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

Executive Summary

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.

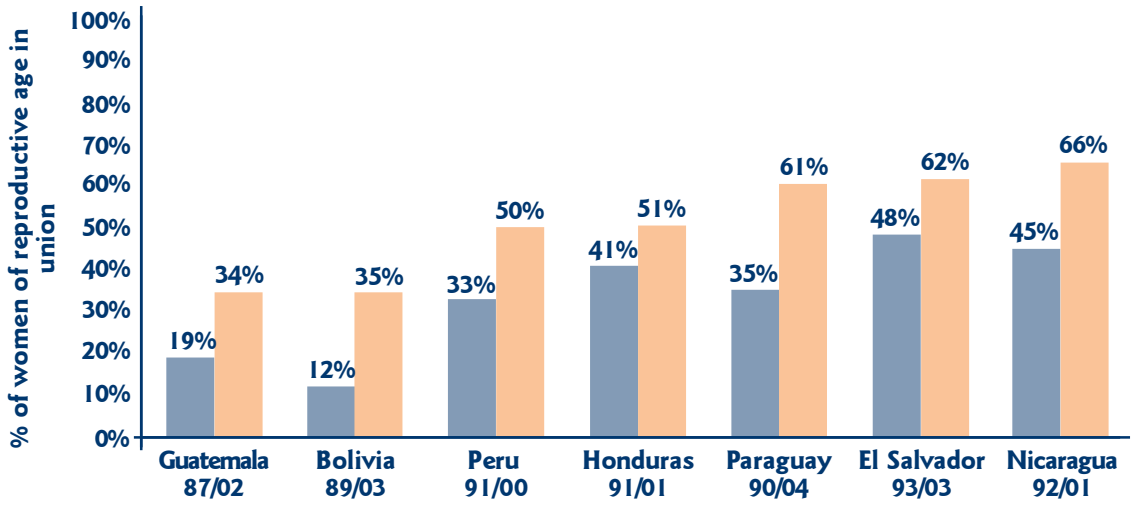
In the year following the Managua conference, Strategic Pathway to Reproductive Health Commodity Security (SPARHCS)[1] assessments were conducted in Bolivia, Honduras, Nicaragua, Paraguay, and Peru. These in-depth studies provided input to determine what elements of contraceptive security planning could 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

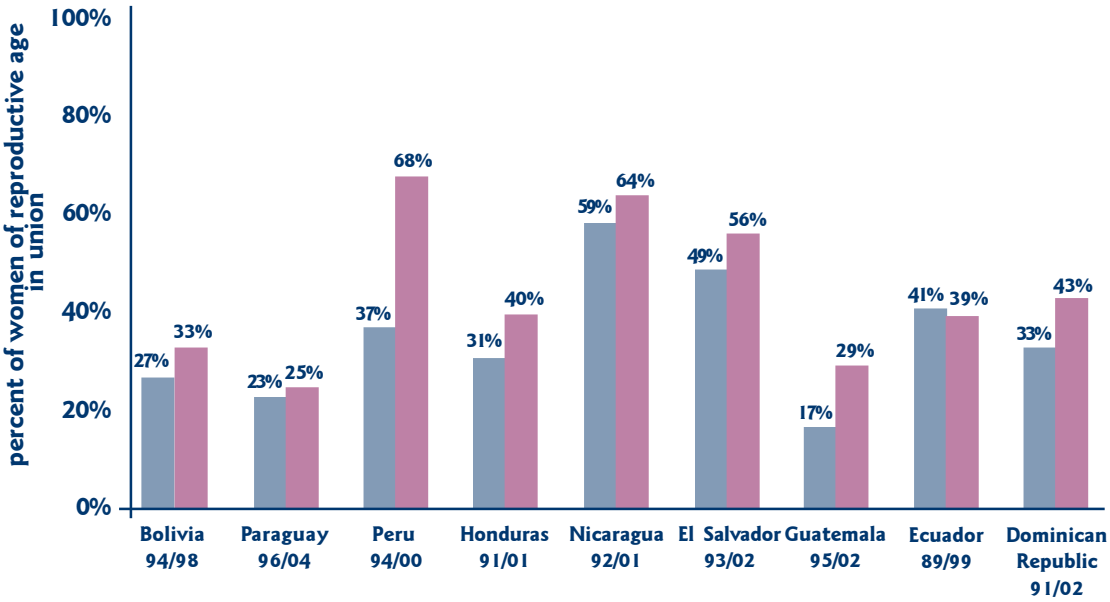
donations since 1998, is credited as a major factor in increasing government purchases despite opposition within the MOH in recent years to family planning. Guatemala also has an explicit agreement between the Ministry of Health, UNFPA, and USAID that is guiding its phaseout process and the creation 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

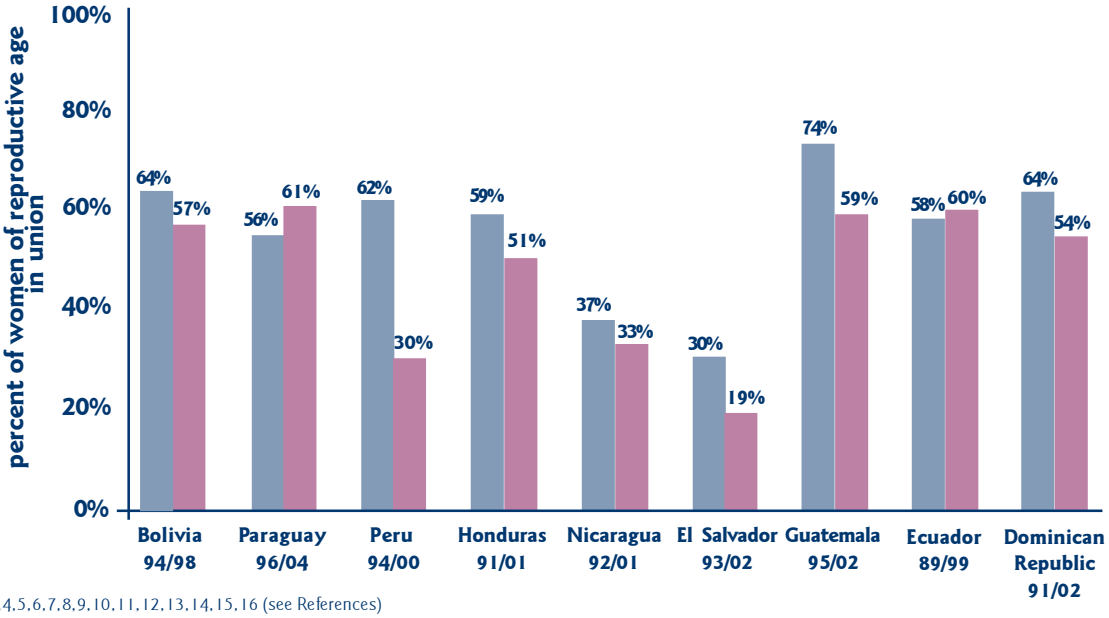
In most countries, the contraceptive market is divided between the Ministry of Health, a social security institute (or institutes), commercial pharmacies, private health providers, and NGOs. The market share and client profile of each of these sectors varies significantly across countries. As shown in 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)

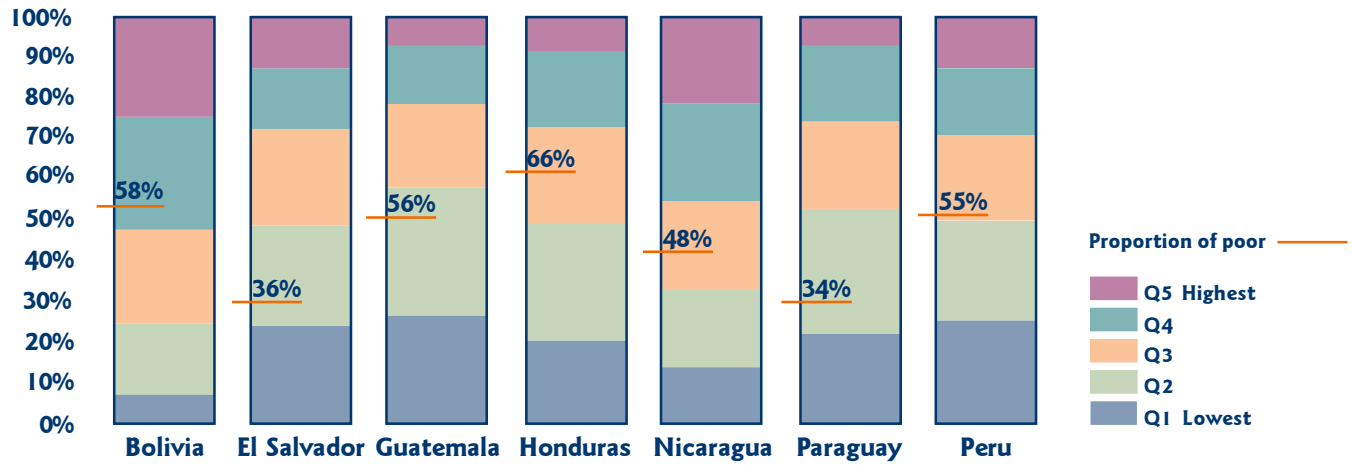
2. Failure to target public resources to the poor

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.

Figure 4: Proportion of women who receive contraceptive methods from MOH by socioeconomic quintile



Sources: Poverty rates: World Development Indicators. Family planning use by source of contraceptive method: Most recent DHS or RHS studies for which source and wealth quintile data are available. 1998 data sets for Bolivia and Paraguay were used because more recent study findings are not yet available to permit analysis by socioeconomic quintile.

3. Social security institutes playing a diminished role

National social security systems have played a more important role in the provision of contraceptives in the past. Although the population covered by social security in most countries is small and restricted to those with formal employment, social security systems are expected to grow in coming years. USAID continues to provide contraceptives to Guatemala's social security institute but has phased out its donations to Peru's ESSALUD, Bolivia's Caja Nacional, El Salvador's ISSS, and Honduras' IHSS. In Honduras and Paraguay, social security institutes are still receiving limited donations from their respective ministries of health.

Of the five countries that were studied in depth, only the social security system in El Salvador appears to make family planning services and contraceptives a priority. As Table 4 shows, a large majority of those who are eligible for social security in most countries access contraceptives through other means. Clearly, because contraceptives are free to all and plentiful in many MOH facilities, social security institutes feel little pressure to provide these products. However, as contraceptive donations decline, ministries of health should consider ways to shift the responsibility for serving eligible clients back to social security health providers. Currently, none of the LAC ministries of health that were studied has an agreement in place with its social security institute for reimbursement of contraceptive costs, although Peru is currently working toward such an agreement.

Table 4: Source of family planning method reported by users who are covered by social security

Country	Social security system clinic, hospital, or program	Ministry of Health clinic, hospital, or program	Commercial pharmacy	Other (private sector clinic or hospital, NGO, community promoter, other)
Bolivia	22%	20%	24%	33%
El Salvador	51%	26%	4%	19%
Guatemala	27%	15%	15%	43%
Honduras	17%	20%	16%	47%
Nicaragua	NA[8]	43%	15%	42%
Paraguay	6%	16%	51%	27%
Peru	27%	45%	12%	16%

Sources: Most recent DHS or RHS studies for which social security enrollment status and contraceptive source are available. 1998 data sets for Bolivia and Paraguay were used because more recent study findings are not yet available to permit analysis by socioeconomic quintile.

C. Procuring contraceptives and condoms

1. Limited contraceptive procurement experience

The capacity to procure low-cost, high-quality pharmaceutical products is improving in most countries, but there is still very limited experience with the procurement of contraceptives. The governments of the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Paraguay, and Peru have all begun to contribute to contraceptive and condom costs, but none has purchased contraceptives on the international market. Instead, the governments of El Salvador and Paraguay, and the social security institutes of Peru (EsSalud) and El Salvador (ISSS) purchase contraceptives from local distributors and laboratory representatives. Other governments in the region use UN agencies as their procurement agents. For example, since 1999, Peru has purchased Depo-Provera and condoms through the UNFPA/New York reimbursable procurement program (see Annex 3). Similarly, since 2003, Guatemala has been contributing increasing amounts each year to a revolving contraceptive fund managed by the UNFPA/Guatemala office. The Honduran MOH included contraceptives and condoms in its large UN Development Program (UNDP) pharmaceutical procurement in 2003, and it is expected to do the same in 2004. Nicaragua and Bolivia are still entirely dependent on donations. As such, neither has experience buying contraceptives, whether locally or through one of the international agencies.

[8] INSS enrollees and beneficiaries receive health services in private and public health facilities that are reimbursed for them. Survey questions to determine source of contraceptive method do not distinguish between public and private clinics that are and are not INSS certified.

2. Regulations and practices that restrict international procurement

Many countries have procurement regulations and systems that facilitate the purchase of most products. These regulations require that government contracting over a specified local currency amount be transparent and open. Publication of government tenders in newspapers and via the Internet is now standard procedure. International and national companies are normally encouraged to compete and systematic scoring of bids and selection of vendors by committees made up of both Ministry of Health and Ministry of Finance representatives are now common features. Governments also include strict product specifications and delivery dates in their contracts and add penalty clauses to supply contracts to give themselves recourse when vendors do not produce. All of these changes are helping governments control their medicine and supply costs and enabling them to make larger quantities of product available to the public. However, where contraceptives are concerned, governments and NGOs face multiple restrictions on international procurement.

With the exception of Peru—where the injectable contraceptive, Soluna®, is manufactured—the LAC countries that are currently facing a donor phaseout of contraceptives or condoms do not produce these commodities locally. A wide variety of contraceptive products are available through local distributors in each country, but prices are higher than in other developing regions, and significantly higher than most cash-strapped governments, social marketing programs, and households can afford to pay. Although ministries of health, social security institutes, and large NGOs are able to issue international tenders and negotiate contracts with international suppliers, national procurement laws, pharmacy policies, and the structure of the multinational pharmaceutical industry favor national distributors, as described below.

- **National procurement practices favor local manufacturers and distributors over international competitors.** In Peru, for example, bids from national companies are automatically awarded extra scoring points before price quotations are opened and evaluated.
- **High-level government approval is required before international procurement is permitted.** Where government regulations permit international procurement, even purchases through UNFPA or the Pan American Health Organization (PAHO) may be allowable only after several requests for bids have failed to produce an acceptable offer and high-level government officials have given their formal approval.
- **Legal representatives must be present in all countries before products can be registered and imported.** Direct contracting between governments and international manufacturers is not possible without local representatives and/or distributors acting as middlemen. This increases costs and affects not only ministries of health but also social security institutes, NGO health providers, and social marketing programs.
- **Regional and local representatives and distributors are a feature of multinational pharmaceutical companies.** Where local distributors and pharmaceutical representatives are present, institutions do not have the option of purchasing directly from contraceptive and condom manufacturers. This is because those manufacturers will only sell through their own regional and country representatives. This makes it almost impossible for governments and NGOs to purchase contraceptives at favorable prices.

- **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

3. Advantages and disadvantages of future procurement options

Most of the countries and NGOs facing a USAID phaseout have begun to identify reliable procurement sources. Table 5 showed that UNFPA procurement offers the lowest contraceptive prices. But, countries that have used this option report lengthy delays and difficulties obtaining approvals inside their own ministries of health. As contraceptive donations end and budgets for national family planning programs are increasingly integrated and decentralized, six procurement options are available (including procurement through international agencies like UNFPA). Table 6 lists the advantages and disadvantages of these options.

Table 6: Advantages and disadvantages of procurement options

Option	Advantages	Disadvantages
1. Centralized procurement through an international organization (i.e., UNFPA, UNDP, IPPF, or PAHO)	○ Economies of scale that offer very low prices ○ UNFPA reimbursable procurement already available ○ Member states, NGOs, and other donor agencies may participate ○ UNFPA requires only a simple memorandum of understanding (MOU) ○ Quality guaranteed by international agency ○ Precedent exists: All countries already have agreements with and experience procuring through PAHO	○ Full purchase price must be paid before processing ○ High-level approval required in most countries to circumvent national purchase ○ Lengthy delays in arrival of products ○ Unanticipated shipping and storage costs ○ NGOs are charged import taxes in some countries ○ Buyer has little recourse in case of delays or other difficulties ○ May be necessary to have a revolving fund to facilitate international procurement and avoid delays ○ PAHO has a revolving fund for vaccines, but no experience procuring contraceptives ○ Need to raise funds to capitalize national or sub-national revolving funds

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Table 6: Advantages and disadvantages of procurement options (cont.)

Option	Advantages	Disadvantages
2. National tender and bid, centralized procurement	○ Consistent with national procurement law ○ No special approvals required ○ Ministries are already using national tender and bids for other products ○ May include delivery to regions or districts with product contract ○ Purchaser has recourse if vendor fails to comply with contract	○ Favors or may be restricted to national suppliers ○ Acceptable products are not manufactured in country ○ Single distributor or few distributors for each product limits competition ○ Limited availability of low-priced products in the market reduces competition ○ Lack of competition increases price ○ Practice of tiered pricing limits negotiation and may increase price ○ Products must be registered locally; manufacturer may not be eager to register if not a high-profit product ○ Quality must be tested locally; limited quality testing capacity in most countries
3. Decentralized financing and procurement	○ Responsive to local needs ○ Multiple sources of financing	○ Contraceptives must be included in budgets, something often not done ○ Very high unit costs ○ No quality control ○ Need for awareness raising at decentralized level to guarantee investments ○ Lack of awareness and lack of resources may lead to under purchasing or purchasing of inappropriate products ○ Difficulties with estimating/ anticipating needs may lead to under- or over-purchasing and wastage

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Table 6: Advantages and disadvantages of procurement options (cont.)

Option	Advantages	Disadvantages
4. Centralized procurement with decentralized financing	○ Lower costs ○ Permits quality control ○ Estimation of long-term needs possible ○ Locally responsive/local control ○ Multiple sources of financing ○ Open contracts or blanket purchasing agreements that include delivery may be more cost effective ○ Plus others mentioned under 1 and 2 above	○ Delays inherent in national or international procurement process ○ Need to capitalize revolving fund to minimize delays ○ Need for awareness raising at decentralized level to guarantee investments ○ Need for logistics training at decentralized level to improve estimates of need and ordering
5. Partnerships between manufacturers and NGOs	○ Manufacturers may provide products without advance payment or offer credit for later payment ○ NGOs that register and become distributors for high-end products may earn substantial income ○ NGOs may open alternative market that is not the comparative advantage of a manufacturer's other commercial distributors	○ Generally of interest for new high-end products or in areas that traditional distributors do not reach ○ May not be best option for reaching priority populations ○ Manufacturer establishes terms and conditions ○ NGO dependent on manufacturer/ distributor for consistent supply and prices
6. Regional pooled procurement or regional negotiation of prices	○ Larger purchases offer economies of scale and result in lower prices ○ Negotiation of prices by a purchasing collective or group results in lower prices	○ Requires cooperation among multiple countries ○ National procurement laws may make both pooled procurement and collective action among countries and/ or organizations difficult or impossible ○ The Central American Free Trade Agreement (CAFTA) may make it difficult or impossible in Central American sub-region ○ Participant countries must be willing to abide by decision of the group ○ May be difficult to hold manufacturers to agreements over time

D. Improving logistics systems

As part of the in-depth assessments undertaken in Bolivia, Honduras, Nicaragua, Paraguay, and Peru, contraceptive logistics systems were evaluated by visiting health facilities and warehouses and by conducting desk reviews. The findings of these assessments are described below.

1. Improved logistics management and contraceptive availability

The logistics information and administration systems (SIAL) that many governments and NGOs adopted during the 1990s have helped to eliminate stockouts and product wastage across the region. In six countries—Bolivia, El Salvador, Guatemala, Nicaragua, Paraguay, and Peru—contraceptive availability has been greatly improved through the introduction of these systems. Features of SIAL include user-friendly registers and reports, PipeLine software,[16] consumption-based forecasting, and establishment of contraceptive buffer stocks. SIALs have helped to improve procurement planning, donor coordination, and the allocation of scarce resources to match local needs. Nationwide logistics training has been an integral part of SIAL implementation in all countries as well, as have improvements in warehouse management.

2. Despite improvements, forecasting continues to be weak

Most countries use PipeLine software to prepare their contraceptive projections. This is an important step forward, but the use of inaccurate data in Pipeline is still common and estimates of need are generally not updated systematically or as frequently as is necessary. In Honduras, for example, the Health Regions, Areas, and Centers use the same form to requisition contraceptives that they use for medicines and supplies. This form splits each unit's annual allocation into four semesters, without attention to seasonal variations in demand and other determinants of consumption. Because consumption and inventory data are not available or not always used in procurement planning, donors sometimes purchase more supplies than needed and overstocks of contraceptives occur in some health centers. In Paraguay, despite continually growing demand for contraceptives, program managers tend to base their estimations of need only on historical past requests and order too few supplies. As a result, the Paraguayan Ministry of Health has required emergency shipments from USAID and loans of contraceptives from Centro Paraguayo de Estudios de Población (CEPEP, the local IPPF affiliate) to meet demand.

3. Integration and decentralization pose new challenges for logistics systems

Efforts towards integration[17] and decentralization[18] are affecting Ministry of Health supply systems across the LAC region. In general, cost containment is the primary motivation for integration, while decentralization is promoted as a way to improve a supply system's responsiveness to local needs and generate local resources. The phaseout of contraceptive donations adds yet another justification for integration, as national contraceptive budgets are often moved into larger MOH budgets for essential medicines and supplies. The trend in the region to integrate logistics systems extends not only to warehousing and transportation but also to the integration of information and inventory management systems.

[16] The Pipeline Monitoring and Procurement Planning (PipeLine) system is a software tool developed by DELIVER that helps program managers gather critical forecasting information, ensure that products arrive on time, maintain consistent stock levels at the program or national level, and prevent stockouts.

[17] Integration generally involves merging the management of a full range of products from different programs.

[18] Health sector decentralization generally pushes procurement responsibility and distribution decisions to intermediate and lower levels of the service delivery system.

Bolivia, Guatemala, Nicaragua, Peru and have either integrated or are preparing to integrate their supply systems. Yet, each of these countries has approached the task in a different way. Because their contraceptive logistics systems are fairly effective and efficient, the ministries of health in Bolivia, Nicaragua, and Peru have chosen to adapt those systems for the management of all medicines and medical supplies. In El Salvador and Guatemala, contraceptives are being added to broader medicine and medical supply systems. Integrating contraceptives into essential drug budgets is effective in promoting the status of contraceptives, but serious challenges must be considered, including—

- **Inadequate budget and competing priorities**—when national governments (and/or regional and municipal governments in decentralized health systems) face inadequate budgets and multiple needs, they may fail to give priority to contraceptives. Inadequate budgets also make it virtually impossible to maintain the buffer stocks that today's successful contraceptive logistics systems depend upon.

- **Fixed-budgets versus consumption-based allocation of supplies**—the rationing of essential medicines is common because national budgets for essential medicines are almost always inadequate to meet full demand. This rationing is most often accomplished by allocating annual budgets to health facilities and requisitioning products within those budgets throughout the year. This creates a system that undermines the use of up-to-date consumption and inventory data to allocate and reorder contraceptive supplies. Furthermore, it is harder with contraceptives than it is with essential medicines to substitute for products that are out of stock. For example, when aspirin is out of stock, Ibuprofen may be substituted. But, when Depo-Provera is out of stock, users generally cannot be switched to another contraceptive method without extensive counseling and/or convincing.

- **Problems with information and product flow in decentralized systems**— well-designed forms and the ease with which information flows on a regular basis from the service delivery points to the central level are strengths of existing contraceptive information systems. With decentralization and integration, forms become more complicated and the lower levels of the health system (such as districts and municipalities) have less need to report to higher levels of the health system because they are managing their own supplies. This is a serious problem in countries where procurement continues to be carried out at the central level because the lack of information affects the ability of national program managers to forecast requirements and ensure that adequate quantities are procured. On the other hand, where products are purchased locally, countries are also unable to take advantage of the economies of scale offered by bulk procurement.

4. Delivery to health facilities and supervision are continuing problems

Contraceptive distribution between lower levels of the supply chain and supervision of product managers are commonly weak in LAC countries. Beyond the regional and departmental levels, resources are lacking for supervision and training of personnel, and for monitoring contraceptive distribution. Consequently, errors often go undetected and are simply passed on from health establishments to the higher levels of the health system as data are aggregated. The central level may also be guilty of failing to systematically monitor or to consolidate the information it receives. Imbalanced distribution (creating both stockouts and overstocking) is a common result.

E. Policies, political commitment, and leadership

1. Supportive policies in all countries

Achieving contraceptive security requires the strong, sustained commitment and leadership of the decisionmakers who set priorities and allocate budgets. All of the countries that were studied have policies, plans, and laws that are generally supportive of family planning. Two of the countries—Paraguay and Peru—have line items within the national health budget for the purchase of contraceptives. As was mentioned earlier, since 1999, the Ministry of Health of Peru has used this line item to purchase increasing quantities of contraceptives each year. In Paraguay, although the line item was not fully funded due to fiscal deficits, it provided an opportunity for the Ministry of Health and Social Welfare to make some initial (albeit small) purchases of contraceptives. Commitments of this nature are important, but as history has shown, they are also influenced by political change.

2. Adjusting to change in the political environment

Family planning is often the victim of strong opposition or budget cuts when governments change. The following examples underscore the fragile nature of political commitment to family planning and the importance of being prepared to counter unfavorable changes.

- In 1979, the Paraguayan government suspended the provision of contraceptive methods to its population. For the next nine years, the national family planning program consisted only of educational efforts and promotion of the Billings Method.[19] NGOs continued to provide modern methods during this period but were unable to achieve national coverage. Since 1998, the government of Paraguay has been supportive of family planning efforts, although government investment is still limited.
- In the late 1990s, after more than a decade of strong government leadership in family planning in Peru, support eroded. Public denunciations of those providing family planning services were common, and the Ministry of Health's family planning staff was drastically downsized. Today, although there is once again political support for family planning, opposition from religious and political leaders continues.
- The Bolivian government has been supportive of family planning since the late 1980s. However, attempts to introduce family planning in the 1970s and early 1980s were met with stiff opposition from anti-family planning forces within the Catholic Church and the country's military government, which believed that Bolivia was under-populated. The government also notably prohibited distribution of contraceptives by NGOs in the 1980s.

[19] The Billings Method (a.k.a. the Billings Ovulation Method or the Cervical Mucus Method) involves checking the texture of the mucus secreted by the cervix to determine when a woman is most likely to conceive. When a woman is not fertile, the mucus is light or sticky. On the day before ovulation and the day of ovulation (the most fertile time period), increased estrogen levels cause a more copious mucus that is clear and slippery.

Given the shifting nature of support for family planning and reproductive health in LAC countries, the role of civil society groups as advocates is essential. In Peru, family planning has been protected from an increasingly well-organized opposition through public advocacy, continuous monitoring, mobilization of the press, and the active participation of NGOs, reproductive health watchdog groups, health forums, and networks of women's development and social organizations. These groups employed advocacy "tools," (e.g., budget line items, policies, and laws for policymakers to consider) and disseminated concrete information on the benefits of family planning. As a result, the Peruvian government's contraceptive purchases have increased annually.

3. Developing commitment to family planning in decentralized settings

Shifts in political commitment and their repercussions are multiplied in decentralized settings. Therefore, as countries within the LAC region decentralize, it becomes essential to mobilize political support and leadership for family planning among local decisionmakers. These are the individuals who will eventually be responsible for priority setting, planning, and budget allocations. Decentralization is already a reality in Bolivia, the Dominican Republic, and Ecuador. Peru is currently decentralizing to the regional level, and the ministries of health of Honduras, Nicaragua, and Paraguay also have plans to decentralize greater authority in the future. Again, the role of civil society groups in advocating for the inclusion of family planning in subnational plans and budgets is critical, as is the presence of specific mandates from the central level. For example, in Bolivia, under the Popular Participation Law, municipalities receive an equitable, population-based share of tax revenues from the central government. The Ministry of Health requires that 10 percent of these "co-participation funds" be allocated to purchase medications covered by the national Universal Insurance for Maternal and Infant Health (SUMI). Until recently, women were only covered by this program until six months postpartum, but the reimbursement package is being expanded to include family planning commodities for all women of reproductive age.

The following recommendations were developed to address issues that are common to a number of countries in the LAC region. Individual country studies contain more detailed recommendations tailored to each setting and are available upon request.

A. Contraceptive security planning

Governments, NGOs, and donors can take action to strengthen family planning services, increase revenues, and reduce future funding needs if they begin planning several years before contraceptive donations end. At a minimum, phaseout schedules are required. However, phaseout schedules alone are not enough to guarantee contraceptive security. Ideally, a comprehensive plan should be developed in each setting. The plan should include all donors and recipients and should establish realistic goals and timeframes for donor phaseout. In this regard, the specific actions at the regional level might include:

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

- **Conduct long-term forecasting of contraceptive/financial requirements at the country level** to guide contraceptive security planning and provide the basis for advocacy and fundraising efforts.

B. Work nationally and regionally to increase budgets for contraceptives

The contraceptive security committees that formed in many countries after the July 2003 Regional Contraceptive Security Conference are now actively engaged in raising awareness about contraceptive security. The committees should seek linkages with each other. The following regional and country actions are recommended:

- **Seek technical assistance to develop advocacy tools and skills related to contraceptive security.** In the past, national family planning advocates have lobbied successfully to keep family planning services on the agenda of governments and international agencies. However, these same people will need new tools, information, and approaches to successfully lobby for budget, elimination of procurement restrictions, and other aspects of contraceptive security at central and decentralized levels of government. The family planning service providers that are actively involved in national contraceptive security committees will also need lobbying skills that they may not have, if they are to raise awareness, raise funding, and push for needed changes in government policy.

- **Establish contraceptive budget line items.** Ministries of health should increase annual budgets and lobby national legislatures and finance ministries to establish protected line items for contraceptives and condoms in annual budgets.

- **Designate contraceptives and condoms "strategic" public health commodities.** By defining contraceptives, condoms for the prevention of HIV/AIDS, and other reproductive health commodities as strategic (or in society's best interest), some countries have been able to protect them from potentially detrimental changes in national health systems, and create funded earmarks or line items for their purchase in national budgets (see Annexes 4 and 5).

- **Identify and secure stop-gap funding, as needed.** Identify sources of funding that will ensure sufficient procurement during the time it takes to achieve self-sufficiency. For example, where government revenues are not likely to be sufficient to cover needs and targeting is not an immediate option, encourage international financial institutions to include family planning commodities in their loan packages for health sector reform and poverty reduction credits.

C. Market segmentation

Over-dependence on free, public sector contraceptives in a world of declining contraceptive donations is detrimental to contraceptive security. Unless governments are able to allocate the resources necessary to continue providing free contraceptives for all, strategies to shift responsibility are needed. To make this shift, governments are encouraged to pay close attention to how their family planning markets are segmented, to target their subsidized or free contraceptives to those who need them most, and to develop partnerships with the private sector to meet the needs of all of their citizens. To do all of this, market segmentation analysis is an important first step.

- **Conduct and update market segmentation analysis.** DELIVER and POLICY II used the most recent demographic and reproductive health surveys to prepare market segmentation analyses for seven LAC countries. The results of these analyses are being used in several of the countries to more deliberately segment public and private contraceptive markets. However, because several of these surveys are now over five years old, as new surveys become available, market segmentation analyses should be updated.

- **Develop market segmentation plans.** Governments and contraceptive security committees should seek technical assistance for the development of market segmentation plans. Market segmentation analysis and other related studies (e.g., price sensitivity studies, qualitative research with under-served populations, mapping of needs and resources, operations research to test targeting protocols, etc.) should guide the development of such plans. Clearly defining the roles and responsibilities of the different sectors and a pro-poor strategy for the Ministry of Health are important elements of segmentation plans. (See targeting discussion below.)

- **Develop in-country capacity to perform market segmentation analysis.** The capacity to conduct market segmentation analysis, to develop segmentation strategies and plans, and to implement these plans does not exist in most countries but should be developed.

- **Standardize survey questions to permit easier use of Demographic and Health Surveys (DHS) and Reproductive Health Surveys (RHS) datasets for market segmentation analysis.** Demographic and reproductive health surveys conducted in LAC countries produce a wealth of data and analysis of survey findings by wealth quintile is becoming common practice. However, questionnaires used in the ORC MACRO- and Centers for Disease Control and Prevention-supported surveys are not the same and not all datasets are readily or immediately available for secondary analsysis. Questions should be added or standardized across survey questionnaires to measure variables that are important in market segmentation (i.e., ability to pay, brands of contraceptives last purchased or received, costs of contraceptives by source, unmet need to limit and to space, etc.)

D. Target free contraceptives and other subsidies

Equitable access to health is a goal in all LAC countries. How equity is to be achieved, however, is ultimately a decision that each government must make for itself. All of the ministries of health included in this study currently operate under a policy of "universal access" that mandates the provision of free contraceptives and condoms by the public sector. This has to some extent created a sense of entitlement among much of the population. As donations decline, offering free contraceptives for all may no longer be feasible for many governments, because of cost. Reaching under-served population groups (i.e., the poor, the young, and those living in rural areas) also implies cost. Several countries are considering the targeting of subsidized products and services to those in the population who are least likely to access them from other sources, while channeling those who can afford to pay for their contraceptives to NGOs, pharmacies, and other private health providers. This type of targeting would help to narrow the contraceptive funding gap that most governments are facing. It would also stimulate competition in the commercial contraceptive market, which has heretofore been flooded with free and highly subsidized products, and often therefore feels no need to promote their products. Specific recommendations for regional support in relation to targeting include:

- **Refine family planning mandates.** Does universal access mean that a government must meet the family planning needs of all clients, or that it will ensure that the needs of all clients are met, whether by the public or the private sector? Is it in the government's interest to be the primary supplier of contraceptives and condoms in the country? Can the government afford to play this role? These are questions that must be answered through legal, political, and financial analysis as well as consultation with key stakeholders before decisions about universal access and targeting can be made.

- **Develop and test mechanisms for targeting free contraceptives to those who need them most.** When sufficient funding is not available or the will to commit funding is unlikely, the targeting of government-subsidized contraceptives to specific populations is the only viable answer. Before adopting targeting strategies, governments must become familiar with different targeting options and their advantages and disadvantages. Governments may seek technical assistance from donors in providing examples of best practices in implementing and fine-tuning a targeting strategy, in hosting study tours and information exchanges with countries that have experience with targeting, and in supporting operations research that tests and/or operationalizes different targeting approaches.

E. Increase the role of the private sector in the contraceptive market

- **Encourage increased commercial sector involvement in the contraceptive market.** Strategic alliances between the government and private sector (pharmacies, private health providers, contraceptive manufacturers/distributors, and other commercial networks) are recommended to expand private sector distribution of contraceptives and condoms into areas that have been served exclusively by the MOH. Companies may also be offered non-monetary incentives to invest in the general promotion of family planning, optimal birth intervals, and so forth. Sharing best practices and creating forums for public-private dialogue would be appropriate ways to promote new partnerships. Also, policymakers and advocates should work with the private sector to identify barriers to their participation in the contraceptive market, and with the public sector to ensure a policy and legal environment conducive to private sector involvement.

- **Expand the role and financial responsibility of the social security institutes in family planning.** In most countries, social security systems are not meeting the family planning needs of their enrollees and beneficiaries. This situation should be examined and country FP advocates should advocate to ensure that family planning care and commodities are not only included in social security benefits packages but also provided in social security-financed clinics and hospitals. Agreements should be brokered to ensure that the ministries of health receive reimbursement for serving social security family planning clients at MOH facilities.

F. Eliminate procurement barriers to reduce costs

Procurement choices affect unit prices and product quality. Ultimately, they also determine the number of family planning users that an organization can serve with its limited resources. Ministries of health and social security institutes face serious obstacles to international procurement, even though this option offers them the best value for their money. Although international procurement through one of the UN agencies is likely to be difficult, the cost savings are significant. Therefore, this option is worth pursuing.

Over the short term...

- **Maximize scarce resources by purchasing contraceptives and condoms through UNFPA or UNDP.** Where government regulations restrict purchasing to national suppliers, ministries of health may wish to seek technical assistance to prepare a formal request for approval from the appropriate authorities (i.e., Legislature or National Comptrollers' Office in Nicaragua's case) and to negotiate MOUs for reimbursable procurement.

- **Explore ways to simplify purchases through UNFPA and/or make them more compatible with national contracting regulations.** This might be done by assisting in the establishment of revolving funds that allow governments to allocate money to an account that can be used for future purchase of contraceptives and condoms, as in Guatemala (See Annex 6). There is also a need to simplify internal approval processes at the country level and take steps listed below (under "eliminate barriers to international tender and bid") to exempt contraceptives and condoms from procurement restrictions that limit international purchase.

Over the long-term...

- **Eliminate barriers to international tender and bid.** Analyze policies and laws that restrict both public and private sector procurement options and lobby to change them. For example, lobby to exempt contraceptives and condoms from procurement laws and practices that favor purchase from national suppliers.

- **Conduct cost analyses of different procurement options to allow decisionmakers to choose the least costly option.** For example, the unit cost of purchasing from local distributors that deliver directly to municipalities may well be less than the unit cost of buying from an international organization that delivers to the central level, requiring that the government incur the additional cost of warehousing and transportation to the subnational level.

- **Investigate and test promising procurement approaches.** Test the procurement of contraceptives and condoms through national suppliers, in conjunction with the annual procurement of essential medicines and medical supplies. Also test other promising procurement options, which may include: 1) pooled procurement involving multiple agencies (governments, NGOs) in a single country, or multiple organizations across countries; 2) regional or sub-regional negotiation with contraceptive manufacturers to achieve lower prices; 3) procurement from national suppliers with delivery of products included in contracts. Evaluate the advantages and disadvantages of chosen options and use results to make future procurement decisions.

- **Develop policies and systems for decentralized financing, with centralized procurement of contraceptives and condoms.** Where commodity budgets and procurement responsibility are delegated to peripheral management teams, advocate to centralize procurement and protect budgets, regulate local purchase of contraceptives and condoms from a central source or sources certified by the MOH; train those in decentralized units to estimate contraceptive requirements; raise awareness about the importance of family planning and contraceptive availability among local health authorities, civil society leaders, and community-based groups and mobilize them to protect contraceptive budgets and monitor supplies.

G. Promote inclusion of reproductive health and commodity security indicators

Over the last few years, there has been a shift in development from donor-funded projects that concentrate on specific areas of need to more broad-based, globally driven goals and strategies. The Millennium Development Goals (MDG); Millennium Challenge Account (MCA); HIPC Poverty Reduction Strategies; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the World Bank's Sector-wide Approach, or SWAP, have had a major influence on country-level plans and programs. While these efforts generally recognize reproductive health as an important area of work, because their stated goals are set at the impact level (i.e., maternal mortality), the programs that are influenced by them at the country level often lack concrete reproductive health indicators or guidance for including such indicators against which progress can be measured. This is a risk because it means that reproductive health commodity security and contraceptive security are not directly linked to the

initiatives that have captured the attention of donors and national governments. Consequently, there is a potential that reproductive health and contraceptive security will be left out of important discussions at the country level. A stronger link is required between the macro-level goals and indicators of these global initiatives and those related to reproductive health and commodity security.

- **Validate the contribution that commodity security makes to improving sexual and reproductive health and ultimately to maternal health by developing a framework of tested indicators.** A standard set of contraceptive security indicators will contribute to the broader mandates as they relate to health.

- **Ensure that reproductive health programs contribute and correspond to both nationally and internationally established goals.** Contraceptive security indicators are an important part of this process. For national and program purposes, it is recommended that these indicators be explicit and nested within those identified at the donor/international level.

H. Form and strengthen advocacy groups for contraceptive security

In order for family planning to continue to be a priority at the national level, it is important that both policymakers and members of civil society advocate for reproductive rights and family planning. The contraceptive security committees that have formed in many countries are examples of groups of advocates who, with limited technical support, have an extremely important role to play in lobbying for policy change and government investment in family planning. The following actions are recommended:

- **Strengthen already existing core groups or networks of advocates for contraceptive security (policy champions), or form new groups by identifying champions of family planning, reproductive health, and women's issues.** Enable these groups to play a "watch dog" role, hold policymakers accountable, and lobby for continuing political and financial support for reproductive health and family planning.

- **Provide policy champions and networks with the advocacy skills and information they need to play this role.** Provide advocates and would-be-advocates with technical assistance, where needed, with training, techniques, and information to develop their advocacy skills around issues of contraceptive security. Arm them with relevant data and arguments on the benefits of family planning and the need for governments and other stakeholders to focus on contraceptive security. Provide opportunities for them to share ideas and learn from policy champions and groups from other countries (Guatemala, Peru) that have a history of successful advocacy. Charge them with expanding their core groups by sharing knowledge and replicating the training they receive.

- **Work closely with these advocates to increase government commitment, counteract changes in leadership both at the central and decentralized levels, and address the public's potential resistance to changes that are necessary for future contraceptive security.** For example, inform and mobilize advocates to explain the need for improved market segmentation and targeting, such that they form a credible front line against the mentality of entitlement.

I. Carefully integrate and continue to strengthen contraceptive logistics

In order to ensure sustainability and maintain the effectiveness of MOH contraceptive logistics systems as they are integrated with essential drug management systems, the following steps are recommended:

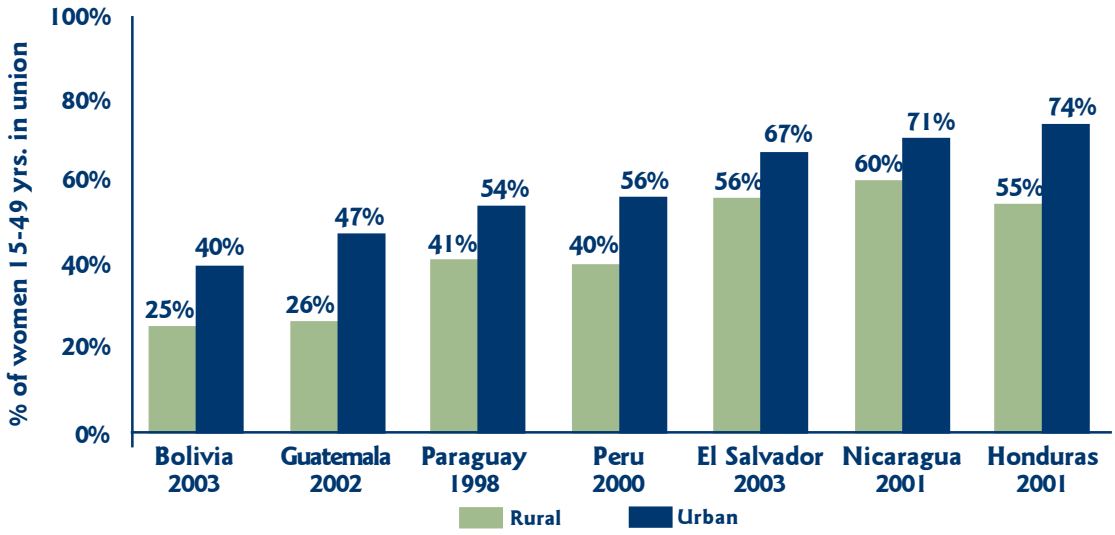
- **When integration and/or decentralization of logistics functions are planned, protect contraceptive logistics systems.** These systems provide accurate and standardized information that is critical to the continued availability and rational procurement and distribution of contraceptives and condoms.
- **Plan ahead for the integration and/or decentralization of supply systems.** Establish guiding principles, develop specifications, and prepare detailed work plans that clearly articulate the responsibilities and expectations of all partners in an integrated supply system. Disseminate these guidelines and provide technical assistance for the design, testing, and capacity building required to put integrated systems into place.
- **Design and carefully test integrated supply systems before expanding them to the national level.** It is important to revise, test, and then finalize all policies and procedures, registers and reports, databases, reference and training manuals, and guidelines and tools for supervision and monitoring and evaluation before introducing a new system countrywide.

Logistics systems, whether integrated or standalone, must ensure that there are adequate quantities of all required contraceptives available in all health establishments, at all times. In order to ensure this, the following actions are recommended:

- **Ensure that all necessary registers, reporting forms, and inventory control tools are available in service delivery points and warehouses, and that staff are trained in the proper utilization of these tools.** Provide continuous training on the logistics management information system to counteract the frequent rotation of personnel and improve the quality of logistics information for all products.
- **Increase the frequency and improve the quality of supervision, particularly in decentralized settings.** Make supervision of logistics and supply chain management functions a priority for all management units and allocate funding for this important function.
- **Develop the capacity to accurately forecast contraceptive and condom requirements.** Train supply chain and program managers to use inventory data (at the central and regional levels), consolidated consumption data, and information on unmet need, along with tools such as PipeLine to forecast realistic contraceptive requirements for the country. Government and future donor funding levels should ideally be based upon information generated from the above-mentioned data. Adapt the methodology for consumption-based forecasting and build the capacity needed in each country to prepare and update forecasts and procurement plans, not only at the central level, but also among decentralized management units.
- **Develop contraceptive procurement capacity.** Technical assistance should be sought to train personnel and prepare reference materials for procurement of contraceptives and condoms from all available sources, both by the public and NGO sectors.

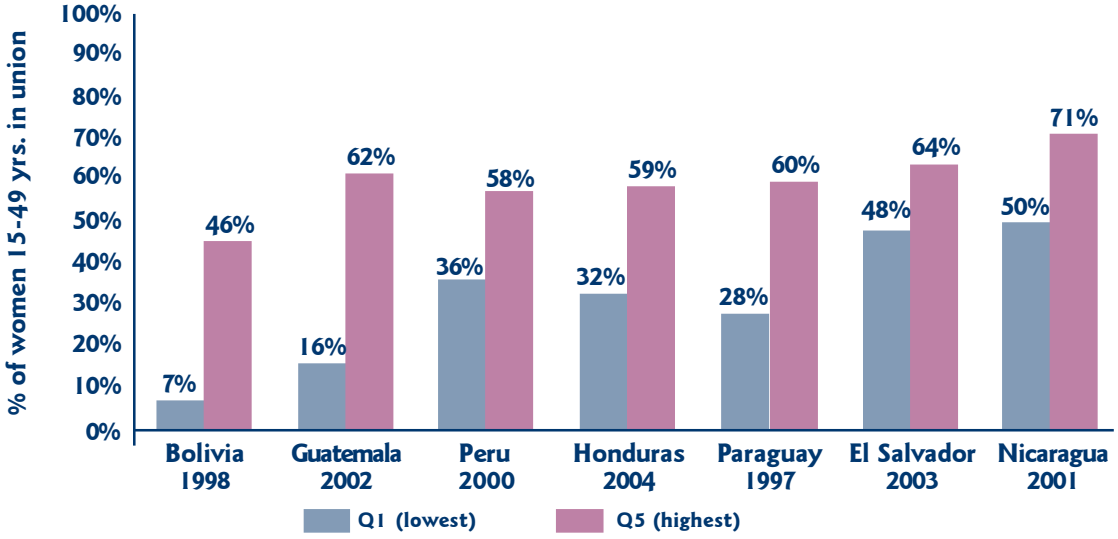
Annex 1: Contraceptive Trends

Trend in modern contraceptive use by urban/rural residence



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

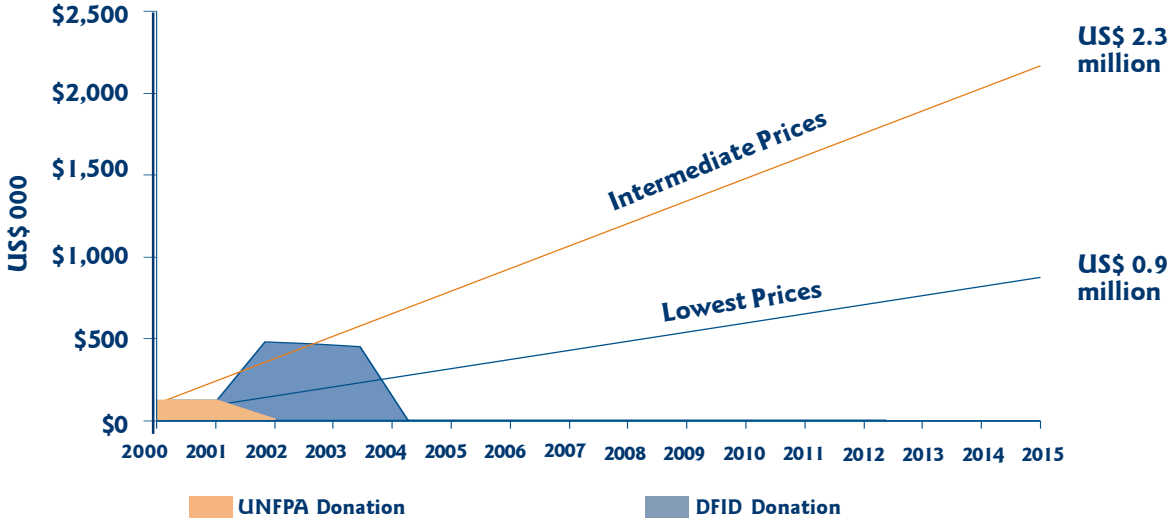
Modern contraceptive use by socioeconomic quintile



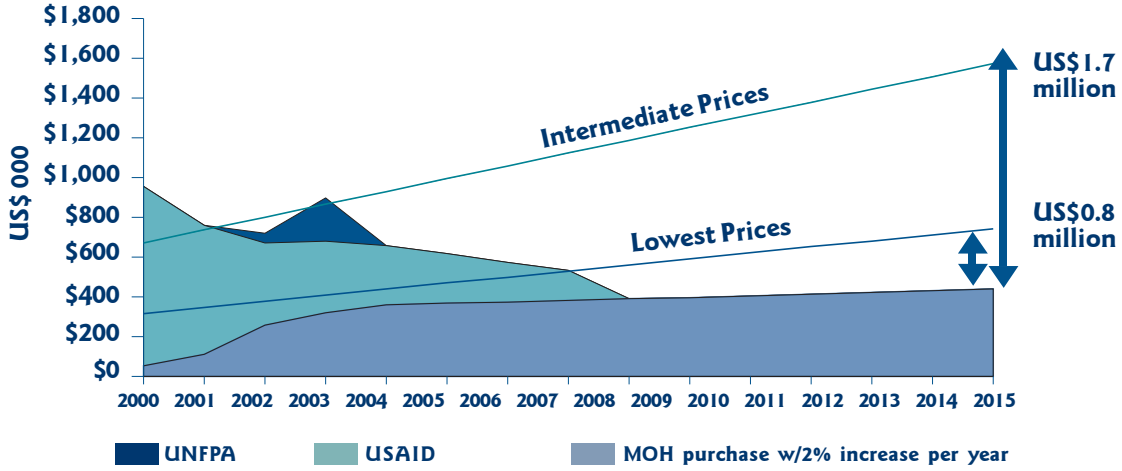
Source: 1, 4, 6, 11, 12, 15, 16 (see References)

Annex 2: MOH Funding Gaps

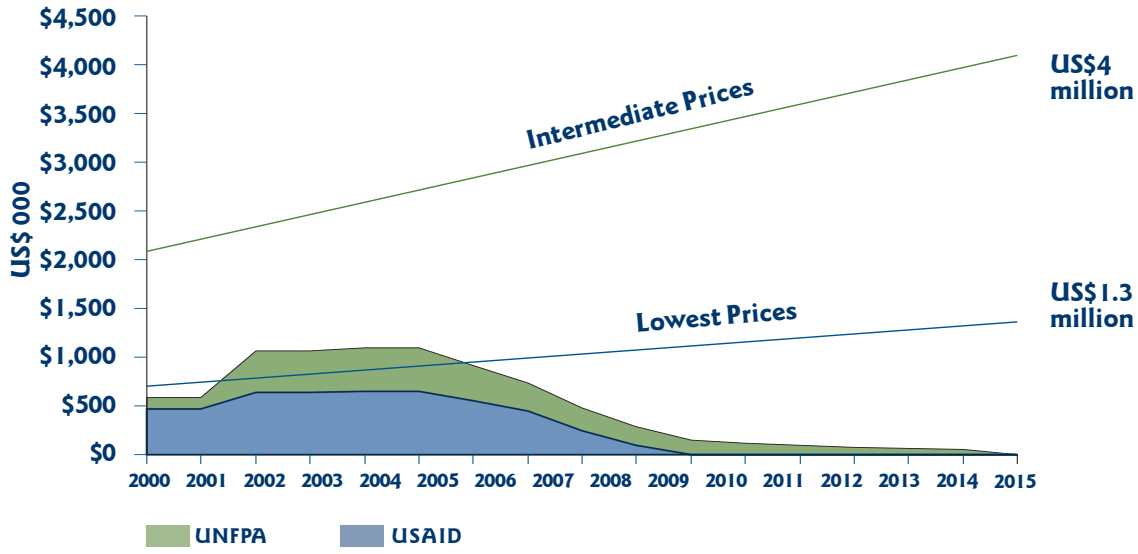
Bolivia: MOH contraceptive funding gap, 2000-2015



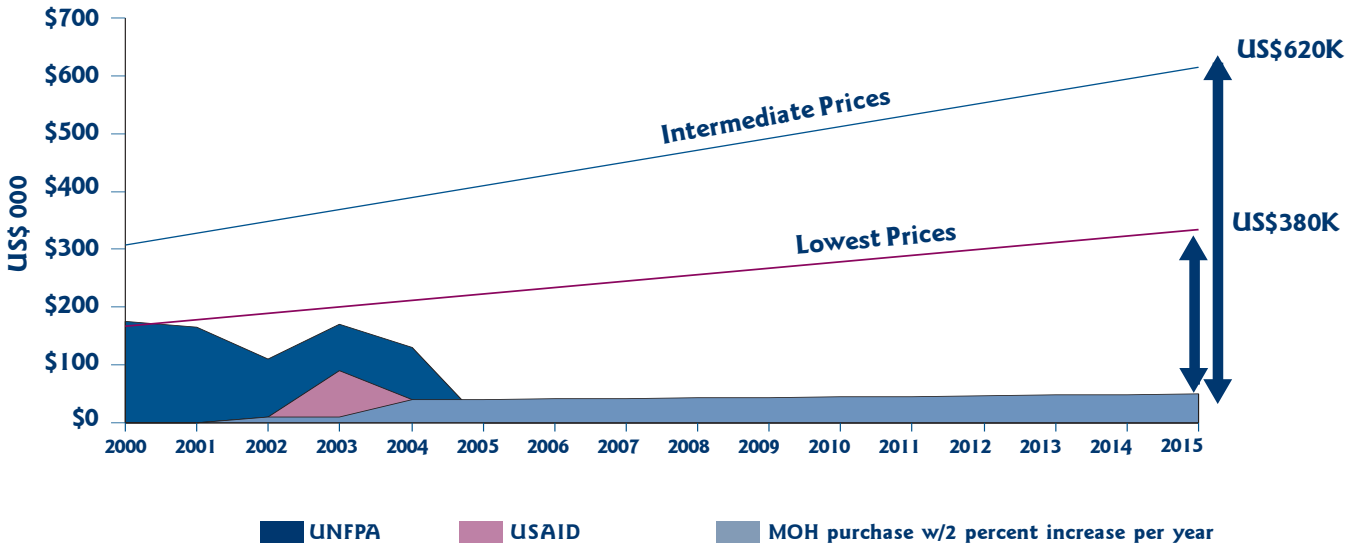
Honduras: MOH contraceptive funding gap, 2000-2015



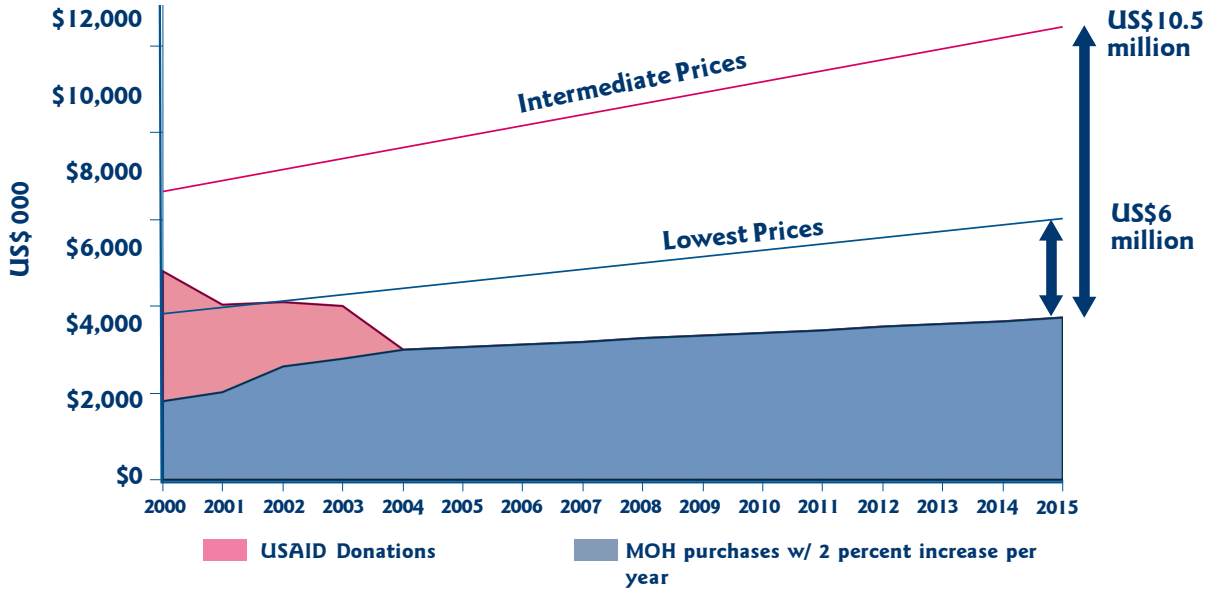
Nicaragua: MOH contraceptive funding gap, 2000-2015



Paraguay: MOH contraceptive funding gap, 1995-2015



Perú: MOH contraceptive funding gap, 2000-2015



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.

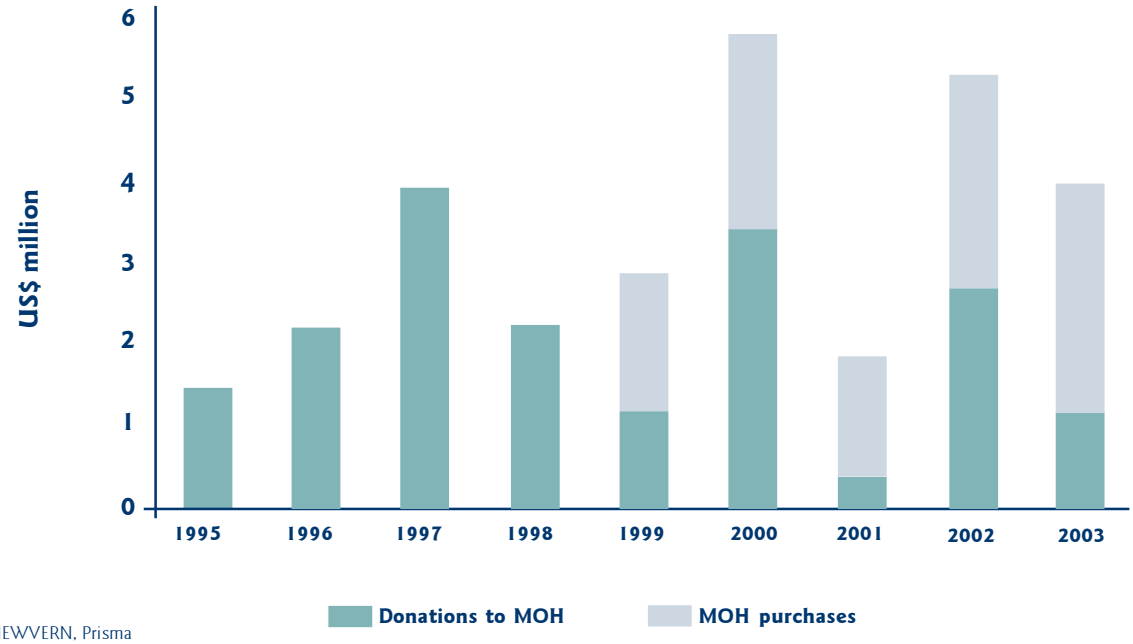
The total estimated cost of a purchase, including shipping and handling, must be deposited with UNDP before procurement begins. However, there is no limit to the number of times in a single year that purchasers are able to request new commodities, nor is there a limit on the US$ value of each procurement.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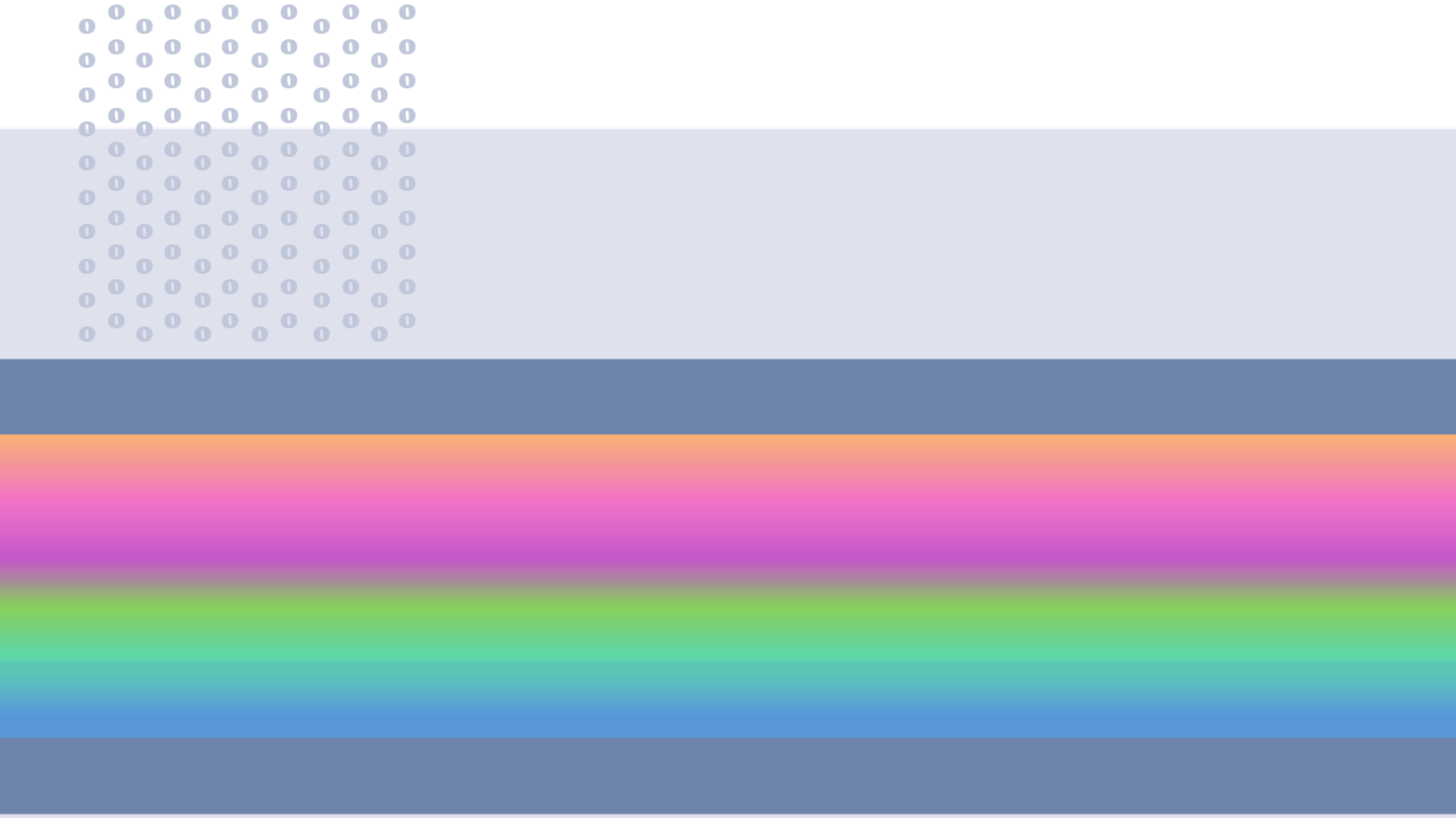

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