

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.



ISSUE PROFILES: LESSONS LEARNED
FROM FIVE COUNTRIES

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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.

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ISSUE PROFILES: LESSONS LEARNED FROM FIVE COUNTRIES

Estimates indicate that by 2005, the gap between the need for contraceptive supplies (including condoms for HIV/AIDS prevention) in developing countries and available donor funds will reach at least US\$65-\$87 million annually.¹ Even if these funds were available, a secure supply of contraceptives would not necessarily be guaranteed. Reproductive health commodity security denotes an adequate supply and choice of quality reproductive health-related supplies for every person who needs them. Achieving contraceptive security is a complex process that involves not only the allocation of resources, but also forecasting, financing, procurement, and delivery. These processes are affected by many factors including quality, coordination, and economic and regulatory issues.

This report highlights real life examples of the struggles faced by both donors and developing country programs in achieving lasting contraceptive security. Five issue areas are discussed and cases profiled that show the critical need for capacity building, commitment, transparency and coordination. These five issue areas and the lessons learned from them are summarized as follows.

Issue One. Donor Phase-Out: Taking on the Supply of Contraceptives.

The withdrawal of donor support for contraceptive commodities is illustrated through the implementation of the United States Agency for International Development (USAID)'s "graduation strategy." During this five-year process, the country has gradually phased out its reliance on donor funding for contraceptive commodities. Despite the challenges, considerable progress has been made towards self-reliance both in financing and procurement. To continue this successful trend, lobbying of the government so that contraceptive security receives necessary attention and financial support is required. This involves the effort of many partners, such as the Ministry of Health, NGOs, civil society, and educational institutions. The government must also continue to move forward with the implementation of alternative funding strategies, including targeting, market segmentation and cost recovery.

Issue Two. Funding for Countries in Crisis: The Need for a Mechanism for Urgent Supply of Contraceptives.

Throughout the development of this country's family planning program, a national coordinating board assumed more and more financial responsibility as USAID began phasing out assistance in the mid-1990s. Donors had planned to complete this process shortly before the country was hit by a severe economic crisis in 1997. Plans to end assistance were abandoned and emergency donations made, with the result that the family planning program was maintained. This case underscores that even those countries that have succeeded in achieving self-sufficiency will continue to need a mechanism for assistance when crises occur. Emergency response on the part of donors can prevent or at least minimize damage to a family planning program by avoiding catastrophic contraceptive supply shortages. Donors currently have the capacity to meet urgent contraceptive needs, but continued political commitment and coordination is critical.

Issue Three. Procuring Supplies: A Condom Procurement.

After more than two decades of reliance on USAID and other donors for contraceptive supplies, this country was able in 1995 to embark on the final stages of transition to World Bank-financed commodities. The Bank's goal was for the government to develop the capacity to independently procure condoms and drugs to treat sexually transmitted infections. However, the government did not have in place an appropriate core group of operations-level individuals who could manage procurement. This case shows that the availability of adequate funding is not enough to guarantee a secure product supply, and that a contraceptive supply crisis can occur due to a lack of efficiency, commitment, and good information. A specialized program of technical assistance related to procurement was—and to some degree still is—needed to help operations-level personnel and decisionmakers identify specific problems and, in turn, develop workable solutions.

Issue Four. Delivering Quality to Clients: The Case of Low-dose Contraceptives.

In this country, family planning providers and clients reported widespread problems with a new type of low-dose oral contraceptive, including crumbled, sticky and cracked pills. These complaints were difficult to evalu-

ate because a formal system to obtain and act on feedback did not exist. Studies were conducted by international agencies to determine the extent of and reasons behind the complaints. The circumstances surrounding the case demonstrate the extent to which the perception of product quality can detract from a successful family planning program. Family planning workers need a comprehensive approach to resolving problems and all input and efforts by stakeholders should be coordinated, from the local service delivery staff all the way to international donors and manufacturers.

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Issue Five. Health Sector Reform: Decentralization and Contraceptive Security.

Health sector reform programs aim to improve the equity, access, quality, and financial sustainability of health services. Decentralization is one health sector reform innovation that is likely to have both positive and negative affects on the supply of contraceptives. In this case,

KEY ISSUES IN CONTRACEPTIVE SECURITY: A CASE STUDY APPROACH

The growing gap between the need for contraceptive supplies (including condoms for HIV/AIDS prevention) in developing countries and available donor funds is projected to reach at least \$65-\$87 million annually by 2005.² Even if this immense sum was provided, a secure supply of contraceptives would not necessarily be guaranteed. An adequate aggregate level of donor funding is a critical part of contraceptive security, but not the only one. Rather, securing contraceptive supplies is a complex process that involves not only the allocation of resources, but also the mechanics of forecasting commodity needs, financing, procurement, and delivery. In addition, quality, coordination, and economic and regu-

latory issues play critical roles. The entire process can be disrupted if any one system collapses or certain aspects are lacking.

This report illustrates real life examples of the struggles faced by both donors and developing country programs in achieving lasting contraceptive security. It focuses on five issue areas in order to engage the reader and raise awareness of the many complex factors that contribute to securing contraceptive supplies. The selected case studies illustrate how processes related to the achievement of contraceptive security are interwoven. For example, the process of "graduating" countries from donor assistance underscores the connections among forecasting, financing, and procurement within an overall system. The condom procurement case highlights the issues between lending institution requirements and borrower's capacity to manage large international procurements. In the case of a country in crisis, creative methods of assuring the financing of supply

meant that delivery to clients was not disrupted. The study of commodity quality in the case of a new low dose oral contraceptive illustrates the linkages between procurement, delivery to the client and the need for feedback between actors involved in the two areas. And finally, the decentralization case study illustrates how health sector reform initiatives can have unintended outcomes and that the potential effects of reform implementation need full and careful consideration.

◀ ISSUE PROFILE ▶

DONOR PHASE-OUT: TAKING ON THE SUPPLY OF CONTRACEPTIVES

As some donor institutions face increasing pressure to show effectiveness while often reducing levels of assistance, they act to shift support to areas of greatest need and to prove that their efforts are efficient. Part of this overall process is the development and implementation of strategies to encourage a country's capacity-building and self-sufficiency and thus ensure that contraceptive security is sustainable in the long term. One example of such a mechanism is the “graduation strategy” carried out by the United States Agency for International Development (USAID). This approach requires governments to enter into an agreement to take over certain reproductive health services functions during a set period of time as donor funding of those services is gradually withdrawn. The procurement of contraceptive commodities is one of the services that is phased out as part of the process of “graduating” countries.

While it remains unclear how “graduated” countries will fare in the long term, it is useful to examine what occurs in the short term. In the case of the country studied, the phase-out of reliance on donors for contraceptive commodities illustrates key aspects of this process. In order for the recipient government to assume responsibility for securing contraceptive supplies, it will have to gain understanding of, and expertise in, many areas. These areas include the length of the procurement process, the make-up of the client population to determine which clients can pay for services and which can not, and understanding the importance of a sufficient buffer stock. This new knowledge and capacity must be acquired at the same time that adequate funds are dedicated to purchase commodities.

The donation of contraceptive commodities to this country by USAID dates back to the 1960s. In 1994, however, USAID and the recipient government announced a phase-out of contraceptive commodity donations over a five-year period. Since the phase-out began in 1995, considerable progress has been made towards self-sufficiency. The country now purchases all of its contraceptives with no assistance from donors

(even though UNFPA offered procurement services, the recipient government has chosen to conduct procurement on its own). However, sustaining government commitment to carrying out technical functions such as forecasting and procuring supplies are ongoing challenges. Family planning advocates and providers continue to struggle to secure political commitment to implementing these processes as well as to realizing necessary alternative funding strategies. Supply problems were exacerbated during the phase-out by changes to the original plan (such as the earlier termination of donor funded condom purchases) despite the agreement by both sides to these changes.

In 1996, the recipient country received all supplies through donations, primarily from USAID (although UNFPA continues providing some contraceptives through its own budget as well as providing procurement services to an NGO). By 2000, the Ministry of Health (MOH) had taken over the procurement of all commodities that are obtained through international tenders. The government steadily increased spending for contraceptives, from \$645,000 in 1997, to \$1.5 million in 1998, and to \$1.8 million in 1999 while USAID gradually phased out all funding for contraceptives. Although this increase demonstrates a growing commitment to contraceptive supply, contraceptive commodities have not yet been included as a line item in the national budget. Rather, they are funded through a “Minister’s Special Fund” that has provided enough money to stave off immediate stock-outs but not to ensure long-term contraceptive security.

In fact, the amount spent to date by the recipient government represents only 50 percent of what is required to meet demand and maintain full stock levels. The MOH has expressed concern that inadequate government commitment to contraceptive commodity supply, coupled with fiscal constraints, will seriously threaten the future success of family planning in the country.

Non-governmental organizations (NGOs) play a critical role in raising awareness of this issue both at the national level and to the general public. A local network of women’s NGOs formed an association that has helped to advocate for increased government spending on contraceptives. Through a public advocacy campaign that included public information, press briefings, news releases and a 1998 visit to the country’s president, the association has helped spur civil society and the general public to support family planning services. The continuation of such advocacy is critical to maintaining strong government commitment—commitment that is fundamental to the future of self-sufficiency and contraceptive security in the country.

Developing countries in general and this country in particular will need to embrace alternative funding strategies such as cost sharing if they hope to attain greater self sufficiency.

In order to develop a viable, sustainable contraceptive supply chain, the government must move forward with the implementation of alternative funding strategies. For example, financial shortfalls can be alleviated through a targeting strategy, whereby subsidized contraceptives are provided only to those clients who cannot otherwise afford them. And in fact, a market segmentation study has helped the MOH to gain a better understanding of the client population and to better forecast supply needs, a role that the government took over from outside consultants. Despite the fact that surveys have shown that large numbers of people who receive free contraceptives could afford to pay for them, the government has been reluctant to change the policy of “free services for all.” Although some progress has been made in this area, developing countries in general and this country in particular will need to embrace alternative funding strategies such as cost sharing if they hope to attain greater self sufficiency.

Building in-country capacity to manage procurement is a critical aspect of a phase-out plan. In this case, condom donations were ended in year three of the five-year

phase-out. However, a governmental procurement process was delayed and stocks were depleted to the dangerously low level of a one-month cushion, rather than the usual 15 months. Despite the significance of the situation, the depletion of stocks did not evoke a sense of urgency on the part of the government because actual clinic-level stock shortages were avoided, albeit narrowly.

Although NGOs provide a very small percentage of the total contraceptive services, the impact of such events on NGOs involved in reproductive health service delivery has been much greater and more immediate than on the public sector program. Four NGOs that previously provided family planning services using USAID-donated commodities have decided to discontinue their family planning services activities. Following an environmental crisis that devastated many parts of the country in 1999, these NGOs received some donated commodities in the form of emergency reproductive health kits. These donations were an emergency one-time event and will not be repeated. The overall impact, however, will be minimal since NGOs have traditionally provided such a small percentage of services in this country.

◀ LESSONS LEARNED ▶

DONOR PHASE-OUT OF CONTRACEPTIVE SUPPLY

- Considerable progress has been made towards self-reliance in this country. The government now conducts its own procurement and has steadily increased its spending on contraceptives. Progress is due in part to the fact that extensive investment into technical assistance and training has left the country with adequate procurement and logistics capacities.
- The phase-out period must be of sufficient length to accommodate the implementation of a comprehensive transition plan. In this case, a complete phase-out of funding for contraceptive purchasing was planned for a five-year period. Although this may seem like a very short period of time, the reality is that the phasing-out of assistance often occurs much more abruptly.
- Government commitment is critical to the success of phase-out strategies that aim to achieve sustainability. Lobbying of government in order that contraceptive security receives neces-

sary attention and financial support requires the effort of many partners, such as the Ministry of Health, NGOs, civil society, and educational institutions.

- Market segmentation, targeting, and other alternative funding mechanisms are critical to easing a country towards self-sufficiency by shifting some clients to the private sector. In countries such as this one, a strong history of free services for all and fear of eroding gains in contraceptive prevalence impede private sector initiatives.
- Although NGOs play a critical role in advancing government and public commitment, in this country, service delivery NGOs provide a small share of the family planning services market. However, in other countries where NGOs are more critical to service delivery, effects of a phase-out of donor assistance on NGOs must be closely watched.

◀ ISSUE PROFILE ▶

FUNDING FOR COUNTRIES IN CRISIS: THE NEED FOR A MECHANISM FOR URGENT SUPPLY OF CONTRACEPTIVES

Family planning programs worldwide have always been subject to periodic acute shortages of contraceptive supplies. Several years ago, particularly critical shortages (e.g., of IUDs in Pakistan, condoms in Bangladesh, and injectables in both Niger and Egypt) were identified by UNFPA and bolstered the proposal for the establishment of a global contraceptive commodity facility. Such an established mechanism for emergency donor assistance for both contraceptives and condoms for HIV/AIDS prevention is clearly useful to donor dependent countries experiencing humanitarian or economic crises. However, self-sufficient countries also rely on such a mechanism when unexpected shortages occur, as the example below illustrates.

discussed in this paper illustrates the process of transition from donor dependence to self-sufficiency, the example here shows what can happen in countries that have already completed this process.

As one of the more populous countries in the world, the country enjoyed a nearly self-reliant system of contraceptive sales and subsidies for almost a decade. As a result, a high proportion (57 percent) of married women currently use contraceptives and many of these women choose injectable contraceptives or implants.⁶

Throughout the development of the family planning program, a national coordinating board assumed more and more financial responsibility as donor assistance declined. USAID, one of the most important donors, began phasing out assistance in the mid-1990s and had planned to complete this process shortly before an economic crisis struck in late 1997. With the economic collapse, plans to finally end assistance were abandoned and commitments were extended.

◀ UNFPA TRACKS URGENT CONTRACEPTIVE NEEDS ▶

The following list of emergency contraceptive orders tracked by UNFPA illustrates situations in which a mostly self-sufficient country resumed its previous reliance on donated contraceptives or in which an entrenched donor-dependent country required an even stronger donor response. The fact that UNFPA, in 1997, established the Global Contraceptive Commodity Program (GCCCP)³, underscores the importance that the agency attaches to the provision of urgent contraceptive supplies. In fact, over 90 urgent requests have been handled through this mechanism in the last three years, totaling over US \$6 million in assistance.

Unexpected shortages⁴

- 1992: The government of Pakistan submitted an emergency request to UNFPA for 650,000 IUDs.
- 1993: UNFPA provided \$600,000 to the national family planning program of Algeria to offset contraceptive shortages.
- 1994: UNFPA provided support to Bangladesh for the purchase of 50 million condoms.

Shortages provoked by emergency and crisis situations

- 1995: UNFPA provided \$133,000 worth of pills and condoms to Somalia for use in NGO clinics.
- 1995: UNFPA provided condoms, pills and IUDs worth \$35,000 as part of emergency reproductive health kits for Bosnia-Herzegovina.
- 1995: \$32,000 worth of condoms, pills, and IUDs were provided by UNFPA to Marie Stopes International, which used the supplies to respond to the emergency needs of refugees and internally displaced women in Croatia.
- 1995/6: Pills worth \$130,000 were supplied to Iraq, along with a commitment of \$633,000 of additional assistance.
- In 1997, UNFPA responded to emergency or urgent requests for contraceptives from Albania, Armenia, Bolivia, Bulgaria, the Republic of Congo, the Democratic People's Republic of Korea, Eritrea, Georgia, Jordan, Moldova, Myanmar, Oman, Rwanda, Sri Lanka, The Turks and Caicos Islands, Turkey, Turkmenistan, and Zambia.⁵

The impact of the fiscal crisis in Asia on the family planning program in this country is one example of how a safety net of emergency donor assistance can be critical in an unexpected situation. Valuable lessons can be learned from this case with regard to the need to maintain emergency donor assistance for commodity purchases.

Some donors, most notably USAID, aim to help developing country governments to improve their internal capacities to independently obtain—either through international procurement or by purchase from local manufacturers—and distribute family planning and other reproductive health services. While the first case

For 33 years before the economic crisis, the country enjoyed a virtually uninterrupted annual growth rate of 7 percent. Following the crisis, the country's Gross Domestic Product (GDP) fell nearly 13 percent and unemployment soared to 20 percent. As per capita annual income decreased from US\$1,200 to \$400, an estimated 40 million people fell below the poverty level.

It was largely hypothesized by reproductive health agencies and donors that the economic crisis would be a disaster for reproductive health services. The popularity of implant and injectable contraceptives—both of which are expensive methods—would only compound the

problem. The price of contraceptives did increase as a result of the crisis and stock shortages of injectable contraceptives in public sector facilities did occur; for example, the cost of an IUD insertion doubled in some facilities. Surprisingly, however, the rate of family planning use did not change between 1997-1998. This stability of contraceptive practice indicates both that the contraceptives themselves remained available and that people wanted them enough to pay more for them. This may reflect a belief that paying a higher cost for contraception is a more appealing option than the risk of having an additional child during difficult economic times. In fact, it appears that a stable supply of contraceptives may be of equal or perhaps greater importance to individuals during an economic crisis than under less stressful circumstances.

The availability of contraceptive supplies was assured because of government subsidies and emergency procurement assistance from several donors. These dual actions buffered the most serious impacts of the crisis on reproductive health and family well-being. Donors were asked to provide contraceptives through grants or highly subsidized programs. The Finnish and U.S. governments, together with UNFPA, quickly focused on maintaining supplies of more expensive contraceptives,

such as the implant. USAID provided 200,000 sets of Norplant and 600,000 Copper-T IUDs. UNFPA provided 50,000 sets of implants, as well as US\$2.5 million worth of oral contraceptives (funded by the Canadian government) and \$1.8 million in injectables (funded by the United States). PT Organon, a pharmaceutical company, donated 20,000 sets of implamon (a single-rod implant contraceptive) to the national coordinating board, while the Asian Development Bank and the European Union provided additional support.⁷ More recently, it was reported that the country has enough contraceptive stocks for subsidized services to last through 2001. Donors such as the Netherlands, Japan, and several European Union countries continue to provide assistance.⁸

Some research suggests that “safety net” contraceptives could undermine the growth of the private sector. Because no decline in contraceptive prevalence was observed during the crisis, and because costs to the client for government-supplied pills and injectable contraceptives were on par with the cost of unsubsidized contraceptives, it could also be hypothesized that a “bailout” is not necessary—with the private sector making up for shortfalls in the government supply of contraceptives.

◀ LESSONS LEARNED ▶

ENSURING SUPPLIES IN TIMES OF CRISIS

- Self-sufficiency in contraceptive supply can be fragile and tenuous. Even those countries that have almost succeeded in achieving self-sufficiency will continue to need a mechanism for assistance when crises occur.
- Heavily donor-dependent countries that regularly receive donated contraceptives may also develop emergency needs during economic, humanitarian, or environmental crises. Such needs would include reproductive health supplies for refugees and internally displaced persons.
- Emergency response on the part of donors can prevent or at least minimize damage to a family planning program by averting catastrophic contraceptive supply shortages.
- Donors currently have the capacity to meet emergency contraceptive needs, but continued political commitment and coordination need to be fostered for the future. In addition, UNFPA is able to respond to humanitarian crisis through the provision of Emergency Reproductive Health Kits that are stockpiled in Europe.
- Demand for family planning services remains high even during (and in some cases, particularly during) times of crisis.

PROCURING SUPPLIES:**A CONDOM PROCUREMENT**

Contraceptive shortfalls can often be attributed to a lack of funding. However, shortfalls can also occur when large sums of money are available but not used in a timely manner. The following example of a poorly managed procurement illustrates how a lack of transparency, commitment, and information can result in a contraceptive supply crisis.

In the fall of 1995, after more than two decades of reliance on donors for contraceptive supplies, this developing country was set to embark on the final stages of transition to commodities financed through the World

other two options to require a procurement process of more than a year, even if there are no problems along the way.

Countries usually view a government tender as the most economical option because of service fees charged by UN agencies and commissions charged by private procurement agents. Such charges can add up to a large amount of money. A charge of only one percent of the cost of the goods for a US \$30 million STI project would amount to \$300,000; a fee of five percent would come to US \$1.5 million. UNFPA charges between 3-5 percent of the cost of goods for procurement services (this is negotiable). Some private agencies have been known to quote fees as high as 13 percent. On the other hand, dealing with UN agencies has the benefit of guar-

All procurement options, whether using a procurement agent, UN agency or government tender, take time, carry costs, and require monitoring and supervision.

Bank.⁹ Funds for condom procurement had been available to the MOH for more than four years, but prolonged delays and several unsuccessful attempts with tendering gave rise to a critical situation: if development bank-financed procurement of condoms was not immediately carried out, the country's family planning and HIV/AIDS programs would face a stock-out of condoms by the end of 1996. The loan agreements were slated to finance the delivery of approximately \$30 million in condoms and drugs for the treatment of sexually transmitted infections (STIs) over the next five years. At the same time, several donors were in the process of developing a new cycle of projects that would depend entirely on access to these goods.

It should be noted that countries normally have three choices for purchasing health-related goods with World Bank funds. They may:

- engage in a government tender process under the rules and safeguards prescribed to ensure transparency and fair competition;
- purchase commodities through a UN agency (i.e., UNFPA in the case of condoms);¹⁰ or
- hire a private procurement agent charged with strictly following the prescribed procurement rules and guidelines.

Each of these options has advantages and disadvantages. In terms of time savings, the UN agency approach can be somewhat faster and less complicated than the others, in part because funds are transferred directly from the Bank to the UN agency but also because the UN may be able to utilize its existing contractual arrangements with manufacturers. It is common for the

anted transparency and high confidence in product quality. Unfortunately, private procurement agents competing for lucrative business have been known to facilitate personal financial gain on the part of well-placed government officials.

In early 1994, the recipient government asked UNFPA to use current development bank funds to supply condoms to the country and executed a Memorandum of Understanding (MOU) to this effect. As part of that request, the Bank insisted that UNFPA issue a full International Competitive Bid procedure. UNFPA agreed to issue a competitive bid, but only to those manufacturers who had been pre-qualified in terms of quality and production capacity. Approximately one year after writing the MOU, the government put into writing a decision to cancel the contract.

In light of the unresolved difficulties associated with MOH attempts to purchase condoms with loan funds, the Bank required the appointment of a procurement agent for all purchases it was going to finance under the new STI project. At the beginning of the process of selecting a procurement agent, the MOH asked UNFPA to detail its capability and interest in serving in this capacity, but subsequently learned that Bank regulation forbid UN agencies from submitting bids as potential suppliers. UNFPA would, however, agree to help the recipient government in any way possible, including engaging in a limited bidding process based on its own list of pre-qualified condom manufacturers. The government declined this offer and proceeded to develop a short list of prospective procurement agents.

The process of appointing an agent soon began to evoke extremely strong opinions from the donor community and other interested parties who had a critical stake in the timely arrival of commodities. When the lending institution issued a “No Objection” statement in response to the government’s short list in early February 1995, it met with an outcry from donors, ostensibly because no open (i.e., advertised) competition had taken place. Several of the firms listed were completely unfamiliar to the donors, who feared that an unqualified agent would be as unsuccessful as the government had been in ensuring good quality contraceptive supplies.

In spring 1995, the MOH and the Bank agreed that the process of hiring a procurement agent would resume, and issued an advertisement requesting an “Expression of Interest” from eligible and qualified firms in IBRD countries.¹¹ Meanwhile, the central government (i.e., the treasury) and a well-known international procurement agent developed an agreement to finance a variety of procurements through government revenue accounts and not using the loan funds. The government reportedly hoped to use the same entity to purchase commodities financed by loan funds. Progress stalled again when the government and the Bank could not agree on the procedure to be used to appoint the procurement agent. The situation became even more complex when a difference of opinion arose regarding the procedures that governed relations between the lending institution staff in the field and in headquarters.

Much of the controversy that surrounded the appointment process was exacerbated by a lack of knowledge and understanding about the development bank requirements on the part of important participants and interested parties. It was difficult to gather and synthesize information from its many publications, and the institution’s requirements seemed complex. While relevant documents were available, most people did not know what could be obtained or where. Furthermore, once the documents were in hand, a concerted effort was required to read, assimilate, and apply the information to specific issues. In the end, a procurement consultant from an international NGO compiled the necessary information.

Institutional strengthening is an important philosophical issue for development bank-financed projects. The goal of the lending institution with regard to this country was for the government to develop the capacity to procure condoms and STI drugs. Accordingly, provisions for counterpart training were eventually included in the draft terms of reference for the procurement agent. For its part, the recipient government did not have in place an appropriate core group of operations-level individuals to receive instructions. A specialized program of technical assistance related to procurement was (and still is) needed to help operations-level personnel and decision-makers identify specific problems and, in turn, to facilitate workable solutions regardless of where and how commodities are obtained.

◀ LESSONS LEARNED ▶

PROCURING SUPPLIES

- Timing means a great deal when it comes to contraceptive procurement. The procurement process must begin at least 12 months before a product is needed in-country (except for emergency procurement) regardless of the entity that makes the purchase, and must run smoothly with minimal delays.
- Programs that rely on commodities from sources outside their control should have a back-up plan in case delays or failures occur during the procurement process.
- All procurement options, whether using a procurement agent, UN agency or government tender take time, carry costs, and require monitoring and supervision.
- The successful use of loan funds for contraceptive procurement requires that a country have the commitment and political will to engage in an efficient, transparent process.
- Lending institution guidelines, which are designed to ensure competition and transparency, are precise and time consuming. However, they are not impossibly complicated, as is often claimed. Operations-level personnel and/or an assigned agent must have a good understanding of the institution’s rules and guidelines, be committed to their diligent execution, and be prepared to work through the challenges of unfamiliar and new requirements. It is critical to be proactive when seeking out information and guidance.
- The lending institution should provide access to information about its rules, policies, and organizational structure (for example, as it now does through its web site). The institution should also engage in the proactive education of stakeholders (particularly the donor community and government operations personnel) and provide quick feedback on errors and deficiencies in documents that are submitted for approval. As evidence of solutions already underway, the World Bank and UNFPA are working together to compile a standard agreement for borrowers to use to facilitate the process of procuring contraceptives.
- Technical assistance should not focus only on the procurement process; it should also help sort out and solve problems in the system, whether products come by way of donation, UN agency, through a procurement agent, or are tendered directly by the government.

This country's experience demonstrates the extent to which a poor perception of product quality can detract from a successful family planning program.

◀ ISSUE PROFILE ▶

DELIVERING QUALITY TO CLIENTS:

THE CASE OF LOW-DOSE CONTRACEPTIVES

Soon after its introduction in this country in 1994, a low-dose oral contraceptive had been subject to wide criticism by both users and providers. Some of these complaints were attributable to changes in formulation (i.e., from a high dose to a low dose of active ingredients). However, numerous complaints were made with regard to crumbled, powdered, broken, and melted/sticky pills, foreign particles in the pill blister packaging, and hairline cracks in pills.

Since these pills were being taken by approximately 40 percent of contraceptive users in the country, such widespread complaints caused great concern among the government and donors. In addition to indicating possible problems with the manufacturing process and the logistics pipeline, formal and informal reports of deteriorated pills threatened to damage public perceptions of family planning as a whole.

In 1995, the government contacted UNFPA to address the issue. UNFPA arranged for samples of the product to be taken from the field and contacted the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (WHO/HRP) for help in determining the causes of the problems. In 1997, an inspection was arranged and the samples tested. It was determined that the pills met U.S. Pharmacopoeia specifications. However, approximately 2 percent of the more than 4,500 monthly cycle sampled had defects such as foreign particles in the blister packaging, cracks, partial tablets, stickiness, and discoloration.

At the request of UNFPA, WHO/HRP then met with the government, donors and one of the pill's three manufacturers to decide what steps should be taken to address the problem. It was deemed important to consider the viewpoints of many different stakeholders, including the government (which provided the service infrastructure and logistics system for the contraceptives), WHO field teams, manufacturers, donors, and the pill's users. Many of the stakeholders conducted their own studies; for

example, one donor sent a consultant to analyze the situation and one manufacturer sent a delegation to inspect warehouses in the country.

In 1998, WHO/HRP commissioned an independent study to determine whether problems occurred during manufacture, were due to the in-country logistics system, and/or were due to environmental conditions. After additional laboratory analysis and extensive on-site investigations (including more product sampling), study results showed that the defect rate was similar (i.e., approximately 2 percent) to that indicated in the 1997 study. The new study also found that the problems were not specific to a single manufacturer and that there was no evidence that quality problems were linked to environmental conditions or the logistics system in the country.

Numerous anecdotal reports of oral contraceptive quality problems existed before the study was undertaken, including from service delivery staff interviewed during the on-site investigation. However, it was difficult to determine the extent or reason for the problems based solely on these complaints. In large part, this was because information about the complaints was not collected systematically. Little concrete data were available to substantiate or quantify complaints, or to distinguish complaints stemming from quality problems from those due to factors such as preferences for one manufacturer's products over another.

Moreover, the lack of a formal system to obtain feedback from clients or providers meant that it was not always possible to know the lot number and age of the product or the source of the complaint. In addition, some complaints that had been linked to product defects were later determined to be due to user practices.

In sum, this country's experience demonstrates the extent to which a poor perception of product quality can detract from a successful family planning program. It also became clear that family planning workers needed a comprehensive approach to resolving problems and that all input and efforts by stakeholders should be coordinated, from the local service delivery staff all the way to international donors and manufacturers.

◀ LESSONS LEARNED ▶

ENSURING PRODUCT QUALITY

- When a new product or product formulation is introduced into a family planning program, time should be taken to inform field workers and users about the change. In this case, field workers needed to understand why the low-dose oral contraceptive was being introduced. Many of the complaints about the product seemed to stem from a lack of understanding on the part of clinic staff with regard to the advantages of the low-dose pill and from client concerns about side effects that occurred when they switched pills. Rumors and general distrust hurt the product's reputation, which field workers were unable to counter with objective information about the new pill.
- Systems should be developed and implemented to collect complaints and determine how to resolve them. Such a system should involve logistics personnel, donors, and manufacturers as needed. Providing for formal feedback reinforces the principle that the consumer is the ultimate arbiter of product quality; her perception of the product is the basis on which the failure or success of a contraceptive should be determined. Visual presentation of products can be as important as actual effectiveness, since field workers and users can lose faith in products that "don't look right."
- Program coordination and leadership by stakeholders are critical factors when responding to complaints. Collaboration between the parties (ideally with leadership from an independent group) helps to identify solutions and prevent their future occurrence

◀ ISSUE PROFILE ▶

HEALTH SECTOR REFORM: DECENTRALIZATION AND CONTRACEPTIVE SECURITY

Throughout the 1990s, increasing numbers of developing countries have been implementing health sector reform (HSR) programs to improve the equity, access, quality, and financial sustainability of health services. Decentralization is one health sector reform innovation that is likely to affect the supply of contraceptives.¹² Other innovations include integration, cost recovery and privatization. The adoption of such reforms can have both negative and positive effects on reproductive health programs. Of particular concern are reports of difficulties in contraceptive logistic management as a result of well-intentioned health sector reform activities.

Decentralization, which pushes responsibility for health services management down to intermediate and lower levels, is one of the key strategies of the current health reform movement. Decentralization encourages policymakers to replace highly centralized, vertical services with decentralized, integrated services. The rationale for decentralization is that local managers can make more effective and efficient resource allocation decisions than distant central-level officials. However, decentralization can multiply, rather than correct, problems of mismanagement.

One potential negative aspect of decentralization is that procurement works best for larger volumes. Bulk purchasing is usually more cost-effective because unit costs often decrease with volume. If decentralization causes procurement budgets, decisions and processes to shift to lower levels, the availability of essential supplies, such as contraceptives, may be jeopardized, or costs may rise. Another major concern is that staff at district health offices, where human resources are

invariably insufficient, cannot assume the added logistics responsibilities that decentralization brings. There are tasks that can be performed satisfactorily only by qualified personnel who receive effective training and supervision.

The 1995-2000 health sector reform program was announced in this country in 1996. Health sector reform is viewed as a long-term effort that will be carried out in successive phases. In 1997 the government transferred infrastructure and human and financial resources to all states in the republic. Political resistance to the redistribution of power in this country is strong due to its history of centralized decision-making and top-down management.¹³ The decentralization of health services coincided with the phase-out of USAID assistance to the public sector family planning program. Political resistance coupled with the withdrawal of USAID technical assistance to the Ministry of Health left the government ill-prepared to adjust to new systems in place under decentralization and may be contributing to contraceptive supply problems.

The central MOH is largely responsible for procuring contraceptives, while responsibility for procurement budgets, product selection, and forecasting has been devolved to the regional level. Since this shift occurred, there has been a striking 75 percent decline in the procurement of oral contraceptives at the central level.¹⁴ The MOH reported that in 1998, 4 million cycles of pills were purchased on behalf of the regions, whereas by 1999 only 900,000 cycles were purchased.¹⁵ Although it is possible that the regions themselves purchased some supplies without informing the central MOH, it is impossible to know in the absence of a strong supervisory and reporting structure between the central and regional levels. Such a precipitous decline in central procurement most likely indicates a decline in overall procurement. This conclusion is bolstered by

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concerns expressed by the MOH that service delivery points were understocked. Clearly a systematic evaluation of the effect of decentralization on contraceptive supplies and an assessment of contraceptive stock levels is in order.

Among other new issues emerging under decentralization that are affecting the supply of contraceptives are the additional layers of decision-makers and conflicting priorities that often result in political agendas taking precedence over public health concerns. In the presence of competing priorities, other more immediate health concerns may take precedence over family planning which is a longer-term, less visible investment in public health. Thus contraceptives may not be seen as important as the procurement of other drugs and supplies.

◀ CONCLUSION ▶

The issues illustrated by these profiles confirm that the achievement of contraceptive security is a complex process involving many actors and taking place in very specific conditions. In most situations, no single solution—for example, increased funding or the use of an international procurement agent—is necessarily all that is required. Instead, the particular history, conditions, and resources of each country must be carefully assessed and a suitable, comprehensive strategy developed. Innovative thinking is required on a case-by-case basis. Nonetheless, real life experiences around the world underscore several universal requirements to achieve contraceptive security. These include serious investment and interest in clients' needs and views; transparent information sharing and ongoing communication among diverse stakeholders; commitment by donors to maintain family planning programs during the process of achieving self-sufficiency; and strong political commitment by governments to making family planning a priority.

◀ LESSONS LEARNED ▶

DECENTRALIZATION AND CONTRACEPTIVE SECURITY

- While some health sector reform strategies and some aspects of decentralization may strengthen contraceptive security, decentralization of all functions is neither desirable nor feasible. Logistics management information systems, product selection, procurement, and quality assurance are often most efficiently handled at the central level.
- Because contraceptives and other preventive products may not be seen as essential by staff at every district level, regulations should be put into place requiring the stocking of these products.
- Historically, staff at lower levels have had little need for such critical skills as financial planning and contraceptive forecasting. Before decentralization takes place, special efforts must be made to provide district and service delivery staff with the skills they need to make contraceptive supply work.
- Decentralizing new functions requires a new supervisory structure. Mechanisms must be designed for contraceptive supply and feedback mechanisms should operate between central and local levels.

Notes

- ¹ Ross J.A. and Bulatao R.A. *Contraceptive Projections and the Donor Gap* (Washington, DC: The Futures Group International for John Snow, Inc./Family Planning Logistics Management Project, 2001).
- ² Ross J.A. and Bulatao R.A. *Op. Cit.*
- ³ The Global Contraceptive Commodity Programme (GCCCP) was established in 1997. Its objective is to provide essential buffer stocks of contraceptives to facilitate prompt response to urgent and emergency requests for contraceptives from developing countries. This need arose as a result of the often lengthy lead time for commonly requested contraceptives in times of urgent need.
- ⁴ UNFPA. *Global Contraceptive Commodity Programme: Report of the Executive Director* (New York: UNFPA, 1996).
- ⁵ UNFPA. *Report of The Executive Director for 1997: Programme Effectiveness* (New York: UNFPA, 1998).
- ⁶ UNFPA in collaboration with the Australian National University. *Southeast Asian Population in Crisis: Challenges to the Implementation of the ICPD Programme of Action* (New York: UNFPA, 1998), p. 23.
- ⁷ UNFPA in collaboration with the Australian National University, *Op. Cit.*, p.24.
- ⁸ Asia Intelligence Wire. Contraceptive Stock Enough Until 2001, Says Official. (Antara: The National News Agency [Kendari], 2000).
- ⁹ The World Bank lends money to governments for various projects and objectives. The governments are responsible for all purchases and subsequent contractual arrangements but must follow World Bank guidelines on procurement processes and the basic terms and conditions of contracts.
- ¹⁰ UNFPA operates a procurement service out of New York City that supplies reasonably priced, good quality contraceptives to government programs in developing countries
- ¹¹ The World Bank has two lending arms: the International Bank for Reconstruction and Development (IBRD) and, for more resource poor countries, the International Development Association (IDA). In the case cited here, the country was working with IDA funds.
- ¹² Bates, James, et al. *Implications of Health Sector Reform for Contraceptive Logistics: A Preliminary Assessment for Sub-Saharan Africa* (Arlington, VA: John Snow, Inc./Family Planning Logistics Management Project, for the U.S. Agency for International Development, 2000).
- ¹³ A. Langer, G. Nigenda, and J. Catino. 2000. *Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links*. Bulletin of the World Health Organization 78 (5).
- ¹⁴ Family Planning Logistics Management/John Snow, Inc. *Programs That Deliver: Logistics' Contributions to Better Health in Developing Countries*, published for the U.S. Agency for International Development (Arlington, VA: John Snow, Inc./Family Planning Logistics Management Project, 2000).
- ¹⁵ Information collected by JSI from the Ministry of Health, National Directorate of Statistics and Evaluation.

