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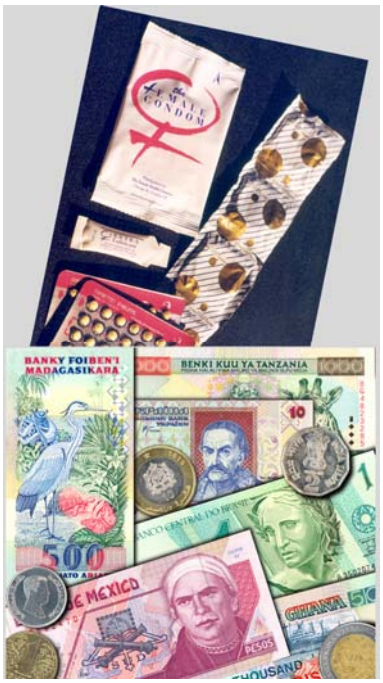
Policy Brief

# Using National Resources to Finance Contraceptive Procurement




**There is evidence that many governments are beginning to finance contraceptive procurement using national resources but there are little publicly available data as to the global extent of this.**

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## INTRODUCTION

Driven by the increasing demand for and popularity of family planning, increasing population size, and changing demographics with more couples entering their fertile years, the financing requirement for contraceptives has become increasingly onerous. Strategies to finance contraceptives include expansion of the donor base; increased use of cost recovery, including revolving drug funds; greater use of the private sector; and direct government financing of contraceptive procurement. None of these is mutually exclusive, and to ensure contraceptive security, most countries are likely to use some or all of these approaches, and many others. Evidence suggests that many governments are beginning to finance contraceptive procurement using national resources, but limited data are publicly available regarding the global extent of this financing.

This brief details the findings of a survey of the extent to which national governments of developing countries are using national resources to finance contraceptive procurement. The brief examines the different types of financing used, some of the benefits of this type of financing, and some of the issues it raises. Hopefully, this study can be repeated to track spending and will spur more rigorous efforts to measure this practice.

## TYPES OF NATIONAL RESOURCES CONSIDERED FOR GOVERNMENT FINANCING

For the purposes of this analysis, national resources include a combination of internally generated funds (IGF), World Bank credits, and/or financing provided by donors through basket funding used by countries to finance contraceptive procurement. Their designation as a national resource is due to the programmatic control and decision-making power over how and where these monies are spent by the government. Although it can be argued that World Bank loans and credits and basket funds are not true national resources, governments consider these funds to be part of their national budgets, count them as part of *government funding* and decide how and where to spend them. Therefore, for the purposes of this brief,

the universe of national resources (i.e., government funding) is considered to be composed of IGF, World Bank credits, and basket funds.

## INTERNALLY GENERATED FUNDS

IGF are generated from government revenue sources. These funds are usually various taxes and duties, including income tax, valued-added tax, property tax, sales tax, import duty, and user fees. They can be generated at the central or lower government levels. Many countries have created budget lines for contraceptives, or contraceptives are included within the budget for general essential medicines. Budget line items not only demonstrate government commitment but also earmark and secure funding for contraceptive procurement.

## WORLD BANK ASSISTANCE

Many countries receive assistance from the World Bank to support development and poverty reduction goals. The World Bank provides interest-free credits and grants to low-income countries through the International Development Association (IDA), the World Bank's lending arm that finances human development (HD), poverty reduction and economic management, private sector programs and infrastructure, and environmentally and socially sustainable development. Any sector can support the financing of family planning and contraceptives, but typically these programs are financed under the HD sector. The credits can be given as investment lending or as development policy lending. Both of these types of assistance have flexibility in how they are used and can be combined to finance projects.

A few countries have also reported the use of funds from the Debt Initiative for Highly Indebted Poor Countries (HIPC) to finance contraceptives. This initiative was started as a way to relieve countries of their external, unsustainable debt, which has been slowing economic growth and increasing poverty. The countries that participate in the initiative must undertake certain economic and financial reforms, increasing accountability and transparency, and prepare a poverty reduction strategy paper that outlines key structural and social reforms[1] in return for debt relief.

World Bank funding can be used for general budget support, sector budget support, or earmarked interventions. In all cases, the government defines the priority area for which the funds will be used. The use of World Bank assistance also demonstrates government commitment to family planning: countries choose their own priorities and family planning, and contraceptive procurement, specifically, must compete with other health and development priorities for funding.

## BASKET FUNDING

Joint funding by various partners including donors and governments or basket funding is usually associated with sector wide approaches (SWAps). A SWAp is a financing and management approach that aims to increase government ownership and improve coordination with other development partners. SWAps can be sector specific, such as for the health sector, and can be defined in many ways. A common definition follows:

> All significant funding for the sector supports a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector and progressing towards relying on government procedures to disburse and account for all funds (Foster, Brown, and Conway 2000).

SWAps are an attempt to address the multiplicity of programs created by the existence of different international funding sources in the health sector of many countries. The SWAp aims to reduce fragmentation, increase cohesion between government and development partners' strategies, build health systems management capacity, and increase the efficiency and usefulness of funding that is channeled through the health system. A medium-term expenditure framework (MTEF) is developed to support the SWAp by allocating and prioritizing financial resources to national strategic objectives.

SWAps can be financed through pooled or parallel financing. Funding that is pooled, also referred to as a "basket," is managed by the government with input from financing partners, but it is always managed

within the framework of the agreed priorities and the MTEF. Funds can be given as general support or can be specifically earmarked for particular programs and activities. Parallel financing is outside of the basket but supports projects that are in line with the sector wide strategy.

The use of basket funds for contraceptive procurement presents a challenge with regard to attribution (see box 1). Regardless of their source, funds may be placed in a common basket, and so it is difficult to link particular funds to particular activities or outcomes. It can be argued that attribution is not that important; the important thing is that family planning is a recognized priority in a SWAp and that adequate quantities of contraceptives are procured using funding deriving from any number of sources.

**BOX 1. MALAWI**

The example of Malawi illustrates both the range of financing options available with basket fund mechanisms and the difficulties of attribution. Before 2005, the Department for International Development (DFID) was a major donor for contraceptives; they provided funds for direct contraceptive procurement through third party procurement agents. Currently, however, they contribute their funding to a basket as part of a health SWAp, along with a number of other donors and the government of Malawi, from which contraceptives are procured as part of an agreed health package. USAID is another major source of contraceptives in Malawi; they provide parallel financing in the form of direct commodity support, also as part of the SWAp, but not to the basket. Because the government of Malawi supports the basket and some contraceptives are procured through the basket, for the purposes of this analysis, we consider Malawi to be using national resources for contraceptive financing.

## METHODOLOGY

To quantify the extent of the use of national resources for contraceptive procurement, a number of information sources were used to gather data.

A questionnaire was designed and distributed by email to all United States Agency for International Development (USAID) missions and regional offices. A variety of respondents completed the questionnaires: these included key informants at USAID missions and Ministries of Health (in cases in which the questionnaire was forwarded to the Ministry of Health). In addition, in countries with USAID | DELIVER PROJECT offices, additional data were compiled from in-country staff, including from project annual reports.

The one-page questionnaire asked whether a government line item budget for procurement of contraceptives was used to purchase contraceptives and what type of funding source was used. Respondents were asked to distinguish between World Bank credits, health basket funds, and IGF, providing the past amount spent from each source. Information on the governments' future commitment toward contraceptive procurement was also gathered. Some of the survey responses were validated through follow-up emails and phone calls with respondents and other key informants.

Demand information came from the *Profiles for Family Planning and Reproductive Health Programs* (Ross, Stover, and Adelaja 2005). This information was used to determine the annual projected cost of contraceptives for the public sector, including condoms, injectables, intrauterine devices (IUDs), implants, and oral contraceptives. Projected demand is based on current estimated demand and historical trends, does not include unmet need,[2] and is provided for the public sector only. This information was then compared with the yearly financial contribution by the government for the year 2006 to estimate the proportion of public sector demand covered by the government. In cases in which 2006 funding levels were not available for a country, 2007 funding was used and is noted. In a limited number of cases, a more accurate estimate of financial need was available using consumption-based forecasts, and when available, these data were used and noted. We use public sector demand only, which is based on most recent survey data for the public sector share. In most

countries, a significant portion of private sector demand also will be met using subsidized products in need of external funding either from donors or government—as in the social marketing and nongovernmental organization (NGO) sectors.

## STUDY LIMITATIONS

While every effort was made to verify the data provided, mainly through crosschecking with country informants, the data are subject to caveats and limitations. The questionnaires were completed on a voluntary basis and therefore there is a self-selection bias. We could not verify through national accounts or the procurement or other financial records whether the data were accurate. In some cases, informants were not certain of the amounts involved, or they could not identify whether the funding amount had been proposed, budgeted, allocated, or actually spent. In most cases, these amounts will not be the same.[3] In some cases, the funding may be strictly for contraceptives, whereas in others it may include other reproductive health commodities. In some cases, respondents were unclear as to the type of funding used, particularly for IGF and World Bank credits; basket fund mechanisms, as already discussed, make attribution difficult. The data may also underestimate the use of public resources for contraceptive financing in cases in which the funding is decentralized to lower levels (see the examples of Ethiopia and Kazakhstan below in the Results section) and in cases in which national insurance plans subsidize contraceptives (see the examples of Kyrgyzstan and Bolivia below in the Results section).

The calculation of the percent of public sector demand filled is based mainly on demographic forecasts (with a limited number of consumption-based forecasts) and projections of public sector demand, taken from *Profiles for Family Planning and Reproductive Health Programs* (Ross, Stover, and Adelaja 2005). For individual countries, these calculations will vary significantly in their accuracy. In many cases, the actual demand for contraceptives will vary significantly from that forecast using demographic data. The demand estimates used are based on current actual demand; they do not include unmet need. In many cases, unmet need may be significantly higher than actual demand. The demand estimates are based entirely on public sector demand; there likely will be demand in other sectors—NGOs and social marketing, for example—that requires some subsidization or external funding to be financially accessible.

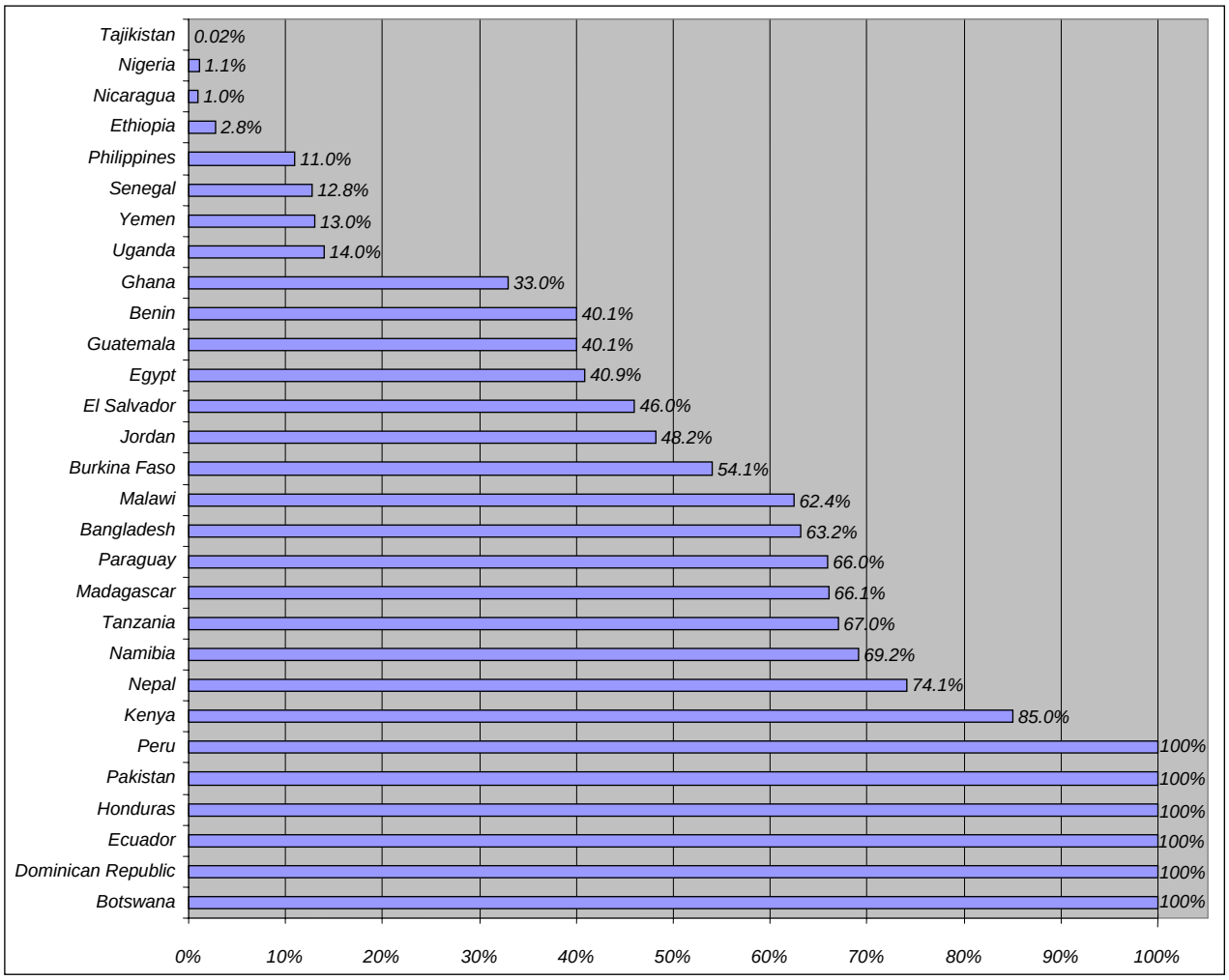
Given the study limitations noted above, the results in this analysis should be considered suggestive of the use of national resources for contraceptive procurement. The data for any individual country should be treated with caution. Our belief is that, for a cross section of countries taken together, and with further improvements in methodology, we can identify possible trends and quantify them in the years to come. Our hope is that more countries will be encouraged to provide greater commitment for family planning and, when appropriate, provide financing for contraceptive procurement. We encourage readers with corrections or more information on the countries concerned, or other countries not included, to contact the authors. We also invite suggestions for improving the methodology used in this paper.

## RESULTS

Responses from 47 countries were received. These included 20 from sub-Saharan Africa (includes northern Sudan); five from Asia; three from the Middle East/North Africa; nine from Eastern Europe, Caucasus, and Central Asia; and 10 from Latin America and the Caribbean. Out of the 47 countries surveyed, 18 did not use any national resources for the procurement of contraceptives (see figure 1). The results below will focus mainly on the remaining 29 countries (see figure 1 and table 1).

Out of 47 respondents, 24 (or 51 percent) stated they have a government budget line item dedicated to the procurement of contraceptives and other reproductive health commodities. In some cases in which countries do not have a specific budget line item, it does not necessarily mean a lack of funds for contaceptives. For example, in Ecuador, there is not a specific budget line item for contraceptives, but the Solidarity Fund, which finances the Free Maternal Child Health Law, guarantees a minimum amount of U.S.$15 million

**Figure 1. Percentage of Estimated Contraceptive Need Covered by National Resources**




each year for maternal and child health services, including contraceptive financing.

Use of national resources for contraceptive financing is seen to be weakest in Eastern Europe, Caucasus, and Central Asia. Among nine countries from the region that responded, only Tajikistan contributed any national resources (IGF) toward contraceptives, and the amount covered by Tajikistan is small.

Half of the countries shown in figure 1 use national resources to finance more than 50 percent of their public sector contraceptive procurement needs. These include countries as diverse as Botswana, Honduras, and Pakistan (100 percent), Kenya (85 percent), Nepal[4] (74 percent), Namibia (69 percent), Madagascar (66 percent), Paraguay (66 percent), Malawi (62 percent), and Burkina Faso (54 percent).

The countries that provided sufficient information on the type of financing used for contraceptives are shown in table 1. Twenty countries reported using IGF. Botswana, the Dominican Republic, Ecuador, Honduras, and Peru reported covering 100 percent of their contraceptive costs for the public sector with IGF, although they may continue to receive support for technical assistance from external agencies. A common theme among Latin American countries is phaseout from USAID-donated contraceptives.

**Table 1. National Resources for Contraceptive Financing by Source**

| Region/Country | World Bank Assistance[a] | Health Basket Funds | Internally Generated Funds | Total (thousands) ($) | Percentage of total public sector (%) |
|---|---|---|---|---|---|
| ***Sub-Saharan Africa*** | | | | | |
| Benin | | X | | 105 | 40.1 |
| Botswana | | | X | 477 | 100.0 |
| Burkina Faso | X[b] | | | 295 | 54.1 |
| Ethiopia | | | X | 113 | 2.8 |
| Ghana | X | | X | 1,000 | 33.0 |
| Kenya | | | X | 5,950 | 85.0 |
| Madagascar | X | | X | 2,500 | 66.1 |
| Malawi | | X | | 3,180 | 62.4 |
| Namibia | | X | | 290 | 69.2 |
| Nigeria | X[b] | | | 50 | 1.1 |
| Senegal | X | | X | 90 | 12.8 |
| Tanzania | X | X | | 4,885 | 67.0 |
| Uganda | X | X | | 41 | 14.0 |
| ***Asia*** | | | | | |
| Bangladesh | X | X | | 18,498 | 63.2 |
| Nepal | | X | X | 1,816 | 74.1 |
| Pakistan | | X | X | 9,220 | 100 |
| Philippines | | X | X | 711 | 11.0 |
| ***Middle East*** | | | | | |
| Egypt | X | | X | 5,953 | 40.9 |
| Jordan | | | X | 211 | 48.2 |
| Yemen | X | X | X | 100 | 13.0 |
| ***Central Asian Republic*** | | | | | |
| Tajikistan | | | X | 0.20 | 0.02 |
| ***Latin America*** | | | | | |
| Dominican Republic | | | X | 1,600 | 100.0 |
| Ecuador | | | X | 5,000 | 100.0 |
| El Salvador | | X | | 375 | 46.0 |
| Guatemala | | | X | 432 | 40.1 |
| Honduras | | | X | 1,100 | 100.0 |
| Nicaragua | | X | X | 9 | 1.0 |
| Paraguay | | | X | 262 | 66.0 |
| Peru | | | X | 2,300 | 100.0 |

*Note:* The following countries reported not using national resources for contraceptive procurement: Angola, Djibouti, Democratic Republic of Congo, Mali, Mozambique, Rwanda, Sudan (Northern), Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Turkmenistan, Ukraine, Bolivia, Haiti, and Cambodia.

a. A number of countries reported using both World Bank assistance and basket funds to procure contraceptives. For the purposes of this survey, these funds are considered to be distinct funding sources notwithstanding the possibility that, in some cases, World Bank credit can also be part of basket funding.

b. HIPC funds.

These countries have correspondingly taken initiatives to fully cover public sector financing of contraceptives from IGF. Out of the 13 sub-Saharan African countries that reported financial data, 6 reported using IGF. Senegal and Ghana were the only West African countries reporting the use of IGF as a source for contraceptive financing, with Ghana funding about one-third of their public sector contraceptive costs, and Senegal funding almost 13 percent. Other African countries that reported use of IGF include Botwsana, Ethiopia, Kenya, and Madagascar.

Basket funding was used by 12 countries. Of the countries that provided a breakdown of different funding sources, the proportion financed by basket funds ranged from 40 percent (Benin) to 70 percent (Pakistan).

World Bank assistance was reported as a source of financing for 10 of the 29 countries that used government funds. Financial data were available for three of these countries: Burkina Faso (54 percent), Madagascar (63 percent), and Nigeria (1 percent).

A number of countries with decentralized systems reported that these lower government levels (region or district) are providing funding for contraceptive procurement either from their own IGF or from general funds received from the central government—these included Ethiopia and Kazakhstan, with the Philippines and Ukraine reporting expected future funding from this source. In Ethiopia, three regional governments in 2006 spent a total of U.S.$1.6 million for contraceptives from their own budget allocations. This type of funding is expected to be particularly difficult to quantify reliably and is not captured in this paper.

## FUTURE FUNDING

The commitment toward the future funding of contraceptives varies widely among the surveyed countries, and certain initiatives were highlighted in the survey responses. Some countries have earmarks for contraceptive procurement through a dedicated budget line item from national or local governments. The Reproductive Health National Program (RHNP) in Ukraine will allow national and local governments to mobilize budgeted resources to procure contraceptives beginning in 2008. A planned amount has been set aside at both the national and local level from 2008–15. However, local family planning programs will still need to compete each year for resources despite the inclusion of contraceptive procurement in the RHNP. In 2007, the Philippines created a budget line item for Artificial Family Planning in the General Appropriations Act, setting aside U.S.$4 million to be used for reproductive health commodities for the national family planning program. Nepal has set aside a dedicated amount of internally generated money for each year from 2007–11. Malawi has allocated funding for condoms and injectables for 2007–09 from its health basket fund.

Other countries are demonstrating their commitment by starting to fund contraceptives or through incremental increases in government funding each year. For example, while Mozambique does not currently fund procurement, they plan to provide more than $300,000 for injectables in 2008. Since 2002, Guatemala has progressively increased funding of public sector needs from 2 percent in 2002 to 40 percent in 2005, and it has committed to funding 100 percent by 2009. Yemen's government has expressed their intent to incrementally increase the percentage of their financial support (currently about U.S.$100,000), while Haiti is trying to establish a budget line item in 2008 for reproductive health.

In Kyrgyzstan and Bolivia, neither country has a budget line item nor do they use their own funds for contraceptives. However, their national health insurance plans facilitate access to contraceptives. In Kyrgyzstan, there is a discount of 25–30 percent, subsidized by the Health Insurance Fund, at pharmacies for oral contraceptives. The public health insurance law in Bolivia allows municipalities to use tax revenues to purchase contraceptives from local providers.

## DISCUSSION

Although there are little quantitative data in the public domain for this indicator, there is strong evidence from stakeholders that part of the so-called funding gap (Ross and Bultao 2001) for contraceptives in

developing countries is being met by country governments themselves. With a combination of internally generated funding, from both the central and lower levels, World Bank credits, and basket funds (albeit derived from a number of sources and not just governments), many governments are demonstrating responsibility for contraceptive security through financing the procurement of contraceptives.

Without more intensive in-country research of actual government accounts or procurement records, it is difficult to quantify with confidence the extent of this support. It is also difficult to separate funding promised, budgeted, allocated, or actually spent, and with basket funds, attribution becomes next to impossible. Without in-country consumption forecasts, it is also difficult to estimate the percent of public needs covered. There is also the question of what percent of total demand in a country is appropriately financed by government financing. This varies from country to country depending on many factors, including income levels, poverty rates, and the extent of public sector reach. In many countries, the need for subsidized commodities extends to social marketing and NGO programs (see box 2).

**BOX 2. BANGLADESH**

Bangladesh reports covering more than 60 percent of its public sector demand for contraceptive procurement through a combination of World Bank credits and basket funds. However, the public sector supplies only just over half of all modern methods used in Bangladesh. For pills and condoms, the private sector has a large market share. The Social Marketing Company (SMC) in Bangladesh provides around 31 percent of all modern methods used and many of these are provided to low-income people. Because of USAID donations, SMC is able to provide access to subsidized oral and injectable contraceptives, as well as provide condoms for HIV prevention.

A number of benefits accrue to governments using national resources for contraceptive procurement. First, it can help diversify contraceptive financing and in this way help stabilize funding. In addition, it demonstrates a national commitment to family planning. Historically, support for family planning has been left more to donors, leading to a lack of ownership at the national level. Although family planning may be a stated health priority in many countries, this does not always translate into actual funding. Financing of commodities can represent an acknowledgment by governments that family planning is a real priority. Government commitment in this way may actually help countries to leverage more donor resources, providing a stimulus to donors to continue or even increase their support.

Using national resources for contraceptive financing does not mean per se that contraceptives become more financially accessible to low-income groups. Contraceptives may be distributed free of charge to the end user, or some cost may be recovered with products sold at subsidized prices, or even at profit, with the funds used to procure more contraceptives or to fund other parts of the health program. Unless the commitment of national resources for contraceptive financing is accompanied with service delivery policies that increase access to all—especially, the poor, rural, and hard-to-reach populations—it may do little for contraceptive security for these underserved groups.

National financing of contraceptives inevitably leads to government procurement, and although this can be executed through third party procurement agents such as the United Nations Population Fund (UNFPA), in many cases, governments will take on procurement. This may lead to a number of procurement-related issues that affect contraceptive security—for instance, government procurement may take longer, governments may not be able to obtain the same prices donors can because of lower volumes, or they may procure different brands than were provided by donors, with consequences for client acceptance. For a full discussion of some of these

issues, see *Options for Contraceptive Procurement: Lessons Learned from Latin America and the Caribbean* (Sarley et al. 2006).

## CONCLUSION

The amount of government financing in real terms and as a proportion of the total need is an important indicator that should be tracked at the regional, national, and global levels. In general, government financing can be an important indicator of commitment to family planning. Given the uncertainty of external funding sources, government funding can be important for the sustainability of a country's contraceptive security. In addition, by demonstrating that family planning is a priority, government financing may actually help increase donor funding for contraceptives.

We hope that the results presented in this paper, although not without their limitations, are suggestive enough to propel further thinking about ways to measure the extent of government financing for contraceptives, and in so doing lend support to regional, national, and global efforts to improve contraceptive security.

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## ENDNOTES

1. Available at http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEBTDEPT/0,,contentMDK:20260411~menuPK:64166739~pagePK:64166689~piPK:64166646~theSitePK:469043,00.html (accessed March 20, 2008).
2. Unmet need is the number of sexually active women who would prefer to avoid becoming pregnant or who are pregnant but the pregnancy was unintended, but who, for various reasons, are not using contraception.
3. Rwanda, for example, provided U.S.$200,000 for contraceptive procurement in 2007; however, as of January 2008, this money had not yet been disbursed or spent.
4. Includes 2007 funding.


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