A photograph of a young girl with short dark hair, wearing a white tank top, looking out from a window. The window frame is made of wood and metal. The room is dark, and a fluorescent light fixture is visible above the window.

Achieving Contraceptive Security and Meeting Reproductive Health Needs in Southeast Asia

Rosalia Sciortino



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Acknowledgments

This synthesis paper was prepared for the Asia Pacific Alliance for Sexual and Reproductive Health and Rights (APA) to provide evidence and sustain advocacy efforts to improve sexual and reproductive health responses in Southeast Asia.

The Asia Pacific Alliance for Sexual and Reproductive Health and Rights brings together NGOs from countries in Asia and the Pacific to mobilise resources for sexual and reproductive health and rights in developing countries. APA works to ensure everyone's right to health is fully achieved through the promotion and inclusion of sexual and reproductive health and rights.

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Acronyms



AIDS	Acquired Immune Deficiency Syndrome	LHVs	Lady Health Visitors
APA	Asia Pacific Alliance for Sexual and Reproductive Health and Rights	MARPs	Most at Risk Populations
ARROW	Asian-Pacific Resource & Research Centre for Women	MCHC	Maternal and Child Health Centre
BAPPENAS	National Development Planning Association	MDGs	Millennium Development Goals
BBT	Basal Body Temperature	MMCWA	Myanmar Maternal and Child Welfare Association
BKKBN	Family Planning Coordinating Board	MMR	Maternal Mortality Rate
BPS	Badan Pusat Statistik (Statistics Indonesia)	MOH	Ministry of Health
CCR	Center for Reproductive Rights	MSIM	Marie Stopes International, Myanmar
CCS	Community Cost Sharing	MSM	Men Who Have Sex with Men
CMS	Central Medical Stores	NCPFC	National Committee for Population, Family and Children
CPR	Contraceptive Prevalence Rate	NFP	Natural Family Planning
CSWG	Commodity Security Working Group	NGO	Non-Governmental Organization
CYP	Couple Years of Protection	NMCHC	National Maternal and Child Health Centre
DALYs	Disability-Adjusted Life Years	NPD	National Population and Development Policy
DFID	Department for International Development	NPFPC	National Population and Family Planning Committee
DHS	Demographic and Health Survey	NRSHP	National Reproductive and Sexual Health Programme
DMPA	Depot Metroxy-Progesterone Acetate	PAI	Population Action International
FHS	Female Health Company	PATH	Program for Appropriate Technology for Health
FPOP	Family Planning Organization of the Philippines	PDA	Population and Community Development Association
FRHAM	Federation of Reproductive Health Associations, Malaysia	PPAT	Planned Parenthood Association of Thailand
FSW	Female Sex Workers	PRB	Population Reference Bureau
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	PSI	Population Services International
GTZ	Gesellschaft für Technische Zusammenarbeit	RHAC	Reproductive Health Association of Cambodia
HIV	Human Immunodeficiency Virus	RHCS	Reproductive Health Commodities Supplies
HSP	Health Strategic Plan	RHSC	Reproductive Health Supplies Coalition
HSSP	Health Sector Support Project	SAMES	Service Autonomous of Medical and Equipment for Health
ICPD	International Conference on Population and Development	SFPPB	Singapore Family Planning and Population Board
IDU	Intravenous Drug Use	SI	Supply Initiative
IIRSH	International Initiative on Reproductive Health Supplies	SPARHCS	Strategic Pathways to Reproductive Health Commodity Security
IMR	Infant Mortality Rate	STIs	Sexually Transmitted Infections
IPPF	International Planned Parenthood Federation	TFR	Total Fertility Rate
IPSR	Institute for Population and Social Research, Mahidol University	UNAIDS	Joint United Nations Programme on HIV/AIDS
IUDs	Intra-Uterine Devices	UNFPA	United Nations Population Fund
IWG	Interim Working Group on Reproductive Health Commodity Security	USAID	United States Agency for International Development
IWHC	International Women's Health Coalition	VINAFPA	Viet Nam Family Planning Association
JSI	John Snow, Inc.	WHO	World Health Organization
KfW	Kreditanstalt für Wiederaufbau		
LAPM	Long-Acting and Permanent Method		
LGUs	Local Government Units		

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Executive Summary



This synthesis report reviews the provision of contraceptive services and commodities in Southeast Asia, assessing progress in achieving contraceptive security and meeting the reproductive health needs of the region's population. The purpose is to systematize fragmented knowledge into an integrated evidence base for follow-up study, advocacy and action.

Global attention to reproductive health commodities gained momentum in the last decade with the realization that unavailability of contraceptives in developing countries was undermining access to reproductive health care, and compromising people's ability to regulate fertility and prevent unwanted pregnancies, sexually transmitted diseases and HIV. A Global Call was launched to advocate for a reliable supply and appropriate mix of quality, safe and affordable contraceptives, as indispensable to the functioning of reproductive health programs.

These international efforts have paid limited attention to Southeast Asia. Still, as this reports shows, sexual and reproductive health needs are substantial and not yet met by the available contraceptive services. Maternal mortality and morbidity is high in a majority of countries, millions of unwanted pregnancies are terminated, often unsafely at great risk, STIs are widespread and HIV infections are rising among women and the general population. These worrisome reproductive health conditions reflect the insufficient reach of contraceptive services.

Although the region as a whole has a higher contraceptive prevalence when compared to other parts of the developing world, absolute use in certain countries and groups remains low. Moreover, in many Southeast Asian countries unreliable, traditional methods of contraception often account for a considerable proportion of the contraceptive prevalence rate.

The gap between women's fertility preferences and their use of contraception, albeit reduced in recent years, is far from being closed. Estimates for the 2000–2005 period, suggest that 11 percent of married women of reproductive age had an unmet need for contraception. Information about the unmet need of never-married women of all ages and youth is not readily available, but it can be expected to be high as most Southeast Asian governments believe contraceptive services are meant for married couples. Unmet needs for condoms to prevent HIV and STIs is acute among both married and unmarried individuals and couples.

Demand for contraceptives is expected to expand as the regional population continues to grow from 586 million people in 2008 to 826 million in 2050, and a large number of young people enter reproductive age. Demand could be higher if contraceptives become more socially acceptable among current non-users, especially if, so-far excluded groups such as single men and women begin to be targeted by contraceptive services, and prevention of STI/HIV is integrated into reproductive health programs for the general population. Growth in demand can also occur if switching from traditional to modern methods increases, discontinuation of modern contraceptive use is reduced and adherence in contraceptive use is enhanced, including consistent condom use (see Cleland, et al. 2006).

In spite of the increasing demand, most governments in Southeast Asia fail to ensure contraceptive security. The degree to which governments are (un)committed to contraceptive security varies according to religious, demographic and/or economic reasons, but generalizing it can be said that, with the exception of Thailand, they all fall under three, at times overlapping, categories: (i) countries with governments taking a pro-natalist stance for religious or demographic reasons that oppose or reduce access to modern contraceptives, namely the Philippines, Malaysia, Brunei Darussalam and Singapore; (ii) countries with strong family planning programs that emphasize those methods considered more effective to achieving population control, yet neglect short-term contraceptives such as Vietnam and Indonesia; and (iii) countries hampered by a lack of resources in the provision of contraceptive services, namely Myanmar, Laos, Cambodia and Timor-Leste, with some not wholly supportive of contraception. These specific environments need to be taken into account in devising tailored strategies at local and national levels. At the same time, efforts at the regional level may address those common threats that cut across more than one country, so as to synergize separate efforts in fostering contraceptive security for the whole region.

Based on the experiences and needs of the various Southeast Asia countries, and taking into account the global discourse on contraceptive security, three key areas of intervention are outlined in this report for enhancing the delivery of contraceptive services and commodities: (i) fostering enabling environments, (ii) harnessing resources and (iii) strengthening information management, logistics and service delivery systems. A regional advocacy agenda for realizing Contraceptive Security for All in Southeast Asia could center on these three key areas through the following efforts:

Fostering Enabling Environments

- Re-invigorate evidence-based policy dialogue and the mobilization of development partners and civil society actors in advocating contraceptive security
- Harness political will to address the lack of integration of contraceptive security into broader development plans
- Recognize that the unmet need for contraceptives exists not only among married men and women, but also among unmarried people who are sexually active, including youth
- Abolish the artificial differentiation, created by packaging, branding and other means, between condoms for family planning and condoms for prevention of STIs/HIV
- Redress the current gender bias in contraceptive policy and programs in Southeast Asia

Harnessing Resources to Meet Growing Demand and to Promote Equity

- Develop strategies to diversify funding in the poorest, donor-dependent countries in the region, which would include obtaining government support for contraceptive use
- Develop mechanisms for joint regional procurement and storage of contraceptive commodities
- Channel donor support through integrated mechanisms institutionalized in government agencies to avoid lack of coordination in forecasting and delivery
- Encourage sharing of information on commodity supplies between donors supporting contraceptives for family planning and donors investing in HIV/STIs prevention
- Endorse generic products that meet international standards rather than brand commodities
- Promote universal health insurance systems to make reproductive health supplies and services more affordable
- Assess the distributional impacts of expanding privatization efforts on health outcomes, access to services and costs of care
- Strengthen governments' stewardship role in determining the "right" mix of private and public services and in regulating the market
- Promote independent assessments of the impact of social marketing on the price of commodities and access for different socio-economic groups

Strengthening Information Management, Logistics and Service Delivery Systems

- Develop management information and forecasting systems that include never-married women (and men) of all ages, youth and other excluded groups
- Integrate family planning and HIV/STI prevention into comprehensive reproductive and sexual health services, including linkages with abortion care
- Integrate the contraceptive commodity chain into already existing procurement, storage and delivery mechanisms
- Establish more comprehensive mechanisms for monitoring procurement, distribution and delivery of commodities in both the public and private sectors
- Devise new mechanisms that support a decentralized supply chain capable of keeping service delivery points stoked
- Enhance quality of care so that greater attention is given to contraceptives' contraindications and side-effects
- Develop a regulatory framework, including enforcement guidelines and mechanisms, to prevent the occurrence of commercially-driven practices and to safeguard the quality and safety of offered commodities
- Launch tailored efforts to address demand-side barriers and reach out to the most disadvantaged groups, especially migrants and ethnic minorities



1.1 Background

The late 1990s saw the formulation of the concept “contraceptive security” defined as the ability of every person “to choose, obtain, and use quality contraceptives and condoms for family planning and for protection from sexually transmitted infections (STIs), including HIV.”¹ Such a concept served to re-emphasize the notion that contraceptive supplies² are the cornerstone of family planning and STI/HIV prevention. Moreover, ensuring and maintaining provision of contraceptive commodities—including hormonal methods (contraceptive tablets, injectables, implants, rings or patches), intrauterine devices (IUDs), barrier methods (condoms and diaphragms) and supplies to perform vasectomies and tubal ligations—is instrumental not only to attain better reproductive health, but also to reduce poverty and foster development (Finkle 2003; IPPF 2008).

The conceptualization of contraceptives as essential commodities for human well-being brought new urgency to addressing the supply gaps caused by the increasing demand for contraception in the face of insufficient funding and inadequate service delivery and logistics systems. To improve contraceptive security globally, a concerted effort was launched by international agencies in collaboration with governments and the private sector. Financing of commodities has been tackled through high-profile fundraising initiatives at the global level (UNFPA 2008), but many challenges remain in building national capacity for commodity forecasting, procurement, financing and delivery. There is also recognition that strategies to provide contraceptives and other reproductive health supplies cannot be de-linked from the broader socio-political environment and the overall functioning of the health system.

In view of this complex scenario, and in order to formulate appropriate strategies under the global framework for action, it is crucial to better understand how the interaction of global and local processes affects contraceptive supply at regional and country levels. This synthesis report aims at contributing to this goal by furthering the documentation of the status of contraceptive security in Southeast Asia³, a region that has received relatively little attention despite its substantial reproductive health needs. A search of published material, gray literature and Internet sources was conducted from March to June 2009 in order to identify key issues, clarify priorities and make recommendations for improved access to contraceptive supplies in Southeast Asia. In spite of the scant information available, the inconsistencies in data⁴ and the difficulties in generalizing about this diverse region, the produced review manages to systematize fragmented knowledge into an integrated evidence base.

The presentation of the findings is structured in four chapters moving from the global to the regional and national levels. After describing the global context of contraceptive security to provide a background to the situation in Southeast Asia, chapter 2 examines the reproductive health and contraceptive needs in the region. Chapter 3 then describes the current contraceptive supply situation at the national level. The various Southeast Asian countries—except Thailand, which will be treated as a case apart—are profiled according to a typology based on the countries’ positions on contraceptive provision and derived gaps in contraceptive security. Finally, chapter 4 provides suggestions for addressing these gaps and proposes a regional advocacy agenda to enhance the delivery of contraceptive services and commodities, and to realize contraceptive security in Southeast Asia.

1. Definition used by the United States Agency for International Development (USAID). Available at http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/supplies.html.
2. In this report, “contraceptive supplies/commodities” as a category will include condoms for both contraception and HIV prevention unless specifically distinguished for clarity purposes.
3. For the purpose of this research, Southeast Asian countries include Brunei Darussalam, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste and Viet Nam.
4. The figures provided in this report are not always consistent as different sources use different calculations and criteria. The same source may also have inconsistencies if it derives figures from disparate studies. Also, when comparisons of countries are made, numbers are only approximately comparable due to variations in the timing of surveys and the details of survey questions.

1.2 A Global Call for Contraceptive Security

Global attention to reproductive health commodities gained momentum at the turn of the millennium. In 1999 a global assessment of the progress made in the five years since the International Conference on Population and Development (ICPD+5) revealed that if the set goal of “universal access to reproductive health care” was to be achieved, the shortages of contraceptives in developing countries had to be addressed. Individuals and couples are dependent on the availability of contraceptives to be able to space pregnancies, limit family size, and prevent unwanted pregnancies, unsafe abortions and STIs/HIV as well as to reduce the risk of maternal and infant mortality and morbidity (IPPF 2008).

the availability of reproductive health services and commodities was acknowledged [...] as critical to meeting the Millennium Development Goals (MDGs)

In successive years, the availability of reproductive health services and commodities was acknowledged by the wider international development community as critical to meeting the Millennium Development Goals (MDGs), because of its contribution to reducing maternal and child mortality, improving maternal health, promoting gender equality, controlling HIV/AIDS and alleviating poverty (UN 2005; USAID 2008). At the 2005 World Summit universal access to reproductive health, including access to contraception was adopted as the second target to be achieved in order to improve maternal health and realize MDG 5. To urge greater commitment to these issues, the 2008 MDG Progress Report warned that “an unmet need for family planning undermines achievement of several other goals” (UN 2008, 27).

In 2001 a global meeting was held in Istanbul to identify strategies for building commitment and mobilizing resources for contraceptive security. In the same year, the United Nations Population Fund (UNFPA), together with other public and private stakeholders, launched a Global Call for Action on Reproductive Health Commodity Security, proposing a comprehensive approach for realizing contraceptive security through enhanced forecasting, finance, procurement and delivery systems. Concurrently, various interrelated initiatives emerged to advocate for a reliable and mix supply of good quality, safe and affordable contraceptives, as indispensable to the functioning of reproductive health programs—a message conveyed succinctly by the “No Product? No Program!” slogan⁵. In 2000 the Interim Working Group on Reproductive Health Commodity Security was formed by John Snow, Inc. (JSI), Population Action International (PAI), Program for Appropriate Technology in Health (PATH) and the Wallace Global Fund, followed in 2001 by the International Initiative on Reproductive Health Supplies (IIRHS) and in 2003 by the Supply Initiative (SI). These and other efforts led to the establishment in 2004 of the Reproductive Health Supplies Coalition (RHSC) to bring together key agencies and strengthen the focus on improving the supply of all commodities, including equipment and medical goods needed for the delivery of reproductive health care globally (UNFPA 2001a, 2001b; Finkle 2003; RHSC 2005).

Growing awareness of the far-reaching benefits of contraceptive provision also brought appreciation for the value of financial support in this area. A 2003 study calculated, without including STI/HIV prevention, that funding in contraceptive services in the developing world—US\$7.1 billion at the time—prevented:

- 187 million unintended pregnancies
- 60 million unplanned births
- 105 million induced abortions
- 22 million spontaneous abortions
- 215,000 pregnancy-related deaths each year
- The loss of 60 million disability-adjusted life years (DALYs)—16 million among women and 44 million among infants and children (Singh, et al. 2003; UNFPA 2006, 9)

Donors, especially USAID and UNFPA, were moved to increase their financing from US\$154.6 million in 2000 to approximately US\$223 million in 2007, with the sharpest augment occurring in 2001 at the time of the Global Call (UNFPA 2008). Even if substantial, these investments still pale when compared to the estimated costs of contraceptive commodities in developing countries over the same period (see figure 1). For 2007 it was calculated that the costs of providing contraception—mainly oral tablets and injectables—to approximately 655 million users reached US\$873 million. This total increased to US\$1.4 billion if condoms for STI/

5. The slogan has been used by DELIVER, a USAID-funded program by JSI on contraceptive supplies.

HIV prevention were added, meaning that actual donor support was sufficient to cover only 16 percent of the supply required (UNFPA 2008a, 29).

Furthermore, demand for contraception is projected to continue to grow, increasing by 40 percent in the next fifteen years (IPPF 2008, 15). Contraceptive users are expected to reach 731 million in 2015 considering the high levels of unmet needs as well as the augment in the number of young people entering reproductive age and becoming sexually active in developing countries (UNFPA 2006, 6; UNFPA 2007). Demand will further be driven by the intensification of STI/HIV prevention efforts promoting safer sex through use of—both male and female—condoms. Condom consumption is expected to grow globally from 5 to 8 percent annually, with parts of Asia and Central Africa being primary areas for accelerated growth (Howe 2005, 11). Donor resources are failing to keep pace, “satisfying a smaller proportion of people’s needs for contraceptives every year” as the user population grows (IPPF 2008, 15).

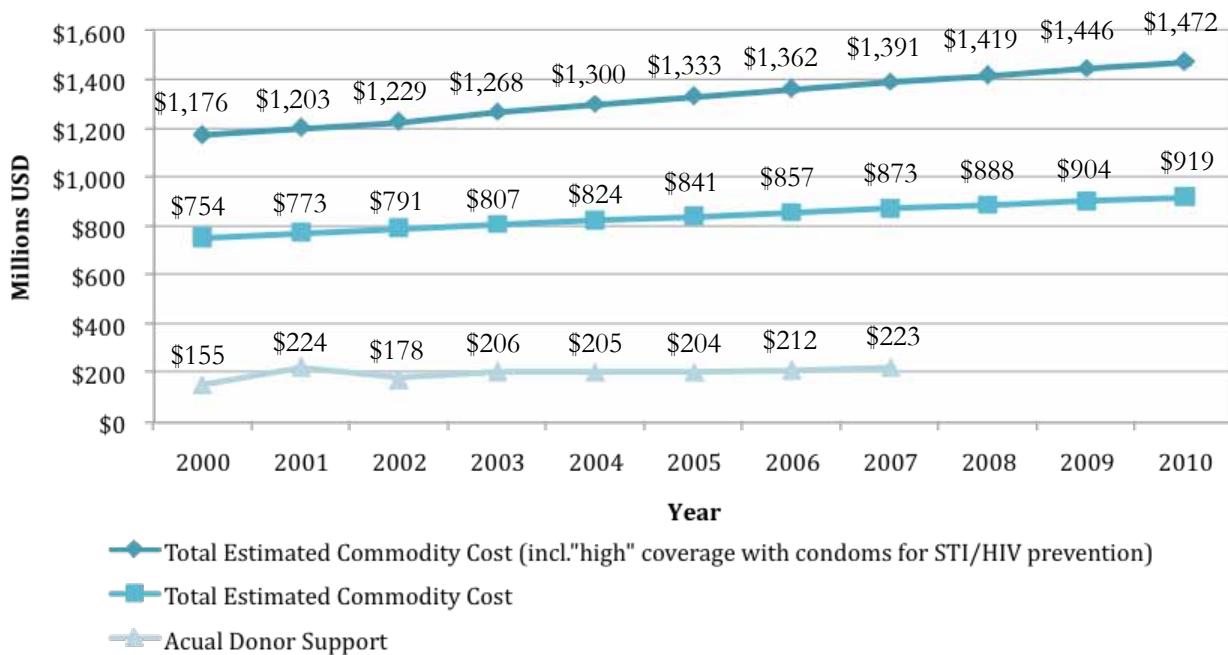
Insufficient commodity financing is not the only barrier to contraceptive availability. Other identified issues include re-

strictive policy environments, lack of political commitment, unfavorable legal and regulatory systems, missing linkages between reproductive health services and poor local procurement capacity, inadequate logistics structures, selective purchasing policies by governments and donors, as well as weak coordination among agencies and sectors:

To ensure that contraceptives are available to clients, the typical situation was less one of [financial] scarcity, although funding is always a constraint, but rather one of (1) vulnerability to frequent disruptions in donor-supported supply mechanisms, (2) weak capacity in countries’ health logistic systems, (3) overall poor planning, and (4) woefully insufficient coordination among the many systems that need to work well and work together. (Sarley, et al. 2006, 15)

This overall picture applies also to Southeast Asia. As will be shown in the next two chapters, sexual and reproductive health needs are not yet fully met by the available contraceptive services for reasons that are only partly of a financial nature.

Figure 1 Comparison of estimated costs of contraceptive commodities and actual donor support, 2000–2007 (in millions USD)





Regional Context

2.1 Reproductive Health in Southeast Asia

In Southeast Asia, reproductive health differentials are intertwined with the socio-economic disparities of the relatively more advantaged countries—Singapore, Malaysia, Thailand, Brunei Darussalam, and to a certain extent Philippines, Indonesia and Viet Nam— having better reproductive health indicators than the resource-poor countries of Myanmar, Laos, Cambodia and Timor-Leste. The needs are many and varied, pointing to inadequate and inequitable access to contraceptive services and commodities.

Greater use of contraceptives to prevent unwanted pregnancies and improve birth spacing could make an important contribution to reducing the still high maternal mortality and morbidity rates in the region. As table 1 indicates, six of the eleven countries in Southeast Asia have maternal mortality ratios (MMRs) of over 200 deaths per 100,000 live births. In-country disparities are marked. Indonesia, for instance, has provincial MMR estimates of 1,025 in Papua, 796 in Makuku and 554 in East Nusa Tenggara (UNFPA 2006b). More generally, access to skilled attendants is lower among the poorest quintiles, and MMR is higher in rural areas because of weaker

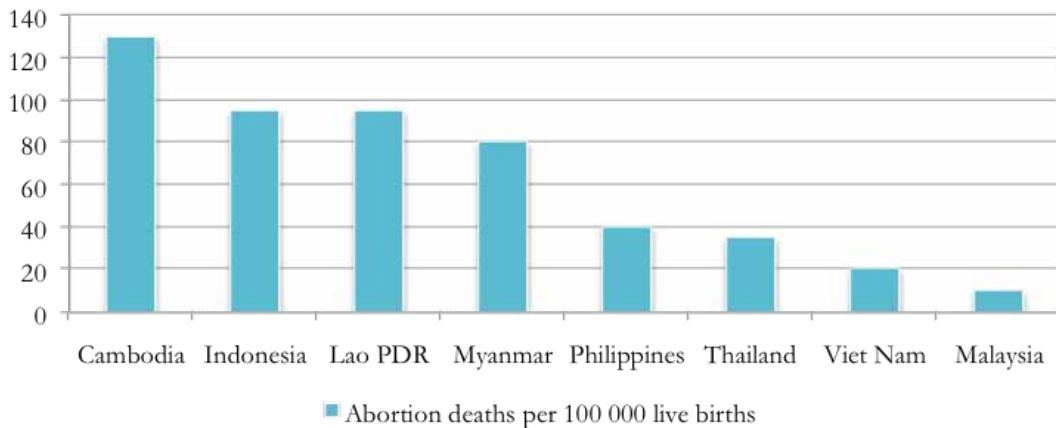
infrastructural development, lower literacy levels and higher levels of poverty when compared to urban areas. Maternal morbidity has not been recorded properly, but the estimation of it being thirty times the number of maternal deaths (UNFPA 2006b, 2) implies a substantial burden of pregnancy-related illnesses in the region.

In line with global estimates, 60 to 80 percent of all maternal deaths in Southeast Asia can be attributed to obstetric hemorrhage, sepsis, obstructed labor, hypertensive disorders and unsafe abortion. An important difference is that abortion-related mortality is thought to be higher than the global average of 13 percent, reaching 19 percent of all maternal deaths in the region (UNFPA 2006b, 1–2, 11). Cambodia, Indonesia, Laos and Myanmar have the highest number of abortion deaths, while Thailand, Viet Nam and Malaysia have the lowest (see figure 2). Regionally, unsafe abortion rates are estimated at about 20 per 1,000 women of reproductive age⁶. In Myanmar, unsafe abortion is the leading cause of maternal mortality, causing 50 percent of maternal deaths, and contributing to 20 percent of all hospital admissions⁷ (for a global overview of abortion, see United Nations 2007).

Table 1 Maternal health indicators for Southeast Asia, 2005

Country	MMR (per 100,000 live births)	Range of MMR estimates	Lifetime risk of maternal death (1 in)	No. of maternal deaths
Laos	660	190–1,600	33	1,300
Cambodia	540	370–720	48	2,300
Indonesia	420	240–600	97	19,000
Timor-Leste	380	150–700	35	190
Myanmar	380	260–510	110	3,700
Philippines	230	60–700	140	4,600
Viet Nam	150	40–510	280	2,500
Thailand	110	70–140	500	1,100
Malaysia	62	41–82	560	340
Brunei Darussalam	13	3–47	2,900	1
Singapore	14	14–27	6,200	5

Source: WHO, et al. 2007.

Figure 2 Unsafe abortion-related deaths per 100,000 live births

Source: Adapted from IPAS Policy Fact sheet in UNFPA 2006b.

Except for Cambodia, Singapore and Viet Nam, induced abortion is illegal or limited to a few conditions in Southeast Asia. Still, millions of women across the region feel compelled to terminate unwanted pregnancies. In Viet Nam, where abortion is permitted on broad grounds, about 1.4 million abortions are executed annually⁸—one of the highest figures in the world. High rates are also found in countries where conservative religious sentiments frustrate legalization of abortion. In Indonesia, according to 2000 estimates, about two million induced abortions occurred yearly, implying an annual abortion rate higher than that of Asia as a whole (37 and 24 abortions per 1,000 women of reproductive age, respectively) (Sedgh and Ball 2008, 1). All through the region, post-abortion care is limited and often does not include contraceptive provision (Warriner and Shah 2006).

The need for widespread condom distribution is evident from regional data. STIs are widespread in the region. In Viet Nam, among women of reproductive age, STIs average 25 percent.⁹ More generally, Southeast Asia is a high-prevalence area for hepatitis B. The World Health Organization (WHO) estimates that the largest portion—almost 50 percent—of about 340 million new STI infections (excluding HIV) per year occur in South and Southeast Asia (WHO 2007, 3). The regional estimate of HIV prevalence among adults aged 15–49 years old is relatively low, in the range of 0.2–0.4 percent, but

the absolute numbers are significant, with about 1.7 million people in 2007 living with HIV/AIDS in Southeast Asia (UNAIDS 2008).

In Thailand and Cambodia, the two countries with the highest levels of HIV prevalence (1.4 and 0.8 respectively), the epidemic is slowing down, but in Viet Nam and Indonesia (in particular in Papua Province) it is growing. The major identified routes of HIV transmission are unprotected sex

with non-regular partners and through contaminated IDU (Intravenous Drug Use) injecting instruments. More and more, however, new infections consist of women who have acquired HIV from unsafe sex

More and more, however, new infections consist of women who have acquired HIV from unsafe sex with their regular partners

with their regular partners. In Thailand, this group accounted for more than 4 in 10 (or 43 percent of) new infections in 2005 (UNAIDS and WHO 2008). In Cambodia, transmission from husband to wife increased from accounting for 25 percent of new infections in 1995 to becoming the main transmission route in 2004 (PSI 2004). In Malaysia, married women represent the largest proportion of women living with HIV (CCR and ARROW 2005, 20). Young people between the ages of 15 and 24 are particularly exposed. In Thailand, this group accounted for 40 percent of the total number of new HIV infections in 2006—an increase compared to previous years.¹⁰ This group is known to have the highest infection rates for STIs (Murugesan and Srinivasan 2001).

6. Available at <http://www.ipas.org/Regions/Asia.aspx>.

7. Available at http://www.searo.who.int/linkfiles/family_planning_fact_sheets_myanmar.pdf.

8. Available at <http://www.medicalnewstoday.com/articles/27187.php>.

9. Available at <http://www.mariestopes.org.vn/index.php?pageID=5>.

10. Available at <http://www.popularq.net/articles/US-News/General/HIV-rates-rise-among-Thai-youth/>.

2.2 Contraceptive Prevalence and Unmet Needs

The reproductive health picture of Southeast Asia reflects the insufficient reach of contraceptive services. Although, the region as a whole has a relatively higher contraceptive prevalence when compared to other parts of the developing world,¹¹ absolute use in certain countries and groups remains low in spite of high unmet need. Moreover, in a majority of countries traditional methods of contraception account for a considerable proportion of the contraceptive prevalence rate (CPR). The share of contraceptive users opting for periodic abstinence, withdrawal or country-specific methods ranges from 2 percent in Thailand to 25 percent in Malaysia (PRB 2008, 76). Use of traditional methods could be even higher than reported if single adolescents, never married women and other neglected groups are included in official statistics, particularly since it is known that these groups resort to traditional methods, given their limited access to modern contraceptive methods. When male methods are considered, it appears that married men make limited use of contraceptive options and when they do, they opt for traditional methods.

As table 2 shows, contraceptive prevalence is the lowest in the poorest countries of Southeast Asia. CPR in Timor-Leste is as low as 10 percent, and in Laos, Cambodia and Myanmar it is between 30 to 40 percent. Philippines and Malaysia, countries with restrictive policy environments, have slightly higher CPRs of around 50 percent, but more than a third of the users prefer traditional methods. Conservative views also play a role in Brunei Darussalam, restraining provision of family

planning as well as gathering of CPR data. At the other end of the spectrum, the middle- and high-level income countries of Viet Nam, Indonesia, Thailand and Singapore, which since the late 1960s/early 1970s have had national family planning programs that promote the use of modern contraceptives to stem population growth, boast high CPRs in the 50–70 percent range and, with the exception of Viet Nam, small portions of traditional methods.

Within countries, disparities in contraceptive prevalence occur along socio-economic, geographical and ethnic boundaries. In all countries, contraceptive use increases with women's education and wealth status. CPR and contraceptive mix patterns are different between rural and urban areas, and vary among regions and provinces. In 2003 the CPR of married women in Thailand was estimated to be as high as 83 percent in the northern region, but approximately 70 percent in the southern region where the Malay population is concentrated (CCR and ARROW 2005, 14). In Indonesia's most populous island of Java, contraceptive use ranged from 61 percent in West Java to 67 percent in the Special Region of Yogyakarta (BPS and Macro International 2008, xxiv). The Central Highlands of Viet Nam, with their diverse ethnic minority population, show the lowest CPR in the country (Teerawichitchainan 2008). In 2004 CPR among married women in Malaysia was 65 percent for the Chinese population and 40 percent for the Malay population (Nai Peng Tey 2007, 270).

The gap between women's fertility preferences and their use of contraception, albeit reduced in recent years, has still to be closed. According to estimates, in South and Southeast Asia

Table 2 Contraceptive prevalence rates in Southeast Asia

	CPR any method	CPR modern methods
Brunei Darussalam	—	—
Cambodia	40	27
Indonesia	61	57
Laos	32	29
Malaysia	55	30
Myanmar	37	33
Philippines	51	36
Singapore	62	55
Thailand	72	70
Timor-Leste	10	9
Viet Nam	78	67

Note: Data are based on various DHSs and other health surveys of currently married or “in-union” women of reproductive age conducted in the 1990s and early 2000s. Data prior to 2002 are shown in italics.

Source: PRB 2008.

in the 2000–2005 period 11 percent of married women of reproductive age had an unmet need for contraception both for spacing and for limiting births. These figures overshadow great inter- and intra-country variance, with rates of unmet needs for family planning varying from 40 percent in Laos¹² and 30 percent in Cambodia and the Philippines to 9 percent in Indonesia and 5 percent in Viet Nam (Sonfield 2006). In the Philippines—a country where more than half of all pregnancies are unintended—the percentage of married women with unmet needs averages 18 percent in the national capital region of Metro Manila, but reaches 60 percent in the Autonomous Region of Muslim Mindanao and 87 percent in that region's poor quintile (Darroch, et al. 2009, 2). In Viet Nam, minority ethnic groups report higher prevalence of unmet need for family planning when compared to the majority population and the national average (UNFPA 2007a).

Information about the unmet need of never-married women of all ages is not readily available as they are not included in CPR data, reflecting the official position of most Southeast Asian governments that contraception is meant for married couples. Not-yet-married young people of both sexes are also overlooked in information gathering as well as services. When awareness-raising activities have been directed at them, no link has been made with provision of contraceptives (IWHC 2007; Khuat Thu Hong 2003). Still, based on the increasing number of single, including sexually active, adult women in Southeast Asia and considering their limited access to contraceptive services, it can be deduced that unmet needs are high in this population group (Jones 2005). Similarly, this is the case for the growing number of young people of both sexes having pre-marital relations. Other underserved populations, whose special contraceptive needs still need to be successfully accommodated, include migrants, refugees and displaced people as well as marginalized urban communities and people living with HIV, to name just a few.

Unmet needs for condoms for STI/HIV prevention among both married and unmarried men is acute in Southeast Asia. Socio-cultural barriers hamper open condom promotion and limit its provision to groups considered at risk by government programs, such as sex workers, injecting drug users and men who have sex with men (MSM). As mentioned above, con-

doms are not promoted and rarely used in family planning programs because of entrenched gender values discouraging male contraceptive use, as well as their being considered less effective than long-lasting contraceptive from a population control perspective. Only national AIDS programs promote mainly male condoms to prevent HIV transmission. As a result, condom use is higher among groups considered at risk by official agencies, but remains low overall. Across the region, people continue not to use condoms in their most intimate and regular relationships, and rarely use them in casual, non-commercial relations. In Cambodia, for instance, among groups considered at risk, policemen's consistent condom use grew from 65.6 to 94.2 percent in commercial sex interactions from 1997 to 2003, but only from 11.4 to 41.2 percent in “sweetheart relationships.”¹³ Among military and female brothel-based sex workers consistent condom use also surpassed 90 percent. Still, “less than 20 percent of sexually active men and women have ever used a condom, representing an enormous unmet need” (PSI 2004,

In all countries, contraceptive use increases with women's education and wealth status

2). Other Southeast Asia countries have even lower condom usage prevalence rates in both general population and target groups. Inconsistent condom use is also rife, implying opportunities for greater use if adherence can be increased. In Singapore, 45 percent of the surveyed clients of sex workers in 2004 used condoms inconsistently (Wee, et al. 2004) and in Viet Nam, in 2006, 60 percent of MSM living with HIV reported inconsistent condom use with their partners during the previous month (MOH, Viet Nam 2008, 99).

Female condoms—available in parts of Asia since 1995—remain underused due to scarce familiarity with the product, their higher cost as well as lack of access.¹⁴ Still, small trials conducted in the region have demonstrated interest among women to use them. In Viet Nam, slightly more than half of the 428 women, mostly STI patients and sex workers who participated in a 2000 trial, expressed the intention to continue using female condoms if they would be more affordable and readily available.¹⁵

If these many contraceptive needs are addressed and contraceptive use becomes more accepted, it can be expected that the already large demand for contraception in Southeast Asia will expand. In Indonesia, for instance, it has been

12. Available at <http://www.prb.org/Datafinder/Topic/Bar.aspx?sort=v&order=d&variable=94>.

13. “Sweetheart relationships” in Cambodia are defined as “non-commercial, non-marital sexual relationships that possess a certain degree of affection and trust from at least one partner.” See <http://www.communit.com/en/node/123705/36>.

14. Available at <http://www.rhrealitycheck.org/blog/2009/02/16/female-condom-access-use-low-asiapacific>.

15. Available at http://www.femalehealth.com/CountryProfiles/VietNam/VietNam_otherdocs/VietNam_Condom_Use.html.

calculated that satisfying the unmet need of married women for spacing (4 percent) and limiting (5 percent) births would result in an increase in CPR from 61.4 to around 71 percent (BPS and Macro International 2008, xxv). The increase would be greater if excluded groups such as single men and women are included, and if prevention of STI/HIV is integrated in reproductive health programs for the general population. Growth in demand can also occur if the switch from traditional to modern methods increases, discontinuation of modern contraceptive use is reduced and adherence to contraceptive use, including consistent condom use (see Cleland, et al. 2006), is enhanced.

An additional driver of future demand for contraceptive services and commodities is Southeast Asia's expanding population with its large number of young people entering reproductive age. Although fertility in the region started to decline in the 1960s and is now reaching the replacement level of about two births per couple, the overall population is expected to grow from 586 million in 2008 to 826 million in 2050, as the demographic momentum continues to build (Hirschman 2001; PRB 2008). Also, decline is occurring at various rates throughout the region as countries are at different stages of "demographic transition". That is a transformation process where decreasing birth and death rates eventually result in slower population growth and aging societies (Atoh, et al. 2004; Ananta and Arifin 2007). As table 3 shows, while Singapore and Thailand are well below replacement levels, Timor-Leste, Laos, Cambodia and the Philippines have total fertility rates in the range of 6.5 to 3.0 children per woman. Consequently, while in Singapore and Thailand the share of people below the age of fifteen is around 20 percent and declining, in

other countries in the region it is in the 25 to 45 percent range and generally growing. How these rates translate into absolute numbers depends on the population size of the various countries, especially since population distribution in Southeast Asia is very unequal. The smallest country in the region, Brunei Darussalam, is expected to grow from 400,000 people in 2008 to 600,000 people in 2050, while Indonesia, the most populous country in Southeast Asia and the fourth most populous country in the world, is projected to increase from 239 million in 2008 to 341 million in 2050 (PRB 2008). In terms of the population below 15 years of age, and in terms of potential future contraceptive users, even if the share of this population in both countries is near 30 percent, in Brunei Darussalam it accounts for approximately 120,000 people, while in Indonesia it represents more than 69 million people.

Considering these and other factors, an augment in contraceptive use and demand is projected for most of the region. Incremental increases are expected rather than great leaps, with the possible exception of condom use if the environment becomes more enabling. Still, numbers of additional contraceptive users will be great. Such a gradual pattern of adding large numbers of acceptors, implies a greater need for commodity support than is the case in situations with larger percentages, but smaller absolute increases like in sub-Saharan Africa (UNFPA 2006a, 9), which in contrast most urgently requires establishment and/or scaling up of institutions to support family planning. While this may hold for the region as a whole, when taking a closer look at individual countries in chapter 3 it appears that both scenarios coexist in Southeast Asia, requiring differentiated strategies to realize contraceptive security.

Table 3 Selected demographic data and estimates for Southeast Asia

	Births per 1,000 population	Total population (millions) (2008)	Projected population (millions) (2050)	Total Fertility Rate (TFR)	Percent of population by age	
					<15	65+
Brunei Darussalam*	19	0.4	0.6	2.0	30	3
Cambodia	26	14.7	30.5	3.5	36	4
Indonesia	21	239.9	343.1	2.6	29	6
Laos	34	5.9	12.3	4.5	44	4
Malaysia	21	27.7	40.4	2.6	32	4
Myanmar	19	49.2	58.7	2.2	27	6
Philippines	26	90.5	150.1	3.3	35	4
Singapore	11	4.8	5.3	1.4	19	9
Thailand	13	66.1	68.9	1.6	22	7
Timor-Leste	42	1.1	3.0	6.7	45	3
Viet Nam	17	86.2	112.8	2.1	26	7
Southeast Asia	20	586.0	826.0	2.5	29	6

* Data for Brunei Darussalam is sourced from PRB 2008.

Source: UNESCAP 2008.



3.1 A Typology of Environments

Political and economic environments shape the way contraceptive services and commodities are provided, as well as their degree of access and affordability to the users. Programmatic capacity in addressing contraceptive needs is highly dependent on government commitment and/or financial self-reliance (Finkle 2003). In Southeast Asia, the degree to which governments are (un)committed to contraceptive security varies according to religious, demographic and/or economic reasons. Three categories, at times overlapping, can be identified: (i) countries with governments opposed to family planning that discourage the use of modern contraceptives; (ii) countries with strong family planning programs that emphasize those methods considered more effective to achieve population control; and (iii) countries hampered by a lack of resources in the provision of contraceptive services.

The first category of countries with restrictive policy environments includes the Philippines, Malaysia, Brunei Darussalam and Singapore. These countries take pro-natalist stances, opposing or neglecting modern contraceptive services and commodities. In the case of the first three countries, provision of modern contraceptive services is viewed as against religious tenets, either conservative Catholic views for the Philippines or rigid Islamist interpretations for Malaysia and Brunei Darussalam. Singapore, ranking among countries with the “lowest-low” fertility rates in the world, argues that a selective procreation policy is essential to long-term development (Yap Mui Teng 2007). Conservative ideologies in all these countries further condemn condom promotion for HIV/STIs prevention as “legitimizing promiscuity” and against “Asian values.” Such an unfavorable standpoint implies lack of political and financial support for promotion and provision of modern contraceptives in public services, as well as reduced access to public services. The pro-natalist position also stalls gathering of relevant information with minimal updated information available on contraceptive use and supplies for Malaysia and Singapore by either government or non-government sources, and for Brunei Darussalam no data is available.¹⁶

At the other extreme of the population policy spectrum are Viet Nam and Indonesia. They belong to the category of countries with an anti-natalist stand, enforcing family planning to stem population growth. In the process, they have come to emphasize selected kinds of long-acting and permanent methods (LAPMs) of family planning—hormonal implants, IUDs, female sterilization, and vasectomy—and discourage use of, in the government’s view, less reliable, temporary methods. Such bias is still reflected in today’s contraceptive mix, even if pressure has, to a certain extent, relented and the role of the private sector in contraceptive provision is expanding. Viet Nam and Indonesia are primary examples of how a policy focus approving of family planning does not necessarily imply “full availability” of contraceptive methods, and contraceptive security. It also does not make these countries more tolerant toward condom promotion for HIV/STIs prevention, as these countries take a conservative stand when it comes to an open discussion of safe sex.

Irrespective of their views on family planning and STI/AIDS prevention, the countries grouped under the third category of resource-poor countries, simply do not have the means to address the great reproductive and sexual health needs of their people. Lacking financial and human resources, the poorest countries of Southeast Asia—Cambodia, Laos, Myanmar and Timor-Leste—have yet to achieve contraceptive security, their fragile delivery systems offering only limited contraceptive choices and not always of adequate quality. Scarcity of means is compounded by a political inclination to ignore or discourage contraception, in spite of the great unmet needs of the population.

Compared to the other countries in the region, Thailand appears as a special case because of the government commitment to contraceptive security for both family planning and STI/HIV prevention. The country’s early embrace of a bottom-up approach to reproductive health and the greater financial and human resources allocated to provision of free contraceptive services to the population make the Thai model an exception in the sub-region.

16. For this reason, Brunei Darussalam will not be discussed in the section below.

The implications of these different environments for the funding and provision of contraceptive services, procurement and distribution services, contraceptive mix and private sector participation as well as other trends (such as decentralization and political unrest) affect contraceptive security as will become clear in the following review of the diverse contraceptive profiles of Southeast Asian countries.

3.2 Countries with Pro-Natalist Environments: Philippines, Malaysia and Singapore

The Philippines has moved from a strong population control policy, especially with an emphasis on female sterilization in the 1970s, to the current stand of abandoning modern contraceptives and instead promoting “Natural Family Planning” or NFP.¹⁷ Still, modern methods of contraception acquired with donor support are tolerated and continue to be distributed in most government facilities. In spite of political opposition by the state and the church, the public health system remains the main provider of contraceptive information and services, accounting in 2007 for 67.2 percent of the contraceptive prevalence rate (at the time estimated at about 49 percent of married women) (USAID Project 2007, 1–2), with the remaining portion being covered by commercial providers, especially pharmacies, and NGOs such as Pathfinder and FPOP (Family Planning Organization of the Philippines), a member of the International Planned Parenthood Federation. Over the years, the method mix offered has maintained a larger share of modern contraceptives, skewed towards pills and sterilization. In 2003 of the 33 percent of married women using modern contraceptives, 13 percent were using pills, 10 percent were sterilized, and the remaining used, in order, IUDs, injectables, and condoms (Connell 2005, 9). Here, it should be noted, however, that the level of sterilization, instrumental in maintaining the supremacy of modern methods, is mainly a reflection of past practices rather than new adoptions having declined in recent years.¹⁸

The observed bias in contraceptive choices is donor driven. Since the 1970s family planning in the Philippines has been funded and shaped by the United States Agency for International Development (USAID). Donations averaged 80

percent of total requirements in the decade preceding 2003, when USAID initiated the phase out of its program activities to encourage more self-reliance through the newly developed contraceptive self-reliance framework (USAID 2007). With the decision of the central government not to directly finance and procure modern contraceptives, and as part of the decentralization process then ongoing, local government units (LGUs) were expected to take over by distributing the remaining donations and later by purchasing new commodities with their own funding. A 2007 survey, however, found that family planning was considered a controversial program of low-priority, and that only 67 of the 122 local government units had used local budget funding to purchase oral contraceptive pills and another three did so by using other sources. Some LGUs, including the City of Manila, went further by banning birth control from city-funded clinics on religious grounds, in spite of women’s groups questioning the constitutionality of such a prohibition.¹⁹ Moreover, many LGUs lack the capacity to forecast, procure and deliver contraceptive commodities.²⁰

In 2008 the phase-out came to an end and USAID procurement of pills, injectables and condoms has consequently stopped. The lack of political will and the LGUs’ insufficient stock status are cause of concern among family planning advocates. There is worry that the needs of the very poor, estimated to be about 30 percent of the existing users of free donated contraceptives, will be neglected and that no safety nets are available for those who use public services (Diaroch, et al. 2009, 6; USAID 2007, 4; Connell, et al. 2005, 24). In an effort to address this situation, UNFPA entered into a Memorandum of Understanding with the League of Municipalities in 2007 and with the League of Cities in 2008 to ensure access to family planning in disadvantaged locations. Up to 2010, UNFPA will provide contraceptive commodities (pills and injectables, inclusive of syringes) as a “stop gap measure” to 750 municipalities and 80 cities on a 60:40 cost share arrangement with LGUs. Starting in the second year, LGUs are expected to mobilize funding and look after their stocks. From the central warehouse maintained by the League of Municipalities, commodities are to be distributed through the provincial health system to the poorest clients, while all others are expected to purchase contraceptives in private outlets.²¹

17. NFPs are based on identifying and preventing intercourse during a woman’s fertile period, including the ovulation method, standards days method, symptothermal method, basal body temperature (BBT) and lactation amenorrhea method (LAM). See <http://www.irh.org/nfp.htm>.

18. Available at <http://nsor12.awardspace.com/fps04.html>.

19. Available at <http://www.time.com/time/world/article/0,8599,1812250,00.html>.

20. Available at <http://www.pia.gov.ph/?m=12&fi=p060421.htm&no=95>.

21. Available at <http://www.unfpa.org.ph/resources/partnership-rh-commodity-security-philippines>.

While poor women see their choices reduced, options for more affluent users have increased.²² In its exit strategy, USAID has promoted a greater role of the private sector in contraception provision with the idea of reducing the burden on LGU budgets and ensuring availability of contraceptives. Support was provided to the FriendlyCare Foundation and the Well Family Midwife Clinics to expand services to low to middle income users. DKT Philippines Inc., a social marketing enterprise already supported by Kreditanstalt für Wiederaufbau (KfW) for condom marketing to prevent STI/HIV in commercial sex settings, was also contracted to market contraceptive pills (Lady Pill), injectables (Depotrust) and, for a brief period, a new brand of condoms for contraceptive use (Trust Classic). In addition to DKT products, the commercial contraceptive market comprises hormonal contraceptive brands from major Western manufacturers consisting of injectables (Depoprovera by Pfizer and Noristerat by Schering) and pills (various brands promoted by Schering, Wyeth and Organon). Commercial suppliers focus on the top end of the market, while DKT is interested in lower-middle and upper-low income families, leaving the low-priced segment less well served (Connell, et al. 2005). Marketing efforts may also prove insufficient to overcome the resistance of non-users and users of traditional methods, if the political environment does not become more enabling toward the provision of modern contraceptives.

While poor women see their choices reduced, options for more affluent users have increased

Like the Philippines, **Malaysia** has moved away from anti-natalist policies formulated in the 1960s. Since the late 1970s, family planning came to be considered a sensitive issue from a strict Islamic perspective and ignored by the government. Economic reasons were also adduced for the launching in 1984 of the National Population Policy to promote population growth up to 70 million by 2100 as resource-rich Malaysia came to be viewed as under-populated and in need of a larger domestic market for industrial development. This policy was put in place, even though, as seen in chapter 2, fertility in Malaysia was and still is well above replacement levels. Since then, the family planning program was dismissed and a subsequent reproductive health policy put focus on spacing rather than limiting birth (as in the slogan “not too soon, not too late, not too close”), with contraceptive services offered by the health system and no longer through a separate family planning line. Modern contraceptive methods are only avail-

able to married couples in Malaysia, and limits have been put on contraceptive advertising. In addition, educative programs have been discontinued in some public health facilities (CCR and Arrow 2005). As of 2008, no national plan had been formulated for contraceptive security and no criteria developed to determine responses to crisis situations (UNFPA 2008).

After the Malaysian government took a pro-natalist stand, the proportion of married couples using any method gradually declined (Nai Peng Tey 2007, 2). In 2004 CPR reached 55 percent, of which only 30 percent refers to modern contraceptives. Rural areas have become poorly serviced and Malays with lower economic status have less access today to contraceptives. A remarkable shift in contraceptive mix has occurred with the use of the pill, as the most popular method of contraception, dropping almost by half in the last three decades from 50 percent in 1974 to 27 percent in 2004, with many switching to rhythm (now the second-most popular method accounting

for about 18 percent of users). Male condoms follow at 14.5 percent, more popular than sterilization (12.7 percent), IUDs (8.6 percent) and various traditional methods (Nai Peng Tey 2007, 2). Modern contraceptive commodities are procured by the government and provided at a cost in public health centers, distributed by NGOs—foremost the IPPF's member, the Federation of Reproductive Health Associations, Malaysia (FRHAM) and its thirteen state member associations—and sold by private outlets. Emergency contraceptives like Postinor and Estinor were introduced in the late 1980s (Glasier, et al. 1996), and can be bought legally from pharmacies and private physicians, but service providers remain hesitant to offer or provide information about these contraceptives, wrongly perceiving them as abortifacients.

Contrary to the Philippines, in richer Malaysia, donor support has been limited. In 2000 and 2001, UNFPA (2005, 13) recorded that international donors provided around ten million pieces of male condoms annually, but no substantial support is noted for other methods. In HIV prevention, condoms are promoted only among drug users, sex workers and other groups considered at risk, and mainly through NGOs. DKT established a social marketing program in 1990 focusing on sex workers and their clients, which is today fully commercial, with some of the profit from sales used to lower the cost of

22. Available at <http://www.pia.gov.ph/?m=12&fi=p060421.htm&no=95>.

condoms.²³ Direct procurement and distribution is avoided by the Ministry of Health (MOH) out of concern that it may be “misinterpreted as advocating promiscuity.”²⁴ This in spite of Malaysia being one of the world’s top producers of condoms (including female condoms manufactured by the Female Health Company or FHC), and the second major producer in Southeast Asia thanks to its ready supply of rubber (see table 4).

Table 4 Estimated annual production of condoms by country or continent, 2005

	Billions of pieces
Thailand	3.0
India	2.9
China	2.5
Japan	2.0
Malaysia	1.2
USA	0.9
Europe	0.8
South Korea	0.6
Indonesia	0.4
South America	0.3
Viet Nam	0.1
Other	0.3

Source: Howe 2005.

reaching of below-replacement level fertility and the aging of the population. As a larger labor force came to be seen as essential to economic growth, the population policy changed to selectively promote marriage and procreation. While the initial system of incentives and disincentives encouraged sterilization and small families, the one employed since 1987 urged middle- and upper-class Singaporeans to have larger families under the slogan “have three or more (children) if you can afford it.” Continued enforcement of family planning measures came to be seen as appropriate only for lower-class Singaporeans. Such a selective pro-creation approach was deemed necessary to reverse the “lopsided pattern of marriage and procreation” where better-educated women increasingly choose to remain single and have fewer children (Yap Mui Teng 2007). Measures include:

- (a) financial incentives (tax rebates for the third and fourth child and income tax relief for up to four children);
- (b) incentives supportive of a childrearing role for women (child care subsidy, rebates on maid levies, leave without pay and part-time work in the public sector);
- (c) housing and child education incentives (priority in the allocation of housing and primary school registration for families with three instead of two children); and
- (d) counseling for women with two or fewer children seeking to undergo an abortion or sterilization to encourage them to reconsider their decision.

(adapted from Yap Mui Teng 2007, 208)

Singapore has also taken a pro-natalist stance since the mid-1980s when it abolished the Singapore Family Planning and Population Board (SFPPB) and its National Family Planning Program. The Program was established in the 1960s to reduce population growth through the provision of both reversible and irreversible methods (particularly sterilization and abortion) in public family planning and maternal and child health clinics. Concerns, however, ensued with the

Data on contraceptive use in Singapore are outdated, leaving us in the dark about the present contraceptive mix and supply. What earlier data show is a clear reduction in the use of modern contraceptives after the introduction of the pro-natalist policies, especially of sterilization—the method most strongly promoted in the now-halted family planning program—as well as a parallel increase in the use of traditional methods (see table 5; see also Ross, et al. 2005). Male condom use has

Table 5 Contraceptive use among currently married women in Singapore, 1982 and 1997

Year	Total Prev.	Modern Methods	Sterilization		Pill	Injectable Implant	IUD	Male Condom	Vaginals	Traditional
			Male	Female						
1982	74.2	73.0	0.6	22.3	11.6	—	—	24.3	14.2	1.2
1997	62.0	53.0	0.2	15.8	10.0	—	5.0	22.0	—	9.0

Source: MOH population planning data in Yap Mui Teng 2007.

23. Available at <http://www.dktinternational.org/index.php?section=32>.

24. Available at <http://www.medicalnewstoday.com/articles/71811.php>.

traditionally been high, but in ongoing HIV prevention efforts, condoms are not actively encouraged, except for MSM and men who pay for sex, due to the government's fears that it might encourage casual sex among youth.²⁵

With the decrease in subsidies to commodities and the closure of government family planning clinics in the mid-1980s, private sources (pharmacies and drugstores) gradually substituted for public sources (Yap Mui Teng 2007, 206). It can be expected that today private sources dominate a possibly reduced market. The need for contraceptives to prevent unwanted or unintended pregnancies both among married and unmarried women, however, remains. It has been reported that abortions, legal in Singapore, increased from 11,933 in 2007 to 12,222 in 2008, as economic worries in a time of crisis may prompt more women to terminate pregnancies.²⁶

*the lack of temporary modern contraceptives
has lead to dissatisfaction and non-use as well
as use of less reliable traditional methods*

3.3 Countries Enforcing Family Planning Programs: Viet Nam and Indonesia

In **Viet Nam** population control is seen as instrumental to the country's development and as essential to improve the welfare of individuals as well as of society. Viet Nam's two-child policy was officially relaxed with an ordinance in 2003, which helped Viet Nam to meet some of the rights-based ICPD recommendations. However, the establishment of a small-family norm remains a top national priority, as does enhancing access to long-lasting contraceptive methods. Having just achieved below-replacement levels, Viet Nam is now experiencing a period of "demographic bonus" with an age dependency ratio under 50 percent (UNFPA 2009). In continuing the thrust of previous policies, the National Population Strategy 2001–2010 is aimed at sustaining the declining fertility trend and improving the quality of its abundant and young human resources.

The National Population and Family Planning Committee (NPFPC), in coordination with the MOH and other relevant ministries and branches of the People's Committees, has the primary responsibility to achieve the country's population goals (SRV 2000). The NPFPC is entrusted with procurement

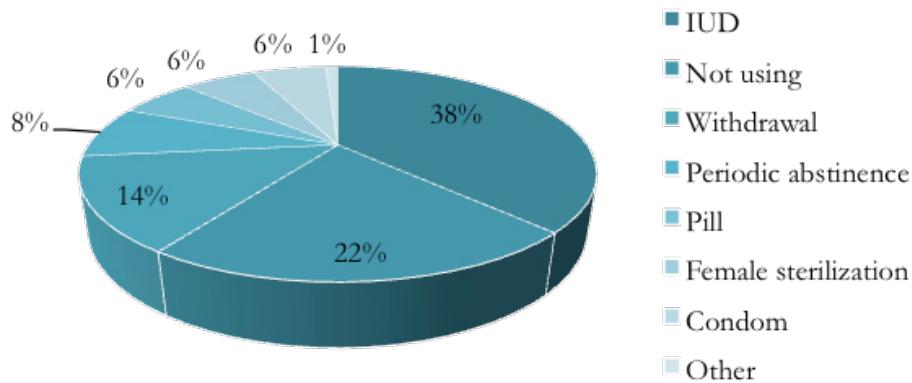
of commodities and mobilization of acceptors, while the MOH is responsible for delivery. The logistic system could be modernized and its procedures simplified, but nonetheless it manages to ensure a regular distribution of selected supplies to the various delivery points. In 2002 the public health system, especially its community health centers and field-workers, delivered 86 percent of modern contraceptives. The remaining share was provided by the private sector, mainly by pharmacies. NGOs, such as Marie Stopes and the Viet Nam Family Planning Association (VINAFAPA) a member of IPPF, try to expand contraceptive choices at an affordable price, but for now they still play a marginal role.

For specific methods, the sources of supply vary. Private pharmacies sell condoms, public fieldworkers, health centers and private outlets

deliver pills, but provision of sterilization and IUDs is the almost exclusive prerogative of the public health system (NCPFC and ORC Macro 2003, 42). In other words, the public health system is geared toward LAPMs, as also reflected in the target sets, in the incentives for providers and in local information management systems recording delivery of sterilization and IUDs but not of pills or condoms. IUDs, in particular, have been a permanent feature of the family planning program since its start in the 1960s, making Viet Nam the only country in Southeast Asia on a par with a handful of countries in the world, where IUDs are the most used contraceptive method (see figure 3). Short-term modern methods only became available under the program in the 1990s after Viet Nam opened up to the global community, but are not widely used yet. Pills are considered impractical and condoms, having been promoted only in the context of AIDS control, are seen as effective for disease prevention but not for contraception. Viet Nam's emphasis on IUDs has led to neglect of its contraindications, contributing to high levels of reproductive tract infections. Furthermore, the lack of temporary modern contraceptives has lead to dissatisfaction and non-use as well as use of less reliable traditional methods. Half of all pregnancy terminations occurred among women using traditional methods, especially withdrawal (31 percent)—the second most used method and the fastest growing (NCPFC 2003, 40–59).

25. Available at <http://www.aegis.com/news/afp/2004/AF0411C2.html>.

26. Available at <http://www.abortionreview.org/index.php/site/article/509/>.

Figure 3 Contraceptive method mix of married women in Viet Nam, 2002

Source: NCPFC and ORC Macro 2002.

The government exercises strong regulatory control, for example, allowing three-month but not one-month injectables, again opting for longer-acting methods. Supplies are procured locally or from abroad with the assistance of international donors. Since the 1990s the government has supported local production of contraceptives²⁷ and imports from other Asian countries to minimize costs. Still, due to economic constraints, Viet Nam has not achieved self-reliance in contraceptive supply and in 2006 was among the ten top recipients of donor support (UNFPA 2008, 22). That year, UNFPA mobilized US\$1.1 million for IUDs, injectables, oral pills and implants, in addition to the regular 7th Country Program 2006–2010, which already included condoms.²⁸ This helped to fill a commodity gap that if not addressed could have lead to “to an increase of 360,000 unwanted pregnancies, 800 maternal fatalities, 11,000 cases of under-5 mortality, and 150,000 abortions.”²⁹ Other donors, especially of pills and condoms, include GTZ, DFID, the European Union and other bilateral agencies.

In recognition that a long-term approach is needed to ensure sufficient finances for a more balanced contraceptive mix, the government with support from UNFPA and other international agencies has been working on a national strategy on contraceptive commodity security for the period 2006–2015, which includes efforts to strengthen procurement of essen-

tial drugs and equipment, program management and quality of human resources. To encourage greater diversity in contraceptive supplies, more involvement of non-government sectors and social marketing along the DKT model is advocated. In Viet Nam, DKT undertakes targeted distribution of condoms to populations vulnerable to STIs and HIV, and sells OK and Super Trust condoms and NewChoice oral contraceptives at subsidized prices to the general public through over 11,000 outlets, including 9,000 pharmacies. In 2008 over 61 million condoms and six million cycles of oral contraceptives were sold (equivalent to 1,085,297 CYPs),³⁰ with sales expected to expand as the market liberalizes further. More choices of methods will be available, at least for those who can afford purchasing them.

Like Viet Nam, **Indonesia** has a long history in population control through the promotion of LAPMs. The Indonesian Family Planning Program, led by the Indonesian Family Planning Coordination Board (in short BKKBN) has a mixed record. The program has been hailed as a demographic success, because it increased CPR of modern methods from about 5 percent in the late 1960s to over 50 in the late 1990s and beyond, contributing to the halving of the Total Fertility Rate (TFR) (Hull and Mosley 2009, chap. 2). However, the program achieved these results by emphasizing LAPMs—IUD and sterilization (mainly tubal ligation), and later implants—

27. Available at <http://www.ncbi.nlm.nih.gov/pubmed/8085369>.

28. Available at <http://vietnamnews.vnagency.com.vn/showarticle.php?num=01SOC200506>.

29. Available at http://vietnam.unfpa.org/comp_rh.htm.

30. Available at <http://www.dktinternational.org/index.php?section=36>.

attracting criticism for its disregard of women's choices and poor quality of care (Smyth 1991). Indonesia introduced implants in the early 1980s when they were still untested, and remains one of the few countries in the world to have used them in large numbers.³¹ Since Indonesia is today close to replacement levels and its two-child family norm has become common, less pressure is put on promotion of fertility reduction and LAPMs (Hull and Mosley 2008).

The contraceptive mix is changing, but it remains biased due to a disproportionate increase in hormonal injections at the expense of most other methods (see table 6). This increase has occurred coincidentally with a shift from public to private services, with a growing number of private providers favoring the provision of three- and one-month hormonal shots, rather than less recurrent LAPMs, as "an ideal way to lock in a flow of payments." Also, health insurance schemes generally do not cover the costs of more expensive operations like insertion of implants and sterilization (Hull and Mosley 2008, 18–19, 44). Moreover, the government's support for sterilization has weakened due to opposition from vocal Islamist groups. One constant feature over time is the minimal role of men in fertility regulation, with male methods accounting for less than 5 percent of contraceptive use in the last decade and a growing preference for withdrawal (BPS and Macro International 2008, 76).

health insurance schemes [...] do not cover the costs of [...] insertion of implants and sterilization

In the last two decades, provision of contraceptives has been privatized and by 2007 it was estimated that 69 percent of married women purchased contraceptives from private sources (BPS and Macro International 2008, 86). In 1987 BKKBN began marketing "Blue Circle" products and services to encourage "acceptors" to become "clients" who purchase contraceptives at a subsidized price from participating providers. In 1992 the "Gold Circle" campaign followed, offering more diverse and higher quality products and services. For poor clients, public services continued to offer selected, mainly unbranded, contraceptives under various types of insurance schemes and subsidies at a minimum service fee. The public sector stayed centered on LAPMs, while the private sector's expansion opted for a "cafeteria-contraceptive basket." With this,

"market segmentation was promoted with an emphasis on quality for all, but better quality [and choices] for those who could pay more" (Hull and Mosley 2008, 15).

Even if cheaper, however, public services are not necessarily accessible. The system's effectiveness in targeting the poor, especially the seasonal poor and the near-poor, has been questioned. Budgets have not been commensurate to the number of poor, and costs in the public sector are rapidly rising to the level of the private sector, as more public facilities aim to become self-reliant and add to their budgets in the context of health sector reform and decentralization.

Table 6 Contraceptive method mix in Indonesia, 1992–2007

Method	IDHS 1997	IDHS 2003	IDHS 2007
Any method	57.4	60.3	61.4
Pill	15.4	13.2	13.2
IUD	8.1	6.2	4.9
Injectables	21.1	27.8	31.8
Condom	0.7	0.9	1.3
Implants	6.0	4.3	2.8
Female sterilization	3.0	3.7	3.0
Male sterilization	0.4	0.4	0.2
Periodic abstinence	1.1	1.6	1.5
Withdrawal	0.8	1.5	2.1
Other	0.8	0.5	0.4

Source: BPS and Macro International 2008.

It also needs to be noted that in Indonesia, as in other Southeast Asian countries, the public and private sectors are intermingled with providers working in both sectors, and commodities and equipment from the public sector inappropriately used in the private sector (World Bank 2008; Sciotino 2008a). In the procurement and distribution of contraceptive commodities as well, public and private lines mix. The public distribution system purchases contraceptives from the national budget and eventual grants of donor agencies and then delivers them to provincial warehouses to be distributed to health centers and other primary health care outlets, as well as to private outlets participating in the Blue and Gold Circles programs (Parawansa and Sudarmadi 2001). Closer monitoring of the volume of contraceptives distributed through government channels (whether central or local) and private

31. Even if the percentage in table 6 may appear small, absolute numbers are high in view of the large size of the Indonesian population and of married women of reproductive age

sales would allow for better forecasting and would preclude eventual diversion of government contraceptive commodities meant for the poor to the private market.

A further challenge is posed by the decentralization process that was initiated in 1999 and implemented in 2004, as poorly equipped local governments (districts and municipalities) have become entrusted with ensuring contraceptive security in their constituencies. MOH together with BKKBN and other line ministries established minimum quality standards and guidelines for managers. With help from USAID, BKKBN in collaboration with Jhpiego, an affiliate of John Hopkins University, adapted the performance improvement framework and the Strategic Pathways to Reproductive Health Commodity Security (SPARHCS) tool to strengthen forecasting and delivery skills at the district level, and to motivate local governments to allocate their, often limited, budget to meet supply needs.³² In 2003 stock-outs of contraceptives at the district level were observed.³³ Decentralization also requires BKKBN and MOH to adjust their respective roles and formulate new operational systems that integrate previously-separated logistic and information management systems in order to assure contraceptive coverage, quality of services and accurate reporting, although tensions between these two agencies and with local governments remain over budgets and responsibilities.

Procurement of contraceptives is mainly done in-country. Indonesia has the capacity to produce all modern contraceptive methods, ensuring a sustainable supply at low cost. Ten contraceptive producing factories are operating in the country and have a reputation for being reliable manufacturers (Armand 2006, 22). Yet for some there remain doubts about these factories meeting international standards for export as defined in WHO's Good Manufacturing Practices and the Pharmaceutical Inspection Cooperation Scheme. Since 2000 Indonesia has also become self-reliant in the funding of contraceptive supplies. Until then, it still appeared among the top ten recipient countries of donor support for contraceptive commodities and condoms by total expenditure (UNFPA 2008, 22). However, with the private sector's increased output and the government's reduced role in the provision of contraceptives, the country's dependency on foreign aid gradually diminished. In 2006 USAID, one of the major donors

completed its phase out initiated in 2003 (Hull and Mosley 2008). Support is still received for condoms for STIs/HIV prevention among sex workers and other groups considered at risk under the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Condoms are barely promoted among the general population and if they are it is in the context of family planning among married couples. Packaging and branding of condoms for STIs/HIV prevention and for contraception have been strictly differentiated in government programs—blue packaging for family planning among married couples and red packaging for HIV prevention among groups at risk—with little coordination between the two programs and the related procurement and logistics systems. Also in social marketing efforts, condoms are branded differently according to their purpose, such as DKT's "Andalan" for family planning and "Sutra" for HIV/AIDS prevention.³⁴ Since contraception is still to this day considered a sensitive matter, the government prefers to entrust distribution of condoms to international and local NGOs and their outreach and social marketing programs.

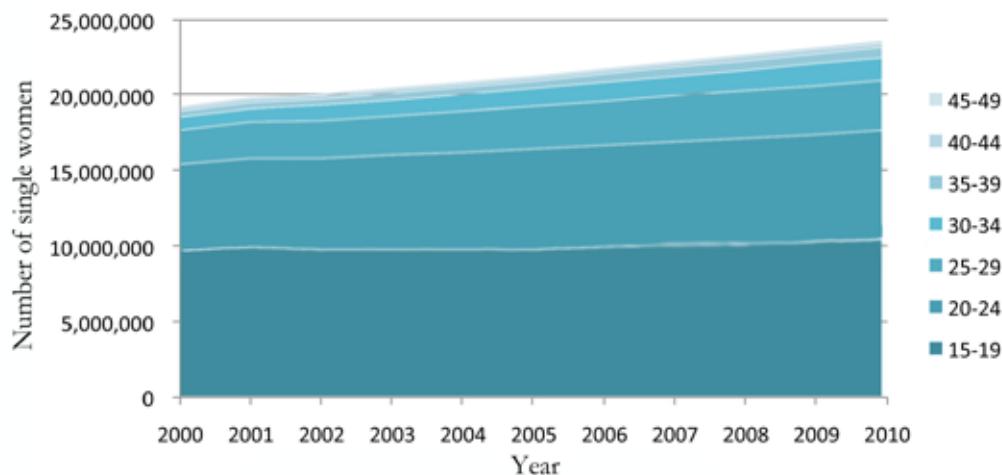
A group overlooked by both family planning and HIV/STIs prevention programs is that of unmarried women (and men). The number of single (never married) women is growing, especially in the 15–24 age group (see figure 4). These millions of women may be sexually active, but have no access to contraceptive services in a country where husbands must give formal consent to their wives to use contraception, and are at the risk of unintended pregnancies and unsafe abortions. The exclusion of this vulnerable group is also reflected in their not being counted in forecasting of commodity demand, in management information systems and in outreach efforts (Hull and Mosley 2008, 13). An additional blind spot in HIV prevention strategies is married women, both in monogamous and polygamous relations. The risk to married women is clear. It has been assessed that at least 50 percent of male clients of sex workers are married or have regular partners and less than 10 percent of them use condoms consistently. Married women remain poorly informed, with little negotiating power and with no access to female or male condoms (Hudiono 2006).

32. Available at http://apha.confex.com/apha/133am/techprogram/paper_116264.htm.

33. Available at <http://www.msh.org/projects/mandl/4.5.html>.

34. Available at <http://www.dktindonesia.org/aboutus.php>.

Figure 4 Growing numbers of never married women of reproductive age in Indonesia, 2000–2010



Source: BAPPENAS/BPS Projections in Hull and Mosley 2008.

3.4 Resource-poor Countries: Cambodia, Laos, Myanmar and Timor-Leste

Cambodia is poorly resourced, with fragile institutions and governance systems, and largely dependent on foreign aid. These conditions also affect the provision of contraceptive services. Management of health and family planning activities at the national and local levels is weak and their funding segmented. The implementation of the National Reproductive and Sexual Health Programme (NRSHP) under the National Health Strategic Plan (HSP) is entrusted to a unit of the National Maternal and Child Health Centre (NMCHC), one of the eight national institutes under MOH, while HIV and STIs prevention constitutes another HSP line belonging to the National Centre for HIV/AIDS, Dermatology and STDs (MOH, Cambodia 2006). To improve the health sector performance and the accessibility and quality of the services, international banks and bilateral donors set up the Health Sector Support Project (HSSP) in 2003, with UNFPA participating at all administrative levels to ensure attention to safe motherhood and birth spacing. Under the HSSP, a Commodity Security Working Group (CSWG) was formed to project future contraceptive supply needs and to ensure transfer of these skills to the Essential Drug Bureau, as the key government agency responsible for contraceptive security. No overall mechanism exists to finance and procure contraceptive commodities and there are few links with STIs/HIV programs in

the procurement of condoms. Bureaucratic bottlenecks and insufficient staff hamper the work of the Central Medical Stores (CMS) in clearing, storing and delivering commodities on the Essential Medical List, including contraceptives and other reproductive health supplies, for the public sector. The management information system has been improved, but it is not yet inclusive enough in types of commodities, outlets and sources of supply to provide an accurate picture of the stock situation (Hall and Chhuong 2006; UNFPA 2007b).

The public sector is the main provider of female sterilization and of the injectable Depot Metroxy-Progesterone Acetate (DMPA) and the second-main provider of IUDs. The commercial private sector, consisting of private hospitals and formal and informal health professional practices, is the lead provider of IUDs and the second-top provider of female sterilization and injectables. NGOs, especially the Reproductive Health Association of Cambodia (RHAC), play an important role in contraceptive security, providing affordable quality services throughout the country, with commodities sourced from the MOH.

Social marketing, mainly by Population Services International (PSI), accounts for a majority of condoms and pills that are branded to convey quality and purpose differentials, such as the Number One Condom for HIV/AIDS prevention among groups at risk, and the OK Condom for family planning and

for “decreasing HIV transmission among sweetheart and married couples.”³⁵ The private sector, especially its social marketing, is more concentrated in the urban areas, and the public sector more concentrated in rural areas.

Income levels determine contraceptive choices. In 2005 of the 27 percent of married women using modern contraceptives (out of an overall CPR of 40 percent), about 75 percent used short-term and re-supply methods, mainly injectables and pills, due to their affordability and availability through health centers and community-based distributors. IUD and female sterilization are the choices of richer consumers, as the majority of the population living at or below subsistence level cannot afford to invest in LAPMs (UNFPA 2007a, 13–16). Non-users and users of traditional methods are concentrated in the poor quintile, especially in rural areas. Quality of care is low, with discontinuation rates high and side effects often quoted as a major reason for not using or stopping the use of contraceptives (MOH, Cambodia, et al. 2005).

Most contraceptives are financed by donors and procured abroad according to procedures set by the concerned agency. The government only contributes 0.038 percent of total family planning commodity needs estimated at approximately US\$2.35 million per year to finance condoms for the public health system (UNFPA 2007b, 21). KfW has been the major donor of contraceptive supplies since 1993 and has committed to continue providing them for use in public health services and social marketing until 2011. Since 2006 USAID

and UNFPA have provided pills and injectables and GFATM condoms for social marketing (UNFPA 2007b, 17). A recent DFID evaluation recently recommended donor agencies to procure reliable generic contraceptives for both public services and social marketing, since the price is lower than that of Western-manufactured brands, such as those procured with KfW funding (Hall and Chhuong 2006, 4). Efficiency in spending is recommended since, as a 2007 UNFPA forecasting and costing exercise indicated, the gap in resources will increase as KfW and other donors gradually phase out while demand increases (see table 7).

In **Laos**, one of the least developed countries in Southeast Asia with a population density of only 23.7 per square kilometer, the specific challenge in attaining contraceptive security is to reach people scattered in rural areas with limited financial and human resources. The predominantly mountainous landscape renders access to health and family planning services difficult and costly. In 2000 it was documented that 40 percent of couples were willing, but not able, to use contraceptives because of the lack of facilities or the compounded costs of transportation and service.³⁶ In the public sector, commodities ought to be provided free of charge, but providers are compelled to charge fees in order to compensate for budget shortcomings. The poor can reportedly get a cost exemption for the services, but the waiver system is inefficient and community-based insurance schemes and drug revolving funds generally do not cover contraceptives (Sciortino 2008b).

Table 7 Projected resources need, committed resources and gaps in Cambodia, 2007–2015 (in US\$100,000)

Year	Total projected resources need	Resources need in 6-month buffer stock	Expected committed resources	Gap (unmet need)
2007	2,270	3,405	3,258	147
2008	2,520	3,780	3,488	292
2009	2,780	4,170	3,488	682
2010	3,050	4,575	1,168	3,407
2011	3,330	4,995	1,168	3,827
2012	3,630	5,445	150	5,295
2013	3,930	5,895	200	5,695
2014	4,240	6,360	200	6,160
2015	4,570	6,855	200	6,655

Source: UNFPA 2007b.

35. Available at http://www.psi.org/Where_We_Work/cambodia.html.

36. Available at <http://lao.unfpa.org/bckgrnd.htm>.

The National Population and Development Policy (NPDP) envisions provision of contraceptives to support primary health care interventions directed at enhancing reproductive and mother-and-child health, regulating the still-high fertility rate, and controlling the spread of HIV. Contraceptives, generally procured with UNFPA assistance, are stored at the MOH warehouse and then distributed from the Maternal and Child Health Centre (MCHC) of the MOH in the capital city of Vientiane to the provincial and district MCHCs, and then delivered to the health centers. In 2000–2001 the public service delivery points for contraceptives increased from 80 to about 700 (UNFPA 2001c, 23). All provinces have designated provincial health department warehouses. Most are in suitable conditions, but the management of the inventory and stock could be improved. Commodity supplies at times run out, with shortages going unreported due to inadequate recording and reporting systems.

Users mostly opt for pills (about 40 percent) and injectables (about 25 percent), followed by sterilization (15 percent) and IUDs (9 percent) (UNFPA 2001c, 19). The public sector is the major provider of contraceptive services, offering two types of combined pills (Mycrogynon and Levon), a mini-pill (Microval), the three-month injectable DMPA, IUDs, male condoms and female sterilization. Sterilization can only be performed at hospitals with operation table facilities and trained staff, mostly at the provincial and national levels. IUDs and injectables are available at the district level and at some health centers, while pills and condoms can be distributed at the health centers and dispensaries. In the expanding private sector, pills, injectables and condoms can be obtained. In 2000 almost 50 percent of ever-users of pills, 25 percent of ever-users of injectables and 35 percent of ever-users of condoms purchased the commodities from private sources consisting of pharmacies, private practices and/or outlets in border areas. Products' safety and efficacy are a concern as fake and outdated products imported from neighboring countries are also on sale (UNFPA 2001c).

International aid is crucial to realizing the NPDP goal of at least 55 percent CPR in 2010 from 32 percent in 2000, in order to meet the country's many reproductive health needs (UNFPA 2001b, 20). The health system and family planning in Laos are fully dependent on international aid, and in 2006 the country ranked tenth among the top ten recipients of

contraceptives in the world by per capita expenditure (UNFPA 2008, 22). UNFPA has been funding most of the contraceptive supply of MOH. GFTAM and USAID support social marketing by PSI of the Number One Condom for STIs/HIV prevention among “most at-risk populations, including female sex workers (FSW) and their clients, mobile populations and MSM.”³⁷ As donors may not be able to continue funding at the current level for long, alternative strategies need to be devised to ensure contraceptive security in Laos.

Financial assistance is also needed in **Myanmar**, but the international community is cautious because of concerns about the military regime and economic sanctions imposed on the country. On humanitarian grounds limited support has been provided. DFID and UNFPA are the primary sources of generic commodities (a few types of condoms, pills, injectables and IUDs) for the public sector. Similarly, DFID and several other bilateral donors and foundations have invested in the social marketing and outreach work of NGOs. Resources, however, remain insufficient to strengthen the quality of the birth spacing program initiated in the early 1990s and to expand the HIV/AIDS control program throughout the country. In 2002 UNFPA, extrapolating from 1997 statistics, noted a “general shortage of contraceptives” and concluded that committed sources were insufficient to cover the total unmet need for contraception and for HIV/STI prevention.

The shortage of contraceptives in the country is substantive, especially if the needs of unmarried youth are to be taken into account (UNFPA 2002, 30–32). This considering that Myanmar, unlike other countries in the region, does not bar unmarried youth from reproductive health services—although discrimination and lack of confidentiality do act as inhibitors. Even before Cyclone Nargis struck in May 2008, people had little access to contraceptive services. Overall CPR was 37 percent in 2001, with the contraceptive mix dominated by injectables and pills. Now, as then, many of the 324 townships have no service outlets or commodities and, when available, delivery of supplies is irregular so that “one in six women living in Myanmar wants to use contraception but cannot.”³⁸ Not only is the reach of contraceptive services limited, but their quality is poor, with method failure a common problem resulting in a high number of unsafe abortions and complications.³⁹

37. Available http://www.psi.org/Where_We_Work/laos.html.

38. Available at http://www.searo.who.int/linkfiles/family_planning_fact_sheets_myanmar.pdf; and <http://www.mariestopes.org.au/cms/Myanmar.html>.

39. Available at http://www.searo.who.int/linkfiles/family_planning_fact_sheets_myanmar.pdf.

Logistical and delivery systems are weak, and storage time is protracted, as medical officers at district and township levels have to collect the supplies at the Central Medical Store Depot in the capital city before distributing them to hospitals and rural health centers. Female sterilization requires approval by a sterilization board before being performed in township hospitals, and IUD insertions are rare, as few providers have relevant skills. At the community level, lady health visitors (LHVs), midwives and auxiliary midwives record and maintain the contraceptive stock and dispense pills, injectables and condoms (UNFPA 2002, 7–9). Contraceptive drugs are sold according to the community cost sharing (CCS) policy at a cost “agreed upon by the community,” although staff can give waivers for poor users. Still, no criteria are set to target those most in need. Condoms should be provided for free, but generally fees are charged. Earnings are transferred to the township level, but rarely used to purchase contraceptives. When stock-outs occur, staff reportedly buy commodities with their own funds and re-sell them to their clients (UNFPA 2002, 20–23). Such practices weaken the distinction with the private sector, already blurred by the fact that most public providers sell contraceptives in private outlets.

The very large private sector includes international and local NGOs, social marketing and commercial outlets, as well as private practices of health providers. The Myanmar Maternal and Child Welfare Association (MMCWA) with assistance from IPPF provides contraceptives through its national network of volunteers. Marie Stopes International Myanmar (MSIM) offers contraceptive services (pills, injectables, IUDs and condoms) through sixteen centers and village-health workers in poor urban areas.⁴⁰ Social marketing is provided by PSI Myanmar. Initially focused on condoms for HIV/

STI prevention, PSI's network of retailers, pharmacists and over 800 private physician-owned clinics under the Packard-funded Sun Quality Health franchise, now sell male and female condoms, pills, one- and three-month injectables, IUDs and emergency contraception with support from the Bill and Melinda Gates Foundation, UNFPA, DFID and others.⁴¹ In spite of the key role as distributors and providers of contraceptive commodities, NGOs encounter many difficulties in importing them, with the clearance process taking three to six months. The for-profit sector is poorly regulated, with quality not paralleling the high costs. Products are imported from China and other Southeast Asia countries through legal and illegal channels and offered for sale without any exercise of quality control (UNFPA 2002).

Unlike Myanmar, in **Timor-Leste** the private sector does not play a significant role. More than 80 percent of women interviewed in the 2003 demographic and health survey had accessed supplies from the public health system (UNFPA 2007c, 15). Private pharmacies in the capital city of Dili sell condoms, pills and injectables, but their costs are too high for the majority of the local population. Since independence from Indonesia in 1999, the Autonomous Service of Drugs and Medical Equipment (SAMES) has ensured distribution of contraceptive commodities from the central warehouse in Dili to service delivery points in health facilities where they are stored in separate rooms or cabinets. Contraceptive commodities are included in the essential drug list and provided as part of primary health care. In 2006 UNFPA was the main source of supply for family planning with a focus on provider-controlled methods, IUDs, implants and injectables for family planning (see table 8), and it was expected in 2007 that this would remain the case for the next five years (UNFPA

Table 8 UNFPA procurement of contraceptives for Timor-Leste, 2006

Description item	Quantity	Units	CYP
IUD Pregna Model T Cu 380A (Copper T)	1,000	Set	25,000
Condoms 49mm	1,000	Gross	1,000
“Ovrette” Progesterone Only contraceptive pill	10,000	Cycle	769
“Microgynon” Combined Oral contraceptive pill	7,000	Cycle	538
“Depo Provera” injectable with single shot syringe	100,000	Vials	3,500
“Jadelle” Implant	700	Set	3,500
Total Cost:			US\$118,355

Source: UNFPA 2007c.

40. Available at <http://www.mariestopes.org.au/cms/Myanmar.html>.

41. Available at <http://www.psish.org/resources/factsheets/myanmar.pdf>.

2007c, 3–23). Condoms for HIV prevention have been provided to vulnerable groups with funding from USAID and more recently GFATM (USAID 2008).

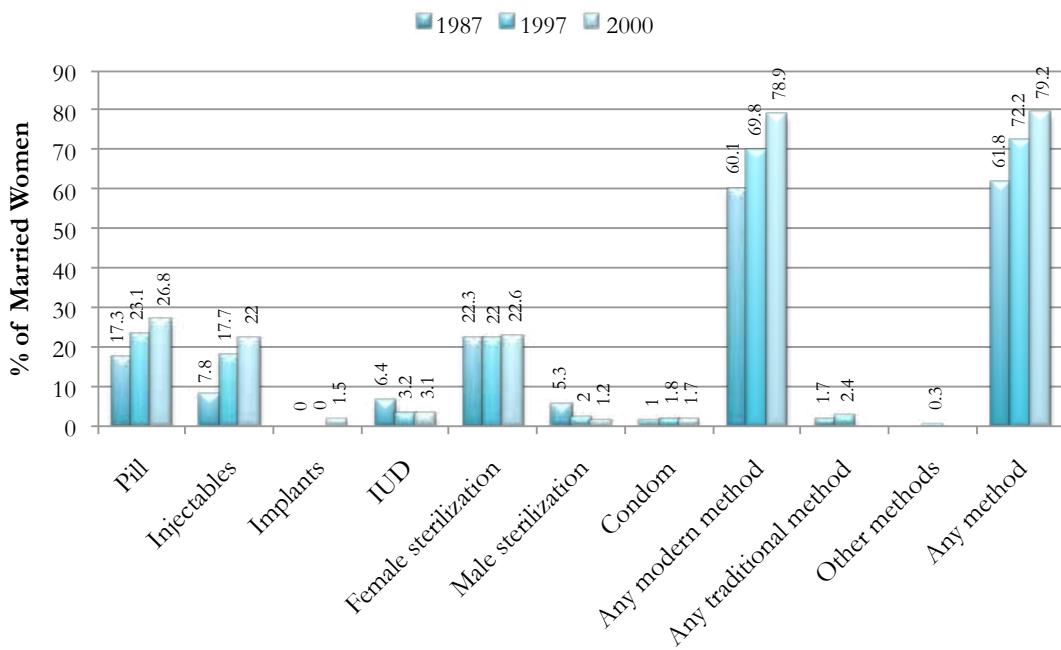
No shortages of contraceptives have so far occurred as demand is very limited in this Catholic country, with less than 7 percent of the population using modern contraceptives (UNFPA 2007c, 17). It can be expected, however, that demand will grow as the implementation of the 2003 National Reproductive Health Strategy intensifies in order to improve reproductive health outcomes by 2015. Strengthening of the health system will also be crucial in boosting demand, as surveys show that users encounter many barriers in accessing maternal and child health services, including (i) insufficient personnel, drugs/vaccines, medical supplies and equipment; (ii) limited staffed opening hours; (iii) poor quality of services; and (iv) facilities lacking even basic requirements, such as water supply, waste disposal systems and energy (UNFPA 2007c).

3.5 A Case Apart: Thailand

In Southeast Asia **Thailand** is a special case. Its features do not fit into the dominant typologies discussed above. Since

the beginning of family planning efforts in the late 1960s, Thailand took a different path than other populous nations in Southeast Asia in trying to control population growth. Family planning activities were integrated into the health care structure instead of devoting a separate entity to that purpose, so as not to lose sight of women's welfare in efforts to slow down fertility growth. The program was also one of the first to favor auxiliary personnel in the provision of contraceptives in order to expand services to places where no doctor, nurse or midwife was available. A cafeteria approach was employed, offering a wide range of methods: pills, injectables and condoms were widely offered, and non-scalpel vasectomy was included among LAPMs. Coercion was quickly dismissed, although incentives, such as participation in microcredit schemes for acceptors, were at times employed to encourage use of contraceptives, especially LAPMs. In 1972 contraceptive research was stimulated and development of new methods, such as modified sterilization technique mini-laparotomy, encouraged. The local pharmaceutical industry (both government and private) was supported in producing contraceptive commodities, and new contraceptives from abroad were quickly adopted if found suitable to meet local needs. For instance, as early as 1977, the MOH approved DMPA, which to this day remains one of the most popu-

Figure 5 Contraceptive trends in Thailand, 1987, 1997 and 2000



Source: Various sources in WHO 2003.

lar methods. NGOs, particularly the Population and Community Development Association (PDA), became partners in mobilizing communities and integrating family planning into community development, conveying the message that fertility regulation is a way of improving livelihoods and quality of life.⁴² When NGOs serviced underserved groups or locations, the government provided them with technology, funds, contraceptives and medical equipment (Rosenfield and Min 2007; WHO 2003).

Contraceptive prevalence has steadily increased (see figure 5) and today is the highest in Southeast Asia (see table 3 in chapter 2),⁴³ thanks to an almost exclusive use of modern contraceptive methods, foremost pills, followed by female sterilization and injectables. Contraceptive services are highly accessible, with contraceptive methods provided “conveniently, largely free of charge, without incentives, and with controls for quality and safety” (WHO 2003). Family planning methods, as well as condoms for HIV and STI prevention, are preventive sexual and reproductive health services covered under Thailand’s universal insurance scheme. Abortion in cases of rape and risk to maternal health is covered under the curative services package (Teerawattananon and Tangcharoensathien 2004). Many contraceptive brands, in-

cluding emergency contraceptives Postinor and Madonna⁴⁴ are also on sale at affordable prices at pharmacies, drugstores and other outlets. Interventions are ongoing in the effort to stop the selling of fake products and to improve dispensing and labeling practices to enhance adequate and safe use. Measures to further expand coverage, as formulated in the National Reproductive Health Policy, include efforts “to provide services for married and unmarried male and female youth, specifically aiming to reduce adolescent pregnancy” and “to better meet the needs of specific populations, including ethnic minorities, Muslims, migrant workers, slum dwellers and the under-served” (WHO 2003, 4).

Thailand’s family planning efforts that started in the 1960s, with funding from USAID and financial and technical support from the Population Council, the Ford Foundation and the Rockefeller Foundation, have now become self-sufficient. Contraceptive commodities are produced in locally developed formulation and brands (see table 9) for internal use and export. Thailand is a supplier to UNFPA, various developing countries in Africa and its neighbors, and it often provides technical assistance internationally on the different aspects of manufacturing, quality control, storage, marketing and distribution of contraceptive commodities. Thailand has even be-

Table 9 Selected contraceptive brands and manufacturers in Thailand

Method	Brand	Manufacturer	Availability
Oral contraceptives	Anna	Thai Nakorn Ptana	Southeast Asia
Ethinyl Eastradiol 30 mcg	Rioget	Biolab Co.	Malaysia
Emergency contraceptive pills Levonorgestrel 0.15 mg	Madonna	Biopharm Chemicals	N/A
Injectable contraceptives DMPA	Contracep	Thai Nakorn Patana	Cambodia, Laos, Myanmar, Viet Nam
	Depo-Gestin, Depo-A	ANB	N/A
	Depo-Progesta	General Drugs House	N/A
	Depo-M, Pheno M	Vesco Pharmaceutical Thailand	N/A
	Depo-progesno	Milano Lab. Thailand	N/A
	Medeton	TP-Drug	Thailand, Cambodia, Laos, Myanmar, Sri Lanka
	Non-Preg	LBS Lab	N/A

Source: Armand 2006.

42. Available at <http://www.context.org/ICLIB/IC31/Frazer.htm>.

43. Note that the data in figure 5 is not consistent with table 3, possibly because of the use of different sources. Still, it is included here to illustrate the growing trend in contraceptive use.

44. Available at <http://ec.princeton.edu/questions/dedicated.html>.

come a donor of commodities to less advantaged countries, donating 50,000 condoms to seven African countries to fight AIDS in 2006.⁴⁵ An observed weakness is production overcapacity, with companies producing within 4–8 weeks their entire yearly quota of oral or injectable contraceptives at the risk of neglecting quality (Hall 2006).

In HIV prevention, Thailand has been a pioneer. Its “100% condom use” effort ensuring condom use in entertainment areas and other complementary efforts resulted in a decrease of about 80 percent in STIs among men.⁴⁶ In 2008, with the realization of the growing number of infections among women in regular relations, safe sex communication campaigns

were launched for the general population. Specific outreach programs to make both female and male condoms more easily accessible to women and youth have, however, still to start. For yet to be-better-understood reasons, condom users in the country use imported brands (mainly from the US, Japan and India), despite the fact that Thailand is the second-largest exporter of condoms in the world. Thailand's ten condom manufacturers produce three billion condoms daily. To ensure production standards, since 1990 condoms have been included in the list of strictly regulated medical commodities, and producers are obliged to register their products and publicize the expiry date on their packages (ThaiDay 2006).

45. Available at http://www.aidsawarenesscenter.com/prevention_condomdonation.php.

46. Available at http://www.atimes.com/atimes/Southeast_Asia/EDO3Ae04.html.



4.1 Learning from National Experiences

In Southeast Asia, challenges remain for governments to fulfill the many urgent reproductive health needs of their countries and region. Great strides have been made towards achieving contraceptive security, but they are still not sufficient to guarantee universal access to a wide range of quality contraceptives for family planning and disease prevention, nor are they adequate to meet the expected increase in demand as the regional population continues to grow and a large number of young people enter reproductive age. While financial and technical scarcity remains a concern in some of the more disadvantaged countries, it is the realization of an enabling policy environment that presents the greatest challenge in achieving contraceptive security.

The policy environment in Southeast Asia is complex and governments in the region do not take the same position with regard to providing reproductive services. The permitted degree of commodity mix similarly varies across the region. Economic conditions are also very different, producing differentiated reproductive health outcomes and disparities in the provision of, and access to, contraceptive services across and within countries. These specific environments need to be taken into account in devising tailored strategies at the local and national levels. At the same time, efforts at the regional level may address certain common threads, such as limitations in condom provision and the exclusive focus on married women for contraceptive services that cut across more than one country, so as to synergize separate efforts in fostering contraceptive security for the whole region.

In this final chapter, lessons will be derived from the various national experiences as profiled in the previous chapter in order to make overall recommendations for enhancing the delivery of contraceptive services and commodities in the region. Taking into account both the global discourse on contraceptive security as introduced in chapter 1 and the reproductive health and contraceptive needs identified in chapter 2, three key areas of intervention are identified, namely fostering enabling environments, harnessing resources and strengthening information management, logistics and service

delivery systems. Structured along these key areas, a regional advocacy agenda can be formulated for realizing Contraceptive Security for All in Southeast Asia.

4.2 Fostering Enabling Environments

The global discourse of contraceptive security as essential to better reproductive health, as well as to reducing poverty, fostering development and realizing the MDGs applies also to Southeast Asian countries. Still, despite being signatories to international commitments and benefiting from international development assistance programs that support these goals, some of the countries in the region continue to pursue policies that are either blatantly unsupportive of achieving contraceptive security or inconsistent with this aim. The ideological opposition to modern contraceptive services and commodities as grounded in religious as well as demographic objections act as a disabler of contraceptive security, precluding gathering of information, accurate planning and effective logistics and delivery systems. Policies that promote institutional biases for certain methods are also a serious barrier to contraceptive availability and choice. These and other hostile policy and social environments rule out achieving contraception security and addressing unmet needs for family planning and prevention of STIs. Ultimately, these barriers translate into severely decreased access to contraception for millions of people in Southeast Asia. It is, therefore, urgent to **re-invigorate evidence-based policy dialogue and mobilization of development partners and civil society actors in advocating contraceptive security for sustainable development, well-being and women's choices**. Innovative advocacy strategies need to be orchestrated that find entry points in unfavorable environments, taking into account each country specific context. In view of the ongoing demographic transition in the region, it is especially important to emphasize that fertility decline is not necessarily a reason to reduce contraceptive services since contraceptive needs remain high, as the significant number of abortions and the rising number of STIs show.

Political will needs to be harnessed to address the lack of integration of contraceptive security into broader development plans. Family planning in Southeast Asia has long been seen as instrumental to poverty reduction and economic growth. Still, there have been very few efforts to support it through economic development. The preoccupation with population control often translates into coercive measures and/or emphasis on only selected LAPMs, thus creating tensions between health concerns and population objectives. As the HIV epidemic continues to spread among the general population, dismissal of the condom as a family planning method is a missed opportunity.

Contraceptive security is meant to play a fundamental role in strengthening the gender-equal and rights-based perspective of development efforts. If this role is to be realized in Southeast Asia, **governments should recognize that the unmet need for contraceptive supplies exists not only among married men and women, but also among unmarried people who are sexually active, including youth.** Governments in Southeast Asia, however, seem hesitant to recognize that not only couples, but also individuals, girls and women included have the basic right to access contraceptives. These governments have still to respond to the ICPD+5 call to provide “the widest available range of safe and effective family planning and contraceptive methods” to their populations (UNFPA 2002, 11). In their projections for contraceptive provision, governments in the region do not take into account that the number of young people and women of reproductive age who delay marriage will continue to increase in the near future, in spite of diminishing growth rates. As Hull and Mosley (2008, 8) note for Indonesia, but which actually applies to most of Southeast Asia:

National family planning program[s] explicitly exclude[s] unmarried women (and men), therefore these women receive little attention . . . This policy may have been rational 40 years ago when the family planning program began and most women, with no opportunity for education, married and began childbearing early. But with development and urbanization, times have changed dramatically, as has the demographic picture and sexual behaviour of unmarried women, yet the old policies remain.

This scenario also challenges other assumptions that are still dominant in the public health and development arena, and that compromise achieving contraceptive security. Chief among these is the emphasis on promoting condoms for HIV prevention mainly among the “most at risk populations”

(MARPs). This is at the exclusion of youth and adult single women as well as of married women, if not sex workers and drug users. These large population groups are considered not at risk of HIV/STIs, nor for that matter of unwanted pregnancies, and are precluded from accessing condoms and even at times from learning about condoms. The stigmatization of condoms as associated with promiscuity continues to undermine efforts to expand the modern contraceptive method mix and also to strengthen integration of reproductive and sexual health, including synergies with STI/HIV prevention. **The artificial differentiation created through packaging, branding and other means between condoms for family planning and condoms for prevention of STIs needs to be revisited.** Such partition perpetuated by governments, public health and family planning experts, donors and even social marketing agencies overlooks the linkages across diverse population groups with varying degrees of exposure to HIV, ignores the growing evidence that “faithful” married women are at risk of infection as well as of unwanted pregnancies. It also misses an opportunity to more efficiently use scarce financial and human resources by integrating family planning and HIV/STI prevention into comprehensive reproductive health services, as recommended at the Cairo Conference. At the same time, due to the lack of service integration, the specific needs of women living with HIV and STIs to make informed sexual and reproductive health decisions are not accommodated (Hamilton 2005).

More needs to be done to redress the current gender bias in contraceptive policies and programs. The promotion of male sterilization using no-scalpel vasectomy techniques in primary health care facilities should be promoted as a cost-effective and practical option for couples who decide not to have children. The spreading of the HIV epidemic further requires that men revisit their ideas of sexual pleasure and overcome their resistance to use condoms. This can be helped by family planning programs that invest in condom promotion and availability, and more open public discussion of power relations in sexuality. Boys should be exposed from an early age to condoms as the only “double protection” method through intense communication campaigns and easy access to affordable condoms. At the same time, female condoms should be promoted with more vigor in recognition that girls and women in regular as well as non-regular relationships are exposed to HIV and unwanted pregnancies. Pressure should also be kept on researchers and manufacturers to invest in finding women-friendly methods to prevent STIs and HIV.

4.3 Harnessing Resources to Meet Growing Demand and to Promote Equity

If the environment in Southeast Asia becomes more enabling, and if the policy framework of contraceptive security is expanded to include hitherto excluded groups (not to mention the projected population increase as the demographic momentum builds), an augment of contraceptive demand and use for most of the region can be expected. As mentioned in chapter 2, incremental increases of a large number of contraceptive users imply a great need of commodity support. Except for the richest countries in the region, the majority of other countries will need to seek additional donor funds.

In the poorest, donor-dependent countries in the region, **it will be important to develop strategies directed at diversifying funding** so as to reduce dependency from only one donor and, in turn, limit disruptions in donor-supply mechanisms due to eventual changes in policy. Diversification of funding would also allow more negotiating power with foreign donors in deciding procurement parameters. As a priority, channeling of donor support should occur through integrated mechanisms institutionalized in government agencies to avoid lack of coordination in forecasting and delivery. Donors supporting contraceptives for family planning and donors investing in HIV/STIs prevention should regularly share information on the procured commodity supplies between them and with governments and other stakeholders to improve coverage, as well as to make more efficient use of scarce resources.

Mechanisms could also be developed for joint regional procurement and storage of contraceptive commodities, maximizing the opportunities that may derive from the fact that three countries in Southeast Asia—Malaysia, Indonesia and Thailand—are significant producers of contraceptive supplies, and that Southeast Asia is in between India and China, two of the largest producers of cheaper goods. This, of course, should be done without compromising quality. Cross-country collaboration could be beneficial to both producer and receiving countries as it could reduce mark-up transaction costs. **Less expensive, and if possible locally-produced, generic products that meet international standards should be preferred rather than brand commodities.** Inclusion of contraceptives into national essential drug lists, for those countries that have not yet done so, may also help in containing costs and safeguarding quality.

Universal health insurance systems should be considered to make reproductive health supplies and services more affordable, like the case in Thailand. Other countries in the region that are at a similar level of economic development could afford thinking about a national insurance system. Such a national insurance system would eventually be composed of various schemes that ensure contraceptive commodities are covered, since these commodities are essential to the population's welfare and the development of the country. The experience of Thailand, when compared to other countries of the region, shows that a universal coverage system contributes to the affordability, as well as the wide availability, of contraceptives in a more effective manner than does providing fragmented subsidies and community-based insurance schemes of limited scope.

An equity perspective should inform strategies directed at fostering contraceptive security in order to avert creating an underclass of people excluded from essential health commodities and services or having access to services of lesser quality. An open and evidence-based policy and public discussion should be promoted concerning the distributional impacts of privatization and decentralization efforts on contraceptive supplies, access to services, costs and standards of care, and sexual and reproductive health outcomes for diverse groups in society. While the involvement of the private sector may prove useful and necessary to contraceptive security, privatization may not fulfill the universality and equity principles implicit in the concept of contraceptive security. This brings up another priority, namely **the need to strengthen the government's stewardship role in determining the "right" mix of private (both commercial and not-for-profit) and public services, and in regulating the market** in a way that fosters contraceptive security and equitable services. As the majority of the poor rely on the public sector for their health needs, it will be crucial to ensure that public services, especially when decentralized, are of comparable standards to private services to avoid the aggravation of creeping “market segmentation.” After all, contraceptive security in its broad sense of availability of a wide range of quality contraceptives is meant for all and not only for advantaged groups in society.

The impacts of social marketing need to be better understood. In many countries, social marketing has increased access to commodities and expanded contraceptive choices. Still, it does not seem effective in transforming restrictive policy environments and, as the experiences in Cambodia

and the Philippines show, it has had only limited success in increasing access for the poorest. New approaches should be considered to ensure that the more vulnerable and marginalized communities are not neglected. When supporting social marketing efforts, donors may also want to consider funding diverse agencies in the same country to spur competition.

4.4 Strengthening Information, Logistics and Service Delivery Systems

The official position of most Southeast Asian governments is that contraception is meant for married, heterosexual couples. Not-yet-married adolescents of both sexes and never-married women of all ages are not included in CPR data and are overlooked in information gathering as well as interventions. **New management information systems need to be developed that include never-married women of all ages, youth and other excluded groups** to enhance the accuracy of forecasting and to improve the reach of contraceptive services. If gender bias is to be countered, it may be time to start to study male use of contraceptives to better understand trends and to forecast accordingly. Documentation and registration cards also need to be adapted and attention paid to how these may reveal the user's marital status, age and other personal information, since this is becoming an inhibiting factor for single women and adolescents to use government services (see also UNFPA 2002).

As sources of contraceptive delivery become more diverse, **there is a need to establish more comprehensive mechanisms for monitoring procurement, distribution and delivery of commodities** both in the public and private sectors at the national as well as the local level.

Health systems need to integrate family planning and HIV/STI prevention into comprehensive reproductive and sexual health services, including linkages with abortion care, if, as previously recommended, the division line in contraceptive security is to be abolished. Barriers to integration are many and there are concerns from stakeholders in their respective programs that an integrated approach would be disadvantageous to their constituencies. Such concerns need to be addressed while gradually resolving issues that keep the programs apart, from de-stigmatizing sexual behavior to eliminating the common practice of differential branding and packaging of condoms depending on their ascribed purpose as a family planning or HIV prevention method. Comprehensive sexual and reproductive health services

are crucial to optimize resources and enhance universal access to contraceptive supplies and contraceptive security.

In countries with weak health systems, improvement of contraceptive security should contribute to the strengthening of the overall system rather than becoming a burden to that system. In view of the scarce resources, **efforts should be made to integrate the contraceptive commodity chain into already existing procurement, storage and delivery mechanisms**. The role of various health workers in contraception provision may also be assessed to decide what contraceptive practices can be entrusted to auxiliaries and volunteers, so as to reduce costs and expand the reach of activities to rural areas and other less well-served areas in resource-poor countries, without compromising standards of care. Quality of care should be given greater attention to reduce side effects as well as contraceptive discontinuation and non-use. More generally, a regulatory framework, including enforcement guidelines and mechanisms, should be developed to prevent the occurrence of commercially-driven practices in contraceptive provision, such as the providers' bias toward hormonal injectables in Indonesia, for example, or the selling of fake or outdated contraceptive commodities.

If decentralization is to work for contraceptive security, **new mechanisms need to be devised that support a decentralized supply chain** capable of keeping service delivery points stocked. When the size of local units is relatively small, collaboration should be encouraged among various units in purchasing and storing commodities. A separate budget line needs to be established at the national as well as local level to ensure financing of contraceptive commodities. Community and civil society groups should also be engaged in the formulation and implementation of decentralization strategies, to ensure commitment for contraceptive security at the local level.

Tailored efforts need to be launched to address demand-side barriers and to reach out to the most disadvantaged groups. Demand side barriers, such as distance to service delivery points and lack of information and knowledge, as well as cultural and social differences are many and complex. In Southeast Asia, groups that are particularly vulnerable are ethnic and religious minorities and, generally undocumented, migrants since they lack residency and/or citizenship recognition. To meet their great need for care, the many barriers that reduce the provision of contraceptive services to these groups should be systematically challenged and tackled.



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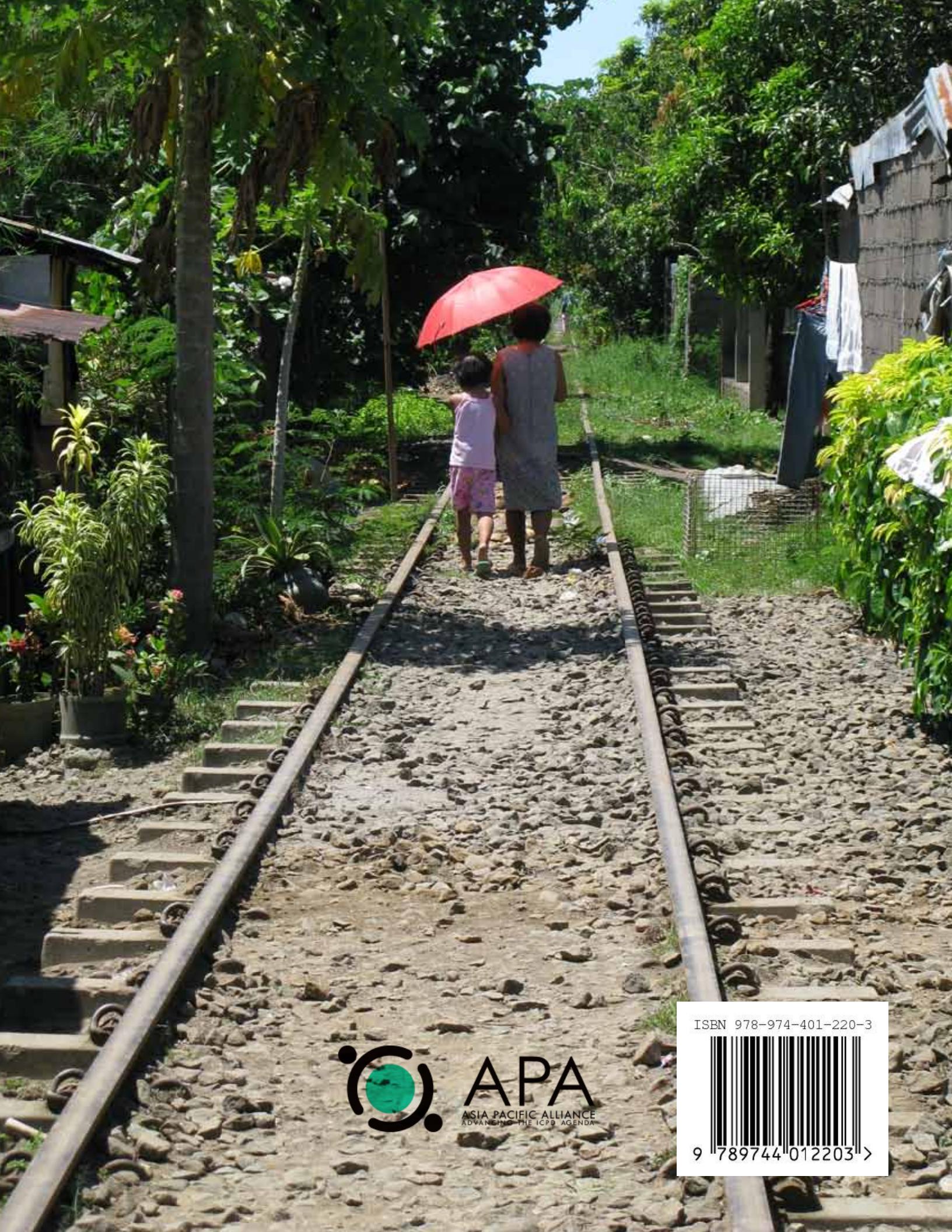
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