Regional Contraceptive Security Report
Latin America and the Caribbean

October, 2004

Findings and Recommendations

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The report is based upon information collected in the five country contraceptive security assessments conducted from September 2003–May 2004 in Bolivia, Honduras, Nicaragua, Paraguay, and Peru and secondary data analyses conducted for El Salvador and Guatemala. This regional report is available in English and Spanish, as are the country summaries on which it is based. All of these documents, as well as the full country assessment reports, are listed in the references for this document and may be obtained directly from the DELIVER and POLICY II projects. Summaries of the country assessment reports can be found on the JSI/DELIVER and FG/POLICY II websites (www.deliver.jsi.com, www.policyproject.com).

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Primary information sources for this summary include the in-country contraceptive security assessment, and demographic health surveys or national reproductive health surveys.

Abbreviations

APROFAM	The Guatemalan Association of Family Well Being (La Asociación Pro-Bienestar de la Familia de Guatemala)
APROFE	Association for Ecuadorian Family Well Being (La Asociación Pro-Bienestar de la Familia Ecuatoriana)
APROPO	Advocacy in Population Programs (Peru)
ASHONPLAFA	The Hunduran Association of Family Planning (Asociación Hondureña de Planificación de la Familia)
CAFTA	Central American Free Trade Agreement
CDC	Centers for Disease Control
CEMOPLAF	Medical Center for Orientation and Family Planning (Ecuador)
CIDA	Canadian International Development Agency
CIES	Center of Research, Education, and Services (Centro de Investigación, Educación y Servicios—Bolivia)
CEPEP	Paraguayan Center of Population Studies (Centro Paraguayo de Estudios de Población)
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Security
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
EMP	Empresas Medicas Provisionales (similar to Health Maintenance Organizations)
EsSalud	Social Security Institute - Peru
FP	Family Planning
HIPC	Heavily Indebted Poor Countries
IADB	Inter-American Development Bank
INPPARES	Peruvian Institute of Responsible Parenting
IPPF	International Planned Parenthood Federation
IHSS	Social Security Institute – Honduras (Instituto Hondureño de Seguridad Social)
ISSS	Social Security Institute – El Salvador (Instituto Salvadoreño del Seguro Social)
IUD	Intrauterine Device
MCA	Millennium Challenge Account
MDG	Millennium Development Goal
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for Development Cooperation
PAHO	Pan American Health Organization
PASMO	Pan American Social Marketing Organization
PSI	Population Services International
RHS	Reproductive Health Survey
SIAL	Logistics Information and Administration Systems
SUMI	Universal Maternal and Infant Insurance (Seguro Universal Materno Infantil) (Bolivia)
SWAP	Sector-Wide Approach
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Beginning in the summer of 2003, the U.S. Agency for International Development Bureau for Latin America and the Caribbean supported a year-long regional study to determine how contraceptive security planning in Latin America and the Caribbean (LAC) could be more effectively addressed and strengthened. This paper focuses on key findings from LAC country assessments that were conducted in Bolivia, Honduras, Nicaragua, Paraguay, and Peru, and includes secondary data analysis for El Salvador and Guatemala. It also presents recommendations that the authors believe merit investment at the regional and country levels and could form the basis of regional contraceptive security initiatives.

Phasing out USAID donations to LAC

The U.S. Agency for International Development is progressively phasing out its contraceptive donations to LAC countries. By reducing their dependence on USAID-donated supplies, countries will improve contraceptive security, which is said to exist when individuals are able to choose, obtain, and use contraceptives and condoms whenever they need them. The timeframe for the phaseout and the rate of decline in donations vary by country.

Contraceptive demand and unmet need

Governments in the LAC region have made significant investments in public sector family planning to increase the number of service delivery points, improve quality, and make donated contraceptives free in government health establishments. And, using donor assistance, NGOs have expanded their social marketing programs. As a result, the demand for contraceptives and condoms has dramatically increased. Nonetheless, modern contraceptive use still remains low for women living in rural areas, for the lowest socioeconomic groups, for the young, for the uneducated, and for specific ethnic groups.

Factors affecting contraceptive security in Latin America and the Caribbean

The most urgent requirement for LAC countries that are addressing a phaseout of USAID contraceptive donations is to identify alternative sources for financing and procuring reproductive health commodities. Equitable market segmentation among ministries of health, social security institutes, commercial pharmacies, private health providers, and NGOs is necessary for attaining contraceptive security beyond the USAID phaseout and for reducing unmet need among populations that are already underserved in current programs.

Further pressure on ministries of health and NGOs comes from a lack of low-priced options for procurement, particularly because most LAC countries have regulations that favor the use of local distributors over international sources. Countries may consider six procurement options—

- Centralized procurement through an international organization (e.g., the UN Population Fund)
- Centralized procurement through a national tender and bid
- Decentralized financing and procurement
- Centralized procurement with decentralized funding

- Partnerships between manufacturers and NGOs
- Regional pooled procurement or regional negotiation of prices

Other non-financial factors that determine the availability of reproductive health supplies include a country's political commitment to family planning and the efficiency of its logistics systems for estimating contraceptive requirements and delivering supplies to service delivery points and clients. Addressing factors such as these has become more challenging in the face of health sector reform, which emphasizes decentralizing decisionmaking and integrating the management of distinct public health programs and logistic systems.

Recommendations

Although the in-depth studies conducted in Bolivia, Honduras, Nicaragua, Paraguay, and Peru were used to make country-specific recommendations, a common set of initiatives and actions for the region can be developed in order to ensure that contraceptive security is maintained beyond the phaseout of USAID donations—

- **Develop comprehensive contraceptive security plans and phaseout schedules among USAID, the government and NGO recipients of USAID-donated commodities**. Include realistic timelines and benchmarks for declining donations and increasing government, commercial sector, and NGO financing. Plans should not only address funding schedules, but also advocacy and fundraising, segmentation of the contraceptive market, cost controls, procurement options, logistics management, reproductive health policy, and donor coordination.

- Work to **increase budgets for contraceptives**, specifically advocating for the establishment of contraceptive budget line items and for the designation of contraceptives as "strategic" health commodities. Identifying funding to bridge the gap between the phaseout of USAID donations and cost-effective and sustainable procurement will be necessary.

- **Conduct market segmentation analyses** to better achieve a share of the contraceptive market between the private and public sectors, and ultimately **target subsidized and free contraceptives** to those who cannot afford them. Further market segmentation analyses and strategic targeting initiatives should be undertaken.

- In the short-term, **procure through UNFPA or UNDP,** or other lower cost options to take advantage of lower prices than commercial pharmaceutical companies. Long-term procurement options, including negotiating and/or purchasing products through a pooled regional approach, should be tested, particularly for their ability to fit a system in which financing is decentralized but purchasing is centralized.

- **Promote reproductive health and contraceptive security** as essential aspects of economic development.

- Carefully integrate and continue to **strengthen contraceptive logistics** by ensuring that the staff who manage contraceptives at all levels of the supply chain have the proper training and the right tools, and are supervised regularly.

Purpose

This paper summarizes the results of an in-depth regional study to improve contraceptive security in the Latin America and Caribbean (LAC) region. The summary focuses on common findings from separate country assessments and on recommendations that the authors believe merit consideration at the regional and country levels. Each assessment also produced a set of country-specific findings and recommendations, which are available as summaries. Complete study reports are available upon request.

Contraceptive security exists when individuals are able to choose, obtain, and use contraceptives and condoms whenever they need them.

Introduction

For more than three decades, the U.S. Agency for International Development (USAID) has supported the growth of successful family planning programs in LAC countries through technical assistance, and by donating contraceptives to ministries of health (MOH) and non-governmental organizations (NGOs). Today, helping programs reduce their reliance on USAID donations while diversifying funding sources and developing their capacity to procure commodities independently are essential steps to improving contraceptive security in the region and sustaining reproductive health programs.

USAID anticipates a gradual phaseout of its contraceptive donations to all programs in the LAC region. The timeframe for the phaseout and the rate of decline in donations varies by country. At present—

- Chile, Colombia, and Mexico no longer receive USAID-donated contraceptives.
- The Dominican Republic, Ecuador, and Paraguay have graduated from USAID contraceptive procurement assistance, but continue to receive limited donations from both USAID and the United Nations Population Fund (UNFPA).
- El Salvador, Guatemala, and Peru are nearing the end of a phaseout of USAID contraceptive donations.
- Nicaragua has not begun the phaseout process but is expected to discontinue receiving USAID contraceptive donations. Honduras has a verbal agreement with USAID under which there will be a gradual reduction of donations over the next few years.
- In Bolivia, the MOH does not receive contraceptive donations from USAID. Donations from the Department for International Development (DFID) are expected to end in 2004. USAID donations to PROSALUD'S social marketing program will continue through the next few years.

In the summer of 2003, the USAID Bureau for Latin America and the Caribbean Office of Population and Reproductive Health organized a regional contraceptive security conference in Managua, Nicaragua through the DELIVER and POLICY II projects. Teams from Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru participated in the conference. As a result of the conference, multisectoral contraceptive security committees were formed in five of these countries.

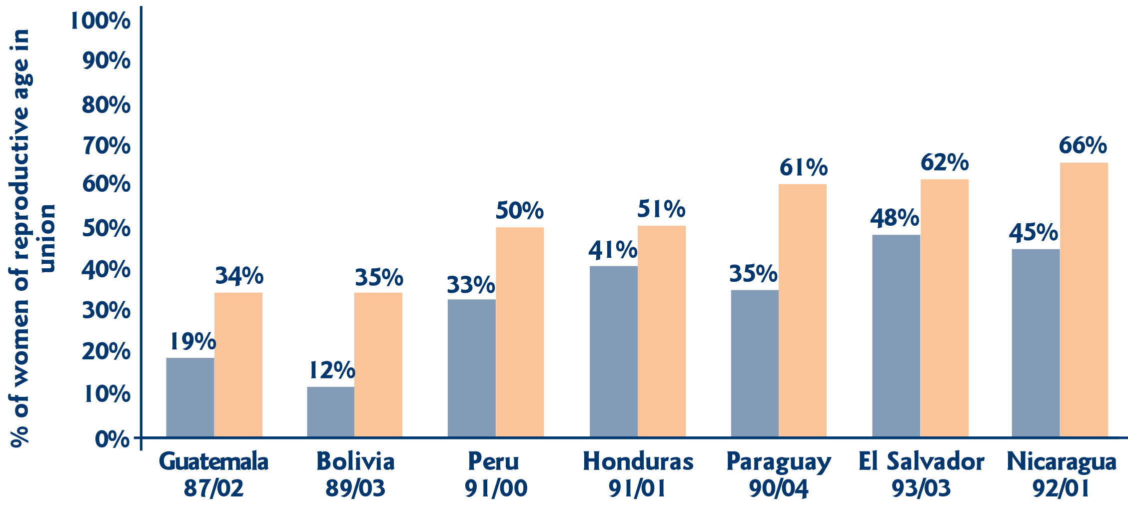
In the year following the Managua conference, Strategic Pathway to Reproductive Health Commodity Security (SPARHCS)[1] assessments were conducted in Bolivia, Honduras, Nicaragua, Paraguay, and Peru. These in-depth studies provided input to determine what elements of contraceptive security planning could be more effectively addressed and strengthened through regional interventions. Although SPARHCS assessments were not carried out in El Salvador and Guatemala, additional secondary data analyses were conducted for these two countries.

[1] Developed by DELIVER, POLICY II, and the CMS projects (in collaboration with USAID, UNFPA, and other donors and technical agencies), SPARHCS is an assessment tool that consists of indicators that gauge a country's progress toward reproductive health commodity security. The indicators are designed to assess the status of a country's, "context, commitment, capital, coordination, capacity, and clients," with respect to contraceptive security.

Contraceptive Demand and Unmet Need

LAC countries experienced dramatic gains in contraceptive prevalence rates[2] (CPR) in the 1990s. As shown in Figure 1, the CPR for modern methods increased by 10 to 26 percentage points in seven LAC countries between 1990 and 2003. During that time, governments made significant investments in public sector family planning to increase the number of service delivery points, improve quality, and make donated contraceptives free in government health establishments. Using donor assistance, NGOs expanded their social marketing programs in most countries. By recruiting distributors, adding mobile sales forces, and increasing their networks of pharmacies, commercial and community outlets, and community promoters, they helped move contraceptives and condoms closer to users. They also invested in aggressive information, education and communication campaigns that raised awareness among the general population and generated demand for socially marketed contraceptives and condoms.

Figure 1: Trend in modern contraceptive use in selected LAC countries, 1990 to 2003



Source: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 (see References)

[2] The contraceptive prevalence rate is the percentage of married women (including women in union) ages 15–49 who are using, or whose partners are using, any form of contraception, whether modern or traditional.

The use of modern contraceptives is markedly lower for women living in rural areas, for those in the lowest socioeconomic groups, for the young, for the uneducated, and for specific ethnic groups. In the same countries shown in Figure 1, CPR is an average of 15 percentage points lower in rural areas than in urban areas (see Annex 1). More critically, a striking disparity exists between contraceptive use among those in the highest socioeconomic quintile[3] and those in the lowest (see Annex 1). For example, in 2003 although the reported CPR among Bolivia's highest quintile was 46 percent, it was only 7 percent in the lowest group.

Unmet need[4] and the use of less effective, traditional family planning methods are highest where modern contraceptive use is lowest. Disparities in contraceptive use and higher rates of unmet need reflect a lack of geographic access to family planning information and services in some cases. In others, the financial and cultural barriers that limit access to otherwise available services and products are perhaps even more important.

In virtually every country in the region, rural women, young women, uneducated women, and women in marginalized ethnic groups exhibit higher rates of poverty and lower rates of contraceptive use. It is clear that poverty and unmet need affect women in both cities and rural communities, and that the poorest women are the least likely to access contraceptives, even when they are provided for free. Although LAC countries have made tremendous progress by offering free and low-cost contraceptives to the public, work remains to guarantee that subsidized contraceptives and condoms are both available to and accessed by these under-served groups.

[3] A population or income quintile divides the population up into five income groups (from lowest income to highest income) such that 20 percent of the population is in each group.
[4] Unmet need for family planning is defined differently by different researchers, but generally refers to women who are not pregnant and who state that they do not want another child, either at the present time or in the future, but who are not using a modern contraceptive method to avoid pregnancy.

The most urgent requirement for LAC countries that are addressing a phaseout of USAID contraceptive donations is to identify alternative sources for financing and procuring reproductive health commodities. Contraceptive security strategies must also take into account a number of other factors that help determine the availability of reproductive health supplies. For example, a country's political commitment to family planning and the efficiency of its logistics systems for estimating contraceptive requirements and delivering supplies to service delivery points greatly affects the availability of family planning commodities for clients. National procurement regulations also present a barrier to accessing lower cost contraceptive commodities in many countries.

A. Financing for contraceptives and condoms

1. Toward financial independence

During the 1990s, USAID and UNFPA supplied most of the contraceptives and condoms used by public sector providers and social marketing programs in the LAC region. Financing sources for these products have changed as USAID has begun to phaseout its procurement support, and governments and NGOs have taken important steps toward diversifying their funding base and ensuring greater commodity sustainability.

USAID financing

Since 1995, USAID has donated US$67 million in contraceptives and condoms for the prevention of HIV/AIDS to nine LAC countries. USAID has been the primary funding source of contraceptives for NGOs and social marketing programs, and has partnered with UNFPA to supply contraceptives to most ministries of health. As noted in the introduction, a phaseout of USAID donations in the LAC region has progressed at a different pace in each country.

UNFPA and other donor financing

UNFPA continues to provide annual contraceptive donations and is also covering short-term country needs for certain donors. For example, the United Kingdom's Department for International Development (DFID) and the Canadian International Development Agency (CIDA) are funding contraceptive and condom donations to the ministries of health in Bolivia and Guatemala. In both cases, the donations are part of multi-year programs that will result in the establishment of revolving funds to facilitate future government purchases. In Nicaragua, UNFPA is raising funding and acting as the implementing agency for pooled financing from the Norwegian Development Agency (NORAD), DFID, CIDA, and Columbia University. Moreover, UNFPA's successful efforts to raise emergency funding for contraceptives and condoms enabled the agency to increase its own donations to a number of countries beginning in 2003. Whether UNFPA contraceptive donations will continue at today's levels into the future will depend on successful fundraising and the priority that UNFPA gives to individual countries in the LAC region.

Government financing

As shown in Table 1, most ministries of health have relied on donations to cover the majority of their contraceptive supply needs over the past three years.

Table 1: Percentage of ministries of health contraceptive and condom needs provided by donors, 2001-2003

Country	2001	2002	2003
Bolivia	100%	100%	100%
Honduras	91%	65%	77%
Nicaragua	100%	100%	100%
Paraguay	100%	89%	95%
Peru	21%	50%	30%

Various plans exist in LAC countries for increasing government financing of contraceptives and condoms—

- The Peruvian government is expected to purchase 80 percent of its contraceptives and condoms in 2004, and to become 100 percent self-financing by 2005.
- Bolivia intends to begin charging its municipalities for contraceptives and condoms in 2004 and will use the proceeds to establish a revolving fund at the national level for future purchases. The source of funding for municipal purchases will be Bolivia's national maternal child health insurance, Seguro Universal Materno Infantil (SUMI).
- USAID and the Nicaraguan MOH do not yet have a schedule for USAID phaseout, and the MOH has no budget for contraceptives or condoms in 2004.
- El Salvador is expected to invest $1.2 million in 2005, covering 100 percent of its needs for that year.
- The Guatemalan MOH will contribute approximately $300,000 (equivalent to 30 percent of its total contraceptive and condom costs) to a UNFPA/Guatemala reserve fund that is being established to facilitate future government procurement. This amount will increase each year through 2006, when the MOH is expected to be covering 55 percent of the total annual cost of the contraceptives it distributes.

NGO financing

As shown in Table 2, the financial independence of NGOs and NGO-managed social marketing programs varies dramatically from country to country. Many NGOs have struggled with the transition from USAID donations to self-financing over the past decade. As a result of their transition from donor dependence to self-sufficiency, NGOs provide a lower volume of services today than in the past. They nonetheless remain important service providers and are now purchasing their own contraceptives and condoms, and recovering costs through resale in their clinics and social marketing programs.

Table 2: Percentage of contraceptive and condom needs of selected NGO and NGO-managed social marketing programs provided by donors, 2001-2003 (aggregate)

Bolivia – CIES	0%
Bolivia – PROSALUD	98%
Honduras – ASHONPLAFA	75%
Nicaragua – PROFAMILIA	63%
Paraguay – CEPEP	74%
Paraguay – PSI/PROMESA	30%
Peru – APROPO	0%
Peru – INPARRES	10%

Sources: NEWVERN and self reporting by organizations listed.

Social marketing programs and household financing

Several of the region's largest social marketing programs are well positioned to achieve financial sustainability. Programs that have already achieved a high degree of financial sustainability include APROPO in Peru, PASMO in Central America (including its affiliate in Nicaragua), and IPROFASA in Guatemala. All are either self-financing or very close to being self-financing in terms of the contraceptives and condoms they purchase and sell. At the same time, most still receive some level of support[5] from USAID and/or International Planned Parenthood Foundation (IPPF). PROSALUD, ASHONPLAFA, PROFAMILIA/Dominican Republic, PROFAMILIA/Nicaragua, CEMOPLAF, APROFE, PROMESA/Paraguay, and APROFAM are all purchasing contraceptives and condoms, and are moving toward greater self financing. It will be challenging for these NGOs to maintain the same low prices that have allowed them to capture their current market shares because they are buying more and more supplies on the commercial market. However, with support from USAID and others, they have all been able to amass some level of reserve funding. In several cases, this will enable them to purchase and at least partially subsidize the cost of contraceptives and condoms for several years after USAID donations end.

[5] Support is provided either through donated contraceptives and condoms, or through grants for marketing and organizational development activities.

2. The looming public sector funding gap

Many governments that have begun to devote their own funding to the purchase of contraceptives and condoms are struggling, due in part to declining tax revenues, and competing priorities for essential drugs and vaccines. Moreover, faltering economic growth across the region in the past three years has led to budget shortfalls and public sector budget cuts in many LAC countries. Substantial cuts in Ministry of Health budgets in Bolivia, Peru, and Nicaragua were expected in 2004. Moreover, at least two of the three HIPC-certified countries[6] in the region—Nicaragua and Bolivia—were compelled to use World Bank and Inter-American Development Bank (IDB) credits in 2003 to purchase essential pharmaceuticals and vaccines that had previously been funded by their national treasury budgets.

The public sector's financial needs were given special attention in this study because ministries of health are now the primary providers of contraceptives in most LAC countries. Using SPECTRUM software,[7] data from the most recent demographic and health surveys, and country price studies, the DELIVER and POLICY study team prepared commodity and financial projections through 2015 for each of the assessment countries. Financial projections, compared to past donations and purchases, were then used to generate the funding gap analysis included in Annex 2. Future financial needs vary based on each country's population size, contraceptive method mix, and contraceptive prevalence, but the factors affecting future funding needs are otherwise the same.

- **Government market share.** In countries where the government funds more than half of the contraceptive methods used, as is the case in Peru, future government financial requirements are high. Given the economic pressures on governments and ministries of health, these costs could easily overwhelm vulnerable ministry budgets.

- **Contraceptive method mix.** Contraceptive costs in most countries have increased since the mid-1990s due to a higher demand for injectables. A drop in intrauterine device (IUD) use in Peru and Nicaragua and of voluntary sterilization in Honduras and Bolivia are all cause for concern, both for financial reasons and because it indicates that all contraceptive methods may not be equally available to users. To some degree, the growing preference for injectables has been fueled by the willingness of donors to increase the supply of Depo-Provera®, on the basis of consumption. It also affects government costs disproportionately, because ministries of health have become the primary providers of injectable contraceptives. As shown in Table 3, Paraguay is the only country among five that has maintained a relatively stable and balanced method mix. Interestingly, the Paraguayan government's market share is very low and donations have been limited.

[6] The Heavily Indebted Poor Countries (HIPC) Initiative aims to reduce the excessive debt burdens faced by the world's poorest nations. HIPC is a joint collaboration between the World Bank and the International Monetary Fund.
[7] SPECTRUM was developed by Futures Group and is available at www.futuresgroup.com

- **Procurement options and unit pricing.** Procurement options available to governments have an important effect on costs. For example, Peru has been able to cover 80 percent of its contraceptive needs in 2004 only because the Ministry of Health is purchasing contraceptives at the lowest available prices, through UNFPA. In Honduras, where the government is paying much higher prices, the ministry's sizable financial contribution in 2002 was sufficient only to cover about 20 percent of total requirements.
- **Accurate forecasting and procurement.** Estimation of need is clearly a problem for ministries of health and donors. Lack of up-to-date consumption data and stock levels have resulted in unnecessary costs and wastage of scarce resources. IUD wastage or potential wastage has become a problem in several countries—including Bolivia and Peru—because actual demand is well below earlier estimations.

Table 3: Use of selected contraceptive methods by women of reproductive age who are married or in union, 1990-2003

Country	Injectables		IUDs		Sterilization	
	1990	2000	1990	2000	1990	2000
Bolivia	2%	16%	16%	18%	15%	11%
Honduras	0%	16%	17%	16%	36%	18%
Nicaragua	2%	21%	18%	9%	39%	37%
Paraguay	12%	14%	13%	16%	17%	16%
Peru	3%	21%	23%	13%	13%	19%

Sources: Paraguay ENDSSR 1990-2004; Peru ENDES 1992-2000; Bolivia ENDSA 1989-2003; Nicaragua ENDESA 1992-2001;Honduras ENESF 1996-2000.

3. Contraceptive security planning

A formal phaseout plan between governments, NGOs, and donors can improve the financial sustainability of family planning programs. USAID has assisted NGO family planning organizations in many LAC countries to achieve financial sustainability through a series of projects over the past decade that have included the gradual phaseout of donations. The preparation time that these projects have allowed the NGOs has greatly increased their chances for success. During this same period, dependence on government provision of donated contraceptives has grown, making a planned and gradual phaseout of USAID donations to the public sector even more important than it has been in the NGO sector. However, to date, only three of the remaining seven countries that are still receiving USAID contraceptive donations have established formal phaseout schedules or agreements with USAID. Peru's phaseout plan, which has been used to guide Ministry of Health contraceptive purchases and USAID

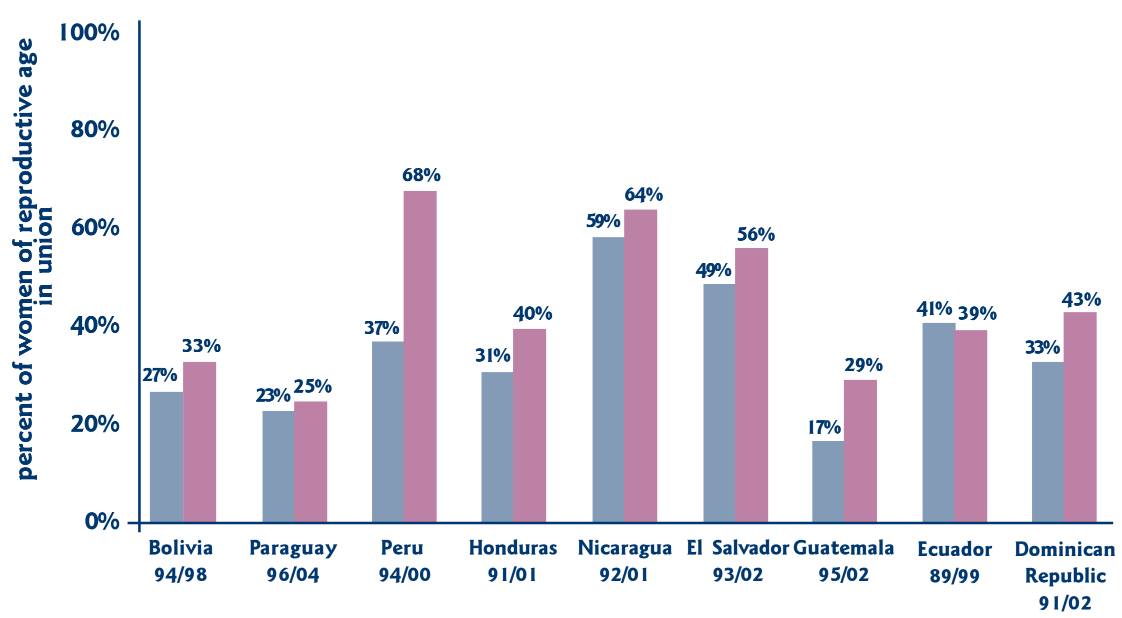
donations since 1998, is credited as a major factor in increasing government purchases despite opposition within the MOH in recent years to family planning. Guatemala also has an explicit agreement between the Ministry of Health, UNFPA, and USAID that is guiding its phaseout process and the creation of a revolving fund for future contraceptive purchases. El Salvador is the third country that is working toward greater government commodity independence on the basis of an explicit phaseout schedule.

B. Market segmentation: Balancing the roles of the public and private sectors

1. Increased dependence on the public sector

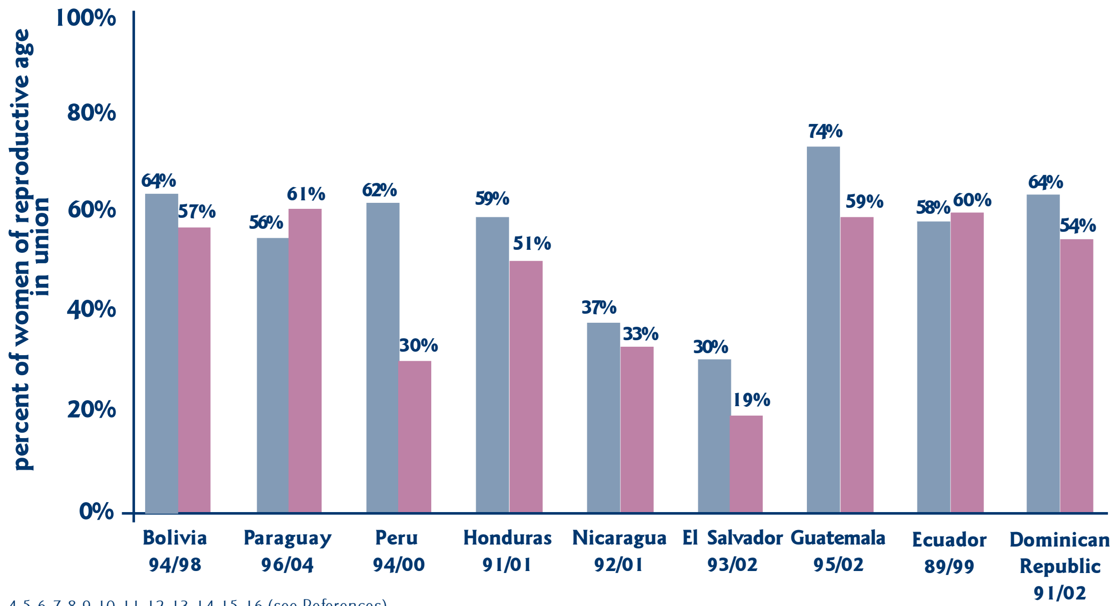
In most countries, the contraceptive market is divided between the Ministry of Health, a social security institute (or institutes), commercial pharmacies, private health providers, and NGOs. The market share and client profile of each of these sectors varies significantly across countries. As shown in Figures 2 and 3, with two exceptions, all of the LAC countries studied have experienced increases in public sector market share over the past 15 years, accompanied by a simultaneous decline in the role of the private sector. In Peru, Nicaragua, and El Salvador, the government role exceeds 50 percent, a proportional role that may not be sustainable in the future, particularly in Peru, where the MOH role is now just under 70 percent.

Figure 2: MOH share of the contraceptive market in LAC countries



Source: 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16 (see References)

Figure 3: Private sector share of the contraceptive market in LAC countries



Source: 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16 (see References)

2. Failure to target public resources to the poor

The role of the public sector in family planning should be to provide services and products to those with the greatest need for subsidies. In the past, donations have made it possible for governments and NGOs to offer free or subsidized contraceptives and condoms to all who requested them in government health establishments. However, as donations decline and government budgets are more constrained, the need to improve targeting is becoming an issue in most countries.

As shown in Figure 4, significant proportions of family planning users in the two top socioeconomic quintiles access free and subsidized contraceptives from the public sector. Unless governments have the funds to provide free contraceptives to users from all income quintiles, clients from the fourth and fifth quintiles (at the very least) should be redirected to the NGO and commercial sectors. Requiring that they pay out-of-pocket for family planning services would relieve the government of some of its future financial burden, while simultaneously stimulating each country's private sector.

Targeting is virtually unpracticed in LAC countries. However, a quasi form of targeting is used by the Paraguay Ministry of Health and Social Welfare. Contraceptives are provided for free to clients, but a small fee is charged for family planning consultations. Those clients judged by a social worker to be among the poorest strata are exempted from this payment.

- **Tiered pricing.** The pharmaceutical industry also applies "tiered pricing" in the region, which means that two countries may be charged very different prices for the same products, based on the pharmaceutical industry's analysis of their respective economies and pharmaceutical markets. When the profit margins of local and regional distributors and "tiered pricing" are factored into unit costs, even the wholesale prices offered to large purchasers can be five to ten times larger than the international market or intermediary (e.g., UNFPA, UNDP or PAHO) pricing.

- **Limited competition for the low end of the contraceptive market.** In all of the countries studied in depth except Paraguay, few distributors offer low-cost oral contraceptives, IUDs, or condoms in their product lines. This is because the contraceptive and condom markets in four of the five countries have been flooded with free and/or highly subsidized products. Where donations of injectable contraceptives are generous, the same situation exists.

Favoritism toward national suppliers and limited competition means that, in the future, low-priced contraceptives and condoms may not be readily available to ministries of health, social security institutes, and NGOs. As shown in Table 5, the countries and organizations that are already purchasing contraceptives and condoms are purchasing them from local distributors at high prices, or through international agencies and procurement services.

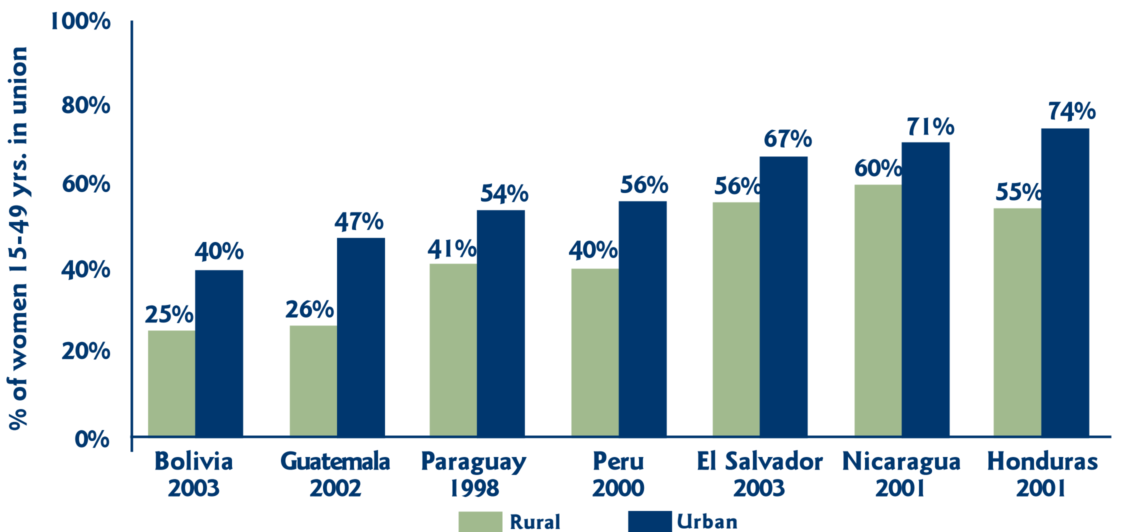
Table 5: Comparison of unit prices paid by source and purchasing organization, 2002/2003 ($US)

Purchased By	Injectable 3 mos. Protection	Orals Low dose	Condoms
Reference prices:	$0.81 UNFPA[9]	$0.24 UNFPA	$.02-0.03 UNFPA
Government purchases			
El Salvador MOH	$5,53	$0.38	$0.04
Honduras MOH	$1.14 local distr.	$.41 local distr.	$.055 local distr.
Paraguay MOH	$6.16[10] local distr.		NA
Peru MOH	$.81 UNFPA		$.02-.03 UNFPA
Peru Social Security (EsSalud)		$.30 Schering	
NGO purchases			
Bolivia PROSALUD			$.03 international
Bolivia CIES	$0.70 local distr.[11]	$0.35 local distr.	$.05-$.07 local distr.
Ecuador CEMOPLAF	$6.67	$2.25 (Microgynon)	$0.02
Honduras ASHONPLAFA	$3.15[12] Schering	$0.22 Profam/Colombia $0.30 local distr.	$0.04-$0.10 local distr. $0.04-$0.06 local distr.
Nicaragua PROFAMILIA	$1.94 Depo (all local distr.) $5.73 Norigynon $7.02 Mesigyna	$0.57 local distr.	
Paraguay PSI/ PROMESA		$0.80 PSI	$0.06 international
Paraguay CEPEP	$7.86[13] local distr. $3.30[14] IPPF	$0.35 IPPF $0.80 Wyeth	$0.08 PROMESA
Peru APROPO		$0.61 local distr.	$.04 international
Peru INPPARRES	$0.92 Depo-Provera $7.92[15] Mesigyna local distr.		$0.15 local distr.

Sources: El Salvador MOH, Honduras MOH, Paraguay MOH, Peru MOH, EsSalud, CIES, CEMOPLAF, ASHONPLAFA, PROFAMILIA, CEPEP, INPARRES,

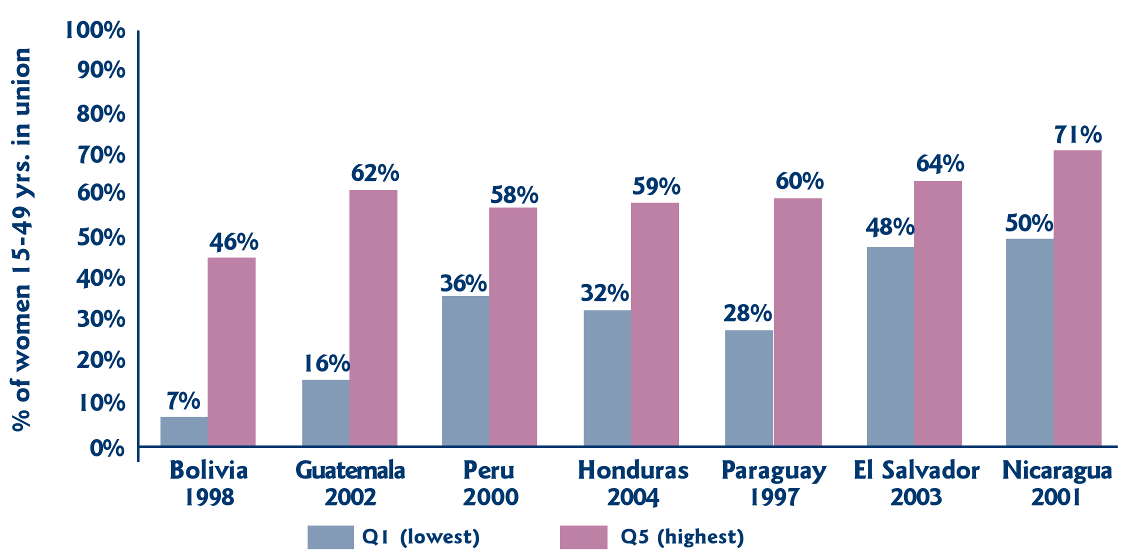
[9] All UNFPA unit prices include 5 percent handling fee
[10] Mesigyna or Norigynon for $2.08 per dose X 3 doses
[11] Source is PROSALUD's social marketing program
[12] Norigynon for $1.05 per dose X 3 doses
[13] Mesigyna for $2.62 per dose X 3 doses
[14] Cyclofem for $1.10 per dose X 3 doses
[15] Mesigyna for $2.64 per dose X 3 doses

Trend in modern contraceptive use by urban/rural residence



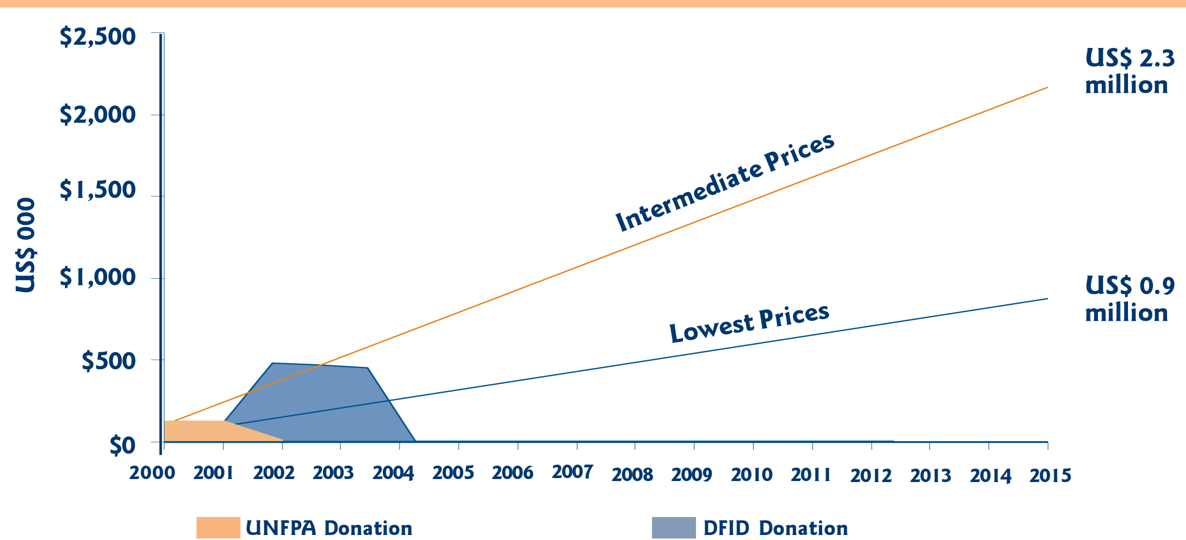
Source: 4, 6, 8, 12, 15, 16 (see References)

Modern contraceptive use by socioeconomic quintile

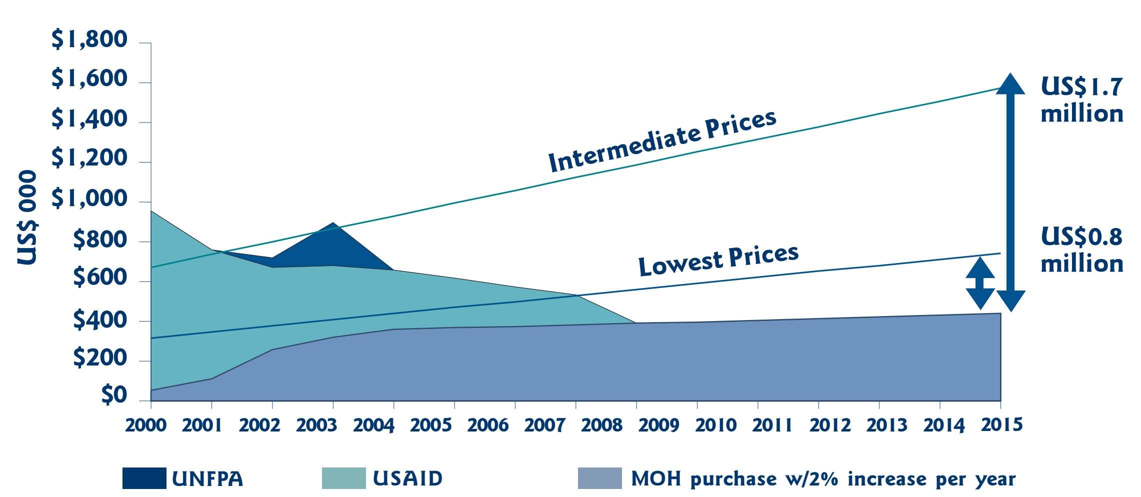


Source: 1, 4, 6, 11, 12, 15, 16 (see References)

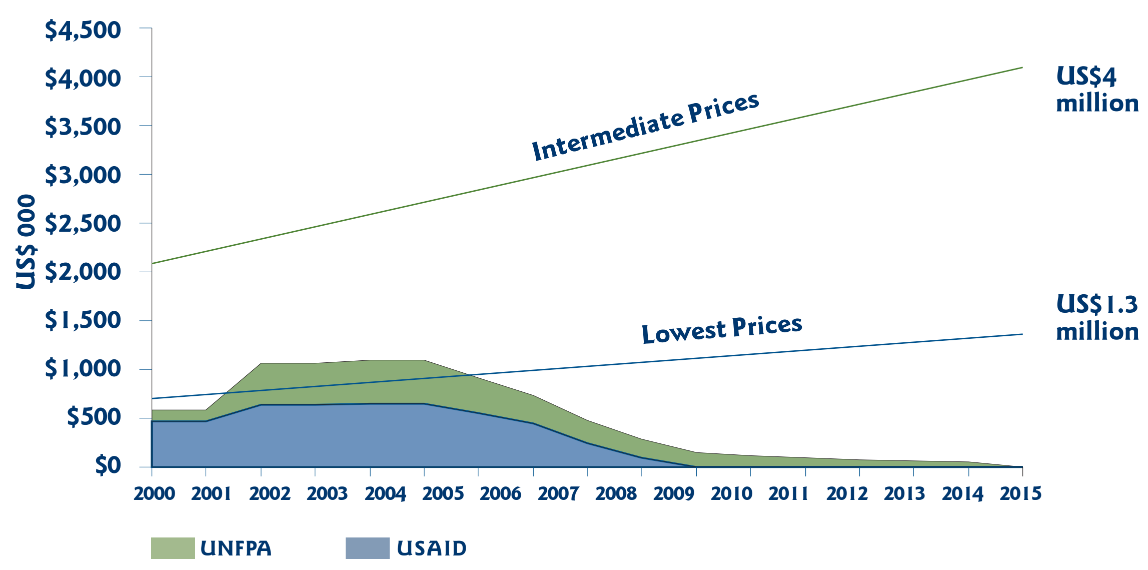
Bolivia: MOH contraceptive funding gap, 2000-2015



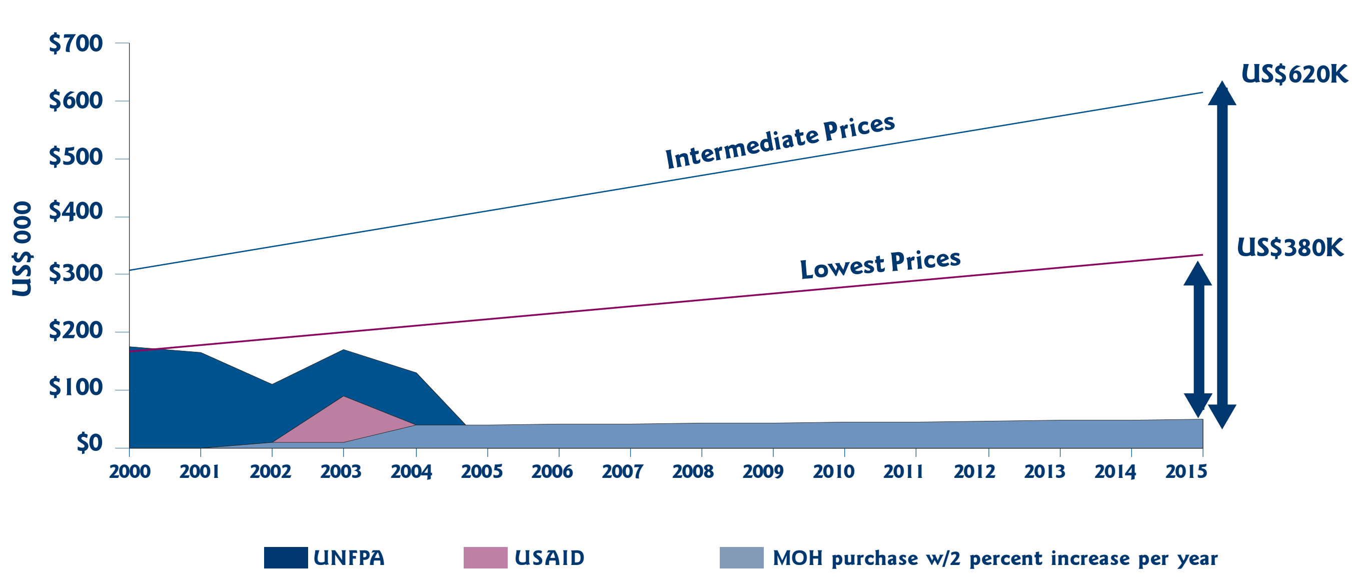
Honduras: MOH contraceptive funding gap, 2000-2015

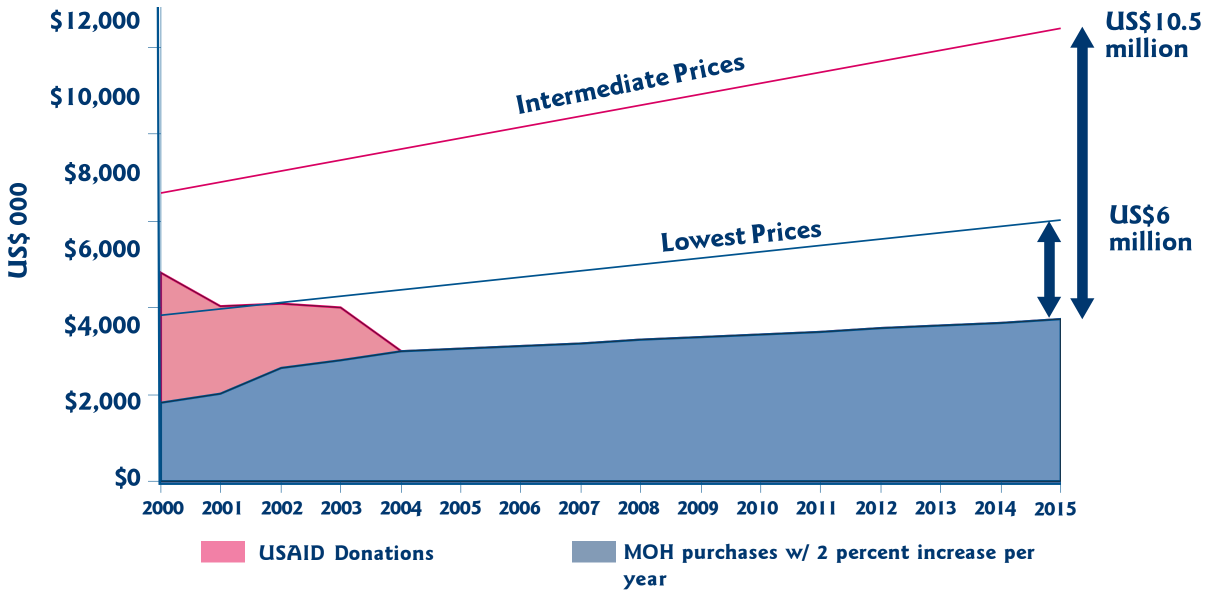


Nicaragua: MOH contraceptive funding gap, 2000-2015



Paraguay: MOH contraceptive funding gap, 1995-2015




$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
US$ 000
Intermediate Prices
Lowest Prices
US$10.5 million
US$6 million
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015
USAID Donations
MOH purchases w/ 2 percent increase per year

Annex 3: UNFPA's Reimbursable Procurement Program

UNFPA offers a reimbursable procurement service that is open to government agencies, NGOs, and international organizations working in the field of reproductive health. This service is different than UNFPA's program procurement service, but it takes advantage of the same procurement process.

Organizations that use UNFPA's reimbursable procurement service participate in pooled procurement at the international level. Therefore, they benefit from the economies of scale and extremely low prices that UNFPA achieves as one of the world's largest purchasers of contraceptives and condoms.

UNFPA requires a signed memorandum of understanding between itself and the government, NGO, or international agency that wishes to use its procurement services and it charges a 5 percent administrative fee on the total cost of each purchase.

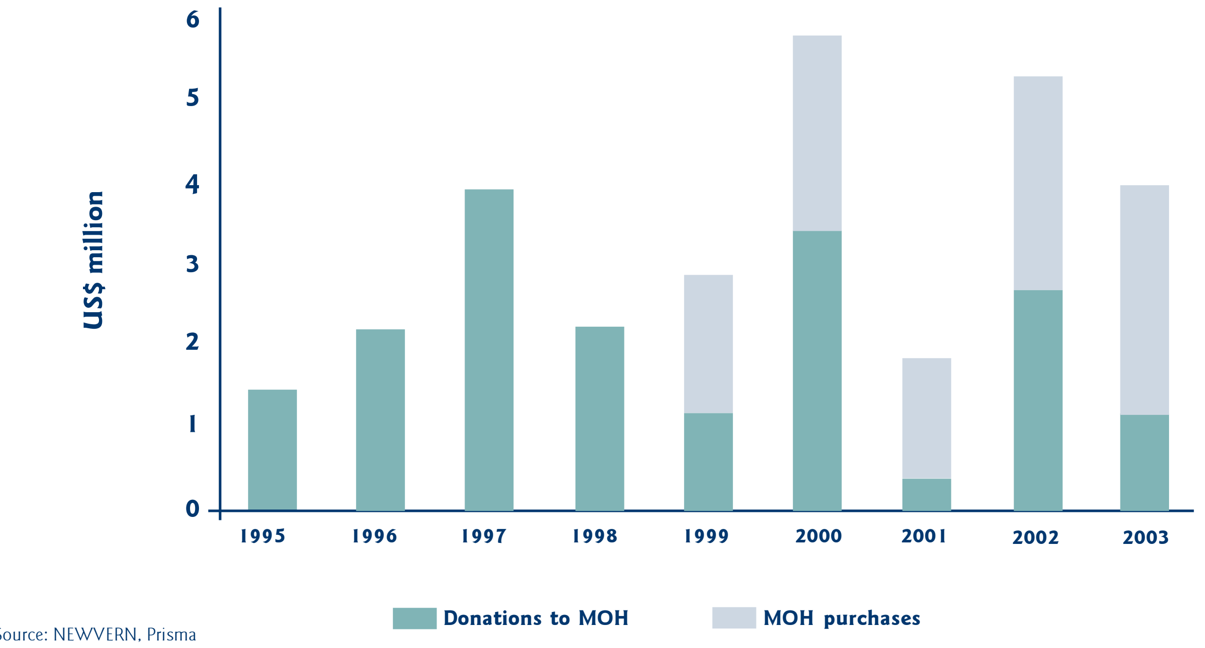
The total estimated cost of a purchase, including shipping and handling, must be deposited with UNDP before procurement begins. However, there is no limit to the number of times in a single year that purchasers are able to request new commodities, nor is there a limit on the US$ value of each procurement. Price ranges for each of the contraceptive products that UNFPA is able to procure appear on the UNFPA website.

Only the Peruvian Ministry of Health (since 1999) and the NGO, Marie Stopes International, have used UNFPA's reimbursable procurement service. Recently, the government of El Salvador also signed an MOU with UNFPA, but it has not yet used the service. The Guatemalan Ministry of Health is also beginning to purchase contraceptives through UNFPA, but through the program and not the reimbursable procurement mechanism.

Annex 4: Peruvian Government Invests in Contraceptives

Peru is one of Latin America's success stories as far as progress toward contraceptive security is concerned. Although the Peruvian government and private sector still face major obstacles to full contraceptive security, the government has committed itself to achieving independence from donated contraceptives and has increased its contraceptive budget every year since 1999.

MOH contraceptive and condom purchases and donations, 1995-2003



Source: NEWVERN, Prisma

The Peruvian government established a contraceptive earmark in its national budget in 1998, and started purchasing condoms and Depo-Provera shortly thereafter through UNFPA's reimbursable procurement program.

Contraceptive purchases have increased every year, and in 2004 the government will purchase 80 percent of its contraceptive and condoms needs, investing just over $3 million.

Peru and Paraguay are the only countries studied that have established contraceptive line items in their annual MOH budgets. Peru's line has been fully funded for a number of years. Paraguay's has not, but the MOH has begun to track public sector spending on contraceptives and condoms as a development indicator. Guatemala is lobbying to establish a protected budget line item, but has not yet succeeded in this effort.

Other factors that have been important to increasing government financing, even during periods of opposition to family planning in the recent past, have included: support for family planning within the Ministry of Finance, a formal phaseout plan between USAID and the Ministry of Health, champions for family planning and reproductive health rights in the Ministry of Health and civil society, and an informed public that has been convinced of its right to family planning care and contraceptives.

Annex 5: Designating Contraceptives and Condoms as "Strategic" Commodities

From 2001-2003, Peru's MOH successfully protected its supply of contraceptives. With anti-family planning sentiment high in the country as a whole and with many of the day-to-day functions of the national family planning program being integrated and decentralized to the health regions, MOH leaders took an important step in ensuring the availability of contraceptives. They declared the commodities of all former national health programs, including the national family planning program, of "strategic importance" to the nation and, therefore, worthy of special protection.

Special protection consisted of maintaining the MOH's contraceptive budget at the national level, even as the budgets and responsibility for procurement of essential drugs were being decentralized to the health regions. It also helped to protect the MOH's annual purchase of contraceptives and condoms through UNFPA's reimbursable procurement program (see Annex 3) by keeping the contraceptive procurement within a special administrative branch of the MOH dedicated to supporting strategic commodities and services.

The concept of strategic commodities is not a new one. In fact, throughout the 1980s and 1990s, PAHO promoted this concept in the LAC region. As a result, vaccine budgets are protected and PAHO's pooled vaccine procurement option (revolving fund) is used by all countries in the region. This allows countries to take advantage of favorable international prices on an annual basis without having to obtain annual exemptions from national procurement regulations.

PAHO is initiating a regional program for the protection and pooled procurement of a larger group of "strategic" health commodities.

Annex 6: Contraceptive Funds

The Guatemalan MOH, the Canadian International Development Agency (CIDA), UNFPA, and USAID are working together to establish a fund for future contraceptive purchases. Since 2002, CIDA has financed contraceptive donations to the MOH and UNFPA has procured these CIDA-financed commodities. USAID is also donating IUDs directly to the MOH, and three contraceptives (orals, condoms, and injectables) indirectly through the IPPF affiliate to the NGOs that deliver community-based services under MOH contracts.

In 2002, the MOH contributed the equivalent of 5 percent of UNFPA's total purchase. In 2003, this contribution increased to 20 percent, and in 2004 it will reach 30 percent of the total requirement. The contributions to the fund are being held in reserve to facilitate future MOH contraceptive purchases, however part of the funding is being used to cover the increase mainly in Depo-Provera requirements for 2005 and 2006. In 2006, it is expected that additional funding levels from CIDA will be assigned, and the MOH will continue budgeting and paying for 40 percent of its annual contraceptive needs until reaching 55 percent in 2009. This fund is currently managed by UNFPA/Guatemala on behalf of the MOH and allows flexibility to advance payment of contraceptives even before the annual MOH budget has been released. This mechanism reduces some of the delays that other countries face that do not have a contraceptive fund. It is also expected that, in the future years, the MOH will have access to this reserve, which will become its revolving fund for contraceptive procurement.

The Bolivian MOH, DFID, and UNFPA are also working toward capitalizing a similar revolving contraceptive fund. In this case, a central fund will be used to procure and make low-cost contraceptives available to municipal governments, on a cost-reimbursement basis.

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