Contraceptive Projections and the Donor Gap

MEETING THE CHALLENGE

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. 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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Contraceptive Projections and the Donor Gap

In calling for universal access to reproductive health services, the Programme of Action of the 1994 International Conference on Population and Development (ICPD) mandates a wide variety of actions. Though not the most glamorous of tasks, securing reproductive health supplies is essential to the provision of reproductive health services, and thus to fulfillment of the ICPD agenda.

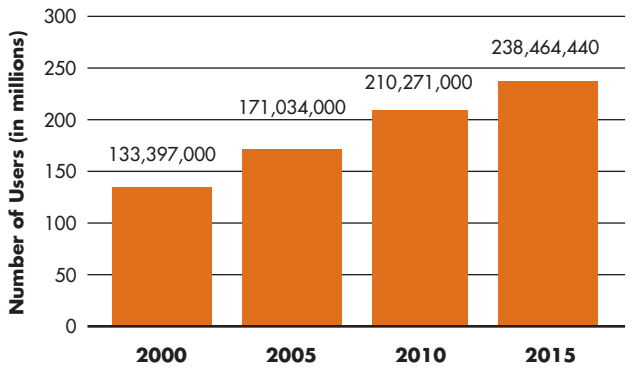
Contraceptive Projections and the Donor Gap addresses issues related to supplying just one type of reproductive health commodity: contraceptives. It begins with an analysis of current and future global demand for contraceptives and lays out the strategies for meeting this demand in those developing countries that depend on supplies from foreign donors. The analysis of demand for contraceptives is based on data from 87 developing countries. It provides an overview of current and projected contraceptive use in these 87 countries, and reviews the factors that contribute to the growing demand for contraceptive supplies.[1] The substantial gap between projected future needs and expected donor contributions requires that the donor community be alerted to potential shortfalls and explore additional ways of strengthening contraceptive supply.

Three trends will together determine the projected growth in demand for contraceptive supplies: the passage of the current large generation of young people into their prime reproductive years; overall population growth; and rising levels of family planning use. In the 87 countries studied, the number of women in their childbearing years is expected to increase by 36 percent between 2000 and 2015, from 529 million to 720 million. The total number of users of modern contraceptive methods is projected to increase during the same period by 79 percent, or 105 million. Increases in the number of people of reproductive age and in their desire to use contraception (as they learn about family planning and gain access to services) will be greatest in Asia and Africa.

Some countries will be able to meet the demand for contraceptive supplies and the private sector will fill at least part of the financing gap. However, it is increasingly clear that donors will have to assume a substantial part of the burden of ensuring the availability of subsidized contraceptives around the world. In the next five years, the gap between the required and available financing for subsidized contraceptive commodities will average about 20 percent. This shortfall could leave 20 million couples without family planning services, leading to elevated rates of unwanted pregnancy, abortion, and HIV infection and contributing to maternal and infant deaths and the numbers of orphaned and neglected children.

Researchers predict that donor funding will have to increase by US$24 million immediately and 5.3 percent annually thereafter to meet rising public sector demands for contraceptive commodities. Without such a substantial increase in donor funding, many countries will not be able to meet growing needs for contraceptives among those who are unable to rely on the private sector. To avoid severe health and socioeconomic problems, donors and concerned agencies must take immediate action to minimize the projected contraceptive shortfall.

◄ FIGURE 1 ►
PROJECTED NUMBER OF CONTRACEPTIVE USERS, MODERN METHODS, ALL WOMEN



◄ PART I ►

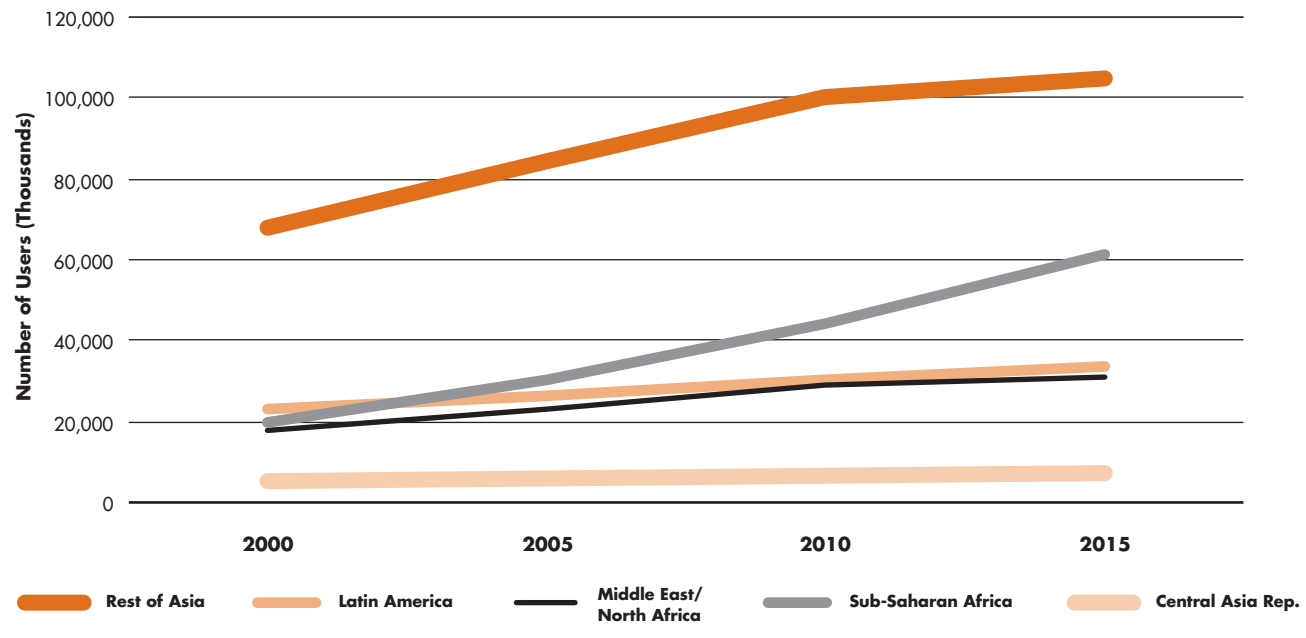
CONTRACEPTIVE PROJECTIONS AND THE DONOR GAP

This analysis projects contraceptive commodity needs and costs in the public sector to the year 2015, and compares them with the likely levels of donor contributions. Emphasis is placed on the gap between growing contraceptive needs and expected donor contributions. The health and socioeconomic consequences of this gap between supply and demand are also discussed.

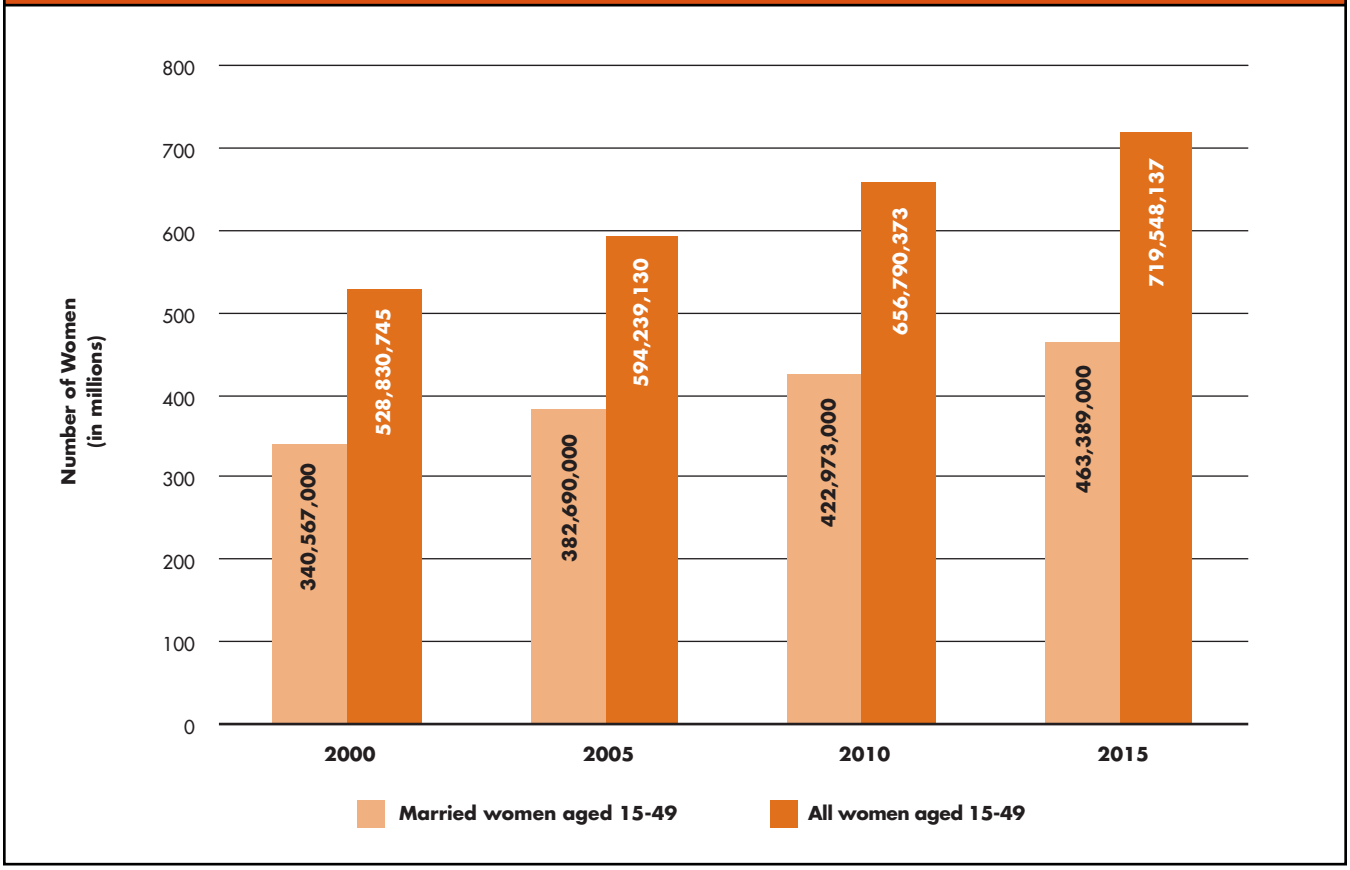
The data used in this report come largely from *Profiles for Family Planning and Reproductive Health Programs*[2] and focus on 87 "donor-relevant countries" in the developing world, i.e., countries where donors provide contraceptive commodities (see Appendix A).[3] The authors have further separated data on contraceptive supplies provided by the public and private sectors; developed cost implications; constructed a separate projection for donations of condoms to prevent HIV/AIDS; anticipated what donors may do; and illustrated the gap between projected costs and likely donor contributions. The countries studied are not dependent on donors by choice. In most, local contraceptive manufacture is not an option due to the economics of the industry and its requirement for high-tech quality control. Moreover, they include some of the poorest countries in the developing world, which lack foreign exchange for purchasing the raw materials required to produce contraceptives.

Representing every region of the world, the 87 countries include 81 percent of the developing world's population outside of China and India. As noted, China and India are excluded because they are self-sufficient in contraceptive commodities; Brazil is also excluded because it is not donor-dependent. Other omissions fall into three general categories: "graduated" countries such as Thailand, South Korea, Taiwan, Hong Kong, and Singapore; non-donor countries such as Iraq, Libya, North Korea, Saudi Arabia, and the United Arab Emirates; and six countries in the former USSR (the three

◄ FIGURE 2 ►
PROJECTED NUMBER OF CONTRACEPTIVE USERS, MODERN METHODS, ALL WOMEN, BY REGION



◄ Figure 3 ►
Number of All Women and Married Women (15-49)



Caucasus countries and Russia, Ukraine, and Moldova). The five Central Asia Republics (CARs) are included, as are five of the largest countries in the developing world (Indonesia, Bangladesh, Pakistan, Mexico, and Nigeria).

Contraceptive Users

The aggregate number of contraceptive users will rise sharply due to the combined forces of the growing number of couples of reproductive age and rising contraceptive prevalence. As Figure 1 shows, the total number of users of modern methods is projected to rise by 28 percent over the next five years, the equivalent of one additional user for every three or four current users. Between 2000 and 2015, the number of users is projected to increase by 79 percent. The 105 million *additional* users far exceed the number of current users in Latin America and the Middle East/North Africa combined.

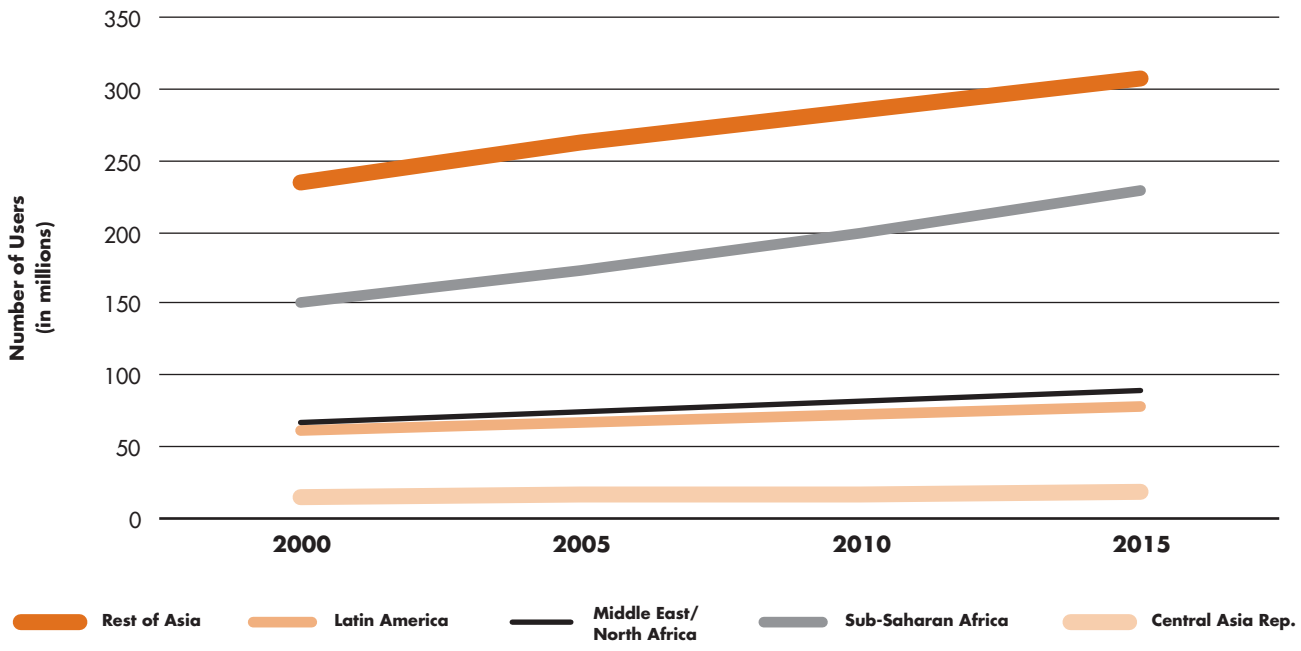
As Figure 2 indicates, most of the regional increases will come from Asia, which will gain some 37 million users even when China and India are excluded. The number of users in sub-Saharan Africa is projected to triple by 2015, a powerful illustration of the compounding effects of both increasing numbers of couples and rising demand for contraceptives (contraceptive prevalence). Although the total numerical increases will be smaller in other regions, the relative increases will be large. For example, the number of users is projected to increase by 50 percent in Latin America and by 79 percent in the Middle East/North Africa.

Demographic Pressures: More Couples of Reproductive Age

Population growth and, in particular, the movement of the current large youth cohort into the reproductive age, will place strong pressure on commodity supplies in all 87 of the countries studied. According to the United Nations, the number of women of reproductive age (15-49) will grow by 36 percent, or 191 million, between 2000 and 2015, from 529 million to 720 million (see Figure 3). During the same period, the number of married women aged 15-49 is projected to grow proportionately, from 341 million to 463 million, or more than the total number of married women currently living in all of the Middle East and North Africa.

The growth in numbers of people of reproductive age will vary substantially among regions (see Figure 4). By 2015, Asia—again, excluding China and India—is projected to gain 71 million women and sub-Saharan Africa 78 million. Sub-Saharan Africa's population is smaller than Asia's but is growing at a much faster rate, resulting in an increase in the number of women in the region of 52 percent, compared with 30 percent in Asia. Logistics

◄ Figure 4 ►
Number of Women Aged 15-49 by Region



systems in sub-Saharan Africa will experience especially sharp growing pains as a result, which in many countries will be compounded by a lack of the skills and infrastructure needed to strengthen those systems.

Increases in the number of women of reproductive age will be comparatively modest in other regions: 21 million more women of reproductive age in the Middle East/North Africa, 17 million in Latin America, and only three million in the Central Asian Republics. The challenges of adjusting to such growth will be greatest in Asia and sub-Saharan Africa, where the growth is not only faster, but is occurring primarily among those least able to pay for services.

Rising Contraceptive Prevalence: Greater Demand for Contraception

The projected rise in demand for contraceptives/contraceptive prevalence is the second major contributor to the dramatic increase in commodity needs over the next few years. The proportion of women who will be using modern contraceptive methods from 2000 to 2015 has been projected for each country based on the 15-year declines in total fertility rates (TFRs) reported by the United Nations.[4] The resulting figures create the patterns shown in Figure 5. The highest levels of contraceptive prevalence are found throughout Latin America, while contraceptive prevalence is clustered at lower levels in other regions. Regional differences will narrow considerably over the course of these 15 years, as the regions with the lowest current contraceptive prevalence experience the greatest increases. Sub-Saharan Africa has the lowest but fastest rising contraceptive prevalence, according to the rather optimistic United Nations projections for declines in TFR in that region.

Method Mix

Knowing the specific mix of contraceptive methods used in any given country is essential for projecting commodity needs. A country's method mix shifts over time as total contraceptive prevalence rises.[5] And total contraceptive prevalence tends to increase faster when varied methods are offered to the public through different channels.

In the countries studied, the numbers of people using each contraceptive method are as follows: the pill, 40 million women; the IUD, 32 million; injectables, 21 million; and sterilization, 29 million. In the next 15 years, the increase in demand for contraceptives will vary by method: a 93 percent increase in demand for the pill; 75 percent for the IUD; and 40 percent for injectables. To date, condoms have played a relatively small role in family planning, and vaginal methods such as the foaming tablet an even smaller one. Condom use is expected to triple in the next 15 years, however, largely due to the widespread need to prevent HIV/AIDS and other sexually transmitted infections (STIs).

The projections in this report allow for changes in method mix as total prevalence rises, and are based upon patterns registered in approximately 200 national surveys (including Demographic and Health Surveys) taken since 1980. Figure 6 shows the numbers of users by method and region in 2000, with data weighted by population size.

Sterilization predominates as the most used method of family planning in both Asia and Latin America, while the pill ranks second in both regions (these figures are weighted by population size). The IUD is also important, and is the predominant method in the Middle East/North Africa (MENA) where it edges out sterilization. The pill is important in both the MENA region and sub-Saharan Africa. The IUD is the principal method in the Central Asia Republics. However, overall demand for it is lessened due to smaller populations in that region and to low IUD prevalence in sub-Saharan Africa. In the 87 countries taken together, the pill is the most common contraceptive method (40 million users), almost twice as many as those who use injectables (21 million). The IUD and sterilization—predominantly of women, but also of men—are not far behind at 32 and 29 million users, respectively. (See Appendix Table D3 for details.)

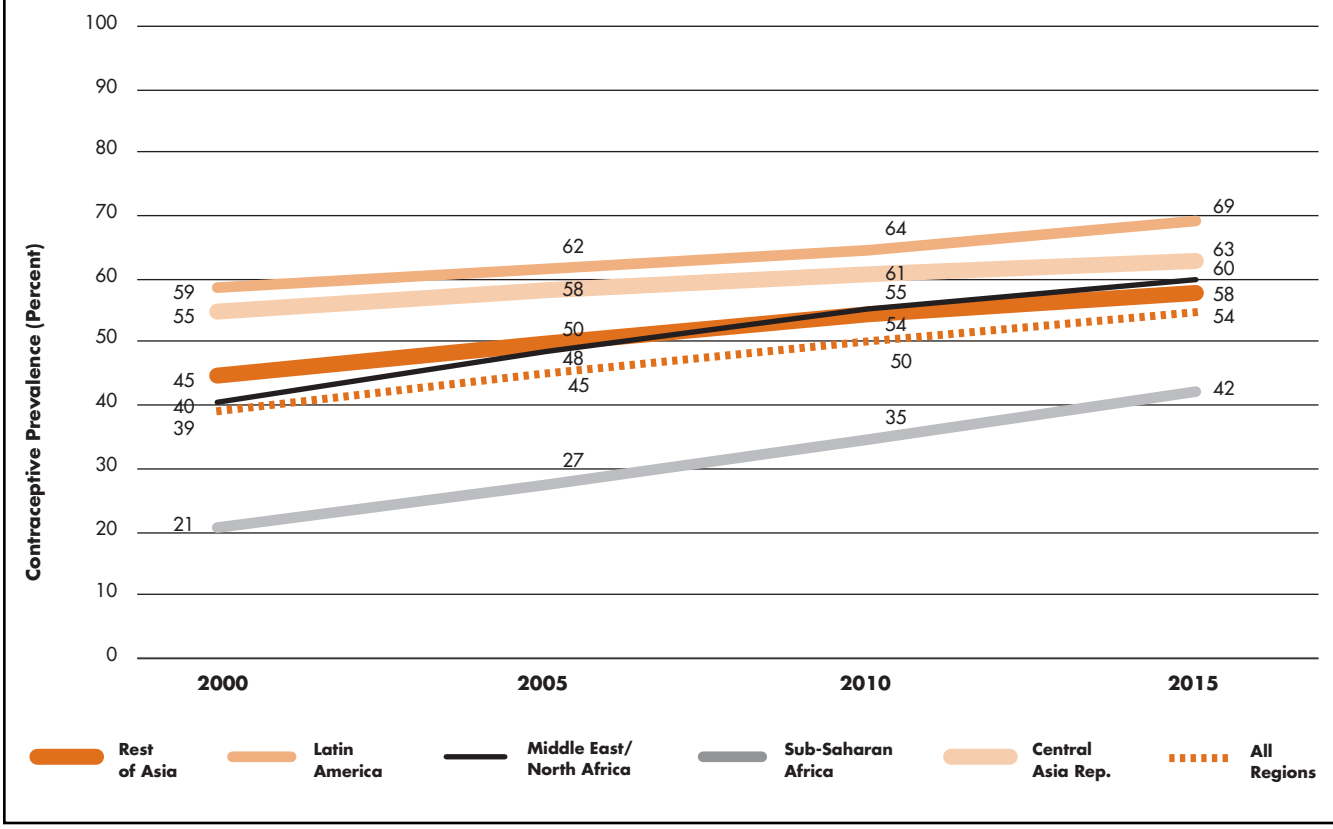
In Asia (excluding China and India) contraceptors use a reasonably wide variety of methods, whereas sterilization and the pill dominate heavily in Latin America. The Middle East/North Africa region essentially offers two methods: the pill and IUD. In sub-Saharan Africa and Asia, the injectable is winning a place. In the Central Asian Republics, only the IUD is important so far. Condoms have played a small role in family planning, and vaginal methods even less.

Setting aside the projected demand for condoms, it is unlikely that the current method mix will change appreciably for the 87 countries in the aggregate, although it is likely to shift somewhat in particular countries. The method mix tends to change systematically as total prevalence rises over the long term. Sterilization's large share cannot change quickly, and the IUD is somewhat stable in having a multi-year continuation. Any changes would rest chiefly on changing adoption patterns for resupply methods and only in selected countries. Consequently, the current method mix picture remains useful for global or regional planning.

The Public Sector's Share of Commodity Supply

The share of supply that continues to rest upon the public sector in each country varies greatly depending on method mix and the sources of each method. (See Figure 7.) The public sector is responsible for most sterilizations carried out in the 87 countries studied. Direct commodity costs for this method, as well as for the IUD, are relatively small. Slightly less than half of pill supplies, about one-third of male condoms, and almost half of vaginal methods are provided by the public sector in the 87 countries. The pill and condom, which account for a large proportion of commodity costs, are

◄ Figure 5 ►
Percent Contraceptive Prevalence for Modern Methods Among Married Women by Region



fortunately the methods best provided by sources other than the public sector.

The public sector's burden in supplying contraceptives is affected by donor contributions, method mix, and the role of the private sector. Some countries, including Saudi Arabia and Libya (excluded from the 87 countries addressed in this paper) are for a variety of reasons not assisted by international donors. There, the public sector plays a greater role. Method mix is another important factor: only some methods require continuous resupply, since many users rely on sterilization and IUDs. The private sector, including both commercial entities and non-governmental organizations (NGOs), is increasingly involved in providing contraceptive commodities. This analysis examines the share that continues to rest upon the public sector.

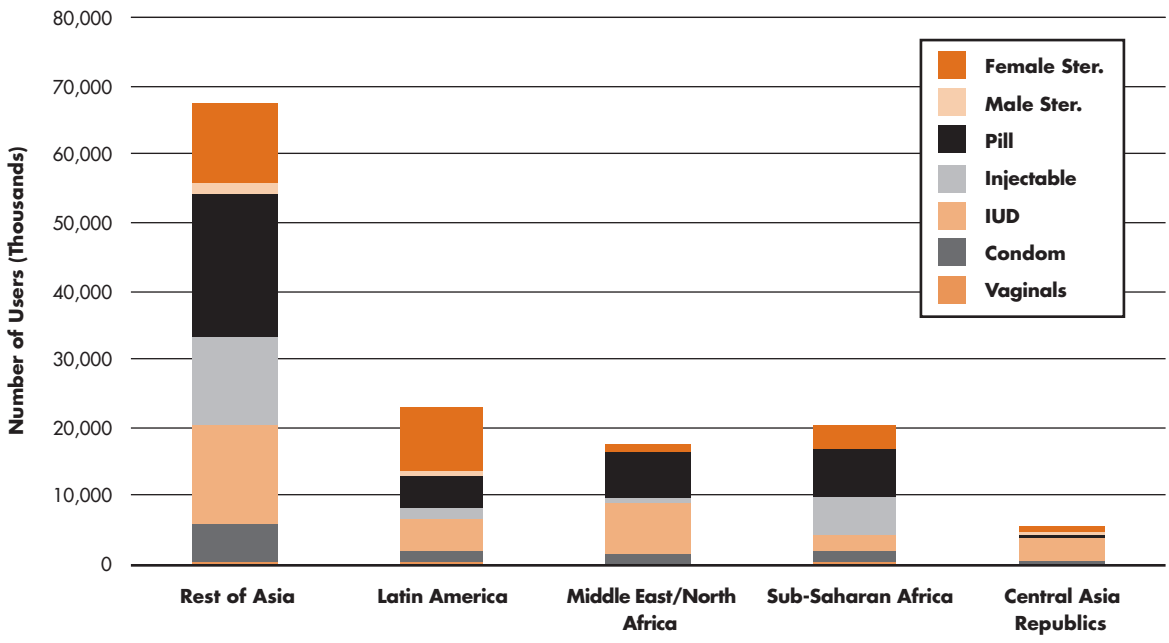
Projections of Commodity Needs

The projections for commodity needs made in this study reflect the combined effects of an increasing number of users, anticipated changes in the mix of contraceptive methods, the proportion of supplies provided by the public sector, and the average supply needed annually per user. Projected costs per piece are held constant, with no allowance made for inflation. The trends sketched out by this analysis are summarized below. (Appendix tables D1-D6 provide figures for each region on users and commodities, both in the aggregate and by public and private sector involvement.)

HIV/AIDS Condom Projections. The HIV/AIDS epidemic has made the condom of special interest to donors, agencies, and service providers and boosted projections of its use for preventing both disease and unwanted pregnancy. The figures presented on condoms for HIV/AIDS prevention are included only in the public sector table of commodities since it is assumed that the very large increase in condom supplies must come primarily through the public sector. The projection methodology is based on the past experiences of countries with high levels of both HIV/AIDS and per capita condom use in order to anticipate possible trends in other countries (see Appendix B for further explanation). Per capita condom use has been projected to increase more rapidly in countries with low levels of HIV/AIDS than in countries where HIV/AIDS is already widespread. However, it has been assumed that HIV/AIDS in low-prevalence countries will rise only to an intermediate level by 2015, in contrast to the levels projected for countries where HIV/AIDS is already prevalent. Projections of annual per capita condom use have been multiplied by the growing numbers of men aged 15-59 in each country as projected by the United Nations. The number of condoms projected to be needed for HIV/AIDS prevention greatly exceeds the number designated for family planning.

Final Commodity Numbers. Table 1 shows projections for the growth in commodities needed for each of seven contraceptive methods supplied by the public sector. Figures for sterilization and the IUD reflect the supplies needed at the time these methods are adopted,

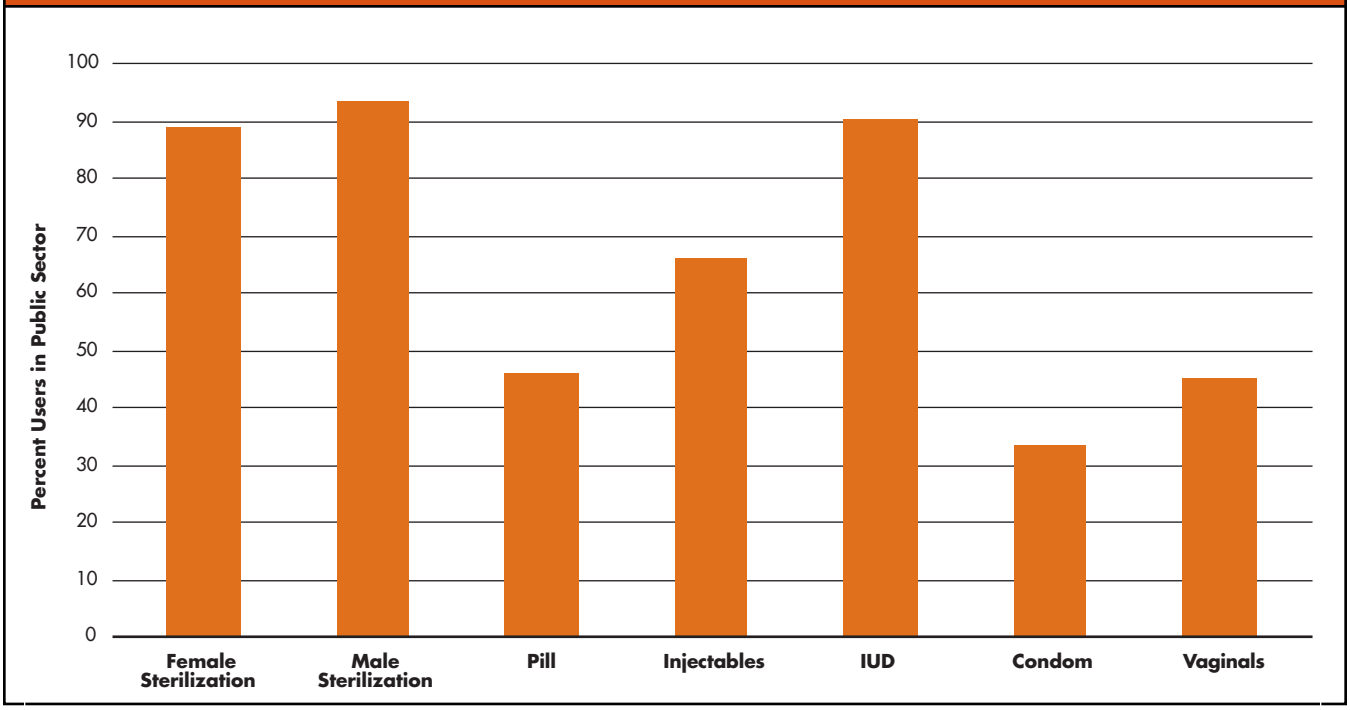
◄ Figure 6 ►
Number of Users for Modern Contraceptive Methods by Region for the Year 2000



◄ Table 1 ►
Projected Subsidized Contraceptive Supply Needs in Donor-Relevant Countries 2000-2015

Method	Estimated Yearly Need in 2000 (piece/procedure)	Projected Yearly Need in 2015 (piece/procedure)	Increase in Annual Need 2000-2015 (percent)	Cumulative Supplies Needed 2000-2015 (piece/procedure)
Sterilization	2.3 million	4.6 million	100	54 million
IUD	6.9 million	12.8 million	86	156.9 million
Pill	292.3 million	563.5 million	93	6.8 billion
Injectable	52.1 million	73.9 million	42	1 billion
Condom	2.5 billion	8.1 billion	224	84 billion
Vaginal methods	32.3 million	57.8 million	79	718 million

◄ Figure 7 ►
Percent of Users in the Public Sector, All Countries for the Year 2000



Note: Where country information was not available, unweighted regional averages were used.

when most commodity costs are incurred. The table shows that the annual number of sterilizations for both men and women is projected to double by 2015; the number of IUDs needed will increase by 86 percent; the number of pill cycles needed will increase by 93 percent; and injectables will increase by 42 percent. The largest of all increases will be in condoms for family planning and HIV/AIDS prevention: the numbers needed will more than triple, from 2.5 billion in 2000 to 8.1 billion in 2015, with a cumulative projected need for 84 billion condoms. In other words, 84 billion condoms will need to be produced and supplied by donors between 2000 and 2015 to meet subsidized needs. It is anticipated that 88 percent of condoms will be used for HIV/AIDS prevention, reflecting the enormous needs related to the epidemic versus the limited use of condoms for pregnancy prevention.

The implications of the cumulative supply needs for the period 2000-2015 are also striking. For example, the projected increases in the numbers of contraceptive users means that 6.8 billion cycles of pills will be needed between 2000 and 2015.

◄ Table 2 ►
Estimated Contraceptive Commodity Support by Donor/Agency in 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		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		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	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		6	1,400	750	0		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%

Note: Figures for UNFPA (1995-99) include procurement for the World Bank and CIDA.
Source: UNFPA, *Donor Support for Contraceptives and Logistics 1999* (New York: UNFPA, 2000).

◄ PART II ►

DONOR PROSPECTS

This section focuses on likely trends in donor contributions for contraceptive commodities. The past record of such contributions in dollar terms is outlined in the United Nations Population Fund (UNFPA) publication *Donor Support for Contraceptives and Logistics*, 1999.

Between 1990 and 1996, donor support for contraceptive supplies increased significantly; since that time, support has been irregular (see Table 2). The spike experienced in 1995 likely reflects the influence of the ICPD in 1994 which called attention to the need for more spending on reproductive health programs generally. The high 1996 figure was the result of unusually high contributions to some countries by a few European donors. As indicated in Figure 8, the supply of contraceptive commodities has otherwise been dominated by consistent and large contributions from the United States Agency for International Development (USAID) and the expanding role of UNFPA. UNFPA's role has included procurement for the World Bank and the Canadian International Development Agency (CIDA), which together with USAID provided 71 percent of total donor support through 1999. Also making significant contributions were the German Ministry for Economic Cooperation and Development/German Agencies for Financial Cooperation (BMZ/KfW) at 10 percent of total donor support, and the International Planned Parenthood Federation (IPPF) and the Department for International Development of the United Kingdom (DFID) at 5-6 percent each.

Between 1992 and 1999, the lion's share of donor contributions went to three contraceptive methods: 35 percent for condoms, 33 percent for the pill, and 18 percent for injectables. IUDs, which are relatively inexpensive and last for several years, constituted only 6 percent of donor support, while vaginal methods received only 2 percent and implants only 3 percent. Donor support for most methods held fairly steady since 1992 with the exception of the pill, which has more recently lost some of its share to injectables. Appendices D7a and b detail donor support in both dollar amounts and the methods supported. (Inflation has eaten into the numbers of commodities that USAID contributions can purchase; see Appendix C for the average annual rise in commodity costs.)

The irregularity of donor contributions since 1995-96 makes it difficult to make projections, and no donor agency has yet provided a firm declaration on the future of its commodity contributions. Two studies currently underway by Population Action International and the Program for Appropriate Technology in Health will provide interesting background information, although respondents from various agencies have not provided

usable projections of their budgetary allocations for contraceptive commodities.

UNFPA previously extrapolated long-term donor trends beginning in 1990 that showed optimistic increases over the next five to ten years. However, the disappointing experience of the last few years calls these assumptions into question and underscores the need for alternative projections. Figure 9 provides two alternative projections: a flat extension of the average 1997-99 donation level (following the 1996 spike) at $137 million, and a 3 percent annual increase. In order to compare the two donor projections to future needs, the commodity projections in Appendix D4 are converted to their cost equivalents (i.e., the cost per method, as explained in Appendix C). In addition, the curve is positioned to start with the line of "best fit" for past donor contributions (i.e., the top line in this figure), which rises according to the need for subsidized contraceptives in the future.[6]

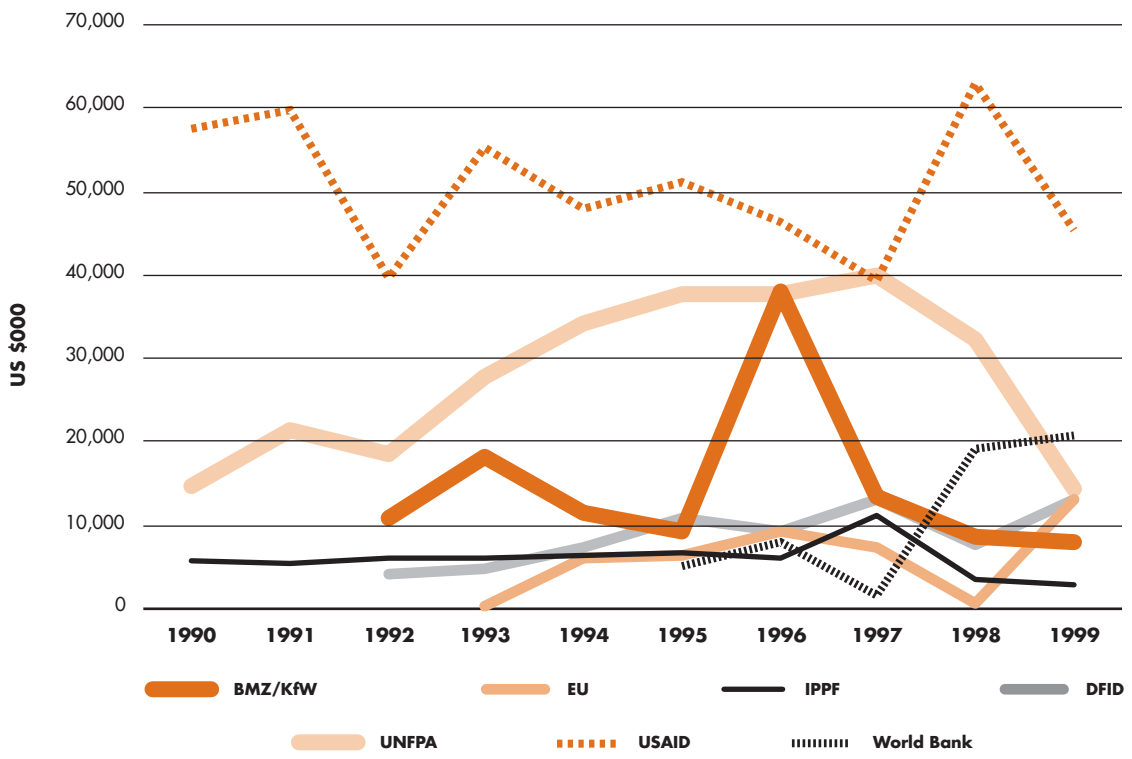
The Gap

As seen in Figure 9, either donor projection points to a large gap between contraceptive needs and supplies. A shortfall for contraceptive commodities of between $140 million and $210 million, annually, is projected by 2015. The gap grows rapidly over the 15-year period; by 2005, it will reach at least $65 million annually from the 3 percent line and perhaps as much as $87 million *at current spending levels*. **In order to meet estimated commodities needs, donor funding will have to increase immediately by $24 million and then rise by 5.3 percent annually thereafter.** Since this is unlikely, it is all the more urgent to alert donors to the seriousness of the projected shortfall and to vigorously examine alternative sources of support. The data presented here call attention to the urgent need for the international reproductive health community, including donors, to address the funding shortfall.

◄ CONCLUSION ►

The potential consequences of the funding shortfall for contraceptive commodities are worrisome. More than 100 million women in the developing world have an unmet need for family planning.[7] Family planning helps men and women plan pregnancies and prevent unwanted childbearing. In addition, condoms distributed through family planning programs also reduce the incidence of infections that can lead to death, disability, and infertility. Current and potential users of contraceptives, discouraged by a lack of adequate supplies, may experience elevated rates of unwanted pregnancies and births, maternal and infant morbidity and mortality, abortions, and increased risk of sexually transmitted infections (STIs), including HIV/AIDS.

◄ FIGURE 8 ►
PATTERN IN CONTRACEPTIVE SUPPLY, 1990-1999, IN US $000

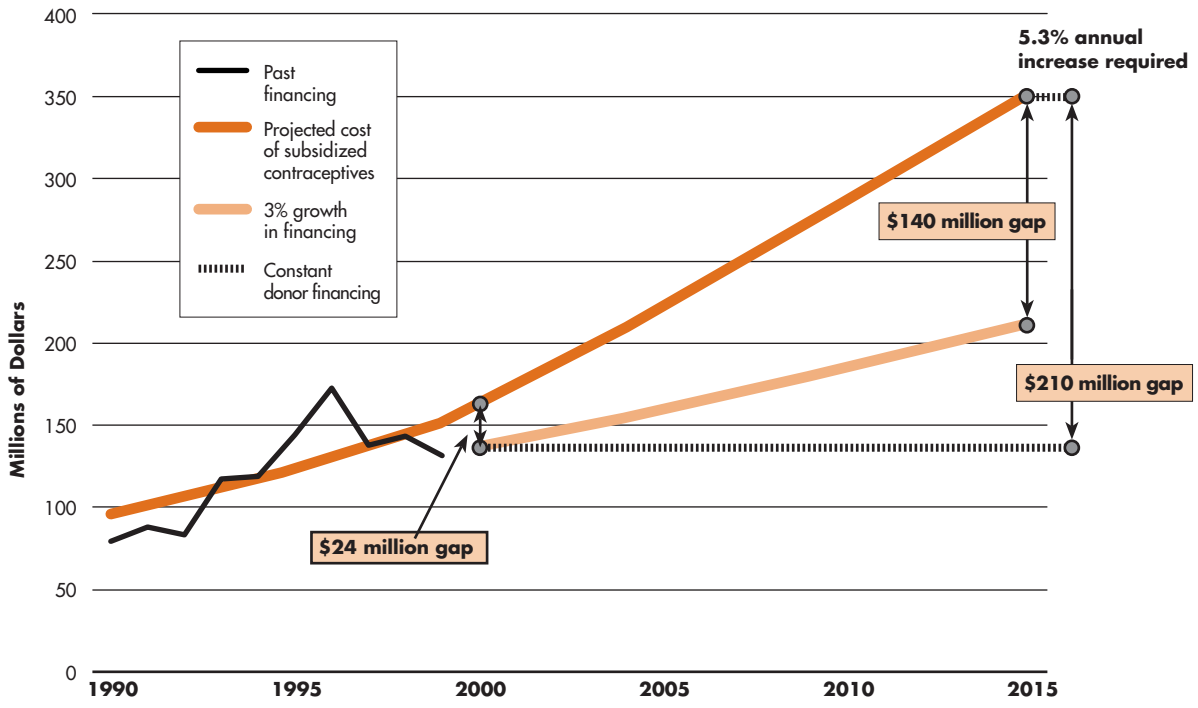


There are societal as well as personal consequences of more unwanted pregnancies and greater incidence of STIs. When contraceptive protection declines substantially, health services are forced to handle more pregnancies, abortions, and sexually transmitted infections. Decisions made by individuals and couples about contraceptive use also have important implications for population growth. Countries already struggling to meet the employment and educational needs of their growing populations will benefit from the slowing in growth that usually results from increased contraceptive use.

A recent report estimated that providing modern family planning services to one million couples could prevent 360,000 unintended pregnancies, 130,000 unintended births, 190,000 abortions, 40,000 miscarriages, 1,300 maternal deaths, and 8,000 infant deaths.[8] However, the projections presented in this paper underscore a gap between required and available financing for commodities of about 20 percent in the next five years. A 20 percent shortfall in commodities in the public sector could leave 20 million couples worldwide without family planning services. Each year, this would mean an additional 7.2 million unintended pregnancies, 2.6 million unintended births, 3.8 million abortions, 26,000 maternal deaths, and 160,000 infant deaths.

In light of inevitable growth in both population and demand for contraceptives, creating effective, swift change in the financing and delivery of family planning and reproductive health services has become one of the central challenges faced by the reproductive health field. How best to address the gap between contraceptive needs and supplies? The active involvement of donors in addressing the shortfall in reproductive health commodities and the systems that provide them will be an important first step.

◄ FIGURE 9 ►
DONOR FINANCING FOR COMMODITIES COMPARED WITH PROJECTED NEED



◄ APPENDIX A ►

LIST OF 87 DONOR-RELEVANT COUNTRIES, BY REGION

Asia
Bangladesh
Bhutan
Cambodia
Indonesia
Iran
Laos
Malaysia
Mongolia
Myanmar
Nepal
Pakistan
Papua New Guinea
Philippines
Sri Lanka
Vietnam

Latin America
Bolivia
Colombia
Costa Rica
Dominican Republic
Ecuador
El Salvador
Guatemala
Guyana
Haiti
Honduras
Jamaica
Mexico
Nicaragua
Panama
Paraguay
Peru
Trinidad and Tobago

Middle East/ North Africa
Algeria
Egypt
Jordan
Lebanon
Morocco
Oman
Sudan
Tunisia
Turkey
Yemen

Sub-Saharan Africa
Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Central African Republic
Chad
Congo
Congo DR
Cote d'Ivoire
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Senegal
Sierra Leone
Somalia
South Africa
Swaziland
Tanzania
Togo
Uganda
Zambia
Zimbabwe

Central Asia Republics
Kazakstan
Kyrgyzstan
Tajikistan
Turkmenistan
Uzbekistan

◄ APPENDIX B ►

PROJECTIONS FOR HIV/AIDS CONDOMS

Special attention went to the condom projections since they depend heavily upon future needs for HIV/AIDS protection. The available information to support the projections is somewhat fragmentary, but over the years UNFPA has obtained donors' records on condom donations to some 158 countries. That record, from 1995 through 1999, became the starting point for the HIV/AIDS analysis.

A baseline as of 1997 was established as the average annual donations to each country (1995-1999). Since a reliable time trend was unavailable the projection rationale was to use the real world experience to date, to move countries at low condom levels over time toward the higher levels already established by the more active countries. On a per capita basis (per males aged 15-59 as projected by the United Nations), the baseline range for donations ran from zero condoms per male per year to over 20. Because the donations represented use for both family planning and HIV/AIDS, the per capita use for family planning was removed by reference to the tables in the Profiles volume, adjusted to pertain to the public sector only (from DHS surveys showing the public/private division, with social marketing figures where known included in the public part, and NGO figures in the private part). The reductions for family planning use were generally small since condoms for family planning are a minor method in most countries and the public sector share is even smaller. The result was a set of baseline per capita figures for HIV/AIDS protection in the public sector for the 87 countries in this report.

Various projection methods were explored to estimate the upward movement of per capita use from 1997 through 2015. These were compared in some detail, and alternative projections were run for all countries. It was decided early that the rate of increase should be faster for countries starting at low levels than for those already at quite high levels, most of which have had years of experience with the epidemic and with donor contributions. Proportionately it is more likely that countries at low and intermediate levels will experience a faster relative pace. However, it was also assumed that they would not rise as far in per capita use as countries with the higher HIV/AIDs rates, so an upper limit of 15 per capita use was chosen for countries with an HIV/AIDS rate below one, and 25 for countries at or above one. These choices are partly arbitrary, but no reliable evidence exists on how fast countries progress toward higher levels of use, and projections must be made, starting from the baseline levels in UNFPA records.

After considerable examination two projections, with rather close results, were averaged to produce the final per capita estimates, by year, to 2015, and these were multiplied by the annual numbers of males 15-59 (UN projections) to produce numbers of condoms. Those were added to the family planning portion to yield total condom numbers. These in turn were converted to cost, at 2.58 cents per piece. Wastage was already taken account of in the *Profiles* tables (through the CYP conversion rules) for family planning, and wastage for HIV/AIDS was already a factor in the end use of the donations recorded by UNFPA.

In both projections that follow, the per capita figure for any year is simply a modification of the year before. The first year, 1997, is the three year average from UNFPA records.

A. For the first projection, assume that per capita condom use in year t is represented by x(t). Then condom use in the following year is represented by

$$x(t+1) = 1 + .96\ x(t)$$

for countries with current HIV prevalence of 1 or more. This formula has an upper limit in the future of 25 condoms per capita.

The formula is

$$x(t+1) = .5 + .967\ x(t)$$

for countries with current HIV prevalence below 1. This formula has an upper limit in the future of 15 condoms per capita.

B. The second specification can be expressed in similar terms, but with two variations according to whether the prior year's per capita level is below 1 or equals/exceeds one. This helps to smooth the curve in the first 1-3 years for countries starting at zero or very low per capita levels.

If x(t) equals or exceeds one:

$$x(t+1) = x(t) + 2.5 / x(t)$$

for countries with current HIV prevalence of 1 or more. This formula has an approximate upper limit in the future of 25 condoms per capita.

$$x(t+1) = x(t) + 1.5/ x(t)$$

for countries with current HIV prevalence below 1. This formula has an approximate upper limit in the future of 15 condoms per capita.

If x(t) is below one

$$x(t+1) = x(t) + 2.0 / x(t)$$

for countries with current HIV prevalence of 1 or more. This formula has an approximate upper limit in the future of 25 condoms per capita.

$$x(t+1) = x(t) + 1.5/ x(t)$$

for countries with current HIV prevalence below 1, as before. This formula has an approximate upper limit in the future of 15 condoms per capita.

Note that in all these variations the actual per capita level reached by 2015 varies by country, and many do not come near the 15 or 25 limit by then.

◄ APPENDIX C ►

USAID EXPERIENCE WITH COMMODITY INFLATION

Prices for contraceptive commodities rise from inflationary pressures, and these are most relevant for USAID and the UNFPA (which together donated two-thirds of total gifts in 1998) and secondarily for the BMZ/KfW, DFID, the World Bank, and the remainder of donors. Since 1994 USAID has experienced serious increases in commodity costs; apart from Norplant these have run at 25%-45% over the last 6-7 years (table) depending upon the method (the condom price rose from 4.5 cents to 6.6 cents between 1994 and 2000.) On an annual basis the increases were 3% to 6%.

COST PER COMMODITY

Female Sterilization (per adoption)	$10.64
Male Sterilization (per adoption)	$5.92
Pill (per cycle)	$0.287
Injectable (per injection)	$1.10
IUD (per adoption)	$1.65
Condom (per piece)	$0.0258
Vaginals (per application)	$0.099

Source: The above estimates for costs per commodity are based on UNFPA schedules and are derived in Rodolfo A. Bulatao. "Reproductive-health commodity requirements and costs in developing regions, 1999-2015," Paper prepared for the United Nations Population Fund (New York: UNFPA, 1999).

USAID Commodity Prices by Calendar Year of Purchase (US$)

	1994	1995	1996	1997	1998	1999	2000	2001	Average Annual Rise (Percent)
Condoms	0.045	0.049	0.053	0.053	0.050	0.059	0.066	-	6.3
Lo-Femenal	0.173	0.187	0.197	0.207	0.207	0.217	0.217	0.227	3.8
Lo-Gentrol	0.173	0.187	0.197	0.207	0.207	0.217	0.217	0.227	3.8
Ovrette	0.179	-	0.197	0.207	0.207	0.217	0.217	0.227	3.4
Duofem	0.195	0.195	.210	0.235	0.247	.248	0.243	0.249	3.5
Depo-Provera	0.960	0.960	0.930	0.930	0.930	0.950	0.970	0.970	0.1
Foaming Tablets	0.101	0.104	0.108	0.116	0.119	0.122	0.125	0.128	3.4
IUD	1.087	1.087	1.185	1.213	1.467	1.188	1.451	-	4.8
Female Condom	-	-	-	-	0.730	0.730	-	-	
Norplant	23.12	23.80	23.80	23.80	23.80	23.80	23.80	23.80	0.41

Note: USAID pays more for contraceptives than the international costs listed under cost per commodity which are used for the projections.

◄ Appendix D1 ►
Users, Public Sector
Modern Contraceptive Methods 2000-2015, by Methods and Region (Thousands)

		Female Sterilization	Male Sterilization	Pill	Injectables	IUD	Total Condom	Vaginals	Total
2000	Rest of Asia	10,214	1,481	11,123	7,985	12,188	1,697	152	44,841
	Latin America	5,927	282	1,496	511	2,860	397	23	11,494
	Middle East/ North Africa	977	80	2,414	296	4,279	343	17	8,406
	Sub-Saharan Africa	2,037	185	4,138	4,290	1,435	509	67	12,659
	Central Asia Rep.	679	156	312	132	3,340	244	11	4,873
	TOTAL	19,833	2,183	19,482	13,213	24,102	3,189	270	82,273
2005	Rest of Asia	11,799	1,611	14,048	9,034	16,302	2,286	194	55,274
	Latin America	6,664	500	1,747	491	3,263	611	21	13,296
	Middle East/ North Africa	1,330	101	3,020	587	5,510	483	23	11,055
	Sub-Saharan Africa	4,542	345	5,792	4,819	2,741	653	89	18,981
	Central Asia Rep.	1,212	207	606	189	2,950	405	13	5,583
	TOTAL	25,546	2,765	25,213	15,121	30,767	4,438	340	104,189
2010	Rest of Asia	12,969	1,638	16,655	9,582	20,652	2,867	234	64,597
	Latin America	7,299	743	1,982	445	3,623	842	19	14,953
	Middle East/ North Africa	1,676	122	3,549	903	6,649	631	29	13,560
	Sub-Saharan Africa	7,853	550	8,003	5,647	4,482	868	116	27,519
	Central Asia Rep.	1,799	262	936	252	2,274	584	14	6,119
	TOTAL	31,596	3,315	31,124	16,829	37,680	5,792	411	126,747
2015	Rest of Asia	11,792	1,545	16,507	9,160	21,110	3,148	222	63,483
	Latin America	7,878	1,011	2,210	385	3,960	1,092	16	16,553
	Middle East/ North Africa	1,879	117	3,835	858	5,544	749	34	13,016
	Sub-Saharan Africa	11,917	769	10,670	6,627	6,553	1,066	117	37,721
	Central Asia Rep.	2,435	311	1,286	314	1,413	773	14	6,546
	TOTAL	35,900	3,753	34,508	17,344	38,580	6,829	404	137,319

◄ Appendix D2 ►
Users, Private Sector
Modern Contraceptive Methods 2000-2015, by Methods and Region (Thousands)

		Female Sterilization	Male Sterilization	Pill	Injectables	IUD	Condom	Vaginals	Total
2000	Rest of Asia	1,509	224	9,897	4,978	2,040	3,724	383	22,754
	Latin America	3,432	156	3,336	1,034	1,739	1,349	308	11,356
	Middle East/ North Africa	247	26	4,060	365	3,291	978	153	9,120
	Sub-Saharan Africa	1,126	113	2,778	1,248	739	1,195	246	7,447
	Central Asia Rep.	63	7	147	23	98	85	24	447
	TOTAL	6,377	527	20,219	7,649	7,907	7,332	1,114	51,124
2005	Rest of Asia	1,915	245	13,076	5,763	3,088	4,621	487	29,195
	Latin America	3,796	276	3,775	1,115	2,059	1,955	280	13,257
	Middle East/ North Africa	369	34	5,171	769	4,290	1,489	211	12,332
	Sub-Saharan Africa	2,005	183	4,673	1,514	1,330	1,474	297	11,476
	Central Asia Rep.	76	9	217	33	100	123	28	585
	TOTAL	8,162	746	26,912	9,193	10,866	9,662	1,303	66,845
2010	Rest of Asia	2,287	252	16,276	6,246	4,211	5,459	587	35,318
	Latin America	4,113	414	4,171	1,173	2,379	2,621	241	15,112
	Middle East/ North Africa	496	41	6,185	1,209	5,224	2,041	268	15,463
	Sub-Saharan Africa	3,138	268	7,209	1,922	2,116	1,908	349	16,910
	Central Asia Rep.	87	11	291	43	95	161	31	720
	TOTAL	10,121	985	34,133	10,593	14,025	12,190	1,477	83,524
2015	Rest of Asia	2,507	255	19,729	6,593	5,406	6,180	687	41,358
	Latin America	4,354	561	4,501	1,202	2,682	3,306	189	16,795
	Middle East/ North Africa	618	47	7,034	1,661	6,023	2,581	326	18,290
	Sub-Saharan Africa	4,591	370	10,545	2,428	3,142	2,428	341	23,844
	Central Asia Rep.	100	12	369	54	89	203	33	859
	TOTAL	12,170	1,244	42,178	11,938	17,342	14,698	1,576	101,146

◄ Appendix D3 ►
Users, Both Sectors
Modern Contraceptive Methods 2000-2015, by Methods and Region (Thousands)

		Female Sterilization	Male Sterilization	Pill	Injectables	IUD	Condom	Vaginals	Total
2000	**Rest of Asia**	11,723	1,705	21,020	12,963	14,228	5,421	535	67,595
	Latin America	9,359	438	4,832	1,545	4,599	1,746	331	22,850
	Middle East/ North Africa	1,224	106	6,474	661	7,570	1,321	170	17,526
	Sub-Saharan Africa	3,163	298	6,916	5,538	2,174	1,704	313	20,106
	Central Asia Rep.	741	163	459	155	3,438	329	35	5,320
	TOTAL	26,210	2,710	39,701	20,862	32,009	10,521	1,384	133,397
2005	**Rest of Asia**	13,714	1,856	27,124	14,797	19,390	6,907	681	84,469
	Latin America	10,460	776	5,522	1,606	5,322	2,566	301	26,553
	Middle East/ North Africa	1,699	135	8,191	1,356	9,800	1,972	234	23,387
	Sub-Saharan Africa	6,547	528	10,465	6,333	4,071	2,127	386	30,457
	Central Asia Rep.	1,288	216	823	222	3,050	528	41	6,168
	TOTAL	33,708	3,511	52,125	24,314	41,633	14,100	1,643	171,034
2010	**Rest of Asia**	15,256	1,890	32,931	15,828	24,863	8,326	821	99,915
	Latin America	11,412	1,157	6,153	1,618	6,002	3,463	260	30,065
	Middle East/ North Africa	2,172	163	9,734	2,112	11,873	2,672	297	29,023
	Sub-Saharan Africa	10,991	818	15,212	7,569	6,598	2,776	465	44,429
	Central Asia Rep.	1,886	272	1,227	295	2,369	745	45	6,839
	TOTAL	41,717	4,300	65,257	27,422	51,705	17,982	1,888	210,271
2015	**Rest of Asia**	14,299	1,800	36,236	15,753	26,515	9,328	909	104,841
	Latin America	12,232	1,572	6,710	1,588	6,643	4,398	205	33,348
	Middle East/ North Africa	2,497	164	10,869	2,519	11,567	3,330	360	31,306
	Sub-Saharan Africa	16,508	1,139	21,216	9,055	9,695	3,495	458	61,565
	Central Asia Rep.	2,534	323	1,655	368	1,502	976	47	7,405
	TOTAL	48,069	4,998	76,686	29,283	55,922	21,527	1,980	238,464

◄ Appendix D4 ►
Commodities, Public Sector
Modern Contraceptive Methods 2000-2015, by Methods and Region (Thousands)

		Female Sterilization	Male Sterilization	Pill	Injectables	IUD	Total Condom	Vaginals
2000	Rest of Asia	1,021	148	166,846	31,936	3,483	1,021,049	18,262
	Latin America	593	28	22,445	2,046	817	257,829	2,698
	Middle East/ North Africa	122	10	36,210	1,184	1,223	228,536	2,092
	Sub-Saharan Africa	254	24	62,074	16,444	409	894,245	8,014
	Central Asia Rep.	75	17	4,680	524	954	65,201	1,286
	TOTAL	2,065	227	292,255	52,133	6,886	2,466,859	32,353
2005	Rest of Asia	1,180	161	210,716	36,139	4,658	1,755,233	23,307
	Latin America	666	50	26,212	1,966	932	474,525	2,515
	Middle East/ North Africa	166	13	45,292	2,349	1,574	448,062	2,758
	Sub-Saharan Africa	568	43	86,855	19,277	783	1,526,826	10,526
	Central Asia Rep.	135	23	9,087	758	843	124,995	1,476
	TOTAL	2,715	291	378,162	60,490	8,790	4,329,641	40,582
2010	Rest of Asia	1,297	164	249,816	38,331	5,901	2,470,132	28,052
	Latin America	730	74	29,737	1,783	1,035	687,473	2,217
	Middle East/ North Africa	210	15	53,224	3,612	1,900	660,949	3,421
	Sub-Saharan Africa	982	69	120,041	22,579	1,280	2,206,251	13,609
	Central Asia Rep.	200	29	14,041	1,006	650	183,847	1,618
	TOTAL	3,418	351	466,860	67,311	10,766	6,208,652	48,917
2015	Rest of Asia	1,374	162	286,864	39,602	7,191	3,161,570	32,909
	Latin America	780	100	32,889	1,516	1,122	896,297	1,862
	Middle East/ North Africa	251	18	60,446	4,869	2,179	873,977	4,033
	Sub-Saharan Africa	1,520	100	164,000	26,680	1,932	2,960,617	17,297
	Central Asia Rep.	271	35	19,311	1,257	403	241,828	1,734
	TOTAL	4,196	414	563,510	73,924	12,827	8,134,288	57,835
15-YEAR CUMULATIVE TOTAL								
	Rest of Asia	19,570	2,555	3,663,792	586,965	84,817	33,674,681	410,311
	Latin America	11,101	1,007	445,749	29,431	15,653	9,272,369	37,342
	Middle East/ North Africa	2,997	225	782,552	47,968	27,575	8,852,590	49,270
	Sub-Saharan Africa	13,070	932	1,712,702	338,652	17,339	30,229,973	196,609
	Central Asia Rep.	2,711	417	187,610	14,162	11,535	2,465,296	24,530
	TOTAL	49,449	5,134	6,792,405	1,017,178	156,918	84,494,909	718,062

◄ Appendix D5 ►
Commodities, Private Sector
Modern Contraceptive Methods 2000-2015, by Methods and Region (Thousands)

		Female Sterilization	Male Sterilization	Pill	Injectables	IUD	Family Planning Condoms	Vaginals
2000	Rest of Asia	151	22	148,465	19,911	583	446,795	45,924
	Latin America	343	16	50,065	4,139	497	161,837	36,865
	Middle East/ North Africa	31	3	60,895	1,463	940	117,346	18,422
	Sub-Saharan Africa	141	14	41,674	4,726	211	143,400	29,668
	Central Asia Rep.	7	1	2,202	92	28	10,255	2,931
	TOTAL	673	56	303,301	30,330	2,259	879,632	133,810
2005	Rest of Asia	192	24	196,140	23,053	882	554,476	58,570
	Latin America	380	28	56,642	4,467	588	234,598	33,590
	Middle East/ North Africa	46	4	77,554	3,073	1,226	178,625	25,249
	Sub-Saharan Africa	251	23	70,077	6,054	380	176,640	35,205
	Central Asia Rep.	8	1	3,251	132	28	14,780	3,363
	TOTAL	876	80	403,664	36,778	3,105	1,159,119	155,978
2010	Rest of Asia	233	25	244,140	24,984	1,203	655,080	70,440
	Latin America	411	41	62,577	4,695	680	314,345	28,690
	Middle East/ North Africa	62	5	92,756	4,839	1,492	244,830	32,307
	Sub-Saharan Africa	392	33	108,130	7,687	605	229,040	41,988
	Central Asia Rep.	10	1	4,372	172	27	19,335	3,687
	TOTAL	1,108	106	511,975	42,378	4,007	1,462,631	177,112
2015	Rest of Asia	262	25	295,948	26,375	1,544	741,628	82,535
	Latin America	435	56	67,516	4,810	766	396,602	22,466
	Middle East/ North Africa	77	6	105,513	6,640	1,721	309,595	39,148
	Sub-Saharan Africa	574	46	158,206	9,709	898	291,355	49,970
	Central Asia Rep.	11	1	5,534	215	25	24,323	3,952
	TOTAL	1,360	135	632,718	47,749	4,955	1,763,503	198,071
15-YEAR CUMULATIVE TOTAL								
	Rest of Asia	3,362	391	3,534,638	379,042	16,809	9,613,049	1,030,431
	Latin America	6,290	560	948,840	72,657	10,129	4,420,031	489,392
	Middle East/ North Africa	865	75	1,350,775	63,868	21,575	3,398,096	460,493
	Sub-Saharan Africa	5,357	464	1,490,677	112,010	8,247	3,332,667	624,880
	Central Asia Rep.	145	17	61,321	2,441	438	274,308	55,897
	TOTAL	16,019	1,506	7,386,251	630,017	57,198	21,038,151	2,661,092

◄ Appendix D6 ►
Commodities, Both Sectors
Modern Contraceptive Methods 2000-2015, by Methods and Region (Thousands)

		Female Sterilization	Male Sterilization	Pill	Injectables	IUD	Total Condom	Vaginals
2000	Rest of Asia	1,172	171	315,312	51,847	4,066	1,467,844	64,186
	Latin America	936	44	72,510	6,184	1,313	419,665	39,563
	Middle East/ North Africa	153	13	97,105	2,647	2,163	345,881	20,514
	Sub-Saharan Africa	394	38	103,748	21,170	620	1,037,645	37,682
	Central Asia Rep.	82	18	6,882	616	982	75,456	4,217
	TOTAL	2,738	284	595,556	82,463	9,145	3,346,491	166,163
2005	Rest of Asia	1,371	186	406,855	59,192	5,540	2,309,709	81,878
	Latin America	1,046	78	82,855	6,433	1,521	709,123	36,105
	Middle East/ North Africa	212	17	122,846	5,423	2,800	626,686	28,007
	Sub-Saharan Africa	819	66	156,931	25,331	1,163	1,703,467	45,731
	Central Asia Rep.	143	24	12,338	890	871	139,775	4,839
	TOTAL	3,591	371	781,826	97,268	11,895	5,488,760	196,560
2010	Rest of Asia	1,530	189	493,956	63,315	7,104	3,125,212	98,492
	Latin America	1,141	116	92,314	6,479	1,715	1,001,819	30,907
	Middle East/ North Africa	272	21	145,981	8,451	3,392	905,779	35,728
	Sub-Saharan Africa	1,374	102	228,172	30,266	1,885	2,435,291	55,597
	Central Asia Rep.	210	30	18,412	1,178	677	203,182	5,304
	TOTAL	4,526	457	978,835	109,689	14,773	7,671,283	226,029
2015	Rest of Asia	1,636	187	582,812	65,977	8,735	3,903,198	115,445
	Latin America	1,216	156	100,405	6,325	1,888	1,292,899	24,328
	Middle East/ North Africa	329	24	165,960	11,509	3,900	1,183,572	43,181
	Sub-Saharan Africa	2,094	146	322,206	36,389	2,829	3,251,972	67,267
	Central Asia Rep.	282	36	24,845	1,472	429	266,151	5,686
	TOTAL	5,556	549	1,196,229	121,673	17,781	9,897,791	255,907
15-YEAR CUMULATIVE TOTAL								
	Rest of Asia	22,932	2,946	7,198,431	966,008	101,626	43,287,730	1,440,741
	Latin America	17,391	1,567	1,394,588	102,088	25,781	13,692,400	526,734
	Middle East/ North Africa	3,862	299	2,133,327	111,836	49,151	12,250,686	509,763
	Sub-Saharan Africa	18,428	1,395	3,203,379	450,661	25,586	33,562,639	821,489
	Central Asia Rep.	2,856	434	248,931	16,603	11,973	2,739,604	80,427
	TOTAL	65,468	6,641	14,178,656	1,647,196	214,116	105,533,060	3,379,154

◄ Appendix D7a ►
Donor Contributions by Method, 1992-1999 (US $Millions)

METHOD	1992	1993	1994	1995	1996	1997	1998	1999	TOTAL	Percent
Condom	20.8	40.1	39.9	60.6	68.1	50.9	51.4	37.9	369.7	35.4
Oral	33.7	48.3	44.1	46.9	64.0	30.2	34.4	44.4	346.0	33.1
Injectable	10.5	15.8	16.8	18.0	21.8	37.8	34.3	31.5	186.5	17.8
IUD	9.5	5.6	8.7	5.3	9.2	6.3	9.7	6.5	60.8	5.8
VTF	2.5	2.8	3.4	3.4	4.0	3.0	2.6	1.9	23.6	2.3
Implant	1.6	1.5	3.9	2.9	3.3	4.0	10.4	8.5	36.1	3.5
Foam/Jelly	4.2	2.7	1.3	6.7	1.7	5.3	0.4	0.1	22.4	2.1
TOTAL	82.8	116.8	118.1	143.8	172.1	137.5	143.2	130.8	1,045.1	100.0

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

◄ Appendix D7b ►
Donor Contributions by Method, 1992-1999 (Percentage)

Method	1992	1993	1994	1995	1996	1997	1998	1999	Average
Condom	25	34	34	42	40	37	36	29	35
Oral	41	41	37	33	37	22	24	34	33
Injectable	13	14	14	13	13	27	24	24	18
IUD	11	5	7	4	5	5	7	5	6
VFT	3	2	3	2	2	2	2	1	2
Implant	2	1	3	2	2	3	7	6	3
Foam/Jelly	5	2	1	5	1	4	0	0	2
TOTALS	100	100	100	100	100	100	100	100	100

NOTES

[1] China and India are excluded from the analysis because they are considered self-sufficient with regard to the provision of contraceptive supplies. Other smaller countries that do not rely on donors for contraceptive purchases are also excluded.

[2] Ross, John, John Stover and Amy Willard. *Profiles for Family Planning and Reproductive Health Programs: 116 Countries* (Glastonbury, CT: The Futures Group International, 1999).

[3] Exclusions made for this study reduced the original listing of 116 countries in *Profiles for Family Planning and Reproductive Health Programs* to 87. Interested readers should refer to that publication for data on the excluded countries, as well as for information on projections for 2000-2015 of all women, women in union, contraceptive users, prevalence of contraceptive use, and contraceptive commodity needs.

[4] These rates have been adjusted to agree with the most recent national surveys. For a detailed discussion of the methodology, see Ross, et al. 1999.

[5] Ross, et al. 1999.

[6] The best fit line was calculated using the least squares regression.

[7] Robey, Bryant, John Ross and Indu Bhushan. "Meeting Unmet Need: New Strategies." *Population Reports,* Series J43, 1996. (Baltimore: Johns Hopkins School of Public Health, Population Information Program, 1996).

[8] *The Potential Impact of Increased Family Planning Funding on the Lives of Women and their Families* (Washington, DC: The Alan Guttmacher Institute, The Futures Group International, Population Action International and the Population Reference Bureau, in consultation with the Population Council, 2000).

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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