

Contraception at a Crossroads

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and an advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Acknowledgments

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Foreword

by the Uganda Chapter of the Network of African Women Ministers and Parliamentarians (NAWMP)

All over the world millions of women, men and young people want to decide for themselves when, if and how many children to have. They want to protect themselves against sexually transmitted infections (STIs) and HIV, and they want and need the ability to protect their health and choose their own destiny.

When they are able to do so, their lives are enriched and they are better able to care for their families. Today, across the globe, there are 200 million women who do not have the supplies they need. In Uganda, over 40 per cent of married women do not have access to vital reproductive health supplies and 435 women die every year for every 100,000 live births. With adequate investment in supplies and the supply chain, we can help turn this situation around. Maternal health will not improve unless all three pillars of maternal health are guaranteed: emergency obstetric care, access to skilled birth attendants and family planning.

When women are able to choose to limit the number of children they have, there are more resources to put toward the nutrition, education and upbringing of each child. When women space their pregnancies they are stronger and healthier and they have stronger and healthier children. It is only through contraception that young women are able to delay pregnancy and avoid the grave consequences of unsafe abortion or obstructed labour, both of which are real and significant threats. Currently, over 26 per cent of young Ugandan women have borne a child. If unmet need for contraception was met in developing nations, 52 million unintended pregnancies could be avoided.



The benefits of contraception are felt not just by women and mothers, but by the wider family and community. Family planning is not just a health intervention: it is a wider development initiative that affects many areas of human and economic development. Better maternal health helps families remain intact, it enables them to earn more and save more, and encourages higher productivity. Investment in family planning complements interventions such as education: both are vital components to enable young people, especially women, to achieve a high level of education and then to participate in the workforce, in governance and in public life. While funding for education has risen dramatically since the '90s, funding for health and for family planning, in particular, has not. Today is an opportunity to finally recognize the worth of contraception: we must take real steps to address the problems that prevent supplies from reaching those that need and want them.

We welcome this report as an important contribution to the development debate at a time when ensuring the maximum impact and cost-effectiveness of aid funding is at the forefront of our minds. We hope that *Contraception at a Crossroads* will provide insight into the supplies problem and spur into action those policy and decision makers who have yet to make the decision that people's lives and family planning are worth the investment.



Hon. Sarah Nansubuga Nyombi
MP, Parliament of Uganda
Chairperson of NAWMP, Uganda Chapter

“Currently, over 26 per cent of young Ugandan women (aged 15-19) have borne a child. If unmet need for contraception was met in developing nations, 52 million unintended pregnancies would be avoided.”



Foreword

by Dr Gill Greer, Director-General of the
International Planned Parenthood Federation



Human rights underpin everything that the International Planned Parenthood Federation does to create a world where all individuals enjoy good sexual and reproductive health and rights. Our services and advocacy are designed, implemented and evaluated to support and promote individuals' human rights within the family and in the community. In doing so, slowly but surely, we are progressing towards the achievement of the Millennium Development Goals.

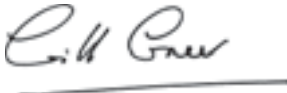
This publication aims to highlight the systemic problems that prevent women, men and young people from accessing reproductive health supplies, such as contraception and condoms, and thus from realizing their fundamental human rights. Quite simply, there can be no programmes without supplies.

Sexual and reproductive rights include the right to choose whether, when and how many children to have; the right to participate in civil, economic, social, cultural and political aspects of society; the right to life, liberty and bodily integrity; the rights to privacy, personal and sexual autonomy; and the right to the highest attainable standard of health.

When people can obtain reproductive health supplies, and when they have access to good quality health services, education and information to complement these supplies, they are better able to realize these rights. But when these vital products are delayed in the distribution chain, or expire before they can be used, or are not available because of a lack of financial or political support, their human rights are denied. The rights of women, of young people, of the poor and marginalized people, in particular, are all-too-commonly overlooked. The urgency of the supplies problem becomes even clearer when the growing demand is considered: global demand for contraception is projected to grow by 40 per cent over the next 15 years; in developing countries alone, there will be an estimated 764 million contraceptive users in 2015.

With the needs and rights of individuals, and the importance of sustainable families and societies in mind, *Contraception at a Crossroads* addresses the larger structural issues that prevent supplies from reaching the people that need them. It considers the wide range of actors and stakeholders that affect the supply chain and identifies the problems. This report also provides suggestions on how all stakeholders can work together in the interests of those people who do not have access and therefore, do not have choice. Working for human rights does not mean sacrificing economic benefits, scientific progress or environmental responsibility. Indeed, human rights are the keystones on which the future of our world depends.

Whether you are an advocate, a service provider, a policy or decision maker, we hope that *Contraception at a Crossroads* will help you ensure that all people everywhere can realize their sexual and reproductive health and rights.



Dr Gill Greer
Director-General, IPPF



Introduction

The world is stumbling towards a contraceptive crisis. For millions, the crisis has already arrived. Today, and every day, we are failing to meet the contraceptive needs and desires of over 200 million women around the world¹, a situation that will only intensify as the largest cohort of young people the world has ever seen – some 1.5 billion young people² – becomes sexually active. Globally, there are an estimated 33 million people living with HIV, with 2.7 million new infections in 2007.³

At a time when the world is more focused on global poverty reduction than ever before, one of the most trusted, most cost effective and proven poverty reduction interventions is being marginalized and neglected. Unless reproductive health supplies, health information, education and services become an immediate priority for governments and donors, current global development efforts will be unachievable and 40 years of women's human development will be reversed.

The world stands at a contraceptive crossroads; our choice of direction will be critical to the lives of women, men and young people for generations to come.





Contraception at a crossroads

The desire to regulate fertility, to choose the number and spacing of pregnancies and births, and to pursue a pleasurable sex life without unwanted pregnancies has been central to women's lives for millennia.

Women's quest for empowerment through effective contraception can be traced back more than 4000 years, reaching its pinnacle with the development of an effective, female-controlled oral contraceptive pill.

'The Pill' became the defining and revolutionary symbol of female emancipation in industrialized nations throughout the 1960s and 1970s. An all too frequent involuntary cycle of pregnancy, birth and child-rearing had been irrevocably broken.

The connection between contraception and human development, and in particular women's development, gave birth to a global family planning movement that can be credited as one of the great development success stories. The benefits of family planning were quickly recognized and the movement spread rapidly as nation's legalized contraception and made it available to women. Women were able to improve their health by avoiding unwanted pregnancies, they were able to participate fully in education, to improve their economic livelihoods and engage as full members of society. In addition, barrier methods of contraception, male and female condoms, are the only proven method for preventing sexually transmitted infections including HIV.

By allowing people to live their lives in dignity, free from the fear of unwanted pregnancy and sexually transmitted infections, access to contraception is now recognized not only as a basic human right, but also as a powerful cost-effective intervention to improve public health and a powerful influence on human development.

Today, the advances contraception has enabled in human rights and health are being undermined and, in some settings, risk being lost entirely. Family planning is at a crossroads: political and financial commitment has stalled to the point that we are now on the verge of reversing hard won gains in many parts of the world and losing services and supplies for the people who want and need them most.

The aim of this report is to synthesize the vast array of issues, structures, players and processes that impact whether women and men can access the reproductive health services that they need and want, when and where they need them, and to provide recommendations on moving forward.

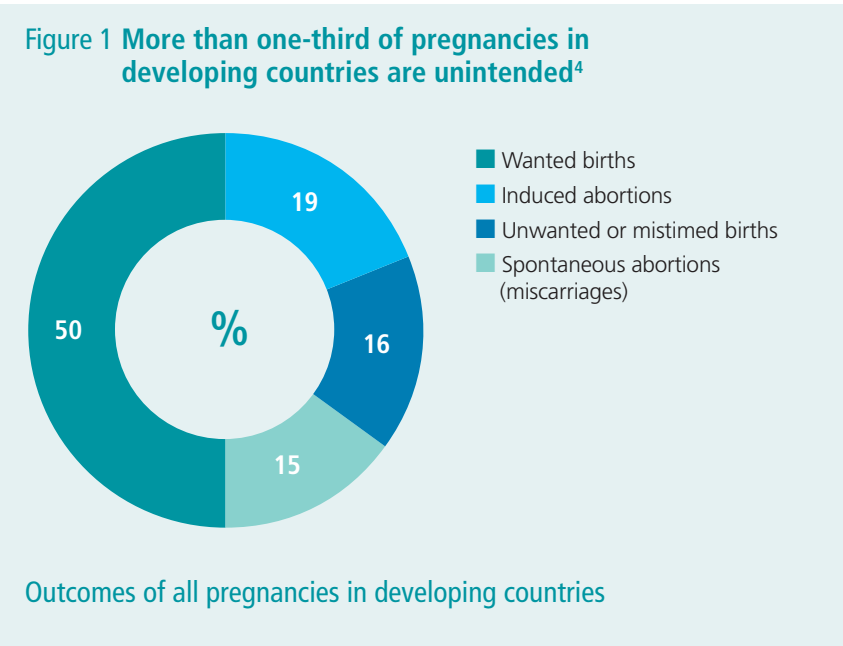
Contraceptive demand is on the increase, especially in developing countries, but unless we understand the problems that prevent contraceptives and other sexual health supplies from being funded, developed, manufactured and delivered into the hands of those that need them, this demand will not be met. The good news is we can rectify these problems.



We can put an end to the inequity that means some people – the poor, the socially excluded, the under-served – do not have access to health supplies, while others do. *Contraception at a Crossroads* offers some insight into the obstacles that disrupt the effective supply of reproductive health products and suggests some solutions so that people everywhere are able to make choices and ensure their own sexual and reproductive health.

“Giving women access to modern contraception and family planning... helps to boost economic growth while reducing high birth rates so strongly linked with endemic poverty, poor education, and high numbers of maternal and infant deaths.”⁵

World Bank, 2008



Unmet need

A woman has an unmet need for contraception if she is married, in a union or sexually active; is able to become pregnant; does not want to have a child in the next two years; and is not using any method of contraception, either modern or traditional.⁶

The fact that women who use traditional methods of contraception are considered to have their contraceptive needs met is a critical barrier in estimating and meeting demand for modern contraceptives. Traditional methods of family planning have repeatedly proven to be ineffective in preventing unwanted pregnancies and protecting against sexually transmitted infections.



A brief history of contraception

The quest for contraception isn't new. Men and women the world over have been trying to separate sex for pleasure and sex for reproduction throughout the ages.

People have experimented with many types of contraception. In 1550 BC, women were advised to grind dates, acacia tree bark, and honey together into a paste and apply it with seed wool to the vulva. Natural objects were also used by women to either block or kill sperm. Sea sponges or soft wool were used as a cap or coil, in combination with lemon juice or vinegar as a spermicide. Other methods included oiled paper or beeswax to cap the cervix. Oral contraceptives have also been available for more than 4,000 years, with Chinese women drinking mercury to prevent pregnancy, while women in India swallowed carrot seeds. Egyptian men wore fabric condoms, mainly for protection from disease, as long ago as 1000 BC. In the 1500s, Fallopius, an Italian, invented a linen sheath to be worn to prevent the transmission of syphilis (at the time considered to be of epidemic proportions). Charles Goodyear developed vulcanization in 1843, the process that turns rubber into a strong elastic material and rubber condoms became available soon afterwards.⁷

The quest for the development of ever better and more reliable contraceptives was not only governed by the need to ensure good sexual health (in part by preventing sexually transmitted infections) among men and women, but also because women wanted it to control their reproduction and their lives.

The Pill

Oral contraception is acknowledged as one of the most important medical advances of the 20th century. It is just one of many contraceptive methods that have transformed people's lives. The pill played a major role in the women's liberation movement, enabling women to control their reproductive cycles and separate sexual pleasure from child bearing in a reliable way.

When introduced to the UK public in 1961, the pill was taken up quickly as a preferred method of family planning. Between 1962 and 1969, the number of users rose from approximately 50,000 to one million in the UK alone.⁸ This was in spite of policies that restricted access: sex outside of marriage was deemed inappropriate and the pill was only available for married women. Obstacles to access based on marital status, parity, or age persist even today, in addition to problems posed by limited supply and the inefficient delivery of contraception.

Today more than 100 million women use the pill worldwide.⁹ One in five women uses an intrauterine device (IUD)¹⁰, and every year men and women collectively use six to nine billion condoms.¹¹

"The pill is just one of many contraceptive methods that have transformed people's lives."



Contraception is maternal health

The health benefits of family planning are many, but are frequently overlooked. Substantial gains have been made in improving maternal and child health over the last 50 years as a direct result of international family planning efforts.

The adoption of 'universal access to reproductive health by 2015' as the second target under Millennium Development Goal 5 is recognition that family planning is a cornerstone in reducing maternal deaths and improving reproductive health. This affirmed declarations in support of sexual and reproductive health, made by 179 countries, in the 1994 International Conference on Population and Development Programme of Action. In 2005 an estimated 536,000 women died from pregnancy and childbirth-related causes.¹² One in three of these deaths could have been avoided if all women who desired contraception were able to access it.¹³ When a woman is able to limit the number of pregnancies she has, the most immediate benefit is the reduced risk of death from pregnancy or childbirth. When births are planned and spaced, health improves and risks decline for both mother and child.

Preventing unwanted pregnancy results in fewer abortions, particularly unsafe abortion. Every year, unsafe abortion is estimated to kill between 65,000 and 70,000 women and girls and inflicts temporary or permanent disability upon five million others.¹⁴ The majority of these occur in developing countries. In Latin America, at least 30 per cent of hospital beds dedicated to obstetric and gynecology services are occupied by women suffering from abortion-related complications.¹⁵

The risk of infant and child mortality also declines as contraceptives are used to delay child bearing and to better space births.¹⁶ Family planning is arguably one of the two most powerful interventions for decreasing child mortality, the other being women's education. Contraception enables women to plan their families, to plan their lives and to make choices to ensure their own happiness.

Annually, the global investment in family planning and contraceptive services prevents an estimated:

- 187 million unintended pregnancies
- 60 million unplanned births
- 105 million induced abortions
- 215,000 pregnancy-related deaths each year
- 685,000 children from losing their mothers as a result of pregnancy-related death¹⁸

Family planning is a fundamental component of reproductive health

Forty years ago, world leaders proclaimed that individuals have a basic right to determine freely and responsibly the number and timing of their children. Millennium Development Goal 5, improving maternal health, affirms this right and yet shows the least progress to date. On World Population Day, let us focus on the critical importance of family planning if we are to successfully achieve the Millennium Development Goals.

The rate of death for women as they give birth remains the starkest indicator of the disparity between rich and poor, both within and among countries. We already know what needs to be done to meet the basic health needs of women

throughout their life cycle, especially during the reproductive years, pregnancy and childbirth. There are three basic interventions necessary to improve maternal health: skilled attendance at the time of birth, facilities to provide emergency obstetric care and family planning.

I call on Governments to honour the commitments made at the International Conference on Population and Development. At the Cairo Conference, nations agreed that all couples and individuals have the basic human right to not only decide freely and responsibly the number and spacing of their children, but also to have the information, education and means to do so.

Ban Ki-moon, United Nations Secretary-General, on World Population Day 2008¹⁹

“There’s a measurable impact when you can go in and educate families, but primarily women, about their different choices... In the countries where health has taken hold, we’re seeing literacy rates improve. We’re seeing, you know, everything about life improve. Once you get this one thing right.”¹⁷

Bill Gates III

In addition to their contraceptive function, male and female condoms are critical to preventing the spread of sexually transmitted infections (STIs), including HIV and AIDS. The loss of life, particularly in sub-Saharan Africa, from AIDS is devastating the development of entire countries, stripping them of their work force, putting a huge strain on limited medical and health care, driving millions of people into poverty due to lost income and disability and exacerbating the hardships of the poorest and most marginalized.

The gains that contraception has made possible – for the health of all people as well as for education and gender equality – make family planning not only one of the most successful international development stories, but also one of the most cost effective interventions for nations and donors.

“If a woman gets sick, her husband has to look after her and the family which means that he cannot work in the fields. Since I have started going into people’s homes to talk about contraception, the health of women in the village has improved and so has the wealth. People are healthier, wealthier and happier because of my work.”

Isatou, community-based delivery agent in Joubert village, The Gambia

The rights to family planning and health were first recognized in the Universal Declaration of Human Rights (1948). They were then refined, and adopted by the international community, in the following human rights treaties:

- the International Covenant on Civil and Political Rights (1976) states that men and women of marriageable age have the right to marry and found a family
- the International Covenant on Economic, Social and Cultural Rights (1976) requires nations to recognize the right to health and to take steps to achieve the realization of that right
- the Convention on the Elimination of All Forms of Discrimination Against Women (1981) addresses women’s rights to health, to family planning services and information
- the Convention on the Rights of the Child (1990) reiterates the right to maternal health and identifies it as a right intrinsically related to the right to health for children²⁰



Wanted and needed, but often unavailable

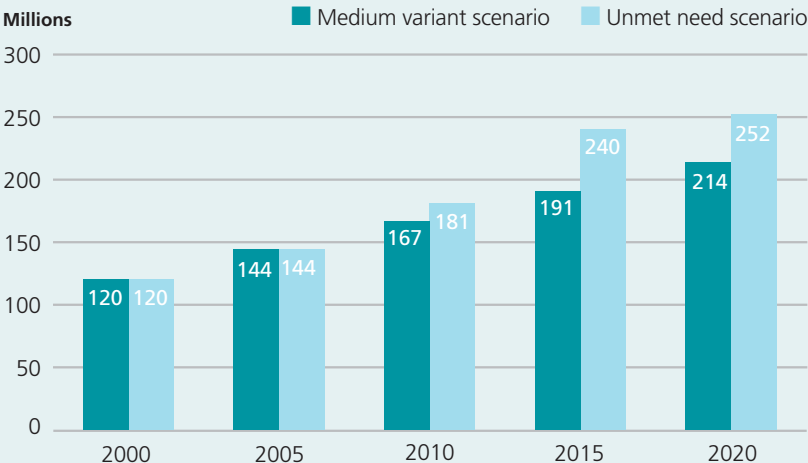
Worldwide, demand for contraception is rising dramatically. According to UN projections, the number of contraceptive users in developing countries and countries of the former Soviet Union is projected to grow by more than 38 per cent by 2015 – from 552 million people in 2000 to 764 million in 2015.²¹

Over half the world’s population is aged under 25 years, and 1.5 billion adolescents are now entering their sexual and reproductive years.²² Current estimates indicate that the global demand for contraception will grow by 40 per cent during the next 15 years.²³

Although donor financing for contraceptive supplies has increased over recent years, from US\$154.6 million in 2000 to US\$223 million in 2007²⁷, this does not reflect inflation and incidental costs that rise over time. When these are taken into consideration, actual donor funding for contraceptives has remained more or less constant since 2001²⁸, but when rising demand is accounted for, donors are satisfying a smaller proportion of people’s needs for contraceptives every year.

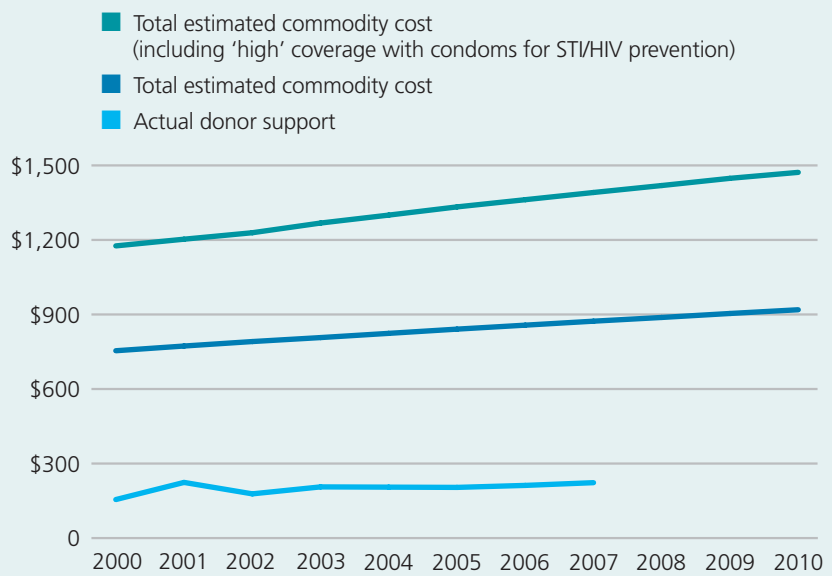
The global shortage of condoms, just one example of an under-supplied contraceptive, is alarming. Condoms are the only effective means of protection against HIV and most other sexually transmitted infections. The estimated cost of providing contraception to the approximately 655 million women and their partners who are already using contraception in 2007 was US\$873 million²⁹ (this does not include the needs of the 200 million women who have expressed a desire for contraception but are not currently using it). The total requirements are US\$1.4 billion when condoms for HIV prevention are included. In 2007, donors provided US\$223 million – or 16 per cent of the total required – in commodities and condoms for HIV prevention.³⁰

Figure 2 Projected number of contraceptive users, modern methods, all women²⁵



“High fertility runs counter to the preferences expressed by millions of women in developing countries who want smaller families... an estimated 10 to 40 per cent of married women of reproductive age in developing countries have an unmet need for contraception.”²⁴

Figure 3 Comparison of estimated costs of contraceptive supplies and actual donor support³¹



This level of donor financing for contraceptives would not be a problem if national governments were dedicating adequate funds from their own financial resources to family planning supplies to meet the demand that donors do not, but this is not the case in most developing countries. There is a vast and growing financial void between what the international community and national governments contribute to the supply of reproductive health commodities and the cost of providing modern contraceptives to women in the poorest countries.³²

Reproductive Health Supplies Coalition

The Reproductive Health Supplies Coalition (RHSC) is a partnership designed to provide global leadership in making essential reproductive health products available to developing and transitional countries. The Coalition was established in 2004 to bring together the diverse agencies and groups that play a critical role in providing contraceptives and other reproductive health (RH) supplies. The Coalition today includes more than 70 official members composed of bilateral donors, foundations, multilateral organizations, non-governmental organizations (including IPPF) and the pharmaceutical sector. A number of IPPF Member Associations are also members.

At the core of the RHSC Strategic Plan are three broad goals, to:

- increase the availability, predictability, and sustainability of financing for RH supplies
- strengthen the capacity of health systems to deliver RH supplies in a sustainable manner
- assure the added value of the Coalition as a productive and sustainable global partnership through support for efficiency, advocacy, and innovation

The Coalition's vision is that all people in low- and middle-income countries are able to access and use affordable, high quality supplies, including a broad choice of contraceptives, to ensure their better reproductive health.

In sub-Saharan Africa, 24 per cent of married women have an unmet need for contraception. Unmet need is lower, on average, among married women in South and Southeast Asia (14 per cent), North Africa and West Asia (10 per cent), and Latin America and the Caribbean (10 per cent).²⁶





Delivering on the promise

Political commitment, and with it greater financial commitment, are desperately required at every step of the supply chain to get contraceptives to those who want them. The prioritization of sexual and reproductive health services within national and district-level governments is at least as important as the support of international stakeholders.

Without the necessary funding, and without an enabling political environment that supports frank and open discussion about sex and reproduction, with adolescents and young people in particular, hard-won gains in health, education and women's empowerment will regress. The achievement of health and wider development goals are also dependent on positive social policies, including policies that promote comprehensive sexuality education, women's empowerment and male involvement in family planning and maternal health.

At international and regional levels, there has been some consensus that sexual and reproductive health and rights must be prioritized in order to meet international development goals, such as the 1994 International Conference on Population and Development (ICPD) Programme of Action and the Millennium Development Goals. In 2006, the African Union (ministers of health and delegates from 48 African countries) adopted the Maputo Plan of Action, which is a detailed and costed implementation plan to ensure universal access to sexual and reproductive health in Africa. Later that year, the UN Assembly adopted a second target – 'to achieve universal access to reproductive health by 2015' – under MDG 5, which is focused on improving maternal health. At a regional level, the German Foundation for World Population, in collaboration with Population Action International, has successfully advocated to have reproductive health supplies ingrained in the strategies and documents of the East African Reproductive Health Network and the East African Community, to name just two examples. While governments have recognized the need and pledged to fulfil it, they have yet to dedicate financial and political resources to family planning services and commodities.

The health system is often a low priority in developing countries, and sexual and reproductive health has even less priority within health spending. The sexual and reproductive health programmes of many developing countries operate almost exclusively through donor support. Lack of willingness to commit a country's own revenue represents a worrying lack of commitment to sexual and reproductive health and rights that is incongruent with the public declarations of support that these countries make in international arenas. Civil society must hold their governments to account so that these promises are translated into services and supplies, so that all women, men and young people have access to these vital, life-changing resources. Civil society has an increasingly important role to play not only as advocates to ensure that budget lines for contraceptives exist and to ensure the budget lines receive the resources they deserve, but as watchdogs – to hold governments to account for health spending.

In Tanzania, UMATI has been campaigning for the sustainability of the family planning programme by asking for increased and predictable government funding. It played a crucial role in persuading the government to create a budget line for sexual and reproductive health.

Pakistan vs Bangladesh: Health spending for women's lives

The low status of women in many countries is delaying progress in human rights, social and economic development. Government spending on health, particularly sexual and reproductive health services, is one clear measure of the priority being placed on women's empowerment and human development.

In Pakistan, total government expenditure on health per capita is US\$49 per person, equivalent to only 2.1 per cent of the gross national product (GDP).³⁴ While the vast majority of people have access to local health services, the fact that less than half of pregnant women receive antenatal care and less than 20 per cent of births are attended by skilled health personnel³⁵ suggests that women's health care needs are not given due priority.

These figures suggest that cultural norms in Pakistan are embedded in the health system. In Pakistan, many women are unaware of their human rights, they rely on family members to make important decisions and they are unable to question the status quo. It is often the husband or an older female family member (such as a mother-in-law) who makes the decisions regarding family planning. These same people may also control household resources and influence the mobility of female family members, which means that their

access to reproductive health care may be limited. In many cases where women are not given permission to make their own choices, they seek out and rely on non-detectable methods that they can keep secret. If or when these women are discovered to be using contraception, they may be beaten or raped. A health care system that fails to meet the needs of women and girls perpetuates gender inequality and severely impacts sexual and reproductive health.

Despite a lower gross national income per capita, Bangladesh spends more on health per person – at US\$57 per capita³⁶ – than Pakistan, and the government has placed a significant focus on sexual and reproductive health, in particular family planning, within that expenditure. The consequences are clear. Well over half of women in Bangladesh use contraception, compared to less than 30 per cent of women in Pakistan³⁷. In Pakistan, there are 500 women dying for every 100,000 live births, a figure that rises to 800 in some areas. While still high, Bangladesh's maternal mortality ratio is significantly better, at 380 maternal deaths per 100,000 live births³⁸. Bangladesh's ability to overcome traditional norms and to raise the priority and appreciation of women is reflected throughout their health system and their efforts to improve it.

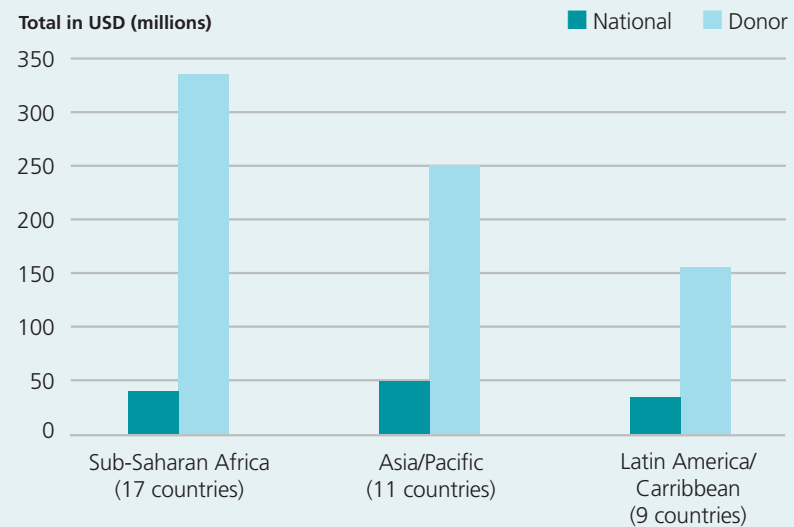




“Having a budget line for sexual and reproductive health for this country is a very positive thing for us. We [are] very happy.”

Walter Mbunda, former Executive Director of Uzazi na Malezi Bora Tanzania (UMATI), IPPF Member Association

Figure 4 Donor and national funding for population activities* by region, 2002³³



* Includes funding for family planning, reproductive health, HIV and AIDS (UNFPA/NIDI 2003)

Combating cultural traditions that instill gender inequality as a core value is challenging but crucial for women’s health. In some societies men are expected to demonstrate their masculinity through their virility and their fertility, which means not only that women are pressured to have and care for more children than they may wish to, but also that men may have multiple sexual partners, which increases the risk of sexually transmitted infection, including HIV, to all his partners and sometimes his children. When governments, communities, male and female heads-of-household ensure that women have the freedom to seek sexual and reproductive health services and to use contraception at their will, the whole society will benefit.

Health systems strengthening: Hand in hand with contraceptive security

Even if demand for contraception is matched with sufficient support and funding, without strengthening fragile and failing health systems there will still be an unmet need for contraceptive supplies, information and services among the poorest and most marginalized men, women and young people.

The financial, human and infrastructure resources that are currently in place in most developing nations are insufficient to meet demand for sexual and reproductive health information and services. Health systems, including efficient coordination systems for the procurement and distribution of contraceptives and other commodities, together with adequate financial and human resources must be strengthened substantially to deliver contraceptive supplies and implement new prevention programmes.³⁹

The World Health Organization describes the basic building blocks for a secure health system as: service delivery, a health sector work force, information, medical products such as contraceptive supplies, financing and leadership and governance.⁴⁰ Only by ensuring that health services are adequately resourced with informed personnel, accurate and relevant information about reproductive health, high quality contraceptive supplies, and good leadership and governance can we ensure that contraceptive services are available to all those who need them.

In Mexico, contraceptive supplies are classified as a national security item, which means a guaranteed budget line. However, funding for contraceptives occurs at the district level, and in some states the funds allocated to this budget line are inadequate. As usual, it is the rural poor and indigenous people who are first denied access to contraceptives because they rely on subsidized supplies that are provided by the public health system. Problems like these are echoed in the health systems of many developing countries. MEXFAM, an IPPF Member Association, is carefully monitoring the budget lines for contraception in Guerrero, and advocates with district health officials to ensure that national priorities are reflected at the state level.

Public provision of contraceptives means that the health system can transgress the economic, administrative and geographic barriers that often prevent women from accessing contraceptives when it is provided exclusively through the private sector. It is almost always women who bear the cost of contraception, so when their own income or access to household financial resources is limited, women may forgo this expense in order to clothe and nourish their families. If they do become pregnant they may turn to abortion, whether or not it is legal and whether or not it is conducted in a hygienic environment by trained medical professionals. Unsafe abortion is a major cause of death and disability in the developing world. Worldwide, at least 175,000 women's lives could be saved if all women had access to contraceptive services.⁴¹ Contraceptive supplies are not only an essential element of a strong health system; investment in reproductive health contributes to the sustainability of health systems by easing the financial burden in other areas. The cost-effectiveness of contraception cannot be underestimated: informed estimates indicate that every US\$1 invested in family planning will save up to US\$31 in spending on health, education, housing, water, sewage and other public services.⁴²



“We can really do something to change the world. The time has come to stop talking and start taking some action. If everyone who wants to see an end to poverty, hunger and suffering speaks out, then the noise will be deafening. Politicians will have to listen.”

Bishop Desmond Tutu

The International Health Partnership (IHP+) aims to improve the way that international agencies, donors and developing countries work together to develop and implement health plans, creating and improving health services for the poor and marginalized, thereby ensuring commodity security for

the most vulnerable people in the most vulnerable circumstances. Supported by donor governments and agencies, the IHP+ pledges to invest US\$14 billion in strengthening health systems in 10 pilot countries: Burundi, Cambodia, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Nigeria and Zambia.⁴³

A crucial aspect of strengthening the health system for sexual and reproductive health is good quality service delivery. All the effort and expense in getting supplies to health care providers and distributors may be wasted in the absence of health care providers that are trained to provide a good quality of care: uptake and continuity of contraceptives is severely limited without it. In 1990, Judith Bruce published a framework – which has since gained international recognition – that outlined six essential elements of quality of care in a family planning programme. These are: the individual's choice of method; full and accurate information provided to the individual; interpersonal relations; technical competence of health provider or distributor; follow-up mechanism and an appropriate constellation of services.⁴⁴ Over and over again, it has been proven that quality of care is a significant factor in the uptake and continuation of contraception among both men and women.⁴⁵

Looking at just one element of quality of care – a range of contraceptive methods – shows the relevance of this issue. Women who aren't able to access services very often may prefer to use implants or intrauterine devices. Women who face difficulties negotiating male condom use, including sex workers, may be empowered if they can choose female condoms to prevent sexually transmitted infections. Men and women choosing to use dual protection against unwanted pregnancy and sexually transmitted infections need a variety of methods to choose. This range must include female or male condoms, the only contraceptive methods that can prevent sexually transmitted infection. Appropriate contraception is especially important and can be very empowering for women living in conflict or emergency situations. If regular contraception fails or if it was not used during intercourse, women are able to prevent unwanted pregnancy by using emergency contraception

within 72 hours. As such, emergency contraception reduces the need for abortion. Though it is frequently left off of national essential drug lists and the mix of contraceptive methods available through the health system, emergency contraception is the only method that can be used to prevent pregnancy after forced or coerced sex and is crucial for women who are subjected to sexual and gender-based violence. The distribution of emergency contraception, as with other methods, must reflect the circumstances under which it is needed and will be effective. Thus, women must be able to procure it cheaply, confidentially and quickly.

Clients are individuals with contraceptive preferences and needs. These needs must be respected in order to ensure that the delivery of supplies results in meeting the demand for contraception. Although it is clear that within regions and countries there are preferences for some family planning methods over others, more research is needed to determine exactly what these preferences are in order to ensure that the correct range of contraceptive methods is being delivered as needed.





Strengthening the supply chain

The supply chain refers to the processes and actors that are involved in delivering contraceptives into the hands of those who need them.

Broad social and political mechanisms that support, or inhibit, family planning influence the supply chain significantly, though the supply chain itself is a series of events, from product selection through to distribution. Urgent action is needed at the operational level in many countries to adequately resource the supply chain and resolve persistent problems. The success of family planning policies and programmes depends on it.

The supply chain should ensure that the end user receives:

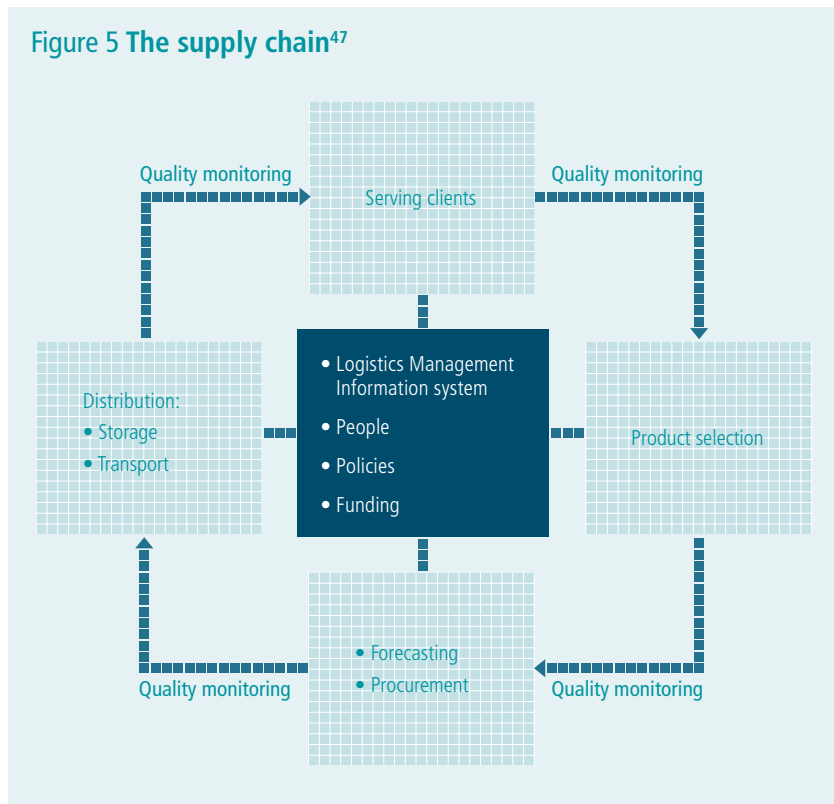
- the right product (this means a wide variety of products should be available so that clients have a free choice of methods)
- in the right quantities
- and the right condition (products of good quality, intact and in-date)
- to the right place
- at the right time
- for the right cost (including the cost of the contraception and indirect costs such as health care services, transportation, loss of income, etc).⁴⁶

When all of the above have been achieved, the supply chain has accomplished contraceptive security. The diagram on the opposite page illustrates the complex chain of factors that influence whether or not contraceptive security is realized.

As each part of the process feeds back into the cycle of supply and demand that drives the supply chain, there is no starting or end point. The components of the supply chain are closely inter-related; failings in one part of the chain will have a direct impact on other events, sometimes including subsequent cycles of the entire process. It is only when all parts of the supply chain work well that all people can access contraception when and where they need it.

Governmental regulatory bodies determine which contraceptives can be distributed in the country by approving them for public use. Donor governments will frequently only distribute contraceptives approved for use in the US or Europe, partly due to concerns about quality and safety. Contraceptives manufactured and approved for use in developing countries, at less cost, may be just as safe and effective as those manufactured abroad, but most donor governments will not distribute them. The public then obtains contraceptives either through national family planning programmes – for instance through public health providers, IPPF or other NGO clinics – or through private clinics, pharmacies and retail outlets.⁴⁸ The ability of clients to choose which contraceptive they want to use, a component of quality of care and contraceptive utilization, depends not only on the government, and/or donor, approving their contraceptive of choice,⁴⁹ but also on the contraceptives that their supplier, whether public, non-governmental or private, chooses to distribute. This can be influenced by a number of factors,

Figure 5 The supply chain⁴⁷



“Reproductive health supply security will never be achieved by a small group of key donors sitting around a table in Europe or the USA. An increasing diversity of sectors needs to come together to solve the problem – including from developing countries, the private (as well as the public) sector, civil society and a variety of other key stakeholders. This is why the Coalition has expanded from the core group of fewer than 20 members it was in 2004 to over 70 members today.”

John Skibiak, Director, Reproductive Health Supplies Coalition

including potential profit for the manufacturer (some contraceptives have a greater profit margin than others). Pharmaceuticals are increasingly uninterested in producing contraceptives after the patent expires as the profit margin decreases significantly at this stage. Women’s choices, especially poor women’s choices, are to some extent manipulated by government policies that, depending on the political will of the day, can provide or take away subsidized reproductive health supplies.

Health providers can also influence a patient’s choice by the methods that they decide to offer to the client. Many women are not given free choice even when the method they want is available. For instance, in some contexts health providers discriminate against women living with HIV, placing undue pressure on them to be sterilized,⁵⁰ while in pro-natalist societies administrators may encourage health providers to provide contraception only to women who have achieved a certain parity.⁵¹

“The community-based agent started visiting less frequently, and sometimes he did not have enough contraceptives. After some time, he stopped everything. There was no education and no contraceptives.”

Benjamin Baavugi, a farmer from Boayili village in Ghana, is caring for his young niece and nephew because their mother died as a result of unsafe abortion after donor funding for contraceptives was stopped.

When the supply chain works well, distribution outlets will always have enough contraceptives in stock to meet demand, but not so many that the products expire before use. Governmental, private and non-governmental providers all have forecasting procedures to anticipate the needs of their clientele so that they order and maintain appropriate quantities of supplies.

Forecasts are based on assumptions: future contraceptive prevalence rates, numbers of users of contraceptives, changes in awareness and acceptability of contraception, and trends in contraceptive method preferences.⁵² Forecasting for national family planning programmes is generally conducted by the National Contraceptive Security Committee, which is composed of Ministry of Health representatives, civil society, donors and other stakeholders. The Committee works with health experts within government to ensure contraceptive security across the country and it advocates for policy change to support contraceptive security.

Accurate forecasting is critically important, affecting budget planning – specifically the allocation of funds for contraceptives – and all subsequent steps in the supply chain, from procurement through to transportation, storage and distribution.

Cumbersome administrative procedures within the Tanzanian government can lead to delays of up to twenty-four months between the forecasting and allocation of resources, and the actual expenditure of the resources and product delivery.⁵³ This means the government is using current budgetary allocations to fund

future contraceptive use. It is putting its national contraceptive security at risk: if demand for contraceptives increases, there will be stock-outs and people will not have access to the basic supplies they need to prevent unwanted pregnancy and sexually transmitted infections.

Forecasting must be linked to procurement schedules to ensure that contraceptives are delivered to the storage facilities when there is space available and to renew stocks at clinics and other distribution points as required. Procurement is the process of obtaining products from suppliers, manufacturers, development partners or procurement agents. Procurement processes must take into account ‘pipeline leakage’: that is, the number or proportion of supplies that will be lost between dispatch from the manufacturer and arrival at the distribution outlet. Some supplies will be damaged, stolen or lost in transportation or storage, a proportion may be taken by customs officials as a sample of the shipment for security purposes,



some may be temporarily misplaced (in the warehouse, for example) and only found after they have expired. Pipeline leakage has a major impact on the effectiveness of the supply chain. Programme managers bear responsibility for managing the flow of contraceptives by calculating pipeline leakage and the rate at which supplies will deplete, and estimating the risks that shipments will be delayed at some point during the transportation and delivery process.⁵⁴

All these elements must be reflected as accurately as possible in information systems, or the logistical management system (LMS), to inform procurement and distribution. The LMS is a software programme which tracks the journey of a contraceptive through the supply chain. The effectiveness of the LMS depends on several factors including the capacity of programme managers to operate the system. Training personnel within the health system to manage the LMS is an area frequently overlooked by donors and governments, until the system breaks down. Information is a commodity of exceptional consequence in the supply chain, with the potential to ensure the smooth running of the whole system or to destroy it completely. When information entered into the LMS is not consistent with actual stock, deliveries and consignments, one of two scenarios is likely: either valuable supplies will be wasted, or distribution points will be unable to fulfil demand.⁵⁵ As such, significant investment and expertise is needed to manage all the data involved.

Highly skilled personnel and other resources are also required to maintain an appropriate storage facility. It must be large enough to house the quantities ordered and must store contraceptives under the correct conditions (with regard to temperature, humidity, etc) so they remain safe for public use. This is a major issue in tropical and maritime regions.

The supply chain relies on effective transportation infrastructure – vehicles, roads and personnel – to carry contraceptives from manufacturers to storage facilities, and from storage facilities to distribution points. Areas which are remote or without good transport links can have problems accessing contraceptives regularly. If fuel and vehicle prices increase, if distances get longer as a result of clinic or storage facility closures, if roads are not maintained to a good standard, the resources and time required to transport contraceptives increases. Distribution costs can add an additional 15-20 per cent of the cost of the contraceptive.⁵⁷ Currently, there are significant logistical challenges in delivering contraceptives effectively to remote and rural locations, to areas with extreme climates, and to areas with security problems. There are also obstacles in delivering contraceptives to marginalized people. These supply chain problems need to be addressed urgently. IPPF's community-based distribution network is an intervention that has made considerable progress in tackling this problem.

Each link in the supply chain comes with own inherent risks and potential problems. Addressing these issues, and achieving contraceptive security will require the commitment, resources and capacity of all stakeholders involved at all links in the chain.

“Another factor limiting contraceptive supplies is the inadequate logistics capacity in many developing countries. At the country level, a sound logistics system ensures the smooth distribution of contraceptive commodities and other supplies so that each service delivery point has sufficient stock to meet clients’ needs.”⁵⁶

World Bank



Empowered with knowledge: The key to demand

Even when political and financial support for family planning are present in a country, if support is restricted to health services and commodities, family planning programmes are effectively cut off at the knees.

Sexuality education for all, including young people in and out of school, marginalized groups and others who may not ever have had access to full information about sex and reproduction, must be available and form a core part of governments' commitment to family planning. This is vital to a functioning supply chain.

Young people have a real need for reproductive health and family planning information and services. The age at which young people have their first sexual experience is falling, while the number of unmarried sexually active young people is growing significantly.⁵⁸

Although many adolescents claim to know about contraception and safe sex, their actual knowledge is often quite poor.⁵⁹ Many young people believe that you can't get pregnant the first time you have sex, for example, or that you can't get pregnant if you have sex standing up.⁶⁰ In collaboration with some leading international organizations, IPPF recently completed a comprehensive study on myths relating to contraceptives and the results are available on the IPPF website. As a result of incomplete knowledge about family planning, adolescents are vulnerable to sexually transmitted infections and unwanted pregnancy. A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2.2 to 4 million annually.⁶¹ Research shows that unmet need for contraception among sexually active adolescents, those who express a desire to prevent pregnancy but aren't using any contraception, is high in many regions.⁶²

Many societies disapprove of premarital sex and consider reproductive health care for young people inappropriate. As a result, parents, educators, and health care providers often are unwilling to give young people the information and services they need. Laws and policies restrict adolescents' access to services, for example by limiting family planning services to married adolescents⁶³ or by including conditions such as parental or spousal approval.

In addition to ignorance about sexual and reproductive health and harmful sexual behaviours that carry on into adulthood, negative attitudes to young people's sexuality lead to:

- stigma against young people who use or ask for contraceptives
- reinforcement of local cultural and faith-based restrictions on access to services
- service providers' reluctance to provide contraceptives to young people
- difficulties for young people in insisting on condom use with their partners and in accessing contraceptives
- unwanted pregnancies among adolescents and young people
- increased rates of sexually transmitted infections, including HIV

Improving access to contraception, and sexual and reproductive health education for young people should be an immediate priority. Even though many young people are not sexually active, one day they will be and it is our responsibility to prepare them for that day.

“Sometimes [women] with seven or eight [children] come to me and cry. They say they wish they had known about family planning before, so they could have spaced their children. Women who work a lot don't want to be pregnant the whole time.”

Community-based reproductive health agent, Ouina market, Uganda





Family planning in the face of opposition

Religious opposition to family planning and contraception is one of the most significant obstacles to securing political support domestically and globally.

The Vatican vehemently opposes contraception, even objecting to the use of condoms for HIV prevention. It has used its influence and financial resources nationally and internationally to undermine family planning, women's health and fundamental human rights.

Other religious groups, including the fundamentalist evangelicals and certain Islamic sects, also oppose contraception and use their clout within certain countries and regions to influence government policies on sexual and reproductive health, including reproductive health supplies.

Filipino men and women are trying to assert their rights and are fighting back against both the State and the Church: on 30 January 2008, 20 men and women filed a case in the Philippine high court against the

mayor of Manila, arguing that the city's eight-year ban on contraception has severely and irreparably damaged their lives and health and that of the majority of women in Manila City.

The Philippines: Fighting for the right to family planning

Though there were early successes in the Philippines' family planning programme, today Filipino women and couples increasingly have to fight for their right to contraception. The national government is orchestrating a coordinated anti-contraception campaign under the influence of the Catholic Church.

In 2002, President Arroyo declared that the government would suspend funding to procure contraceptives and pushed natural family planning as the most effective contraception. Every year, 27 per cent women using the withdrawal method of family planning (as it is commonly practised) become pregnant, compared to only 3 per cent of women using monthly injectables or 8 per cent of women using oral contraceptives.⁶⁴ Shortly after the President announced the funding cut, USAID, which had previously supplied most of the contraceptive requirements of the Philippines, announced that it would be phasing out all support for contraceptives beginning that same year, with the aim of withdrawing all support by 2007. For poor women who depended

upon public service outlets for affordable contraception, these events were devastating.

In 2000, an estimated 78,900 women were hospitalized for post-abortion care, 473,400 women had abortions and the abortion rate was 27 per 1,000 women aged 15–44 per year.⁶⁵ The Catholic Church's 'war' on contraception in the Philippines visibly became a war on poor Filipina women.

The Catholic Church continues to pressure elected officials to retain strict policies on contraception. In early 2008, the Catholic Church threatened to withhold communion from politicians who support measures to increase access to contraception. In fall 2008, the Philippine parliament began debating and considering a Reproductive Health Bill (HB 5043) which would ensure the provision of a comprehensive range of services and programmes addressing sexual and reproductive health. Unsurprisingly, the Catholic Church is opposed and continues to exert pressure on members of parliament to reject the bill.

The decline in contraceptive availability and access is "violence against women of the more insidious kind, the violence that deprives women and girls of basic reproductive health information and services, which is becoming more pervasive and the costs just as devastating."

Dr Alcantara, Executive Director of the Family Planning Organization of the Philippines, IPPF



Contraceptive inequity: Undermining poverty reduction

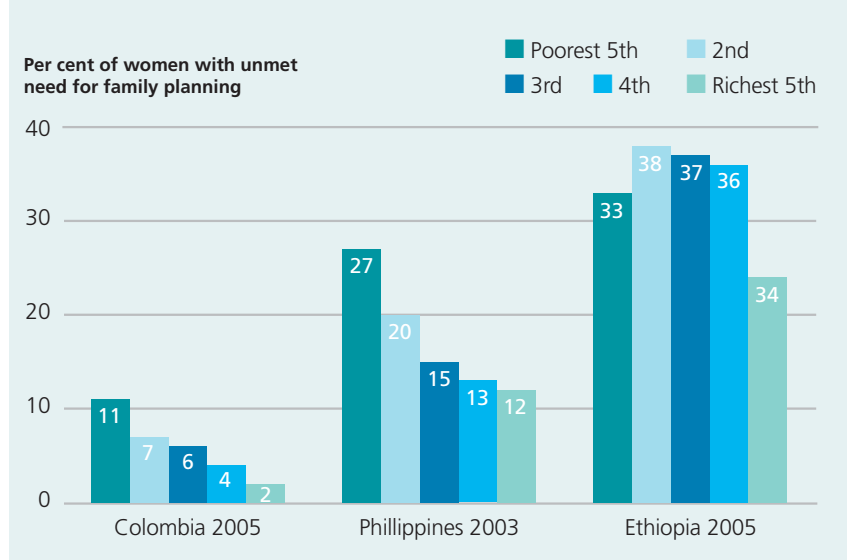
Despite impressive global gains, the uptake and usage of contraception is uneven between global regions, between countries, and between socio-economic groups within countries.

On average, the wealthiest women are four times more likely to use contraception than the poorest. In some countries, the rate is 12 times higher. Access varies according to income, education, ethnicity, proximity to clinics and the strength of family planning services.

Full access to safe and affordable contraceptive methods is essential to achieving the Millennium Development Goals. Contraception improves gender equality, maternal health, child survival rates; and family planning can help reduce poverty and promote economic growth.⁶⁷ Restricting access to contraception prevents women taking up opportunities that could lift them and their families out of poverty, and make a profound impact on their lives and the lives of their children. The poor have the most to gain from family planning programmes, but are all too often the least likely to be able to access services.

The fact that many of the world's poorest countries have made slow progress over the past 30 years in increasing access to contraceptives is no coincidence.

Figure 6 Unmet need for family planning by wealth⁶⁹



Countdown 2015: Campaign for reproductive health supplies

International organizations and civil society groups are becoming increasingly aware and concerned that international development goals and government commitments related to sexual and reproductive health will not be met. The IPPF European Network is leading a consortium of 10 European NGOs that together comprise the Countdown 2015 steering committee. The focus of the Countdown 2015 campaign is to renew priority and attention on a number of key international commitments and goals. These are:

- the 1994 International Conference on Population and Development (ICPD) Programme of Action, which was built on the cornerstones of gender equality, eliminating violence against women and ensuring women's ability to control their own fertility

- the eight Millennium Development Goals, which are focused on reducing poverty by half by 2015
- 'universal access to reproductive health by 2015' – the new target 5b under MDG 5 which was adopted by the United Nations General Assembly in 2006
- a set of indicators for tracking progress to reach MDG 5 target 5b on universal access to reproductive health by 2015
- the goal of universal access to comprehensive HIV and AIDS prevention programmes, treatment, care and support by 2010, which was adopted in 2006 by the United Nations General Assembly⁷⁰

Countdown 2015 highlights the fundamental truth that none of the selected targets will be met unless urgent action is taken to ensure the sustained availability of reproductive health supplies.

“Behind the words there lies an inviolable truth: the MDGs are doomed unless we make gender inequality history.”

Stephen Lewis, United Nations Special Envoy for HIV/AIDS in Africa

Africa: Failing the most vulnerable

The dramatic and worrying failure to make modern contraception available has led to a large unmet need among women and men in many parts of sub-Saharan Africa: in 21 countries 25 per cent of the population have an unmet need for contraception, in seven countries this rises to a third of all women who are married or in union.⁷¹ Consequently, women in 15 countries continue to have an average of more than six children in their lifetime.⁷² In most cases, they will have had several more pregnancies, abortions (both involuntary and induced) and births.

In the absence of contraception for preventing unwanted pregnancies and child spacing, maternal and child deaths and ill health remain extremely high. A woman in a developing country faces a one in 76 chance of dying in pregnancy or childbirth, while in industrialized nations the risk is only one in 8,000.⁷³ The inequity felt by women in the poorest countries and communities across the globe is inexcusable.

Uganda

Uganda is an example of a country where family planning continues to remain inaccessible despite increasingly positive government policies. Unmet need for family planning among married women has reached

a staggering 41 per cent.⁷⁴ The government has identified reproductive health as a priority and contraception is included on the national essential drug list, but Uganda relies heavily on external funding for sexual and reproductive health activities and family planning is not part of primary health care services. Even though contraceptives are free to non-governmental service providers, major logistical flaws in the delivery of supplies – particularly beyond the district level – result in frequent stock-outs and the delivery of poor quality or expired stock.

Reproductive Health Uganda, an IPPF Member Association, is working with government agencies and civil society organizations to create a long-term plan to improve infant and maternal health and is advocating for a dedicated government budget line for sexual and reproductive health services. Their campaign has produced exciting results.

At a meeting designed to raise awareness of reproductive health supply issues in Uganda, Reproductive Health Uganda collaborated with civil society partners, parliamentarians and technical experts to develop a coordinated advocacy campaign. Those members of parliament who attended the meeting

pledged to lobby their fellow members of parliament to support reproductive supplies and they presented information on the links between reproductive health supplies and maternal health in parliament. Following a heated debate, the Minister of Finance pledged additional funds for reproductive health and reproductive health supplies from a US\$100 million World Bank loan for health. This 13 per cent increase is testament to the power of civil society to influence government decision-making and to ensure that sexual and reproductive health is given due priority. However, in a country of 28.5 million people, this money will not go far.

At a time when world leaders and national health ministers are making increasing numbers of public statements of support for family planning, falling funding for sexual and reproductive health across Africa threatens to reverse the gains that contraception has achieved. It should come as no surprise that Africa accounts for 50 per cent of the global total of women and girls killed by unsafe abortion, despite only accounting for 14 per cent of the world's population.⁷⁵ Civil society has an important role in ensuring that sexual and reproductive health services and commodities are adequately funded and delivered.

“Sometimes donors bring in [sexual and reproductive health] commodities, more than can be consumed at that particular time, and more than what the national medical stores can have in their stores. We know that it is cheaper to procure in bulk, but it is no use for the [national medical stores] to procure in bulk when, at the end of the day, we see an expiry of those drugs. And then we have

to look for funds – like now we are looking for 800 million* – to dispose of the expired drugs. [That] 800 million will not be used to provide drugs, to provide commodities, in my district. Using [this money] to dispose of expired drugs is a real waste in this country.”

Hon Silvia Ssennabulya,
Member of Parliament, Uganda

“The gap in modern contraceptive use prevalence between the absolute poor and the rest of the population in developing countries is increasing over time and tends to widen in countries with higher incomes... the steadily increasing gap, in combination with greater national income inequalities, is a question of political priority for contraception and more broadly for reproductive health services.”⁶⁸



* 800 million Ugandan shillings is equivalent to approximately US\$493,000.



Latin America and the Caribbean: Turning success into failure?

Throughout the 1990s, governments in Latin America and the Caribbean made large investments to increase the number of service delivery points, improve quality, and make contraceptives free in government health facilities. Non-governmental organizations (NGOs) expanded social marketing of contraceptives, thus increasing access to contraceptives by adding mobile sales forces and expanding the network of service outlets and community-based distributors.

On the surface, Latin America and the Caribbean represent success in the delivery of contraceptive services. Regionally, contraceptive usage (CPR) has reached 71 per cent, which compares favourably with the most developed regions. The number of service delivery outlets and the number of women accessing services have also increased. Regional averages are deceiving, however – disguising inequities across the region and within countries. While Brazil and Colombia have contraceptive prevalence rates of nearly 79 per cent, Haiti achieves only 25 per cent.⁷⁶ Across Latin America, women in rural areas, those with less education, adolescents, and certain ethnic groups are far less likely than urban and middle-class women to have access to or to use contraception. The gap between actual and desired fertility is widest among poor women.

The use of regional and country averages in assessing contraceptive needs may be partially to blame for the rising number of donors who are reducing their support and funding for contraceptive services to the region. And unless national governments are willing and able to pay for services and supplies after donor phase-out, people in the poorest countries will continue to be denied the right to family planning.

Many Latin American countries must now undertake urgent action so that family planning successes are not undermined. They must consider what options they can afford and they must identify sources for financing and procuring contraceptives that are different from their usual donors. In the long term, they should build in-country capacity for manufacturing, producing and delivering a range of high quality contraceptives so that a predictable supply and mix of contraceptives are available.

Nicaragua: Countering restrictive policies with entrepreneurial solutions

In recent years the Nicaraguan government changed the policies that regulate how non-governmental organizations (NGOs) procure and distribute donated contraceptives. As of 2007, NGOs, including IPPF Member Association Profamilia, are only permitted to accept donated contraceptives if they provide them to their clients at no charge. This policy change posed a significant threat to Profamilia's operations, affecting their entire system for delivering contraceptives to their clients.

Previously, NGOs such as Profamilia were able to accept the donations and sell them to clients for a small fee to cover costs relating to their distribution, for example storage, administration and transportation costs, and to subsidize other, more costly services.

In Nicaragua – a country of 5.6 million people⁷⁷ – the government budget line for contraceptives in 2008 is about US\$560,000,

of which US\$300,000 is donated. This is not nearly enough to meet demand. To ensure that contraceptives are available to all people who need and want them, service providers such as Profamilia depend on donated supplies and on a policy environment that enables them to deliver supplies to their clients.

In response to the change in legislation, Profamilia decided to create a private sector company – PROFACSA – which will serve as its contraceptive procurement and distribution partner. PROFACSA will allow Profamilia not only to recuperate the cost of the products from its clients, but also to distribute products through commercial outlets. All profit will be reinvested in Profamilia to strengthen its programmes and services for poor and marginalized people. Profamilia anticipates that PROFACSA will be operational in 2009.





Products for people

Meeting demand for family planning is to a large extent dependent on the availability of products that are consistent with cultural expectations and the particular needs of individuals. The demand for new products may come from users themselves, from academics, health providers or health experts.

Once support and funding have been secured, it can take decades to undertake the research and development necessary to show that a new contraceptive is safe and effective. The pharmaceutical industry has a major impact on whether women and men in developing countries have access to reproductive health supplies, and which products they have access to.

Since the 1950s, research and development in the private sector have been responsible for many of the significant advances in the field of contraception. However, in the 1970s, concerns were raised about the willingness of the pharmaceutical industry to supply products to developing countries or expand its portfolio to develop alternative products that might provide broader choice and acceptability. In response, three major public sector organizations became involved in the research and development of contraceptive methods in order to ensure that new developments took an active interest in the needs of poor people and other less profitable segments of the market. These organizations are the Population Council, the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (WHO/HRP), and CONRAD, a research institute.

The oldest of these is the Population Council, which was established some 50 years ago. Through its International Committee for Contraception Research (ICCR), established in 1970, it has developed four contraceptive products which have reached the market: two implantable devices, including Norplant, and two intrauterine devices (IUDs).

The UNDP/UNFPA/World Bank/WHO Special Programme for Research, Development and Research Training in Human Reproduction (WHO/HRP) has worked on many different approaches to contraception since its establishment in 1972. These include a range of contraceptive methods, from the intranasal administration of hormones to immuno-contraception. Except for certain kinds of injectables and emergency contraception, however, little of this research has led to products reaching the market. But the Programme has made a significant contribution to increasing the availability of products developed by others. Its clinical and epidemiological studies have also helped establish codes of good practice for assessing the safety and effectiveness of existing methods, with particular relevance to developing countries.

In 1995, CONRAD established the Consortium for Industrial Collaboration in Contraceptive Research (CICCR) to revitalize the pharmaceutical industry's commitment to developing new contraceptives. CONRAD gives priority to the development of chemical barriers that prevent pregnancy and/or sexually transmitted infections; hormonal methods for men; non-hormonal methods for women and men; and mechanical barriers for women.

Although implants, IUDs and monthly injectables have become options for many women (to a greater or lesser extent depending on the country and context), oral contraceptives are the principal commodity of interest for the private sector. In spite of efforts to increase the availability of different kinds of contraceptives for women for whom oral contraceptives are not suitable or preferable, oral contraceptives account for almost 50 per cent of contraceptive sales worldwide.

Because the oral contraceptive market is so valuable, major pharmaceutical companies have been reluctant to introduce the new products that they have been developing. This is because they feared sacrificing what was already an extremely lucrative market. By 2004 there was a significant reduction of the number of major pharmaceutical companies in the field, primarily because of mergers and acquisitions, so competition was fierce.

The contraceptive market has changed in recent years partly because of the growth of generic oral contraceptive manufacturers. Two companies in particular, Barr and Watson Pharma, introduced quality generic oral contraceptives and have basically pushed most of the traditional big players out of the oral contraceptive business. It was only when the 'big four' pharmaceutical companies – Organon, Ortho, Schering and Wyeth – realized that they were losing market share on oral contraceptives that they began seriously looking at new products. The 'big four' have since introduced a vaginal ring, contraceptive patches and implants, and an IUD to try and retain some share of the hormonal contraceptive market. These products are available in Europe and the USA, but they are all virtually unaffordable for the general public in the developing world.

A trend of mergers and acquisitions in the pharmaceutical industry has created some turbulence in the contraceptive industry, with the research, development and marketing of contraceptives and other women's health products going from strong to weak, and back again. Both Wyeth and Ortho have substantially reduced their contraceptive business, and when Schering-Plough bought Organon in 2007 they downgraded its contraceptive business. The exception to all this has been Schering. It was purchased by Bayer in 2006 and Bayer has continued to support its role in hormonal contraception. Schering – now Bayer-Schering – is the last of the 'big four' to retain a research and development programme and to be involved in the supply of oral contraceptives to developing countries. Organon has recently renewed interest in the contraceptive market, but only to a limited extent.

So the 'big four' have become the 'big one'. While Bayer-Schering manufactures high quality products, the lack of competition is a big problem for procurement agencies. Without alternative suppliers, procurement agencies are forced to pay the manufacturer's asking price, whatever it is, and the products that can be procured are dependent on what the manufacturer chooses to make available, and sometimes what products donor governments choose to donate.⁷⁸ This will affect whether women and men in developing countries have access to their product of choice. Even before the rise of generic manufacturers and the series of mergers and acquisitions that transformed the business of contraception, stakeholders were beginning to ask whether the pharmaceutical industries of developing countries could fill the gap and provide products of assured quality at an affordable price.

“No one should die from having sex.”

Hilary Benn, former Secretary of State for International Development (UK)



There are two dominant views on the pharmaceutical industry in developing countries. Some groups feel that we should support manufacturers and governments to build in-country capacity to develop and regulate contraceptives; local producers will also be empowered to develop their own export markets.⁷⁹ Other parties have argued that the existing contraceptive suppliers are adequate and there is little need to establish new facilities to meet the demand for supplies of hormonal contraceptives. Instead, they say, we should focus attention on developing a network among existing generic pharmaceutical manufacturers in lower and middle income countries that could supply products to people in the developing world. Provided, of course, that these generic products are of appropriate quality and are affordable and accessible.⁸⁰

A recent study assessed 47 manufacturers of oral and injectable hormonal contraceptives in 15 lower and middle income countries.⁸¹ A summary of the findings states:

“Although all 47 factories visited comply with national good manufacturing practices (GMP), it is probable that less than 35% could eventually meet the current GMP requirements of the World Health Organization (WHO), the Pharmaceutical Inspection Co-operation Scheme (PIC/S) or any stringent regulatory authority over the next two years. A further 30% might be able to comply with significant investment and improvements in quality management and practice. The other 35% of the facilities visited are manufacturing products under conditions that give cause for grave concern.”

While it was anticipated that up to 15 of these companies could by this time have met the requirements of WHO’s Prequalification Programme, none have yet done so. There are two or three companies that are very close, however, and independent assessments, including one by UNFPA, have shown that products from these companies do meet the stringent requirements necessary for the manufacture of assured quality products. So at the end of 2008, there are the ‘big one’ and the ‘little three’ manufacturers of quality hormonal contraceptives. There is also a group of three or four companies that have been getting external technical assistance to improve their manufacturing competence. In addition, UNFPA have prequalified, as being of appropriate standards, a copper IUD and condoms which are produced by a group of manufacturers in developing countries.

After 50 years of modern contraception, we are still struggling to provide appropriate products of assured quality at an affordable price to people throughout the world. This remains a challenge for governments, donors and all those involved in improving access to contraception.

Empower people to lead productive, self-sustaining lives

Three converging forces are putting unsustainable pressure on family planning services and supplies of contraception around the globe.

Firstly, insufficient funding for reproductive health from donor and developing country governments; secondly, the largest youth population heading for sexual maturity in the history of the planet; and finally, the growing demand for protection from HIV transmission in the developing world. Without immediate action, these pressures will cause undue and unnecessary suffering. Only with the ability to choose whether, when and how many space births or to have sex for pleasure without fear of pregnancy, can women play an ever more important role in their societies and attain their rights. Their health, economic livelihoods and educational advancement are at stake because of the lack of investment in one of the most cost-effective and reliable health and development interventions the world has known: contraception.

More than 200 million women do not have access to the contraceptive services they need.⁸¹ There are over 80 million unintended pregnancies each year, over half end in abortion and about five million women and girls face death or disability as a result of unsafe abortion each year.⁸² Almost half of the deaths occur among girls and young women under 25 years of age.⁸³

There are 1.5 billion young people approaching sexual maturity⁸⁴ who will drive an unprecedented demand for contraception for which the world is singularly unprepared. The foreseeable, and preventable, result will be the continuation of tens of millions of unwanted pregnancies, unsafe abortions, maternal and child deaths, and a fatal undermining of global efforts to improve health, women's and young people's rights, and to raise billions of people out of poverty.

The HIV and AIDS epidemic is already taking an enormous toll globally, but particularly in sub-Saharan Africa and especially among the youth of sub-Saharan Africa.⁸⁵ More than 40 per cent of new HIV infections worldwide occur in young people and preventing HIV transmission in this population could change the course of the AIDS epidemic.⁸⁶ A young person is infected with HIV every 14 seconds, a majority of them young women.⁸⁷

In order to turn this story around, in order to empower women, men and young people with the supplies they need to ensure their own sexual and reproductive health and to realize their human rights, there are some clear, evidence-based actions that governments need to take.





Recommendations

The time to act is now. Over the last 40 years family planning has improved the lives of hundreds of millions of people: its overall contribution to poverty reduction, its contribution to human health, human development and human rights must not be lost, or denied to the many millions of people in developing countries who have a right to access the same benefits that the developed world takes for granted.

1. Donors and developing countries must increase funding for reproductive health supplies to levels that are in line with demand.
 - Developing countries must own sexual and reproductive health and rights by dedicating national funds to supplies through a dedicated and protected budget line.
2. Supplies must form an essential component of health system strengthening initiatives. They must be incorporated into the national health plan and budgeted for accordingly.
 - Health system strengthening initiatives and the national health plan must include provisions for the monitoring of procurement and distribution of reproductive health supplies.
 - Financial and human resources must be strengthened substantially to deliver contraceptive supplies and sexual and reproductive health services and programmes.
3. Governments should increase collaboration with private sector stakeholders, including non-governmental organizations and pharmaceutical companies, to ensure that reproductive health supplies are accessible for all people, and not merely the most profitable segments of the market.
4. Build capacity and invest in supply chain management in developing countries
 - Invest in adequate storage facilities at national and municipal levels and invest in a logistics management system (LMS), including training and support so that personnel use it correctly.
 - Provide resources to national contraceptive security committees to ensure they can hold regular meetings and have a diverse membership, including the ministry of health, the ministry of finance, civil society, technocrats, donors and health service providers.
 - Ensure that a wide range of reproductive health supplies are included in the national essential drug list. The range should reflect those endorsed by the Interagency List of Essential Medicines for Reproductive Health. The national essential drug list should be reviewed frequently and in a transparent way to ensure that new technologies and products are considered.

5. Simplification and harmonization of forecasting and procurement procedures
 - Increased harmonization among donors and ministries of health in developing countries to coordinate reproductive health supply donations, procurement and distribution.
 - Simplify product registration procedures so that products reach the market faster and more cost-effectively.
6. Create an enabling environment for sexual and reproductive health and rights
 - Make sexuality education mandatory for young people in school and support universal access to sexuality education programmes for young people who are out of school.
 - Ensure universal access to information, education and communication about sexual and reproductive health and rights, including information about contraceptive methods.
 - Develop and reinforce institutional practices and structures (in the delivery of contraception) that reinforce gender equity and that include groups which are often marginalized and under-served.
 - Build capacity for quality of care among all health professionals that deliver supplies, including health care providers, pharmacists and nurses.
 - Increase the participation of civil society (service providers and advocates) in national and sub-national budget processes.
 - Implement strategies to increase male involvement, to reduce sexual violence and coercion, and to eliminate child marriage.



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Contraception at a Crossroads

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“Women are not dying because of diseases we cannot treat... they are dying because societies have yet to make the decision that their lives are worth saving.”

Dr Mahmoud Fathalla, Professor of Obstetrics and Gynaecology, Egypt

Worldwide there are at least 200 million women who want, but do not have access to safe and effective methods of contraception. There are over 19 million unsafe abortions each year as a consequence of unplanned and unwanted pregnancies. The irony is that at a time when the world is more focused on global poverty reduction than ever before, one of the most trusted, most cost effective and proven poverty reduction interventions is being marginalized and neglected.

Contraception at a Crossroads highlights some of the structural and systemic problems that prevent reproductive health supplies, particularly contraception, from reaching those who need them most. By giving priority and resources to reproductive health supplies, and by tackling ineffective processes and systems, we have a chance of reaching current global development goals and improving the lives of millions.

The world stands at a contraceptive crossroads; our choice of direction will be critical to the lives of women, men and young people for generations to come.