Donor Funding for Reproductive Health Supplies:
A Crisis in the Making

MEETING THE CHALLENGE

CONTENTS

The Interim Working Group on Reproductive Health Commodity Security (IWG) is a collaborative effort of John Snow Incorporated (JSI), Population Action International (PAI), the Program for Appropriate Technology in Health (PATH) and Wallace Global Fund. The IWG was formed in response to a meeting of the Working Group of the Global Initiative on Reproductive Health Commodity Management of UNFPA in January of 2000. At the meeting, UNFPA called on the participation of a wide variety of stakeholders to address the looming crisis represented by the shortfall in contraceptives around the world. The IWG's objective is to further the goals of the 1994 Programme of Action by raising awareness about the importance of securing reproductive health supplies. The IWG seeks to identify the causes of failures and weaknesses in commodity systems and to spur actions that will contribute to securing essential supplies for the delivery of reproductive health care.

The IWG understands the importance of addressing the full range of reproductive health commodities. The group is focusing on contraceptives first, however, due to the widespread lack of consensus within the population and reproductive health field regarding which commodities to include in an essential list of supplies. Moreover, there is little information on donor contributions for non-contraceptive reproductive health commodities. Through its efforts on contraceptive security, the IWG is working to bring together stakeholders to develop strategies for addressing the broader issues of reproductive health commodity supplies in the future.

ACKNOWLEDGMENTS

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Donor Funding for Reproductive Health Supplies: A Crisis in the Making

The Programme of Action, adopted in 1994 at the International Conference on Population and Development (ICPD) challenges donors to address a broad range of reproductive health needs. At the same time, many donors have emphasized integrating other reproductive health services into family planning programs. While this increased interest reflects the success of ICPD, there is little data to indicate that donors have increased funding for the supplies that are necessary to support these broadened services.[1] This report profiles bilateral and multilateral donors' reproductive health commodity or supply (specifically contraceptives) assistance programs and trends. Each profile explores the context of the donor's assistance, including historical trends and policy issues affecting levels of assistance; the technical capacity of the donor to project need and procure and handle logistics; the donor's plans to provide commodity-related assistance in the future; and the donors' perception of what is needed to improve contraceptive security.

Declining Donor Support: Total donor support for contraceptive commodities is estimated by the United Nations Population Fund (UNFPA) to be US$130.8 million in 1999, a 9 percent decrease compared to 1998, down 5 percent from the 1997 level, and down 24 percent from a high of $172.2 million in 1996 (although the high level in that year was due to an unusually large donation from the German government).[2]

Erratic Levels of Funding: Many donors seem to fluctuate yearly in the amount of funds allocated—both in real terms and as a percentage of population assistance. The erratic nature of past funding makes projections difficult to formulate. A key to ensuring a constant and adequate supply of funds for the purchase of contraceptives is the ability to accurately project future needs and match with adequate funding. Both incomplete reporting and the erratic levels of funding make this a very difficult task. Overall trends in funding for population assistance are much more consistent than trends in the specific area of contraceptive commodity funding.

Reporting Difficulties: At present, most bilateral and multilateral aid agencies are unable to accurately monitor spending on contraceptive supplies and none have the ability to monitor spending on broader reproductive health commodities. Nor do most have the ability to predict future levels of commitment for contraceptives. UNFPA's Global Initiative on Reproductive Health Commodity Management is an important initiative to improve the monitoring of financial data on contraceptive assistance.

No Global Mechanism for Coordination Among Donors and with Recipient Country Governments: Major bilateral donors such as the United Kingdom, Canada, Germany and the United States participate in UNFPA's working group on contraceptive commodity assistance as part of the Global Initiative on Reproductive Health Commodity Management. A broader group of donors convenes at annual IPPF and UNFPA donor meetings. However, there are no global mechanisms or established procedures for donors and recipient countries to coordinate need forecasting, divide funding responsibilities or pool procurements. The level of donor coordination at the national level varies greatly across countries, reflecting among other factors, the capacity of governments to take the lead in coordination, and the level of donor involvement, as well as the personalities of individual donor representatives.

A Few Donors Account for the Majority of Assistance Given: The top five donors—USAID, World Bank, UNFPA, DFID, the EC—accounted for 84 percent of contraceptive commodity assistance in 1999. Among those donors who fund contraceptive commodities, but at low levels, are Canada, the Netherlands (not including year 2000 assistance), Germany, and Sweden. In addition, IPPF was a more important donor in the past but its support for commodity funding has declined recently.

The top five donors are:

- United States Agency for International Development (USAID)
- The World Bank
- The United Nations Populations Fund
- Department for International Development of the UK (DFID)
- The European Union's European Commission (EU-EC)

Many Bilateral Population Assistance Donors Do Not Fund Contraceptive Commodities: Only about one-third of bilateral donors of population assistance report funding contraceptive commodities as well. Norway, Denmark, Switzerland, Australia, Belgium and Finland are among those donors who could be supporting commodities but are not. (In the absence of bilateral programs, Norway and Denmark largely disperse their population assistance through UNFPA and non-governmental organizations [NGOs].) Other development banks could also help by joining the World Bank in funding contraceptive commodities.

Assistance is Concentrated in Asia: Assistance for contraceptive commodities has been concentrated in countries in Asia, specifically in Bangladesh. Several countries in East and Southern Africa also received substantial assistance. General population assistance is much more evenly divided among the regions than contraceptive commodity assistance.

◄ TABLE 1 ►
CONTRACEPTIVE ASSISTANCE RECEIVED IN 1999 (US $MILLIONS)

Bangladesh ($27.3 million)	Zimbabwe ($5 million)
Indonesia ($16.7 million)	Pakistan ($4 million)
Philippines ($7.5 million)	Uganda ($3.1 million)
Kenya ($6.5 million)	Ethiopia ($3.1 million)
Tanzania ($5.3 million)	Nepal ($3 million)

◄ SECTION I ►
DONOR POLICY ANALYSIS

INTRODUCTION TO REPRODUCTIVE HEALTH COMMODITY SECURITY

The Programme of Action adopted at the International Conference on Population and Development (ICPD) in 1994 establishes the right of men and women to be informed about their reproductive choices and health, and to have access to the information and services that make good health possible. The Programme of Action mandates access to a range of reproductive health care services, including health education, information and counseling on sexuality and reproductive health issues, including parenting, family planning, prenatal care, delivery and post-partum care, abortion and post-abortion care, and the prevention and treatment of reproductive tract infections, sexually transmitted infections (STIs), and infertility. Given the anticipated increases in demand for such services over the next few decades, large supplies of contraceptives and "other commodities essential to reproductive health programmes"[3] will be needed in order to meet the ICPD's challenging programmatic objectives.

A secure supply of essential reproductive health commodities will be crucial to achieving the goals of the Programme of Action. Reproductive health commodity security denotes an adequate supply and choice of quality reproductive health-related supplies for every person who needs them. This form of security requires not only the commodities themselves, but the capacity to forecast, finance, procure, and deliver them to the places they are needed, at the times they are needed.

Contraceptives are just one type of supply that is necessary to achieve reproductive health security. Due to the widespread lack of consensus within the population and reproductive health field regarding which commodities to include in an essential list of supplies, an initial focus on contraceptives is necessary. Moreover, there is little information on donor contributions for non-contraceptive reproductive health commodities. Finally, this approach makes it possible to build on the experience of existing logistics systems that have generally separated contraceptives from other supplies. It should be recognized, however, that programs will have to overcome this separation as reproductive health care systems integrate their services.

At the ICPD it was estimated that the cost of providing basic reproductive health care in developing countries would reach $17 billion in the year 2000 and nearly $22 billion in the year 2015. All nations agreed that donor countries would provide one-third of these funds, and developing countries the remaining two-thirds. This amounts to $5.7 billion needed from donors for 2000. The relative donor share of the costs of maintaining an adequate supply of contraceptives could perhaps be even higher. Self-sufficiency in contraceptive supplies is not feasible for the majority of the poorest countries due to a lack of resources, technology and infrastructure to establish their own manufacturing. These countries must obtain contraceptives, often at high cost, from the international market, or rely on donors to meet the bulk of their need.

Although the ICPD did not estimate the level of funding necessary for contraceptive and other reproductive health commodities, UNFPA estimates that the amount required for contraceptives alone to be $572 million in 2000. Donor support for contraceptive commodities

averaged 40.9 percent of this amount between 1992 and 1996, but has since fallen to under 25 percent in 1999. In 2000, two donors, the governments of the United Kingdom and the Netherlands, together added $80 million in support in response to the shortfall in funding.

ABOUT THIS REPORT

This report profiles trends in bilateral and multilateral donor funding of contraceptive supplies as a component of reproductive health assistance programs. Each profile explores the context of the donor's commodity assistance, including historical trends in funding, and policy issues affecting levels of assistance; the technical capacity of the donor to project need, procure and handle logistics; a summary of any research work the donor is funding in the commodity area; and the donor's plans to provide commodity-related assistance in the future.

The following donor agencies are profiled in this report: the Canadian International Development Agency, the European Commission of the European Union, Finland's Ministry of Foreign Affairs, the International Planned Parenthood Federation (IPPF-London), Germany's Agency for Financial Cooperation (KfW), Japan's Ministry of Foreign Relations, the United States Agency for International Development (USAID), the World Health Organization (WHO), the World Bank, the United Kingdom's Department for International Development (DFID), and the Foreign Ministries of Sweden and the Netherlands. All but the last two responded to a survey submitted by PAI. Also profiled is UNFPA, which has provided a great deal of information about its own work and its interaction with other organizations.

THE CURRENT AND GROWING GAP IN COMMODITY SUPPLY

Satisfying existing demand

The crucial importance of adequate contraceptive supply has been highlighted by recently reported research.[4] Substantial increases in contraceptive use over the past 30 years in the countries surveyed were found to be less the result of increased interest in family planning than the result of meeting existing demand. Couples who earlier wished to avoid pregnancy but were not using contraceptives, were far more likely to be doing so more recently—not because their attitudes changed, but because the contraceptives and services were available. It's clear that access to a secure supply of contraceptives is critical for men and women to fulfill their fertility preferences.

Causes of the shortage

For the past several years, donors, public sector programs, non-governmental organizations (NGOs), and in-country providers have grown increasingly concerned about the availability of reproductive health commodity supplies. Observers have reported supply shortfalls throughout the developing world. Many shortfalls are the result of poor supply chain management practices, for example, the inaccurate forecasting of contraceptive need or inadequate storage and transportation systems. However, several studies have indicated that inadequate funding may also be responsible for a growing number of shortages.

Many shortfalls are the result of poor supply chain management practices, inaccurate forecasting….However, inadequate funding may also be responsible for a growing number of shortages.

In fact, given the trend in donor funding for contraceptives that is outlined in this report, the gap between funding and need is projected to reach hundreds of millions of dollars a year by 2015. A potential shortage of such magnitude could stall or reverse progress toward the reproductive health goals set by 179 nations at the International Conference on Population and Development (ICPD) held in Cairo in 1994.

Five major factors contribute to the growing shortfall of contraceptive supplies:

- Growing interest in contraceptive use;
- Changing method mix;
- More people of reproductive age;
- Insufficient, poorly coordinated donor funding;
- Inadequate logistics capacity in developing countries.

Growing interest in contraceptive use (rising contraceptive prevalence). The success of family planning programs worldwide has enabled more and more couples to choose to have smaller families. This trend means that there is an increase in the number of contraceptive users and requires an increased supply of commodities. The number of contraceptive users is projected to increase by 28 percent in the next five years and by 79 percent by 2015, an increase of 105 million people.[5] According to UN projections, the average number of

children a woman has (Total Fertility) in these countries will continue to decline as smaller families become the norm for more and more women and couples. Contraceptive prevalence is expected to increase fastest where it is now lowest, so the differences among regions will narrow substantially.

Should the populations of these countries experience the fertility declines projected by the United Nations over the next 15 years, the much higher proportions of contraceptive users will exert pressure on commodity supplies and logistics capabilities.[6]

Changing Method Mix. Some contraceptive methods require re-supply more than others. For example, users of oral contraceptive pills and condoms require a steady source of these items, whereas those choosing sterilization require supplies only once. Thus the relative levels of use of different contraceptive methods (or method mix) is important to projecting future supply shortages. The demand for contraceptives that require a steady supply of materials and moderate or intensive logistical support is expected to grow substantially between 2000 and 2015. The demand for IUDs will increase by 86 percent—reaching a total of 157 million insertions—and the number of pill cycles used will increase by 93 percent to reach a total of 6.8 billion cycles through the period. Sterilization, which reduces the need for continuous supply and logistic support, faces strong demand in Latin America and Asia and is expected to remain important in those regions. However, this is not the case in Africa or the Middle East where IUDs are the preferred form of long-term contraception and sterilization is, and is expected to remain, rare.

Condoms offer dual protection against pregnancy and STIs, most notably HIV/AIDS. The demand for condoms will be fueled by the expansion of HIV/AIDS prevention programs. By the end of the 15-year period, demand for condoms is expected to more than triple, from the current 2.5 billion pieces a year to 8.1 billion annually, with cumulative use amounting to 84 billion condoms.

More people of reproductive age. More people mean more contraceptive users. Demographic projections alone indicate substantial growth in contraceptive demand in these developing countries. Population growth and the large size of recent generations mean that many people are just now entering their reproductive years. An even larger group of adolescents will soon follow them. The number of women of reproductive age in donor-dependent countries is projected to grow by 36 percent by 2015, or 191 million women. This is more than the total number of women who currently live in either Latin America or sub-Saharan Africa.[7] The regions that will experience the largest increases of women of reproductive age are Asia (outside of India and China) and sub-Saharan Africa, with 30 percent and 52 percent more women of reproductive age respectively.

Insufficient, poorly coordinated donor funding. Donors do not provide enough money to meet the need for subsidized contraceptives, i.e., those contraceptives that are supplied free or subsidized. A lack of coordination between national governments and donors and among donors themselves represents a missed opportunity for increased efficiency and effectiveness. The annual gap between needed and provided funding for subsidized supplies is projected to exceed $100 million by 2015. Developing country governments and the private sector are unlikely to be able to make up for such funding shortfalls.

Inadequate logistics capacity in developing countries. Securing a sufficient supply of contraceptives will require tremendous capacity building in developing countries. Both a stronger commitment by governments to a steady supply of contraceptives and expanded assistance to develop and implement plans and mechanisms for a secure supply chain are sorely needed.

A lack of coordination between national governments and donors and among donors themselves represents a missed opportunity for increased efficiency and effectiveness.

Perspectives from the South[8]

The perception that contraceptive supply needs will increase is held not only by the international community and reproductive health advocacy organizations, but by developing country programs themselves. A survey of 21 reproductive health program officials in developing countries found that all respondents anticipated an increase in contraceptive supply needs in the next three to five years. However, the scale of anticipated increase varies widely, ranging from 2 to 80 percent.

Inadequate donor funding for and government commitment to contraceptive supply, fiscal constraints on governments for the purchase of contraceptives, and high contraceptive prices on the international market were most commonly cited by respondents as posing a

threat to the future success of family planning in their countries. Most program officials expect their own governments to contribute budget funds to cover the additional demand, as well as an increase in donor support. Other respondents indicated that the private sector will ensure contraceptive supply. A few respondents, all from government programs that are heavily donor-dependent, pointed to loans as a means for purchasing contraceptives. Respondents seemed to think that the private commercial sector can and should alleviate future program demands made by wealthier clients. However, they recognize that the issue of affordability continues to present an obstacle to providing for poorer clients through the private sector.

Interestingly, those respondents who expect donor support for contraceptives to decrease also believe that contraceptive supplies will continue to come from donors in the future. Moreover, they expect that external donors will support future supplies to a greater degree than will in-country NGOs, private service delivery systems, or loans. This discrepancy suggests that family planning programs are generally quite uncertain about the future role of donors with regard to contraceptive supplies. Almost all the respondents who expect donor support for contraceptives to decrease stated that the need to prepare for this trend in the future would require attaining greater financial independence today.

TREND ANALYSIS: TRACKING CONTRACEPTIVE SUPPLY ASSISTANCE

At present, most bilateral and multilateral aid agencies are unable to accurately monitor spending on contraceptive supplies and none have the ability to monitor spending on broader reproductive health commodities. Nor do most have the ability to predict future levels of commitment for contraceptive supplies. UNFPA's Global Initiative on Reproductive Health Commodity Management is an important initiative to improve the monitoring of financial data on contraceptive assistance. The Resource Flows Project, funded by UNFPA in collaboration with the Netherlands Interdisciplinary Demographic Institute (NIDI) and which tracks overall population assistance, is another potential means for more closely tracking funding for reproductive health commodities (although this project does not currently track spending on commodities apart from total population assistance.)

Global Trends

It has been particularly difficult for UNFPA to develop an accurate assessment of the levels and sources of commodity support at the global level. Some information on funding and commodities is likely missing or may have been double counted. This is even more likely due to the fact that some donors report incomplete information on the cost of contraceptives, and therefore international prices must be used to estimate their financial contributions.

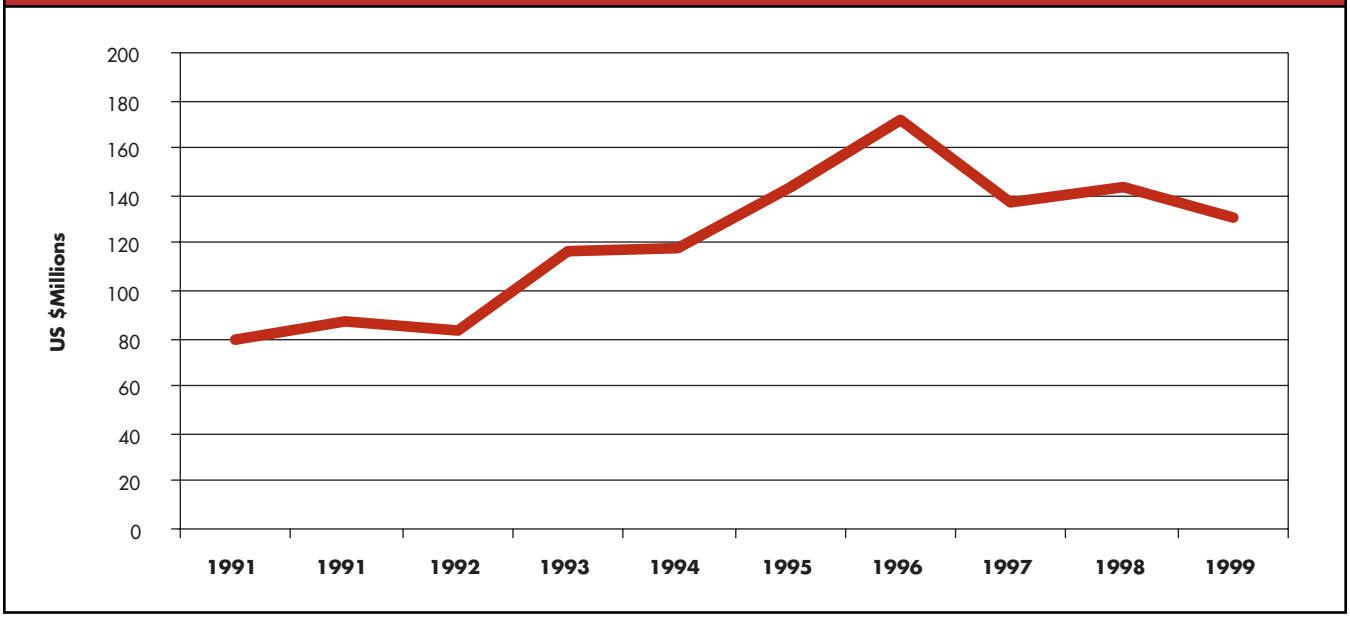
Despite the difficulties of tracking financial data for contraceptive supplies, the available information points to an inconsistent pattern. Past funding has been erratic, making projections difficult to formulate. A key to ensuring a constant and adequate supply of funds for the purchase of contraceptives is the ability to compare future estimated needs with expected funding. Both the incomplete reporting and the erratic levels of funding make this a very difficult task. Trends in overall funding for population assistance are much more consistent than trends in the specific area of contraceptive commodity funding.

About one-third of bilateral population assistance donors report funding contraceptive supplies as well. These bilateral donors are Canada (CIDA), Germany (BMZ/KfW), Japan (JICA), the Netherlands, Sweden (Sida), United Kingdom (DFID), and United States (USAID). Only four (one-fifth of population assistance donors) provide substantial assistance (CIDA, KfW, Netherlands, DFID, and USAID).

Despite the difficulties of tracking financial data for contraceptive supplies, the available information points to an inconsistent pattern. Past funding has been erratic, making projections difficult to formulate.

Not all donors use bilateral channels to fund population activities. Those donors who provide core funding to UNFPA are indirectly providing some contraceptive assistance through the core UNFPA funds used for this purpose. In addition, some countries may be providing funds for contraceptives through multi-bilateral channels (when funds are given to a UNFPA program specifically for one country). Among population assistance donors who are not listed as directly supporting contraceptive purchases are Denmark and Norway.

◄ Figure 1 ►
Total Donor Assistance for Contraceptive Commodities (US $Millions)



Note: According to UNFPA, total donor support for contraceptive commodities is estimated at US $130.8 million in 1999. This level is 9 percent lower than in 1998, down 5 percent from the 1997 level, and down 24 percent from the high of $172.2 million in 1996 (although the high level in that year was due to an unusually large donation from the German government).

Although some donors could be encouraged to begin supporting contraceptive supply through bilateral channels, it should be noted that increasing the number of bilateral donors has implications for coordination and for the work load of recipient countries. An alternative option would be to encourage new contraceptive supply donors to increase support through existing channels, such as increasing core support to UNFPA, instead of creating new bilateral programs.

From 1990 through 1994, USAID led the donor community providing 53.6 percent of all support for contraceptives. In 1997, UNFPA support represented more than 29 percent of the total global donor support for contraceptives, surpassing USAID by a small margin. By 1998, USAID re-emerged as the largest donor, with other donors such as the European Commission and the World Bank joining the top five donors. The significant increase on the part of the European Commission can be accounted for by large donations of contraceptives to Indonesia and South Africa.

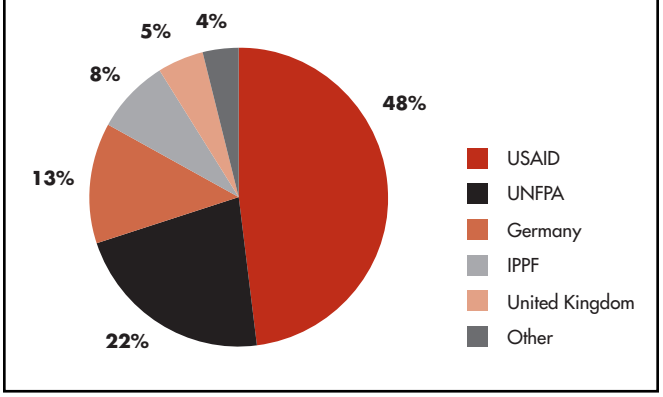
USAID and UNFPA decreased support substantially in 1999, by 38 percent and 55 percent respectively (a total of $18 million less than 1998 levels). Indeed, four of the five top donors decreased support for contraceptive supplies between 1998 and 1999. DFID was the one exception, which suffered a decline in 1998 and bounced back the following year. Unfortunately, over the last four years, the overall trend for all donors combined has been one of declining support. Although data for 2000 is not yet available, two donors, the governments of the United Kingdom and the Netherlands, together provided an additional $80 million in support in 2000 in response to a shortfall in funding for contraceptives.

Untapped Potential

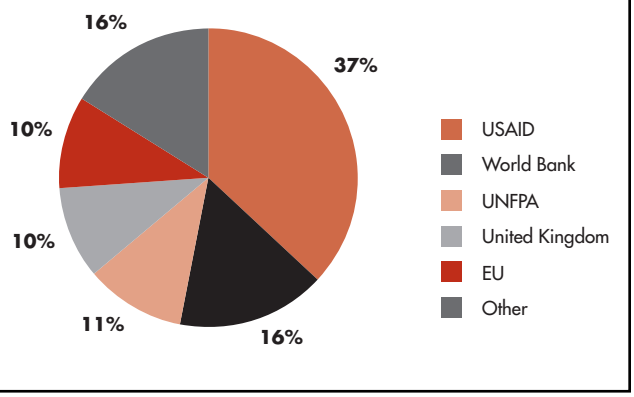
Many population assistance donors do not directly fund contraceptive commodities. Only about one-third of bilateral population assistance donors report funding contraceptive supplies specifically. Norway, Denmark, Switzerland, Australia, Belgium and Finland are among those donors who could be supporting commodities but are not. (In the absence of bilateral programs, Norway and Denmark largely disperse their population assistance through UNFPA and NGOs, hence some funds may be going towards contraceptive supplies.) In addition, other development banks, such as the Asian Development Bank, could join the World Bank in funding contraceptive commodities.

Although some donors could be encouraged to begin supporting contraceptive supply through bilateral channels, it should be noted that increasing the number of bilateral donors has implications for coordination and for the work load of recipient countries. An alternative option would be to encourage new contraceptive supply donors to increase support through existing channels, such as increasing core support to UNFPA, instead of creating new bilateral programs.

◄ Figure 1 ►
The Top Five
Commodities Donors in 1992



◄ Figure 2 ►
The Top Five
Commodities Donors in 1999



Some donors fund contraceptive supplies at very low levels. The top five contraceptive commodity donors accounted for 84 percent of contraceptive commodity assistance in 1999. Among those donors who fund contraceptive commodities, but at low levels, are Canada, the Netherlands (not including the generous year 2000 donation to UNFPA), Germany, and Sweden. In addition, IPPF was once an important donor but has decreased its support for contraceptives recently.

The private commercial sector, including pharmaceutical companies, remains largely untapped. Pharmaceutical companies offer significant price reductions to donors and public sector providers who purchase large amounts of contraceptives. Other avenues of assistance, such as private service delivery mechanisms and fee for service could be explored. The private commercial sector has a place at the contraceptive security table. Further research and efforts need to be undertaken to develop a strategy to maximize their contribution.

Foundations and Non-governmental Organizations

The International Planned Parenthood Federation and DKT are the mostly likely NGOs to contribute to global contraceptive assistance. Most NGOs, however, depend on money channeled through them by bilateral donors for contraceptive purchases. Non-governmental organizations themselves are unlikely to assume a much greater share of the purchase of contraceptive supplies.

The significance of U.S. private foundations in the donor arena has grown dramatically since ICPD. Since

◄ Table 2 ►
Estimated Contraceptive Commodity Support by Donor/Agency (US$000)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	TOTALS	%
BMZ/KfW	—	—	10,798	18,312	11,350	9,317	38,071	13,305	8,627	7,976	117,756	9.7
CIDA	—	—	—	—	1,385	4,514	7,249	0	1,036	2,885	17,069	1.4
DKT	—	—	—	—	—	177	0	N/A	3,759	5,148	9,084	0.7
EU	—	—	—	180	6,122	6,510	9,215	7,435	644	13,109	43,215	3.6
IPPF	5,843	5,410	6,204	6,165	6,258	6,746	6,003	11,148	3,416	3,016	60,209	5.0
JAPAN	—	—	—	—	28	315	300	838	36	159	1,676	0.1
NETHERLANDS	—	—	—	—	—	102	N/A	3,749	2,700	2,584	9,135	0.8
MSI	—	—	568	1,173	405	0	0	1,439	61	N/A	3,646	0.3
DFID	—	—	4,125	4,712	7,192	10,924	9,205	13,149	7,807	13,188	70,302	5.8
PATHFINDER	—	—	700	1,692	462	892	0	N/A	N/A	N/A	3,746	0.3
PSI	—	—	418	1,210	2,323	7,419	7,239	2,885	200	264	21,958	1.8
SIDA	—	—	1,297	0	6	1,400	750	0	N/A	514	3,967	0.3
UNAIDS	—	—	—	—	—	—	—	—	—	218	218	—
UNFPA	14,752	21,499	18,534	27,817	34,087	37,857	37,610	39,861	32,200	14,395	278,612	23.0
USAID	57,636	59,892	39,575	55,142	47,848	51,059	46,481	39,383	63,087	45,522	505,625	41.7
WHO	957	975	628	483	968	1,663	2,099	2,673	481	1,078	12,005	1.0
WORLD BANK	—	—	—	—	—	5,000	7,930	1,662	19,137	20,718	54,447	4.5
TOTALS	79,188	87,776	82,847	116,886	118,434	143,895	172,152	137,527	143,191	130,774	1,212,670	100.0

Source: UNFPA, *Donor Support for Contraceptives and Logistics 1999*, (New York: UNFPA, 2000).

1995, the contributions of population foundations have grown more than five-fold and in 2000 represented an estimated US $541 million in contributions to population and reproductive health issues.[9] Recognizing the critical importance of adequate supplies to the achievement of the goals of ICPD, a handful of foundations are committed to supporting research, advocacy, and perhaps even pilot activities on contraceptive security. The Bill and Melinda Gates Foundation, the United Nations Foundation, the David and Lucile Packard Foundation and the Wallace Global Fund have already given funds to the issue. The William and Flora Hewlett, Summit and Compton Foundations have all expressed interest as well. However, these foundations do not see themselves as substitutes for public funds. While their support is critical to ensuring action and progress around contraceptive security issues, they should not be seen as a vehicle for purchasing supplies—at least not in the long-term.

Geographic Priorities

A variety of influences can shape the geographic allocation of population assistance in general. Donors may have designated priority countries, regions of greatest need, a desire for closer ties with neighboring countries, relationships with former colonies and many other strategic considerations.

The geographic allocation of assistance for contraceptive supplies is also subject to these same influences. However, some unique factors come into play as well. Some countries do not receive any assistance for contraceptive supplies because they are self-sufficient in this area, even if they may still receive assistance for service delivery, capacity-building, or other areas of reproductive health. The concentration of aid also reflects the ability of some countries to use aid funds more effectively than others. Among the donor community, some countries have a reputation as difficult environments. Although this is consistent with the allocation of overall population assistance funds, challenges specific to contraceptive supplies include the fact that procurement is particularly vulnerable to corruption. Developing countries themselves play a key role in requesting and receiving funds as well. Countries with well established family planning programs such as Bangladesh, are more likely to have honed their skills in negotiating for assistance.

Most donors report either that a specific policy on geographic preference does not exist or that these decisions are made at the country level. Specific geographic priorities that do exist are set for overall assistance and not for contraceptive supplies in particular. Despite the lack of specific policies, geographic trends in the distribution of assistance are quite evident. Of the ten countries that received the most donor support in 1999, five are in Asia and five are in Africa, with the majority of assistance (among the top 10) given to Asian countries. It is interesting to note that general population assistance is much more evenly divided among the regions than contraceptive commodity assistance. Bangladesh is by far the largest recipient of support for contraceptive supplies (and has been the largest recipient since 1992), receiving more than $27 million in assistance in 1999.

◄ Table 2 ►
Top Ten Countries Receiving Support for Contraceptive Supplies in 1999 (US $Millions)

Bangladesh ($27.3 million)	Zimbabwe ($5 million)
Indonesia ($16.7 million)	Pakistan ($4 million)
Philippines ($7.5 million)	Uganda ($3.1 million)
Kenya ($6.5 million)	Ethiopia ($3.1 million)
Tanzania ($5.3 million)	Nepal ($3 million)

It is worth noting that Indonesia had become largely self-sufficient and had dropped off the list only to reappear as the number two recipient in 1998 following the Asian economic crisis. Nigeria received $14.1 million in support as the third largest recipient in 1995. However, following sanctions imposed on Nigeria in 1996 by the United States, the country now only receives $1.9 million. India received $17 million in 1996, but that amount had fallen over the past four years to less than $1 million as the country has become more self-sufficient in the production and procurement of contraceptives.

In addition to contraceptive commodity support, the top ten countries received an amount equal to 4.8 percent of the commodity support for logistics management in 1999.

Following the top ten countries, these five countries are also notable in the assistance they received in 1999.

- Ghana (US $2.9 million)
- Mozambique ($2.6 million)
- Egypt ($2.6 million)
- Vietnam ($2.5 million)
- South Africa ($2.3 million)

The total amount of assistance represented in these top 15 recipient countries is $94.4 million or 72 percent of all contraceptive commodity assistance. Of the assistance given to the top 15 recipient countries, 65 percent

Of the ten countries that received the most donor support in 1999, five are in Asia and five are in Africa, with the majority of assistance (among the top 10) given to Asian countries.

goes to countries in Asia, while 35 percent goes to Africa. Similar calculations made for population assistance in general shows much less bias towards Asia, with only 22 percent of all population assistance going to Asia in 1997 (data for 1999 for population assistance are not available).

Another useful analysis of the data is to compare assistance given per capita. UNFPA calculated the average amount spent per woman of reproductive age over five years for each recipient country. This analysis shows that some countries receiving large amounts of commodities assistance actually received a much smaller amount per woman than other countries. For example, although Indonesia received $16.7 million in 1999, this amounted to only $0.10 or 10 US cents per woman. Zimbabwe received $5 million, which amounts to $1.65 per woman. [10]

Donor Policy Trends

Several indicators can be used to examine changes in a donor's commodity assistance. Through a survey sent to major bilateral and multilateral donors, we elicited information on the following indicators for each donor:

- Percent of population assistance provided for contraceptive commodities;
- Existence of a policy on contraceptive commodity assistance;
- Staffing levels;
- Expressed priority given to the issue of contraceptive supply;
- Future commitment to support contraceptive supply;
- Support to capacity building and logistics strengthening;
- Number of countries assisted;
- Support to research into contraceptive supply;
- Maximum years of commodity provision commitment made to recipients.

Percent of population assistance provided for contraceptive commodities[11]. Similar to studying levels of assistance in relation to a country's gross national product, one can track the change in the percentage of funds given for commodity assistance in relation to population assistance as a whole. However, the lack of consistent data for contraceptive commodity funding makes discerning trends difficult. Many donors seem to fluctuate yearly in the amount of funds allocated, both in real terms and as a percentage of population assistance. In addition, there is no agreement on the percent of population assistance that should be devoted to commodities. Nonetheless, we found this indicator to be interesting and it has been calculated in each donor profile in Part II of this document.

Trends in the percentage of population assistance that each donor gives as commodity assistance are erratic. The EU has given anywhere from 0-65 percent of its population assistance as commodity assistance, and Germany's KfW has given from a low of 6 percent to a high of 36 percent. USAID and DFID, both large commodities donors, have been relatively consistent, at around 8 or 9 percent. The recent generous donation of $37 million by DFID to UNFPA for contraceptives will inflate the percentage for the year 2000, as will the donation of $39 million by the Netherlands for the same year.

Existence of a policy on contraceptive commodity assistance. The formulation of a policy is another indicator of trends in commodity assistance. Out of thirteen commodity assistance providers contacted, six do not have an explicit commodity security policy, five do, and information was unavailable for the other two. However, the existence of a policy is not always a reliable indicator of donor interest and involvement in supporting contraceptive commodities. For example, USAID, the largest donor, does not have a stated policy on the funding of contraceptive commodities. The European Union has had a written policy for five years, while funds allocated for contraceptive commodities were minimal until 1999. In addition, not all donors with an explicit policy have a budget line item for contraceptive support.

Staffing levels. The shortage of expert reproductive health staff in donor country aid agencies is a constraint on all aspects of donor programs. This is often the case in every sector of development activity. Yet increases in population and reproductive health staff in general, or in contraceptive procurement staff in particular are unlikely. In fact, the survey results showed that permanent staff with training in logistics are not common, especially at the central level, and many donors do not consider it a priority to have such trained staff. Only IPPF, USAID and UNFPA have specialized personnel in charge of contraceptive procurement. There are various strategies that donors employ in light of these constraints. Some rely on trained personnel at the field level, or work on a contractual basis, such as USAID and KfW. Other donors rely on UNFPA or other multilateral agencies for technical procurement tasks.

Expressed priority given to funding contraceptive commodities. Some donors, while supporting population and reproductive health assistance, feel that they should not be in the business of paying for supplies such as contraceptives. Other donors such as Sweden, prefer to take on the responsibility of funding neglected areas such as abortion, and choose not to become involved in contraceptive supply issues.

When asked to rank the priority given to funding contraceptive commodities (not a priority/somewhat important/important/high priority) WHO, IPPF, KfW (Germany), and DFID (United Kingdom) find funding of contraceptive supplies to be high priority. Funding contraceptive commodities

is not considered a priority by CIDA or Finland's Ministry of Foreign Affairs, whereas it is "somewhat important" for the European Union and Japan. Surprisingly, in spite of its high share of total donations, USAID considers funding contraceptive donations "important." This is also the case of the World Bank, although it notes that other health supplies are equally important.

Future commitment to support contraceptive supply. Donors responded to a survey question that first asked if they were able to predict the likely level of commodity support from their agency in the next ten years. Secondly, they were asked to further specify the increase or decrease. The European Commission, World Bank, and DFID expect their funding for contraceptive supplies to increase somewhat, while IPPF expects to remain at the same level. CIDA, Finland, USAID and WHO could not predict what the future will hold. Although KfW cannot really predict, they ventured a guess that a slight decrease would occur. None of the donors reported that they expected assistance to cease altogether over the long term.

Support to capacity building and logistics strengthening. Contraceptive commodity security is not simply about financing the purchase of supplies. A reliable supply cannot be achieved without effective logistics management on every level, from forecasting future needs to preventing stock-outs at clinics. UNFPA reports annually not only on the level of donor funding for contraceptive purchases, but also on the level of support dedicated to the strengthening of logistics management systems. Although there has been no research to determine the ideal proportion of funds that should be dedicated to logistics strengthening activities, UNFPA estimates that an investment equal to at least 15 percent of the value of the contraceptive commodities is desirable.[12]

In terms of the level of assistance to logistics capacity building, the only organizations that can account for resources applied in 1999 are USAID ($14 million) and UNFPA (see the detailed appendix on logistics support found in UNFPA's publication *Donor Support for Contraceptives and Logistics 1999*. Others could not provide the information, either because they do not keep track of it as a separate expense or because they have not collected it at the central level.

Only the foreign assistance agencies of Japan and Finland do not provide any assistance for capacity building in logistics management. CIDA has done it in the past and is open to providing such funding in the future, whereas IPPF supports only technical assistance for capacity building in logistics. DFID has provided support for training, infrastructure strengthening, resource mobilization, and donor coordination, in addition to technical assistance, in several countries on an ad hoc basis. Other donors appear to have the various aspects of capacity building support as a permanent and mandatory component of contraceptive support. This includes WHO, whose Essential Drugs and Medications Department considers this type of capacity development a key objective. Of course, WHO's support is not limited to contraceptive logistics but applies to all essential health care supplies.

Number of Countries Assisted. Not all donors are able to identify the number of countries receiving commodity assistance through their aid programs. Of those who are able to access this information, KfW and Japan report between 20 and 25 countries, DFID reports 20 countries, whereas UNFPA supported 141 countries with contraceptives in 1999 and IPPF reports assisting 100 countries. USAID reports assisting some 120 countries per year.

Funding Research. In an effort to determine other areas of support that may not be reflected in commodity support numbers, the survey elicited information from donors regarding any research undertaken on the topic. Five of the donors (the EU, USAID, World Bank, DFID, and KfW) report funding research in such areas as market studies and contraceptive need forecasting.

Maximum years of commodity provision commitment made to recipient countries. The number of years into the future to which a donor can commit can have a big impact on the security of contraceptive supply in a country. The duration of the commitment that donors can make varies substantially, underscoring the difficulties of establishing a system of coordination. Donors often can only commit for a year or less of supply needs, yet the time needed to negotiate such an agreement may take months or years itself, and the donor's own budget planning cycle probably spans two or three years. Once a commitment is made to provide contraceptives, the lead-time to proceed through the donor's own procurement regulations may take six months to two years. Good forecasts of contraceptive requirements cover at least three years (the current year plus two future years). Given such time frames, short-term commitments greatly complicate the forecasting and procurement planning process and require exceedingly strong management skills within the recipient organization.

The range of donor responses includes the European Commission and Finland, which would not commit themselves to any period of time; Japan, which can commit for "less than one year;" IPPF, which reports an ability to commit for one to two years; WHO and KfW, which can commit to three years; and finally USAID, DFID, and CIDA, which would make commitments of up to five years. For the World Bank, the length of commitment depends on country needs.

COORDINATING SUPPORT AMONG DONORS

More consistent coordination of donor inputs is essential to improve the efficient use of available resources for reproductive health. This is even more critical for the funding of contraceptive and other reproductive health supplies. Major bilateral donors, such as DFID, CIDA, Germany/KfW and USAID, participate in UNFPA's working group on contraceptive commodity assistance.[13] A broader group of donors convenes at separate annual donor meetings hosted by IPPF and UNFPA. However, apart from these periodic meetings, there are no mechanisms or established procedures for donors and recipient countries to coordinate forecasting, divide funding responsibilities, or pool procurements.

Donor coordination often takes place at the country level. The level of coordination appears to vary greatly across countries, however, reflecting among other factors the capacity of governments to take the lead in coordination, the level of donor involvement, as well as the personalities of individual donor representatives. In Bangladesh, the World Bank plays a leadership role in a consortium involving a large number of bilateral donors. In Tanzania, too, the donors have worked closely with the government to ensure that they provide complementary assistance. In other cases, donor coordination has been less effective. In Pakistan, for example, two different bilateral donors support social marketing activities with different objectives. As a result, they sometimes work at cross purposes or duplicate each other's efforts.[14]

In order to assess the importance attached to coordination among contraceptive commodity donors and to solicit input on this issue, the survey asked respondents a series of questions on their interest in coordination at different levels (country and global), lessons learned, and challenges encountered. The survey also solicited suggestions and recommendations on ways to enhance donor coordination.

All respondents express some interest in coordinating commodity supply at the global and at the recipient country levels, although IPPF and Japan are skeptical about its feasibility. In addition, some donors report current participation in "some" coordination effort. However, most assistance providers express dissatisfaction with both past and current coordination experiences. Comments range from CIDA's view that donors engage in enthusiastic discussions but are slow to act, to USAID's assertions that higher priority is given to cutting edge projects than to providing supplies and that donors should have common norms and standards with open and accessible plans. DFID states that the most important lesson in coordination — or lack thereof — is that commodity security is vulnerable. In fact, DFID suggests that, in order to enhance coordination, UNFPA should boost its role as a strategic coordinator and broker at the local and global levels.

Challenges to coordination. Donors cite a variety of challenges with respect to coordination, especially at the local level. CIDA maintains that, except for USAID, donors lack technical expertise in family planning which gives other issues an edge in competing for funds within bilateral agencies. In turn, USAID finds challenges in the diversity of donor regulations and required procedures, the growing demand for affordable contraception, the lack of political support within beneficiary countries, and insufficient donor resources. At the global level, USAID points to the weakness of the links among key donors even when it comes to sharing data on needs and shortfalls. KfW echoes this concern by stating that distributing tasks among donors and avoiding duplication is essential, as is a sense of flexibility and an ability to compensate for the shortfall of another donor if necessary.

Finland states that "policy discrepancies" are a major obstacle to commodity coordination. However, the World Bank is more specific and contends that each donor has its own agenda and that some donors fail to see contraceptives in the context of overall essential medicine. WHO asserts that the challenges at the national level are to build reliable channels of communication, to obtain sufficient funds and human resources, and to get all actors to adhere to local and technical regulations. At the global level, WHO describes the challenge as, on the one hand to design strategies based on relevant information and on the other to persuade other actors to follow its technical guidance. DFID points to the need for sharing lessons and experience, and for sharing currently relevant rather than historical experience. The foremost challenge at the global level according to DFID is the need to achieve consensus on UNFPA's role—a view shared by Finland and Canada's CIDA as well. These donors state that UNFPA would provide the most effective leadership in coordinating reproductive health commodity supplies over the next 15 years.

In contrast, the European Commission proposes a consortium of international agencies and a new "global commodity facility." Such a consortium, although not necessarily a global facility, is also supported by IPPF and Japan. However, the World Bank describes the global facility as a risky initiative that would have limited support from other stakeholders, would keep aid recipient countries from developing their own capacities, and limit the role of private markets. For its part, USAID believes that no single mechanism will provide effective leadership and that various models of coordination among all actors would be best.

Finally, although WHO believes that the best strategy is central procurement, it states that the involvement of national governments and their partners, at the local level, is key to ensuring that national needs are met.

◄ RECOMMENDATIONS ►

While donor views of both the challenges to coordination and possible solutions vary greatly, the following recommendations emerge:

- The donor community needs to strengthen coordination of commodity purchasing and funding with the major international organizations taking a lead role. This coordination should also include national governments.
- Donors should move towards a more comprehensive view of reproductive health supplies that extends beyond contraceptive funding and procurement.
- UNFPA and the donor community need to improve the tracking and reporting of all spending related to the provision of reproductive health supplies.
- UNFPA currently has an important complementary role to play in filling geographic gaps left by the bilateral donors. This procedure should be examined to determine if this is the most effective role for UNFPA.
- The level of procurement expertise within donor agencies varies widely and it is probably not feasible for many to develop the capacity internally. A global coordinating mechanism needs to take advantage of existing expertise and take into account the varying capacity of donors.
- The level of procurement expertise varies also among developing countries. Assistance for capacity-building should be built into commodity assistance, perhaps with a target percentage of funds.
- Close coordination between national governments and donors is needed in order to match the specific commodity assistance needs with the different technical and financial resources available from different donors.
- Donor country governments must immediately increase their support for contraceptive supplies while exploring longer-term efficiencies and alternative funding strategies.
- Coordination at the global level should include analysis of funding trends (such as per capita assistance), the prioritization of countries in greatest need, and perhaps allocating assistance as a set percentage of population assistance.
- Current fluctuations in year-to-year giving make planning all but impossible. Donors need to commit to consistent levels of funding for contraceptive supplies.
- Many donors rely on requests coming in from developing countries. Since some developing countries are more skilled than others at navigating donor processes, assistance becomes concentrated in certain areas. Capacity-building in developing countries is required for aCapacity-building in developing countries is required for a more equitable distribution.
- Donors and recipient countries need to reach consensus on a mechanism for global coordination of contraceptive commodity supply.
- Advocacy by interested parties should be targeted to multiple stakeholders, including those population assistance donors who are not funding contraceptives, contraceptive donors who are funding at low levels, the private commercial sector, and developing country governments themselves.

◄ CONCLUSION ►

The good news is that the last few decades have seen an enormous increase in the use of reproductive health services around the world. Many women and couples in developing countries rely on government programs funded through international population assistance. Though not the most glamorous of tasks, assuring that supplies are available is essential to their reproductive health care. Declining and irregular contributions from donor nations towards the purchase of supplies threaten continuation of crucial services. UNFPA reported that in 1999 donor funding available for supporting contraceptive supplies fell to $130.8 million, a decrease of $12.4 million, or about 9 percent, compared to 1998. Shortfalls of supplies are being reported in many developing countries and may become increasingly common as the number of contraceptive users increases.

The International Conference on Population and Development served to strengthen the commitment of many donors to help stem the largely preventable death toll resulting from inadequate access to reproductive health care. Developing country governments are shouldering a large part of the burden themselves but, for the majority of the poorest countries, donor assistance is critical to maintaining a secure supply of contraceptives. Donor country governments must first and foremost acknowledge the unique challenge of assuring contraceptive supplies given the growth both in population size and in the use of family planning, and the difficulty many countries experience in maintaining supplies. Secondly, donors must increase their support for contraceptive supplies, give more predictably year-by-year, and explore ways of achieving long-term efficiencies and alternative funding strategies.

◄ SECTION II ►
DONOR PROFILES

1. BILATERAL DONORS

A. United States of America

a. The resource environment for commodity financing

Through its Agency for International Development (USAID), the United States is (and has historically been) the world's leading donor and provider of technical assistance in reproductive health. Although the United States is also the country that devotes the larger share of its development aid budget to population assistance, it falls far behind other donors in overseas development assistance (ODA) as a percent of gross national product (GNP), ranking last of the 22 development assistance countries (DAC). In addition, although USAID's policies and programs are undergoing a transformation toward a more integrated approach to reproductive health, the Agency continues to maintain a strong focus on family planning.

U.S. contributions to multilateral organizations in population activities are relatively small. Instead, the bulk of reproductive health assistance is administered bilaterally through in-country missions and cooperating agencies. USAID also has the largest and most diverse population program expertise of any donor with regard to both staff and a network of specialists in private and non-profit organizations. These capabilities have expanded during more than three decades of activities in the field.

Despite the importance of the U.S. leadership role in funding population activities, the U.S. Congress imposed major cuts on family planning funding in 1996, which resulted in significant reductions of USAID staff and overseas field missions. Any improvements in overall funding levels have been undermined by restrictions such as the "metering" of funds and abortion-related restrictions imposed on NGO recipients.

b. Trends in commodity support

Contraceptive supplies have been an integral part of USAID's population assistance program since its inception in the mid-1960s. However, as the table below shows, contraceptive commodity assistance by the United States has declined during the past decade. Although donations of contraceptives have remained on average at the same level in absolute terms during the better part of the last decade, they have consistently dropped as a percentage of total population assistance. This pattern of relative decline started before the 1994 International Conference on Population and Development. Some reductions could be at least partially attributed to the broader definition of reproductive health that resulted from the Cairo conference (which makes overall population assistance levels look larger from 1995 on, and therefore the percentage accounted for by commodities look smaller).

c. The policy environment for commodity support

USAID considers funding supplies important, maintaining a Contraceptive and Logistics Management Division in its Population Office within it's the Bureau of Global Programs. In addition, the Agency funds capacity-building in logistics management through training, infrastructure strengthening, and other technical assistance, in addition to resource mobilization and donor coordination. USAID spent US $14 million supporting the latter activities in 1999.

USAID does not have an explicit policy concerning the funding of contraceptive supplies. There is not a line item in the agency budget for contraceptive procurement at the central level, but individual missions may include the purchase of contraceptives as a bilateral activity. USAID has between 6 and 10 staff members in Washington, DC who handle contraceptive procurement and distribution. In addition, contract staff provide valuable services in support of the Agency's contraceptive procurement system (e.g., management information systems, or MIS). In addition another 6 to 10 personnel are funded through other organizations, such as John Snow, Inc. (JSI).

USAID currently funds research studies related to reproductive health commodity supply through the DELIVER Project (formerly the Family Planning Logistics Management project), which is implemented by JSI. The research examines the performance of contraceptive logistics systems in developing countries where health sector reform (HSR) programs are taking place.

◄ TABLE 3 ►
USAID'S POPULATION AND CONTRACEPTIVE COMMODITY ASSISTANCE (US $MILLIONS)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	310.0	366.6	462.9	667.1	637.7	662.4	619*	—
Commodity support	39.6	55.1	47.8	51.1	46.5	39.4	63.9	45.5
Commodity support as percent of population assistance	12.8	15.0	10.3	7.7	7.3	5.9	10	—

* Unofficial, unpublished figure from UNFPA.

d. Commodity assistance program and perspectives

USAID serves more than 120 program recipients. Nevertheless, the Agency is unable to project the likely level of commodity support that it will provide in the next ten years. The Agency has a keen interest in coordinating donor programs and currently participates in donor coordination at the country level, as well as at the global level.

USAID proposes the following steps to best enhance coordination at the global level:

- Share and provide timely and accurate information on budgets, products, recipients, and shipments;
- Attend regular meetings;
- Fund, otherwise support, or participate in a coordination mechanism; and
- Create and maintain mechanisms for identifying program needs (and future shortfalls) and create "extranational" procurement mechanisms that programs can access easily.

In turn, USAID states that the greatest challenges to coordinating donor programs for commodity funding or donation at the *country level* are:

- Competing donor requirements such as specifications, rules, brands, and lead times;
- Growing demand for contraception;
- The need to harmonize the contributions of multiple sources of supply to sustain program performance;
- Political commitment at the community and national levels to ensure contraceptive availability; and
- Competition for scarce donor and program resources.

USAID has learned a number of significant lessons about coordinating with other donors with respect to contraceptive commodity supply. At the country level, these include the fact that contraceptive security is often eclipsed by other pressing development needs; that donors are driven more by funding cycles than by program requirements; that it is necessary for local programs to take the lead on and ownership of contraceptive supply; and that commodity supply should be customer or client driven. In addition, in-country coordination requires openness regarding budgets, selections, timelines, and client needs in order to succeed.

According to USAID, there is a need at the global level to translate good intentions and rhetoric into real collaboration. Commodity donors should agree on standards and specifications and cooperation is required in relation to both policy and, more importantly, implementation. This is closely related to the need to produce guidelines and procedures for general use. In addition, difficulties exist in terms of obtaining reliable and useful information on the plans of various donors. Challenges at the global level include growing demand for commodities and the need to create greater awareness and urgency around the issue of contraceptive security. USAID therefore advocates that it is necessary to create and maintain effective communication links among key donors, including sharing data on program needs and shortfalls.

USAID believes that no single mechanism is likely to provide effective leadership to coordinate contraceptive commodity supply. Instead, various joint activities with UNFPA, the World Bank, and a consortium of international agencies would be the best option.

B. The United Kingdom

a. The resource environment for commodity financing

During the past decade, Britain's capacity, innovation, and effectiveness as a population donor have grown substantially. A population program that is widely considered to be well-managed and results-oriented has been built by increasing numbers of health and population staff in the field, making a commitment to innovative programs, and implementing effective technical cooperation with collaborating institutions. In addition to core family planning, safe motherhood, and adolescent reproductive health services, the Department for International Development-UK (DFID) has funded projects in such cutting-edge areas as post-abortion care, vaginal vesicular fistula prevention, and sexual violence.

Since its inauguration, the current British political administration has expressed strong support for population activities as a component of foreign assistance. However, it became clear as early as 1998 that no significant funding increases were forthcoming due to the new leaders' stringent commitment to budgetary austerity. It was therefore expected that DFID funding of reproductive health would not reach the level of Britain's "fair share" of the resources needed to meet the goals established at the 1994 ICPD. What was not expected is that funding would be sharply reduced.

DFID let it be known in early 2000 that all new reproductive health programs would receive only 50 percent of their total funding. Lobbying efforts managed to ameliorate this sudden cut by persuading policymakers to phase in the cuts by maintaining funding levels of 85 percent in the first year, 70 percent in the second, and 50 percent in 2003. However, the All Party Group on Population Development and Reproductive Health in London stepped up efforts to convince the political leadership that a full reversal of the cuts is crucial. The British government announced last July incremental cuts in international aid spending of 6.2 percent, in real terms, over the next three years. The specific consequences of this decision for population and reproductive health assistance are not yet clear.

◄ Table 4 ►
DFID's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	50.7	47.2	58.0	98.2	106.4	117.4	—	—
Commodity support	4.1	4.7	7.2	10.9	9.2	13.1	7.8	13.2
Commodity support as percentage of population assistance	8.1	10.0	12.4	11.1	8.6	11.2	—	—

b. Trends in commodity support

As indicated in Table 4, DFID was an important donor of contraceptives during the 1990s, both bilaterally and as a contributor to UNFPA's global contraceptive commodity fund. DFID's contributions in 1999 were more than three times those of 1992, having decreased slightly in 1996 and again sharply in 1998 during Britain's foreign aid hiatus. Prior to 2000, contraceptive commodities had fluctuated around 10 percent of DFID's total population assistance. In 2000, in response to UNFPA's report of a crisis in condom supply, DFID contributed $37 million largely for contraceptives. Although official data for 2000 are not yet available, the generous donations of both DFID and the government of the Netherlands for contraceptives are certain to be almost on par with the yearly total contraceptive support of USAID, and are a five-fold increase over UNFPA's 1998 contraceptive budget. Although the influx of funds will go a long way toward helping to alleviate immediate shortages, DFID reports that it cannot commit such extra funds beyond one year. That said, DFID does expect that if ministries of health or finance demonstrate a need, it could probably lend assistance.

c. The policy environment for commodity support

DFID has an established policy concerning commodity support within the context of a reproductive health strategy. Reproductive health is seen as an element of overall health and development, within which commodity supply plays a prominent role. DFID increasingly concentrates on sector-wide approaches.

DFID funds the purchase and distribution of contraceptives, including condoms, and specifically supports access to barrier methods to prevent reproductive tract infections. DFID does not have a budget line in its central accounting that is earmarked for contraceptives. Instead, expenditures are made in response to the needs of each country in coordination with its government. Three-quarters of all DFID funds are allocated to country programs.

Although there are no contraceptive procurement specialists at London headquarters, DFID has set up resource centers where specialist assist countries in conducting procurements on their own. Also at the country level, DFID funds contraceptive requirement studies as well as research to examine contraceptive supply issues within a broader health context.

d. Assistance program and perspectives

Commodity support by DFID is provided to the same 20 countries favored by the Britain's health and development assistance. Bolivia, Nicaragua, and Peru are the only three countries in Latin America that receive support, whereas coverage is more extensive in Anglophone sub-Saharan Africa and South East Asia, in addition to Bangladesh and Pakistan.

DFID recognizes that contraceptive security appears to be vulnerable as demand increases and donor support lags behind. The Department reports that better contraceptive logistics coordination at the global level is needed. As a coordination mechanism, DFID remarks that the UNFPA working group has been useful. However, it has operated more as an emergency response team, but has the potential for playing a much larger role in contraceptive security. During the 1994 International Conference on Population and Development, DFID introduced as a specific objective that UNFPA play a major role in the global coordination of contraceptive supplies. DFID remarks that while UNFPA has moved in that direction, it needs to do so decisively. The Department identifies UNFPA country representatives as having a crucial role in coordination, sharing lessons learned, anticipating commodity supply issues and sharing relevant and current project information.

Contraceptive support is a high priority for DFID and they state that it is impossible to be effective in raising the quality of reproductive health for the long-term without guaranteeing supplies of contraceptives. DFID also supports logistics capacity-building through its work with the Family Planning Logistics Management (now called DELIVER) project.

Although DFID will most likely continue to fund contraceptive supplies and logistics capacity-building at increasing levels, the agency is unable to predict the size or pace of such increments in the future. Should any given country among those being assisted become unable (or unwilling) to adequately maintain its contraceptive supply, the Department will probably choose to increase its support in order to ensure that needs are met. In addition, the length of the agency's program commitments is gradually increasing from three to five years.

C. Canada

a. The resource environment for commodity financing

After several years of budgetary reductions, Canada's foreign aid has increased slightly and appears stable. At approximately $2.1 billion in 1997, funding is not expected to increase significantly in the coming years. This means that the current concentration of aid in fewer countries than in the past will continue. Although the Canadian International Development Agency (CIDA) now gives higher priority to women's health and reproductive health—at least at the policy level—there has not been a higher proportional allocation of resources in those areas. On the contrary, whereas 2.3 percent of official development assistance was applied to population assistance in 1996, only 1.6 percent was used for the same purpose in 1997, representing a decrease in absolute terms from $36.5 to $34.5 million. More than half of this assistance is channeled bilaterally, although mostly to fund multilateral projects. Together with contributions to UNFPA, this strategy allows CIDA to be effective in the field despite limited in-house technical expertise in population and reproductive health.

b. Trends in commodity support

The limited information available on CIDA's commodity support suggests an erratic trend in the funding of contraceptive commodities. Levels of funding varied considerably and increased quite rapidly between 1994 and 1996 both in absolute terms and as a proportion of population assistance. CIDA provided no funding for contraceptives in 1997, however, although support did resume at a much lower level than before in 1998.

c. The policy environment for commodity support

Although CIDA funds the purchase and distribution of contraceptives, including condoms for STI prevention, the agency does not have an explicit policy on reproductive health commodity security, nor does it does have a line item in its budget for contraceptive procurement. There are no earmarked funds for any one specific sector or activity within reproductive health assistance.

CIDA has between one and two staff members at the central level who (among other duties) conduct contraceptive procurement on an "as needed" basis. CIDA funds logistics capacity development in Bangladesh through UNFPA using Canadian technical assistance in connection with the provision of Canadian products. As for training in logistics management, only one staff member (at the technical assistant level) was trained for the Bangladesh program. Others usually learn on the job.

d. Assistance program and perspectives

CIDA cannot specify the total number of its program recipients due to the fact that a substantial amount of its support for reproductive health is channeled through UNFPA. The Agency is a significant donor to Bangladesh, which is CIDA's only priority country.

CIDA reports that the most significant lesson it has learned about coordination with other donors on contraceptive supply pertain to the global level. The Agency believes that there is a lot of enthusiasm on the part of the private sector, foundations, social marketing organizations, and recipient governments to jointly address outstanding issues. However, all these actors turn out to be quite slow when it comes to translating ideas into actions. In addition, CIDA remarks that the lack of expertise in family planning and reproductive health in some donor agencies gives other issues an advantage over reproductive health in competing for funds.

CIDA states that funding commodities is not a priority for the Agency, which believes that UNFPA is in the best position to provide leadership to coordinate contraceptive commodity supply. However, as mentioned before, CIDA does fund capacity building in logistics management through UNFPA, and would not object to also funding training, infrastructure strengthening, and/or technical assistance in the future if it makes sense to do so in a given program situation. Similarly, CIDA does not currently fund research studies related to reproductive health commodity supplies, but might in the future.

◄ Table 5 ►
Canada's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	28.1	24.7	22.8	37.3	36.5	34.5	—	—
Commodity support			1.4	4.5	7.2	0	1.0	2.9
Commodity support as percentage of population assistance	—	—	6.1	12.1	19.7	—	—	—

D. Germany

a. The resource environment for commodity financing

Germany's commitment of financial resources for population and family planning programs following the ICPD has been mixed. Despite public support for development assistance, relief and reconstruction efforts in Europe have taken precedence over efforts in the developing world and allocations to international aid has declined. During the 1990s, Germany also shifted its support for multilateral population programs in favor of its own bilateral efforts. German officials have cited a lack of demand from developing countries for reproductive health assistance as a significant constraint to expanding the overall bilateral program in this area.

According to UNFPA, Germany's population assistance peaked in 1995 at $145 million and was $122.5 million in 1997. According to Germany's Agency for Financial Cooperation (Kreditanstalt für Weideraufbau or KfW), assistance peaked in 1995 at 195 million DM or US$128 million and was 188 million DM or US$114 million in 1997).[15] Germany is an average donor when its population assistance is evaluated in terms of national wealth. In 1997, it gave $59 per million dollars of GNP—much less than the Netherlands' $402 per million dollars of GNP, but much more than France which contributes only $12 per million GNP. KfW reports that Germany gave 0.28 percent of its GNP to ODA in 1997, 0.26 percent in 1998, and 0.26 percent in 1999, the latter equaling 5.494 billion Euro (or $6.4 billion) in 1999. Recent political developments in Germany do not promise to improve this record. Germany's new government-wide austerity program has disproportionately affected the Ministry for Economic Cooperation and Development (BMZ), and its contributions to UNFPA and IPPF were almost halved between 1999 and 2000. It is projected that this trend will be partly reversed in 2001.

b. Trends in commodity support

Germany began reporting its assistance for contraceptive commodities to UNFPA in 1992. Between 1992 and 1998, Germany provided about 10 percent of the donated contraceptives worldwide. This support has fluctuated from a high of more than $38 million in 1996 to a more customary $8.6 million in 1998. The majority of German commodity assistance flows through KfW, which provides significant support to contraceptive social marketing programs in developing countries.

Contraceptive commodity assistance from KfW was erratic during the 1990s, both in absolute terms and as a percentage of total population assistance. This situation is complicated by the fact that the latter has also been subject to wide fluctuations. For example, in 1995, Germany's population assistance reached its highest level but the contraceptive commodity support component of such assistance sunk to its lowest level, only to increase four-fold the following year when overall population assistance was reduced by 34 percent.

◄ Table 6 ►
Germany's Population and Contraceptive Commodity Assistance
(US $Millions or DM Millions, as noted)

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000
Population assistance	62.9	50.6	114.8	145.3	96.0	122.4	—	—	—
Commodity support	10.8	18.3	11.3	9.3	38.1	13.3	8.6	8.0	
All reproductive health support that includes commodities	—	—	DM151	DM98.5	DM39	DM90.3	DM61	DM26.8	DM74
Commodity support as percentage of population assistance	17.2	36.2	9.8	6.4	39.7	10.9	—	—	—

c. The policy environment for commodity support

KfW reports that funding contraceptive commodities for use in developing countries is a high priority for the agency. KfW also funds logistic management capacity building, including training, infrastructure strengthening, and technical assistance. Despite the high priority given to commodity support, financial realities in Germany are likely to produce a negative impact on the actual financing of such supplies. Officials at KfW predict that contraceptive commodity support is likely to decrease over the next ten years.

d. Assistance program and perspectives

During 1992–1998, KfW financed the purchase of condoms, injectables, oral contraceptives, and vaginal foaming tablets. Spending on oral contraceptives made up a full 64 percent of the $109 million in commodity support provided by Germany over this six-year period.

A third of total funding during this period was allocated to the purchase of condoms. KfW's financing of condoms increased during the 1990s, just as funding for oral contraceptives declined. In 1992, KfW purchased about $34,000 worth of condoms and more than $10 million worth of oral contraceptives; by 1998, this balance had shifted to more than $6 million in condoms and just $1.2 million in oral contraceptives.

In 1999, KfW provided contraceptive commodity support to 25 programs in 16 countries through various mechanisms.

KfW acknowledges the need for coordination among commodity donors at the country level, however, due to the fact that KfW usually does not have a physical presence in-country, the agency is generally unable to participate in coordination that may exist between donor representatives in a particular developing country.

Despite the fact that Germany is considered to be one of the major donors of contraceptive commodities, it does not conduct its own procurement of these supplies. KfW reports that it has no staff designated to manage contraceptive procurement and distribution, but prefers to have an outside agent conduct the procurement for a fee, or to fund staff to manage procurement through a partner agency.

E. Japan

a. The resource environment for commodity financing

Japan has given generously to UNFPA , and until 2000, had been UNFPA's largest donor. Although Japan's overall population assistance program has increased over the past decade, it still lags behind other major donors. Japan provided $93.8 million in 1997 and ranks 15th among donor nations in terms of the percent of GNP spent on population assistance, which is just $22 for every million dollars of GNP.

b. Trends in commodity support

Although the government of Japan does not have a specific policy on or a budget line item for contraceptive supplies, it does fund the purchase and distribution of condoms on a very small scale. Japan accounted for less than 1 percent, or $159,000, of all contraceptive commodity assistance in 1999.

c. The policy environment for commodity support

The policy environment in Japan has encouraged increased spending on population. Despite domestic economic recession in Japan and in addition to its support to UNFPA, the government of Japan met its commitment to disburse $3 billion to its own Global Issues Initiative for Population and AIDS in the period 1994-2000. Moreover, it met the commitment in 1998—two years earlier than planned.

Funding contraceptive commodities, although limited to condoms, is considered somewhat important by the Japanese government. No plans exist to include resources for capacity building in logistics management or to carry out research studies related to reproductive health commodity supply. The survey respondent was unable to provide a projection on the likely level of commodity support ten years from now.

d. Assistance program and perspectives

Although the Japanese government has attempted to increase its support to specific country programs, its bilateral program is limited by a lack of technical personnel with expertise in reproductive health. In addition, the program's operational definition of "population activities" is broad and does not emphasize family planning.

Japan is interested in coordinating donor programs for commodity funding both at the country and the international levels, although it is not sure that coordination is feasible in either case. The respondent states that a consortium of international agencies would best provide effective leadership to coordinate contraceptive commodity supply and to ensure that developing country needs are met.

F. Finland

a. The resource environment for commodity financing

Finland devotes a larger share of its development budget to population assistance than do many other donors. However, Finland's support for population activities has suffered significant reductions during the last eight years due to drastic cuts in the country's foreign aid program. The level of population assistance has not returned to the $25 million peak reached in 1991.[16]

Finland allocates most of its population assistance through contributions to UNFPA, although it also oper-

◄ Table 7 ►
Japan's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	74.8	83.2	82.7	93.8	93.8	93.8	—	—
Commodity support			0.03	0.3	0.3	0.8	0.4	1.6
Commodity support as percentage of population assistance	—	—	0.04	0.3	0.3	0.9	—	—

◄ Table 8 ►
Finland's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1991	1992	1993	1994	1995	1996	1997	1998
Population assistance	25.5	20.9	8.8	7.8	22.5	19.8	17.3	—
Commodity support	—	—	—	—	—	—	—	—
Commodity support as percentage of population assistance	—	—	—	—	—	—	—	—

ates a small bilateral program that focuses more broadly on reproductive health issues than specifically on family planning. The program is dispersed among 20 recipient countries, primarily in Africa.

b. Trends in commodity support

Information on the amount of foreign aid provided by Finland for contraceptive supplies is not available, nor is it clear that any of it's the country's population assistance is used for this purpose. Although on rare occasions Finland may fund a small amount of contraceptives (as well as condoms for the prevention of STIs) through NGO activities in the field, UNFPA does not include Finland among the list of donors that fund contraceptive supplies.

c. Assistance program and perspectives

The Department for International Development Cooperation of Finland (formerly FINNIDA) is not interested in taking on the supply of contraceptives. However, it believes that either UNFPA or a consortium of international agencies would provide effective leadership to coordinate contraceptive commodity supply and ensure that developing country needs are met over the next 15 years.

G. Sweden

a. The resource environment for commodity financing

Sweden's strong and comprehensive support of population and development focuses on social and economic elements that both affect reproductive health and underlie human rights and gender concerns. As one of the first bilateral donors to begin providing population assistance, Sweden continues its role as a pioneer by shifting emphasis to often-neglected areas such as violence against women, sexual health education, adolescent health, and safe abortion.

Although considered a generous and consistent donor, Sweden's contributions are difficult to assess due to its broad definition of sexual and reproductive health, currency fluctuations, and a move toward a sector-wide approach to programming. In 1996, Sweden was the seventh largest contributor to population programs. In the mid-1990s, Sweden's contributions declined when measured in U.S. dollars but remained steady when measured in Swedish crowns. Contributions to UNFPA fell between 1994 and 1997, but increased again in 1998.

b. Trends in commodity support

Since 1992, Sweden has only rarely provided direct support for contraceptive supplies. In both 1992 and 1995, Sweden provided just under 1.5 million. Apart from this support, funding for contraceptives has been negligible.

c. The policy environment for commodity support

Sweden's foreign aid agency, Sida, does not have an interest in contraceptive security per se, preferring its pioneering role in addressing the more controversial aspects of sexual and reproductive health and rights. Specific areas of interest include maternal and newborn care, fertility regulation, abortion, HIV/AIDS, adolescent health, female genital mutilation, and violence. Sida is notable for its commitment to expanding the availability of medically safe procedures to terminate pregnancy, improving access to quality post-abortion care, and supporting the liberalization of abortion laws. In this context, Sida seems unlikely to take on a larger role in the funding of contraceptive supplies.

H. The Netherlands

a. The resource environment for commodity financing

The Netherlands has a strong history of reproductive health funding, having doubled its contribution to reproductive health activities between 1994 and 1996. Currently, the Dutch government allocates 4 percent (about $160 million) of official development assistance to reproductive health.

◄ Table 9 ►
Sweden's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1991	1992	1993	1994	1995	1996	1997	1998
Population assistance	42.2	62.7	37.0	44.7	44.7	57.8	—	—
Commodity support		1.3		.006	1.4	0.7	0	
Commodity support as percentage of population assistance	—	—	—	—	0.3	1.2	—	—

◄ Table 10 ►
THE NETHERLAND'S POPULATION AND CONTRACEPTIVE COMMODITY ASSISTANCE (US $MILLIONS)

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	39.6	43.0	37.5	43.8	88.6	111.7	146.4	—	—
Commodity support					0.1		3.7	2.7	2.6
Commodity support as percentage of population assistance	—	—	—	—	—	—	2.5	—	—

Political support for foreign aid in general, and assistance to reproductive health in particular, is very strong in the Netherlands. The Dutch government is currently interested in concentrating its support and projects in fewer countries, shifting emphasis from sub-Saharan Africa to the former Soviet Union. In the last few years, Dutch development cooperation policy has shifted toward sectoral reform and the number of countries and projects has been reduced. Twenty-one countries have been identified for bilateral assistance based on need, good governance, and sound macroeconomic policy.[17] In addition to narrowing the number of recipient countries, the Dutch government has identified four sectors for support: environment, good governance, peacebuilding and human rights, and private investment.

Although the Dutch government expanded its bilateral aid program in 2000, it continues to channel much of its population assistance through UNFPA. In 2000, the Dutch government increased its initial contribution to UNFPA of $32 million to more than $50 million (in excess of the supplemental donation for contraceptive commodities), surpassing Japan as the largest donor to UNFPA.

b. Trends in commodity support

Although the Netherlands' support for reproductive health activities is evident by high donations relative to the size and resources of the country, it is not easy to discern the proportions specifically spent for contraceptive and logistical support.

Figures obtained by UNFPA, as reported in Table 10, suggest that contraceptive and logistical expenditures either make up a low proportion of reproductive health support or that accounting and reporting of that support is incomplete. Although complete figures for 2000 are not available, a generous contribution of $39 million to UNFPA for contraceptives is notable.

2. MULTILATERAL PROVIDERS OF ASSISTANCE

A. United Nations Population Fund (UNFPA)

a. The resource environment for commodity financing

The United Nations Population Fund (UNFPA) was established more than 30 years ago with a mandate to provide population assistance to developing countries through financial and technical assistance. Although developing countries themselves provide the bulk of support for their reproductive health programs, some countries are only able to afford even the most basic reproductive health services because of the support they receive from UNFPA. UNFPA provides population assistance to more countries than any other bilateral or multilateral organization and is the sole source of such assistance in several countries. Declining and irregular contributions from donor nations to UNFPA, however, are a major impediment. UNFPA reports that contributions are down $50 million from just a few years ago—despite recent increases for general funding that took the Fund from $242 million in 1999 to an estimated $260 million in 2000.

UNFPA is the only organization that can advocate for increased population funding with both donor and developing country governments.[18] UNFPA continues to face the challenge of mobilizing funds for reproductive health at the global level with regard to its own programs as well as those of developing countries. Changing patterns of donor assistance (for example through expanded bilateral programs), developing country partnerships, and the expanded role of the European Union and development banks mean that UNFPA must advocate for even greater coordination of donor assistance.

b. Trends in commodity support

UNFPA is the third major commodity assistance provider (after USAID and the World Bank) and accounted for 11 percent of all such assistance in 1999. Since UNFPA depends heavily on governmental contributions that fluctuate from one year to the next, both its support for family planning and commodity supply are subject to significant variations. Contraceptive commodity assistance provided by UNFPA decreased by 55 percent from 1998 to 1999. When procurements undertaken on behalf of CIDA and the World Bank are included, the level of this decrease is smaller at 27 percent.

In addition to the portion of its own budget assigned to contraceptive support, UNFPA administers contraceptive procurement and distribution for other major providers, notably the World Bank and CIDA, which provided $21 million and $3 million, respectively, in commodities in 1999.

UNFPA plays an increasing role in countries experiencing emergency situations. Its Procurement Section is responsible for sending emergency obstetric equipment and reproductive health kits via airlift to many countries in crisis. Afghanistan, Albania, Bosnia and Herzegovina, East Timor, and Rwanda are a few of the countries that have recently received supplies. UNPFA also responds to natural disasters.

to the evolving contraceptive commodity crisis. To this end, UNFPA has developed a Global Strategy on Reproductive Health Commodity Security (RHCS) and has established a new Commodity Management Unit (CMU) that will manage the implementation of the strategy. UNFPA leadership has stated that RHCS is a top priority for the agency for 2001 and beyond.

UNFPA already employs a number of mechanisms that address RHCS and will work to strengthen others according to the objectives of the Global Strategy. As a priority, it will be necessary to more fully incorporate RHCS into reproductive health programming exercises. The CMU and UNFPA's Procurement Section will work on a variety of new initiatives such as the development

◄ Table 11 ►
Funding for UNFPA and UNFPA's Contraceptive Commodity Support (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	238.2	219.6	265.3	312.6	308.8	289.7	278	251.9
Commodity support	18.5	27.8	34.1	37.9	37.6	39.9	32.2	14.4
Commodity support as percentage of population assistance	7.8	12.6	12.9	12.1	12.2	13.8	11.6	5.7

c. The policy environment for commodity support

Since the International Conference on Population and Development in 1994, UNFPA has established three areas of programmatic action: reproductive health (including family planning and sexual health); population and development strategies; and advocacy.

Regarding reproductive health supplies, UNFPA established the Global Initiative on Reproductive Health Commodity Management (the "Global Initiative") in 1992 with the specific purpose of monitoring and supporting logistics systems and commodity supplies. The Global Initiative works to integrate its activities into the core work of UNFPA, with specific attention to the following areas:

- advocacy and donor coordination to improve the supply of reproductive health commodities and associated technical backstopping;
- national capacity building in logistics management and distribution of reproductive health commodities to help national programs meet present and future needs; and
- sustainability of agencies and institutions that supply reproductive health commodities, including the for-profit sector, in order to make affordable products and services more accessible to users in developing countries.

The Fund, and the Global Initiative in particular, has through its advocacy and donor coordination activities, played a pioneering role in alerting other stakeholders of a "Common Assessment Framework" and collaborative activities with UNFPA's Country Support Teams (which will include new UNAIDS-supported logistics advisors) to strengthen management capacity. Other efforts will be aimed at strengthening global and national coordination, such as the establishment of national working groups. Condom programming will be a priority in every country.[19]

B. European Union-European Commission (EU-EC)

a. The resource environment for commodity financing

With contributions from the foreign aid budgets of its member countries, the European Union (EU) has emerged as the fifth largest source of development aid funds in the world. Its budget for development assistance in 1996 was close to $5.5 billion, or 17 percent of the combined official development assistance of its member countries.

In 1999, the European Commission merged its special development aid budgets for population and reproductive health and HIV/AIDS into a single line item. The Commission also cut funding over the previous year from $23 million to $20 million (with $7 million for population and reproductive health and $13 million for HIV/AIDS). The consolidation of the reproductive health and HIV/AIDS line items is seen by the reproductive health community as a step forward for the EC in implementing a more integrated vision of reproductive health. NGOs successfully fought an initial plan to cut an additional $8 million from the reproductive health budget.

Although well disposed to fund reproductive health assistance at the policy level, the EU has experienced severe difficulties in getting its executive branch, the European Commission (EC), to act accordingly. For example, the EC reached its ICPD annual *commitment* to reproductive health of $347 million per year in 1996, although it was originally set for the year 2000. However, actual spending has lagged far behind, at approximately $14 million in 1996. Assistance levels for population increased dramatically in 1997.

b. Trends in commodity support

In 1999, the EC became one of the top five donors for contraceptive commodities, matching the contribution of DFID and falling just below UNFPA.

c. The policy environment for commodity support

The EC has a stated policy supporting reproductive health commodities and funds the purchase and distribution of contraceptives, including condoms for STI prevention. In addition, the EC does have a line item in its budget for contraceptive procurement. The Commission does not have a contraceptive procurement and distribution unit as such, but funds (albeit indirectly) two staff members. Personnel in charge of contraceptive commodities are hired by the implementing agencies.

Funding commodities is considered somewhat important by the EC. The organization funds capacity building in logistics management, including forecasting and procurement. This means assistance in training, infrastructure strengthening, and technical assistance, although it is unclear how much is spent on these activities. Staff members of the EC predict that the likely level of commodity support that it will provide within the next ten years, will increase somewhat, up to 24 percent of current levels.

d. Assistance program and perspectives

Since resources from the EC for population activities are concentrated primarily in Asia and North Africa, it is to be expected that commodity support would also favor the same regions. Nevertheless, some EC funds are used to support contraceptive commodity assistance through interregional projects and in sub-Saharan Africa and Latin America.

The EC has not had real experience with contraceptive commodity supply either at the national or the global level. However, the Commission has expressed strong interest in this area and noted that it currently participates in some donor coordination at the national and global levels. The EC survey respondent stated that the best coordination mechanism would take the form of either a consortium of international agencies and/or a new global commodity facility.

C. World Health Organization (WHO)

a. The resource environment for commodity financing

As a specialized agency of the United Nations, the World Health Organization (WHO) has a unique, decentralized organizational structure. Whereas its headquarters in Geneva provides scientific and technological leadership, technical guidelines, and global coordination of health policy and initiatives, it is the regional offices that provide technical assistance, policy dialogue, and support to member countries. At least one such regional office, the Pan American Health Organization (PAHO), precedes WHO in existence by several decades.

◄ Table 12 ►
European Union's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance	—	—	3.7	3.6	14	79.4	—	—
Commodity support		0.2	6.1	6.5	9.2	7.4	0.6	13.1
Commodity support as percentage of population assistance	—	—	—	—	65.7	9.3	—	—

b. Trends in commodity support

Although WHO funds the purchase of only a small amount of contraceptives, the experience and expertise of the organization in procurement of a whole spectrum of basic medicines and essential drugs can offer important insight for reproductive health commodity security. The World Health Organization's Department of Reproductive Health and Research (WHO-RHR) purchases contraceptives for research projects, and to a much lesser extent as part of its technical support to country programs. The Ministries of Health of member states may decide to allocate some of the WHO country budgets for the purchase of contraceptives and STI treatment drugs. When requested, WHO procures them on behalf of country programs.

c. The policy environment for commodity support

While WHO-RHR does not currently have an explicit policy concerning reproductive health commodities, nor a budget line item for contraceptives, it does collaborate fully with UNFPA on an interagency group. Contraceptives are obtained according to a reciprocal arrangement, whereby WHO purchases contraceptives through contracts with UNFPA, which purchases essential drugs through WHO.

◄ Table 13 ►
WHO's Population and Contraceptive Commodity Assistance (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Commodity support	0.6	0.5	1.0	1.7	2.1	2.7	0.5	1.1

Procurement is done through the WHO Procurement Services Office, which has a staff of 31 and takes care of all WHO procurement needs, which are expected to exceed $400 million this year. Two staff members have responsibility for contraceptive procurement, which amounted to 1.5 percent of total purchases last year. In addition, about 60 staff members of the WHO Essential Drugs and Medications Department (EDM) provide support to and strengthen capacity in logistics management in countries.

d. Assistance program and perspectives

One of the most significant lessons that WHO-RHR has learned with regard to contraceptive commodity supply is that coordinating such work with governments, donors, and other partners at both the national and global levels is key to success. In 1996, WHO contributed to this type of coordination by publishing the first version of *Guidelines for Drug Donations*. In addition, WHO participates in coordination at the national and regional level.

The greatest challenge to coordinating donor programs of commodity funding or donation identified by WHO at the national level is to secure reliable information and communication channels, as well as sufficient human and financial resources. In addition, it is necessary to ensure adherence to national guidelines for procurement and distribution, treatment, and the rational use of drugs and commodities. At the global level, the key challenges are to obtain relevant information from which policies and strategies can be developed. It is also important to work with all aid agencies and other stakeholders to ensure that they adhere to WHO technical recommendations.

WHO feels that effective leadership to coordinate contraceptive commodity supply should be found in national governments and with partners at the local level. At the global level, however, UNFPA is the lead agency to take on this role. In addition, WHO notes that the benefits of a centralized procurement system are most obvious for health commodities that are difficult to produce and need significant quality assurance. Local production is not a reasonable option for commodities such as vaccines and contraceptives. The poorest countries have difficulty both purchasing and ensuring the quality of imported products. Such constraints are most easily overcome through a coordinated, centralized supply system.

D. The World Bank

a. The resource environment for commodity financing

The World Bank has great influence on national development policies through policy dialogue with developing countries and the dissemination of its own applied research. However, the most effective of the Bank's instruments are the loans it provides to fund development programs. The fact that loans are also endowed with technical and administrative assistance guarantees the continued presence of the Bank in the field during loan execution, above and beyond the policy guidelines and goals that countries agree to as part of the contractual obligations of loans.

The World Bank's resources could help finance the new investments in reproductive health services called for at the 1994 ICPD, including contraceptive supplies. In spite of large reductions in the financing of population, health, and nutrition (PHN) projects, the World Bank increased its loans for population and reproductive health to $446 million in 1999, from about $425 million the previous year.

The Bank's analysis of overall development needs frequently fails to address population concerns. There is no set of indicators on population and reproductive health that Bank staff must take into account when assessing a country's development needs. Moreover, Bank officials responsible for the assessment of funding priorities often have little or no expertise in reproductive health or population issues.

b. Trends in commodity support

Due to the emergence and strong endorsement by the Bank of a new public health funding paradigm for developing countries during the last decade, the Bank has shifted toward providing loans for sector-wide approaches or broad health sector reform.

c. The policy environment for commodity support

The World Bank does not have a policy concerning reproductive health commodity supply, although it does fund the purchase and distribution of contraceptives and condoms for STI prevention. Nor does the Bank have a line item in its budget for contraceptive procurement, since that aspect is part of the budgets of specific loans and programs.

According to the response received to the survey, the World Bank views funding contraceptive commodities as important, but carries it out along with funding for

◄ Table 14 ►
World Bank's Population and Contraceptive Commodity Funding (US $Millions)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Population assistance*	318.3	340	423.7	448.1	508.9	232	425.5	446.7
Commodity support				5.0	8.0	1.7	19.1	20.7
Commodity support as percentage of population assistance	—	—	—	1.1	1.6	0.7	4.5	4.5

*Commitments for population/reproductive health in loans/credits as reported by the World Bank in *Population and the World Bank: Adapting to Change, Revised Edition*. UNFPA is the source for the data on commodity support.

essential drugs. Commodity support from the Bank is expected to increase somewhat over current levels over the next ten years. Other related areas that are funded by the Bank include capacity building in logistics management through training, infrastructure strengthening, and technical assistance. The costs of these activities are embedded in loan budgets, and thus it is difficult to track the level of such expenditures.

d. Assistance program and perspectives

Although the Bank does not conduct procurement of contraceptive supplies on its own, it does require borrowers to follow guideline for procurement when loan funds are used. These guidelines are often the subject of criticism among developing country loan recipients.

The World Bank finds that the greatest challenges to coordinating donor programs are posed at the country level, with each donor having its own agenda. In addition, some donors fail to recognize the importance of looking at contraceptives in the context of overall essential medicine. The Bank is highly interested, and currently participating in donor coordination at the national level. However, they are not sure it is feasible at the global level. The Bank considers the option of "a new global commodity facility agency" to be high risk. Reasons cited for this include the possibility that such an agency would postpone the need for countries to develop capacity and undermine the development and growth of private markets.

3. NON-GOVERNMENTAL ORGANIZATIONS

A. International Planned Parenthood Federation

a. The resource environment for commodity financing

The International Planned Parenthood Federation (IPPF) is an international non-governmental organization that has pioneered family planning and reproductive health in many developing countries since its founding in 1952. IPPF serves a total of 100 program recipients, with geographic priorities in sub-Saharan Africa and South Asia. Its financial resources come from voluntary contributions by private individuals, charitable trusts, foundations, intergovernmental organizations, and governments, including in developing countries where national IPPF affiliates operate. The Federation is committed to providing reproductive health services, especially contraception, to as many beneficiary countries and persons as it can reach. In this context, the organization is well aware of the crucial role that adequate contraceptive supplies play in reproductive health policies and programs.

b. Trends in commodity support

Given that resources applied by IPPF (financial, technical, or in kind) for population and/or reproductive health assistance are provided by private donors and governments, these donor agencies are likely to report such resources as their own contribution. In the absence of detailed information, it is not possible to ascertain the level of funding that IPPF applies to reproductive health and/or contraceptive commodities *other than that categorized as "governmental" and "intergovernmental."* If IPPF's income and expenditures for 1999 (over $89 million) are representative of those of the past decade, all but a very small fraction ($7 million) of its yearly budget has been funded by donor governments.

c. The policy environment for commodity support

IPPF has a policy concerning reproductive health supplies and funds the purchase and distribution of contraceptives, including condoms for STI prevention. In addition, IPPF has a line item in its budget for contraceptive procurement. There are between three and five staff members who handle contraceptive procurement and distribution, in addition to another three to five whose employment is funded through another organization. Two of these personnel are mid-level management within IPPF.

Funding commodities, as an essential component of programs, is a high priority for IPPF. In addition, IPPF supports capacity building in logistics management through technical assistance, although it is not able to report specific as distinct from other technical assistance. The Federation anticipates that the level of commodity support that it will provide in the next ten years will be similar to the current level.

NOTES

[1] Conly, Shanti and Shyami de Silva. *Paying Their Fair Share? Donor Countries and International Population Assistance* (Washington, DC: Population Action International, 1998).

[2] Unless otherwise noted, all monetary amounts are in U.S. dollars.

[3] United Nations. *Programme of Action of the International Conference on Population and Development,* Cairo, 5-13 September 1994 (New York: United Nations, 1995), Paragraph 7.25.

[4] Feyisetan, Bamikale and John Casterline. 2000. "Fertility Preferences and Contraceptive Change in Developing Countries," *International Family Planning Perspectives,* 26(3).

[5] Ross, John and Randy Bulatao. *Contraceptive Projections and the Donor Gap* (Washington, DC: The Futures Group International for John Snow, Inc./Family Planning Logistics Management Project, 2001), p. 2.

[6] United Nations Population Division. *World Population Prospects 1950-2000,* 1998 revision, New York: United Nations, 1999).

[7] Ibid.

[8] This section draws from the Vail, Janet and Clea Finkle. *Country Perspectives on the Future of Contraceptive Supplies* (Seattle: Program for Appropriate Technology in Health, 2000).

◄ TABLE 15 ►
IPPF'S POPULATION AND CONTRACEPTIVE COMMODITY ASSISTANCE (US $MILLIONS)

Year	1992	1993	1994	1995	1996	1997	1998	1999
Commodity support	6.2	6.2	6.3	6.7	6.0	11.1	3.4	3.0

d. Commodity assistance program and perspectives

The most significant lessons that IPPF has learned with regard to working with other donors on contraceptive commodity supply are that there is lack of coordination at the national level and coordination at the global level only involves information sharing. The Federation is interested in enhancing coordination of donor programs at the national level but is not sure that such coordination is feasible. However, it is currently participating in some donor coordination at the global level.

IPPF believes that a consortium of international agencies would be the best way to provide effective leadership in coordinating contraceptive commodity supply and ensuring that the needs of developing countries are met in the next 15 years.

[9] Personal communication, J. Joseph Speidel, MD, MPH, William and Flora Hewlett Foundation

[10] UNFPA, 2000.

[11] Following the International Conference on Population and Development, UNFPA adopted a new definition of population assistance, broadening the definition used in previous years to reflect new priorities such as HIV/AIDS prevention. As a result, data on donor assistance for years prior to 1995 are not strictly comparable with data for later years. For further details, see Conly and de Silva, 1998.

[12] UNFPA, 2000.

[13] See "Donor Profiles" below for more information on UNFPA's Working Group.

[14] Conly and de Silva, 1998.

[15] UNPFA must make estimates of levels of population assistance based on the information available from different donors. Some adjustments are necessary for the figures to be comparable across donors. As a result, figures provided directly from the German government for this report differ slightly from those reported by UNFPA. Despite these small discrepancies, the trends observed are consistent between the two sets of figures.

[16] Reported increases in the mid-1990s were most likely due to reporting differences based on the broader definition of population assistance adopted after the 1994 ICPD.

[17] These countries include India, Bangladesh, Sri Lanka, Indonesia, Vietnam, Tanzania, Zambia, Mozambique, Ethiopia, Eritrea, Mali, Burkina Faso, Uganda, Yemen, Bolivia, Nicaragua, Macedonia, Egypt, South Africa, and the Palestinian Territories.

[18] Shanti Conly. *Taking the Lead: The United Nations and Population Assistance* (Washington, DC: Population Action International, 1996).

[19] UNFPA. "Reproductive Health Commodity Security, a UNFPA Priority" (New York: UNFPA, 2001).

MEETING THE CHALLENGE

Securing Contraceptive Supplies

SECURING SUPPLIES FOR REPRODUCTIVE HEALTH

The Interim Working Group on Reproductive Health Commodity Security (IWG) is a collaborative effort of John Snow, Inc. (JSI), Population Action International (PAI), the Program for Appropriate Technology in Health (PATH) and Wallace Global Fund. Recognizing the important leadership role of the UN Population Fund (UNFPA) in meeting the goals of the 1994 Programme of Action, the IWG's objective is to further these goals by raising awareness about the importance of securing reproductive health supplies. The IWG seeks to identify the causes of failures and weaknesses in commodity systems and to spur actions that will contribute to securing essential supplies for the delivery of reproductive health care.

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