relieve the public sector burden, including market segmentation, public-sector cost recovery, social marketing, and commercial and social health insurance.

Information systems. Effective information systems produce reliable and useful data critical to most programming functions: policy planning, priority setting, logistics, evidence-based interventions, program implementation, and monitoring. They are also important for galvanizing program support and for raising awareness among policy-makers and other potential advocates.[11]

Advocacy. Key stakeholders, parliamentarians, and concerned public and private organizations play an important role in raising awareness and mobilizing political support for supplies. These activities encourage governments, funding partners, and others to direct their resources to ensure the availability of health supplies; to reduce policy and process barriers, including taxes, price controls, and advertising; to promote consumer-centered strategies; and to improve the funding environment.[3] In Brazil, for example, successful advocacy campaigns led the government to eliminate tariffs and other retail taxes that were making condoms too expensive for many potential users. As a result, the average price of a condom dropped from a high of approximately US$1 per condom in 1992 to $0.20 in 1999, while annual sales increased sixfold.[12]

Environment. Conditions over which programs have no or little control also can influence contraceptive supply security.

Legal and policy environment. Favorable laws and regulations facilitate importing contraceptives and raw materials, and support expanding the commercial family planning sector. They also encourage a range of approaches to enable contraceptive distribution, promotion, or advertising.

Regulatory agency. With adequate authority and independence, drug and device regulatory agencies ensure the safety, efficacy, and quality of drugs (including contraceptives) by establishing a legal framework specifying requirements for manufacturing, importing, registration, certification, labeling, dispensing, and product problem reporting and recall.

Political commitment. A government committed to family planning works actively to eliminate barriers to its promotion and access; ensures contraceptive access to vulnerable groups; urges other stakeholders, such as social marketing and commercial providers, to play a meaningful role; and, when necessary, shoulders a significant share of family planning costs.

Commercial sector. When there is a vibrant commercial contraceptive market, the burden of providing supplies is not wholly borne by the public sector, and subsidized public sector supplies can be distributed efficiently.

Out-of-pocket payments account for 50 to 90 percent of health care spending in developing and transitional countries, compared to less than 30 percent in industrialized countries, where insurance and other third-party mechanisms share the cost burden.[13] Many who pay for their own supplies purchase them from the commercial sector, which includes private hospitals and clinics, pharmacies, employers, markets, and shops.

The commercial market share for family planning varies significantly across developing countries. For example, in much of Latin America, the commercial market share is more than 35 percent; in the Dominican Republic, Paraguay, and Bolivia, it is 50 percent or higher. Commercial shares in Asian countries vary widely, but rarely exceed 30 percent and typically are much lower.[14] In some countries in North Africa and the Near East, the share is also large, but it is relatively minor in most sub-Saharan African countries.[15]

Whether the commercial sector can play a major role in contraceptive security depends on a number of factors, including a country's public sector policy, income levels, contraceptive demand, and distribution channels.[15–19] Policy-makers who consider these factors in realistically assessing future market shares will be better able to ease the public sector burden and thus increase contraceptive supply security.

resources are rare. Stakeholders—including finance and health ministries, program managers, nongovernmental organizations (NGOs), and the commercial sector—need to work together to strengthen national programs.

The absence of global coordinating mechanisms contributes to overlapping or conflicting donor efforts as well as to supply emergencies. Donors, with country guidance, can establish global systems to coordinate needs forecasting, technical assistance, and advance procurement; divide funding responsibilities; and track and report supply support. Putting these systems in place will make assistance complementary among donors and appropriate to country needs.

Challenges to Ensuring Contraceptive Security

Achieving contraceptive supply security involves addressing several key challenges.

Funding. A survey of program managers in 13 countries revealed they believe that funding problems are the most serious threats to supplies and family planning programs. Limited resources combined with competing health concerns have made investing in family planning and reproductive health difficult for developing-country governments and individuals alike. Managers do not see the commercial sector as the answer to supply problems because it does not serve poor segments of the population.[20] As one survey respondent stated, "We do consider it our responsibility to provide quality services to all citizens."[21] Countries can make resources go further by minimizing inefficiencies, maximizing partnerships with the private sector, and targeting limited resources to those most in need.

Public-sector cost recovery is an underutilized approach to easing funding challenges. The feasibility of such a measure will vary from country to country, depending on what clients are able to pay. Where possible, charging a realistic price for contraceptives sold in the public sector will reduce the need for subsidies.

Government and donor commitment. Governments are key to the success of national family planning programs and contraceptive security. The proportion of their financial burden is evident in UNFPA figures for 1996: Of the $10 billion that was budgeted for all family planning worldwide, international donors gave $1.4 billion, development banks provided $0.6 billion, and developing-country governments and private sources supplied the $8 billion balance.[22] However, many countries have yet to show their full commitment. A recent review of essential medicines lists in 112 countries found that many national lists did not include basic contraceptives such as IUDs (which were on only 34 percent of lists) and condoms (35 percent).[23]

There are signs that countries are reorienting their programs around supplies. For example, a statement on supply security was written into Bangladesh's new population policy. In Mexico, federal health authorities recognized the importance of securing contraceptives for the national family planning program. Their negotiations with the health authorities of the country's 32 states resulted in classifying contraceptive supplies as a national security item (along with vaccines and other drugs), a step that establishes a budget line item to aid in procurement.[24]

Even while country governments expand their role, donor support for supplies is declining, erratic, and geographically limited.[9,25] A handful of donors account for most contraceptive supply assistance (see Table 1, page 6).[9] Furthermore, support often is committed only for a year or two, making planning for long-term product availability impossible. Longer-term funding commitments are needed to ensure that capacities are in place before donors withdraw support.[20,26]

HIV/AIDS and condom supply. HIV/AIDS has placed extraordinary demands on public health budgets of developing countries, and the burden is growing. By 2005 in Kenya, the expenditure on HIV/AIDS is projected to consume 50 percent of the health budget; for Zimbabwe, the estimate is 61 percent.[27] Those countries with the highest incidence of HIV/AIDS are in many cases the poorest with the weakest logistics infrastructures. They also are expected to have the highest increase in contraceptive demand in the next decade.[10]

Donor support for condoms has not kept pace with the rapidly escalating demand for condoms for HIV/AIDS prevention and for contraception. The amount provided in 2000 was approximately 60 percent of that provided in 1996 (the peak year of donor support), and was slightly less than the 1990 figure.[9] Estimates of future HIV/AIDS condom requirements vary markedly, depending on the assumptions, methodologies, and number of countries used in the calculations.[5,10,28–30] Nonetheless, it is clear that the number of condoms available to developing countries is inadequate. In sub-Saharan Africa, which has the highest prevalence of HIV/AIDS in the world, the condom supply amounts to about five for every man aged 15 to 59 per year, including the contribution of the country governments in this region (1999 figures).[28,31] Currently, an estimated six billion condoms are distributed annually worldwide, including industrialized countries.[32] UNFPA estimates that developing countries now need at least 9 to 10 billion condoms a year and will need nearly twice that many by 2015.[5]

Health sector reform. Many countries have been undertaking sweeping initiatives to make national health programs more responsive to local requirements, and to improve the efficiency, equity, access, and quality of health services. Health sector reform may involve integration of reproductive health services, cost recovery, privatization, and decentralization of the management and provision of care.[33,34] Although reform generally has had a positive effect on health care systems, contraceptive supply security has

Table 1. Estimated Contraceptive Commodity Support by Donor/Agency, 1990–2001, in Millions ($US)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL
BMZ/KfW			10.8	18.3	11.4	9.3	38.1	13.3	8.6	8.0	35.5	16.4	169.7
CIDA					1.4	4.5	7.2	0	1.0	2.9	4.8	0.2	22.0
DFID			4.1	4.7	7.2	10.9	9.2	13.1	7.8	13.2	7.3	6.1	83.6
DKT International						0.2	0		3.8	5.1	4.8	7.8	21.7
European Union				0.2	5.8	1.8	9.2	7.4	0.6	13.1	0	0.3	38.4
IPPF	5.8	5.4	6.2	6.1	6.3	6.7	6.0	11.1	3.4	3.0	3.8	3.7	67.5
Japan					0	0.3	0.3	0.8	0	0.2	1.7	0.3	3.6
MSI			0.4	1.2	0.4	0	0	1.4	0.1			3.7	7.2
Netherlands						0.1			2.7	2.5			5.3
Pathfinder Intl.			1.4	1.7	0.5	0.9	0						4.5
PSI			0.4			7.4	7.2	6.6	0.2	0.3	0.5	22.4	45.0
SIDA			1.3		0	1.4	0.8	0		0.5			4.0
UNAIDS										0.2			0.2
UNFPA	14.8	21.5	18.5	27.8	34.1	37.9	37.6	39.8	32.2	14.4	16.7	89.2	384.5
USAID	57.6	59.9	39.6	55.1	47.8	51.1	46.5	39.4	63.1	45.5	58.1	67.9	631.6
WHO	1.0	1.0	0.6	0.5	1.0	1.7	2.1	2.7	0.4	1.1			12.1
World Bank						5.0	7.9	1.7	19.1	20.7	20.7	6.1	81.2
TOTAL	**79.2**	**87.8**	**83.3**	**115.6**	**115.9**	**139.2**	**172.1**	**137.3**	**143.0**	**130.7**	**153.9**	**224.1**	**1,582.1**

Adapted from UNFPA, 2000.[9] Figures for 2001 provided by UNFPA.[35]

Notes: All figures are rounded to the nearest 100,000. In 2000, the significant increase in BMZ/KfW support was related to increased support to Bangladesh in that year. UNFPA figures represent the procurement from the UNFPA Country Programme budget. In 2000, UNFPA also procured and supplied contraceptives on behalf of CIDA, the World Bank, and the European Union. In 2001, the significant increase in UNFPA support was due to the special funding provided to UNFPA from the Netherlands, the United Kingdom, and Canada.

BMZ/KfW = Federal Ministry for Economic Cooperation and Development/Agency for Financial Cooperation (Germany)
CIDA = Canadian International Development Agency
DFID = Department for International Development (U.K.)
MSI = Marie Stopes International
PSI = Population Services International
SIDA = Swedish International Development Cooperation Agency
UNAIDS = Joint United Nations Programme on HIV/AIDS
USAID = United States Agency for International Development
WHO = World Health Organization

been adversely affected in some regions. Problems include inefficient procurement, a breakdown in supervision and training activities, stockouts, increased prices, and inequity between districts.[34] Many of these problems stem from the lack of the necessary skills among local and district program officials who have assumed greater technical and management functions.

In Mexico, where 60 percent of reproductive health services are provided through public sector sources, decentralization of the health system led to higher contraceptive prices. Mexico's most important supply donor, the United States Agency for International Development (USAID), ended its support in 1999. The government then found itself paying two times more for IUDs and nine times more for oral contraceptives. (The high prices resulted from "buy Mexico" regulations and associated high local production costs.)[26] As a solution, most states and service delivery NGOs now participate in a coordinated bulk purchase of contraceptives through UNFPA, which procures supplies from Mexican and non-Mexican sources at lower prices than are available with direct purchases.[36]

Promising Approaches

Recent efforts to create awareness about reproductive health supply problems have involved key stakeholders working together for solutions. International and national meetings held to foster such cooperation include one in Istanbul in May 2001 and another the following month in Kochi, India. The latter meeting, convened by Partners in Population and Development, promoted South-to-South collaboration to address contraceptive and other reproductive health supply issues. Working together ensures that various project efforts complement rather than duplicate one another so that resources are used more efficiently. Several initiatives are being undertaken to enhance coordination and strategic planning at the national and global levels.

Country coordinating committees. In national supplies coordinating committees, key stakeholders plan for reproductive health supply security. Bangladesh, Ghana, Kenya, Mali, Cambodia, Myanmar, Nepal, Nigeria, Laos, Yemen, and Zambia are among the countries that have established or reinvigorated existing national working groups for reproductive health supplies.[37–39] Their

goals and responsibilities vary according to needs and circumstances, but national committees can effectively coordinate actions aimed at achieving program priorities, such as securing funding or building logistics capacity.

Global coordinating committee. UNFPA has made reproductive health supply security a priority, and launched a global initiative to coordinate input from government, NGO, and private sector partners toward this goal. As part of this effort, UNFPA plans to revitalize the Global Initiative Working Group on Reproductive Health Commodity Management to ensure that the principal funders and technical agencies are working together, sharing information, and coordinating technical and supply support to developing countries. Keys to success will be the ability of individual agencies to harmonize aid strategies and procedures, commit funds beyond the immediate future, simplify rules and regulations, and make procurement processes transparent.

Other coordinating mechanisms. Since late 1998, several NGOs, donors, and private foundations have been working together to raise awareness, mobilize resources, and enhance donor coordination toward supply security worldwide. The latest organizational stage of this effort is the Supply Initiative (www.rhsupplies.org), which opened its new headquarters in Brussels, Belgium, in June 2003.

A centerpiece of the Supply Initiative mission is the RHInterchange, a Web-based tool to support a common procurement and shipment data platform for major contraceptive donors. The RHInterchange, which will become operational in 2003, will be used to coordinate efficient procurement and exchange vital information, including reports on product orders, shipments, schedules, and recipient programs and countries. By diminishing supply emergencies and enhancing knowledge of donor strategies and commitments, it will help avoid overlap and identify gaps in supply security efforts.

A separate collaborative tool, the Strategic Pathway for Reproductive Health Commodity Security (SPARHCS), is in the final stages of development, with input from many international and national agencies. It will provide a strategic framework to assess the strengths and weaknesses of a country's efforts to make reproductive health supplies broadly available to men and women. The tool will guide a country-driven process aimed at strengthening coordination of financing, policy-making, service delivery, and supply systems involved in maintaining reliable, long-term availability of supplies. SPARHCS was field tested in Nigeria, and a revised version is now being tested in Madagascar.

Conclusion

Contraceptive supply security can only be achieved if resources are increased and applied more efficiently. Public sector programs can reduce fiscal pressures without jeopardizing services to the poor through strategies such as charging clients affordable fees for services, market segmentation, targeting subsidized supplies to clients most in need, and encouraging commercial sector growth in the contraceptives market. Initiatives aimed at bringing stakeholders together can help reduce financial claims on government budgets.

Ideally, the responsibility for ensuring adequate supplies to a population should rest with its government. There are certain actions essential to establishing supply security that only in-country stakeholders can take, including the coordination of sectors needed for an effective response. Unfortunately, developing countries—especially those that historically have relied on donors for a large share of their contraceptive requirements—have limited foreign exchange with which to purchase supplies, inadequate implementation capacity, and competing health claims to government funds. Establishing the conditions necessary for sustainable supplies poses significant challenges that defy a simple solution or technical fix.

Because the security of most countries' contraceptive supplies depends on a constellation of global actors and systems, addressing supply security requires a worldwide response. The promising approaches now under way and the solutions that follow will need to be comprehensive, strategic, and long-term, requiring sustained efforts at all points of the global supply system.

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