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CONTRACEPTIVE SECURITY

PRACTICAL EXPERIENCE IN IMPROVING GLOBAL, REGIONAL, NATIONAL, AND LOCAL PRODUCT AVAILABILITY

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DELIVER
No Product? No Program. Logistics for Health

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Abstract

At the Istanbul Conference in 2001, participants identified strategies for increasing contraceptive security to ensure that clients can chose, obtain, and use the methods they need. Particular emphasis was given to increasing donor funding for contraceptives and to ensure the government's work with the private and nongovernmental (NGO) sectors meets the contraceptive commodity needs of their populations. Since 2001, DELIVER and other cooperating agencies have worked at the global, regional, national and sub-national, and community level to implement the strategies from the Istanbul meeting; and to develop new approaches to improving contraceptive product availability.

Five years after Istanbul, this report documents the progress made in improving contraceptive security. It begins by describing the experiences of contraceptive clients in different parts of the world. It describes the experiences countries have had in learning to understand their clients' needs and improve their contraceptive security. The report documents the lessons learned in increasing and diversifying contraceptive finance; understanding and expanding the total market; and working with the public, private, and NGO sectors to improve service delivery and product availability. It also describes different regional initiatives adopted in Latin America, Africa, and Eastern Europe; and it identifies new challenges countries face around procurement and donor coordination and how these challenges have been addressed. The report describes what has been done and defines what remains to be done to improve contraceptive product availability.

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
ATP	ability to pay
AWARE-RH	Action for West Africa Region-Reproductive Health
BCC	behavior change communication
BKKBN	(Indonesian family planning coordinating agency)
BLM	*Banja La Mtsogolo* (a Marie Stopes affiliate, Malawi)
CA	cooperating agency
CAFTA	Central America Free Trade Agreement
CBV	community-based volunteer
CCSS	Costa Rican Social Security Fund
CDC	Centers for Disease Control and Prevention
CENABAST	(Chile's semi-autonomous procurement agency)
CIB	coordinated informed buying
CIDA	Canadian International Development Agency
CMS	central medical store
CPR	contraceptive prevalence rate
CS	contraceptive security/commodity security for contraceptives
CSR	contraceptive self-reliance (Philippines program)
CYP	couple-years of protection
DFID	Department for International Development (U.K.)
DGFP	Directorate General of Family Planning (Bangladesh)
DHS	Demographic and Health Survey
DMAIC	supply chain process improvement approach
DSW	German Foundation for World Population
ECOWAS	Economic Community of West African States
EHP	Essential Health Package
EMEA	European Medicines Agency
EML	essential medicines list
ENDSSR	(Paraguay's national Survey of Demography and Reproductive and Sexual Health)
EU	European Union
FBO	faith-based organization

FDA	U.S. Food and Drug Administration
FP	family planning
FPLM	Family Planning Logistics Management
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GDF	Global Drug Facility of the Stop TB Partnership
GMP	good manufacturing practice
GOB	Government of Bangladesh
GP	general practice
GSMF	Ghana Social Marketing Foundation
HIV	human immunodeficiency virus
HMIS	health management information system
ICB	international competitive bidding
ICC/CS	Interagency Coordination Committee for Contraceptive Security (Ghana MOH)
ICPD	International Conference on Population and Development
IDA	International Dispensary Association
IEC	information, education, and communication
IMR	infant mortality rate
IPPF	International Planned Parenthood Federation
IPS	(Paraguayan Social Security system)
IRP	international reference price
ISO	International Organization for Standardization
ISP	public health institute of Chile
IU	international unit
IUD	intrauterine device
IWG	Interim Working Group on Reproductive Health Commodity Security
JICA	Japan International Cooperation Agency
JSI R&T	John Snow Research and Training Institute, Inc.
KfW	*Kreditanstalt für Wiederaufbau*
LAC	Latin America and the Caribbean
LAM	lactational amenorrhea method
LGU	local government unit (Philippines)
LMIS	logistics management information system
MDG	Millennium Development Goal
MERCOSUR	*Mercado Común del Sur*
MIU	million international units
MOF	Ministry of Finance

MMR	maternal mortality rate
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MWRA	married women of reproductive age
NORAD	Norwegian Agency for Development Cooperation
NGO	nongovernmental organization
NSU	nonsurgical vasectomy
NTT	Nusa Tenggara Timur (Indonesian province)
OB/GYN	obstetrician/gynecologist
OI	opportunistic infection
ORS	oral rehydration solution
PACTO ANDINO	Andean Community of Nations
PAHO	Pan-American Health Organization
PAI	Population Action International
PATH	Program for Appropriate Technology in Health
PDA	personal digital assistant
PHC	primary health care
PHR*plus*	Partners for Health Reform*plus* (USAID)
PMTCT	preventing mother-to-child transmission
PNSSR	Paraguay National Reproductive and Sexual Health Plan
PPAG	Planned Parenthood Association of Ghana
PPD	Partners in Population and Development
PRB	Population Reference Board
PRH	Office of Population and Reproductive Health (USAID)
PRSP	poverty reduction strategy paper
PSI	Population Services International
PSP	Private Sector Program (USAID)
RCHU	Reproductive and Child Health Unit (Ghana MOH)
RH	reproductive health
RHCS	reproductive health commodity security
RHI	Reproductive Health Interchange
RHSC	Reproductive Health Supplies Coalition
SDA	Salvadoran Demographic Association
SDP	service delivery point
SI	Supply Initiative
SIDA	Swedish International Development Cooperation Agency
SMC	Social Marketing Company

SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STARH	Sustaining Technical Achievements in Reproductive Health and Family Planning (USAID)
STG	standard treatment guideline
STI	sexually transmitted infection
SUMI	*Seguro Universal Materno Infantil*
SWAp	sector wide approach
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VAT	value added tax
VCT	voluntary counseling and testing (HIV/AIDS)
WAHO	West Africa Health Organisation
WHO	World Health Organization
WHO/AFRO	World Health Organization/African Regional Office
WRA	women of reproductive age
WTO	World Trade Organization

1. OVERVIEW

Projections prepared by the Interim Working Group on Reproductive Health Commodity Security (IWG) (Interim Working Group 2001a) in 2001 showed that donor funding would need to increase, initially by $24 million[1] and then by 5.3 percent per annum, if donor-funded contraceptive supplies were to meet the projected demand in 2015. While global data are incomplete, available information suggests that over the last four years donors have largely failed to sustain the increases in funding required. Donor funding has, at best, grown at a slow rate in nominal terms, while actually decreasing in real terms for some donors. This is despite the recent resource mobilization efforts by the Supply Initiative and the United Nations Population Fund (UNFPA).

On closer inspection, however, the situation appears to be far more positive. Concerted and coordinated actions have taken place simultaneously at global, regional, country, district, and local levels, that have helped improve reproductive health commodity security (RHCS). While many constraints remain and much needs to be done, this practical experience shows how to attain future gains in commodity security (CS)[2] for contraceptives, as well as for any other essential health commodity.

TEN THINGS YOU NEED FOR CONTRACEPTIVE SECURITY

The tremendous differences in regions, among countries, and even within countries, mean that there is no single or *cookie-cutter* approach to improving contraceptive security (CS). Nonetheless, common themes have emerged from the concrete and successful work completed in the last five years in sustaining improvements in CS. Much of this work has involved applying the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) (Hare et al. 2004) framework. This tool—which has been used to assess RHCS, strategic planning, and implementation—has increasingly been adopted and adapted in different ways to meet different local conditions and situations. The SPARHCS framework focuses attention on seven components that are necessary for RHCS: context, commitment, coordination, capital, capacity, client, and commodities. DELIVER's experience in applying SPARHCS suggests that the capacity component should be further disaggregated to focus explicitly on procurement, logistics, service delivery, and monitoring and evaluation. We have also recognized the importance of distinguishing between the RHCS policy environment and wider contextual issues (e.g., socioeconomic and political trends) that impact RHCS but usually cannot be addressed.

Our work suggests that there are 10 areas that can be and need to be addressed if CS is to be attained and maintained:

1. Commitment of key stakeholders to CS is critical if improvements are to be sustained.
2. Favorable policies, often included in health sector reforms, need to encourage public and private provision of contraceptives.
3. Coordination among all stakeholders is required for true partnerships and information flow to avoid duplication and address gaps.

1. All references to dollar amounts are U.S. dollars.
2. In this paper, commodity security refers to contraceptives unless otherwise indicated.

4. Adopting a total market approach is one element of coordination to ensure all segments of the market are being reached and the role of different public, private, and nongovernmental organization (NGO) providers is understood.

5. Diversified funding mechanisms (i.e., capital) need to be adopted and coordinated among public, donor, NGO, and private sectors.

6. Effective and efficient commodity management needs accurate forecasting of commodity needs based on accurate consumption data and procurement capacity to ensure that the best prices and quality are obtained through transparent, efficient, and timely ordering.

7. A well-functioning logistics system needs to be in place to ensure contraceptives are always available where they are needed.

8. Equity in and access to service delivery must be in place to ensure that clients, including underserved populations, are reached.

9. A monitoring and evaluation capacity is needed to make necessary adjustments as new constraints emerge or outcomes do not meet work plan targets.

10. A focus on the client and an understanding of the broader context that influences whether clients do or do not access services is essential to understanding the reasons for unmet need.

Since independence, *Bangladesh* has had a strong commitment to family planning, marked by a national family planning policy and strong public service provision. Contraceptive security (CS) gains are, however, being undermined by a lack of commitment to work with the private and NGO sectors, and a failure to create a cross-sector task force to coordinate on CS issues.

Commitment is necessary at the highest political level and among family planning (FP) advocates at all levels of the public, NGO, and private sector. National leaders need to talk about the importance of the relationship between increased contraceptive prevalence and the reduction of maternal mortality rates (MMRs) and between increased birth spacing and decreased infant mortality rates (IMRs). FP targets should be in national policy documents, such as poverty reduction strategic papers (PRSPs) and sector-wide workplans; these must be linked to CS strategic plans.

There must be—

- recognition that plans need to be implemented and individuals held accountable in attaining national FP objectives
- a willingness to address complex issues around partnerships with the private sector and NGOs
- a commitment to discuss emerging issues with different stakeholders on a regular basis so that emerging problems can be overcome.

While countries are increasingly including family planning commodities in their funded EMLs, the need for full supply of contraceptives requires close attention to making sufficient dedicated funds available.

A commitment to family planning should be reflected in a policy environment that encourages and enhances the provision of services by both the public and private sectors. Many policies impact FP service delivery: restrictions on who is qualified to dispense commodities

and provide services, regulation of private and NGO clinics, value added taxes (VATs) and import tariffs, restrictions on advertising, and inclusion of FP products in essential medicines lists (EMLs), and insurance drug benefits. The policy environment needs to strike a clear balance between quality assurance and expanding access for both the public and private sector.

To create and sustain CS improvements, active coordination is continually required among all FP stakeholders. A multisector working group or committee should be established under the leadership of the Ministry of Health (MOH), and it should be clearly connected to the decision-making structure of the government and donors. Existing forums can be used if their mandate overlaps sufficiently with CS. Strong leadership is essential and must reflect commitment. Regular meetings facilitate true partnership and information flow, and permit monitoring of funding and commodity availability. Smaller technical teams can be tasked to address specific issues and report back to the committee.

Adopting a total market approach is one crucial area of coordination. This requires recognition of the contributions different public, NGO, and private suppliers can make in meeting client needs; and that populations may have a different willingness and ability to pay (ATP) for their FP methods. An understanding of the contribution made by different sources of funds can be gained from reproductive health accounts. An analysis of the contraceptive market by different segments, defined by the different socioeconomic and geographic characteristics of FP users, can help policymakers better serve the entire population. Market segmentation can help ensure that free public FP methods are targeted at the poorest segments of society, while people who are able to can purchase products from the private sector. Armed with market segmentation analysis, policymakers must be willing to work with the private and NGO sectors to ensure they are enabled and encouraged to provide contraceptives to clients who can afford to pay.

Historically, developing countries have relied on one or two donor sources for their public contraceptives. While donors such as the U.S. Agency for International Development (USAID) and UNFPA continue to be important sources of supply, individual donor commitments have failed to keep up with expanding demand. Governments have to rely on new diversified sources of funding. Basket funding arrangements, in which the World Bank and bilateral donors pool their funding to give governments greater responsibility, offer important opportunities for governments to expand the resource pool for contraceptives. In addition, governments are increasingly providing budget lines for contraceptives, funded by their own tax revenues. Careful coordination between donors and government is essential but it is sometimes constrained by the different demands donors continue to have for committing their funds, and for placing and managing orders.

Market segmentation analysis in *Paraguay* highlighted the tremendous success both the public and private sector have had in expanding the availability of a wide variety and balanced mix of methods. Some 65 percent of free public services are reaching the poorest 40 percent of the population, while private providers account for 69 percent of total CPR. Nonetheless, scope still exists for both the public and private sectors to do more, particularly in providing longer-term methods in rural areas.

Diversified sources of funding have placed an increased burden on in-country procurement capacity. Basket funding, often under sector wide approach (SWAp) arrangements, requires government agencies to follow World Bank procurement guidelines, which are designed to ensure the best value for the money and to promote transparency in the use of public funds. To obtain the best price and quality combination, effective procurement management requires—

- specialized knowledge of the technical specifications of contraceptives so the right product is ordered and the product quality differences of bids can be distinguished
- an ability to manage the procurement process from prequalification through tendering, evaluation, selection, and postcontract award monitoring
- a regulatory framework that enables competitive bidding through access to domestic and international suppliers to obtain the best prices.

Procurement planning needs to include accurate consumption-based forecasts, driven by an effective logistics management information system (LMIS) as part of a well-functioning, in-country logistics system. Getting products to users at service delivery points (SDPs) requires good warehouse facilities at central and decentralized levels, well organized transportation to service delivery points, an LMIS that tracks dispensed-to-user (consumption) data and months of stock on hand, and an analytical capacity that can compare these to maximum and minimum stock levels to identify and address shortfalls and overstocks. Strengthening the public-sector logistics system includes examining ways to work with private and NGO organizations to contract out parts of supply chain management, including transportation services and warehouse management.

Service delivery must be addressed through an equity perspective if underserved populations are to be reached and access increased. Research by DELIVER has shown a strong correlation between reduced disparity in access between the lowest and highest wealth quintile and increasing contraceptive prevalence rates (CPRs). Market segmentation analysis can help identify who benefits from public services and who has access to private-sector services. Why do poorer rural women in Paraguay use oral pills more often, and long-term and permanent methods less often, than do richer women? Whether access is defined geographically or by socioeconomic criteria, public services should be designed to reach underserved and vulnerable groups. This can include contracting NGO and private providers as well as targeting public services in areas underserved by the private sector. While a focus on commodities is important, the capacity and availability of trained staff and essential supplies and equipment should not be overlooked.

In *Malawi,* recognizing the important role that NGOs play in providing FP services, the public sector is looking at community-based voucher schemes that give women greater access to services. The MOH would reimburse NGO and private providers for approved services provided to poorer women.

Contraceptive security is not an objective that remains static once it is obtained. Rather, it is a dynamic process that evolves over time, requiring coordinated efforts, even as progress is attained. The complex factors that influence it can include political changes, changes in key staff in the public sector, changes in donor funding commitments, increasing demand as populations of reproductive age expand, changes in the procurement and manufacturing cycle, and the emergence of new contraceptive methods. Countries need an ability to monitor and evaluate their CS and program performance and make necessary adjustments if new constraints emerge or outcomes do not meet workplan targets. This function should be the responsibility of a CS committee or working group, which must routinely monitor stock status reports, procurement pipeline status, existing funding and future commitments, and the quality and reach of service delivery. Developing annual forecasts, examining demographic and health survey (DHS) data, conducting market segmentation analysis, and constructing reproductive health accounts can all provide important information to identify gaps and evaluate impact.

Finally, we should not lose sight of the client. We need to understand both the clients' needs and the context in which they make their contraceptive choices. In addition to ensuring availability of a balanced method mix and access to services, a broad array of other factors must be considered: girls' education, women's employment, religious beliefs, and other social and cultural dynamics. The impact of health sector reform and competing demands on health and social resources should also be considered. DHS data have shown that, in many countries, there is a significant unmet need for modern methods of contraception. Understanding the reasons for this unmet need is crucial to addressing it. Unmet need can be caused by many things: distance to rural FP clinics; a lack of commodities or trained service providers after clients reach a clinic; or lack of access to alternative, affordable NGO or private-sector services. Addressing all the other influences on CS will make little difference if the client is not considered.

While no two countries face the same CS situation, significant similarities across countries suggest that lessons can be learned and solutions duplicated from one context to another. Adopting the SPARHCS tool—whether designing and conducting an assessment, organizing a key informant workshop, or monitoring and evaluating an ongoing program—can help provide a strategic vision and framework needed to address CS. Regional initiatives that provide countries an opportunity to share experiences and lessons learned in addressing CS can also help strengthen commitment to increasing access to FP services.

PUBLICATION PURPOSE AND OUTLINE

This publication reflects the findings of much of the contraceptive security work undertaken by DELIVER and funded by the U.S. Agency for International Development (USAID) over the last six years. It provides in a single document both a record of work completed and the lessons learned during the process. Given the investment in CS, we have documented and evaluated outcomes to help determine what really has worked and what has not. The potential audience for this publication is diverse. It includes DELIVER staff and field teams, USAID staff in Washington and in the field, counterparts from partner countries, other donors, and other cooperating agencies (CAs). It provides both a strategic overview of what has and has not worked in CS, details of what countries and stakeholders should consider doing, and, to a limited extent, some guidance on how to plan and implement CS activities. More detailed analysis and guidelines and tools can be found in various DELIVER publications at www.deliver.jsi.com; they are cited specifically throughout this document.

The nature of DELIVER's work—practical and in response to demands from the field—requires results-oriented outcomes that contribute to improving contraceptive commodity availability. While DELIVER has a well-developed and robust monitoring and evaluation function, we do not always have the scope to return to a project to evaluate objectively all of the earlier interventions undertaken. For example, how successful was the very first SPARHCS field test in improving awareness of and commitment to contraceptive security in Nigeria? Some of the questions raised in the following sections demand further analysis and review. Furthermore, the timing of the production of this paper means that much has been written before key elements of applied research into CS

Bangladesh: Field worker gives client birth control pills.

are complete. Now that the *Contraceptive Security Index 2003* (John Snow, Inc./DELIVER and Futures Group/POLICY 2003) is updated *Contraceptive Security Index 2006* and other research products are completed, we will update the contents of this report. While DELIVER has often played a leading role, much of this work has been undertaken in collaboration with other cooperating agencies and MOH agencies. We acknowledge and cite their work, as appropriate. The remainder of this document addresses the 10 components described earlier in this chapter, adding additional country examples and a regional and global dimension.

- Chapter 2 presents the perspective of the client and some of the contextual constraints affecting demand and product availability.
- Chapter 3 looks at the global perspective to identify how multilateral and bilateral agencies working with new and diversified donors and interest groups are tackling product availability.
- Chapter 4 summarizes some of the different regional and subregional initiatives that have been undertaken in Latin America, Africa, and Eastern Europe to improve product availability, often in the context of difficult political environments and competing health agendas.
- Chapter 5 provides a more detailed explanation of the importance of commitment, coordination, strategic planning, and implementation at the country level.
- Chapter 6 addresses regulatory and policy constraints on improving CS.
- Chapter 7 provides practical examples of the total market approach and how it can be used to improve coordination with the private sector and expand contraceptive availability and use.
- Chapter 8 elaborates on how strategies programs may be used to take advantage of diversified financing sources; linking options at the global, regional, national, and local level.
- Chapter 9 provides an outline of the steps required to strengthen procurement capacity and some of the challenges that countries are facing.
- Chapter 10 describes the importance of and challenges to establishing and maintaining a functioning and efficient logistics system to ensure CS.
- Chapter 11 considers some of the CS issues surrounding service delivery and product availability.
- Chapter 12 summarizes emerging issues and next steps.

2. CLIENT PERSPECTIVE

Contraceptive security (CS) is experienced one client at a time. Therefore, the client must be the central focus of any CS strategy. But, because there are so many components that must be considered, and so many systemic, financial, and policy issues that must be addressed, it is easy for policymakers and program managers to lose sight of the ultimate beneficiaries—the people who use or want to use modern contraceptives. It is their voices that must be heard if their needs are to be met. With that thought, we present stories of real clients in four countries—Ghana, El Salvador, the Philippines, and Romania—to illustrate the intersection of the 10 CS components and the impact they have on the lives of these women.

CYNTHIA IN GHANA

Ghana has been grappling with contraceptive security since 2002 when it developed a national strategy to ensure that clients would have access to the contraceptives of their choice regardless of where they lived, where they went for family planning services, or how much money they had. In Ghana, the use of modern contraceptives among married women was just over 18 percent in 2003, the second highest in West Africa, and a considerable improvement over 1988, when it was just 4 percent. About 23 percent of married women have an unmet need for contraception, which contributes to a total fertility rate of nearly 4.5 children for each married woman. Almost half of all clients (47 percent) get their contraceptives from the public sector; therefore, the increasing contraceptive prevalence rate (CPR), combined with continued growth in the general population, means that demand for contraceptives is going to grow and the government must ensure that it has the resources to meet that demand.

Since launching the national strategy in 2002, the government has started using its own funds to finance and procure contraceptives while continuing to distribute donated contraceptives from international donors. The multiple sources for contraceptives have required close coordination among the government, donors, and nongovernmental organization (NGOs) to ensure supply needs are met and to avoid duplication and oversupply—or undersupply due to omission—of any particular method. The Ministry of Health (MOH) has strengthened its logistics system to make sure supplies are available at service delivery points (SDPs), and has promoted the acceptance of and demand for family planning services through mass media and community outreach campaigns. The total contraceptive market in Ghana is undergoing changes as the public sector focuses on providing free contraceptives to the poor, and NGOs and the commercial sector work to meet the needs of clients who are able to pay either subsidized or full prices for their supplies. This policy shift has happened as traditional bilateral donors reevaluate their contraceptive commodity support; the MOH has had to rethink its funding approach for contraceptives, recognizing the need to increase funding from domestic sources. This includes increasing the government budget lines, using pooled donor sector wide approach (SWAp) basket funding, and looking at private households to share the cost of contraceptives.

Cynthia is the type of client Ghana's national strategy is trying to help. She is 27 and lives in a village about an hour outside Ghana's capital city, Accra. Cynthia has had to overcome many obstacles that could easily have deterred her from the consistent use of contraceptives. But, for Cynthia, the security of planning her family is too important to neglect (Supply Initiative 2005).

In her first serious relationship, Cynthia became pregnant with her son, now five years old, and she and her boyfriend married. When her son was a toddler, Cynthia, who had seen advertisements about family planning on television, decided to visit the government-run clinic in her village. They provided her with regular three-month contraceptive injections. However, she developed painful side effects and was unable to find relief at the government clinic.

Rather than ending her use of contraception, Cynthia began making the hour's trip to Accra in a tro-tro (shared taxi) to visit a clinic run by Planned Parenthood Association of Ghana (PPAG), which is Ghana's largest private provider of reproductive health services. Despite the transportation costs, she found the environment at PPAG more welcoming than the government-run clinic. "They told me about all the methods, how the drugs work, what the benefits and side effects are. I chose the one-month injections and they told me that if I have any problems, I can come in right away," Cynthia explains. Fortunately, because she switched to the monthly injections, the side effects have subsided.

Cynthia and her husband would like to eventually have three children but plan to delay the birth of their second child for another year. Birth spacing for health and economic reasons is very important to Cynthia. "Now I can choose when to get pregnant. Also, it allows me to work," Cynthia says. "I've set up my own shop selling drinks. There is nothing about family planning that I don't like."

ANA IN EL SALVADOR

Contraception is a critical part of the public health picture in El Salvador. Although political and religious trends tended to limit family planning efforts through the late 1990's, today 67 percent of married women use contraceptives (CDC 2003). This figure is largely dominated by female sterilization (about one-half of all users), followed by injectables (18 percent) and oral contraceptives (6 percent). Roughly 47 percent of Salvadoran contraceptive users receive free or subsidized family planning commodities from the government. They obtain supplies at public hospitals, clinics, and smaller health centers. Health promoters also visit homes to deliver needed contraceptives.

A fundamental aspect of attaining contraceptive security is providing clients with a choice of family planning methods. However, program planners in many resource-poor countries face tough budgetary decisions, and often consider limiting the range of products they make available to users. In addition, there is the constant need to ensure that choices are informed by fact, not fiction. El Salvador confronted these challenges as it prepared for the phaseout of contraceptive donations from USAID in 2005.

Ana is a 23-year-old woman living in the town of Cojutepeque in central El Salvador. She and her husband are among many people who had to rebuild their houses following a devastating earthquake in 2001. Ana's only child, a vibrant 18-month-old girl, is always in her arms when she goes to the public hospital for her free quarterly dose of the injectable contraceptive, Depo-Provera. "I chose Depo because it's much easier than keeping track of daily pills," Ana explains. "The hospital has always been able to give it to me, but if they weren't, I'd look for another place to get it; even if it meant figuring out a way to pay for it."

Ana and other Depo-Provera users represent 18 percent of all contraceptive users in El Salvador, but every user's reason for choosing the method varies greatly. In San Ramon, only 10 miles from Cojutepeque, Dr. Fátima de Calderón refers to her consumption records, which show that injectables are nearly the only form of modern contraception used by her clients. "Here we live in a traditional environment in which a woman who wants to use contraception must often hide it from her husband," she says. "Many men are

against contraceptive use in the home because they believe that it provides an opportunity for their wives to cheat on them."

For its low frequency and low visibility, Depo-Provera is an excellent option. In using the same thinking, it would seem that intrauterine devices (IUDs) are an even better solution. Inserted just once and effective for as long as 10 years, the device offers the type of easy maintenance that Ana is looking for and the discretion that Dr. de Calderón's clients require. But misconceptions that IUDs cause cancer are common, as are fears that the device will become dislodged and insert itself into the body of the fetus whose conception it was supposed to prevent.

"When counseling new users of family planning options, we obviously try to dispel urban legends of this type. It ultimately comes down to them making a choice that they can use with confidence over the long term," suggests Cojutepeque family planning advisor, Rosa Catalina Burgos de Hernández.

Dispelling misinformation and educating the public are also important tasks for service providers, but they need accurate information. *Profamilia* clinics are a network of health facilities and pharmacies geared toward lower-middle-class clients and run by the Salvadoran Demographic Association (SDA), an affiliate of the International Planned Parenthood Foundation. These clinics do not carry Depo-Provera because Profamilia doctors originally compared the strength of the product to *horse medicine*. That decision resulted in the loss of a number of Profamilia clients.

Injectables are the most expensive contraceptives on the market. A year's dosage can cost nearly four times the price for the same duration of protection from oral contraceptives. Nonetheless, in 2005, El Salvador's budget for contraceptive procurement put Depo-Provera right at the top of the list for funding, helping secure Ana's method of choice for another year.

A significant amount of technical assistance has supported El Salvador's contraceptive security efforts. MOH staff now has the capacity to accurately forecast their needs based on information from a functioning logistics system. Policies have been implemented to expand peoples' access to contraceptives, particularly through community-based distribution. This has taken place within the context of El Salvador's graduation from USAID's contraceptive donations. This graduation has required close coordination between the MOH, USAID, and UNFPA as the procurement agent, and the Salvadoran Demographic Association, which has also been receiving donated contraceptives from USAID. As a result, El Salvador has taken ownership of the country's contraceptive security, with both the government and SDA financing and procuring contraceptives. This demonstrates political commitment at the highest levels in the country. Dr. Herberth Betancourt, the former Minister of Health and a pediatrician explains, "We are not only binding ourselves to an agreement with USAID to procure contraceptives independently, but also to a social contract with the people of this country to meet their demand for reproductive health supplies."

LORNA IN THE PHILIPPINES

The Philippines health system is largely decentralized to the level of the local government unit (LGU)—province and municipality—and, therefore, most of the country's contraceptive security work has been focused at this level. USAID has been phasing out its contraceptive donations, which are due to cease in 2008. At the national level, the government has decided not to procure contraceptives to replace USAID's donation; they left that decision to the LGUs.

Pangasinan, a province of 2.5 million people in northern Luzon Island, has long been a success story in family planning. The CPR for the province is 55 percent, compared to a national CPR of 49 percent

(Philippines National Family Planning Survey 2005) among married women of reproductive age (MWRA). Starting in 2005, with the phaseout of USAID-donated contraceptives, the province began procuring its own supply of pills and injectables, and it has budgeted three million pesos ($57,500) for procurement in 2006. In addition, 29 of the 477 municipalities in the province also have contraceptive budgets and procurement systems in place. This is part of Pangasinan's contraceptive self-reliance (CSR) program, as Filipinos refer to contraceptive security.

Lorna is 42 years old and has five children, ranging in age from 8 to 16 years old. She lives with her husband and children in the small rural village of Inlambo, in the municipality of Mangaldan in Pangasinan. She has been a family planning client of the Inlambo Rural Health Unit since the birth of her last child. Lorna was married when she was 26, and she soon became pregnant. She had a baby every two years until the birth of her youngest daughter. "My husband told me when we got married, 'let's have five children, then let's start family planning'," says Lorna. "I'm happy with five—we never wanted fewer."

But five children are a lot of mouths to feed and bodies to clothe and minds to educate. "Life is difficult," she explains. "It's difficult to send so many children to school, and if they get sick, instead of buying food, we buy medicine." Still, Lorna wasn't sure she was ready to stop having babies. "I wanted one more child. But my children are saying 'mama, that's enough, we are too many.' My oldest daughter (she's 14) says when she gets married, she only wants three children."

Lorna has been using three-month injectables for the last eight years and is very happy with the method. When asked whether she has considered a long-term or permanent method—both of which are readily available in Pangasinan—she smiles and says she's happy with the injections. She is particularly glad that she and her neighbors receive them free of charge, because few people in rural villages can afford to buy their contraceptives. However, a few of her neighbors said that if they weren't able to get them for free, or if they were stocked out, as happened in 2004 because of distribution delays from the central level, they would find a way to purchase their contraceptives. That would require traveling by tricycle (a motorcycle with sidecar for passengers) to the pharmacy in Mangaldan town. But stockouts are not a problem now that the province and the municipality are procuring pills and injectables out of their own budgets.

Philippines: Lorna receives regular counseling and contraceptive injections from her midwife.

This support is critical, and the result of strong commitment by both the provincial governor and the mayor of Mangaldan, Herminio Romero. "I believe one of the causes of our poverty is overpopulation," says Mayor Romero. "Uncontrolled population growth is hindering our development, and much is being spent on services for all these people." The 2006 budget for the municipality includes a budget line for contraceptive procurement of about $4,000, as well as $2,400 for training community-based volunteers (CBVs) who form the backbone of the rural distribution and data collection system. While not a large sum, this financial support is a significant commitment for the municipality. The province's logis-

tics management information system has been adapted to capture data on supplies that municipalities procure, providing a complete picture of the provincial stock status and allowing the province's policy-makers to allocate their resources rationally.

One positive step that Pangasinan has taken is to work with pharmacies throughout the province to ensure that they stock a range of products. This total market approach is a first step in encouraging a better segmentation of the contraceptive market. "Almost all pharmacies in Pangasinan now carry a good selection of methods, including pills, injectables, and condoms, of course," says Luz Muego, the Provincial Population Officer. This effort to provides better access to people who can afford to buy their own contraceptives and, therefore, improve market segmentation. While no specific socioeconomic eligibility criterion names the recipients of free-of-charge contraceptives, the province is encouraging local governments to focus their resources on serving the poor. To facilitate the process, the province is using CBVs to conduct regular household surveys, and is using the living standard indicators to help municipalities develop lists of specific families and specific MWRAs, in particular, who should receive free-of-charge contraceptives.

"We're reforming a three-decades-old system," explains Governor Victor Agbayani, who has been a champion of family planning and CSR, both in his province and nationally. "There are things that don't work…Free commodities are accessed by both the poor and nonpoor, so the poor have to compete with others who can afford to pay," he notes. "About half of those who now use [free contraceptives] can pay for contraceptives. So, with limited resources, how do you say 'you cannot access [free contraceptives] because you can afford to buy them at the pharmacy'?" The answer lies in the market segmentation: the living standards data will provide municipalities with the information they need to make informed policy decisions about targeting available resources to the neediest people. And the province will support this by issuing identity cards to people who meet the eligibility criteria."

Pangasinan's CSR strategy is a model that the governor is happy to share with his peers, because he recognizes that his province is in the forefront of CSR in the Philippines. "Other provinces are just focusing on replacing donations [from USAID]," he observes. "That's a simple solution, but doesn't solve it all."

MARIANA IN ROMANIA

In Eastern Europe and Eurasia, most countries are experiencing population decreases due, in part, to low total fertility rates. Couples prefer a small family size, but health systems have relied on abortion to meet couples' desire to limit their number of children. It is only since the mid-1990's that this situation has begun to change.

Romania posed one of the greatest challenges in the region due to a legacy of pro-natalist policies of the former communist regime, that virtually banned any form of contraception and abortion. This changed in 1989 when both abortion and contraceptives were legalized. But, providers had little knowledge about modern contraceptive technology and were biased against hormonal methods. Family planning services could only be provided by urban-based obstetricians and gynecologists (OB/GYNs), who had financial incentives to provide abortions rather than offer contraceptives to their clients. During the 1990's, the emerging private sector began offering contraceptives, but their market was primarily in urban areas. Donors, such as UNFPA and USAID, provided limited quantities of contraceptives for the public sector; these were provided free to certain eligible clients through 210 family planning cabinets in urban polyclinics. However, access for poor and vulnerable people, particularly in rural areas, remained poor.

By 2004, this situation had changed dramatically as family planning was integrated into primary health care (PHC) services. A large cohort of rural family doctors was trained, and access to both services and

contraceptives expanded tenfold. As of January 2006, more than 2,000 of the 2,690 rural communities have PHC units, with trained providers who can offer services and free contraceptives to eligible clients. As a result, Romania has seen a remarkable increase in modern methods CPR, from 14 percent in 1993 to over 38 percent in 2004, and a dramatic decrease in the abortion rate from 3.4 per women (during their reproductive years) in 1993 to 0.84 in 2004 (Ministry of Health et al. 2005).

Mariana and her family are among the many beneficiaries of the changes in Romania. She is 29 and lives with her husband, son, and daughter in Prundu Bârgâului, a rural community of about 6,000 people in northern Romania. She is a client of the local primary health center, which is staffed by three family doctors who, since 2004, have been providing Mariana and her neighbors with family planning services.

Mariana's son, who is six, was born with significant physical disabilities. "My child can't walk, doesn't speak, mentally he is OK, but not physically," she says. "After giving birth to my first child, who is physically impaired, I was not exactly sure whether I wanted to have a second one." But Mariana didn't have many options after the birth of her son. "My husband was careful enough, also [we used] condoms and abortion. After the abortion, I found out that free contraceptives were available…[but] I didn't take any before my second pregnancy. I was afraid I might become overweight."

One of the eligibility criteria for receiving free contraceptives was if women had had a recent abortion. However, there was insufficient counseling to address Mariana's concerns about gaining weight. And, the contraceptives were only available at the polyclinic in the city of Bistriţa, which is 45 minutes away by car.

The next time Mariana got pregnant, she and her husband decided to have the baby. "When I found out I was pregnant, I had to make a decision: whether to keep the baby or have an abortion. I yearned for the crying of a normal baby and for the steps of a normal baby." Mariana got what she'd hoped for—she gave birth to a healthy daughter four years ago. But Mariana came to a decision. "I didn't want any more babies," she explained.

Romania: Mariana (right) receives counseling on injectable contraceptives from her family doctor, Viorica Bonia.

Because 90 percent of Romania's poor live in rural areas, in 2003 policy changes were made that expanded the eligibility for free contraceptives to all rural clients, and family planning services were included in the basic package of services funded by the national health insurance scheme. At the same time, family doctors were being trained to provide family planning services at primary health care centers.

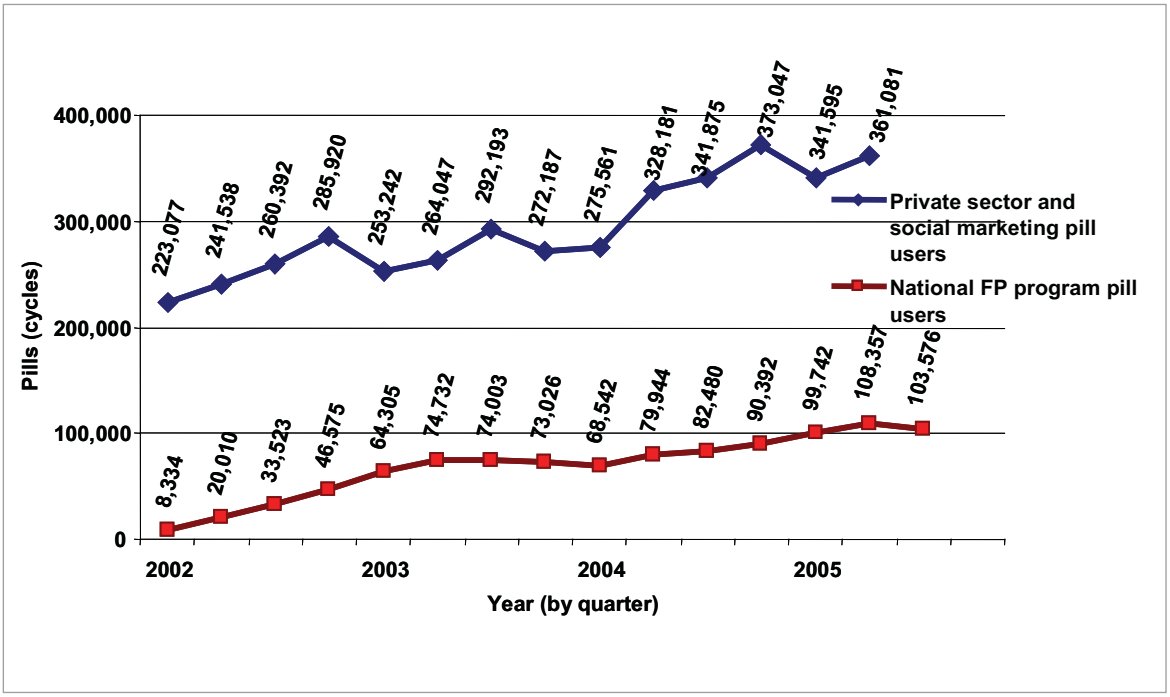
When her local primary health clinic began offering free contraceptives, Mariana decided to visit. "I started taking pills, but there was one day during the month when I forgot to take them," she says. "At first I was a little bit afraid to take them because some of my colleagues had grown fat." Mariana decided to switch to Depo-Provera. "It's much more convenient to do it by injections. It really made a difference."

Mariana works full time caring for her children. Her family receives a small monthly allowance from the government to help cover the cost of her son's care and support, but her husband was recently laid off

from his job at a factory in Bistrița, so money is tight. "It's my dream to go to work, but I can't, because my children—at least the older one—needs all my care." Mariana is particularly grateful that she can get contraceptives for free. "It is a great idea to provide them for free, because otherwise…I wouldn't be able to buy them. I can't give up our daily bread for them, they are too expensive."

While the provision of free contraceptives was a critically important aspect of the Romania program, no negative impact was felt by the growing private-sector contraceptive market. In fact, as the use of free contraceptives has expanded, so has the private market for contraceptives (see figure 1). This consideration of the total market was vital for the sustainability of the program in Romania. While the government is striving to meet the needs of the poor, it cannot afford to become a majority supplier of free contraceptives. A middle-income country like Romania must ensure that the private sector provides the majority of contraceptives.

FIGURE 1. ACTIVE USERS OF PILLS FROM FAMILY PLANNING PROGRAM AND PRIVATE SECTOR IN ROMANIA



Romania's success resulted from a number of changes in policies, finances, and systems, all of which impact contraceptive security. New policies were implemented that allowed family doctors to provide family planning services and to dispense free-of-charge contraceptives to eligible clients. Services were expanded and improved by providing training to family doctors in modern contraceptive methods and client-centered counseling, and by including family planning in the basic package of services covered by the national health insurance scheme. New financing was secured through the national government to procure contraceptives that are provided free to poor and vulnerable populations, especially in rural areas. A new logistics system was created to make sure those contraceptives are always available at the clinics when clients needed them. Behavior change and service promotion campaigns, with simple-to-understand information and education materials, built demand in rural communities for family planning services. The program expanded quickly thanks to close coordination between public, private, and NGO stakeholders at both the national and local levels. All this occurred within the context of significant health

sector reform that introduced primary health care services and national health insurance, the general population's continuing desire for small family size, and a history of over-reliance on specialists for services and on abortion for fertility control.

CONCLUSION

As each of these stories illustrate, contraceptive security is experienced one client at a time. Each country is strengthening their contraceptive security in unique ways, reflecting their distinct contexts and individual challenges. But, the overall strategies touch on some or all of the 10 components that determine whether people like Cynthia, Ana, Lorna, and Mariana will be able to choose, obtain, and use quality contraceptives whenever they need them.

3. THE GLOBAL CHALLENGE

CONTRACEPTIVE SECURITY, 1998–2006

As a concept, contraceptive security is a vision similar in breadth to the old *Health for All* rallying cry, or to the current *universal access* demands for acquired immunodeficiency syndrome (AIDS) treatment. Each is an overarching goal toward which the global health community strives to make progress; because the goal is not something that can be attained and crossed off the list, they will have to continue to strive indefinitely. Like Health for All and universal access, the effort has generated a new vocabulary and new ways of doing business; engaging a broader range of partners, establishing new alliances, and aligning activities toward a newly articulated common purpose. And, like those concepts, contraceptive security, to be fully realized, requires action at the individual, program, national, and global levels. This chapter looks at contraceptive security in the global setting, and at how multilateral and bilateral agencies working with new and diversified donors and interest groups are addressing product availability. Taking the global perspective means asking: how can systems become synchronized and how can resources be allocated most effectively, efficiently, and equitably to meet growing demands worldwide?

INTERIM WORKING GROUP

The notion that contraceptive supplies must be available to enable individuals to plan the number and spacing of their children is, of course, not new; it has been a hallmark of family planning programs for nearly half a century. It was underscored in the Cairo Programme of Action adopted at the 1994 International Conference on Population and Development. But the concept of *contraceptive security* arose in the late 1990's out of a unique partnership between John Snow, Inc.'s (JSI) health logistics program and a U.S. population advocacy organization (Population Action International), a U.S. foundation (the Wallace Global Fund), and another U.S. technical agency (PATH).

Samples of various contraceptives

In 1998, JSI was asked, "We keep hearing of anecdotal stories of clinics without supplies in developing countries. Is there a contraceptive shortage?" Our response was that, to ensure that contraceptives are available to clients, the typical situation was less one of 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 logistics systems, (3) overall poor planning, and (4) woefully insufficient coordination among the many systems that need to work well and work together. If only, we

said, contraceptives were thought of as an essential commodity—like food or water—so that country governments, donors, and lenders would commit unequivocally to the availability of needed supplies and synchronize their financial, program planning, and delivery systems to secure it. That is how the concept of *contraceptive security* was born (Hart 1998).

The analogy to food security is an imperfect one; food is a basic necessity for all life, there is, of course, a high demand for food. Whereas addressing reproductive health typically meets the needs of more defined sub-populations. But, the most useful aspects of the analogy are—

- Access to life-sustaining food is universally understood to be a basic human right. At the International Conference on Population and Development (ICPD) in 1994 and ICPD+5 in 1999, the world community committed to reproductive health (RH) as a human right; and reliable access to contraceptives is a critical component of realizing that right (United Nations 1994a, 1994b).
- Just as countries are obligated to their citizens to avert famine, they are obligated in the practice of public health to avert disruptions in the availability of contraceptives.
- In addressing food crises, donors are aligned to step in when poor countries cannot meet their people's needs; early warning systems have been established to track signs of inadequacy in the food supply. This synchronization of systems and the proactive use of data are possible in the realm of reproductive health as well.

The Wallace Global Fund had thrown the pebble in the water, and the ripples began to spread. In 1999, Population Action International (PAI), PATH, the Wallace Global Fund, and JSI formed an alliance: the Interim Working Group on Reproductive Health Commodity Security (IWG). The IWG engaged UNFPA, USAID, Department for International Development (DFID), and other donors, and was formalized in 2000 when it secured foundation support from the Bill and Melinda Gates Foundation, the David and Lucile Packard Foundation, the William and Flora Hewlett Foundation, and the Better World Fund of the United Nations Foundation (Supply Initiative 2006).

The IWG conducted research and developed materials to support a major meeting in Istanbul in May 2001 (Interim Working Group 2001b), "Meeting the Reproductive Health Challenge: Securing Contraceptives, and Condoms for HIV/AIDS Prevention." (All nine Istanbul papers are available online at http://www.rhsupplies.org.)

USAID played a critical role in the Istanbul meeting, both by engaging enthusiastically at the highest levels of the Office of Population (as it was known then) and by sponsoring the participation of country teams, which allowed field perspectives to be articulated in their own voices.

In one of the nine pre-Istanbul papers, "Contraceptive Projections and the Donor Gap," the Interim Working Group on Reproductive Health Commodity Security projected that even in the near future there was a large gap looming between contraceptive needs and supplies. The paper projected a shortfall of between $140 million and $210 million annually by 2015. Other IWG papers and findings focused on issues, including defining RH supplies, country perspectives and lessons, financing options, assessing contraceptive security, and raising awareness. Based on this research and the presentations and dialogue at the Istanbul conference, delegates concluded that a more robust response was needed from donors, country governments, and civil society alike. Specifically, the conference participants' final recommendations identified the need to—

- strengthen national capacity in areas of logistics management, analysis, and in-country donor coordination

- establish a web-based system of procurement
- develop a list of essential reproductive health supplies to help guide policies and resource allocation for basic health services
- revitalize donor coordination at the global level
- develop a plan of action for expanding the role of the private sector
- undertake an advocacy leadership campaign, backed by regional meetings on reproductive health commodity security (RHCS).

A call to action was issued in the Istanbul Declaration, that concluded—

> *The Istanbul meeting is a milestone in a dynamic process of partnerships, solidarity, and commitment to action the stakeholders pledge to continue. We know what to do about this crisis of shortfalls in reproductive health supplies, and how to do it…advocacy, national capacity building, financing, and donor coordination…* (Interim Working Group 2001b, pp. 20–21)

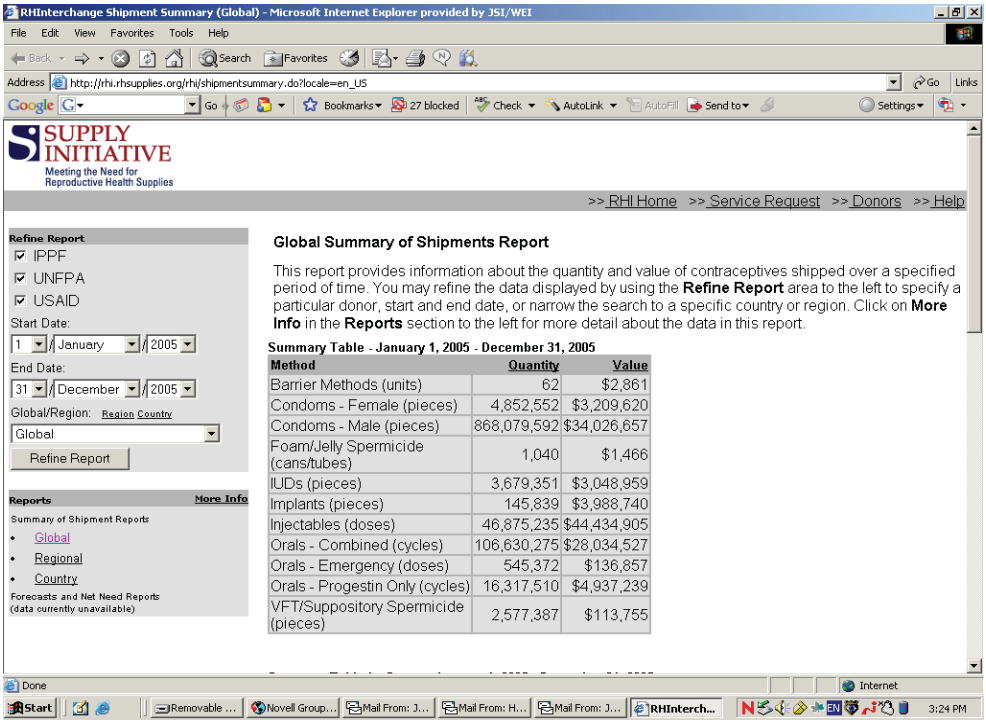
SUPPLY INITIATIVE

After the Istanbul meeting, the members of the IWG continued to work together and continued to receive foundation support to implement parts of the Istanbul action plan. A new Reproductive Health Supply Initiative was formed, with the German Foundation for World Population (DSW) joining JSI, PAI, and PATH (see Supply Initiative website at http://www.rhsupplies.org/about.shtml?navid=1).

The Supply Initiative (SI) was officially launched in 2003, and established an office in Brussels, Belgium. The SI worked until mid-2006 on four main aspects of the RH commodity security issue:

- advocacy, especially to engage, educate, and mobilize European nongovernmental organizations (NGOs), bilateral donors, and the European Union around RHCS (led by PAI)
- communication and support of a virtual community, which included a website, electronic and print newsletters; and several fact sheets, press releases, and other publications on various aspects of RHCS (led by DSW)
- creation and operation of the Reproductive Health Interchange (RHI), which is a consolidated contraceptive procurement database for USAID, UNFPA, and IPPF (led by JSI)
- establishment of a forum to develop and enhance synergy toward RH commodity security, now known as the Reproductive Health Supplies Coalition (RHSC) (led by PATH).

The SI has completed its work; these major activities have been successfully launched and will continue into the future. Resources have been secured to continue and expand the RHI and RHSC; new resources are being sought for advocacy. The Bill and Melinda Gates Foundation is the main funder of this work (Population Action International 2006).



Sample page from the RH Interchange website

REPRODUCTIVE HEALTH SUPPLIES COALITION

At the Istanbul meeting, a community was begun that continues to grow and mature in the way it is organized. Major players in the RHCS movement came together to form the RHSC in 2004. The RHSC has met five times, semi-annually, since its establishment; it was hosted by the World Bank in Washington (April and November 2004), the Gates Foundation in Seattle (May 2005), the Netherlands Ministry of Foreign Affairs in the Hague (October 2005), and UNFPA in New York (April 2006). As of the last meeting, the members of the RHSC are a diverse group of some 20 multilateral organizations, bilateral donors, private foundations, representatives of developing country governments and NGOs, technical agencies, and civil society, including the—

- Bill and Melinda Gates Foundation
- Department for International Development (DFID)
- European Commission
- German Development Cooperation (the GTZ)/KfW Development Bank
- GSMF International, a Ghanaian social marketing company*
- International Planned Parenthood Federation (IPPF)
- Ministry of Finance, Planning & Economic Development, Uganda*
- Ministry of Health, Romania*
- Ministry of Health and Family Welfare, India*
- Netherlands Ministry of Foreign Affairs

- Partners in Population and Development (PPD)
- Population Services International (PSI)*
- Profamilia Colombia*
- Shanghai Institute of Planned Parenthood Research, China*
- Supply Initiative
- United Nations Foundation
- United Nations Population Fund
- United States Agency for International Development
- World Bank
- World Health Organization.

(Denotes two-year rotating membership)*

The first chair of the RHSC was Elizabeth Lule, of the World Bank, who served from 2004 to 2005. Current co-chairs are Margret Verwijk (Netherlands Ministry of Foreign Affairs) and Wolfgang Bichmann (KfW Development Bank). UNFPA and USAID are major players in the coalition, but it is a significant demonstration of the expanding ownership of the contraceptive security imperative that the World Bank and key European donors have stepped up to assume leadership of the RHSC in its early years.

In addition to its regular meetings, the RHSC operates through three well-established working groups, each one grounded in the priorities that emerged from the Istanbul conference (RHSC 2006):

- The Resource Mobilization and Awareness Raising Working Group aims to increase political and financial commitments to RH supplies and supply systems by increasing and strengthening advocacy at country, regional, and global levels.
- The Systems Strengthening Working Group focuses on developing financing, procurement, and distribution systems that are more data driven, better aligned, and better coordinated, so that RH supplies will be more reliably available to and within countries. An innovative, ongoing activity of this group is the Countries at Risk Working Group, which is made up of representatives of commodity donor/funder organizations (e.g., UNFPA, USAID, KfW, World Bank), who meet regularly by conference call to share information about the current status of contraceptive supplies in each country, raise early warnings of disruptions in the supply chain, and devise short-term solutions to meet emergency needs.
- The Market Development Approaches Working Group aims to expand commercial markets for RH supplies among low- and moderate-income consumers, and to promote policies and regulatory environments that support better allocation and use of public subsidies and expanded provision of RH supplies by the private sector.

After two initial years of operation, with SI support, the RHSC now has a dedicated secretariat, with a full-time executive director and a small technical and administrative staff based in Brussels, as of August 2006. The secretariat is hosted by PATH and financially supported by the Gates Foundation.

As all movements and coalitions do, the RHSC should be expected to continue to evolve in the years ahead. Priorities for its evolution might include becoming even more inclusive, especially finding a way to engage Southern partners more effectively; leveraging support from strategic alliances with other public health efforts, such as the Global Fund; encouraging and enhancing candor, transparency, and mutual accountability; and keeping itself refreshed and focused on the ultimate objective—ensuring that women and men everywhere can always choose, obtain, and use the reproductive health products they desire.

KEY FUNDING AND TECHNICAL ASSISTANCE PARTNERS IN RHCS

There is not space in this publication to catalog the complete range of contraceptive security–related activities of even the major global agencies active in the field. In the last five years, there has been a great deal of attention and productive effort made in this area. The following is a very brief synopsis of key partners' roles.

UNFPA: As a United Nations organization, UNFPA plays an unparalleled leadership role in RHCS—and has always done so—with a truly global mandate and global reach. UNFPA's leadership role in commodity security was internally embraced in 1999 as a follow-up to the five-year review of ICPD. A UNFPA RHCS strategy was developed soon after. UNFPA has elevated RHCS to be a strategic priority and has embodied that in organizational changes and hiring. To meet shortfalls in its own budget, UNFPA has successfully used RHCS to secure extraordinary funding from major donors, including the British, Dutch, Canadian, and European Union (EU) aid agencies. As a supplier of contraceptives, UNFPA's procurement service is always either the first- or second-largest donor (USAID is the other), providing in excess of $42 million worth of products, on average, annually (1990–2002). UNFPA's procurement service has been used increasingly by ministries of health as a cost-effective way to access low international prices, particularly in the face of local procurement capacity and policy constraints. UNFPA also produces useful annual data on donor spending on contraceptives and condoms, which are especially helpful for supporting advocacy and efforts to operationalize RHCS (UNFPA 2005 and UNFPA n.d.).

UNFPA was a co-sponsor, with USAID, in the development of SPARHCS. Finally, UNFPA is in the process of developing a new "Global Programme to Enhance RHCS," which will be a major global initiative, for which they are now seeking funding.

U.S. Agency for International Development (USAID): USAID is the single largest bilateral donor of reproductive health supplies (contraceptives and condoms), and in some years, even exceeds UNFPA. Since 2003, USAID has donated, on average, $70.3 million of contraceptive commodities each year. Not long after Istanbul, USAID established contraceptive security as one of the strategic priorities of the agency's Office of Population and Reproductive Health (PRH). USAID established a contraceptive security team of advisors within PRH, and allocated special funds to support a wide array of cooperating agencies' contraceptive security activities. USAID operates country-specific and global PRH projects using grants and contracts with cooperating agencies in all the major aspects of contraceptive security; including logistics and supply chain management, policy development, private-sector mobilization, health system strengthening, family planning service delivery, and contraceptive research and development. By sustaining long-term relationships with trusted partners, USAID has developed its cooperating agencies (a large and diverse collection of academic and technical assistance organizations—Abt Associates, EngenderHealth, Family Health International, the Futures Group, John Snow, Inc., Johns Hopkins University, Management Sciences for Health, Pathfinder, the University of North Carolina, etc.)—into a critically important resource for global RHCS, to which other donors are increasingly turning for expertise.

U.K. Department for International Development (*DFID)*: DFID is a major supporter of UNFPA and RHCS, having been an early force behind UNFPA's joint donor working group on commodities and logistics throughout the 1990's. On average, during the past decade, DFID has been the fourth largest funder of contraceptive supplies. Recently, DFID partnered with the Netherlands Ministry of Foreign Affairs to commission several new country studies of RHCS (Druce 2006). DFID has also led, participated in, or sponsored other contraceptive security–related work, recently on aid architecture and finance, aid effectiveness, HIV/AIDS, and so on (e.g., Schwanenflugel 2005). DFID also pays special attention to the prospects for RHCS in countries with *basket funding* and/or sector wide approaches (SWAps) for health.

European Union (EU): Thanks to targeted advocacy conducted by UNFPA, PAI, DSW, the Supply Initiative, and several European population/sexual and reproductive health NGOs (EuroNGOs), the EU is now a much more active and integrated participant in the RHCS movement.

International Planned Parenthood Federation (IPPF): The outgoing secretary general of IPPF, Steve Sinding, has been an effective, eloquent, and persistent advocate for RHCS globally. IPPF's network of member associations (country affiliates) is currently an underutilized resource for RHCS. With new foundation funding, that situation is likely to change; the country-level power of the IPPF global federation can be harnessed more effectively for long-term RHCS. With UNFPA and USAID, IPPF was one of the founding participants in the RHInterchange, consolidating its contraceptive procurement information with UNFPA's and USAID's in order to foster better coordination and ease the management burden on country programs.

Kreditanstalt für Wiederaufbau (*KfW)*: The German funding agency for international development (KfW) has been the third major funder of contraceptive supplies after USAID and UNFPA. KfW's long-time, generous support of social marketing programs makes it a major voice in efforts to develop new contraceptive markets and engage the commercial sector. KfW currently co-chairs the RHSC with the Netherlands Ministry of Foreign Affairs.

Millennium Development Goals (MDG): Kofi Annan said, "The Millennium Development Goals were adopted five years ago by the world's Governments as a blueprint for building a better world in the 21st century" (http://www.undp.org/mdg/). Three of the eight MDGs are explicitly about health (reduce child mortality; improve maternal health; and combat HIV/AIDS, malaria, and other diseases), and the rest are inextricably connected with health, as they deal with poverty, hunger, education, gender issues, the environment, and development partnerships. Remarkedly, though, there is no MDG target for reproductive health. Nevertheless, UN agencies, the World Bank, the UN Millennium Project, the Supply Initiative, and others have all steadfastly researched and documented the importance of reproductive health to the ultimate attainment of the MDGs. RHCS has been inserted into this dialogue as an example of a *quick win*; we know what to do now, and how to do it, and doing it will help jumpstart *large-scale progress* on the broader array of MDGs. As stated in the final paper of the UN Millennium Project, the RHCS-related quick win would be to "expand access to sexual and reproductive health information and service, including family planning and contraceptive information and services, *and close existing funding gaps for supplies and logistics.*" (italics added to quote) (UN Millennium Project 2005).

The Netherlands: The Dutch Ministry of Foreign Affairs is another leading bilateral donor in the field of RH supplies, and like DFID, one that strongly supports the role of UNFPA. The Dutch have also been instrumental, with DFID and KfW, in securing increased attention to this issue by the EU. Indeed, during the six-month Dutch presidency of the EU in 2004, RH supplies were a focal point of the

development dialogue. Further indicating their support, the Netherlands Ministry of Foreign Affairs currently co-chairs the RHSC.

World Bank: As a lender and grant maker to developing country governments, the World Bank plays a potentially major role in RHCS, but to date it has not articulated an agency vision to do so explicitly. Nevertheless, the World Bank supplied the inaugural chairmanship of the RHSC, providing engaged, visible leadership during the coalition's critical first two years. Additional evidence of the bank's seriousness about strengthening its role with respect to RH supplies is that it has welcomed the secondment of a reproductive health logistics advisor for the past four years (supported by USAID, the United Nations Foundation, and the Gates Foundation). It is imperative that country recipients of World Bank health funding and their technical assistance partners fully understand the latest priorities and strategies, and its project development, funding, and review cycles, so that they can utilize every opportunity to include RH supplies and system strengthening into World Bank–financed instruments.

World Health Organization (WHO): Both the Reproductive Health and Research, and the Medicines Policies and Standards, departments of the WHO, have become actively engaged in RHCS, especially around the creation of *The Interagency List of Essential Medicines for Reproductive Health* (WHO 2006). WHO is also engaged with PATH and JSI in RH commodity pricing studies and, on a larger scale, working with PATH and the Gates Foundation on the quality assurance of RH supplies and procurement harmonization and strengthening.

Foundations: U.S. private foundations, both small and large, have been instrumental in developing, guiding, and supporting the global RHCS community. The principal foundations have been the Wallace Global Fund, which no longer works on this issue, however; the Bill and Melinda Gates Foundation, which is expanding its support of the issue as part of its commitment to women's and reproductive health; the David and Lucile Packard Foundation, and the William and Flora Hewlett Foundation, whose individual funding for RHCS has declined, but whose commitment to reproductive health remains strong; and the United Nations Foundation, which only supports work with, by, and for UN agencies. In the past, the foundations sought to co-fund RHCS initiatives, or at least to collaborate closely; as of this writing, the foundations' future emphases and preferred collaborative arrangements are not clear.

CHALLENGES AND OPPORTUNITIES

The final report of the Supply Initiative states:

> In 1996, two years after Cairo, a handful of bilateral and multilateral donors were providing $172 million worth of contraceptive supplies to the developing world. Despite rising need for contraceptives, by 1999, that number had dropped to $154 million. In 2001, an historic meeting in Istanbul on the issue marked a turning point for the global community and set into motion efforts to raise awareness, increase support, and seek solutions to the crisis in supplies. By 2004 (the year of most recent available data), bilateral and multilateral donor support for contraceptives had increased to $203 million and the issue is now firmly on the global agenda (PAI 2006).

But, despite demonstrable progress, because contraceptive security comprises many components and involves many actors, there remain plenty of challenges inherent in the quest. Those challenges—and many proven solutions—are detailed throughout the following chapters in this publication.

Globally, some of the most prominent challenges and opportunities ahead include—

- *Applicability of the concept to and adoption by other health product categories*

  It is a measure of the power of the contraceptive security concept that it has now been adopted and adapted to address other health commodities, such as HIV/AIDS drugs and diagnostic materials, TB drugs, and malaria treatment and prevention supplies. Commodity security is now a phrase that is often used in global public health. The concept is indeed beneficial for other categories of health products, but that phenomenon enhances the real or perceived competition for the scarce resources for health. Keeping the focus on a narrow product category, such as contraceptives, is helpful; one understands intuitively that there cannot be *security* for *all* drugs and other health supplies in poor (or even rich) countries, and that successful advocacy requires focused messages targeted to specific audiences. But, this challenge also presents opportunities for mutually beneficial linkages as new resources are mobilized and new financing structures are organized (e.g., the Global Fund, the airline ticket tax).

- *Making and measuring progress*

  Some of the biggest challenges for contraceptive security are establishing a baseline, measuring progress, and attributing impact to the variety of interventions that are often undertaken together. How do we know we're getting there, and how do we know what worked and what did not? USAID projects—DELIVER, POLICY, PHR*plus*, and PSP—have developed tools to track contraceptive security. USAID, UNFPA, DFID, and the EU have all conducted a wide variety of assessments, but there are no broad community standards. There is a real opportunity here for the RHSC to provide international leadership.

- *Sustaining interest*

  When speaking of the need to expand and sustain family planning services and program success, Thailand's famed Mechai Viravaidya commented on the inherently increasing difficulty of doing so, using the expression "the baby gets heavier every year" (Cantlay [Hart] 1984). Every year, thanks to population growth and rising prevalence, the world's demand for contraceptives grows. Sustaining governments' and donors' interest in meeting a never-ending, ever-growing need is certainly challenging. New vocabulary, new paradigms, new partnerships and alliances all help, and opportunities for creativity must be exploited.

- *"Addressing big tent" versus tight group*

  Another challenge for the RHCS movement is to strike the right balance between welcoming all interested parties to join in (i.e., erecting a *big tent*) and finding ways to stay focused, action-oriented, transparent, and accountable. This will be a major point of deliberation and policy setting for the RHSC in 2006–2007. There may be opportunities to create sub- and/or supra-organizations to complement the RHSC, and to engage all interested stakeholders meaningfully in appropriate roles that maximize comparative advantages.

CONCLUSION

The next five years will be critical ones for global RHCS efforts. Competition for health resources has never been greater, but by the same token, within the community the consensus around RHCS as fundamental to reproductive health appears to be stronger than ever. The newly formalized and more generously funded RHSC will be at the center of future developments in this field, as will UNFPA, the Bill and

Melinda Gates Foundation, key European donors, and USAID and its cooperating agencies. The keys to successful activities at the global level remain communication, coordination, synchronization of systems, transparency, and candor.

4. REGIONAL APPROACHES

A regional approach can provide many benefits to country teams addressing contraceptive security (CS). Regional workshops and conferences provide venues for the exchange of ideas and lessons learned with neighbors who face similar problems. Countries that seem to have intractable problems may encounter suitable solutions through the experience of others. Local solutions are most likely to be successful because of historical (cultural and demographic) similarities. Bringing neighboring countries together can also engender some beneficial competition as countries can compare their performance to their neighbors. This can prove to be a powerful stimulant for change; included in this chapter are several examples of previously recalcitrant countries becoming energized after seeing their neighbors' successes in family planning.

Analysis of common contraceptive security (CS) issues can be the basis for identifying, designing, and implementing regionwide solutions that use economies of scope or opportunity, as well as economies of scale. A regional perspective can highlight opportunities for collaboration and harmonization of approaches like pooled procurement or common drug registration, ideally through existing regional mechanisms and institutions. Solutions like these work best in the context of established regional cooperation, whether it is a regional health secretariat—such as the West Africa Health Organisation (WAHO) or the Pan-American Health Organization (PAHO)—or an existing trading block—such as the Central America Free Trade Agreement (CAFTA) or the Southern Africa Development Community.

Adopting a regional approach requires careful coordination, management, and collaboration. Ideally, it should involve representatives from the public and private sectors, from different donors and representatives from the ministries of finance, as well as ministries of health.

In this chapter, we examine experiences from five different regions, each initiative building on lessons learned from its predecessors. All were conducted in collaboration with several technical assistance providers, as well as additional support from UNFPA, the World Bank, and KfW. Most started with some type of regional workshop. This required very careful management to ensure that the event was more than a mere talking shop but was connected to subsequent action and tangible outcomes.

In many cases, country teams formed at the opening workshop became the basis for a CS working group in the country. The durability of these working groups is a litmus test for the success and sustainability of regional CS work. This is best shown in the Latin America and Caribbean (LAC) region where, three years after the regional CS work began, the CS committees continue to meet and implement their strategies.

While experience and the approaches adopted in the different regions have been dissimilar, several common themes are evident for the regional CS work undertaken:

- The countries within each region all experienced common problems that lent themselves to cross-country analysis.
- CS bottlenecks in one or more countries were often overcome in others, providing opportunities for exchanging lessons learned.

- While some regionwide work has been undertaken, this has been complemented and coordinated with country-specific work.

The rest of this chapter elaborates on the regional initiatives in Latin America, West Africa, Asia, Eastern Europe, and East Africa. In each case, we summarize the context, key constraints, activities undertaken, and actions and achievements completed to improve CS in each region.

LAC: CONFRONTING PHASEOUT AND PROCUREMENT CONSTRAINTS

In recent years, USAID has begun a gradual phaseout of contraceptive donations to all programs in the LAC region. As countries have started to prepare for impending phaseout, many governments have struggled with similar challenges to ensure long-term product availability. National family planning programs, NGOs, and social marketing programs face major constraints to achieving sustainability in contraceptive financing, procurement, and service provision, while dealing with the added complexity of major health reforms, usually involving the integration and/or decentralization of various aspects of the health sector.

Simultaneously, as a result of increased awareness and education about family planning, countries are challenged with satisfying the rising demand for contraceptives throughout the region. In addition, although governments and donors in the LAC region have made significant investments in family planning and reproductive health programs, modern contraceptive use remains low and unmet need remains high for several groups: those living in rural areas, the lowest socioeconomic groups, the young, the uneducated, and specific ethnic groups.

During the early 2000's, several key constraints affected CS in the region, including—

- little financial planning and limited political commitments toward sustaining the long-term supply of contraceptives
- varied capacity for the selection, forecast, and procurement of contraceptives
- fairly restrictive regulatory environments surrounding the purchase of essential medicines
- lack of information sharing on the varying experiences, lessons learned, and options available for countries in the regions
- increasing demand for the use of contraceptives
- minimal access to basic health services for the hardest to reach, poorest, and least educated segments of the population.

When first faced with donor withdrawal, the USAID-supported countries—Bolivia,[3] Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru—began to consider the need to implement phaseout plans. Countries hoped these plans would help programs reduce their reliance on USAID donations while diversifying funding sources and developing their capacity to procure commodities independently. Acknowledging the constraints above and systematically preparing solutions for them were essential steps to improve CS and to sustain reproductive health programs in the region.

3 Contraceptive commodity support to Bolivia is still being considered.

To begin tackling these constraints, Latin America and the Caribbean (LAC) Bureau of USAID, with assistance from the DELIVER and the POLICY projects, convened a meeting in Nicaragua in July 2003 that focused on the development of a CS committee and strategy for each country in the region. Participants included representatives from governments, donor agencies, and the commercial sector in Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru.

At that meeting, many stakeholders recognized that a successful CS strategy must be customized country-by-country; taking local needs, priorities, constraints, and political context into account, while learning from regional experiences. Consequently, five countries (Peru, Bolivia, Nicaragua, Paraguay, and Honduras) agreed to do the SPARHCS assessments. Conducted jointly by DELIVER and POLICY, the assessments evaluated each country's political environment; financing, procurement, and service delivery capacity; and management of the contraceptive supply chain. The assessments included interviews with stakeholders both in public and private sectors, brief logistics assessments, and analyses of reproductive health demographic data.

At a USAID-sponsored LAC regional CS forum in Lima, Peru, in October 2004, DELIVER and the POLICY projects presented reports of the completed assessments. The *Regional Contraceptive Security Report for Latin America and the Caribbean* (Taylor et al. 2004) summarizes the results of all the assessments and makes recommendations for initiatives to improve the long-term availability of contraceptives in the region. The assessments have fed directly into each country's CS strategy, and the results have encouraged various stakeholders (national and international) to take action.

For instance, after attending the meeting in Peru, representatives from Ecuador, Dominican Republic, and Guatemala also recognized the importance of an in-country SPARHCS assessment to stimulate and inform the process of achieving CS. As a result, Ecuador and the Dominican Republic jointly conducted assessments with DELIVER in 2005; Guatemala followed suit with a full assessment conducted in early 2006.

Additionally, after attending the regional forum, several governments began to focus on the need to coordinate the provision of family planning services with the private sector. In an effort to determine the most efficient way of coordinating services, and with DELIVER's support, Bolivia, Nicaragua, and Paraguay conducted a market segmentation analyses that fed into the development of inclusive and coordinated CS committees, strategies, and implementation plans. The POLICY project did a market segmentation analysis for Peru.

In summary, the LAC region has undertaken regional CS activities since 2003, including an initial regional workshop in Nicaragua, which stimulated in-country assessments and coordination shortly after the workshop. Next, the region shared local progress achieved at a regional forum in Peru, which provided impetus for further analysis and implementation of CS strategies country-by-country.

Key outcomes have included—

- establishment of multisector CS (*Disponibilidad Asegurada de Anticonceptivos* [DAIA] in Spanish) committees that have continued to meet and be a source of coordination, planning, and action
- completion of SPARHCS assessments and market segmentation analyses that led to the development of CS strategies and an increasing recognition of the need for a public- and private-sector response to meeting CS needs for the population
- establishment of an increased number of funded budget lines to finance contraceptives as donor funds phase out

- increased use of UNFPA as a procurement agent and other procurement options to avoid identified local procurement constraints and to obtain contraceptives at competitive international prices.

Although significant progress has been made in recent years and all nine USAID-presence countries have taken major steps to achieve CS, further progress must be made if these countries are to be successful in assuming responsibility for providing contraceptives to their citizens. Some areas for future focus include—

- further strengthening the capacity in the LAC region to finance, forecast, procure, and deliver contraceptives to those who need them
- maintaining a robust and effective supply chain during health sector reform
- developing alternative procurement options
- streamlining and/or coordinating the regulatory environment in which contraceptives are currently being procured
- increasing information sharing to obtain better prices from qualified suppliers
- ensuring adequate and sustainable financing for the purchase of contraceptives, including the establishment of budget lines
- developing the capacity of governments to put quality assurance measures in place
- implementing creative strategies for reaching the least accessible, poorest. and less educated segments of the population.

The collaborative process in the LAC region has shown that by comparing challenges, solutions, and successes among countries, representatives have been encouraged, inspired, and at times, embarrassed into returning home to develop customized strategies and implementation plans based on local realities and regional experiences.

ASIA: WORKING WITH THE MEDIA

In Asia, the focus was on working with the local media to promote positive CS messages. A regional workshop funded by USAID led to a flurry of reporting and the formation of several local media groups, which have done follow-up work in their countries and made progress in addressing CS at the national and local levels.

Media Advocacy for Contraceptive Security: An Asia Regional Workshop brought together key stakeholders from Bangladesh, Indonesia, Nepal, Pakistan, and the Philippines. Delegations from each country—including representatives from government agencies, NGOs, the private sector, and the media—worked together to identify obstacles, opportunities, and key messages and players for working with the media to advocate for CS. The conference produced country-specific action plans to partner with the media in support of country-led CS goals.

Nepal: Woman receives a birth control injection.

The results were immediate. Reporters with the Philippine country team filed news articles and commentaries directly from the conference and conducted live radio interviews with participants. Within a month after the workshop, more than 15 newspaper and Web articles had been published in the five countries. A participating journalist from Nepal conducted a seminar to raise awareness among his peers about the issue. Indonesia launched a new "Coalition for Healthy Indonesia" website, which features CS information.

The real success of the conference was the increased understanding between government and NGOs about how to partner with the media in pursuing CS—or any national health strategy. Mutual suspicions about the motives of both reporters and government officials were discussed candidly; this helped the two sides begin to understand each other and laid the groundwork for closer cooperation. Reporters met champions of CS (and family planning programs in general) from NGOs and even the private sector, resulting in greater public exposure for the champions and their cause, and new sources of reliable information for the reporters about national health issues. The conference was a model for raising awareness about CS in Bangladesh, which was at the forefront of discussions when the countries focused on CS. In 2004–2005, a series of district-level workshops were held to engage the district health officers in talking about CS. The workshops also helped raise awareness among local news reporters about the decreased use of long-term and permanent contraceptive methods, and the importance of targeting free public-sector family planning services and supplies to the people who most need them. Both issues were identified as key factors affecting CS in Bangladesh in a 2002 national CS launch.

In Indonesia, the conference helped convince the Indonesian family planning coordinating agency (BKKBN), of the necessity to develop a CS plan to help the country cope with a sweeping decentralization of government services to the district level, including family planning. Local governments were empowered to make decisions about resource allocation and local priorities, but they lacked the information, experience, and tools needed to make informed decisions. The result was that Indonesia's successful family planning program, widely regarded as a global model, was suddenly in danger of falling apart. BKKBN, with the assistance of the USAID-funded Sustaining Technical Achievements in Reproductive Health and Family Planning (STARH) project, developed a CS strategy that enabled districts to assess their own CS status and take action to improve CS through local, and often very innovative, means. Districts have allocated significant funds for contraceptive procurement, licensed new pharmacies in rural areas to broaden access to contraceptives through the private market, and improved the targeting of free contraceptives provided through public clinics.

In the Philippines, where CS is referred to as contraceptive self reliance (CSR), conference participants returned re-energized to tackle the issue at the provincial and local government levels, where responsibility for health services rests. The national government has been reluctant to commit its own financial resources toward the procurement of contraceptives, even though donations from USAID will end in 2008. Currently, approximately 75 percent of users rely on the free contraceptives provided by USAID. Therefore, journalists and business leaders are now championing the need for self-reliance by supporting efforts to target free public supplies provided through the local government units (LGUs) to the 20 percent of users unwilling or unable to pay for them, and by encouraging an expansion of the commercial market through private-sector sources such as private midwives and pharmacies. The Employers Confederation of the Philippines is advocating support for contraceptive provision through employer-supported health plans and clinics.

WEST AFRICA: CONNECTING A REGIONAL STRATEGY TO EXISTING CHALLENGES

Since 2003, DELIVER has been working with the WAHO and the health secretariat of the Economic Community of West African States (ECOWAS) to develop a regional RHCS strategy and to design and implement a coordinated informed buying (CIB) procurement information system. These efforts have been actively supported by regional partners (e.g., WHO/AFRO, the *Association Africaine des Centrales d'Achats de Médicaments Essentiels* [ACAME], and the *Centre d'Etudes et de Recherche sur la Population pour le Developpement* [CERPOD]), and donors, including UNFPA, KfW, and the World Bank. The process began with an analysis of common challenges among the 16 ECOWAS countries[4] and the presentation of options and solutions to annual meetings of the region's ministers of health.

The challenges facing the region are substantial and include—

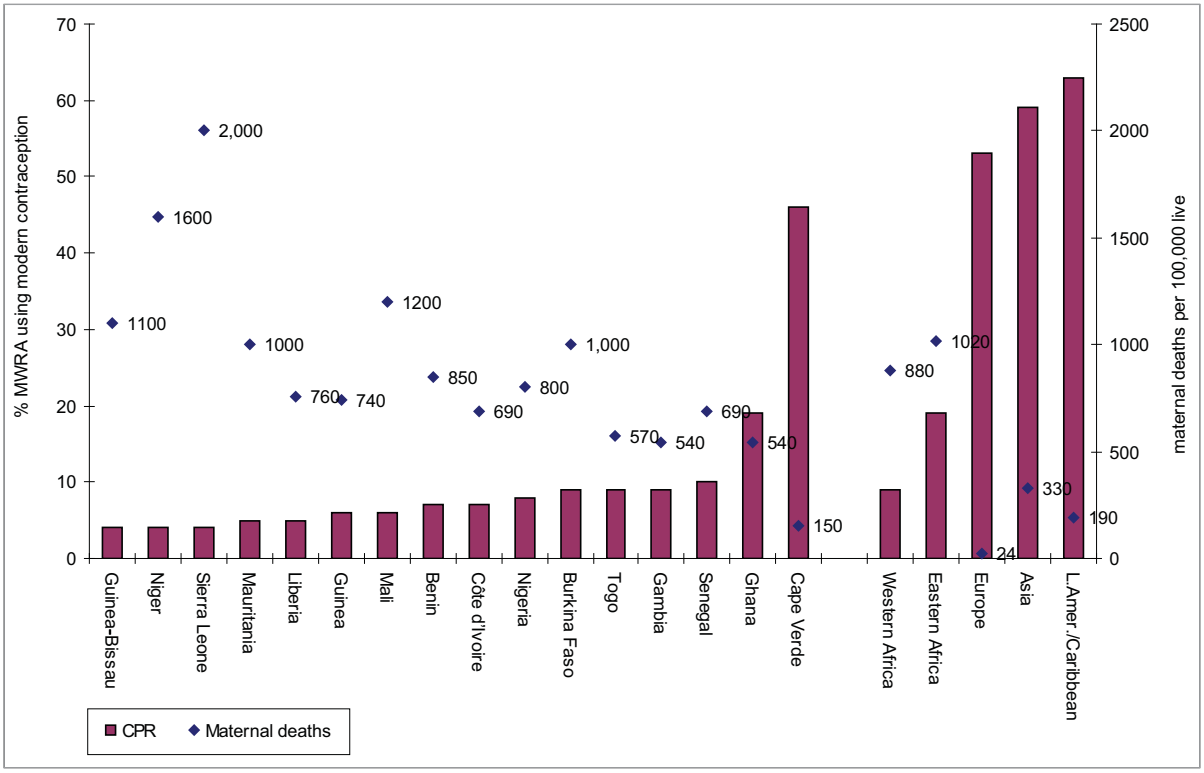
- limited access to quality reproductive health commodities and services
- weak national logistics systems for managing RH commodities
- insufficient financing for RH commodities and services from all sources (household, community, national governments, multilateral and bilateral donors, and funders)
- lack of coordination mechanisms between partners in the subregion
- multiplicity of poorly coordinated activities in countries, leading to unnecessary redundancies and an inefficient use of the limited resources available for RH
- substantial national and operational policy barriers to RHCS.

Together, these challenges have resulted in poor reproductive health outcomes throughout the subregion. For every 100,000 live births in West Africa, there are 880 maternal deaths and more than 10,000 infant deaths (PRB 2005). The percentage of married women using modern methods of contraception in the region stands at 8 percent—which is near the bottom worldwide for contraceptive use.

The United Nations' Millennium Development Goals (MDGs) include among its indicators improving maternal and infant health outcomes and reducing the spread of HIV/AIDS, all of which depend on the consistent availability and use of RH commodities. Figure 2 illustrates the relationship between high maternal mortality ratios (MMRs) and low contraceptive prevalence rates (CPRs).

4. Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo.

FIGURE 2. CONTRACEPTIVE PREVALENCE RATE COMPARED TO AND MATERNAL MORTALITY IN WEST AFRICA



Sources:
MMR: PRB 2005 Women of Our World
CPR: PRB 2006 World Population Data Sheet (Liberia CPR from 1998 World Population Data

Where MMR is high, for example in Sierra Leone (2,000 per 100,000 live births), CPR is 4 percent. In Ghana, CPR is 19 percent, while MMR is 540 per 100,000 live births.

To address these reproductive health challenges and advance its Strategic Plan for the Reduction of Maternal and Perinatal Mortality, WAHO has identified and is systematically addressing the interdependence between RHCS and maternal health outcomes. At the Fifth Annual Assembly in Accra in 2004, ECOWAS health ministers recommended that WAHO and its partners develop a regional strategy for RHCS to support the maternal and perinatal strategic plan (see box 1). The health ministers subsequently endorsed a road map for that strategy, which was presented in the RHCS Concept Paper at their 2005 annual meeting in Dakar, Senegal.

Three key areas have been identified where the regional strategy will add maximum value for supporting and advancing RHCS, including strengthening human and institutional system capacity (e.g., supply chain and service delivery); a harmonized regulatory and policy framework (e.g., common essential medicine lists, standard treatment guidelines, and import tariffs), and establishing the CIB system to allow national procurement; and supply managers to share information on supplier price, quality, and performance with their counterparts in the region.

BOX 1. BENEFITS OF THE WEST AFRICA REGIONAL APPROACH

The West Africa regional approach—

- Serves as an excellent vehicle for advocacy at the regional level and for working across countries (with multiple countries simultaneously) to compare, inform, and influence public health policies.
- Brings key decision makers from different settings (countries, multilateral agencies, bilateral donors, etc.) together around a common conceptual framework, terminology, tools, and methods for assessing and addressing challenges.
- Helps countries share their experiences with each other.
- Stimulates countries and individuals to higher levels of performance.
- Brings together individuals who should be talking to each other (but are not necessarily doing so). This gives these individuals the time and space, outside their politically charged and busy environments, to share experiences and problem solve with each other.
- Attracts the attention of governments, along with multilateral organizations, bilateral donors, and other partners.
- Allows for the introduction and rapid testing of new approaches and tools across countries, resulting in substantial savings for organizations and projects.

Using the CIB mechanism to increase the procurement efficiency among ECOWAS member countries has been a major WAHO initiative. The small countries in the region are often unable individually to obtain lower prices through the bulk purchase of commodities. Recent DELIVER work has indicated that potential cost savings for RH commodities can be achieved through pooling commodity requirements among ECOWAS countries. The resulting savings could potentially be used to finance additional procurements, and mitigate part, but not all, of the enormous RH commodity financing burden faced by countries in the subregion. Based on the quoted unit prices for the pooled volume of RH tracer commodities for the subregion, a 14 percent average savings is possible compared to the median international reference price (IRP).[5] While this is only an estimate provided by procurement agents, and the averages provided are unweighted,[6] it indicates that bulk procurements can have an affect on unit prices. As table 1 shows, the unit price reductions were most significant for contraceptives (28 percent), while the savings in the *Other* category (examination and surgical gloves, and oral redehydration solution) were minimal (2 percent). The greatest price reduction was seen with the combined oral pill; reference prices indicated $0.35 per cycle. When the subregion's projected demand was aggregated, the total projected volume amounted to nearly 26 million cycles for 2004, resulting in a $0.22 per unit quoted bulk price—a 60 percent reduction over the IRP. The RH commodity pricing analysis demonstrated that there may be a potential for savings through bulk procurement. However, such a system also requires a complex pooled

5. Management Sciences for Health issues an annual International Price Indicator Guide (http://erc.msh.org) comprising two sections. The first section lists procurement prices offered by not-for-profit suppliers to developing countries for multi-source generic procurements. The second section lists tender prices offered to procurement agencies in developing countries. For each product, a median unit price is calculated. The median price is used as the international reference price.
6. Actual savings would be more or less depending on the volume procured for individual commodities. If lower quantities were procured for items with larger price differences, the savings would be less.

financing arrangement, national regulatory approval, and adequate procurement capacity. A DELIVER 2005 assessment revealed that these requirements are not all currently in place in the subregion. Options resulting from the assessment were presented to the ECOWAS health ministers, who adopted a recommendation for WAHO to begin the implementation of the CIB system (as part of the RHCS strategy). The reasoning was that the CIB mechanism would enhance each country's ability to share and access product, supplier, and pharmaceutical market information without committing countries to a more complex pooled procurement system at this time.

TABLE 1. COMPARISON OF IRP AND BULK PRICES

COMMODITIES				
	Dosage	**IRP**	**Bulk Price**	**Variance (%)**
CONTRACEPTIVES				
Condom	condom	0.026	0.020	-31
Injectable	injection	0.893	0.850	-5
IUD	IUD	0.404	0.310	-30
Implant	rod	26.565	23.000	-16
Pill	tablet	0.347	0.217	-60
Subtotal Average				**-28**
STI/HIV/OI				
Nevirapine tabs	tablet	0.145	0.143	-2
Nevirapine syrup	syrup	2.232		
Benzath. pen. 2.4 MIU	vial	0.236	0.203	-16
Co-trimoxazole 480 mg	tablet	0.009	0.008	-9
Doxycycline 100 mg	tablet	0.008	0.008	-8
Metronidazole	injection	0.775	0.688	-13
Metronidazole tab 250 mg	tablet	0.004	0.004	-9
Subtotal Average				**-9**
ANTENATAL				
Tetanus vaccine .5 ml	injection	1.020	0.952	-7
Iron (tabs) 65 mg	tablet	0.002	0.002	-10
folic acid 5 mg	tablet	0.003	0.003	-9
Fansidar (tabs) 500/25 mg	tablet	0.020	0.019	-7
Subtotal Average				**-8**

TABLE 1. COMPARISON OF IRP AND BULK PRICES (CONTINUED)

COMMODITIES				
	Dosage	**IRP**	**Bulk Price**	**Variance (%)**
OBSTETRICS/NEONATAL				
Oxytocin 10/IU	ampoule	0.095	0.093	-2
Ergometrine injection	injection	0.158	0.140	-13
Ergometrine (tabs) .2 mg	tablet	0.013	0.009	-44
Subtotal Average				-20
OTHER				
Gloves (examination)	piece	0.025	0.025	-1
Gloves (surgical)	pair	0.160	0.153	-5
ORS 1000 ml	sachet	0.060	0.059	-1
Subtotal Average				**-2**
TOTAL AVERAGE				**-14**

As a next step—following the health minister's approval in 2005 to implement the CIB mechanism and proceed with the regional strategy—DELIVER is working with WAHO to put a CIB manager in place to help develop and manage a system design workshop that involves procurement managers from West African countries. The aim of the meeting is to identify operational procedures (e.g., design of reporting format, initial product list, and dissemination schedule), which will enable the flow of information between programs and a central database at WAHO. Concurrent to the CIB process, WAHO has hosted a series of three strategic planning workshops with program managers and other experts that resulted in a draft regional RHCS strategic plan to be presented for approval at the 2006 meeting of ECOWAS health ministers.

EASTERN EUROPE: CROSS FERTILIZATION OF REGIONAL SOLUTIONS

USAID, since the early 1990's, has been a leading partner in promoting family planning in Eastern Europe and Eurasia. This investment has been tremendously successful as countries that formerly banned family planning have promoted access to modern methods and consequently increased their CPR (table 2). While there have been notable regional successes, much work remains to be done. The region continues to face ongoing challenges and constraints to expanding access to and availability of family planning commodities and services. While abortion rates have declined, they remain among the highest in the world.

TABLE 2. SELECTED FAMILY PLANNING INDICATORS FOR EASTERN EUROPE

Country	Abortion Rate (per 1,000) Estimates 1997–2001	Modern Method CPR (%) (year)	Unmet Need for Contraception (%)
Romania	74	38 (2004)	39
Russia	80	53 (1999)	33
Azerbaijan	116	12 (2001)	53
Armenia	81	22 (2000)	52
Georgia	125	20 (1999)	44
Albania			68
Ukraine	55	38 (1999)	47

Source: CDC Presentation at the Ensuring Access to Family Planning Conference

Several key constraints affect CS in the region:

- declining populations and declining fertility rates contribute to a lack of political attention to FP as political leaders assume increased fertility is desired—FP will adversely affect this
- overuse of specialists in providing FP services—focus on pathology rather than prevention
- strong provider biases about different methods, misinformation, and a lack of independent information and continuing education for providers
- lack of attention to choice for consumers
- regulatory and financial constraints on the availability of contraceptives
- counterproductive incentives for providers to provide abortion as a leading method of fertility control
- lack of NGOs and limited tradition of public-sector provision of contraceptives
- limited access for the poor, vulnerable, and rural populations, in general
- limited donor commodity support.

Despite these challenges, a common Semashko[7] medical tradition, and the common problems of moving from centrally planned to market-driven economies provide ample opportunity for countries to learn from each other. One country in the region, Romania, had made a concerted effort to increase CPR as a way to address its high abortion and MMR (see box 2). These efforts provided countries with practical lessons learned and strategies for tackling impediments to expanded FP use. What was needed was a way to share these within the region.

7. This tradition was characterized by a uniform model of organizing health services, which was introduced in Soviet-bloc countries after World War II and was abolished in the early 1990's. Financing of health services was entirely through the state budget with publicly owned health care facilities and publicly provided services.

BOX 2. ROMANIA—A REGIONAL FAMILY PLANNING SUCCESS STORY

As Romania embarked on its ambitious program of expanding family planning coverage, it faced a dilemma in trying to increase the contraceptive prevalence rate (CPR). The high level of unmet need for modern contraceptives was coupled with a considerable difference in ability to pay and access between urban and rural areas. While there was a clear need for free public-sector contraceptives, the government did not have the resources to fund the needs of the whole country. Simultaneously, higher urban income levels and willingness to pay meant that private households and suppliers in pharmacies were already meeting the growing needs of the urban population. With one of the highest abortion rates in Europe, which contributed to the high maternal mortality, this was seen as an impediment to future accession to the European Union. Market segmentation analysis by the POLICY project was interpreted by DELIVER to show that free public supplies should be targeted at rural women through their local primary health clinics. This approach required the training of a new cohort of family planning providers: the general practice (GP) physicians who staff the rural clinics. In addition, a number of depressed urban centers were also targeted, leaving other urban centers to continue to be supplied by the private sector.

Increased availability of commodities in rural clinics was coupled with an information, education, and communication campaign, changes in regulations to allow provision by GPs, and a training program for rural GPs. Consequently, the CPR for modern methods has continued to grow from 29.5 percent in 1999 to 38.2 percent in 2004. Free contraception has not impaired the private sector. Between the first quarter of 2002 and third quarter of 2004, the number of oral pill users increased 44 percent from 223,000 to 322,000 in the private sector; while in the same period, users of free oral pills from the public sector increased tenfold, from 8,000 to 82,000. With donor support decreasing, public-sector contraceptives have been increasingly funded from a national budget line.

The Ensuring Access to Family Planning: Europe and Eurasia Regional Conference was held in Bucharest April 11–15, 2005. The conference resulted from a convergence of interest from USAID in Washington and from eight countries in the region to share experiences and lessons learned in moving FP forward in the region. Romania was chosen as the host because of the country's impressive performance in increasing contraceptive prevalence and reducing abortion and maternal mortality rates.

USAID-supported country teams from Albania, Armenia, Azerbaijan, Georgia, Russia, and Ukraine; they were joined by one team member from the USAID team in Serbia and Montenegro. USAID is supporting FP and maternal and child health programs in each country, although there is some variation in the length of time that this support has been provided. While these countries share many policy, health, family planning, cultural, and historical factors, all have adopted individual strategies to increasing access to FP in the last decade. The conference was an opportunity for participants to showcase their approaches and achievements in expanding FP, as well as to identify problems and priorities for action.

The workshop involved a mix of plenary and small group working sessions for country teams, open sessions on cross-cutting technical issues, and field visits to sites in Romania. Each country formulated a draft action plan based on the exchange of ideas at the event. They returned home with renewed interest in applying some of the lessons learned.

Subsequent to the workshop, bilateral delegations from Georgia, Russia, and Ukraine have visited Romania again, with an additional visit planned by a group from Kazakhstan. Because of the lessons learned

from Romania, the Georgian MOH reversed its policy of limiting FP service provision to a narrow group of specialists called *reproductologists*. The role of the private sector has also been highlighted, and strategies have been developed in several countries to work with manufacturers to continue to market low cost brands of oral contraceptives rather than establish subsidized social market programs. The Romanian example of targeting publicly provided contraceptives to specific population groups, while the private sector supplies the rest of the contraceptive market, is also being examined in Georgia and Ukraine.

USAID is supporting further exchanges and sharing of lessons learned through written case studies of activities in Romania and Russia. While it is too early to quantify the benefits of this intraregional exchange of ideas, the initial regional workshop has clearly stimulated an exchange of ideas and experiences that seems set to endure.

EAST AFRICA: BUILDING ON LOCAL EXPERIENCE

In November 2005, KfW, USAID, and UNFPA sponsored a regional CS workshop in East Africa. The goal of the workshop was to address the critical need of improving access to RH supplies and services for women and men in the region. Meeting participants represented diverse interests and needs influencing reproductive health CS. Country delegations from six East African countries—Ethiopia, Kenya, Malawi, Rwanda, Tanzania, and Uganda—included representatives from the ministries of health, ministries of finance (MOFs), social marketing organizations, NGOs, and private-sector service providers, as well as other reproductive health and family planning advocates.

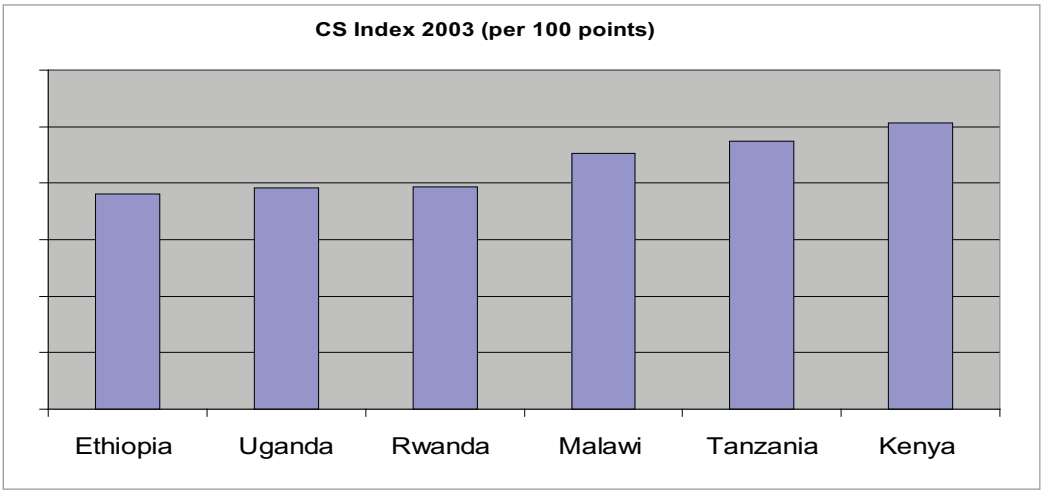
Ethiopia: Health worker in front of shelves stocked with contraceptives and anti-malarials.

The workshop was framed around several common issues and priorities that influence contraceptive availability in the region. Most notably, the high HIV prevalence is an important and unfortunate characteristic shared by countries in East Africa. Clearly, this factor necessitates a significant claim on health resources and policymakers' attention—yet it is often at the expense of family planning.

> *This workshop has come at the right time when most countries are trying to balance distributions… between family planning and HIV/AIDS.* - quote from participant

The East African countries also have relatively low CPR and high unmet need. CPR among married women ranges from about 6 percent to 32 percent and unmet need from 22 to 36 percent. The *Contraceptive Security Index 2003* (JSI/DELIVER and Futures Group/POLICY 2003) offers a snapshot of the CS situation in the six East African countries, combining 17 indicators related to supply chain, financing, health and social environment, access, and use issues. The six countries are all close, in the range of about 40 to 50 on a 100 point scale see (figure 3).

FIGURE 3. CONTRACEPTIVE SECURITY INDEX SCORES FOR EAST AFRICAN COUNTRIES



These similarities, with other prevailing issues, such as institutional capacity and health sector reform (decentralization, integration), were the foundation for the workshop. The workshop highlighted five key themes associated with RHCS common in the region:

- the role of RHCS in achieving health outcomes and Millennium Development Goals (MDGs)
- maximizing resources through financing and procurement
- a whole market approach to achieving the public health mandate
- transforming systems—how recent paradigm shifts affect RHCS
- the bottom line—clients access to knowledge, services, and products.

Inherent in each were the cross-cutting themes of HIV/AIDS, human capacity issues, and logistics and supply chain management.

The workshop incorporated a number of approaches to facilitate the exchange of ideas and to ensure that the event yielded results. The first approach was to build on existing efforts. Some of the countries had made more progress in CS than others, and had already developed plans and strategies. To avoid duplicated efforts, the workshop built on any existing CS strategies. For example, Rwanda has an active CS committee and had developed an MOH CS plan. The Rwanda team developed activities that could be implemented, and they facilitated discussions between the MOH and the social marketing sector, as well as shared their experience with a broader audience.

The second approach was to allow country teams to learn from each other. Dr. Catherine Sanga, head of the reproductive and child health section at the Tanzanian MOH, shared Tanzania's experience of using government funds to procure contraceptives. These experiences proved very timely and helpful for the other participating countries. In her presentation, Dr. Sanga showcased the MOH commitment to fund and procure a significant amount of the country's contraceptive requirements, a commitment that has grown from $1.5 million for injectables in 2002–2003 to $6.9 million for injectables, pills, and implants in 2005–2006. Key lessons learned by the Tanzania MOH are that (1) the annual procurement requirement and plan is a powerful tool when advocating for funds, (2) regular joint annual planning is crucial for ensuring accountability among partners, and (3) it is possible for governments to fund commodities.

However, Dr. Sanga also noted that financing was not the only barrier to securing an adequate supply of contraceptives. One of the major challenges encountered by the MOH is *turning cash into contraceptives*, which requires improved governmental capacity for managing complex procurement procedures.

The third approach was to emphasize intra-country dialogue. One of the obvious strengths of a regional workshop is that it provides an opportunity for the participating countries to learn and share with each other. Not only did this workshop provide regional sharing opportunities, it also allowed for discussion strengthening within each of the countries. For example, despite their similar mandates, many of the country participants (social marketing, Ministry of Finance, advocacy representatives) have few opportunities to meet and share their perspectives and contributions to CS. Ensuring diverse representation from each country resulted in stronger and more comprehensive country CS plans. For example, one priority action area identified by the Uganda country team is the uneven distribution system below the district level to the service delivery points (SDPs)—in many districts only an ad hoc system is in place. The team agreed to four interventions to improve distribution: strengthen supervision through targeted interventions; engage and empower communities to demand availability of RH supplies; improve district planning and managerial skills; and strengthen zero tolerance for stockouts at the district, health subdistrict, and SDP levels. This strategy required the input of policymakers, logisticians and service delivery representatives, and community-based organizations.

> Uganda faced condom shortages in 2004 and 2005 due to concerns over the quality of condoms being distributed in the country. Approximately 10 million public sector condoms were withdrawn from the market because of their odor; part of the government's response was to require post-shipment testing for all condoms distributed in the country. This meant that NGOs and social marketing organizations distributing condoms were required to carry out further testing on their products despite the fact that they were manufactured to international ISO quality standards, and no suitable laboratory in Uganda could perform the testing. The result was shortages all over the country while regulations were clarified, and arrangements were made to equip a national laboratory to carry out required analyses.

The fourth and final approach was to leverage the power of collaboration. Coordination and partnership among the three major donors was often challenging in terms of ensuring a harmonized approach to addressing CS in the region. Yet, for each challenge, there was a corresponding benefit to the regional approach; it was clear the impact far outweighed any difficulties. Most important, the leadership of these three donors in CS sent a strong message about the importance of RHCS to countries. The collaboration of UNFPA, KfW, and USAID supported the overall CS approach of multisectoral commitment and donor coordination, and resulted in benefits and lessons learned at the country, regional, and global levels. In addition, the involvement of three donors helped extend the weight and reach of the workshop because each donor engaged a unique set of stakeholders, which ensured diversity in participation. While it was difficult to engage the right people from each of these groups and to meet their varying expectations and needs, the diversity gained through multi-donor sponsorship resulted in expanded discussions and forged new relationships. In fact, as a result of the positive experience and results in East Africa

> *I learned that some problems were regional issues, but each country was at a different stage in terms of tackling the challenges.* - quote from participant

> *The country/Africa focus of the meeting was critical for sharing experiences that have regional relevance.* - quote from participant

and the identified need in West Africa, KfW, UNFPA, and USAID plan to sponsor a similar activity in West Africa in 2006.

One of the biggest challenges of the East Africa workshop was ensuring that the momentum continued within the respective countries. Each of the country teams committed to a series of next steps within their own country. The extent of this continuation varies considerably from country to country because of different levels of donor involvement, the existence and involvement of a CS champion, and so on. Again, this is one of the challenges of a multi-donor sponsored activity where country participants are not held accountable to one organization. Despite these challenges, countries have made measurable progress since November 2005.

For example, within one month of the East Africa RHCS Workshop, the MOH Health and Technical Support Services in Malawi organized a Malawi CS workshop that brought together an expanded group of stakeholders to share findings from the regional workshop and to obtain consensus on the main issues, strategies to address those issues, and what the next steps should be to strengthen CS. Particular emphasis focused on the significant policy changes that are predicted to impact CS in Malawi. The most significant is the introduction of a SWAp mechanism for funding the health sector. Malawi also faces other major challenges to ensuring CS, including a lack of capacity for supply chain functions; hiring, training, and retention of staff at all levels; and an underdeveloped private sector.

In part, as a result of their participation in the East Africa RHCS workshop, the Uganda team has continued their in-country CS strategies. Team representatives have met with and engaged the broader family planning community, and are using the regional workshop to reinvigorate their monthly CS working group meetings and action tasks. In June 2006, the RHCS group developed procedures and responsibilities for routine information sharing, analysis, and reporting on stock status, product distribution, shipments, facility ordering, and issues at facility level.

CONCLUSION

Many of these regional approaches have yielded tangible results, as countries discover that their challenges are not unique and that proven solutions do exist. One of the most important factors common to all the regional activities is that they allow for peer-to-peer exchange between experts and policymakers from the participating countries. This exchange provides international recognition for the difficult work they are undertaking, on the one hand; and the motivation to address challenges that once seemed insurmountable on the other. Regional CS approaches are essential tools in building in-country support for CS and in sharing lessons learned in strengthening CS.

5. COMMITMENT AND COORDINATION

Commitment is the foundation for all improvements in contraceptive security. It begins with the top levels of government and extends down to the lower levels, other stakeholders, program managers, and opinion leaders. That commitment must be translated into concrete action, which must be coordinated among all stakeholders to ensure a coherent response. While commitment without coordination will achieve some results, there will likely be wasted resources and gaps in coverage. And, coordination without commitment will result in little more than frustration and opportunities lost. Therefore, commitment and coordination must go hand-in-hand, and in most cases, are mutually reinforcing, as strong commitment facilitates effective coordination and effective coordination gives rise to stronger commitment.

Sogakope, Ghana: DELIVER staff at the Meeting the Commodity Challenge, May 2002.

COMMITMENT

Commitment is needed not just from the highest leadership of a country, but also at other levels of the public sector and from civil society. In this respect, commitment needs to be understood as part of the broader sociocultural context in a country. Various indicators demonstrate this through concrete actions commitment to contraceptive security (CS) and family planning.

These include—

- strong national policies containing explicit support for the right of all people to plan their families
- earmarked and protected budget line items for commodity procurement

Commitment by top country leadership, when manifested through concrete actions, can ensure continued donor support. Benin faced many problems in ensuring commodity availability—a weak public-sector supply chain led to major stockouts of all contraceptive methods over a several years. In 2005, a new Minister of Health provided, for the first time, budget support of about U.S.$100,000 a year for three years for contraceptive procurement. This galvanized donors to increase their support for procurement. Currently, UNFPA, USAID, KfW (through social marketing), and IPPF, with the Ministry of Health, are providing funds for commodities and technical assistance to strengthen the entire supply chain to ensure that commodities get to users.

- reference to CS and to access to family planning services in other major policy documents, such as poverty reduction strategy papers (PRSPs).

It is important to remember that commitment does not end with the top levels of leadership. Advocacy efforts may need to continue to ensure support for CS and family planning at all levels. Where health management is decentralized, with increasing power devolving to lower levels of government, this lower-level advocacy takes on added significance. In many developing countries, support for family planning and CS at lower levels of government and among service providers may be, at best, lukewarm, and at worst, may even amount to opposition. In that situation, it is important to continue advocacy efforts. In Madagascar, advocacy continued after the President of the Republic had come out with public support for CS. In West Africa and Southeast Asia, DELIVER has helped facilitate efforts to bring together media, parliamentarians, and program managers to discuss CS issues, and to encourage coordinated advocacy to all levels of society in their countries. In some cases, service providers and local health officials have made a strong commitment to family planning in the face of ambivalence (Kazakhstan) or outright resistance (Philippines) toward family planning at the national level.

COORDINATION

Coordination is an essential element in achieving CS, and nowhere is that truer than in coordinating the sources of supply. To be effective, contraceptive supply chains must include many partners working together to ensure that commodities are available to all who need them. To reduce the likelihood of waste, duplication of resources, or contradictory decisions; coordination between partners ensures efficient and optimal utilization of often limited resources. Coordination is needed at many levels, including—

- the central level between the different sources of commodities, such as ministries, UNFPA, USAID, IPPF, and social marketing organizations
- internationally between donors
- among the various sectors providing products and services: public, nongovernmental organizations (NGO), faith-based, social marketing, and private (commercial)
- among various technical agencies supporting CS and family planning.

For many years, DELIVER has promoted coordination through its technical assistance for supply chains (see box 3). Forecasting and quantification for contraceptives and other commodities is typically done at a national level for all programs—not just for USAID-funded procurements. The results of quantification exercises are shared with all stakeholders, particularly donors and other procurers, so that procurement planning becomes a coordinated exercise. The *PipeLine* software that DELIVER uses for procurement planning contains information from as many procurers as possible to ensure coordination and avoid over- and understocks. Ministries of Health are encouraged as part of their stewardship role to oversee procurements, consumption, and stock levels for all programs. Procurement is not the only area that needs coordination, but it is the most common reason for establishing a coordination mechanism, and often results in a regular forum that facilitates communication and information sharing between stakeholders on other relevant topics.

BOX 3. WORKSHOP IN WEST AFRICA LINKS PARTNERS

The contraceptive security (CS) situation in many West African countries is fragile at best. Low prevalence—often less than 10 percent for modern methods, high unmet need, weak supply chains, limited financing, low education levels (particularly for women), and lack of commitment for family planning at all levels of society called for coordinated action to increase awareness of the importance of CS. In 2005, working with Africa Consultants International (ACI), a development organization with experience strengthening the capacity of journalists to report on HIV/AIDS, DELIVER helped conduct a workshop that brought together news media, parliamentarians, and technical people from five countries in the region—Burkina Faso, Côte d'Ivoire, Mali, Mauritania, and Senegal. The objective was to create links between these partners and encourage the sharing of information to lead to better promotion of CS and family planning by news professionals and parliamentarians. Since that event, there have been country-specific events. For instance, in Mali, a national mass media and information, education, and communication campaign to promote family planning was facilitated by this effort, with most national newspapers featuring articles about family planning and CS, written by journalists who had attended the regional workshop or a subsequent national follow-on event. The ultimate goal of these types of activities is to build commitment for CS and family planning at all levels of society.

A key lesson learned by DELIVER in strengthening contraceptive security at the country level—or in decentralized countries, at the subnational level—is the necessity to create a CS committee to bring together stakeholders involved in contraceptive procurement or provision (see box 4). These groups have many names—CS committee, family planning technical working groups, steering committees—but all share certain similarities. They include a wide variety of stakeholders representing the various sectors, programs, and partners involved in providing family planning products or services.

BOX 4.TYPICAL COMPOSITION OF A CONTRACEPTIVE SECURITY COMMITTEE

Typically, a contraceptive security committee may include the following stakeholders:

- Public sector:
  - Family planning directorate
  - Pharmaceutical directorate
  - Central medical stores (CMSs) (may be independent of the MOH)
  - Procurement unit (may be part of CMS)
  - Ministry of Finance (often not a regular attendee but presence is desirable).
- International partners:
  - Multilateral donors: e.g., UNFPA, other UN agencies, World Bank, etc.
  - Bilateral donors: e.g., USAID, DFID, KfW, JICA, etc.
- Technical agencies:
  - Social marketing organizations, other agencies involved in supply chain, service provision, etc.
- Private sector:
  - Nongovernmental organizations
  - Faith-based service providers
  - Representatives of service provider professional associations (midwives, pharmacists, doctors)
  - Representatives of private wholesalers and distributors.

The exact composition of a committee will depend on the country context and the willingness of partners to become involved. Some structures may only need to be represented on an occasional basis; for example, the national drug registration authority may need to be present when new product registration issues are involved but, perhaps, not regularly.

DELIVER's experience with these committees has provided a number of useful lessons learned for the norms and procedures in creating and running them:

1. Committees are not necessarily formal, legal, or legislative authority. In fact, they may be better created as an informal coordinating body with the mandate to share information and achieve consensus through cooperation and agreement. The MOH will always retain decision-making authority; trying to give these committees statutory powers or status can be an extremely time-consuming process and can create the perception that they might usurp powers. A more informal body can be created quickly and is more likely to be acceptable to all stakeholders.

2. While the status of the committee may be informal, it should have formal, well-understood procedural norms. For example, it is important to have a regularly scheduled meeting (for example, the first Friday of the month); minutes should be kept and circulated in a timely manner; a secretary should be appointed and held responsible for calling meetings and circulating agendas; and the role of meeting chair should be defined (although this may rotate).

3. The leadership of the committee will usually rest with the public sector, although this does not preclude other stakeholders taking an informal lead in other areas (convening meetings, for example).

4. The committee should be multisectoral, with a broad representation.

5. It may be necessary to have a smaller *working committee* with technical representatives that meet regularly (monthly, for example), as well as a larger committee with higher-level policymakers that may meet less often (once or twice a year) to review broader policy-level recommendations.

6. Subcommittees may be convened around specific technical areas, such as procurement and logistics, service delivery, behavior change communication (BCC); and information, education, and communication (IEC), and so forth.

7. It should be clear that the MOH has the final say in approving any recommendations made by the committee.

The scope of the committee may be as broad or as narrow as the committee desires. The following are examples of the types of activities that have been used successfully in the countries where DELIVER works:

- overseeing the CS strategic process: developing, approving, implementing, and monitoring CS plans
- facilitating annual (or biannual) country forecasting and quantification exercises
- providing a forum for stakeholders to regularly share information on procurements, consumption, and stock levels

- providing technical guidance for a broad range of technical activities—for example, developing capacity at a central medical store (CMS), introducing a new product to the market, or conducting pricing studies.

The main role of the committee is coordination (rather than executive decision making); sharing information and concerns, and providing a forum for discussion and consensus building (see box 5). In some cases, it may not be necessary to create a new body because a structure may already be in place that can also consider CS issues as part of an existing mandate.

BOX 5. GHANA MOH AND PARTNERS DEVELOP STRATEGY TO ENSURE LONG-TERM CONTRACEPTIVE SECURITY

Ghana has seen a rapid growth in contraceptive prevalence in a situation where all commodities were provided by donors. In 2002, the MOH and partners decided to develop a strategy to address current and long-term commodity supply. As a first step, the ministry, with USAID support, convened a workshop that brought stakeholders together, including several other ministries, donors, nongovernmental organizations, and technical agencies. In addition to raising awareness about contraceptive security in Ghana and building consensus on priority issues, the workshop created the Interagency Coordination Committee for Contraceptive Security (ICC/CS).

The Family Planning Coordinator in the MOH Reproductive and Child Health Unit (RCHU) was elected to lead the ICC/CS in the full development of a national strategy, to monitor the progress of other stakeholders, and to coordinate with other relevant partners involved in the process. Membership in the ICC/CS includes individuals from the RCHU, Public Health Division, Supplies Directorate, private manufacturers and distributors, and other partners.

In 2003, the ICC/CS formed a smaller technical working group among its members to complete the development of a national CS strategy. The responsibilities of this group were to carry forward the issues identified in the workshop, promote collaboration and communication, and integrate the strategy into the Ministry's Program of Work. The group remains active today in monitoring implementation of the strategy, coordinating forecasts and quantifications, and developing a financial sustainability plan for contraceptives.

Of course, coordination is about more than creating a CS committee. But, in most cases, the creation and operation of a committee is the essential first step in fostering coordination and cooperation. The very act of providing a regular forum for partners from various sectors to come together to discuss issues of common interest can create an environment where partners work together to enhance CS and provide family planning and reproductive health products and services. Similarly, the lack of will to establish a committee can be symptomatic of broader problems of commitment or willingness to engage the wider community of stakeholders involved in CS. For example, Bangladesh's failure to form a CS task force has undermined CS gains and resulted in tensions that continue today between the MOH and the Social Marketing Company (SMC), which is one of the largest and most effective social marketing organizations in the world.

In some countries, particular problems for coordination in creating linkages exist between the public and private sectors—NGO, faith-based organization (FBO), social marketing, and commercial companies. Partners on both sides may not see the need to work together, there may be mutual suspicions, and sectors

may see their role as competing for the same customers rather than complementing each other to satisfy the whole market. Some groups may be reluctant to share information or allow outsiders to scrutinize public- or private-sector activities. By encouraging dialogue, CS committees foster cooperation. Other concrete strategies to improve cooperation include—

- encourage sharing commodities during shortages (coordinated procurement planning and use of PipeLine databases can help accomplish this)
- establish common standard treatment guidelines
- conduct joint training—for example, private-sector providers participating in public-sector trainings.

CONCLUSION

For contraceptive security to improve in any resource-constrained country, there must be commitment by leaders at many levels of government and society, and coordination among all sectors that have a stake in family planning services. With sufficient commitment, the poorest and most vulnerable people will have access to contraceptives, while the private sector will serve the needs of those who can afford to buy their products. With effective coordination, the limited resources available to national programs and NGOs will be used efficiently enough to consistently meet the needs of all people who rely on them for their contraceptive needs.

6. POLICY CONTEXT

This chapter outlines how policies impact contraceptive security (CS), and includes concrete examples from countries where DELIVER has worked. Changing policies takes time and effort, and while it is important to develop initiatives to address policy change, it is also important to work within an existing policy environment. DELIVER's work means that we are usually involved in adapting to existing policies and regulations rather than actively trying to change them. Therefore, this chapter will—

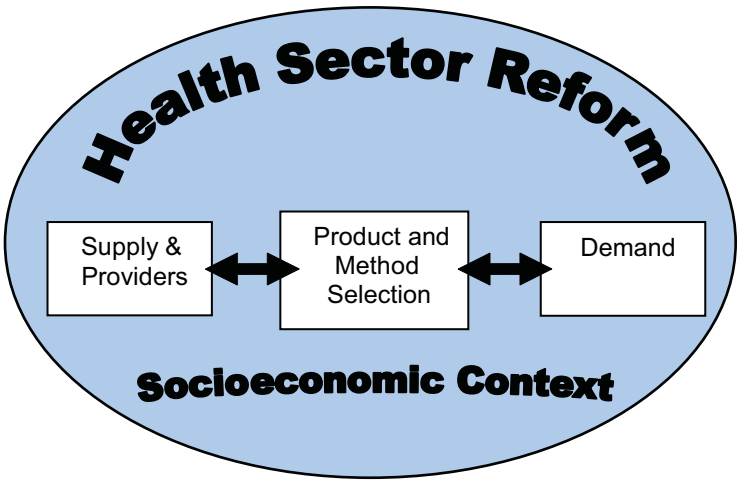
- offer a framework for assessing the policy environment as it impacts contraceptive security
- provide practical examples of DELIVER's policy work in developing countries
- suggest ways in which programs can overcome or take advantage of policies and regulations to improve contraceptive security.

POLICY FRAMEWORK

We adopted a simple framework (figure 4) to organize logically the issues that need to be considered in assessing the policy environment. The framework is intended only as a guide, to help us think systematically about the issues. We divided the policy issues into four categories:

- product (or method)
- supply and provider
- demand
- health sector reform.

FIGURE 4. POLICY FRAMEWORK



PRODUCT-RELATED POLICY ISSUES

These policy issues directly impact the types, brands, and prices of the contraceptives and other reproductive health commodities on the market. Standard treatment guidelines pertain to methods, rather than

specific products, but we include them here for simplicity. There are six major categories of product-related policies:

- product registration
- product quality
- presence of a product on other *lists*: national essential medicines list; supplier approvals, prequalification, and so forth; and standard treatment guidelines
- patents/proprietary issues
- tariffs, duties, and other importation issues
- pricing policies and regulations.

PRODUCT REGISTRATION

Most countries have a drug registration authority, usually a government agency responsible for regulating the pharmaceutical products that can be legally sold in that country. They review product registration dossiers, approve products for marketing, and monitor post-approval marketing, including post-market surveillance and changes in labeling. Many countries where DELIVER works have limited capacity to evaluate drug registration dossiers. The process can be time-consuming and slow. Demands for country-specific labeling can add expense and time to the process of getting a product into a market. One of the recommendations DELIVER made as part of a study to develop a regional approach for CS in West Africa (Rao, Mellon, and Sarley, 2006) was to introduce regional drug registration; given the small size of many of the contraceptive markets in the region, new manufacturers may be reluctant to register their products in those countries. The costs of registration in small markets were cited as a barrier to entry by contraceptive manufacturers participating in the East African Regional Contraceptive Security workshop in 2005. Central American countries are exploring the scope for harmonized drug registration as part of the Central American Free Trade Agreement.

PRODUCT QUALITY

In addition to product registration, a mechanism should be in place to ensure the quality of specific batches of products that arrive in a country. Most countries have a National Quality Control Laboratory with the power to sample and test products for purity and potency. The capacity for countries to ensure the drug quality varies considerably from country to country; many countries either subcontract this testing to third parties or accept manufacturer certificates of analysis. However, countries will usually reserve the right to test products at any time. Lack of clear policies in this area, or the absence of clear application of those policies, can seriously impact CS when problems arise. Products may be held for several months awaiting adjudication. Donors that provide financing for procurement, but do not procure directly, may require assurance of product quality before allowing procurement from a particular manufacturer. The sourcing of generic products from new pharmaceutical manufacturers based in developing countries, for example India and China, offers significant potential for developing countries to cut their costs and improve financial sustainability. The challenge is to access these cheaper products while ensuring product quality. Countries with limited capacity can consider a number of options, including accepting international standards such as the U.S. Food and Drug Administration (FDA) or the European Medicines Agency (EMEA), the EU's drug regulatory authority. Manufacturers should be able to demonstrate good manufacturing practice (GMP) and International Organization for Standardization (ISO) certification. Inspections by international organizations, such as the International Dispensary Association (IDA), can

also provide some endorsement. Another option would be to consider a CIB approach involving the Internet-based exchange of information on supplier performance.

ESSENTIAL MEDICINES LISTS AND DRUG BENEFITS LISTS

Inclusion on essential medicines lists (EMLs) is usually a prerequisite for public procurement of pharmaceuticals, including contraceptives. Experience has shown that contraceptives are not always consistently included on the EML. This may be because family planning was not seen as a priority when the EML was drawn up or because World Health Organization (WHO) best practice for rational pharmaceutical management requires the specification of generic formulations of drugs—excluding contraceptive brand names. Medical devices, such as IUDs and condoms, are also frequently excluded from EMLs because they are not medicines.

In *Benin*, the essential medicines list (EML) list includes levonorgestrol implants, but only a single brand, Norplant. The manufacturer of Norplant is discontinuing the product; if Benin wants to continue to offer implants, they will need to choose a new implant. It is not clear if any replacement implant, in addition to obtaining product registration, would need to be added to the EML list as a specialty.

Other lists can help determine product availability. For instance, in Malawi, there is a separate essential health package medicines list that includes the medicines that can be procured under the SWAp mechanism in that country. The most recent list (active as of the end of 2005) included no female condoms and only one implant, Norplant, which is being discontinued by its manufacturer.

In Kazakhstan, four types of contraceptives are included in the EML, but they are excluded from the outpatient drug benefit package, which is intended to limit free drug provision to priority interventions. This has limited the scope of local health authorities to purchase contraceptives for their vulnerable populations. In South America, where health insurance exists in many countries, adding contraceptives to the health insurance drug benefit package is a prerequisite for enabling the mobilization of health insurance funds.

Standard treatment guidelines (STGs) list the preferred drug (and nondrug) treatment regimens for a health system. Specific contraceptive methods may or may not be recommended for particular situations. In many countries, IUDs are restricted—in many cases against current WHO recommendations—based on STGs that were developed from older guidelines or incorrect information.

In addition to these country lists, international donors have restrictions on the products that they can supply; these can also have implications for CS. For instance, USAID has long-term contracts with certain manufacturers, and will only supply products from that manufacturer. Normally, USAID will require manufacturers to have FDA approval; which precludes many developing world manufacturers, given the investment in time and resources needed to get that approval. UNFPA is more flexible but still requires ISO 9000 certification and sometimes site visits (Armand 2006). Countries, many from the developing world, wishing to procure from generic manufacturers, will often need to procure those products themselves. Many donors, for example KfW, are more flexible in the products they will fund, provided programs can provide assurance of the product quality.

While, currently, there is no WHO prequalification scheme for contraceptives, the current program for HIV/AIDS commodities—primarily antiretroviral (ARV) drugs and HIV test kits—includes a number of *reproductive health commodities* (UNFPA 2005). This precludes the use of Global Fund and United

Nations money to procure commodities that have not been prequalified. The future trend is likely to be toward increased scope for prequalification of contraceptives, although this will depend on additional funding being made available to WHO to undertake prequalification assessments.

PATENTS AND PROPRIETARY ISSUES

Currently, no significant issues exist for most reproductive health commodities, including contraceptives. ARV drugs for preventing mother-to-child transmission (PMTCT) programs may be impacted, and countries may be required to invoke the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) to freely procure these commodities.

TARIFFS, DUTIES, AND OTHER IMPORTATION ISSUES

The costs and effort involved in importing contraceptives can be substantial. They are affected by import tariffs, other duties, port charges, and taxes, such as value added taxes (VAT). They can also be affected by import regulations and the need for an import license. World Trade Organization (WTO) reforms have tried to reduce tariff and non-tariff barriers to trade, but barriers still remain. While donated commodities often get waivers from import duties, there are exceptions. In Kazakhstan, the government required that the contraceptives USAID donated had to be registered, and also required that a registered importer had to bring them into the country with an individual import license for the shipment. Future regulations will require that generic products demonstrate certificates of bioequivalence as a further precondition for importation.

Table 3 summarizes the duty/tariff VAT and transport costs identified in nine Latin American countries (Sarley et al. 2006). This shows that import duty varies across the region: in some countries, the government is exempt; in others, nonprofit NGOs are exempt; but in other countries, neither are exempt. The same is true of VAT exemptions.

TABLE 3. COSTS ASSOCIATED WITH TRANSPORTATION, DUTIES/TARIFFS, AND VALUE ADDED TAX

	Duty/Tariff (%)		Value Added Tax		Transport
Country	Public	Nonprofit	Public	Nonprofit	(%)
Bolivia	<15	<15	No	Yes	NA
Chile	5–10		Yes	Yes	3.5
Ecuador	NA	NA	No	Yes	<1.0
Paraguay	<5	NA	No	Yes	NA
Peru	5–10	<5	Yes	Yes	2.7*
Dominican Republic	<15	<15	No	Yes	NA
El Salvador	<5	5–10	Yes	Yes	NA
Honduras	NA	NA	No	Yes	6.5**
Nicaragua	NA	NA	No	Yes	5.4**
* public-sector ** nonprofit sector					

When countries apply VAT as part of their fiscal system, exempting contraceptives from VAT is a powerful indicator of the importance afforded to family planning in national policy priorities.

PRICING POLICIES AND REGULATIONS

Pricing needs to be considered for all products and in all sectors. Governments sometimes control prices, not just in the public sector but also in the NGO and private (commercial) sectors. Pricing can impact both consumer access to products and their availability, as markets may not make products available if profit margins are too low, or if prices are so high that there is little demand (see box 6). Pricing controls may restrict the ability to have a well-segmented market with different price points for different sectors targeting different clients. That said, the main obstacle to improving CS through increased private-sector participation, particularly in sub-Saharan Africa, is not price controls but limited purchasing power, thus making markets unattractive to commercial manufacturers. It is also important to look beyond pricing policies to actual practices. In many countries, providers may overcharge for products or for related services such as costs for consultations, for inserting IUDS or implants, or for an injection. Often, providers are unaware of official pricing guidelines; in other cases, they ignore them.

BOX 6. MALI REGULATES PRICES FOR COMMODITIES

To increase access to commodities, many countries keep prices low. However, if prices are too low, there may not be enough incentives for channels to distribute them. *Mali* regulates prices in the public and NGO/social marketing sectors. Contraceptive prices in the public sector were so low compared to other essential drugs that facilities had little financial incentive to stock them. Margins were increased for contraceptives to overcome this problem. However, price controls on social marketing products made it difficult for social marketers to differentiate their products from the public sector and provide incentives to their distribution channels. The MOH opposed price increases in the social marketing sector, arguing that it ran counter to its goal of increasing access. The social marketing sector was unable to communicate their arguments effectively for increases based on the creation of a differentiated, segmented market, and perceived ability to pay.

SUPPLY SIDE ISSUES

We examine five supply issues that impact product availability and accessibility:

- supply chain
- outlets and provider registration
- prescription/dispensing policies
- human resources at the service delivery level
- integration/referrals and family planning services.

SUPPLY CHAIN ISSUES

Specific technical issues that impact supply chains will be considered more completely in chapter 11 on logistics. However, specific policy issues may need to be considered, particularly for private-sector distribution. In many developing countries, there may not be adequate distribution networks for the private

sector. Often, social marketing organizations created their own distribution channel to get their products to outlets, adding to the expense of doing business.

SERVICE DELIVERY POINTS

In many developing countries, the absence of outlets for contraceptives is the major obstacle to access for the clients. Many people live too far from public health centers to obtain contraceptives on a regular basis, or not enough private-sector outlets are available to allow them access to private supplies. Part of the problem may be general restrictions on private business, which can include rules and regulations on opening a private-sector clinic or pharmacy and the costs of complying with government regulations. Restrictions on who can open and operate a facility contribute to limited private-sector participation and decreased contraceptive security. In Bangladesh, government regulations on the registration of private-sector clinics were originally intended to provide some quality control. They failed to do this because the regulations focused on regulating service inputs, including the size of the facility and equipment present, without focusing on the actual quality of care provided. Furthermore, opportunities for government inspectors to require unofficial payments have led many private clinics to avoid official registration (Health Economics Unit Research Note No.15 1998).

Bangladesh: Customer buying condoms in a drug store.

PRESCRIBING AND DISPENSING

Most countries restrict the personnel allowed to prescribe and dispense most contraceptives, including hormonal methods. These rules are intended to ensure that only properly qualified and trained staff provide services but often they are unnecessarily restrictive. The acute shortage of pharmacists and doctors in developing countries means that some of these rules are the greatest barriers to access. This can be particularly true for private-sector practice. In many cases, doctors can only prescribe and pharmacists can only dispense, meaning that private-sector clients face extra time and cost in obtaining supplies. This issue has been one of the major obstacles countries have faced in expanding community-based distribution of contraceptives. When CBD agents can only distribute condoms, their effectiveness is constrained. The widespread popularity of IUDs in countries, such as the Philippines and Pakistan, may be attributed in part to the fact that trained midwives are allowed to insert them.

In *Rwanda*, public- and private-sector clinics with trained medical staff, but no pharmacist, are not allowed to dispense oral contraceptives. Pharmacists are not allowed to dispense injectables, and district hospitals are the lowest-level facilities allowed to dispense or provide the whole range of family planning products and services available in the country. This affects client access, as it reduces the number of service delivery points from which commodities can be dispensed.

See box 7 for more information about the effects of the provider's lack of training.

HUMAN RESOURCES

Human resources refers to both the quantity and the quality of staff available at the service delivery level, and includes a diverse range of issues, from training of staff to regulations on who can carry out certain procedures or dispense particular methods (see prescribing above). Policies that do not train, hire, and retain adequate professionals for FP service delivery and other technical areas, such as the supply chain, cannot achieve CS. In many countries, inadequate attention is paid to contraceptive technology in training for medical staff. Efforts to revitalize long-term methods, such as the IUD and implants, have identified inadequate training as a key factor in limiting the popularity of those methods. Inadequate training, resulting in poor management of side effects, can negatively impact the perception of certain products.

Georgia initially proposed restricting family planning service provision to specially trained reproductologists. A study tour to review Romania's successfully expanded rural general practice-based family planning services led to a change of policy allowing Georgian general practitioners to provide family planning services.

BOX 7. SOME PROVIDERS MAY LACK TRAINING IN MANAGING SIDE EFFECTS

In Benin, Depo-Provera is very unpopular with public-sector providers and hence clients. Among the complaints made are that the product makes clients sterile. Yet, Noristerat, a closely related product, with a similar side effects profile, is by far the most popular product in the same country; and Depo-Provera is popular in neighboring countries. At least some of this fear can be attributed to lack of training of providers and consequent poor management of side effects. Branded Depo-Provera is socially marketed in the country, and the social marketing program is concerned about the negative impact of these rumors on their sales. And, because some donors only provide Depo-Provera and not Noristerat, the public sector must procure this product themselves or rely exclusively on a single donor.

INTEGRATION/REFERRALS OF FAMILY PLANNING SERVICES

Access to FP products and services can be greatly increased if there is an efficient system of either referrals from other services or actual integration of those services. Significant synergies can be gained by integrating some programs. For instance, it may be desirable for effective HIV/AIDS services, such as voluntary counseling and treatment (VCT) and preventing mother-to-child transmission (PMTCT), to include information on family planning and provide products at the point of service. Some FP programs are trying to leverage the increased funding for HIV/AIDS programs by integrating family planning into these programs. Integration and referrals work in both directions and family planning customer services can be improved by referrals to other programs.

DEMAND ISSUES

The level of unmet need in developing countries points to a significant problem in that people want to limit or space their families but are unable to do so. While many of the problems are supply-related, many others can be linked to a lack of awareness, lack of education, and lack of information about products or services.

Some of the major demand-related issues that create problems for contraceptive security are—

- advertising of products and methods
- information, education, and communication and behavior change communication (IEC/BCC).

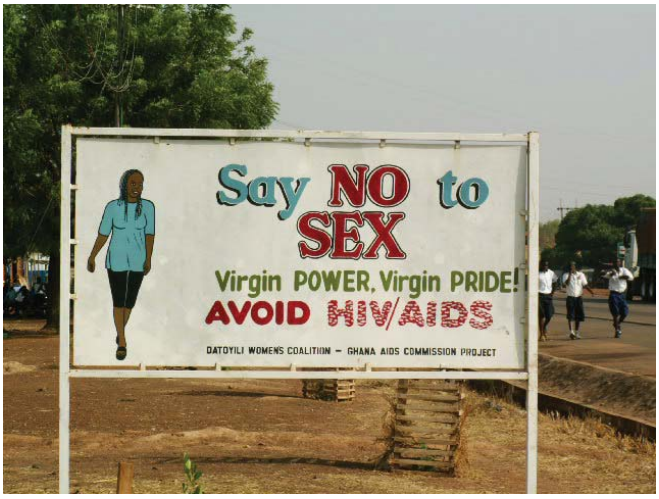
ADVERTISING

Most countries restrict advertising of pharmaceutical products, including most contraceptives. Pharmaceutical companies and distributors may be reluctant to fund method-specific advertising thinking that it may help their competitors as much as themselves. Even where brand-specific advertising is allowed—condoms, for instance— governments or even donors may impose significant restrictions on the content of the advertisements. These rules are usually unwritten and may reflect societal mores and standards. In some instances, advertising is required to be so vague that it is not clear what is being advertised. On the other hand, rules on brand-specific advertising may not be enforced: in many countries, social marketing organizations have advertised hormonal contraceptives without drawing censure.

Addressing these issues is important where social marketing and commercial market solutions are important components of contraceptive security. Working with local stakeholders, including community and private-sector leaders and local politicians, can be an effective way to build support.

INFORMATION, EDUCATION, AND COMMUNICATION, AND BEHAVIOR CHANGE COMMUNICATION

Apart from mass media advertising, peer education and community mobilization campaigns offer messages and communication concerning family planning and contraceptives. Restrictions—both formal and informal—may be imposed on these types of messages. One of the strongest predictors of contraceptive prevalence is girls' education. Countries where female education levels are low often have low prevalence (and high unmet need). Low female education and low female status in society lead to a lack of contraceptive security. Programs can design IEC/BCC campaigns taking into account broader socio-cultural issues; for example, many campaigns in patriarchal societies target men or other decision makers such as mothers-in-law.



Ghana: Billboard in Tamale, Ghana, promotes abstinence.

ISSUES RELATED TO HEALTH SECTOR REFORM

In the drive to reform the public sectors of developing countries, the health sector in particular, continues. The goals of reform for the health sector are to improve the quality, equity, and financial sustainability of services and to increase access. Health sector reform creates particular issues for contraceptive security, to such an extent that, in this paper, we consider them as a separate category. Four major reforms are worthy of attention:

- integration of contraceptive supply chains with essential drugs and other commodities
- cost recovery
- sectorwide approaches to financing
- decentralization.

Tanzania integrated the supply chain for contraceptives into essential drugs between 1999 and 2000. While the contraceptive supply chain was working reasonably well, the potential cost savings that could be achieved through integration with a well-functioning system for essential drugs was a major motivator. By mid-2000, distribution costs for contraceptives had decreased by 58 percent (Sanga 2001) over the previous year, and contraceptive stockout rates had decreased from 27 percent in 1996 to 11 percent by the end of 1999. Integration improved the overall sustainability of the supply chain for both contraceptives and essential drugs.

INTEGRATION OF CONTRACEPTIVE SUPPLY CHAINS WITH ESSENTIAL DRUGS

The integration of vertical contraceptive supply chains with larger essential drug systems continues to occur in many countries. Integration can have both positive and negative impacts on CS. Long term, integration can improve CS as investments strengthen national supply chains for all commodities. However, short term, it can create problems, as the process of integration disrupts existing roles and management structures, and staff need to learn new procedures.

The Tanzania example demonstrates how integration into an existing, well-functioning supply chain can improve CS and reduce costs. While simply investing in a vertical program could potentially produce even better results for indicators like product availability, it would be highly unlikely that it could do so more efficiently. Integration makes sense from a financial sustainability point of view. Of course, integration is not a fixed point, but rather a continuum. The integration of physical processes like storage and transportation can be accompanied by a degree of vertical program oversight and management to ensure product availability. DELIVER supports the MOH to oversee contraceptive distribution—forecasting, procurement, and distribution—as part of both integrated and vertical supply chains. The process of integration requires good preparation and planning to ensure success.

Ghana's contraceptive security strategy identified the need for more research on ability and willingness to pay (ATP) for contraceptives to help set price points. On the basis of subsequent ATP analysis, opportunities were identified to increase some prices in the public and social marketing sectors and thereby enhance program sustainability.

COST RECOVERY

One of the goals of the Bamako Initiative[8] reforms was to increase the sustainability of health systems and cost recovery; having users pay for a portion of the goods or services they receive was one way to achieve that goal. Cost recovery in the public sector is a reality in most developing countries and it has an impact on CS. On the positive side, it can enhance sustainability, enabling facilities to improve the services they offer and providing funding for procurement through revolving drug funds. On the negative side, it can decrease access to products.

In most countries where DELIVER works, prices are usually set sufficiently low to allow access for most of the population. However, low-income groups may be negatively impacted and, in most cases, waiver schemes for the poor are ineffective. This impact may be more significant for contraceptives, often perceived as a discretionary spending item, as opposed to other medicines for acute care. The positive impact of cost recovery schemes are often harder to discern. Often, contraceptives are donated, which means acquisition prices are low and, therefore, so are the margins. Facilities have relatively little incentive to stock contraceptives because more profit can be made on other essential drugs. Some countries collect a portion of returns on pharmaceutical sales and use that money to fund procurement. Often follow-up for these funds is insufficient to ensure that they are used for their intended purpose. Many of the CS assessments DELIVER participated in have identified the need for country-level research to identify consumer willingness and ability to pay (ATP) for contraceptives. Subsequent CS strategies have validated this need and identified partners to fund or carry out the work. The need for financial sustainability must be balanced with concerns that price increases may negatively impact access, recognizing the many difficulties associated with waiver schemes.

SECTOR-WIDE APPROACHES TO FINANCING

Many of the countries where DELIVER works are moving from a situation in which donors earmark funding for vertical health programs to one in which they provide funding to a common *basket*, which is then allocated by the ministry according to predetermined priorities. In many countries, family planning and CS are strongly driven by donors, leading to concerns that they may receive reduced attention in a basket funding situation. Even where donors do not pool their funding in a SWAp basket, their funds are included in the basket planning (see box 8).

The movement to SWAps provides an opportunity for advocates to increase government support for contraceptive security. The process needs to be closely managed to ensure contraceptives and family planning continues to receive support, particularly during the transition period, a time usually characterized by uncertainty and confusion.

8. The Bamako Initiative, launched in Bamako, Mali, in 1987 by UNICEF and WHO, sought to improve maternal and child health in Africa through more equitable access to quality health care and a more efficient use of resources.

BOX 8. MALAWI IMPLEMENTS SECTOR WIDE APPROACH

Malawi began implementing a sector wide approach (SWAp) in 2005, and included most health sector donors—MOH, DFID, NORAD, WHO, World Bank, and UNFPA. Funding priorities are determined by the Essential Health Package (EHP), which outlines a packet of activities to be funded, with priorities and an associated list of commodities. Donors that do not pool their funds in the SWAp are included for planning purpose, e.g., USAID commitment to contraceptive procurement (part of the EHP) is included in financial planning by the SWAp secretariat at the ministry. As part of the transition to the SWAp during 2005 and 2006, DELIVER advocated for special donor funding to ensure commodities were available during the transition period. This was important because part of the SWAp meant the MOH would procure its own contraceptives, something it had not done before, and, therefore, required a significant period of time to become operational. The DELIVER office has worked closely with the SWAp secretariat, providing detailed forecasts for commodity requirements.

DECENTRALIZATION

The movement to devolve power to lower levels in public administration creates both opportunities and challenges for CS. Decentralization in health systems typically pushes varying degrees of responsibility for management functions from the central to the district or even facility level. The degree of decentralization varies between functions and between countries, and significant differences exist between policy and practice. While decentralization can be beneficial, it poses significant challenges, particularly where capacity is low. In some respects, decentralization runs counter to many global trends for logistics systems, where greater efficiencies can be obtained by centralizing decision making; for example, in areas such as procurement and information systems. In some countries, procurement has been decentralized, leading to increases in commodity costs when the high-volume purchasing is lost.

In decentralized environments, advocacy for CS at lower levels becomes even more critical and needs to be targeted to a larger number of decision makers. Local decision makers may not consider family planning a priority or may be susceptible to forces actively opposed to modern methods. On the other hand, they may prove to be active and engaged partners in CS; in the Indonesian example (see box 9), development of CS strategies at the district level led to strengthened advocacy from the districts to the central level for CS. Similarly in the Philippines, local districts took active ownership of CS with decentralization and forged stronger partnerships with NGOs and the private sector at the local level.

BOX 9. INDONESIA DEVELOPED ADVOCACY AND PLANNING TOOL

Indonesia devolved authority for its family planning program to more than 400 districts in 2002. For the first time, local authorities were expected to forecast, procure, and distribute contraceptives and ensure quality services. Working with the Indonesian Family Planning Coordination Board, DELIVER developed a district contraceptive security (CS) advocacy and planning tool, based on the SPARHCS framework. The authorities used the tool to assess CS in two districts and to develop strategic plans to improve CS. Among the achievements of this effort were agreement of an Indonesian-specific definition of CS, establishment and funding of local budget lines for contraceptives, better targeting of free public contraceptives, introduction of expanded fees for service public provision, expansion of private provision through more streamlined procedures for establishing pharmacies, stronger partnerships between pharmacies and private service providers, and standardization of private provider fees.

In Kazakhstan, management decision making for health budgets has been devolved to the regional and district level, subject to national health policy priorities. National procurement laws now govern the purchasing of drugs and contraceptives now being undertaken by *oblast* (regional) health administrations and *rayon* (district) hospitals. Public procurement for hospital inpatients can only include drugs on the essential medicines list (EML). The EML includes three types of oral pills and spermicide, but no condoms or IUDs, because these are medical devices, not injectables or implants. There are, however, very few inpatient clients for contraceptives. Most maternity cases are advised to adopt the lactational amenorrhea method (LAM) as their postpartum contraceptive method. For outpatients, the outpatient drug benefits list defines the commodities that can be procured and provided free of charge to clients. National priority is given to diabetes, tuberculosis, oncology, and the health of children under five years old. Because contraceptives are not technically included, public-sector contraceptives cannot be procured and provided free of charge to the poor and vulnerable groups. While the private sector is well developed and provides a good method mix at a wide range of prices, key groups in the population are still vulnerable and cannot afford to pay for their contraceptives.

One advantage of decentralized decision making is that, while FP may not be seen as a national priority, it is seen as a priority in at least 8 out of the 15 regions in Kazakhstan. Several have identified loopholes in the national procurement regulations that allow them to procure the contraceptive methods their clients need. These have included using discretionary funds in the budget (3–5 percent), asking for special permission after priority drug purchases have been made, and buying contraceptives for hospitals but dispensing them to outpatients through attached polyclinics. While this helps solve a short-term problem, in the long term FP needs to be included as a priority for vulnerable groups in the outpatient drug benefit package. Work is needed with national-level policymakers to highlight the link between FP, reductions in abortions, and reductions in both the MMR and IMR. The latter are crucial components in Kazakhstan's attempt to reach its Millennium Development Goals, and they have been recognized by the President. The importance of FP for spacing and limiting the number of births needs to be stressed, with the importance of FP for reducing the number of abortions and its adverse impact of too many abortions increasing cases of infertility.

CONCLUSION

Policies affect every element of contraceptive security, from product selection to where, how, and by whom a particular contraceptive method can be provided. Policies affect the cost of contraceptives, whether in the private sector or from public sources. Policies affect demand, both for family planning products and services in general, and for specific contraceptive methods. And, policies themselves are driven by the context in which health care is provided. Health sector reform has introduced many changes in policies that have affected health care delivery and the supply chain on which it depends. Done right, these changes can greatly enhance contraceptive security. The following chapters present some of the practical approaches that are needed to ensure that reforms result in policies that promote greater contraceptive security.

7. TOTAL MARKET APPROACH

WHAT IS A TOTAL MARKET APPROACH?

In USAID's Ready Lessons series (USAID 2004) the whole or total market approach to contraceptive security (CS) is defined as—

> *A coordinated approach that responds to the multiplicity of family planning needs in a country will ensure that the entire market of clients—from those who require free supplies to those who can and will pay for commercial products—is covered. This will avoid overlapping efforts, inefficient use of resources, and goals that are neither agreed upon or defined.*

Policymakers in developing countries have the challenging mandate of achieving family planning (FP) goals in an environment of competing priorities and limited resources. Traditionally, when developing strategies, they have focused only on the important contribution of public-sector services. Explicit consideration has not always been given to *use trends* and the current and potential impact of other sectors' contributions to these goals.

Market segmentation analysis can help policymakers examine the supply and demand data for the entire FP market (total market, also known as whole market). The findings can provide important information to government planners interested in improving the efficiency and effectiveness of national resource allocations and improving equity, as well as an opening for improved public- and private-sector coordination. Market segmentation is an important tool for increased contraceptive prevalence rate (CPR) and for attaining Millennium Development Goals (MDG) goals for reducing maternal mortality rate (MMR) and infant mortality rate (IMR) (see box 10).

BOX 10. PREMISE: HOW BETTER COORDINATION AND MARKET SEGMENTATION CAN IMPROVE CS EFFICIENCY

By definition, each type of contraceptive provider has a different comparative advantage in providing contraceptive methods. That is, each supplier can provide some methods relatively more efficiently and more effectively than other methods. Efficiency can be measured in terms of the unit cost of commodities or services provided, while effectiveness can be gauged from the number of clients served. If providers focus on the services in which they have a comparative advantage, then the amount of contraceptive commodities and services supplied to clients can increase. This requires an understanding of the strengths and weaknesses of different providers and coordination between them to avoid overlap and duplication.

The need for a total market approach to CS is based on two observations and one premise:

- Contraceptive users obtain their methods from a variety of public, private commercial, and nongovernmental organization (NGO) sources.
- Different providers typically have different strengths and weaknesses in providing different methods.
- Better coordination between providers can improve the efficiency of service and product delivery, reduce wastage, and ensure that more clients are served.

For example, male users of condoms in many countries are more likely to pay for them at private pharmacies or retail outlets than to obtain them free at public family planning clinics. Simultaneously, long-term and permanent methods are often more likely to be provided at public-sector clinics than private clinics. Should the public sector continue to spend scarce resources providing free condoms to all clients, or should it focus more resources on providing long-term and permanent methods that are not widely available elsewhere?

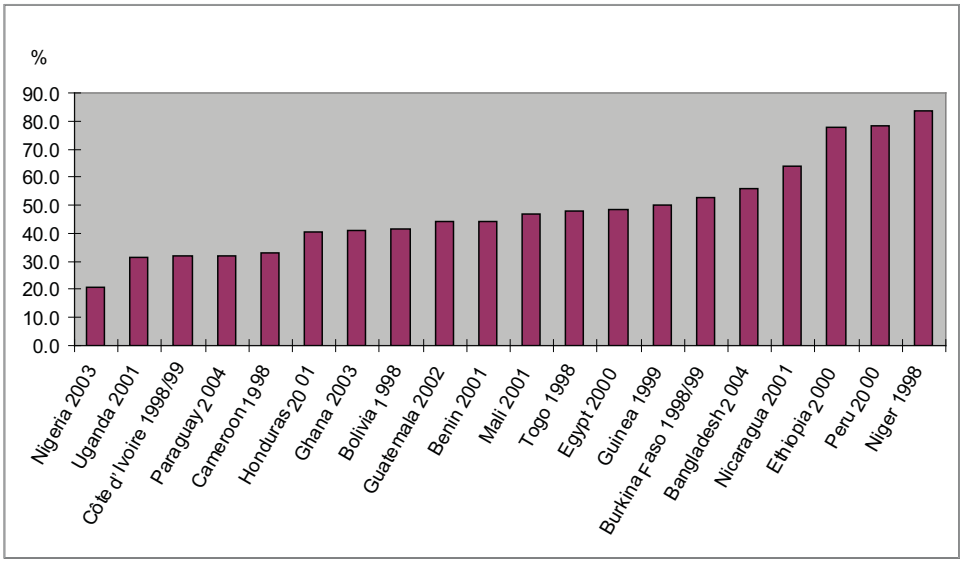
To address this question requires an understanding of how the contraceptive market is segmented. Who is served by the public sector? Do some clients need contraceptives but can't afford to pay for them? Do some potential clients for contraceptives not receive them? Why? Where are they? Do some clients who can afford to pay for their contraceptive methods obtain them for free or subsidized prices?

Market segmentation analysis of Demographic Health Surveys (DHS) or reproductive health survey data can be the basis for answering these questions. Different contraceptive market segments can be defined according to the method used; the source of that method; and the economic status, educational level, geographic location, and age of the user. In the remainder of this section, results are highlighted from recent market segmentation analyses. Evidence is then presented to improve the targeting of free contraceptives. Alternative strategies are then given for ensuring that a total market approach can deliver improved contraceptive market efficiency.

MARKETS ARE ALREADY SEGMENTED

Most developing countries already have a mix of public, NGO, social marketing, and commercial suppliers providing contraceptives to different segments of the FP market. Figure 5 shows that, for a cross section of 20 countries, the public sector can account for a wide range of total CPR, from only 20 percent in Nigeria to 84 percent in Niger. Just over one-half of the 20 countries analyzed show a more balanced mix, with between 40 to 60 percent of supply provided by the public sector. How much of this variation in the segmentation between the public and private sectors is the result of a deliberate policy, rather than public-sector neglect?

FIGURE 5. PERCENTAGE OF CONTRACEPTIVE PREVALENCE RATE PROVIDED BY THE PUBLIC SECTOR



To better address this question, we classify the countries that were analyzed depending on—

- whether they have been encouraging or restrictive of the private sector, and
- whether their public sectors has been more or less successful in meeting FP client needs.

Table 4 is divided into five groups of countries:

1. *Countries with a public-sector failure and virtually no private sector.* These countries are characterized by very high public-sector share (greater than 75 percent) in the supply of modern contraceptives but very low CPR and high unmet need. Typically, the public sector is failing to meet the needs of its population while a lack of economic purchasing power, combined with a discouraging policy environment, has left little room for the private sector to contribute. The emphasis in these countries should be on improving public-sector provision while exploring ways to encourage a greater contribution from the private sector.
2. *Countries with both public- and private-sector failure.* In these countries, the private-sector contribution to total modern contraceptive is greater than the countries in the example above, but total CPR remains low and unmet need high. This includes countries where the private sector dominates but CPR is less than 10 percent, such as Nigeria, Côte d'Ivoire, and Cameroon. The public sector is failing to reach vulnerable groups, while the private sector is typically only reaching urban elites. Improved public- and private-sector performance is required for these countries, with the public sector identifying and targeting services to vulnerable groups, while doing more to encourage the private sector.
3. *Countries with improved public- and private-sector performance but still high unmet need.* This group has higher CPR, greater than 18 percent but less than 35 percent, and a more balanced contribution from the public and private sectors, but still shows very high unmet need. In this group, the private sector is the largest source of supply and is typically meeting the needs of the richer urban population. The public sector is also making an important contribution but may be missing key vulnerable populations. Market segmentation strategies for these countries should focus on reaching more of

the poor and vulnerable populations with public-sector programs while coordinating and encouraging the private sector further. Interestingly, unmet need for Ghana and Togo is higher than in the countries that show public- and private-sector failure, perhaps reflecting less awareness of FP in the latter.

4. *Successful countries with market balance.* These countries are characterized by higher modern method CPR, a balanced public- and private-sector contribution, and lower unmet need. While these countries have done better in meeting the needs of their populations, there is still scope for improvement with better coordination between public- and private-sector providers. This may mean better targeting of public-sector methods to meet persistently high unmet need, as in Paraguay, or defining an even bigger role for the private sector as the public sector targets services to vulnerable groups, as in Bangladesh.

5. The final group of countries represents an interesting group. *Countries with a public sector–dominated success story demonstrate high CPR*, primarily attained by strong public-sector contraceptive provision and relatively lower unmet need. The key for these countries is that there is still double-digit unmet need and, clearly, the very successful public-sector programs are not reaching the entire population. In Niger, for example, only 12 percent of public-sector methods are reaching the poorest 40 percent of the population (see figure 6). Better targeting of public methods to the poor would improve this percentage but would require a larger contribution from the private sector. In Peru, the strong success of the public sector poses another issue: what would happen if political objectives changed, and family planning became less of a priority? Could the private sector, presently providing only 12 percent of modern methods, do more?

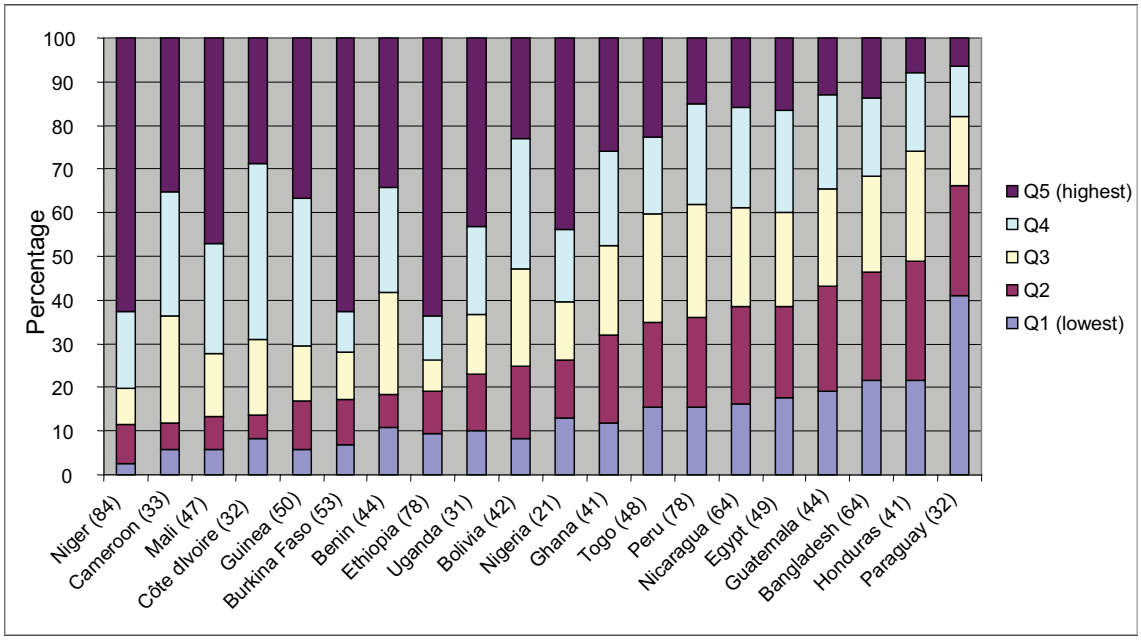
TABLE 4. CLASSIFICATION OF THE RELATIVE CONTRIBUTION OF THE PUBLIC AND PRIVATE SECTORS

Country and Survey Year	Percentage Public Sector	CPR	Unmet Need
Public-sector Failure and Virtually No Private Sector			
Ethiopia 2000	77.5	6.3	35.8
Niger 1998	83.5	4.6	n.a.
Private and Public-sector Failure			
Nigeria 2003	20.9	8.2	17.4
Côte d'Ivoire 1998/99	31.8	7.3	27.7
Cameroon 1998	33.0	7.1	19.7
Benin 2001	44.3	7.2	27.2
Mali 2001	47.1	7.0	28.5
Togo 1998	48.0	7.0	32.3
Guinea 1999	49.9	4.2	24.2
Burkina Faso 1998/99	53.0	4.8	25.8

TABLE 4. CLASSIFICATION OF THE RELATIVE CONTRIBUTION OF THE PUBLIC AND PRIVATE SECTORS (CONTINUED)

Country and Survey Year	Percentage Public Sector	CPR	Unmet Need
Improved Public- and Private-sector Performance but Still High Unmet Need			
Uganda 2001	31.2	18.2	32.3
Ghana 2003	40.9	18.7	34.0
Bolivia 1998	41.5	25.2	26.1
Guatemala 2002	44.1	34.4	23.1
Even Better Public/Private Performance			
Paraguay 2004	31.8	61.0	19.9
Honduras 2001	40.7	50.9	11.2
Egypt 2000	48.6	53.9	10.7
Bangladesh 2004	56.0	47.3	11.0
Public Sector–dominated Success Stories			
Nicaragua 2001	63.9	66.1	14.7
Peru 2000	78.3	50.4	10.2

FIGURE 6. SOCIOECONOMIC PROFILE OF PUBLIC-SECTOR FAMILY PLANNING USERS



IMPROVING THE TARGETING OF FREE AND SUBSIDIZED CONTRACEPTIVES

With limited resources, public-sector FP products and services should focus on or target the poorest and most vulnerable in the population; typically, people who for economic, geographic, social, cultural, and other reasons do not have access to contraceptives from the private sector. Evidence suggests that unless specific attention is given to meeting the needs of the poor (Karim et al. 2004), public service provision can actually be skewed toward wealthier groups. Figure 6 provides a comparison of the socioeconomic profile of public-sector FP users in 20 developing countries. From an analysis of DHS data, the figure categorizes public-sector FP users based on a standard wealth index derived from respondent information. The bracketed number next to each country is the share of methods originating from the public sector.

We would typically expect poorer quintiles (Q1 and Q2) to have less access from the private sector because of their reduced ATP. Depending on where the poverty line is defined in each country, well-targeted public FP programs should seek to serve clients in the bottom two or three quintiles. In the majority of the countries analyzed, the poorest 40 percent are getting access to less than 40 percent of public-sector FP commodities and services.

In fact, in only four out of the 20 countries analyzed do the poorest 40 percent have access to 40 percent or more of public-sector services. In Niger, 80 percent of public FP services and commodities go to the wealthiest 40 percent; while in Mali, Côte d'Ivoire, Guinea, Burkina Faso, and Ethiopia, 70 percent go to the wealthiest 40 percent. These countries are failing to provide public services to their poorest populations. This public-sector failure is compounded where the private sector is also failing to deliver services and commodities (see table 4 earlier in chapter).

Figure 7 provides two cross plots: the first plot shows the correlation between total CPR and public-sector targeting, and the second plot shows the difference between CPR disparity and public-sector targeting. The higher the disparity ratio, the lower the difference between the CPR for the richest and poorest quintile, and the more equity in contraceptive use; the higher the public-sector targeting ratio, the greater the share of public-sector methods going to the poorest population.

FIGURE 7. CORRELATION BETWEEN EQUITY IN CONTRACEPTIVE USE AND PUBLIC SECTOR TARGETING

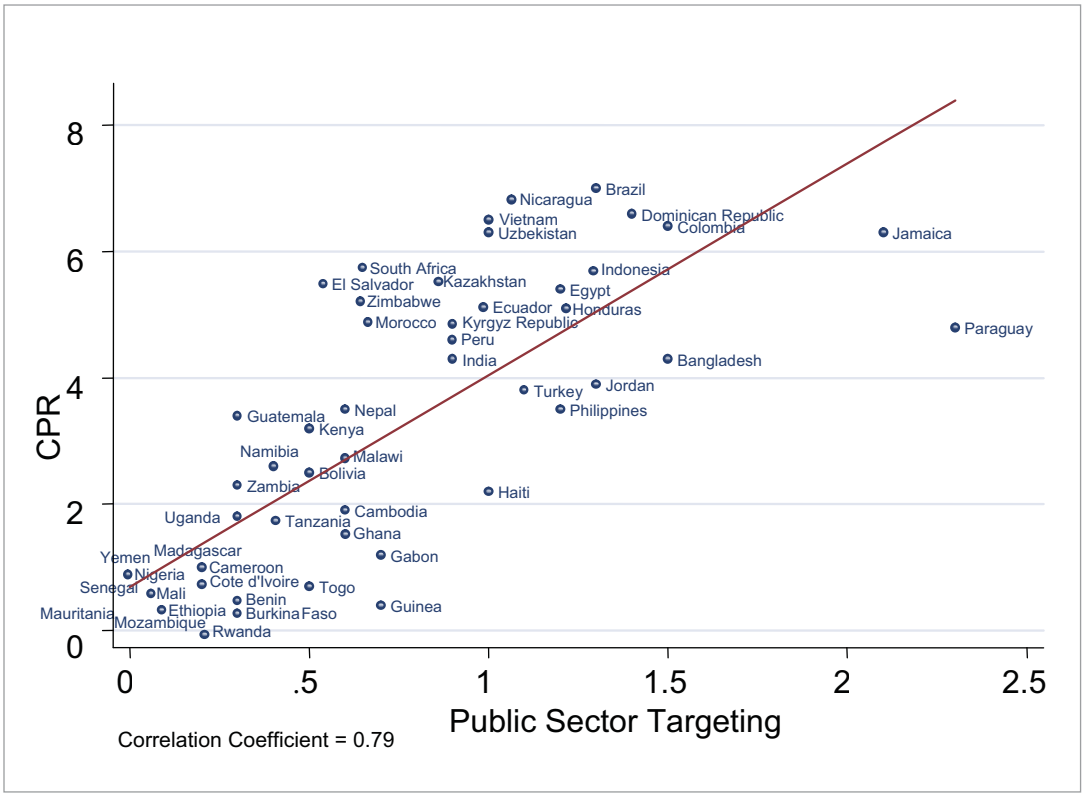
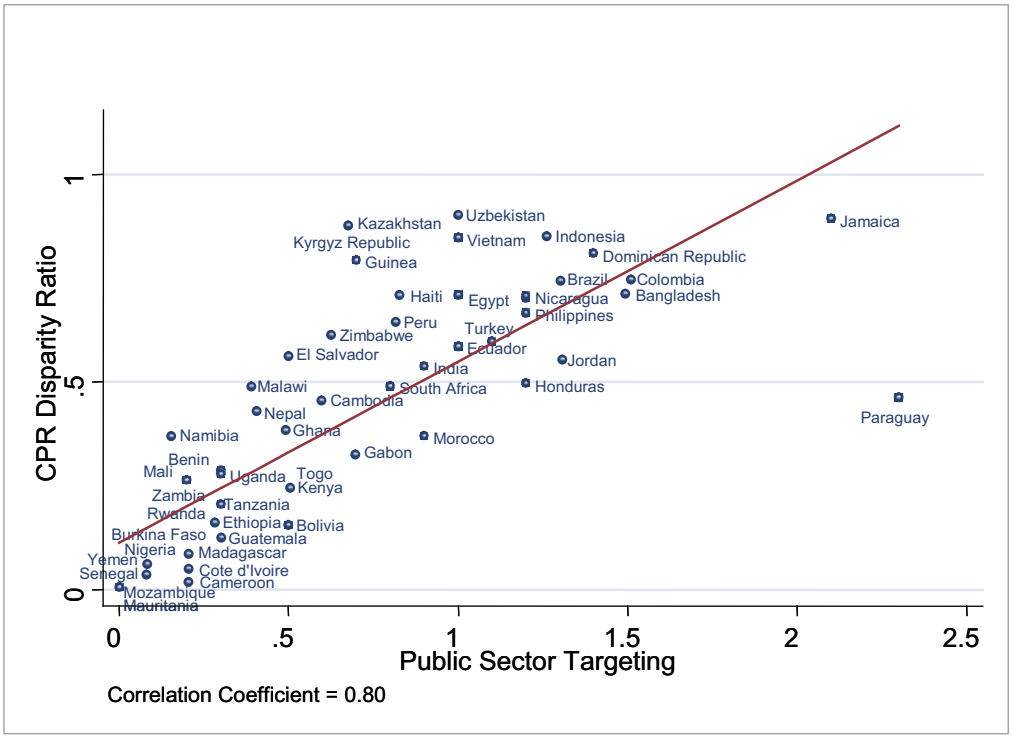


Figure 8 shows a direct correlation between the public-sector's success in reaching the poor, improved equity in contraceptive use, and higher overall CPR. Countries where the public sector does better in meeting the needs of the poor also do better in ensuring access to all groups and in increasing their CPR. Conversely, countries that do worse in targeting the needs of the poor typically witness greater inequality between rich and poor and have a lower overall CPR rate.

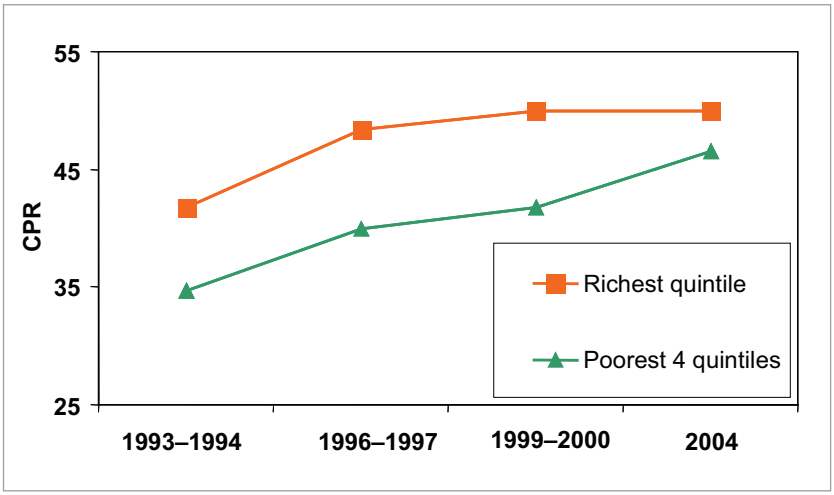
FIGURE 8. CORRELATION BETWEEN EQUITY IN CONTRACEPTIVE USE AND PUBLIC SECTOR TARGETING



Countries, such as Bangladesh, Jamaica, Paraguay, Colombia and Honduras, all demonstrate more effective targeting, lower CPR disparity, and higher overall CPR. In contrast, Mali, Rwanda, Niger, Burkina Faso, Ethiopia, and Cameroon all show lower levels of targeting, higher CPR disparity, and lower overall CPR.

If countries can improve their targeting of public subsidies to the poorest and most vulnerable groups, they can increase their overall CPR. This is illustrated in figure 9 (Dowling and Sarley 2004), which maps DHS data for Bangladesh (Karim, Sarley, and Hudgins 2006) on the evolution of CPR by quintile, over time. It shows both that CPR is converging for all the quintiles and that much of the overall increase in CPR in the period has come from increases in the CPR for the poorest quintiles.

FIGURE 9. CONVERGENCE IN CONTRACEPTIVE PREVALENCE RATE IN BANGLADESH 1993 TO 2004



MARKET SEGMENTATION CASE STUDIES

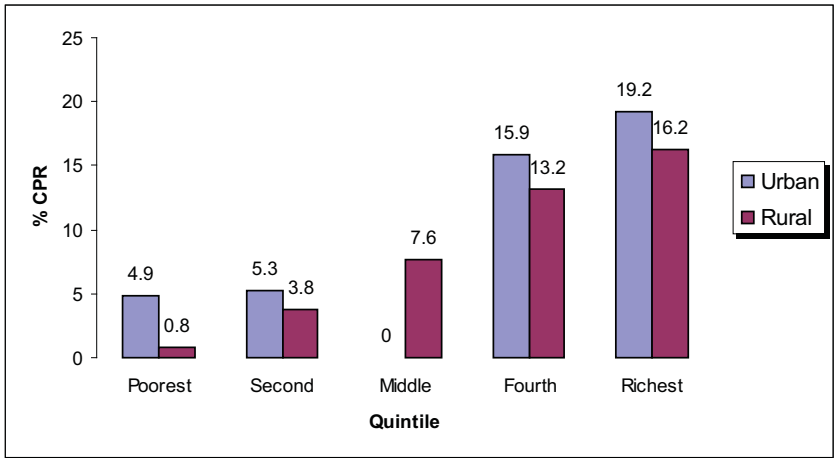
Detailed market segmentation studies have been undertaken for an increasing number of countries. In this section, we focus on results from four studies completed by DELIVER for countries with varying public- and private-sector performance.

MALI: PUBLIC- AND PRIVATE-SECTOR FAILURE

Despite years of support from the Government of Mali, international donors, and NGOs, the contraceptive prevalence rate in Mali remains low, at less than 7 percent (Cellule de Planification et de Statistique du Ministerè de la Santè et al. 2001). Growth in the use of modern contraception has stalled, unmet need is still high, and fertility and maternal mortality rates show no signs of decreasing. Donors are seeking more cost recovery to boost sustainability, while the high levels of unmet need suggest failures in service delivery and product availability. According to the official government contraceptive security plan (Ministère de la Santé, Republique du Mali 2003), the percentage of contraceptive costs to be covered by the state is planned to increase from zero in 2001 to 75 percent in 2011. The total cost to the state for this 10-year plan is more than $32 million, based on projected annual increases in contraceptive prevalence of between 10 and 15 percent, depending on the method. At the same time, there is a strong desire within the government to boost prevalence by reducing contraceptive prices in line with recent decreases in the price of some essential medicines.

Mali has some fundamental problems with contraception, such as service quality, access to products and services, and lack of information. Nonetheless, market segmentation holds some promise for improving accessibility and prevalence, allowing greater sustainability and contraceptive security. As figure 10 shows, despite low overall prevalence, some market segments have significantly higher uptakes. For instance, urban women from the highest income quintile have a CPR of more than 17 percent; for urban males in the same quintile, CPR is 20 percent. In contrast, CPR for rural women in the lowest income quintile is less than 1 percent (Gwatkin et al. 2000). An estimated 50 percent of users in Mali belong to the richest quintile and about 90 percent belong to the top three quintiles. The irony of contraceptive uptake in Mali is that the group with the highest uptake, the group profiting the most from subsidies, is the group with the highest purchasing power.

FIGURE 10. CONTRACEPTIVE PREVALENCE RATE BY QUINTILE FOR WOMEN OF REPRODUCTIVE AGE MALI, 1995–1996



In assessing ATP for different income quintiles in Mali, figure 11 (showing the share of total income captured by each income quintile) and table 5 suggest that higher income groups have an ATP more for contraceptive commodities, and some evidence indicates that they would also be willing to pay more. A rule of thumb adopted by social marketing groups is to consider contraceptive spending up to 1 percent of household expenditure as being affordable. While this simplified rule does not take into account personal preference or the lack of disposable income among poor and rural groups, a 0.5 to 1 percent range can be used to gauge affordability.

FIGURE 11. INCOME DISTRIBUTION IN MALI

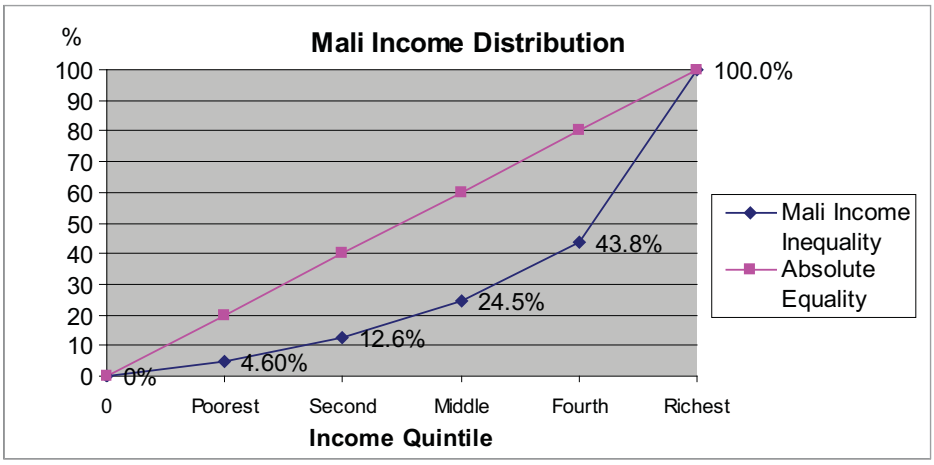


TABLE 5. ESTIMATED ANNUAL COST OF COUPLE YEARS OF PROTECTION AS A PERCENTAGE OF HOUSEHOLD INCOME FOR POOREST AND RICHEST DECILES BY PRODUCT, 2002

	Decile	
	Poorest	**Richest**
Estimated Household Income	$241	$5,406
Products	**Annual Cost as a Percentage of Income**	
Condoms	1.41	0.06
Pills (Pilplan-d)	1.06	0.05
Injection (Confiance)	0.84	0.02

While the current prices being charged for commodities may not be a significant obstacle to uptake for the rest of the population (except, in some cases, for the lowest quintile), any price increases for these groups could lead to cost becoming a factor in non-uptake.

How can more of the commodity cost be extracted from current users who have an ability—and probably a willingness—to pay more, while still ensuring that products remain affordable to lower-income quintiles, most of whom are currently nonusers? Public-sector services should continue to supply currently available products at prices the same as or close to those currently being charged by social marketing programs. The introduction of newer, differentiated products at more expensive prices that would appeal to higher income groups would allow greater cost recovery and sustainability. These products can then be used to cross-subsidize current products for lower income groups. It is possible, with product presentation and packaging, to introduce a differentiated condom; this approach has been tried, with apparent success, in neighboring Ghana. For hormonal products, the situation is more complex, as a newer product would need to be a new dosage form, raising issues of equity if access were restricted to those with greater ability to pay (ATP).

While increasing prices may seem inconsistent with increasing CPR, the reality in Mali is that service and commodity delivery failure in the public and private sectors are bigger constraints. Improving the quality and reach of services from the private and public sectors is a priority, and greater flexibility for the private and social marketing sector to increase prices would help increase the attractiveness and sustainability of the market.

GHANA: IMPROVED PUBLIC- AND PRIVATE-SECTOR PERFORMANCE AND TARGETING UNMET NEED

An important objective of Ghana's 2003 national CS strategy was the identification and utilization of sustainable financing mechanisms to address increasing demand and reduce unmet need. Part of this strategy has included the increased use of health funds and taxation revenue to support contraceptive procurements. This approach has been partially effective by helping to close the short- and medium-term financing gap for contraceptives. However, CS decision makers also recognized that they needed a well-segmented contraceptive market that would enable them to target scarce public-sector resources toward FP services for the poor and underserved by encouraging wealthier clients to use the commercial market.

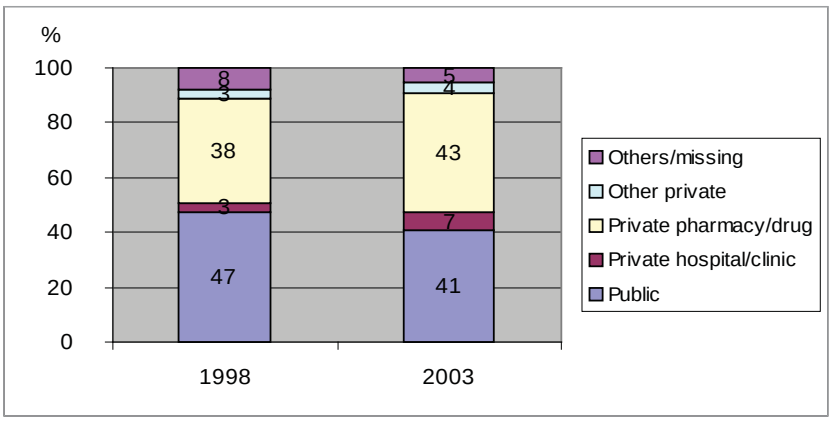
Ghana can be characterized as showing improved public- and private-sector performance but with substantial unmet need. CPR increased from 13 to 19 percent from 1998 to 2003 (Ghana Statistical Service 2004), while unmet need remained virtually unchanged (33 to 34 percent in the same years). Public-sector facilities supply the majority of clinical methods—female sterilization (69 percent) and IUD insertion (78 percent). Public-sector facilities also dispense nearly 87 percent of injectables consumption. The public-sector's market share of oral pills and male condoms account for only 19 and 5 percent, respectively, of the market.

In *Ghana,* the Interagency Coordinating Committee for contraceptive security (CS) initially met without influencing CS implementation. With renewed emphasis from the MOH, the committee has become a vibrant forum. It has addressed commodity pricing, market segmentation and the role of social marketing, forecasting of commodity needs, and donor funding coordination.

During the past several years, gaps in public-sector coverage have been filled by a shift in the source of contraceptives in Ghana toward private-sector distribution channels. The percentage of private-sector users has increased from 44 percent in 1988 to 54 percent in 2003 (Ghana Statistical Service 2004)[9] (see figure 12). However, as in most West African countries, the majority of these private-sector sales are through subsidized social marketing programs rather than from commercial distributors. The Ghana Social Marketing Foundation (GSMF) accounts for the top selling condoms, oral pills, and injectable methods available in the private market.

Ghana: Women wait for reproductive health services at the Tamale Hospital.

FIGURE 12. GHANA MARKET SEGMENTATION DATA

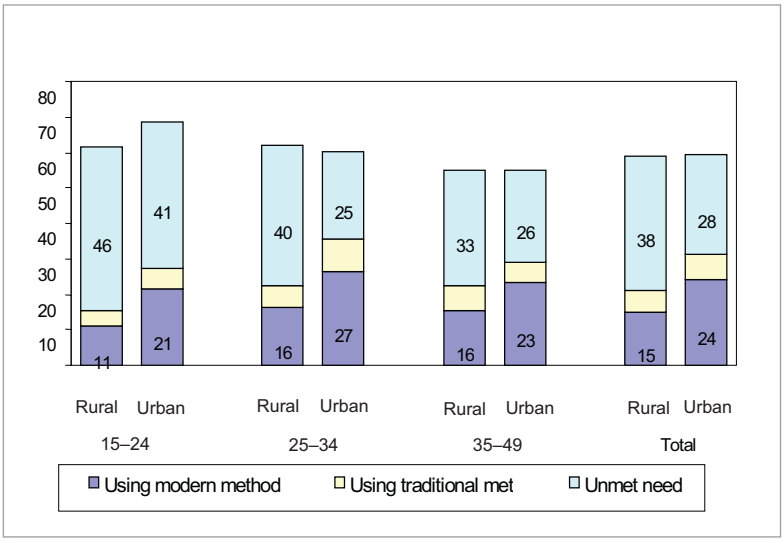


9. These figures equal the total share among all private-sector provider categories in the 2003 Ghana DHS (pharmacies, hospitals, clinics, and other private).

The findings from a recent market survey indicate that GSMF brands constitute 69 percent of the private-sector condom market. The remaining 30 percent, a significantly high number for West Africa, comprises a number of unsubsidized commercial products. Moreover, GSMF'S *Secure* brand oral pill accounts for 90 percent of retail pill sales, while *Famplan*, GSMF's socially marketed three-month injectable, constitutes 91 percent of the retail market. These figures support the findings of a recent ability-to-pay analysis, which indicated that the price of unsubsidized oral pills ($3.50) and injectables ($7.00) may be discouraging the development of a larger unsubsidized market. The introduction of lower-priced commercial alternatives for oral pills and injectables should be examined to fill a market demand for clients who can afford to pay more than GSMF's products but less than current unsubsidized prices.

While the recent analysis revealed a strengthening private sector for the provision of FP products, it has also allowed the MOH to identify the demographic characteristics of individuals who are not being served. Unmet need for women of reproductive age living in rural areas is 38 percent, while CPR for this group is 15 percent, compared to 28 and 34 percent for urban residents. By age, the 15–24 age group in rural areas has the lowest CPR and an alarming 46 percent unmet need (see figure 13).

FIGURE 13. CONTRACEPTIVE PREVALENCE RATE AND UNMET NEED BY AGE AND RESIDENCE



As table 6 shows, unmet need and CPR also vary by region. The Central, Volta, and Upper East regions all have levels of unmet need above the median. These regions are primarily rural, and this may serve to explain the differences for Greater Accra and Ashanti (two wealthier, urban regions). The Northern and Upper East regions have the lowest CPR, but not the highest unmet need—which is 50 percent in the Central Region. This suggests more IEC/BCC work is required in these regions.

TABLE 6. CONTRACEPTIVE PREVALENCE RATE AND UNMET NEED BY REGION

Region	CPR (traditional)	CPR (modern)	Unmet need
Western	11	18	33
Central	2	13	50
Greater Accra	8	26	31
Volta	4	19	41
Eastern	6	21	34
Ashanti	9	21	29
Brong Ahafo	8	25	31
Northern	4	8	34
Upper East	2	10	39
Upper West	7	19	25

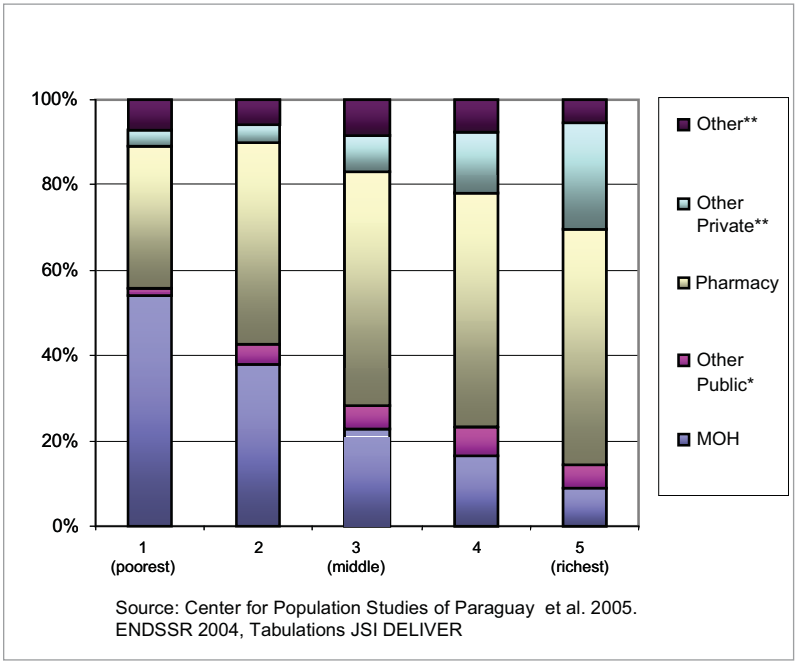
As a result of the analysis, the MOH is responding to the persistent problem of unmet need, in part by decentralizing FP to the community level through community agent distribution. This strategy will help reduce physical/geographic barriers and those related to financial access (reducing time and transportation costs for clients). It has also formed a Whole Market Working Group—made up of the MOH, GSMF, NGOs, and private-sector providers—to implement and monitor segmentation strategies. An overriding concern of this group is addressing unmet need, which is significant for all income groups, ages, and regions.

PARAGUAY: EFFECTIVE PUBLIC TARGETING AND STRONG PRIVATE-SECTOR PERFORMANCE

The political environment in Paraguay is supportive of reproductive health and family planning, with the constitution recognizing an individual's rights to freely and responsibly decide the number and frequency of births, as well as to receive education and services in this area. In addition, the constitution supports the establishment of *special reproductive health and maternal-infant health plans for low-income populations*. The National Reproductive and Sexual Health Plan (PNSSR) 2003–2008, which was ratified through a presidential decree in February 2004, has identified priorities: family planning, reproductive and sexual health education, adolescent reproductive health, and training and supervision programs for reproductive health service providers. The PNSSR 2003–2008 includes CPR as one of its key indicators, and has resulted in resources being allocated in the national budget to purchase contraceptives, as well as in regional and municipal budgets.

The contraceptive market in Paraguay reflects a total market approach in which both the public and private sectors have been moderately successful in serving different populations. Figure 14 shows the source for contraceptives for each of the five quintiles. Note that 52 percent of the poorest quintile obtains its contraception from the Ministry of Health, while only 7 percent of the wealthiest quintile named the MOH as its source. The use by the higher quintiles of *Other Public* as a source with increasing wealth reflects the higher coverage by Ministry of Defense facilities, the Red Cross, and several large hospitals.

FIGURE 14. PERCENTAGE OF WOMEN OF REPRODUCTIVE AGE USING MODERN METHODS AND SOURCE OF METHOD ACQUISITION BY QUINTILE, PARAGUAY 2004



Sources: Center for Population Studies of Paraguay et al. 2005. ENDSSR 2004. Tabulations JSI DELIVER

* Other public-sector sources include the Military and Police Hospital, National Hospital and Clinics for Maternity, Red Cross, hospital and clinics of the Paraguay Social Security Institute, and Maternal and Infant Hospital.

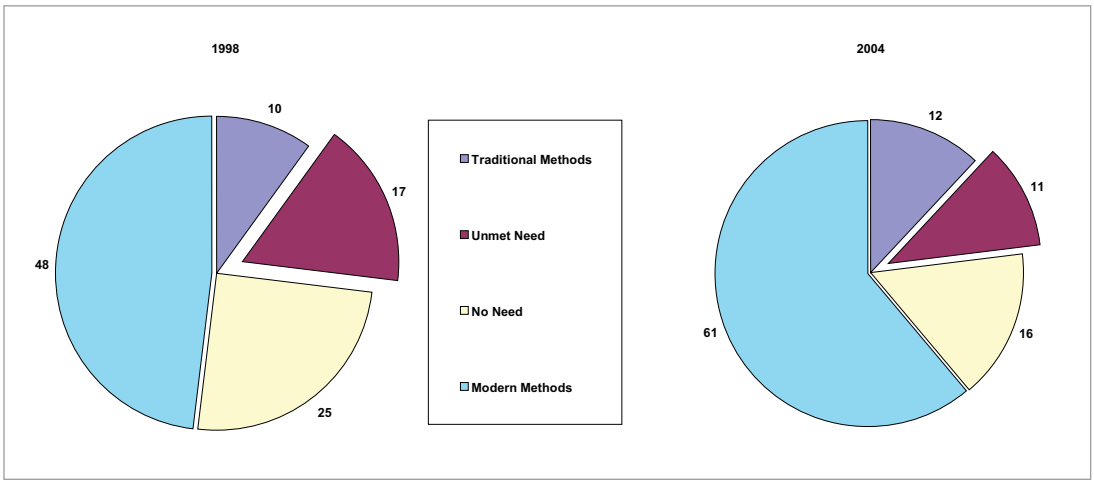
** Other private-sector sources include private hospitals, clinics, and independent medical practitioners.

Paraguay is one of the most socially equitable countries with respect to contraceptive resources, providing approximately 65 percent of public-sector funds for contraceptives available to the lowest-two wealth quintiles of the population. Most of Paraguay's poor (80 percent) tend to live in rural areas, while the majority of the richest quintile (90 percent) lives in urban areas. From a logistics standpoint, this is a significant challenge for the MOH because the two-thirds of the target population for free commodities, the lowest two quintiles, live in rural areas. Careful planning on commodity demand and distribution in rural areas is integral to the efficient use of public funding resources.

While the public sector has worked well in providing contraceptives to poor and vulnerable sectors of its society, the MOH accounted for only 32 percent of the contraceptive market in 2004. The private sector, by comparison, plays a predominant role in providing contraceptives to consumers in Paraguay, accounting for 61 percent of the market in 2004. Paraguay's pharmacies provide commodities comprising commercial and social marketing brands that span a wide price range, making them affordable to most consumers.

The benefits resulting from public and private sectors working to provide contraceptive security in Paraguay have been impressive: between 1998 and 2004, the fertility rate fell from 4.3 to 2.9 births per woman, the contraceptive prevalence rate increased from 57 to 73 percent; the use of modern methods increased from 48 to 61 percent nationally and from 41 to 55 percent in rural areas (figure 15).

FIGURE 15. PERCENTAGE OF WOMEN USING CONTRACEPTIVE METHODS AND WOMEN WITH UNMET NEED IN PARAGUAY, 1998–2004



In most countries, women in rural areas have a higher unmet need because of disparities in wealth, education, and access. In Paraguay, however, the program has been especially successful in reaching rural women, who had a much higher unmet need in 1998. By 2004, the unmet need among these women was reduced from 25 percent to 16 percent. However, as expected, there is still a gap between urban and rural areas, with rural unmet need (16 percent) being more than double the urban rate (7.4 percent).

To continue with the current trends, the public and private sectors in Paraguay must keep working to satisfy the unmet need that still exists. To accomplish this goal, several options can be explored:

- The one-third of the lowest two quintiles living in urban areas can probably be geographically targeted at the local level because this segment of the population tends to live only in certain areas. This approach should simplify product distribution to these people.
- The private sector could analyze where it has growth potential, such as in sterilization and IUDs. If they increase their targeting toward wealthy segments of the population, especially those who are currently using the public sector for these methods, it would free public funds for other segments. Likewise, the MOH may be able to direct wealthier couples to the private sector for certain methods, such as sterilization and IUDs.
- The MOH could analyze whether consultation fees are a barrier to poor clients, particularly in clinics serving the poor.
- Finally, the Paraguayan Social Security (IPS) system does not currently play a significant role in providing family planning services. Because the wealthier quintiles are the segments of the population most likely to purchase insurance, the IPS could be encouraged to become more active in providing family planning services and supplies to its beneficiaries.

BANGLADESH: PUBLIC AND SOCIAL MARKETING SUCCESS STORY

DELIVER has completed two market segmentation analyses for Bangladesh, in 2003 and 2006 (Chawla et al. 2003) (Karim, Sarley, and Hudgins 2006). They have shown the gains the Government of Bangladesh (GOB) and the private sector have made in meeting the growing demand for contraceptives (see

figure 8 in previous section). The public sector currently serves 56 percent of the country's contraceptive market, while the remainder is served by private providers/clinics, commercial pharmacies, the Social Marketing Corporation (SMC), and NGOs.

The public sector is the major source for oral pills and long-term methods. The SMC dominates the private sector and subsidized supplies, as well as unsubsidized contraceptives. The SMC is the major provider of condoms and the second major provider of oral pills. The analysis in 2003 determined that about two-thirds of women in the wealthiest quintile obtained contraceptives that were unsubsidized or partially subsidized through private clinics or commercial pharmacies, while most (84 percent) of the poorest quintile obtained fully subsidized contraceptives from the public sector.

The 2006 analysis reviewed past and current Bangladesh DHS data to examine trends and variations in FP program service utilization between the different contraceptive market segments—mainly wealth, status, age group, place of residence, parity, and geographic division. The analysis revealed the following:

- Disparity is decreasing in modern method CPR between the rich and the poor and between urban and rural.
- The shifting method mix from long-term and permanent methods to short-term methods observed in BDHS 1999–2000 is still continuing. Nevertheless, there is some evidence that the trend will change soon.
- The effectiveness of the public-private partnership in the contraceptive market of Bangladesh is improving: public-sector clients who were in the richest quintile are gradually shifting to the private sector, while the public sector is continuing to expand its services among the poor.
- The effectiveness of the public sector of Bangladesh in serving the poor is comparable to the effectiveness of the public sector of other countries that have successful FP programs.
- The private sector is increasingly playing a significant role in the contraceptive market of Bangladesh. It has emerged as a potential supplier for injectables, and the SMC has emerged as the major source for condoms and one of the major suppliers for the oral pill market in Bangladesh.
- The private sector, in serving the rapidly growing urban population, is increasingly reaching out to the younger family planning clients and is also serving the poor.

Nevertheless, the analysis revealed major challenges to the national family planning program that need to be addressed to ensure the contraceptive security of the country. By 2015, almost nine million potential future contraceptive users will join the existing pool of 13.6 million married women currently using contraceptives, creating a mammoth task for the national family planning program. In developing the strategy to serve the future contraceptive market in Bangladesh, the following issues should be considered:

Bangladesh: Field worker explains family planning methods to clients.

- The national FP program is unable to keep up with the contraceptive needs of the rapidly growing urban population; the modern method CPR in the urban area has remained stagnant over the last eight years.
- There is a huge disparity in the modern method CPR among the six divisions of Bangladesh—mainly due to access issues, among others; while the modern method CPR in Sylhet and Chittagong Divisions is unexpectedly low; it has remained stagnant in Khulna Division over the last eight years.
- Only 17 percent of the 6.1 million modern method users with three or more children (most of whom do not want any more children) have currently adopted long-term or permanent methods, leaving a huge number of potential clients for longer-term methods.
- Although the role of the private sector in the long-term contraceptive market in Bangladesh is improving, it is still negligible; the private sector has a huge opportunity to increase its role in providing longer-term contraceptives.
- Opposition to family planning is still a cause for contraceptive non-use among the underserved segments of the country.
- Although family planning service delivery is improving, a disparity continues in family planning service delivery between the rich and the poor.

For the national family planning program, a strong public-private partnership will be the key to facing these challenges. Continuing dialogue and an even stronger recognition of the respective contributions of the public and private sectors will be crucial if these challenges are to be met.

PRACTICAL STRATEGIES FOR PROMOTING A TOTAL MARKET APPROACH

As the preceding case studies have shown, a range of different approaches can be taken to promote a total market approach. Several elements from these and other examples are worth highlighting:

Awareness of the total market. It is important for RH policymakers to be aware of the contribution a total market approach can make, even where the existing private sector is underdeveloped. Market segmentation analysis can help demonstrate the existing contribution of different partners as well as identify opportunities for future coordination.

Ensuring that public subsidies go to those that need them. Market segmentation analysis can be a key tool in developing a government's poverty reduction strategies by identifying the beneficiaries of public services, how well public services are reaching the poor and vulnerable groups, and what needs to happen to improve targeting.

Coordinating with all partners. Bringing public, private, and NGO stakeholders to the table can facilitate identification of barriers and opportunities for a more efficient total market.

An encouraging policy environment. When looking at the contribution of the private sector, it is important to understand the legal, regulatory, institutional, and procedural barriers to wider private participation.

Social market versus commercial market. In promoting contraceptive security, it is important to evaluate what sustained private-sector response is possible before advocating for subsidized and socially marketed products. Urban populations in most middle- and even low-income economies usually have purchasing

power that is of interest to the private sector. While different manufacturers adopt different marketing strategies, several generic manufacturers offer competitive prices that may be affordable to a significant market.

Segmentation strategies. Markets can be segmented geographically, by product, and by target client. Ensuring availability of free methods in rural clinics and selected urban neighborhoods may be sufficient to reach the majority of the poorest. Focusing services on adolescents/students in urban areas is another approach. Yet another approach would be to have the public sector focus on free provision of some specific methods not found in the private sector. And, where vulnerable and at-risk populations can be identified, another approach would be to focus on free provision to these groups.

CONCLUSION

A total market approach ensures that contraceptive security is a broad-based effort that includes all providers of family planning products and services, and it leverages the strengths of each sector to meet the needs of all users, regardless of wealth, geography, or other factors. It is essential for improving the public-sector's effectiveness in meeting the needs of the poorest and most vulnerable populations and in ensuring that scarce public resources are used in the most rational and equitable manner. It is also useful for identifying barriers to greater private-sector involvement in meeting the needs of people willing and able to pay for products and services. The approach requires commitment and coordination, and often significant policy changes result. The benefit is a rational contraceptive market that serves the greatest number of people.

8. FINANCIAL DIVERSIFICATION

THE FUNDING CHALLENGE

The UNFPA figures presented in table 7 show that, while there was a 46 percent increase in donor funding from 2000 to 2001, this was followed by a 12 percent decrease in 2002. Overall, between 1996 and 2002, donor funding increased by only 2.3 percent per annum, less than one-half the annual increase estimated by the Interim Working Group on Reproductive Health Commodity Security to meet demand through 2015 (Interim Working Group 2001a).

TABLE 7. ESTIMATED CONTRACEPTIVE COMMODITY SUPPORT BY DONOR AGENCY 1990 TO 2004, IN THOUSANDS $U.S.

	1990	1992	1994	1996	1998	2000	2001	2002	2003	2004
BMZ/ ZFW		10,798	11,350	38,071	8,627	35,482	16,387	20,115	26,912	8,688
DFID		4,125	7,192	9,205	7,807	7,317	6,130	16,403	22,289	6,706
IPPF	5,843	6,184	6,258	6,003	3,416	3,814	3,667	4,226	1,855	2,606
PSI		418		7,239	200	456	22,359	30,943	28,152	47,831
UNFPA	14,753	18,534	34,087	37,611	32,201	16,721	89,205	41,209	57,455	65,034
USAID	57,636	39,575	47,848	46,481	63,087	58,093	67,908	49,628	69,400	71,226
IBRD				7,930	19,138	20,781	6,130	21,060		
OTHER	957	3,734	9,099	19,613	8,717	11,381	12,424	13,925	2,970	660
TOTAL	**79,189**	**83,368**	**115,834**	**172,153**	**143,193**	**154,045**	**224,210**	**197,509**	**209,033**	**202,751**

Source: United Nations Population Fund 2002

Data from USAID shows that since 2003 contraceptive funding from this single largest donor has increased to the peak above the 2001 level. Total USAID contraceptive donations in 2003 reached $69.4 million and, in 2004, $71.2 million. While encouraging, this still only represented an annual 2.2 percent growth rate between 2001 and 2004.

To recognize the largely flat donor response since the May 2001 Interim Working Group (IWG) Istanbul conference, the Supply Initiative[10] campaigned with European donors to help mobilize $80 million in 2005 for UNFPA to fund commodities and support supply chain improvements. This is a major new investment and one that European donors have asked UNFPA to use in ways that explicitly help to generate a sustained response to current financing shortfalls. For this funding to be continued, UNFPA will need to demonstrate that it is supporting a sustained improvement in contraceptive security (CS) in the countries where it gives support.

10. The SI was established in January 2003 to create a forum to enable reproductive health organizations to work together to identify the main causes of RH supply shortages, and to make recommendations to governments and donors on how to alleviate these shortages.

At the global level, traditional sources of funding for contraceptives are proving to be inadequate to meet growing client needs. In the face of this constraint, and to allow existing resources to go further, one strategy global funding agencies should consider is to classify countries according to their ability to generate internal funding for contraceptives. Donors could then refocus their funds on those countries with the largest gap between available resources and unmet funding need. Simultaneously, countries need to consider their contraceptive funding options and identify ways they can *diversify* funding to either reduce dependence or complement available donor funding.

OPTIONS TO DIVERSIFY

For many years, public-sector programs have relied on one or more donors to provide their contraceptive commodities. Growing uncertainty about future commitments combined with increasing demand means that in many countries the levels of donated contraceptives will not be sufficient to ensure that people can choose, obtain, and use the methods they need. Programs, therefore, need to recognize this and mobilize new sources of funding to achieve CS. Table 8 summarizes the potential options and sources for funding contraceptives.

TABLE 8. POTENTIAL SOURCES OF FUNDING FOR CONTRACEPTIVES

Sources	Description
Donors	
Donated commodities	Commodity donations come from bilateral agencies (USAID, KfW, and DFID) or multilateral agencies, (i.e., UNFPA). Commodities can also be donated by international NGOs (e.g., IPPF). Recipients typically include the public and NGO sectors, including social marketing organizations.
International funds	The Global Drug Facility (GDF), the Global Alliance for Vaccines and Immunization, and the Global Fund (GFATM) address the global imbalance in need versus financing for health commodities. The Global Fund, for example, solicits, manages, and disburses funds for HIV/AIDS (including condoms), TB, and malaria programming to recipient country programs.
SWAp Basket Funds	
Development bank loans and grants	The World Bank or Inter-American, African, or Asian Development Banks are typically central parts of a sector wide approach (SWAp) basket funding arrangement.
Direct budgetary support	Bilateral donors such as DFID, Canadian International Development Agency (CIDA), SIDA, the EU, and multilateral lenders (e.g., the World Bank) are increasingly providing direct budgetary support to complement basket funding SWAp arrangements. This provides MOHs with resources to finance and procure their contraceptives.
National Budgets	
Earmarked national budget line	The earmarking and funding of national budget lines for contraceptives, which are funded from domestic tax revenue, are becoming more prevalent in many countries, reflecting successful efforts in increasing political commitment to FP.
Local budget line	In decentralized health management settings, local budgets managed by regional, district, or municipal governments are an important source of potential funding for local FP services.

TABLE 8. POTENTIAL SOURCES OF FUNDING FOR CONTRACEPTIVES (CONTINUED)

Sources	Description
Private Funding	
Third party private providers	These can include health insurance funds, employer-based health care and family planning service provision, and domestic NGOs.
Households	These account for out-of-pocket private expenditure in pharmacies, retail outlets, and private NGO and public clinics.

Countries with widely differing socioeconomic, health, political, and development settings will have differing abilities to access these potential sources of funds. Diversification of funding for contraceptives will mean very different things for countries as diverse as Mali, Ghana, Bangladesh, Peru, and Kazakhstan. The use of increased household financing in Bangladesh, for example, may be a more viable option than in Mali, where much lower per capita income makes this strategy less feasible. The next section illustrates how existing funding patterns for contraceptives vary between different countries.

CLASSIFYING COUNTRIES BY THEIR SOURCES OF CONTRACEPTIVE FUNDING

Table 9 classifies 21 countries according to their source mix of contraceptive funding. The table groups them into five levels of financial diversification ranging, on a spectrum, from high donor dependency to a dominant private-sector presence. The potential sources of funding identified in table 9 are summarized into four main sources of funds: (1) donated commodities, (2) use of SWAp funds, (3) government budget line, and (4) level of household contribution. The situation in each country was examined and the table includes the following:

- *Donated Commodities*. This category demonstrates how much countries rely on donations for their contraceptive commodity needs—from complete dependency for some, while others have medium or less dependency or no donated commodities.
- *SWAp Funds*. This column indicates whether SWAp funding mechanisms are in place and being used to buy contraceptives—either yes or no. These give governments ownership and control in allocating and setting policies with more flexibility in how these funds are used. When a country uses SWAps to fund the purchase of contraceptive commodities, it is an indicator of government political and financial commitment.
- *Budget Line*. Another sign of financial commitment is the establishment and funding of a budget line. The column indicates whether the government has allocated funds in the national budget to finance the purchase of contraceptives or if local governments provide funds in their budget.
- *Household Income*. The household column was used to gauge the level of household financing. Here we examined both the percentage of household contributions and the absolute contribution to CPR.
- *Private Contribution to CPR*. This takes the proportion of the methods from the private sector[11] multiplied by a country's CPR—(private-sector share of CPR) × (CPR) = weighted CPR.

11. The private-sector share is an estimated value that takes the balance of the public source of supply from DHS and reproductive health surveys.

TABLE 9. CLASSIFICATION OF COUNTRIES BY THEIR SOURCE OF CONTRACEPTIVE FUNDING

Country/Classification	Sources				
Groups	**Private CPR**	**Donated Commodities**	**SWAp Funds**	**Budget Line**	**Household Income**
A: High donor dependency		Public sector dependent on commodity donations (over 90%)	Not used yet	None or limited	Small contribution/ market
Benin	4.0				
Burkina Faso	2.3				
Cameroon	4.8				
Ethiopia	1.4				
Mali	3.7				
Nigeria	6.5				
Rwanda	2.0				
B: Still donor dependent but greater household funding and more government input		Less dependent in relative terms on donations than the first group but still receiving important commodity donations (over 80%)	Being increasingly used	Limited but increasing	Larger percentage of household contribution
Bangladesh	20.8				
Ghana	11.1				
Nepal	4.6				
Tanzania	5.4				
Uganda	12.5				
C: Less donor and government funding with more private-sector contribution		Some donations but phasing out (between 30–80%)	Being increasingly used	Some funding	Significant household contribution
Bolivia	14.8				
Guatemala	19.2				
Honduras	30.2				
Paraguay	41.6				
Nicaragua	23.9				
D: More balanced public and private contribution		None or limited (5–30%)	No	Yes	Varied contribution
Chile	NA				
Peru	10.9				
Egypt	27.7				
Jordan	25.8				
E: Private-sector and household funding the largest source		Phased-out or no commodity support (less than 5%)	No	Limited local	Very high relative to the previous groups
Georgia	15.8				
Kazakhstan	14.0				
Ukraine	NA				

A: High donor dependency (Nigeria, Cameroon, Mali, Rwanda, Ethiopia, Burkina Faso, and Benin). Countries are characterized by low CPR (less than 10 percent), a public sector that is dependent on donors, and small absolute levels of funding from the private sector. The public sector typically does not earmark funds to purchase any commodities. While some portion of the population is able to access contraceptives, there is still high unmet need. How feasible is it for these countries to move away from high donor dependency? To do so would mean dedicating funds in their government budgets for the purchase of contraceptives or using SWAp funds to earmark funds for contraceptives.

B: Still donor dependent but greater household funding and more government input (Ghana, Bangladesh, and Uganda). While this group of countries is still donor dependent, they have a more balanced source of funding for their contraceptives than the first group. These countries have higher CPR, are still receiving donor donations, and have started to use SWAp mechanisms; coupled with households taking a larger part in the financing of contraceptives. Although several countries in this group have the public sector taking a greater role, additional government commitment is necessary before donors can further reduce aid. For increased diversification, these countries could consider additional donor sources and expanded use of SWAp funds to replace commodity donations as these donations phase out.

C: Donor and government funding with more household contribution (Tanzania, Nicaragua, Paraguay, Bolivia, Guatemala, and Honduras). Countries in this category are faced with a much more advanced stage of donation phaseout, and have been successful in increasing government funding and strengthening local procurement capacity. Many of these governments have national budget lines for procuring contraceptives. But, with relatively greater household incomes and higher average CPRs than the previous groups, ranging between 15 (Bolivia) to 42 percent (Paraguay), more effort should be made to shift the wealthier income quintiles toward accessing the private sector in order to free more public-sector resources. This can encourage better targeting to focus on reaching the most vulnerable populations.

D: Government financing the largest source (Peru, Chile, and Egypt). These countries are in the midst of or have already undergone phaseout of donor commodity donations. They have local capacity to procure their own contraceptives (Chile and Peru) or have funds to procure them through UNFPA. All these countries have budget lines dedicated for contraceptives, and have been successful in increasing procurement capacity. Because these countries have households with the ATP for contraceptives, the focus should be on increasing resource mobilization from the private sector.

E: Private sector and household funding the largest source (Kazakhstan, Ukraine, and Georgia). The private sector is very strong in this group, supplying a variety of contraceptives. The government needs to identify how to provide low-cost contraceptives that will reach a wider segment of the population who are unable to access or afford private-sector prices. These countries need to provide better publicly financed and subsidized products to reach those unable to access the private market.

In two recent contracts with private manufacturers, *Peru's* MOH has negotiated a delivery price to district stores, thereby avoiding the need for public-sector distribution.

STRATEGIES TO IMPROVE FINANCIAL DIVERSIFICATION

The absence of information on private-sector and government budget spending in each of the countries discussed makes it difficult to estimate the relative shares of each source of funding for contraceptives. Nonetheless, indicative shares for each group of countries described above can be presented graphically, both present and possible future sources of funding. The actual approach taken for individual countries

will need to be tailored according to local factors and adjusted as country data become available. Figure 16 illustrates how countries in each group defined above could consider improving resource mobilization. It should be stressed that the focus is on changing relative shares while seeking to expand the total resource envelope. Thus, for countries in group A and B, the total amount of donated commodities may increase. However, the share of donated commodities in the total might decrease as additional resources from other sources are mobilized.

FIGURE 16. ILLUSTRATIVE FINANCIAL DIVERSIFICATION STRATEGIES

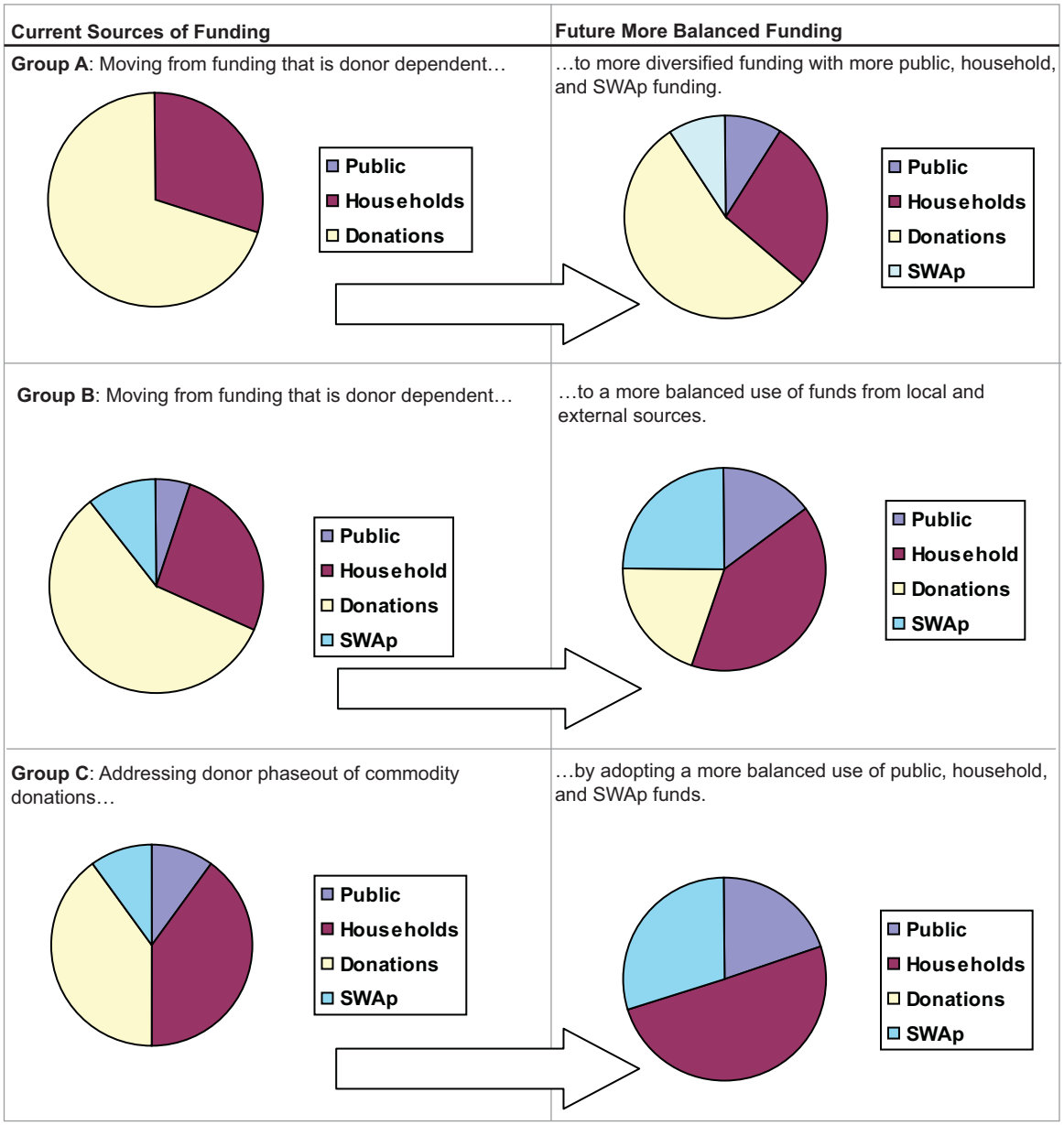
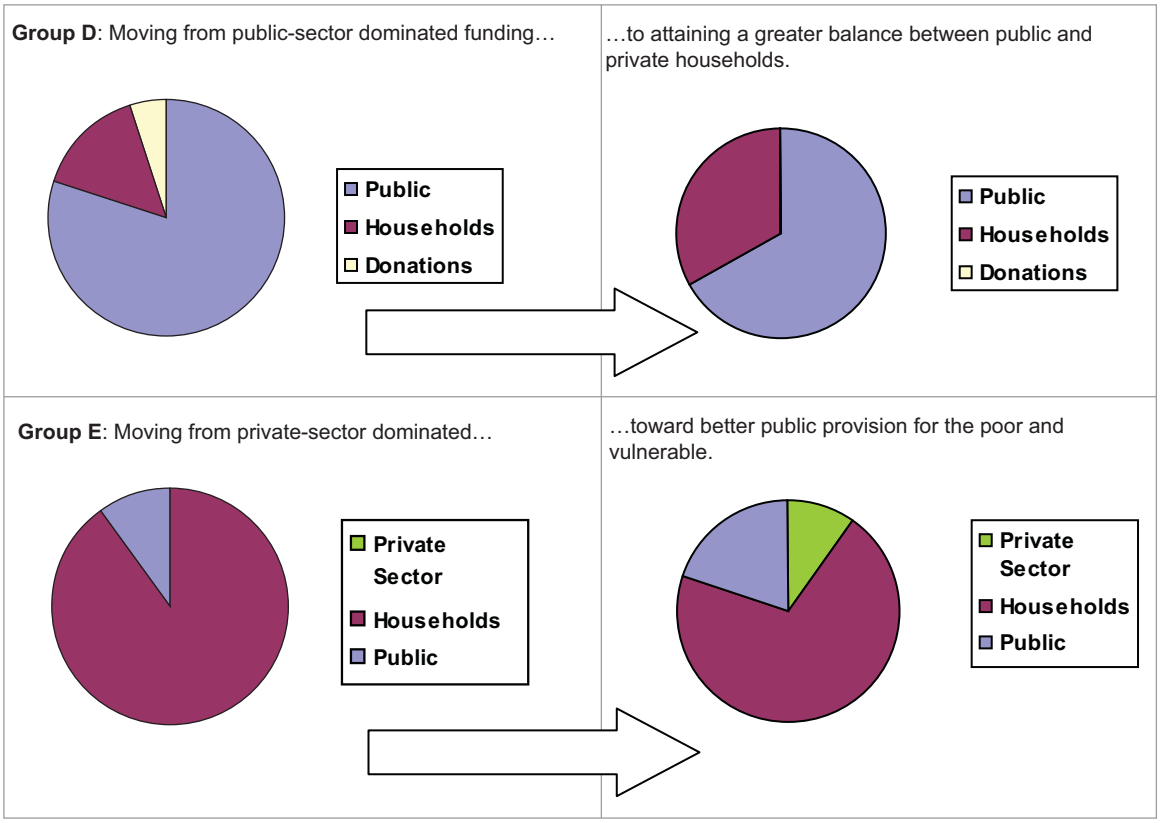


FIGURE 16. ILLUSTRATIVE FINANCIAL DIVERSIFICATION STRATEGIES (CONTINUED)



GROUP A

Group A countries are characterized by low CPR, low per capita income, and a limited tradition of support for FP. These countries will probably continue to be dependent on donor support for the foreseeable future. They should continue to seek increased support from international donors and look at different donor funding mechanisms if procurement capacity can either be strengthened or contracted to third parties. These countries could provide some nominal funding from their own budget as a sign of commitment to FP. They should also recognize that their own urban populations may have some ATP for contraceptives. In short, they should seek a funding mix that looks like that experienced by the countries in group B.

GROUP B

Group B countries are typically already using funding from a variety of sources for their contraceptives. Here, the issue is as much about increasing the overall resource pool as shifting from one source to another. These countries will usually have some continued dependence on donor funding but, with more developed commodity management capacity, they can take greater responsibility for the financing and procurement of their contraceptives. These countries should, therefore, look to a greater use of SWAp arrangements and to their own budget commitments. As the reliance on donated commodities decreases, further efforts can be made to expand the contribution of the private sector, whether through social marketing or the private commercial sector.

GROUP C

Group C countries may still be receiving some commodity donations but are increasingly being phased out of direct donor support. As commodity donations end, strategies are required to replace these from SWAp funds, public-sector funding, and the private sector. The exact balance between these will depend on local conditions and the scope for better market segmentation, and an increased private-sector contribution.

El Salvador: Pharmacy staff at hospital ensuring that contraceptives have not expired.

GROUP D

Many of the group D countries have already been phased out of direct donor support and rely on their own public-sector funds to finance the majority of their commodity needs. This may be sustainable while political support is in place, but consideration should be given to expanding the contribution of the private sector, including third party insurance and employer-based schemes. This will be crucial as contraceptive demand increases.

GROUP E

In group E countries, commodity donations have ended[12] and, because of a lack of central or local public-sector funding, private households are taking the main responsibility for funding contraceptives. Private household–dominated funding is feasible where income levels provide the necessary purchasing power. But, even in the most developed economies, there are likely to be poor and vulnerable groups unable to afford private-sector prices. The public sector needs to identify these groups and provide subsidized funding for their commodity needs.

FINANCIAL DIVERSIFICATION STRATEGIES

Summarized below are some of the approaches being undertaken to diversify funding sources in countries where DELIVER is working. Because DELIVER is working primarily with the public sector, the strategies focus on concrete actions for governments, while encouraging the private sector, including social marketing.

Group A—Benin. As a sign of government commitment in 2005, the MOH has made available 500 million CFA ($100,000) for contraceptives over the next three years (2006–2008). A SWAp has been discussed, but this is still in the planning stages. Benin continues to practice cost recovery mechanisms for contraceptives.

Group B—Ghana. In anticipation of greater demand for contraceptives and a growing financing gap for purchasing contraceptive commodities, the Government of Ghana created a National Contraceptive Security Strategy to provide a framework for achieving contraceptive security. With DELIVER support, the Inter-agency Working Group on Contraceptive Security has established itself as an effective mechanism for

12. USAID contraceptive support to Georgia ends in 2010. UNFPA provides some support to the public sector, but future plans are uncertain. However, household income is the primary source of financing.

advocating, planning, and implementing contraceptive security strategies in Ghana. Led by the Ministry of Health and the Ghana Health Service, it has developed and is now implementing an RHCS strategy to increase product availability and improve contraceptive security. Several examples of using multiple financial resources were identified, including the use of International Bank for Reconstruction and Development (IBRD) SWAp funds, with procurement conducted by contracted procurement agents; this gives the MOH more decision-making authority for purchasing contraceptives. This, with the use of the MOH tax revenue and health funds, provided a short-term solution to close the financing gap in 2004. In addition, the strategy calls for establishing a national budget line, and foresees continued, though decreased, donor support from USAID, DFID, and UNFPA. Plans are in place to determine a medium-term strategy to expand the contribution of the private and social marketing sectors.

Group B—Bangladesh. In 2004, the Government of Bangladesh for the first time earmarked $690,000 from its revenue budget, specifically for contraceptive commodities, to help close the funding gap. World Bank funds, donations from other bilateral projects, and social marketing further reduced the gap. This savings resulted from DELIVER's technical assistance to the Directorate General of Family Planning (DGFP) in procuring its first shipment of condoms, injectables, and IUDs in 2000. The high volume of condoms and pills purchased meant that the DGFP was able to obtain unit prices from their Indian suppliers far lower than typically quoted international prices. For example, the GOB paid $0.07 per cycle for pills compared to $0.23 per cycle for commodities procured by CIDA and KfW in 2000. The MOHFW estimated savings to be as large as $17.2 million. To address how future funds will be identified, a five-year Health Nutrition and Population Sector Program includes provisions to explore health finance diversification options and pooled funding from donors; which will enable the government to procure services and commodities following World Bank procurement guidelines.

Strategies for addressing government procurement capacity include using contracted procurement agents, particularly if they provide technical assistance to strengthen local capacity. However, this can be undermined by civil service turnover. In *Chile,* an autonomous public procurement agent, independent of the MOH, helped ensure staff stability. UNFPA is being used elsewhere in Latin America where local procurement regulations restrict access to international suppliers.

Group B—Nepal. As donors grappled with the continuing funding gap for contraceptives in Nepal, national leadership and coordination efforts, supported by DELIVER, helped identify strategies to reduce the commodity gap. Through its own procurement unit, with technical support and partial commodity financing from KfW, Nepal was able to obtain prices on the international market for contraceptives below the unit cost obtained from donor-supported procurement agencies. A procurement and pricing analysis, conducted by Nepal's Logistics Management Division, demonstrated the benefits of central government procurement, which then led to the purchase of quality, low-priced contraceptives from the growing South and Southeast Asian manufacturing market. The MOH has also established a budget line for contraceptive procurement that is increasing at an annual rate of 8 percent. The net result of the shift toward MOH procurement has been an increase in local capacity and increased funds for further procurements. Nepal has also recently moved toward a sector-wide basket funding for health, enabling it to draw on World Bank credit for contraceptive procurements.

Group C—Guatemala. Similar to other LAC countries, Guatemala is in a more advanced stage of donor phaseout because USAID, in 2001, ended all contraceptive donations except IUDs. The Ministry of Health is an example of coping with reduced assistance through procurement and financial planning. In

March 2002, the MOH signed an agreement with UNFPA under which the UN agency—using funds from Holland and Canada—would donate 100 percent of the public-sector contraceptive needs. In turn, the MOH would deposit an amount equivalent to a specified percentage of the total donation for each year (5 percent of the total donation in 2002, 20 percent in 2003, 30 percent in 2004, 40 percent in 2005, and 45 percent in 2006) in a joint bank account. This money will create a fund that will be used to purchase contraceptives when donations end in 2008, as well as improve the logistics functions of the public health system. It is expected that, by the year 2008, the Government of Guatemala will have enough funds to cover 100 percent of its contraceptive needs. However, in 2008, the government will need to allocate enough funds in its budget to cover its needs for 2009.

Group C—Bolivia. The public sector in Bolivia continues to receive donated contraceptives from UNFPA and JICA to support its Sexual and Reproductive Health Program, whereas USAID continues to donate contraceptives to PROSALUD, the major NGO in the country. To date, the Ministry of Health has not used public-sector funds to directly purchase contraceptives. However, the municipalities fund the purchase of contraceptives through their local municipal pharmacies (*Farmacias Institucionales Municipales*), which sell them to users who can afford to pay. The Universal Maternal-Infant Insurance (SUMI) (*Seguro Universal Materno Infantil*) includes family planning for all women as one of its benefits. While the principal source of contraceptives for the SUMI is donations, municipalities are often compelled to use SUMI funds to purchase additional contraceptives to cover frequent shortfalls. These local purchases take place through commercial pharmacies, at very high prices.

Group C—Paraguay. USAID and UNFPA continue to donate contraceptives to the Ministry of Health. The ministry's investment in contraceptives to date has been very small. In 2004, the MOH only purchased $21,500 worth of contraceptives. The amount programmed for 2005 was significantly higher, $130,000; however, these funds were not fully spent. The decision to procure through UNFPA took place in 2005, and an agreement for a one-time purchase through UNFPA was not signed until November 21, 2005. For 2006, the MOH has allocated $260,000 for contraceptive procurement, which would cover 80 percent of the needs for this year, using UNFPA as the procurement agency. The MOH estimates that if it used those funds ($260,000) in the local market, they would only be able to cover 53 percent of actual need. As mentioned before, in Paraguay, public-sector purchases can be exempted from the public tender process for *technical reasons*, one of which is price advantage. If Paraguay signs a procurement agreement with UNFPA, the purchase of contraceptives under this agreement, without a public tender, could be justified on the basis of the comparatively low prices that UNFPA can obtain for contraceptives on the international market. However, to do this, the government would need to commit from an estimated $350,000 to $450,000 upfront to UNFPA, because UNFPA does not have the ability to advance fund purchases.

Group E—Kazakhstan. UNFPA and USAID are phasing out commodity donations, but with no national budget line, the majority of contraceptives are being provided by the private sector. Competition in the domestic pharmaceutical distribution market means that a wide variety of methods are available for a range of prices. However, regional and district health authorities are trying to find budget support to fund contraceptives for the poor and vulnerable population that cannot access private-sector supplies.

CONCLUSION

The financing situation for contraceptives has changed dramatically since 2001, when international donors provided most of the funding or donated commodities to support the contraceptive needs of family planning programs in developing countries. Although the financing gap identified by the IWG

in Istanbul still exists, and donor support has increased only modestly, the range of financing options has expanded, giving countries a variety of tools to use. This is particularly true where a Total Market Approach has been taken to reduce the financial burden on public resources. But, even in countries that will continue to rely on substantial donor support for the foreseeable future, SWAp funding, competitive bulk procurement, and greater involvement of the private sector offer real opportunities to diversify their sources of financing and improve their contraceptive security.

9. PROCUREMENT

Routine and efficient procurement of contraceptives is an essential element necessary to achieve contraceptive security (CS). It requires specialized knowledge and expertise with contraceptives and the markets where they can be obtained. It involves accurate forecasting, careful product selection and specifications, specific testing protocols and procedures, consideration of brand preferences, committed financial resources, precise tender preparation, and transparent negotiations and contract management. Procurement is also a key step in the supply chain. A well-functioning supply chain, necessary to distribute products to service delivery points (SDPs)—and therefore to clients—can only be achieved with a reliable procurement process in place.[13]

Capacity for programs to procure and distribute commodities also plays a critical function in achieving broad commodity security targets. Service providers, for example, cannot fulfill their functions without the reliable operation of procurement systems and supply chains that deliver the commodities to their clients. To ensure that health systems have adequate quantities of supplies, routine and coordinated procurement—often for multiple supply programs—must be conducted.

Without an internal procurement capacity or the means to contract the process to a third party, and adequate financial resources, a client's ability to choose, obtain, and use quality contraceptives will be greatly compromised. As government programs increasingly assume the procurement function for contraceptives and other health commodities, the effectiveness of local capacity to conduct efficient, transparent, and timely procurements will have an increasing impact on CS.

A GROWING NEED FOR PROCUREMENT CAPACITY

Historically, developing country governments have not taken responsibility for contraceptive procurements when bilateral donors provided contraceptives as in-kind donations. For example, in 1990, USAID and UNFPA funded 91 percent of global contraceptive donations, taking direct responsibility for the entire procurement process and delivery to the central stores in their partner countries. This pattern began to change in the 1990's when USAID graduated several middle-income countries from receiving contraceptive donations. Countries, such as Colombia, Chile, Costa Rica, Brazil, Mexico, Turkey, and Morocco, had to develop their own capacity to procure needed contraceptives.

The 1990's also witnessed an increasing diversification of donor funding sources. Initially at least, new donors—KfW, DFID, JICA, and IPPF continued to provide in-kind contributions. This began to change in 1996 as countries began to use World Bank loans to buy contraceptives and essential drugs. Countries had to take responsibility for their procurement process, sometimes appointing procurement agents to manage commodity purchases. This trend accelerated in the late 1990's with the adoption of sector wide approach (SWAp) health reforms that used pooled basket funding arrangements rather than relying on bilateral donor support. Under SWAp arrangements, bilateral donors are now increasingly funding contraceptives through health-sector basket funding and direct budgetary support to the government rather than by providing in-kind donations. As governments take greater ownership and responsibility

13. This chapter draws heavily from two DELIVER publications: Sarley et al. 2006 and Rao, Mellon, and Sarley 2006

for contraceptive supply, an increasing number are also using their tax revenue–funded budget lines to contribute to contraceptive purchases.

Recent data have shown that, in parts of the world where access to international markets is low, procurement agencies are paying multiple times more than standard international reference prices for essential medicines, effectively reducing products available in clinics and hospitals. In addition, lack of capacity to select, forecast, quantify, and manage the procurement process disrupts the flow of health commodities from supplier to client. In this environment, commodity security cannot be realized unless the effectiveness of the procurement function increases.

WE HAVE THE MONEY, BUT WHERE ARE THE COMMODITIES?

With increased sources of funding and adoption of a total market approach in many countries, is CS now assured? As many countries are now discovering, having funds committed is necessary but not sufficient to guarantee product availability. Governments need to ensure that their procurement capacity can indeed purchase the right contraceptive products, at the right time, in the right place, at the right price, in the right quantity, and with the right quality. These six procurement *rights* are crucial to the procurement challenge that countries are now facing. Recent experience has not always been positive, as the following examples illustrate:

- *Brazil's* public procurement of health commodities has suffered from weak commodity management capacity and poor governance at local and central levels. Public procurement performance has varied, with some states and municipalities paying too much for their commodities. Several agencies were under investigation in 2005 for corrupt practices. A lack of post-registration drug testing has led to public safety concerns about public procurements.
- In the *Dominican Republic* and *El Salvador*, local procurement policies restricted access to competitive international suppliers. Local agents were able to charge prices close to those paid in the U.S. market. The MOH has switched to procurement through UNFPA to overcome local regulatory restrictions and to get better value for the money.
- *Bangladesh* adopted a sector-wide, health-sector program with $500 million in funding from the World Bank and bilateral donors in 1998. Procurements were governed by World Bank procedures that were designed to ensure good governance. The Government of Bangladesh refused to appoint a procurement agent, preferring to develop its own capacity. Unfortunately, unfamiliarity with World Bank procedures delayed purchases for more than two years as local staff were trained. A DELIVER/PATH procurement primer has been developed and training provided to MOH staff.
- Under *Tanzania's* sector wide approach (SWAp), World Bank funds were to be used to buy contraceptives and other essential health commodities. An inability to meet World Bank procurement guidelines delayed purchases and led the government to use its own tax revenue to make necessary purchases. Despite this, delays in delivery were still experienced due to problems in clearing the port at Dar es Salaam.

Each of these countries has taken positive steps to address its procurement issues. Before describing these, the main components of a working public procurement model are outlined.

WHAT IS AN IDEAL PUBLIC PROCUREMENT MODEL?

The public purchase of contraceptives should adhere to the following four procurement principles (see table 10):

As the preconditions show, these procurement principles require several regulatory, institutional, management, and technical capacity preconditions. Attaining these ideal procurement conditions will not be possible unless regulations allow access to products from different sources; procurement staff must be accountable for following clear guidelines and allowed to make informed purchasing decisions based on price and quality comparisons, while ensuring product safety. In many countries, the conditions are not yet in place to allow these procurement principles to be applied.

TABLE 10. FOUR PROCUREMENT PRINCIPLES FOR THE PUBLIC PURCHASE OF CONTRACEPTIVES

Principle	Rationale	Preconditions
Procurement management efficiency	The process should be as smooth and efficient as possible, and managed carefully from initial product specification to product delivery and use. This requires pre- and post-shipment procurement management to ensure that supplier quality standards and shipment issues are addressed.	Requires a procurement management capacity.
Transparency	The procurement process should be transparent, clearly following defined guidelines and criteria that encourage rational decision making so that procurement decisions can be understood by stakeholders.	Supposes good governance, management oversight, and public accountability.
Value for money	Use of public funds demands that spending demonstrates value for money and obtains the best possible deal, with due consideration for quality and safety. This requires the review of a variety of products from different national and international sources, with comparisons of price, product shipment conditions, and product quality. Bulk purchase is a key way to obtain economies of scale in delivery and, thus, lower unit prices.	Requires regulations that allow unrestricted access to supplies from different sources and centralized procurement. It also requires funding be made available in one block rather than in smaller amounts through the year.
Effective, safe, and efficacious methods	Effective quality control is important to protect public safety and ensure that effective and efficacious products are procured. In addition to assessing the quality of products tendered, tests of each shipment should be conducted.	Requires technical quality assurance capacity and access to testing laboratories.

STRENGTHENING PROCUREMENT PLANNING AND MANAGEMENT

Improved procurement planning and management are essential if countries are to ensure that public funds are used wisely in purchasing contraceptives. Better management requires improvements across the procurement cycle. This begins with identification and quantification of product requirements, which includes a budget review and approval process, a tender process that is either international or national depending upon the product, a tender evaluation process, post-tender contract management, and a quality assurance process to ensure only products meeting requirements are accepted for delivery.

Key elements or steps of the procurement cycle include the following:

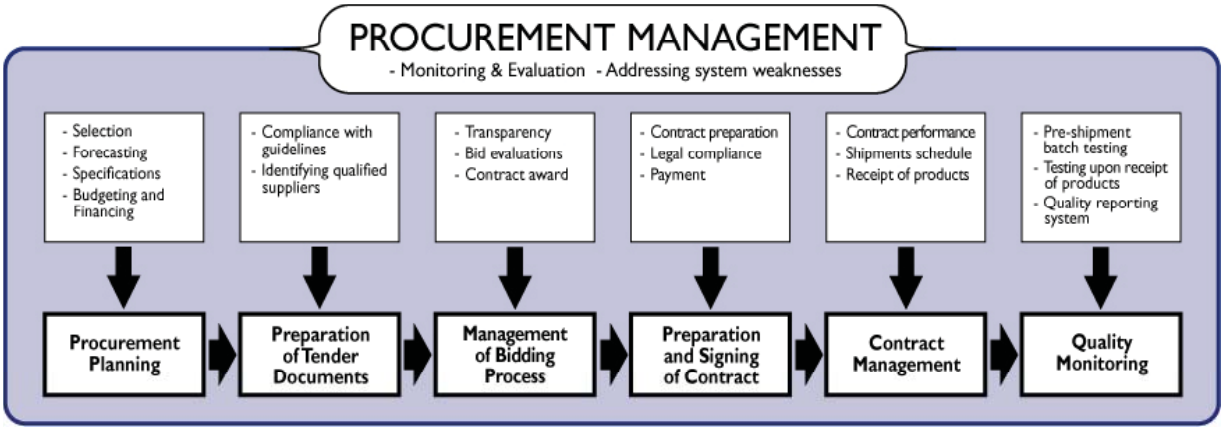
- Select the safest, most cost-effective essential medicines.
- Forecast and quantify needed purchase volumes.
- Ensure adequate financing for the purchase of essential medicines.
- Identify qualified suppliers.
- Manage the tendering, bidding, award, and contracting process.
- Maintain transparency and accountability in all transactions.
- Ensure good-quality, safe commodities.
- Monitor the performance of the range of processes involved in procurement management.

Figure 17 illustrates that the procurement process must be organized chronologically and must successfully orchestrate a number of complex tasks, including the development of exacting product specifications, identification of financing, and a budget process to secure that financing. As figure indicates, the process must also include the preparation of tender documents; management of the bidding process; preparation, award, and management of the contract; a quality assurance process to ensure that only products meeting requirements are accepted for delivery of the contract; and the management and monitoring of each function in the process. Failure to address accurate forecasting, for example, could result in the production of erroneous tender documents—leading to supply imbalances. Similarly, financing sources should be identified and secured before beginning the procurement process. Further, the number of agencies involved dictates a high level of coordination between the regulatory bodies, logistics functions, financing agencies, and others involved in the process. Chile's semi-autonomous procurement agency CENABAST is a good example of efficient procurement management. Box 11 presents a synopsis of its procurement management cycle.

The **Six Rights** are the—

- right product
- at the right time
- in the right place
- for the right price
- in the right quantity
- the right quality.

FIGURE 17.THE PROCUREMENT PROCESS



Source: Rao, Mellon, and Sarley 2006

BOX 11. CHILE'S CENABAST: CASE STUDY IN EFFICIENT PROCUREMENT MANAGEMENT

CENABAST is an autonomous and decentralized public purchasing agency in Chile. It is managed independently of the MOH and is run on commercial business lines that emphasizes the achievement of pre-negotiated performance goals. One strong mechanism used by CENABAST to ensure the goal-achievement mentality is to directly relate the remuneration of its high executives to the success in attaining the pre-negotiated institutional performance goals. CENABAST can purchase contraceptives and essential drugs from local representatives of international companies, from local producers and, occasionally, directly in the international market. The openness of the Chilean economy means that there is greater competition, so that local prices are close to international prices and international procurements are infrequent.

CENABAST distributes products to the 26 regional health authorities, from there they are distributed to public facilities. Public facilities then provide contraceptive products free-of-charge to affiliated public-sector clinics to reach low-income and general populations. Attention to client needs and efficient management processes help CENABAST maintain its public-sector clients; so the districts rarely purchase from other sources, even though they have the right to do so.

CENABAST's procurement management cycle is straightforward and involves nine major steps:

Step 1: Once a year, the first-line facilities fill in a form with their forecasted commodity needs for the following year and send it to the person—usually a midwife—in charge of the program at the district health service (the regional health authority).

Step 2: Each district health service sends the forecasts from all of the health facilities under its jurisdiction to the directorate of the Women's Program in the Department of Macro-Networks.

Step 3: The directorate of the Women's Program consolidates the forecasts in coordination with the directorate of Women's Health.

Step 4: The directorate of the Women's Program, with the directorate of Women's Health, sends a memo to CENABAST with the technical specifications needed to procure the commodities: type, formulation, quantity, reference prices (based on past bids), and delivery intervals.

Step 5: CENABAST, with the consolidated demand, calls for bids which may or may not be open to foreign firms but, in most cases, is only addressed to local firms.(Public Health Institute)(ISP) authorized bidders are invited to participate.

Step 6: The bids are evaluated and a contract award made.

Step 7: ISP ensures that the products are of good quality. If the commodities are imported, the ISP will proceed to the screening of samples for each purchase. In the case of a local product, quality control is assured at the certification process that is conducted to register a provider as an authorized bidder.

Step 8: CENABAST pays the provider and takes responsibility for distribution to the district Health Services.

Step 9: District Health Services distribute to the first-line facilities under their jurisdiction.

Source: Morales 2006

TRANSPARENCY

Ensuring good governance and transparency with procurement is a persistent problem worldwide, in developed as well as developing countries. During recent analysis of procurement experience in Brazil, access to some public-sector procurement experts was undermined because of a corruption scandal affecting the central procurement unit of the Ministry of Health (MOH). Staff did not want to meet the research team because of ongoing investigations. Similarly, Costa Rica has recently experienced corruption scandals at all levels of government, including difficulties with transparency of drug procurements. Elsewhere, procurement regulations are often cumbersome because of a need to safeguard good governance; this imposes delays and additional management costs. A number of strategies have been adopted to improve transparency and safeguard good governance; these can be categorized under three headings:

- appointing independent procurement agents, e.g., UNDP in Honduras and UNFPA in El Salvador and the Dominican Republic
- improving accountability to clients, e.g., CENABAST in Chile and increased public vigilance in Costa Rica
- improving transparency of information flows, e.g., in Chile and Costa Rica with Internet-based information systems.

APPOINTING INDEPENDENT PROCUREMENT AGENTS

A common objective of World Bank–led health sector reforms is to improve the efficiency and governance of public-sector management. Concerns around corruption in the use of loan funds have led the World Bank to develop strict and sometimes cumbersome procurement guidelines for the use of its loan funds globally. World Bank loans frequently require appointment and use of a procurement agent to manage the procurement process. In Honduras, UNDP has been appointed as the procurement agent. In other countries outside of the region, commercial procurement agents, including Crown Agents, SGS, IDA, and Charles Kendall, have been used. Procurement fees can vary from 5 to 10 percent for these and other agents.

Using UNFPA or IPPF provides more specialized contraceptive procurement expertise, and both have been considered in Latin America. UNFPA certainly has access to low-cost global suppliers but it only delivers to the central level and charges a 5 percent fee. There is also some variability in the capacity and willingness of UNFPA local offices to manage the procurement process. UNFPA has undertaken procurements in Peru and is now being used in Guatemala, the Dominican Republic, and El Salvador, and is being considered in Paraguay. UNFPA has also been used as a procurement agent by Ghana and is being considered in several Central Asian countries.

Another issue with using UNFPA is that typically it will not make purchases on account but rather requires payment in advance. This can be problematic when budget allocations are not made in a timely manner or in a single tranche. As mentioned in the previous chapter, Guatemala has overcome this by combining support from Canadian International Development Agency (CIDA) with the establishment of a revolving fund and escalating contributions from the Ministry of Finance. CIDA donated $3.5 million to the Government of Guatemala for contraceptives. This money is managed by UNFPA, which procures the contraceptives and donates them to the MOH. The MOH, in turn, deposits the funds in a bank account, a percentage matching amount based on the total value of the donated products for a specific year. The amount deposited is meant to increase each year, creating both the tradition of the MOH setting aside funding and providing the upfront financial purchasing power to continue to pay UNFPA for the procurements.

IMPROVING ACCOUNTABILITY TO CLIENTS

In Costa Rica, a healthy public debate has emerged on the topic of procurement. The debate is driven by public concern about impending changes resulting from the CAFTA and increased public vigilance generated by corruption scandals at all levels of government, including some involving drug procurements. Citizens are deeply concerned about the sustainability of the Costa Rican Social Security Fund (CCSS), efficiency in the procurement process, quality of health commodities, and better governance throughout the procurement process. During 2005 and into 2006, much public debate has taken place about how to improve prices while preserving quality of products, both in the public and private sectors. As a result, various new laws, decrees, and regulations are being discussed at all levels of government. These policies are meant to streamline the procurement process, increase transparency, and improve the quality of products within the CCSS, in partnerships with private industry and throughout the private sector.

For example, as a result of public pressure, a national commission was recently established to ensure the quality of health commodities. In January 2004, a decree was passed that transferred quality control from the CCSS to the Ministry of Health; this transition took place during the last quarter of 2005. Government officials aim to include all medications sold within the country, rather than only those purchased by CCSS. Another reason for the establishment of the national commission is to ensure that an autonomous entity is checking the quality of the products purchased by the public sector. In addition, the national commission has required that generic commodities be tested for therapeutic equivalence. It is expected that more changes and reforms will take place as CAFTA is ratified and citizens continue to demand more transparency and efficiency from the public sector.

Box 10 summarizes the procurement management process undertaken by CENABAST in Chile. Chile's health management system is decentralized, and the district health offices have latitude to purchase from the source with the best service or price. The fact that all the districts continue to use CENABAST points to the quality of its service and its attention to clients' needs. The independence of CENABAST means that it has maintained management independence separate from political considerations, and has been able to adopt a business management style without the constraint of civil service staff terms and conditions. Staff are rewarded for good performance and penalized for poor performance. Indeed, Chilean health reform, which began implementation in the early 2000's, has given more autonomy to public health facilities, allowing them to choose where and from whom they buy drugs and supplies, and to provide monetary incentives to their staff for attaining program goal achievements. This exerts a direct pressure on CENABAST to improve its own performance. In the same vein, the remuneration of CENABAST senior executives depends directly on the realization of pre-fixed institutional goals and objectives. These strategic goals are tri-annual and are subject to the management model negotiated with the National Direction for Civil Service, which is the entity that supervises all public institutions in Chile. Another innovation recently introduced by CENABAST and related to accountability is the outsourcing of the auditing process of biddings, demand consolidation, and classification of providers to a private firm. Finally, quality control has been outsourced to an international firm, ISP, this year, mandating the firm to ensure accreditation of CENABAST'S providers.

IMPROVING TRANSPARENCY OF INFORMATION FLOWS

Both Chile and Costa Rica have started using the Internet to promote e-commerce procurement. The advantages include increased competition by providing information to more suppliers; it also helps potential bidders understand the process more clearly. The Chilean case is particularly instructive in this respect. CENABAST, an autonomous and decentralized public agency in charge of providing drugs and supplies to the public health network, works within the site www.Chilecompra.cl. In this platform, calls to provide

the public sector with goods and services are centralized. This Internet-based platform is a transparent mechanism where all documents and information related to the bidding process are made available. The platform also helps make the results of the bidding transparent. Several other bidding-related processes may also be undertaken electronically.

The Costa Rican Social Security Fund is also looking for ways to improve efficiency and transparency through technology. They have considered the feasibility of automating tenders, increasing use of the Internet as a procurement vehicle, and even conducting their own procurements online. Currently, public information is made available via the CCSS website (http://www.ccss.sa.cr/), and eventually, the CCSS will provide price and procurement data online to ensure accountability, as well as reduce the amount of staff time spent responding to audits.

VALUE FOR MONEY STRATEGIES

Countries have adopted a number of value-for-money strategies. The underlying premise is that procurement management capacity is needed to make informed buying choices.

ECONOMIES OF SCALE IN BANGLADESH

Bangladesh's World Bank–sponsored SWAp provided the opportunity for national contraceptive procurement to generate economies of scale in purchasing contraceptives. For this to be realized, DELIVER and PATH provided technical assistance to strengthen the national procurement capacity in the Directorate General of Family Planning (DGFP) in the Ministry of Health and Family Welfare (MOHFW). As mentioned in the previous chapter, the benefits of this capacity building meant that, with the high volume of condoms and pills purchased, the DGFP was able to obtain unit prices from the winning Indian suppliers that were far lower than typically quoted international prices. The estimated savings was as much as $17.2 million. Forecasts of Bangladesh's funding needs for 2010 were reduced downward from $60 million, estimated in 2000 prices, to $40 million for the same volume of commodities at the lower prices obtained. To recognize this savings, the Ministry of Finance, for the first time, approved $690,000 to fund contraceptives from the government's own revenue budget in 2004 and again in 2005.

Bangladesh: Woman holding a package of birth control pills.

INFORMED BUYING IN PERU

In 2004, the Ministry of Health (with UNFPA) conducted a market study to identify the best prices available for the four contraceptive commodities that the FP program procures. Condoms were not procured that year because there were still sufficient stocks from previous years. For IUDs, the UNFPA price was far lower than prices available on the local market. The local and UNFPA prices for the three-month Depo-Provera were identical. The MOH opted to buy both products from UNFPA. However, the price of the oral contraceptive used by the public sector was significantly lower in the local market, even after including the cost of distribution to local delivery points, a service not offered by UNFPA. Therefore, in 2004, the MOH chose to procure oral contraceptives locally, thereby achieving significant savings.

The supplier was ESKE, the local representative of the Indian company, *FamyCare*. The entry of companies like ESKE into local markets has great potential to increase competition among local suppliers and, thereby, yield better prices for contraceptives.

This experience underscores the importance of establishing, updating, and maintaining a systematic, comprehensive price comparison tool to inform decision makers about the various supply options available in both the national and international market.

INFORMED BUYING IN COSTA RICA

The CCSS has procured contraceptive products at competitive pricing levels during the last five years, from both international and local manufacturers. The cost information provided by the CCSS suggests that they have established several cost-effective alternatives by rotating between local and international manufacturers for the procurement of contraceptive supplies. The fact that they are able to procure locally manufactured, as well international competitively priced–products, provides important alternatives that are not available to many countries.

Further, the CCSS is currently developing and evaluating new strategies to improve procurement efficiencies and ensure more competitive prices. Staff from CCSS were concerned about the limitations of negotiating prices with suppliers for supplying a small market. They have considered the possibility of merging with larger countries to conduct what they describe as *parallel* purchases—they would purchase some medications directly from these larger countries in order to receive access to the same economies of scale. This strategy has still not been fully evaluated, and the details are under development by CCSS staff. In addition, CAFTA may facilitate the establishment of a regional procurement system, and help the region obtain better prices as a result of demands for higher volume. In addition, the Central American region is currently evaluating the feasibility of having a customs union that would standardize and regionalize the requirements for registration of all medicines and medical supplies and, consequently, streamline the procurement process.

NEGOTIATING WITH MANUFACTURERS

Peru also negotiated a contract with the local Pfizer distribution office for Depo-Provera. The MOH was willing to pay 20 percent over the UNFPA price to have Depo-Provera delivered to the district level rather than the central level. It thus used the UNFPA price as a reference price in negotiating better delivery terms from the local Pfizer office than UNFPA could offer. The Pfizer office was able to make a small profit; whereas, it would have otherwise been bypassed, because UNFPA would have procured from Pfizer's international headquarters. There may be other examples of manufacturers being willing to negotiate price because of competition. Several manufacturers' agents approached the MOH after UNFPA had been awarded the procurement contract to say they could have offered better prices—exactly the sort of competitive response governments should encourage.

El Salvador: Health center workers stock their store room.

POOLED PROCUREMENT MODELS

In West Africa, governments are taking an increasing responsibility for the purchase of reproductive health commodities through national budget lines and the use of World Bank credits. However, because of their small national markets, they are paying prices that exceed those obtained elsewhere. Variation in prices paid by the different member states of ECOWAS was not entirely due to differences in purchase volume. For example, Burkina Faso paid less for certain RH commodities than did Ghana, despite having a smaller population. In addition to volume, higher prices may also be explained by market restrictions that protect higher-cost local manufacturers or poorly managed competitive bidding. One approach under development in the region is the implementation of a procurement information-sharing mechanism. This will enable information about contraceptive prices paid by different ECOWAS countries to be shared among procurement managers; members could then be informed about prices being obtained across the region. DELIVER is presently working with the West Africa Health Organization (WAHO) to implement the system. The LAC region already has two positive experiences with pooled procurement, including the PAHO regional vaccine initiative and negotiations on regional prices for and access to ARV drugs. Experience elsewhere in the Caribbean, Asia, and Africa has shown that successful pooled procurement requires a number of preconditions and it takes time to achieve. However, a number of intermediate steps can be considered, such as using existing subregional integration initiatives (MERCOSUR, PACTO ANDINO[14]) to harmonize drug registration and establish a network of quality assurance laboratories. A first step would be to share information on prices obtained through public procurements in different countries to enable procurement offices to conduct better-informed buying.

ENSURING THAT BUDGETS ARE FUNDED

Procurement using public funds is frequently affected by two problems that undermine efficient planning and result in higher costs to the public sector. First, even when budget lines are allocated, cash flow and treasury management constraints can undermine the ability of the Ministry of Finance to make all the necessary procurement funds available at one time. If budgets are made available on a quarterly basis, the MOH may be forced to make four smaller purchases of commodities rather than one single bulk purchase. Second, payment delays can be experienced depending on how purchases are actually paid for, with invoices for approved purchase orders being sent to the treasury for payment. These delays and risks of nonpayment will reduce the scope for negotiating lower prices from suppliers and may even deter qualified suppliers from bidding on advertised tenders.

IMPROVING QUALITY CONTROL

Contraceptive procurements require management of contraceptive quality control at several levels (see table 11).

14. *Mercado Común del Sur,* or MERCOSUR, is a customs union between Brazil, Argentina, Uruguay, Paraguay, and Venezuela; it was founded in 1991. Its purpose is to promote free trade and the fluid movement of goods, people, and currency. Bolivia, Chile, Colombia, Ecuador, and Peru have associate member status. PACTO ANDINO, also known as the Andean Community of Nations, is a trading block comprising Bolivia, Columbia, Ecuador, Peru, and Venezuela.

TABLE 11. MANAGEMENT OF CONTRACEPTIVE QUALITY CONTROL

Level	Conditions
Pre-qualified manufacturers	Manufacturers participating in tenders should ideally be pre-qualified to ensure they apply good manufacturing practices (GMPs), are internationally recognized with U.S. FDA and/or EU/EMEA approvals, and are recognized by WHO.
Correctly specified tenders	Contraceptive commodity tenders should have clear technical specifications that can be verified by the tender evaluation committee.
Drug registration	All countries require that new drugs be registered. This should strike the right balance between supporting public safety and not creating a barrier to supply. Scope for regional harmonization of drug registration should be explored.
Pre- and post- shipment inspection and quality testing	Protocols for testing the quality of contraceptives should specify the basis and frequency for quality testing. Use of international and regional laboratories should be considered where in-country facilities are underdeveloped.
Addressing manufacturer liability for failed shipments	Supplier contracts should specify that manufacturers assume responsibility for disposing of failed lots of contraceptives.

A balance must be struck between drug safety and ensuring patient access to needed contraceptives and essential drugs. Internationally accepted quality guidelines should be used for quality assurance testing to avoid unnecessarily rigorous testing protocols being applied. FDA and EMEA drug certification should be accepted where local capacity is underdeveloped.

INDEPENDENCE FROM POLITICAL CONSIDERATIONS

Several unique factors related to the Costa Rican experience have served to facilitate contraceptive procurement. First, the procurement of all medicines and medical supplies is driven by a transparent and autonomous procurement process. The fact that there is an autonomous agency in Costa Rica—the CCSS—responsible for managing the essential drug list and all related procurements means that there is little room in the process for political pressure and/or stalling tactics that could be used to inhibit the procurement of contraceptive commodities.

Second, because there is a single agency in Costa Rica that procures all medical supplies for the public sector, it has managed to gain stronger leverage with commercial suppliers—even though Costa Rica represents a relatively small market. The fact that the CCSS procures the majority of its medicines centrally does give it significantly more negotiating power, as well as more control over the quality of products received.

In Chile, CENABAST's independence from political interference has helped it make independent technical procurement decisions. Its ability to hire and fire staff based on merit and performance without civil service restrictions has also contributed to the development of a strong technical and managerial staff.

PROCUREMENT KEY STEPS

Experience suggests that a number of key elements are required to strengthen procurement capacity:

- Attaining the six procurement *rights* requires careful planning and management.
- MOH staff need to be given specialized training in procurement best practice, particularly in World Bank procurement procedures.

- Use of procurement agents should be considered, particularly while MOH staff are being trained in international competitive bidding (ICB) and World Bank procedures.
- Funding should be earmarked and disbursed in a timely manner to ensure that economies of scale can be achieved with public procurement.
- The regulatory environment should permit ICB to encourage price competition.
- Procurement agencies should review international reference prices, and where possible, exchange information with neighbors to allow better informed buying.
- UNFPA can act as a procurement agent to allow access to international prices, particularly where regulations are a constraint. UNFPA performance should be monitored and managed as with any procurement agent to ensure the advantages of lower prices are actually being delivered on time.
- Negotiations with manufacturers should look at the benefits of generic purchase while ensuring proper quality and drug safety standards.
- Manufacturers may be able to quote prices for in-country delivery to districts or regional stores.
- Procurement decisions should be transparent and independent of political interference.
- Use of the Internet to publicize procurement opportunities and to document procurement decisions can help improve governance by putting procurement decisions under public scrutiny.
- Use of regional and international quality standards and laboratories can offset the cost of contraceptive quality control.

CONCLUSION

Procurement is one of the critical components in contraceptive security and one of the most complex. Good procurement decisions depend on proper product selection, accurate forecasts, and adequate financing. Procurement requires institutional capacity to plan and manage the timely preparation of tenders that meet strict regulatory and ethical standards and include comprehensive technical specifications. Awards must be made independent of outside influences and based on the best price and the ability to meet the quality and delivery specifications of the tender. Good procurement decisions also require the ability to monitor product quality and ensure timely payment to suppliers. At every stage, there can be obstacles that delay the process, which increases both the potential cost of the product and the possibility that in-country supplies will be depleted before new stock arrives. A smooth procurement process is, therefore, an essential element in ensuring contraceptive security.

10. LOGISTICS

DELIVER and its predecessor project, Family Planning Logistics Management (FPLM), have worked to strengthen family planning logistics systems for the last 20 years. This experience has shown time and time again that a well-functioning logistics system is pivotal to contraceptive and commodity security. Procurement and finance planning both require accurate consumption-based forecasts, which, in turn, require an effective logistics management information system (LMIS). After the forecasts, financing, and procurement steps have been completed, an efficient supply chain needs to be in place to ensure the right products are delivered to the right place, in the right quantity, for the right price, at the right time and the right quality. Attaining these six rights requires the establishment and constant management, as well as monitoring and evaluation, of a supply system to ensure product availability.

"No product, no program" has become synonymous with supporting logistics systems to improve contraceptive security. Donors, governments, and the private sector are increasingly aware that explicit attention to the supply chain is required if product availability is to be improved.

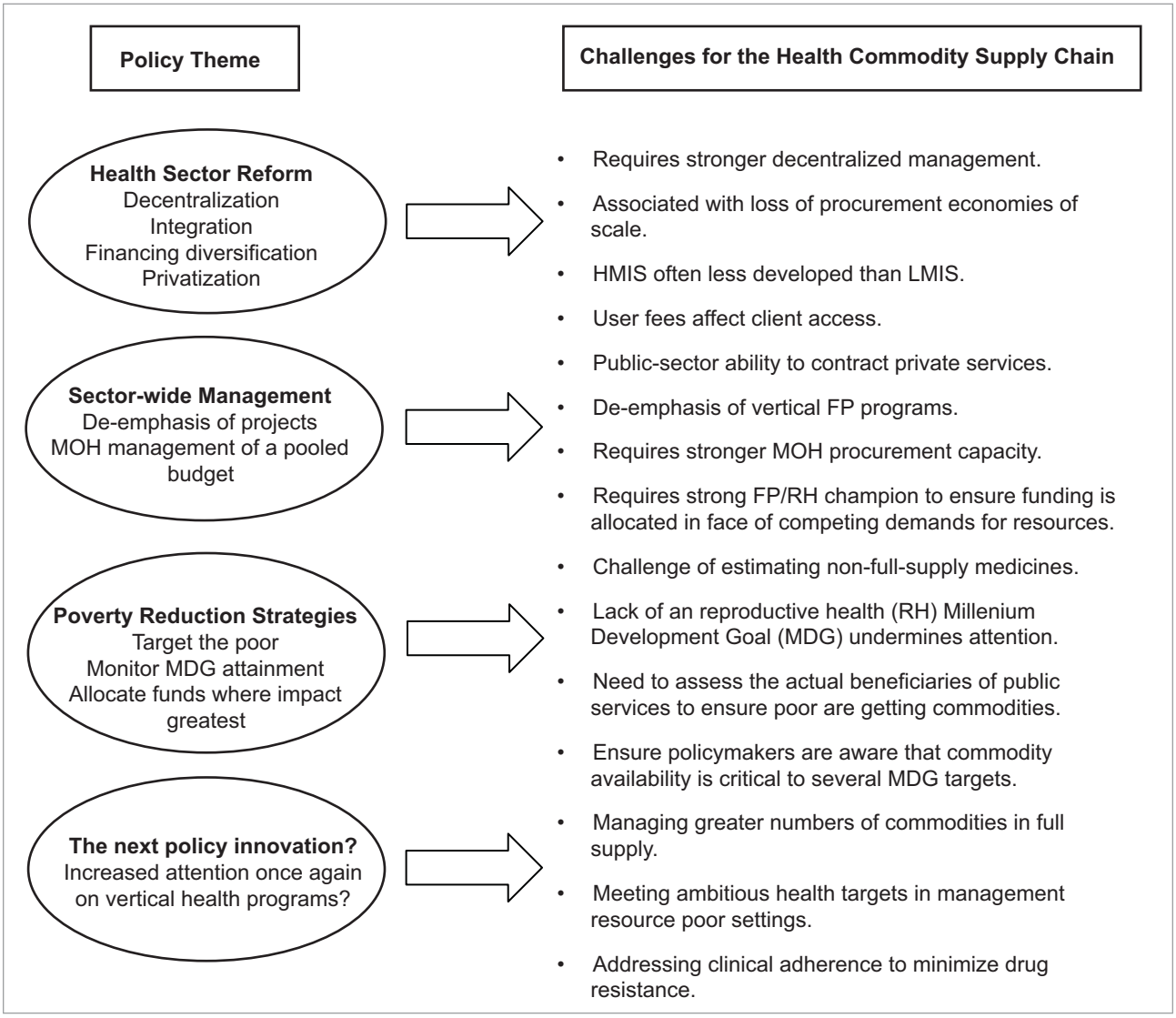
While recognition of the importance of logistics is growing, health policy decisions continue to be made without adequate attention to health commodity supply chains, which in many countries continue to lag behind logistics innovations elsewhere. This chapter examines both issues.

ENSURING A SUPPLY CHAIN PRESENCE AT THE POLICY TABLE

Health policy reform in the last decade has been driven by efforts to improve the equity, efficiency, and effectiveness of health services. The World Bank's *World Development Report 1993: Investing in Health* (World Bank 1993) highlighted the need for reforms that refocused health services toward integrated primary care–based interventions that addressed community needs, particularly those of the poor and vulnerable. Donor-supported health sector reforms sought to establish integrated packages of basic health care services, with decentralized management decision making and diversified funding. From the late 1990's on, these reforms were increasingly implemented as sector wide approaches (SWAp) with basket funding arrangements; donors sought to reduce the administrative burden of individual donor projects and give recipient governments greater control over the allocation and use of health funds. Poverty reduction approaches have tried to ensure that public expenditures were indeed reaching the neediest, while tracking performance in attaining national Millennium Development Goal (MDG) targets.

While, in many cases, the health and economic reforms being implemented have helped improve health service delivery, there have been examples of unintended adverse affects on the operation of health commodity supply chains. These largely occurred because the implications of change for family planning (FP) and health commodity logistics systems were not considered during the program design. They also occurred because the capacity of local management to implement change was not thought through. Figure 18 summarizes some of the supply chain challenges emanating from health and economic policy reform.

FIGURE 18. IMPACT OF HEALTH SECTOR AND ECONOMIC REFORMS ON THE SUPPLY CHAIN AND COMMODITY SECURITY



Specific examples include—

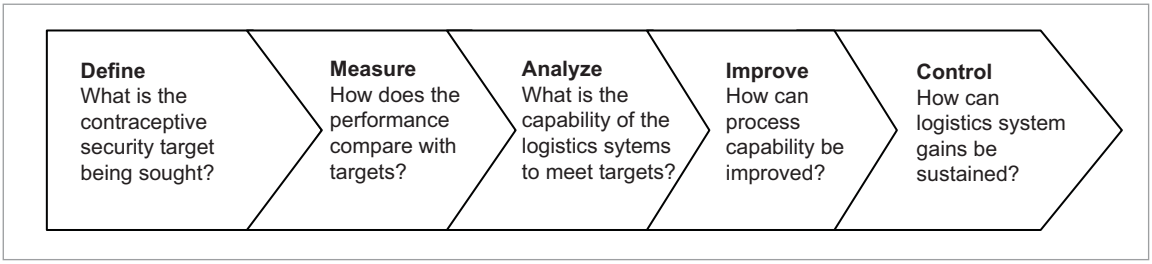
- In implementing *Bangladesh's* first health sector wide approach (SWAp), the Government of Bangladesh (GOB) procurement capacity to purchase health commodities was not assessed, leading to more than a two-year delay in purchasing contraceptives. With support from DELIVER, capacity was strengthened and considerable program savings were eventually achieved, as low unit prices were obtained on subsequent bids.

Bangladesh: Field worker receives supplies of birth control pills.

- In *Zambia*, planners assumed the health management information system (HMIS) stock availability data for a few tracer drugs would be sufficient for all logistics management purposes. District staffs were informed they no longer needed to submit monthly activity reports for FP and other vertical programs. Unfortunately, these LMIS activity reports contained data the HMIS did not provide; central-level logistics staff lost access to information to monitor stock status and prepare forecasts (Bates et al. 2000).
- Ghana's cash-and-carry system, designed to allow local management and funding of drug budgets, was undermined by delayed and inadequate reimbursement of exemptions. Decentralized management, combined with weak supervision, also resulted in a wide variation in price margins being charged to clients (Sarley et al. 2003).
- Decentralized management and procurement in Ecuador resulted in local health authorities paying substantially higher prices for contraceptives than would have been possible through centralized procurement (Sarley et al. 2006).

These examples and others highlighted elsewhere in this publication reinforce the need for a logistics perspective when implementing health reforms. In designing and implementing reform, health policy planners could consider the supply chain process improvement approach (DMAIC) process improvement approach adopted in commercial supply chain settings—namely, define targets, measure performance, analyze capacity, improve capability, and control results (see figure 19).

FIGURE 19. SUPPLY CHAIN PROCESS IMPROVEMENT APPROACH (DMAIC) PROCESS



Source: Goldsby and Martichenko 2005

In a health reform setting these can be evaluated as follows:

1. *Define.* What supply chain performance indicators will be tracked and what explicit targets will be set to monitor logistics system performance?
2. *Measure.* How do the health reform changes affect the performance of the existing logistics cycle: forecasting, financing, procurement, and delivery?
3. *Analyze.* What is the present capacity in each of these supply chain functions to implement the proposed changes?
4. *Improve.* What transition arrangements and capacity building are required to improve the logistics system so that it can implement the proposed changes; what funding is set aside for this improvement?
5. *Control.* How will analysis of logistics system performance be fed back to policymakers to ensure performance improvement can be adapted to the needs of the health reform program?

Access to accurate and timely data through the LMIS to guide decision making is crucial to each of these considerations. Ensuring that the right information flows accurately and in a timely manner to managers and policymakers can be the difference between a health reform working or failing.

GOALS OF AN OPTIMIZED DISTRIBUTION SYSTEM

In implementing health reforms, policymakers should also consider how improvements in the logistics system can be a driver for change. As an analogy, in commercial settings, optimizing the supply chain is seen as a driver for competitiveness and profitability. Companies that can get their products to the customer quickly and cheaply can increase customer satisfaction, sales, and net returns. For public health commodities, the emphasis is less on profitability and more on maximizing product availability for the lowest cost. Keeping this in mind, public health policymakers should consider several factors as they seek to optimize their distribution systems:

- Meet customers' needs but at the lowest cost possible. This often translates into fewer distribution levels to reduce inventory, training, and supervision costs; improving the operation and condition of distribution centers; and more effective use of transportation resources. It also implies a performance monitoring system that program managers can use to track and address performance issues. Ideally, this would mean a frequent flow of small shipments to sites to minimize their inventory-carrying costs and the need for storage space; to maximize responsiveness to changes in demand; and to limit the possibilities for expiry, theft, and stockout.
- Standardize inventory management and ordering procedures to the extent possible. This reduces the burden on the service provider, reduces training requirements, facilitates supervision, and should reduce the total distribution cost. It also makes the addition of new products to the system simpler and cheaper if their handling requirements are similar to existing products.
- Address decentralization requirements. In decentralized settings, lower-level units may have control over budgets, personnel, and facilities. Any design must be able to respond to those needs, while avoiding the fragmentation of the supply chain into many disconnected and inefficient islands. DELIVER's decentralization study concluded that standardizing inventory management procedures and information system requirements yielded performance gains in decentralized settings.
- Provide for transparency and accountability. The procedures and records used in the distribution system must provide for a verifiable chain of custody for medicines to, at least, the subnational level, if not the facility level. This means that for any particular batch of a medicine, the program manager should be able to trace its movement and the person responsible for it to either the subnational or facility level. Reducing the number of distribution levels in the system makes this easier.
- Improve visibility of inventory and demand to the facility level. This is usually achieved through a logistics management information system.
- Utilize best value service providers. Part of the system design process is a consideration of options for operating the system. In many countries, the use of the private sector for certain logistics operations is expanding. Management of the central medical stores in Zambia is outsourced to Crown Agents; the Kenya Medical Supplies Agency is using Securicor, a private transporter, for distributing HIV supplies; and the Department of Health in South Africa contracts with private

distributors for the procurement, storage, and distribution of condoms. JSI will work with its clients to evaluate the private-sector logistics providers that are available in-country, the current and future capacity of the client to carry out different distribution functions, the work that needs to be done over the medium term, and the cost and risk of various options.

INNOVATIONS FOR IMPROVED LAST MILE DELIVERY

The last mile in any distribution system, but especially in developing country distribution systems, is the hardest mile. Getting contraceptive and health commodities to clients is often hampered by poor transport infrastructure, inadequately trained staff at SDPs, inaccessible rural clients, uncertain commodity needs, and incomplete LMISs. While problems persist in many countries, several logistics innovations are being pioneered to achieve improvements. Solving last mile problems requires a combination of approaches, including—

- Improved distribution system design—for example, by delivering directly to facilities, if possible, making sure that the last mile is the first mile. In Peru, the MOH cut out the need for central storage of Depo-Provera by negotiating a price with Pfizer for delivery direct to district stores. For expensive commodities like ARV drugs, use of commercial delivery solutions like UPS, DHL, or FedEx can be considered.
- Improved skill development—for example, doing team training for subnational and local facilities to minimize staff turnover problems and partnering with local organizations to enable them to provide support over the long term.
- Better analysis of resource needs to deliver to the last mile—for example, cost analysis for last mile distribution and inclusion of sufficient funds in national or subnational budgets or payment directly to the national distribution center.
- Improved data management and performance monitoring systems to allow managers to monitor last mile performance and take remedial action, as needed.
- Use of mobile phones and PDAs to upload data on stock status from remote settings.
- Adopting smart card technology to track dispensed-to-user data and stock status, and combining these with mobile phones to transmit information from remote sites.
- Increased advocacy for last mile availability by civil society groups.

CONCLUSION

Optimizing logistics systems is pivotal to improving contraceptive and commodity security. Health sector reforms that fail to consider the impact of proposed changes on the supply chain and its ability to adapt risk undermining reform objectives. To sustain health sector goals, policymakers and planners should define supply chain targets as part of their reforms, analyze the capacity of the logistics system to deliver commodities with the reforms, measure performance against targets, and improve the capability of the system. Logistics system performance can be optimized by ensuring a client focus, standardizing management and procurement of integrated systems, focusing on strengthening decentralized management capacity, supporting transparency and accountability, ensuring accurate and timely information flow, and looking for value for money options. Specific attention to the last mile is necessary in most developing countries; this requires innovation and flexibility from planners and participation from civil society.

11. SERVICE DELIVERY

CHOOSE, OBTAIN, AND USE

One of the key objectives of the 1994 International Conference on Population and Development (ICPD) Programme of Action is that "By 2015 all primary health care and family planning facilities [should be] able to provide… the widest achievable range of safe and effective family planning and contraceptive methods" (Supply Initiative n.d.a). So far in this paper, we've discussed the importance of policy, financing, logistics, and procurement, and how these components influence product availability and impact contraceptive security and the achievement of the International Conference on Population and Development (ICPD) goals.

This chapter focuses briefly on service delivery as a vital component of contraceptive security (CS). An examination of service delivery considers the range of access and quality service considerations that directly affect clients' ability to choose, obtain, and use contraceptives. The ideal result of service delivery would be a satisfied client making an informed choice. Are service providers' skills and service facilities adequate to satisfy clients' needs? Are providers well trained in clinical skills and counseling related to method choice? Do providers have adequate equipment and supplies to offer good quality contraceptive services? How does the service delivery process address barriers to access to and utilization of contraceptives?

Romania: Doctor counsels a patient about her reproductive health choices.

As demand grows for contraceptives, the capacity of the service delivery system must also expand. Understanding the ability of the service delivery system to provide quality products and services through a range of outlets is vital to enhancing contraceptive security.

While it is not part of DELIVER's core mandate, much of our work on CS has influenced and affected service delivery. Prior to illustrating examples (both positive and negative) of CS issues at the service delivery level, this chapter will review the definition of CS as it relates to service delivery. Contraceptive security exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever she or he needs them. In reviewing the definition of CS, several requirements are specific to the service delivery level.

Every person. This means that every woman, man, and child, regardless of wealth, geography, or ethnic group, has access to commodities and services that he or she needs. This ensures that the CS approach is nondiscriminatory and universal in ensuring access. Intentionally, this definition is customer focused and the service delivery level is the point of interaction with the ultimate client—the user of family planning (FP) methods.

Choose. Choosing is crucial in the case of family planning because all consumers have different needs at different points in their lives. For example, in planning her family, Roxanne (see chapter 2) used a variety of different methods with her partner including, initially, a traditional method. When this proved ineffective, she switched to oral pills that allowed her to space her next pregnancy. After her second child, she wanted to change her method of contraception to an intrauterine device (IUD) because she was unhappy with some of the side effects from the oral pills. This helped her space her third pregnancy. After three healthy children, she and her partner did not want any more, and her partner had a nonsurgical vasectomy (NSV). During the 12 years that these family planning choices were being made, Roxanne and her partner needed information, education, and communication (IEC) from their local FP service provider on the options available to them. They also needed unbiased counseling on the benefits and side effects of different methods. While using oral pills, they needed access to a reliable source of supply. They also needed access to clinical services for the IUD insertion and removal and the NSV procedure; both methods required trained staff, necessary supplies, and a clean facility that gave both clients privacy.

Obtain. This includes the supply chain and the *six rights*. As highlighted in the logistics section, *obtaining* means that the customer received the right quantity, of the right product, at the right time, in the right place, in the right condition, and at the right price. *Obtain* means *access to,* including geographic access; access to information that drives health-seeking behavior; and access to service providers, among other things. In the total market approach, findings indicate how barriers to access affect contraceptive prevalence rate (CPR), unmet need, and ultimately CS. The policy section highlights the importance of standards of care and protocols in ensuring quality service delivery and products.

Use. This word is another sign that CS is a customer-focused rather than a product-focused concept: it only exists when the client has received the appropriate quality product for their maximum effect and benefit whenever she or he needs it. The procurement chapter highlighted some of the components that are needed to guarantee high quality and appropriate supplies.

KEY SERVICE PROVISION INFLUENCES ON PRODUCT AVAILABILITY

Some of the issues implicit in the definition in previous chapters have been discussed: access issues in the total market section; and quality and availability in the logistics, procurement, and policy chapters. However, these issues resurface as we get closer to the client. The following are illustrative examples of how specific service delivery considerations directly affect clients' ability to choose, obtain, and use contraceptives.

Provider attitudes. Service provider attitudes can play an important role in limiting choice for clients. This has been illustrated by recent DELIVER work in Eastern Europe, the Caucasus, and Central Asia. In each region, there has been a long tradition of over-medicalization of reproductive health, with a lack of emphasis on the needs or wishes of the client, historically poor-quality hormonal contraceptives, and a lack of up-to-date information on modern methods. The statement of a medical officer from Kazakhstan that "we do not insert IUDs because they cause diseases" indicates how incorrect information might influence the clients' ability to choose, obtain, and use family planning supplies. Added to this, the fact that in some settings abortions provide obstetrician/gynecologists (OB/GYNs) with their main source of income, almost ensures that the clients will receive mixed messages on contraception.

Provider capacity. In one case in Kyrgyzstan, the chief of the Oblast Reproductive Health Centre, who is responsible for the redistribution of contraceptives, refused to issue supplies to clinical facilities located in the oblast capital on the grounds that family group practice–based general practice (GP) physicians

are not competent to prescribe them safely. Again, client access is limited by service delivery capacity and quality. In Georgia, senior policymakers wanted to limit contraceptive service provision to specialist *reproductologists*, a change that would have further reduced provider capacity. Advocacy work with the MOH, including a study tour to observe the positive impact of Romania's GP-based family planning program in increasing CPR and reducing the abortion rate helped reverse this restrictive policy change.

Private-sector access. Restrictions often exist on what services the private sector can provide. While intended to ensure quality of care, a side effect is usually to limit service availability. The following examples illustrate that fact:

- In Rwanda, as described in the chapter on policy, restrictions on who can dispense hormonal contraceptives effectively limit the public- and private-sector outlets from which clients can get their oral pills.
- In Mali, price controls limited the scope for the Social Marketing Company to introduce differentiated products to generate revenue, for increased sustainability.
- In Bangladesh, regulation of private-sector clinics, while necessary for quality control, has created opportunities for interference by civil servant inspectors. This has contributed to discouraging formalized clinics from providing FP and health services by the private sector, and has encouraged clinics to avoid registration.

In contrast, Indonesia found ways to improve access through the private sector. In 2003, the Boyolali District in Central Java had only three pharmacies, all located in the district capital. Through a decentralized Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) activity, the district stakeholders determined that this concentration of outlets limited access to contraceptives in the private sector. The stakeholders also identified barriers to opening new pharmacies and eventually brokered an agreement between the district administration and the pharmacy association to streamline the licensing process for new pharmacies, as long as they were located at the subdistrict level and stocked a variety of contraceptive methods. As a result, by March 2005, 10 new pharmacies were opened. The stakeholders are also establishing a district referral pharmacy that will stock all methods. In addition, the team found that private practitioners could not afford to keep a stock of contraceptives and, therefore, could not offer them to their clients. The stakeholder group brokered an agreement that allowed private midwives to purchase contraceptives from pharmacies and delay payment for one month.

Choice and method mix. At the East Africa RHCS Workshop mentioned in chapter 4, a Marie Stopes affiliate, *Banja La Mtsogolo* (BLM) Malawi, presented their experiences in expanding method mix to improve access to and uptake of family planning in the country. BLM's contribution to the national couple-years of protection (CYP) is 18 percent, and plays a major role in the provision of long-term and permanent methods for the country. BLM is the only NGO in Malawi that provides permanent contraception. It also provides services for the government and the Christian Health Association of Malawi centers in the country. BLM's lessons include working with other organizations to tap into the comparative advantage of each and to avoid duplication.

Strengthening community outreach. As a result of a decentralized SPARHCS process in Ende District in Nusa Tenggara Timur (NTT) province, Indonesia, stakeholders recognized that new users had high rates of discontinuation of their method, contributing to NTT having the highest total fertility rate in the country. The team decided that better community outreach and education would lower the discontinuation rate, and lobbied the district government to hire 100 community-based family planning outreach workers. Fifty workers were hired in 2005, and the district government committed to hiring the additional 50 in 2006.

CONTRACEPTIVE SECURITY AND FAMILY PLANNING SERVICE DELIVERY

USAID has several global, regional, and bilateral country-based projects working to improve family planning service delivery. These projects, implemented by experienced cooperative agents (CAs)—including Engenderhealth, MSH, Abt Associates, FuturesConstella, the University Research Corporation, and John Snow Research and Training Institute, Inc. (JSI R&T)—have increasingly included a contraceptive security dimension that seeks to build on their FP service delivery and program management expertise. Selected examples of logistics-based CS collaboration include—

- A contraceptive availability assessment for the Healthy Women in Georgia project estimated commodity needs, assessed logistics system weaknesses and private-sector capacity, and prepared forecasts for USAID procurement to support improvements in FP service delivery.
- A joint SPARHCS assessment was conducted with the Private Sector Program (PSP) *One* project in Kazakhstan and Kyrgyzstan to support Zdrav*Plus* to strengthen family planning service provision. The assessments identified the scope for the public and private sectors to increase product availability to meet client contraceptive needs.
- Worked with the Action for West Africa Region-Reproductive Health (AWARE-RH) project to develop regional contraceptive security strategies to ensure product availability.
- Supported JSI R&T's work in Romania in expanding family planning service provision through the development and implementation of a nationwide three pillar strategy that stressed ensuring product availability for target rural populations, expanding training for FP service providers, and funding IEC/ BCC campaigns.
- Worked with the URC-implemented USAID bilateral in Guatemala to conduct a SPARHCS assessment and develop a CS strategy to support FP service provision by improving product availability.

Other collaborative work in Azerbaijan, Egypt, Jordan, Bolivia, the Philippines, Indonesia, Russia, Albania, Palestine, and Ukraine has ensured that service provision is seen as a crucial part of contraceptive security.

CONCLUSION

Service delivery is the final step in the long process of getting a contraceptive into the hands of a client. Service providers must respond to and, in some cases, encourage demand for contraceptives by providing a sufficient range of choice. Providers must be knowledgeable about contraceptives, be skilled in counseling and managing side effects, and must not let their own bias or attitudes influence the choices their clients make. Both public and private providers must maintain quality and comply with standard treatment guidelines and protocols. It is at this level that clients experience contraceptive security and find the method of their choice, at a price that enables them to obtain it, and with the information they need to use it.

12. NEXT STEPS

The analysis and country examples presented in this publication provide evidence on what has worked in improving contraceptive and commodity security. The paper also identifies lessons learned and challenges still facing program managers and policymakers trying to ensure product availability. While much has been achieved, much remains to be done. Public and private providers of contraceptives and essential health commodities are failing to meet all their clients' needs. Ensuring that women and men can choose, obtain, and use the health products they need requires commitment and coordination at the local, national, regional, and international levels. Clients must understand and advocate for their rights; community leaders and civil society must empower their communities; local and national governments and public and private service providers must respond to client needs; and regional and global organizations and donors must remain committed to ensuring product availability. Additionally, the challenges facing contraceptive security become more complicated as security for a wider range of essential health commodities is considered.

To overcome these challenges, the work highlighted in this publication will need to continue. Our experience suggests a number of next steps that should be taken—from the local to the global level—always with the client in mind.

FOCUSING ON THE CLIENT

Every client deserves access to contraceptives and other essential health commodities. Whether this is seen as a fundamental human right or a necessary prerequisite for attainment of Millennium Development Goals (MDGs), a client focus is essential. Public-sector and nongovernmental (NGO) programs need to continuously assess if they are meeting their clients' needs. Generally, in the private sector, successful commercial companies focus on their clients' needs to help maximize sales. Public and NGO supply chains should similarly keep the client as the center of their attention. This requires that everyone is involved aware of the clients' needs—and indeed raising the customer service expectations—of public health clients; and, subsequently, monitoring and evaluating client satisfaction. It also means making sure that free and subsidized supplies are reaching the poor and vulnerable who are least able to access the private sector.

Uganda: Mother and child waiting for health services.

REINFORCING GLOBAL EFFORTS

While much has been done to promote global donor commitment, much remains to be done to improve and sustain coordination. As traditional bilateral sources of funding dwindle, new multilateral sources need to be identified. Basket funding mechanisms, usually established as part of sector wide approach (SWAps), and direct budgetary support can help governments take responsibility for their own health

programs—but they require careful support. In addition to funding for supplies, health systems need increased funding to strengthen the capacity of forecasting, procurement, and delivery operations. To provide longer term funding commitments to recipients, donors need to find ways to overcome their short-term budget constraints. They also need to find more effective mechanisms for allocating funds to ensure that scarce donor resources actually go to the countries most at risk and most in need. A global alliance, the Reproductive Health Supplies Coalition (RHSC), which supports RHCS, is coalescing now; key stakeholders from country and donor governments, multilateral organizations, civil society, NGOs, and technical agencies meet regularly. Still in its early years, the RHSC needs to establish itself as a viable forum for effective, transparent coordination, and resource mobilization.

REINFORCING REGIONAL GROUPINGS

Formal regional groupings already exist in Latin America, West Africa, East Africa, and Southern Africa, working on a variety of economic, health, and social issues. In the first three regions, these groups have been used to leverage regional contraceptive security meetings and networks, which have allowed countries to compare experience and, where appropriate, take a common approach in addressing similar problems. In Eastern Europe, the Caucasus, and Central Asia, less formal networks have been established. In most cases, regional meetings and the exchange of ideas have involved intensive resources to organize and manage. While there is no substitute for a well-organized conference as a platform for exchanging ideas and information, less-resource-intensive Internet-based mechanisms fostering south-to-south exchange are also needed. In West Africa, the coordinated informed buying (CIB) mechanism is one example where procurement information will be managed and shared between countries in the region. In Eastern Europe, this has involved bilateral exchanges between countries. Using the Internet to create and maintain information exchange should be explored and mechanisms found to fund sites that can disseminate and facilitate access to available information.

DIVERSIFYING COMMODITY SECURITY

Throughout this publication we have used the terms *contraceptive security* and *commodity security* interchangeably. While related, they imply different things and have different requirements. Contraceptive security focuses on the clients' right to choose, obtain, and use needed contraceptives. It implies a full supply of a range of contraceptive methods. As countries diversify the sources of supply, contraceptive security means that a full supply of methods from public, private, and NGO sources is available to meet the needs of clients at every price point. Public policymakers need to focus simultaneously on the efficient function of public-sector supply chain for public-sector clients, as well as ensure an encouraging environment for private and NGO service providers, in general, and supply chains, in particular, to work. In diversifying from contraceptive to wider commodity security, less emphasis is placed on choice and more on obtaining and using essential medicines. Resource constraints, uncertainty over health needs, and the potentially insatiable demand for medicines means that it may be impractical to consider full supply for all essential drugs. Commodity security could be defined in terms of meeting program needs for essential medicines for target populations. It could be a short list of essential medicines to support a basic benefits package, or TB drugs for directly observed treatment short-course (DOTS) patients, or bed nets for a malaria prevention program. In each case, security would imply ensuring that client needs are accurately estimated and the right products are supplied in the right place, in the right quantity and quality, for the right price, at the right time. In other cases, commodity security could be applied to ensuring the full supply of all essential medicines to a country. In all cases, family planning should not be forgotten. Contraceptive security was identified as a point of focus for a reason—it was often forgotten by many

programs. Expanding the definition of CS to include broader commodities may result in the community moving full circle and risking our progress in family planning CS.

ADDRESSING KEY POLICY ISSUES

With increasing demand for contraceptives and competing demands on limited available public resources, countries face three key policy questions.

- First, they need unequivocally to specify contraceptive and commodity security as a public health policy priority, recognizing the benefits this will have for attaining their MDG targets. The lack of an explicit reproductive health MDG has undermined this.
- Countries then need to determine the level of funding needed to attain contraceptive security.
- Finally, they need to determine how to allocate public funds to most effectively meet their population's needs. In some less- resource-constrained settings, governments might try to provide free or subsidized methods to the entire population. In other settings, the focus might be on providing free or subsidized methods to the poor and socially vulnerable. In both cases, evidence suggests a better job can be done with explicit targeting of services to the poor and vulnerable, and the monitoring and evaluation of the actual effectiveness of public services in reaching them.

MAKING THE TOTAL MARKET WORK

Taking a total market approach to contraceptive security presents many challenges. The public, private, and NGO sectors have different interests, different operating models and approaches, and different opinions of each other. Talk of a partnership can be misleading: it implies each partner is equal, whereas in many countries there is a very unequal relationship. The public sector has the responsibility and mandate to meet population needs. Government policymakers need to recognize that they can do so by looking to private and NGO sectors to complement their efforts. As demand for contraceptives grow, they need to recognize increasingly that public- and private-sector supply chains and funds need to be used to the maximum. It is essential to understanding the total market for contraceptives, how it is made up, what each source of supply provides best, and where each source of funding seeks to purchase their commodities. In many countries, the total market is already working; in other countries, the market is rather badly skewed, with public subsidies inappropriately going to those able to pay and leaving unserved those most in need. In any case, the key is to gather and analyze data, recognize the situation, and then determine how to make it work better.

FINANCING CONTRACEPTIVE SECURITY STRATEGIES

Diversifying funding sources requires several components. Public policymakers need to understand the total needs of their population. They need to understand the purchasing power of different households, what the national and local government budgets can afford, and what the local private sector can do to maximize domestic sources of revenue. They then need to estimate what share these domestic sources can fund and what external support might be required. Donors need to recognize that national budget constraints and weak local purchasing power will continue to constrain many countries' ability to self-finance their contraceptive needs. Even in some middle-income countries, donor support will continue to be necessary for many years to come. Stakeholders need to develop consensus on these issues and develop national financing strategies that both set funding targets and identify actions to ensure the public, private, and donor community can reach those targets.

ADDRESSING PROCUREMENT CAPACITY

Local procurement capacity presents one of the main opportunities for strengthening commodity security but also one of the greatest challenges. News stories of procurement scandals occur regularly, whether in Azerbaijan, Brazil, Costa Rica, Tanzania, the United States, Vietnam, Yemen, or Zambia. The need to ensure good governance, monitoring, and supervision in the use of public funds is an imperative that sometimes limits a country's ability to conduct timely, transparent commodity procurement. As more countries take ownership and responsibility for funding their contraceptives and health commodities, careful attention must be given to strengthening procurement capacity and addressing good governance.

IMPROVING LOGISTICS SYSTEMS

Health policy planners must factor logistics explicitly into their health reforms if these reforms are to have a sustained impact in meeting MDGs and other health targets. Using a private-sector supply chain improvement process can help this process by focusing attention on the consumer, defining clear logistics system metrics, evaluating the capability of the supply chain to meet these targets, monitoring operations, and addressing ways to improve performance. Attention to the last mile and value for money considerations can also help ensure that products are delivered where they are needed, most cost effective and in the way. A well functioning logistics management information system (LMIS), adapted to local conditions and needs, is essential, including innovations with cell phone and smart card technology or relying on simple paper-based tracking. The point is to ensure the timely and accurate flow of information to guide logistics management decision making.

IN CONCLUSION

This publication has shared experiences and provided evidence on the key themes required to improve contraceptive and commodity security. Because each country is unique, the examples cited here do not provide a panacea or suggest a one-size-fits-all approach. Rather, they provide a menu of approaches and strategies that countries can consider as country stakeholders assess their situation and develop and implement strategies to sustain improvements in product availability. The references quoted here provide more detailed information; more details can be accessed at www.deliver.jsi.com and from other Internet-based resources managed by international organizations too numerous to list.

Countries should take comfort that, although they face seemingly unique challenges, they are not alone. Other countries have addressed many of the issues they are facing now, and these countries offer many strategies and approaches they can build upon and adapt to their own setting. We hope this publication helps them and helps improve contraceptive availability for the Cynthias, Anas, Lornas, Marianas, and millions of other contraceptive users to whom it is dedicated.

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