Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2008

Acknowledgements

UNFPA is grateful for all of the invaluable contributions to this report, which would not have been possible without the active engagement and support of countless donors and agencies. Nor would the annual report have been possible—or as useful—without the guiding efforts of Jagdish Upadhyay, Chief of UNFPA's Commodity Security Branch. Also within UNFPA, special thanks goes to Kabir Ahmed, Howard Friedman and Daniel Assefa for coordinating with donors and other stakeholders to collect, compile and clean data. The text of the donor support report was written by Christina Vrachnos with the support of the rest of the Commodity Management Branch.

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LIST OF ACRONYMS

AE	**Arab States/Eastern Europe**
AF	**Sub-Saharan Africa**
AP	**Asia and the Pacific**
BMZ/KfW	**Federal German Ministry for Economic Cooperation and Development/Kreditanstalt für Wiederaufbau**
CDC	**United States Centers for Disease Control and Prevention**
CPR	**Contraceptive Prevalence Rate**
CYP	**Couple Year Protection**
DFID	**UK Department for International Development**
GFATM	**Global Fund to Fight AIDS, Tuberculosis and Malaria**
HIV/AIDS	**Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome**
ICPD	**International Conference on Population and Development**
IPPF	**International Planned Parenthood Federation**
IUD	**Intrauterine Device**
LA	**Latin America and the Caribbean**
MDGs	**Millennium Development Goals**
MSI	**Marie Stopes International**
NGO	**Nongovernmental Organization**
OCEAC	**Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale**
PSI	**Population Services International**
RH	**Reproductive Health**
SRH	**Sexual and Reproductive Health**
STI	**Sexually Transmitted Infection**
UNDP	**United Nations Development Programme**
UNFPA	**United Nations Population Fund**
UNGASS	**United Nations General Assembly Special Session**
UNPD	**United Nations Population Division**
USAID	**United States Agency for International Development**
WHO	**World Health Organization**

I. HIGHLIGHTS AND KEY MESSAGES

Since 1990, the United Nations Population Fund (UNFPA) has been tracking donor support for contraceptives and condoms for STI/HIV prevention. The Fund publishes an annual report based on this donor database to enhance the coordination among partners at all levels to continue progress toward universal access to sexual and reproductive health, as set forth in the ICPD Programme of Action and, subsequently, the Millennium Development Goals. This report represents the 2008 installment of the series and has three main sections. The first section summarizes patterns and trends—by method, by donor and by region—in donor support from 2000-2008. The second section takes a closer look at donor support for male and female condoms over time and by region. The third and final section compares aggregate donor support to global contraceptive need for 2000-2008 and provides projections of contraceptive needs through 2015.

Highlights of the 2008 report include:

- Donor support in 2008 was just under US$ 214 million, approximately a **4% decrease** from 2007. Donor support has ranged between US $ 205 million and US $223 since 2003.

- Eighty per cent (80.4%) of donor support in 2008 was allocated to three types of commodities: male condoms (30.7%), oral contraceptives (24.7%) and injectables (24.9%). **There is a significant drop from 2007 to 2008 in the number of male condoms supplied.** This could be due to the fact that the report does not capture GFATM support and other government resources, which are directly going through the basket funding mechanisms.

- Sub-Saharan Africa received 62% of total support in 2008. Asia and the Pacific region received 25%. Latin America and the Caribbean and Arab States/Eastern Europe received 9% and 4%, respectively.

- Latin America and the Caribbean was the only region which saw an increase (US$ 16 million in 2007 to US$ 19 million in 2008). While support for Sub-Saharan Africa was down less than 1% as compared to 2007, Asia and the Pacific region and Arab States/Eastern Europe region both experienced major declines in donor support (12% and 25% declines respectively as compared to 2007).

- Donor contributions would nearly need to double in order for the current unmet need to be met in 2015.

II. BACKGROUND

The Reproductive Health Context

Held in Cairo in 1994, the International Conference on Population and Development (ICPD) marked a major milestone in the international community's struggle to improve sexual and reproductive health (SRH) for all. The 179 signatories to the ICPD's Programme of Action agreed to a broad spectrum of interrelated, mutually reinforcing development objectives, including access to comprehensive reproductive health (RH) services as a human right. The Programme of Action also called for significant reductions in maternal mortality by 2000 and 2015.

Five years later, at ICPD+5, the UN General Assembly agreed to an expanded set of benchmarks that included, among others, reducing unmet need for contraceptives and family planning services through 2050 and, by 2015, a target coverage rate for skilled birth attendance of 90%. The ICPD goals are essential to achieving the reductions in poverty, hunger, disease and gender inequality set forth in the Millennium Development Goals (MDGs), which were established in the Millennium Declaration in 2000 and reaffirmed by the UN General Assembly in 2005. In fact, some of the key ICPD goals—75% reduction in maternal mortality and universal access to RH services by 2015—are explicit targets in the MDGs themselves.

Unfortunately, while the year 2009 marked the 15th anniversary of ICPD, progress toward the these goals and the MDGs has been uneven, and in some parts of the world, too slow. The global inequities are starkest for maternal mortality. Each year, more than 500,000 women die from treatable or preventable complications of pregnancy and childbirth.[1] The vast majority of these deaths occur in sub-Saharan Africa and southern Asia.[2] In sub-Saharan Africa, a woman's risk of dying from such complications over the course of her lifetime is 1 in 22 compared to 1 in 7,300 in the developed world.[3] The inequities among regions are compounded by little progress within regions over time. Sub-Saharan Africa has witnessed a reduction of only 20 maternal deaths per 100,000 live births between 1990 and 2005. While progress in Asia and Latin America has been more rapid, these regions, on average, are not on track to achieve maternal mortality targets either. Globally, the maternal mortality ratio has dropped on average 1% per year between 1990 and 2005—a rate far below the estimated 5.5% average annual reduction required to reach ICPD goals and the MDGs.[4]

The Role of Reproductive Health Commodities

Effective strategies to achieve global RH goals will require integrated, country-driven approaches that include: (1) expanded reach and quality of affordable reproductive health services in the context of overall health systems strengthening; (2) improved capacity to plan, implement and monitor and evaluate at country level; (3) increased government and international financial and technical resources; (4) enhanced coordination within the donor community; and (5) advocacy and changes in attitudes that prevent women and girls from exercising their RH choices.

[1] *The Millennium Development Goals Report 2008 [MDG Report 2008].*
[2] WHO, UNICEF, UNFPA, World Bank 2005. *Maternal Mortality in 2005*.
[3] *The Millennium Development Goals Report 2008 [MDG Report 2008].*
[4] WHO, UNICEF, UNFPA, World Bank 2005. *Maternal Mortality in 2005*.

One of the critical components underpinning any strategy is the availability of affordable, quality RH commodities to all individuals who need them. Availability and access to RH commodities are not only basic human rights, as established in the ICPD and MDG frameworks, but are also critical to improving related health outcomes, such as maternal health and HIV prevention. Some estimates indicate that, by preventing pregnancies and unsafe abortions, reliable access to quality family planning commodities alone can reduce maternal deaths by one-third, which equates to saving 100,000-175,000 women's lives each year.[5] RH commodities play integral roles not only before pregnancy but also during pregnancy and childbirth. Most antenatal services, delivery and post-partum care and emergency obstetric care could not be delivered effectively and safely without appropriate RH commodities in the right place and at the right time.

In addition to improving maternal and newborn health, sustainable availability and access to RH commodities has other beneficial impacts, particularly for HIV prevention. An estimated 33 million people are living with HIV worldwide, about half of whom are female.[6] Similar to many developing regions worldwide, the AIDS epidemic is quickly feminizing in sub-Saharan Africa, where girls and young women face twice the risk of HIV infection as young men. With approximately 650 million people, this particular region experiences far lower life expectancies and higher age-adjusted mortality rates than the rest of the world. RH commodities, including HIV test kits and diagnostics, are critical for successful HIV prevention strategies and programmes. Male and female condoms, which can reduce risk of STIs, including HIV, are another case in point. Experience has shown that access to simple messages and training on RH and HIV/AIDS prevention, together with availability of RH commodities, including male and female condoms, can have a significant impact on women's health as well as the livelihoods of households in general. Because HIV/AIDS is implicated in a significant percentage of maternal deaths each year in sub-Saharan Africa, condoms have an even greater impact in preventing maternal death—directly by preventing unintended pregnancies and indirectly by preventing the spread of a major killer during pregnancy.

Global Donor Support Database

While the international development community works closely with governments to build national capacity for commodity planning, procurement, financing, distribution and monitoring and evaluation, many developing countries have lacked sufficient domestic financial resources to operate commodity programmes entirely on their own. Many of the least developed countries will continue to rely on continued financial support from the international community, at least over the near-term. As a leader in the area of SRH, UNFPA tracks this international financial support through a global donor support database. The largest database of its kind, the global donor support database has tracked over 21,000 procurement records of contraceptives, condoms for HIV prevention and other types of related RH commodities by major bilateral, multilateral and NGOs since 1990. The database records the financing organization, the recipient country, and commodity type, quantity and expenditure. UNFPA actively solicits relevant data from major donors on an annual basis; the database itself is updated continuously based on latest information. UNFPA publishes an annual Donor Support Report that summarizes and analyzes the data for the benefit of donors, national governments and other partners. UNFPA hopes that, among its many potential benefits, this annual report can help enhance coordination among donors, improve partnerships between donors and

[5] (a) Singh, S. et al. 2004. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. Washington D.C. and New York: The Alan Guttmacher Institute and UNFPA; (b) *MDG Report 2007*
[6] UNAIDS/WHO 2007. *2007 AIDS Epidemic Update*. Published December 2007. http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

national governments, and mobilize the resources needed to ensure sufficient progress toward universal access to SRH. (N.B. This database does not capture private sector, country procurements or procurements financed by the Global Fund or World Bank.)

III. INTRODUCTION

This report represents the 2008 installment of the Donor Support Report series. In addition to including the latest year (i.e., 2008) for which data are available, the report also updates data from previous years where new information is available. Consequently, data prior to 2008 may differ from that which appears in previous years' reports.

The report has three main sections. The first examines patterns and trends in donor support from 2000-2008. Trends are analyzed in terms of expenditures, quantities and, in some cases, approximated couple-year protection. These trends are then analyzed by several major variables—or combination of variables—such as distributions by commodity type, individual donor governments/agencies, and regions. The second section takes a closer look at donor support for male and female condoms over time and by region. The third and final section compares aggregate donor support to global contraceptive need for 2000-2008 and provides projections of contraceptive needs through 2015.

A few caveats should be noted:

- First, this report tracks donor support, not the entire universe of global commodity procurement. Most commodities procured directly by countries, for example, are not included. This is particularly the case for large, middle-income countries, such as Brazil and China. The database currently does not include data from the Global Fund. The reported procurement by Global Fund's recipients for male and female condoms in 2007 was approximately $7.6 million. World Bank contraceptive financing, which amounted to US$ 728,000 in 2008, is not included since these are loans provided for contraceptive procurement.

- Second, while UNFPA makes every effort to obtain comprehensive, reliable and current data, some error in reporting and maintaining such a large database inevitably occur. An infrequent error in male condom reporting is the ambiguity or misclassification of procurement quantities. UNFPA reviews records to ensure accuracy, making modifications where possible when errors are evident. Such errors and adjustments occur infrequently in the database and should not have a large influence on the outcomes of this report's analyses.

- Third, the data in this report pertain to the supply of commodities not ultimate utilization. A variety of factors can affect rates of commodity utilization by end users.

- Finally, it should be remembered that certain commodities covered by this report are utilized for purposes in addition to or other than contraception. Male and female condoms, for example, are mostly procured and utilized for HIV prevention. This report does not distinguish between the dual purposes of condom use.

IV. PATTERNS AND TRENDS IN DONOR SUPPORT

This section examines trends in donor support for RH commodities from 2000-2008. It has three subsections. The first summarizes overall procurement trends by commodity type in terms of expenditures, quantities and approximated couple-year protection. The second examines these same data by donor; the third, by region.

Overall Patterns and Trends By Commodity Type

Table 1 summarizes expenditure trends for major commodity types from 2000-2008. Figure 1 represents these data pictorially. Since 2001, male condoms have constituted the single largest donor expense as tracked in the donor support database. While donor expenditures have remained roughly constant since 2001, in 2008, this figure dropped by about 4%. The bulk of the remainder is split fairly evenly among oral contraceptives and injectables. Female condoms and implants saw large increases in donor support while support for condoms dropped significantly.

Table 1. Trend in Donor Expenditure by major Comodity Method, 2000-8

	Expenditure, in US$ Millions (%)				
Method	Average 2000 - 2004	2005	2006	2007	2008
Male Condoms	70.3	75.7	68.9	83.5	65.7
Oral Contraceptives	57.0	55.9	58.2	52.3	52.8
Injectables	51.4	58.9	58.4	53.3	53.2
Implants	4.2	5.5	7.2	16.2	23.3
Female Condoms	2.7	5.3	9.0	12.8	14.3
IUDs	5.6	4.3	4.0	2.5	1.7
Other*	2.3	1.8	2.8	2.6	2.7
Total	**193.5**	**207.5**	**208.6**	**223.2**	**213.7**

*Includes emergency contraceptives, vaginal tablets, foams/jellies, and sampling/testing of condoms

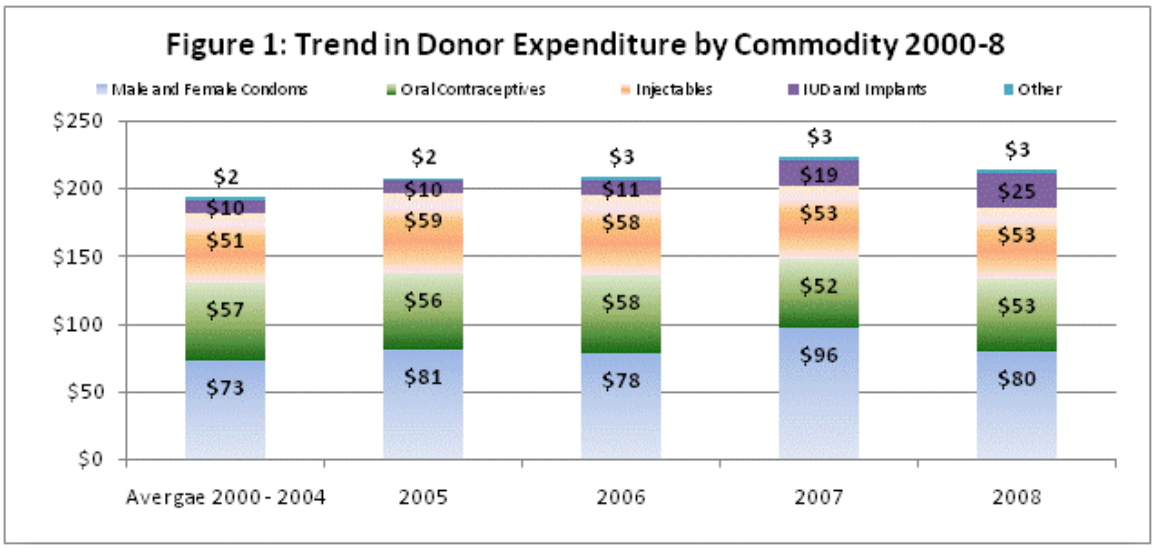


Figure 2 reflects trends in the quantities of major commodities procured by donors from 2000-2008. Quantities of donor-procured commodities have remained roughly constant

until 2007, with the notable exception of male condoms which decreased from 2007. (See Section 5 for an analysis that disaggregates male and female condoms for more). Quantities of oral contraceptives, on the other hand, which had fallen by nearly 50% since 2000, increased in both 2007 and 2008.

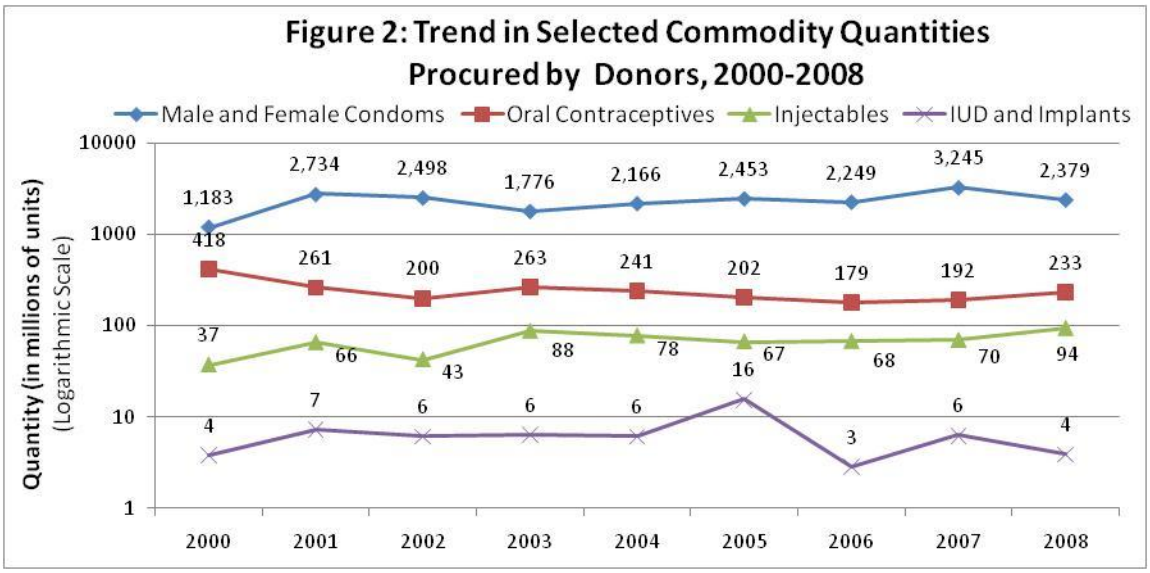


Table 2 and Figure 3 estimate the number of couple years of protection (CYP) afforded by donor-financed commodities. CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives distributed during that period. The calculated CYP converts quantities into the number of years of protection that are offered. As a result, trends over time for individual commodity types should generally mirror those in Figure 2. The utility of the CYP calculation lies in enabling comparisons among units of different commodities. The estimates for condoms should be considered an upper bound, as most condoms are provided for HIV prevention. In 2007, male condoms provided the largest share, with the remainder distributed fairly evenly among oral contraceptives, IUDs and injectables. This number, as well as that for IUDs, drops significantly in 2008, offset by an increase in oral contraceptives and injectables.

Patterns and Trends by Donor

Table 3 and Figures 4-6 illustrate trends in commodity expenditures among major donors from 2000-2008. Even after the decrease in expenditure noted in 2008, consistently the largest two donors over the period, USAID and UNFPA together account for over two-thirds of overall donor support for contraceptives and condoms for STI/HIV

Table 2. Trend in Donor-Financed Couple Year Protection (CYP) By Major Commodity Methods, 2000-2008

	CYP, in thousands				
Method	**Average 2000 - 2004**	**2005**	**2006**	**2007**	**2008**
Male Condoms	17,226	20,381	18,628	26,904	19,671
Oral Contraceptives	18,438	13,489	11,911	12,813	15,560
Injectables	15,554	16,772	16,922	17,353	23,613
Implants	635	651	860	2,586	3,166
Female Condoms	36	58	112	137	152
IUDs	17,342	46,282	7,714	16,397	8,532
Foam/Jellies	148	238	-	68	
Diaphragms	73	1	1	-	
Vaginal Tablets	32	8	2	0	1
Total	**69,484**	**97,880**	**56,148**	**76,258**	**70,694**

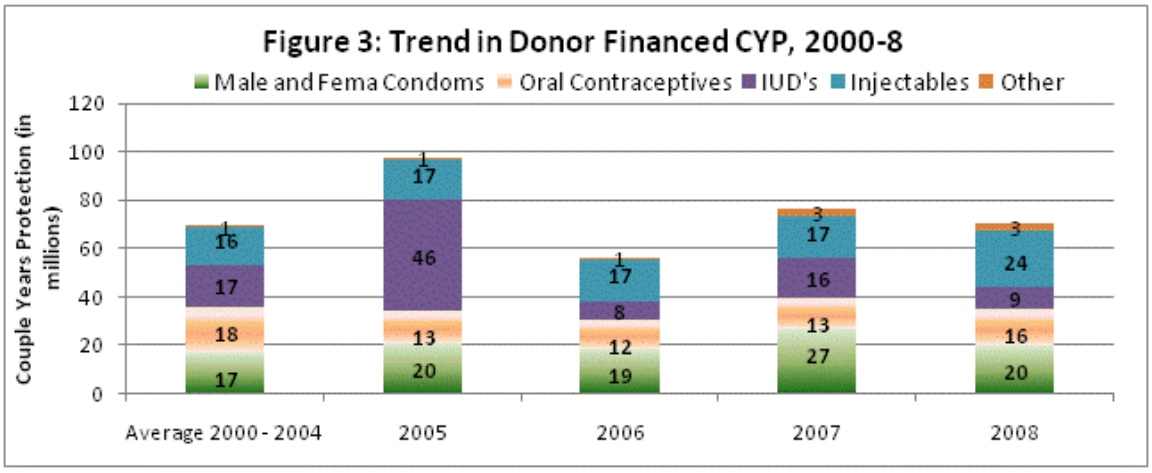
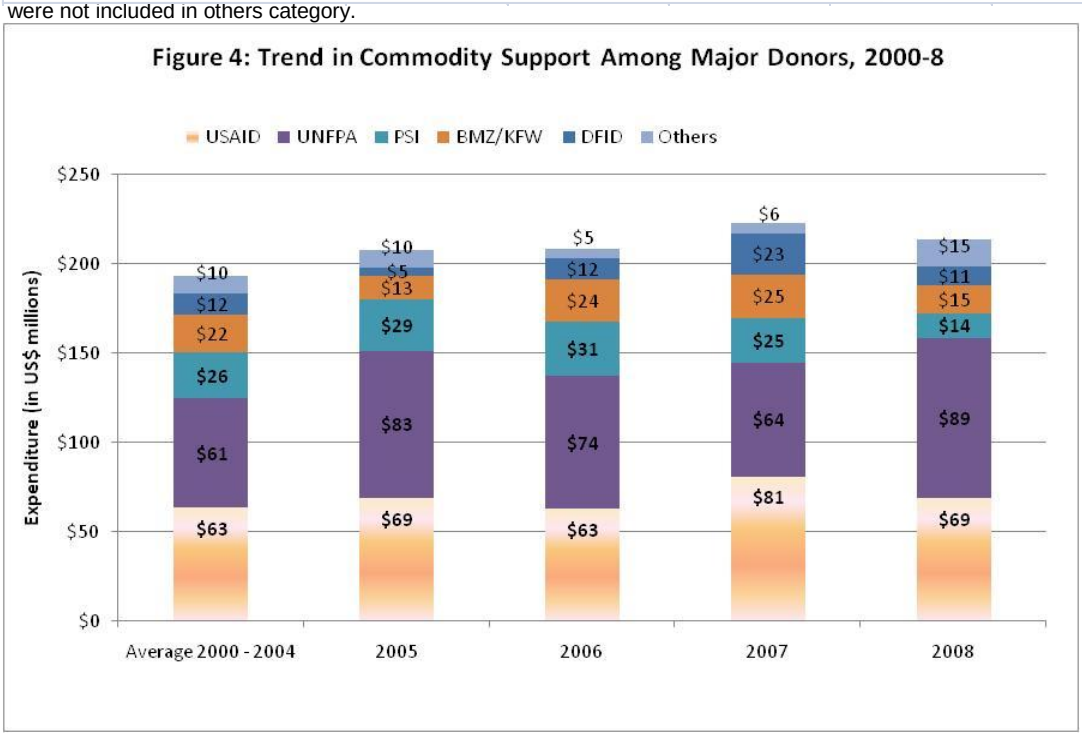


Table 3. Trend in Commodity Support Among Major Donors, 2000-2008

	Expenditure, in US$ Millions				
Method	Average 2000 - 2004	2005	2006	2007	2008
USAID	$ 63.4	$ 68.8	$ 62.8	$ 80.9	$ 68.9
UNFPA	$ 61.3	$ 82.6	$ 74.4	$ 63.9	$ 89.3
PSI	$ 25.6	$ 28.8	$ 30.6	$ 25.0	$ 14.1
BMZ/KFW	$ 21.5	$ 13.1	$ 23.6	$ 24.6	$ 15.5
DFID	$ 11.8	$ 4.6	$ 12.1	$ 22.5	$ 11.1
Others*	$ 9.9	$ 9.6	$ 5.1	$ 6.3	$ 14.9
Total	**$ 193.5**	**$ 207.5**	**$ 208.6**	**$ 223.2**	**$ 213.7**

*Includes IPPF, MSI, Japan,, GFATM, OCEAC, UNDP, among others. For 2008 figures, GFATM, OCEAC and UNDP were not included in others category.



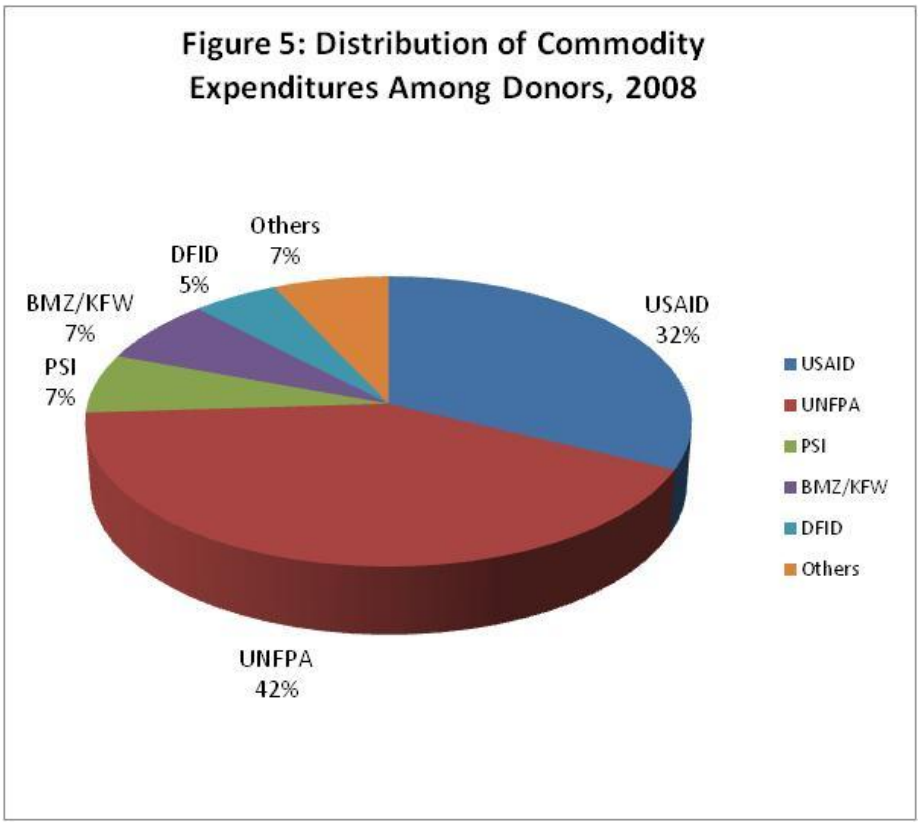


Figure 5: Distribution of Commodity Expenditures Among Donors, 2008
Others 7%
DFID 5%
BMZ/KFW 7%
PSI 7%
USAID 32%
UNFPA 42%
USAID
UNFPA
PSI
BMZ/KFW
DFID
Others

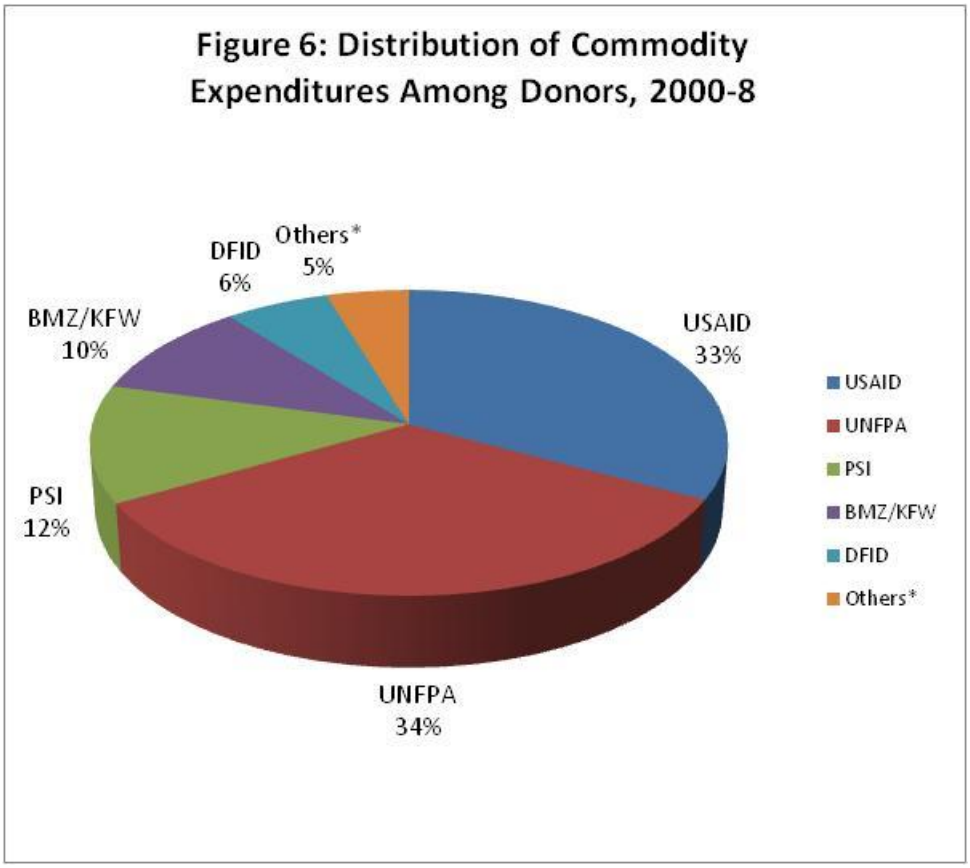
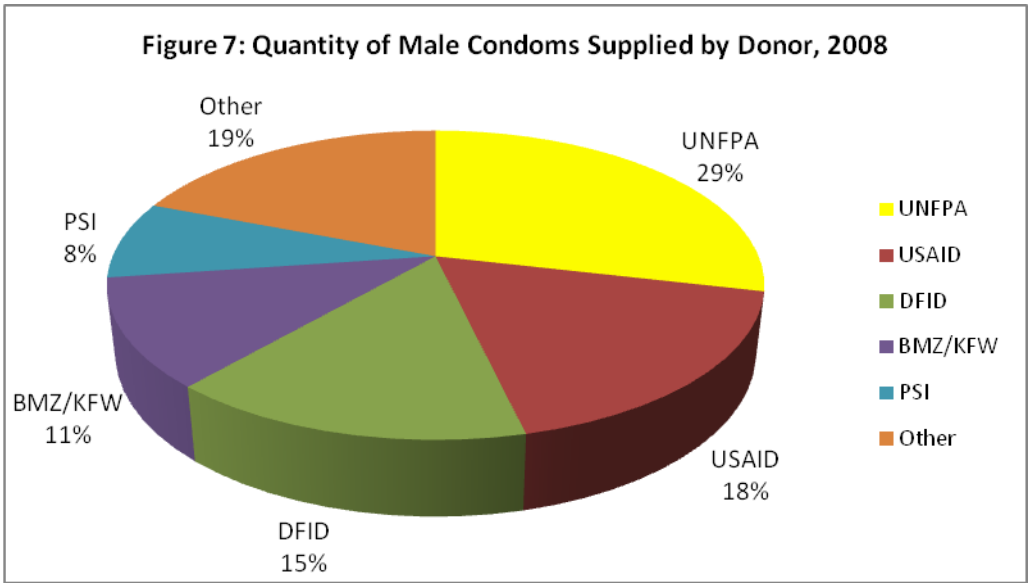
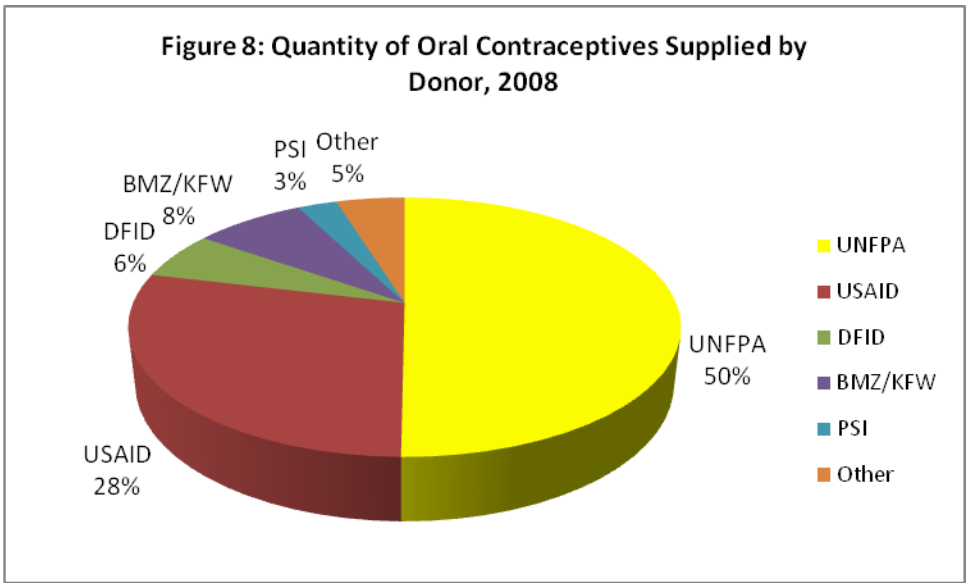


Figure 6: Distribution of Commodity Expenditures Among Donors, 2000-8
DFID 6%
Others* 5%
BMZ/KFW 10%
USAID 33%
PSI 12%
UNFPA 34%
USAID
UNFPA
PSI
BMZ/KFW
DFID
Others*

Figures 7-12 illustrate the quantities of contraceptives, including condoms, provided by donors for 2008. USAID was the largest supplier of female condoms (46%). UNFPA was the single largest procurer of injectables (80%) implants (65%) IUDs (63%) and oral contraceptives (50%). It should be noted that the quantity estimate for injectibles is largely definied by the number of syringes provided, rather than being limited to the ampule volume.





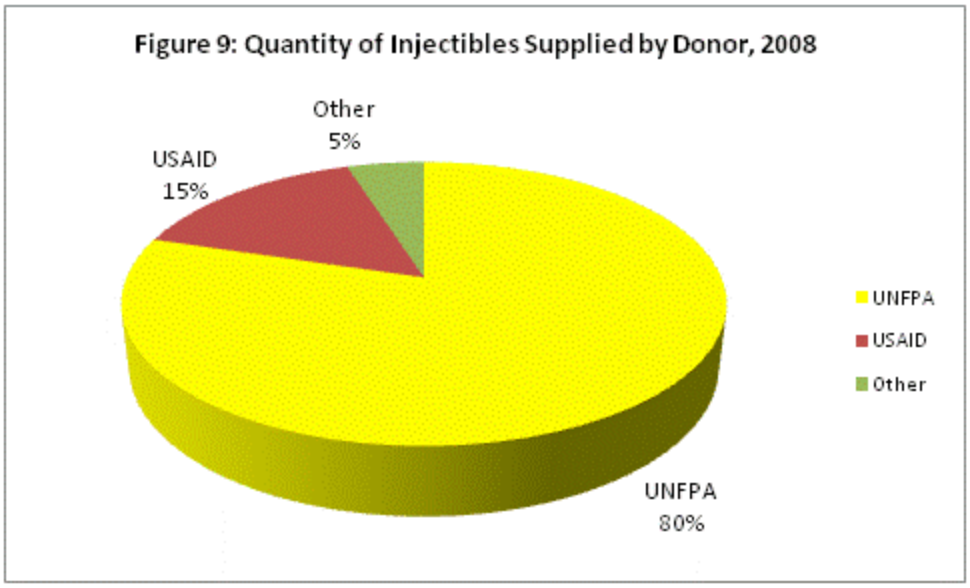


Figure 9: Quantity of Injectibles Supplied by Donor, 2008
Other
5%
USAID
15%
UNFPA
80%
UNFPA
USAID
Other

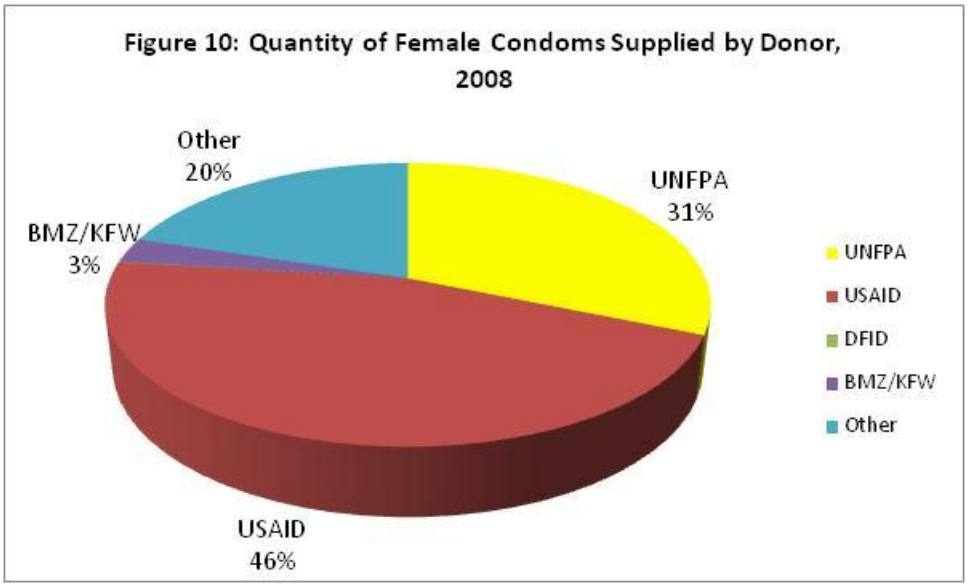
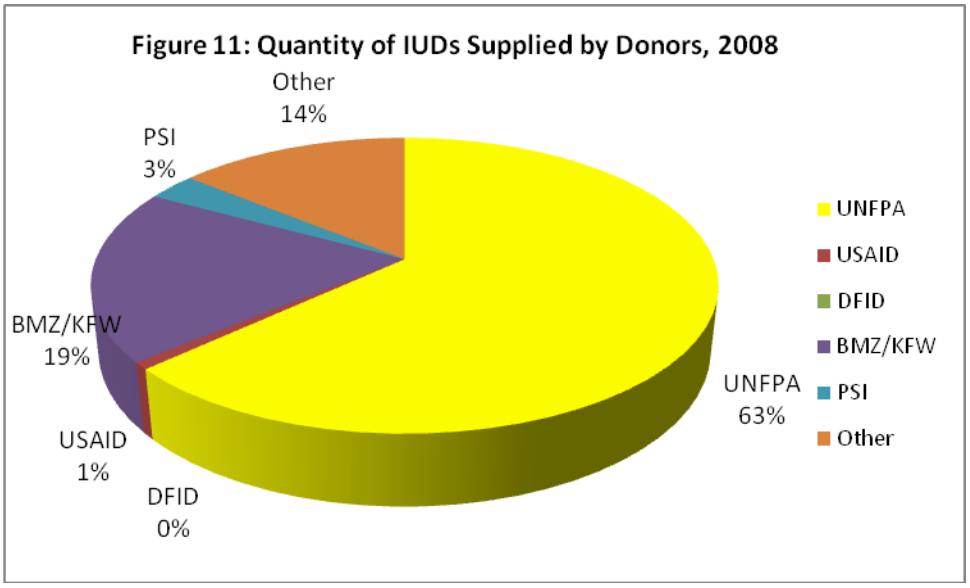


Figure 10: Quantity of Female Condoms Supplied by Donor, 2008
Other
20%
UNFPA
31%
BMZ/KFW
3%
USAID
46%
UNFPA
USAID
DFID
BMZ/KFW
Other



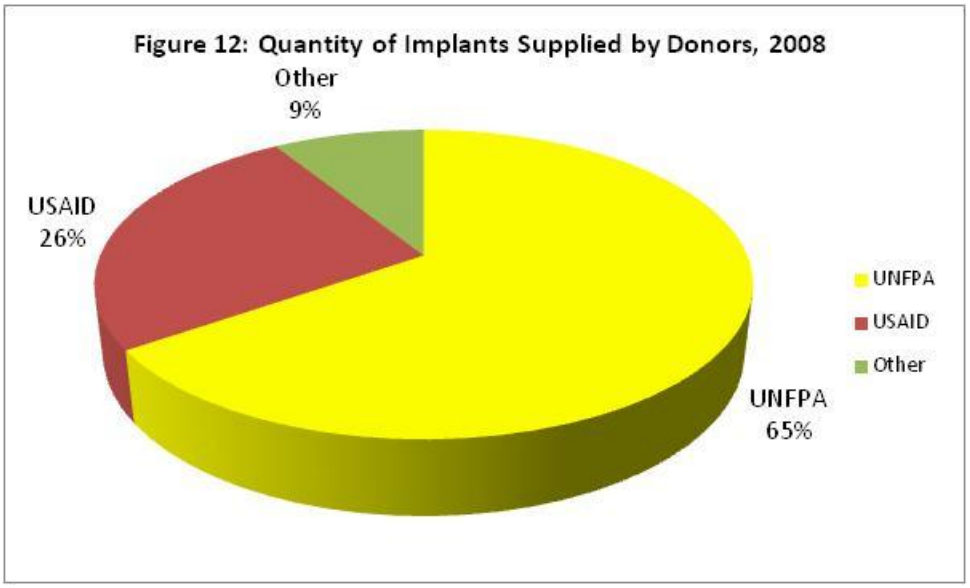


Figure 13 depicts the distribution of donor support for three major commodities in terms of expenditures in 2008. USAID is the clear leader in terms of donor support for the male and female condom, and UNFPA, the clear leader for injectables. USAID and UNFPA are also the top supporters for oral contraceptives.

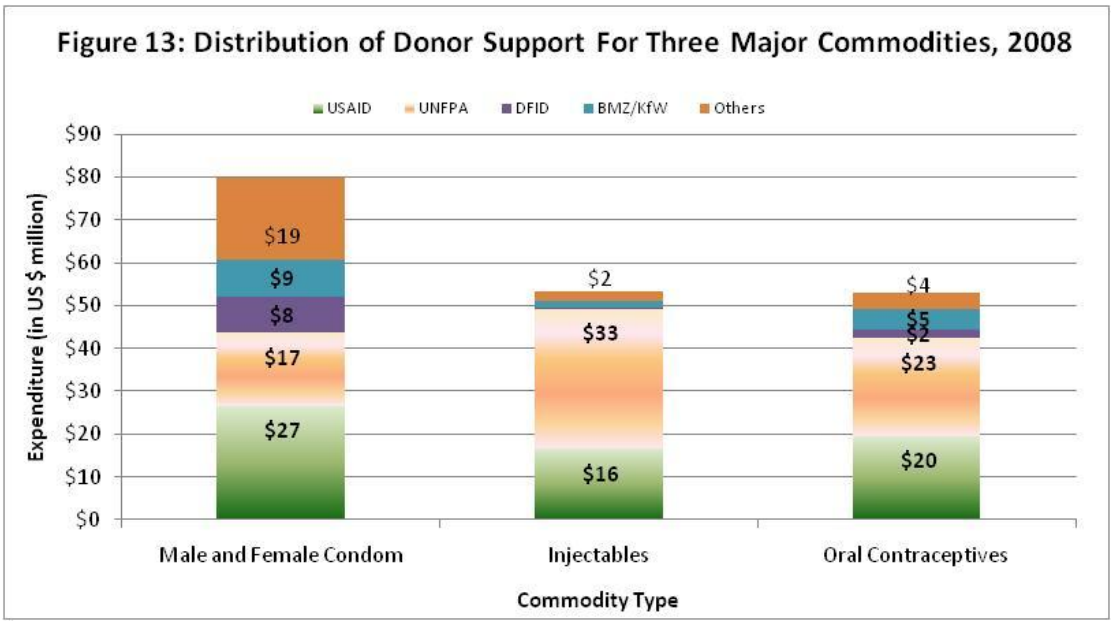
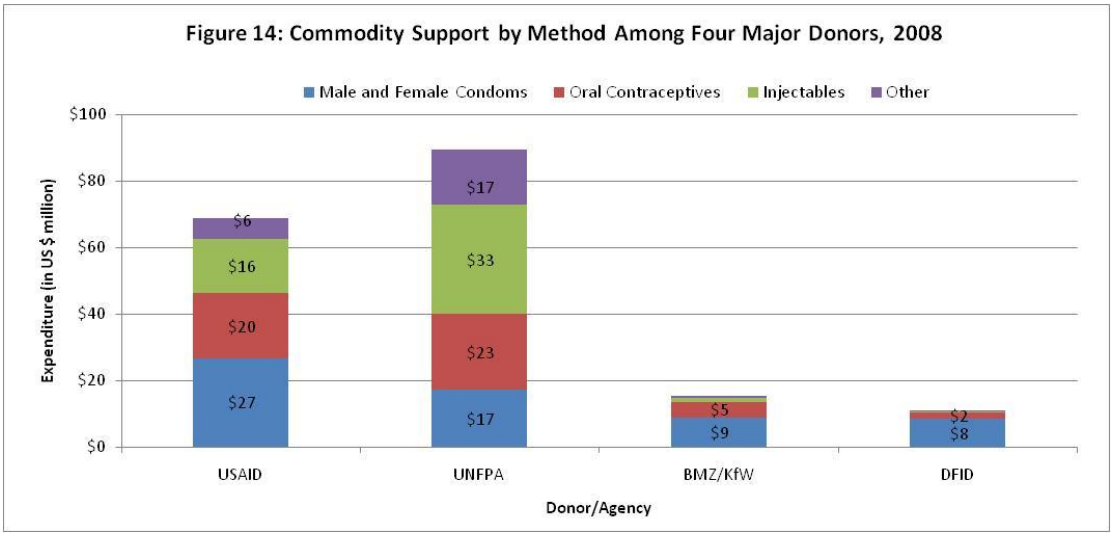


Figure 14 illustrates the expenditure patterns of four major donors in 2008. The majority of USAID, BMZ/KfW and DFID funds were allocated to male and female condoms, while UNFPA's single largest expenditure was on injectables (US$ 33 million), which was also the largest absolute expenditure on injectables among the four donors depicted.



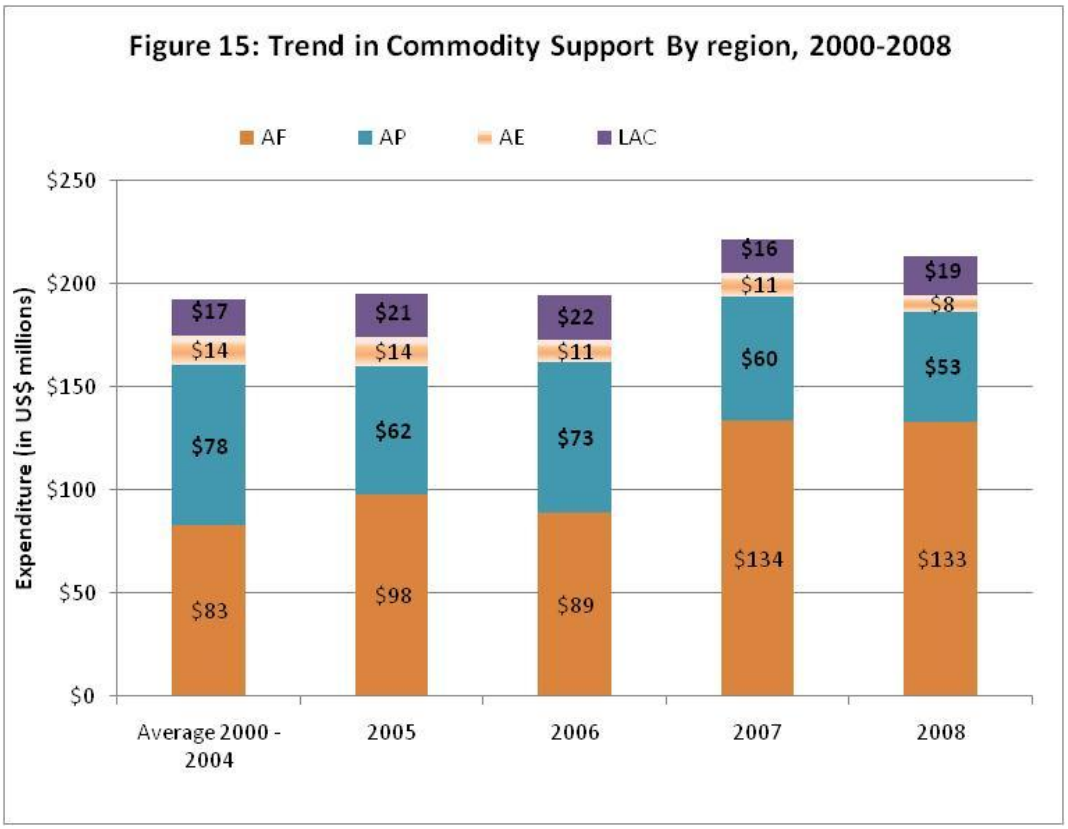
Patterns and Trends by Region

Table 4 and Figures 15-17 (next page) illustrate trends in commodity expenditures by region for 2000-2008. The four regions tracked are sub-Saharan Africa (AF), Asia and the Pacific (AP), Latin America and the Caribbean (LA) and Arab States/Eastern Europe (AE). Sub-Saharan Africa is the largest single recipient of donor support for all years except 2000. The most striking trend remains the near tripling of donor support to this region since 2000. In absolute terms and as a percentage of total donor support, the largest decreases in expenditures were seen in Asia and the Pacific (AP) and Arab States/Eastern Europe (AE). Such a decrease could also be related to countries within

these regions using their own funds to procure or perhaps, contributions from a dynamic private sector.

Table 4. Trend in Commodity Support Among Recipient Regions, 2000-2008

	Expenditure, in US$ Millions				
Region	Average 2000 - 2004	2005	2006	2007	2008
AE	$ 14	$ 14	$ 11	$ 11	$ 8
AF	$ 83	$ 98	$ 89	$ 134	$ 133
AP	$ 78	$ 62	$ 73	$ 60	$ 53
LAC	$ 17	$ 21	$ 22	$ 16	$ 19
Other/Unknown	$ 1	$ 12	$ 14	$ 2	$ 0
Total	**$ 193**	**$ 208**	**$ 209**	**$ 223**	**$ 214**



The distribution of support amongst regions shows clearly that the majority of donor support for condoms was directed towards Africa and Asia (Figure 16). To account for differences in population sizes among the regions, Table 5 summarizes the per capita regional distribution of commodity support. Large, middle-income countries, many of which have largely graduated from external support, are excluded as indicated. According to this analysis, sub-Saharan Africa received the highest donor support in per capita terms in 2008 (US$ 0.18 per capita). Arab State/Eastern Europe received the least (US$ 0.01 per capita).

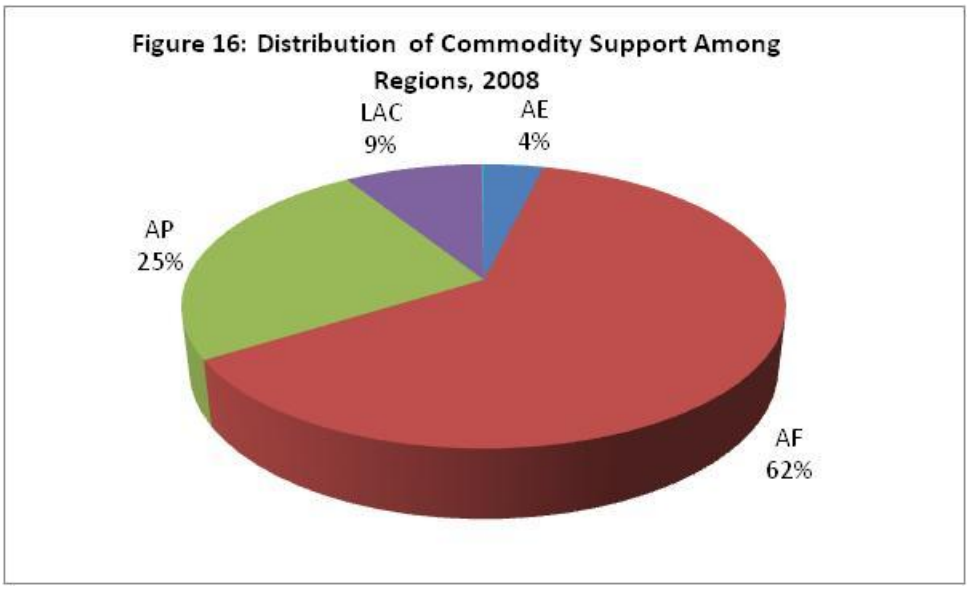


Table 5. Per Capita Donor Support By Region, 2008

Region	Population	As % of Regional Sum in Previous Column	Donor Support	As % of Total Support in Previous Column	Support Per Capita
AE (excl. Russian Federation)	615,744,369	16%	$ 8,214,680	4%	$ 0.01
AF (excl. NA and S. Africa)	760,292,667	19%	$ 133,109,503	62%	$ 0.18
AP (excl. China)	2,805,360,758	57%	$ 53,243,126	25%	$ 0.02
LAC (excl. Brazil)	395,574,392	8%	$ 18,877,820	9%	$ 0.05
Other/Un-indentified			$ 283,037	0.1%	

Population from 2006 World Prospects medium variant projection

Table 6. Top 10 Recipient Countries By Total Expenditure

	2005	2006	2007	2008	2008 total (US $ Million)	% 2008 Total
1	Ethiopia	Bangledesh	Zimbabwe	Ethiopia	$ 27.5	12.9%
2	Nigeria	Pakistan	Ethiopia	Bangladesh	$ 19.7	9.2%
3	Bangledesh	Zimbabwe	Bangledesh	Zimbabwe	$ 16.4	7.7%
4	Pakistan	Vietnam	Nigeria	Pakistan	$ 13.5	6.3%
5	Vietnam	Ethiopia	Pakistan	Tanzania	$ 7.5	3.5%
6	Kenya	Madagascar	Kenya	Nigeria	$ 7.4	3.5%
7	Uganda	Tanzania	India	Kenya	$ 6.8	3.2%
8	Tanzania	India	Uganda	Madagascar	$ 6.5	3.0%
9	Egypt	Ghana	Ghana	Uganda	$ 6.1	2.9%
10	Nepal	Uganda	Tanzania	Mozambique	$ 6.0	2.8%

Table 7. Top 10 Recipient Countries By Per Capita Expenditure

	2005	2006	2007	2008	2008, Per Capita
1	Nicaragua	Zimbabwe	Zimbabwe	Moldova	$ 1.36
2	Fiji	Swaziland	Bhutun	Zimbabwe	$ 1.21
3	Republic of Congo	Republic of Congo	Lesotho	Tanzania	$ 1.09
4	Guinea	Lesotho	Swaziland	Cote d'Ivoire	$ 0.59
5	Zimbabwe	Madagascar	Fiji	Rwanda	$ 0.56
6	Central African Republic	Haiti	Haiti	Fiji	$ 0.50
7	Cape Verde	Fiji	Zambia	Liberia	$ 0.41
8	Bhutun	Suriname	Cambodia	Sao Tome and	$ 0.33
9	Ethiopia	Cape Verde	Botswana	Mali	$ 0.32
10	Mongolia	Lao PDR	Sao Tome & Pr	Ethiopia	$ 0.32

Figures 17-22 illustrate the quantities of major contraceptives, including condoms that donors provided to regions in 2008. These data show a strong association between commodity type and region. Sub-Saharan Africa, for example, is by far the largest recipient of donor-procured quantities of female and male condoms, implants and injectables. The Asia and Pacific region was the largest recipient of units of oral contraceptives and IUDs. Percentage of units of IUDs fell dramatically in Arab States/Eastern Europe (75% in 2007 to 24% in 2008). Though this drop does not reflect consumer demand, it is a major risk as it is a long-term method that is effective and has been the preferred method in the region.

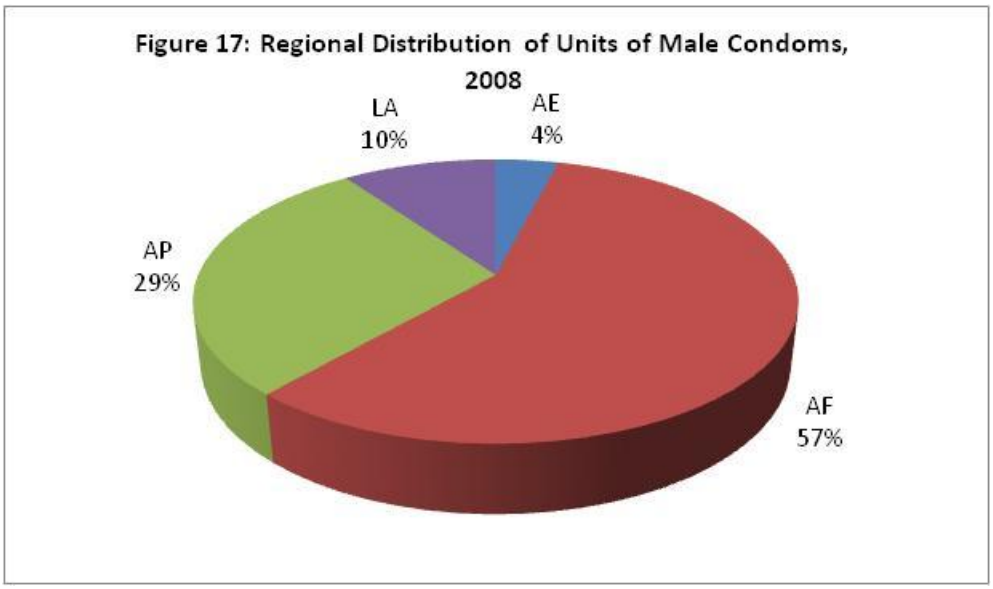


Figure 18: Regional Distribution of Units of Female Condoms, 2008

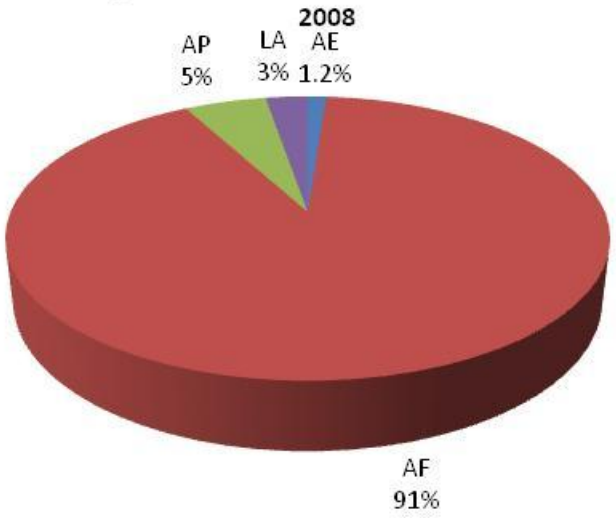


Figure 19: Regional Distribution of Units of Oral Contraceptives, 2008

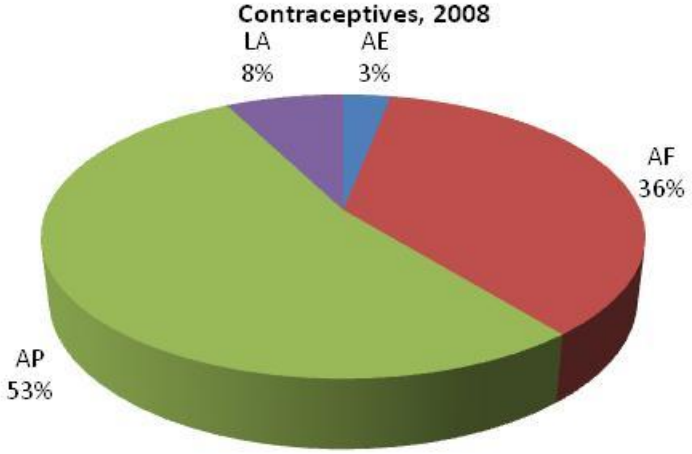


Figure 20: Regional Distribution of Units of IUDs, 2008

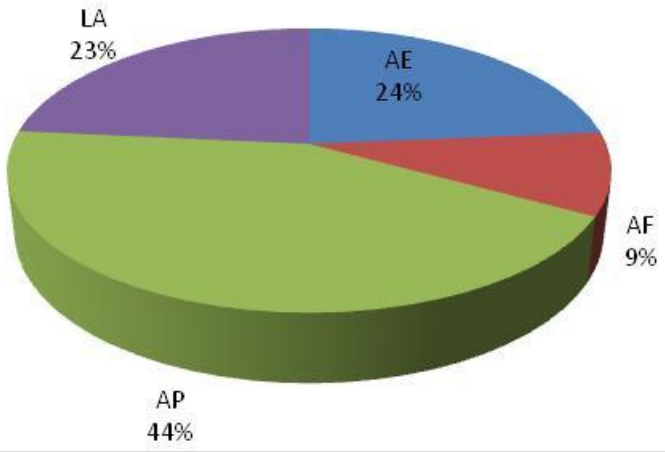


Figure 21: Regional Distribution of Units of Injectables, 2008

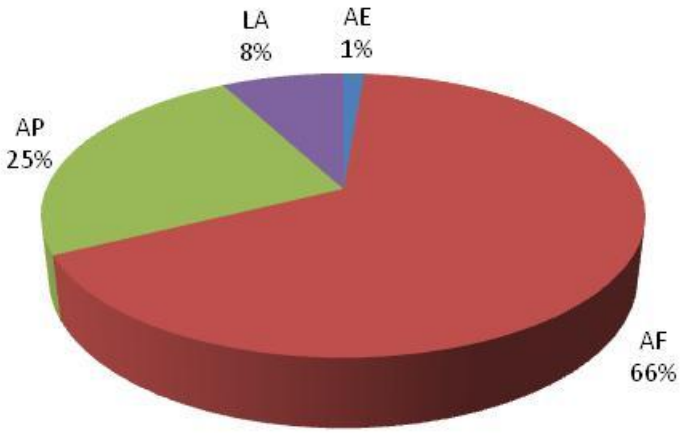


Figure 22: Regional Distribution of Units of Implants, 2008

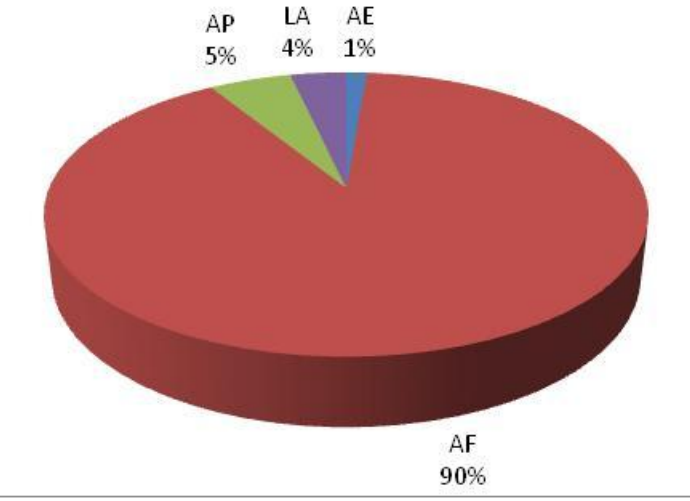


Figure 23 depicts the regional distribution of commodity expenditure by commodity type in 2008. Regions with less than US$ 1 million in expenditure by commodity type were excluded from the graph for ease of visual representation. Regional patterns in terms of expenditure mirror the patterns in terms of quantities procured.

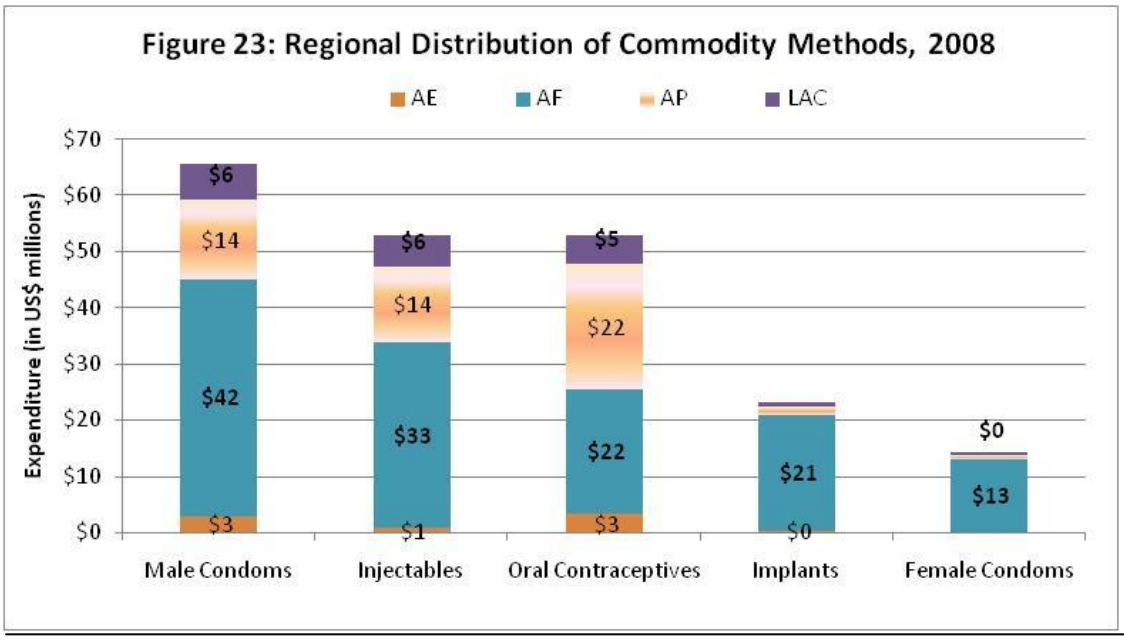
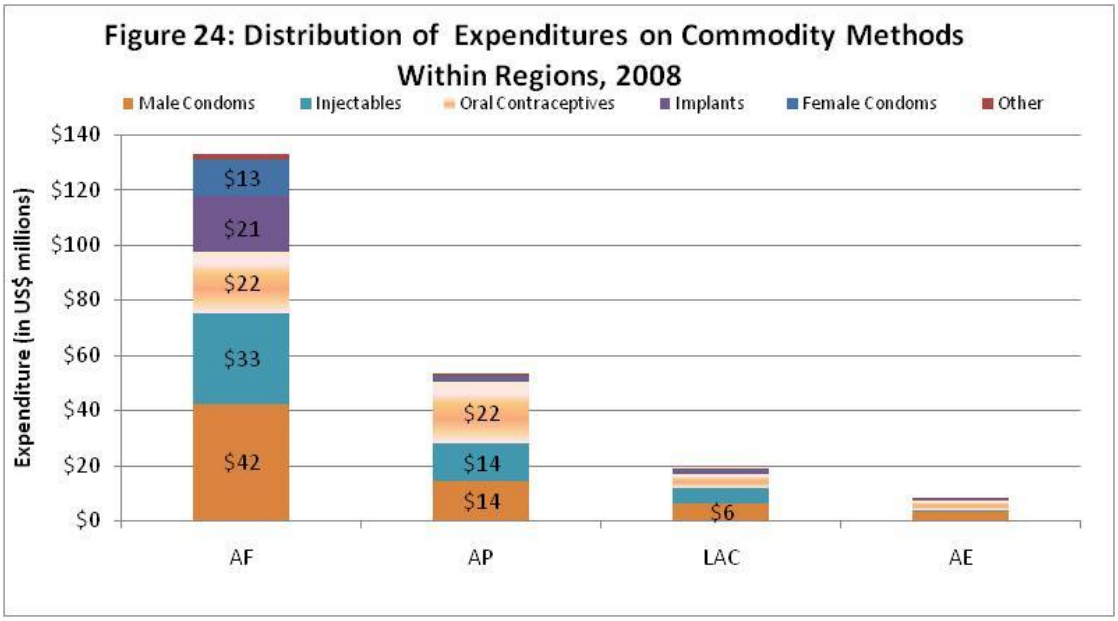


Figure 24 illustrates the expenditure patterns in the four regions in 2008. Sub-Saharan Africa received over twice the amount of support for male condoms (US$ 42 million) and about 1/3 of the total for injectables (US$ 33 million) than the other three regions. Sub-Saharan Africa also received nearly all of the donor support for implants (US$ 21 million) and female condoms (US$ 13 million). Male condoms represented the largest donor-financed commodity expenditure in sub-Saharan Africa. In Asia and the Pacific, oral contraceptives constituted the largest expenditure, followed by male condoms and injectables. Largest donor expenditures in LA were split between male condoms and injectables.



V. DONOR SUPPORT FOR MALE AND FEMALE CONDOMS

Male and female condoms, when used consistently and correctly, are highly effective at preventing STIs, including HIV. Indeed, male and female condoms are central to efforts to halt the spread of HIV as recognized at the ICPD in 1994 as well as by the UNGASS Political Declaration on HIV/AIDS, adopted unanimously by United Nations Member States on 2 June 2006. Male and female condoms are also the only methods that provide couples simultaneous protection against unintended pregnancies and STIs/HIV.

In particular, the female condom is currently the only technology that gives women and adolescent girls greater control over protecting themselves from HIV, other STIs and unintended pregnancy. The product, however, has not yet achieved its full potential due to inadequate promotional activities, insufficient supply and comparatively higher cost than male condoms (US$ 0.80 for a polyurethane female condom versus US$ 0.03 for a male latex condom). The Female Health Company recently developed a new version of the female condom FC2, which is nearly identical to its predecessor but is made of synthetic nitrile and considerably less expensive to manufacture. After technical consultation with WHO in January 2006 to review the new female condoms dossier, experts concluded that FC2 was compatible with the FC1 and recommended that UNFPA consider procuring it for public sector programmes.

Condom Requirements

According to a *2009 Reproductive Health Supplies Coalition* report, where condom requirements are estimated separately (those used primarily for family planning and those used primarily for prevention of HIV and other sexually transmitted infections), total need for family planning condoms in low- and middle-income countries is estimated at almost 5 billion in 2015. The total (for both purposes) would be nearly 18 billion in 2015. Yet as large countries such as Brazil, China, India, and South Africa do not depend on donors for their condom supply, donor provided condom requirements would be nearly 4.4 billion in 2015 -- 2.4 billion for HIV prevention and 2.0 billion for family planning[7].

Patterns and Trends in Donor Support for Condoms versus Other Contraceptives

Figure 25 shows trends in the distribution of donor support for condoms relative to other types of contraceptives. Some data may differ slightly from previous year's reports due to updating of database records. It is important to note that most condoms are provided and utilized for STI/HIV prevention rather than contraception.

[7] Reproductive Health Supplies Coaltion, *Contraceptive Projections and the Donor Gap: Meeting the Challenge* 2009.

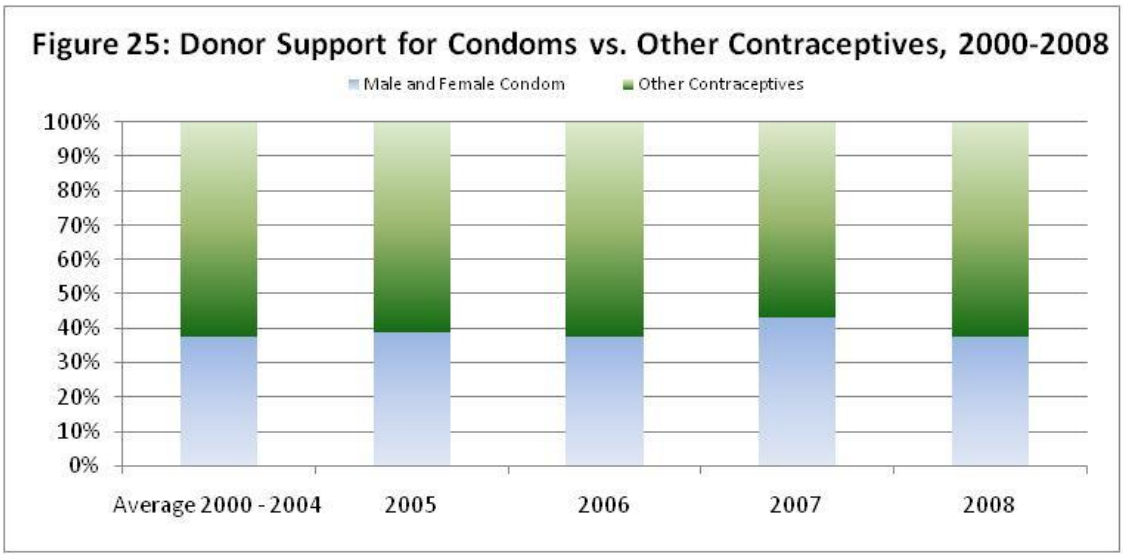


Figure 26 depicts trends in donor expenditures on male condoms by region over the period 2000-2008. Total donor expenditure on male condoms appears relatively constant over the last few years. Sub-Saharan Africa received its highest levels of donor support (US$ 54 million) for male condoms in 2007.

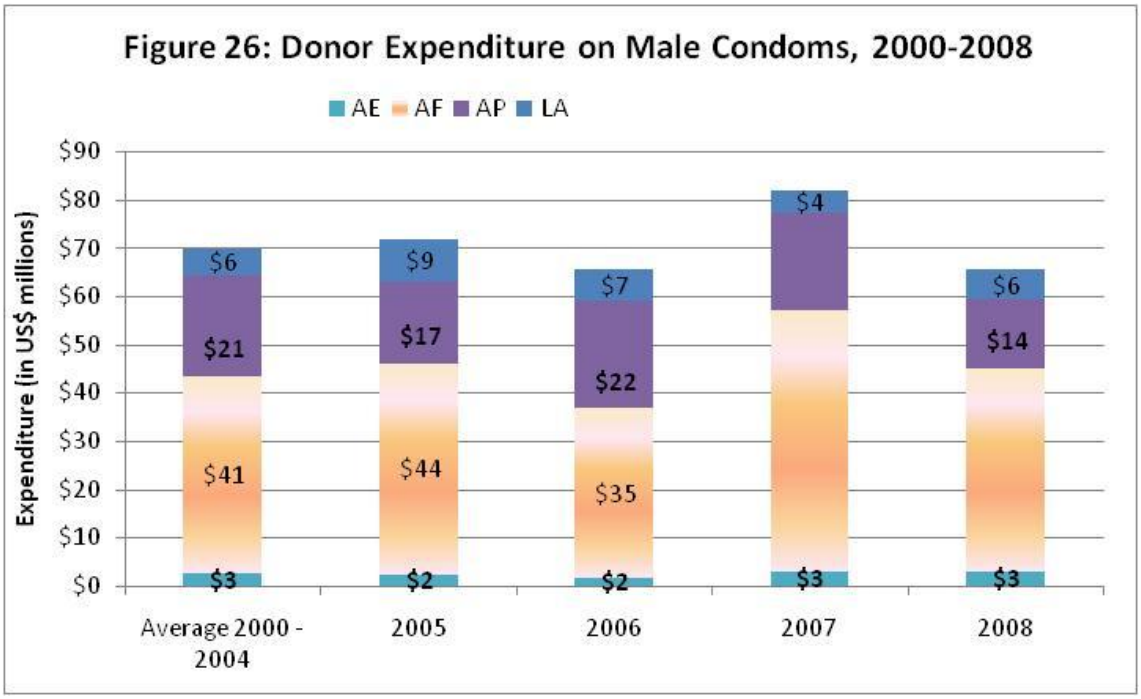


Table 8 summarizes the quantity of male condoms procured by donors in each region from 2000 to 2008. Donors provided a record high of over 3.1 billion male condoms in 2007, representing a near tripling of procurement since 2000 as well as a sharp increase from 2006. Most of these increases have been driven by increased quantities to sub-Saharan Africa, which received over 2 billion male condoms in 2007. In 2008, this number dropped to around 2.4 billion condoms, close to 2005 levels.

Table 8. Quantities of Male Condoms (in millions) Provided By Donors

Region	Average 2000 - 2004	2005	2006	2007	2008
AF	1,136	1,297	1,025	2,004	1,357
AP	704	584	785	900	675
LAC	137	337	235	161	233
AE	79	86	53	90	95
Total	2,056	2,305	2,098	3,155	2,361

Female Condoms

Table 9. Donor Expenditures on Female Condoms (in thousands) Provided By Donors

Region	Average 2000 - 2004	2005	2006	2007	2008
AF	$ 3,021	$ 3,800	$ 5,965	$ 11,798	$ 12,878
AP	$ 77	$ 363	$ 590	$ 465	$ 805
LAC	$ 100	$ 92	$ 325	$ 501	$ 411
AE	$ 8	$ 11	$ 36	$ 43	$ 171
Total	$ 3,206	$ 4,265	$ 6,917	$ 12,807	$ 14,265

Table 10. Quantities of Female Condoms (in thousands) Provided By Donors

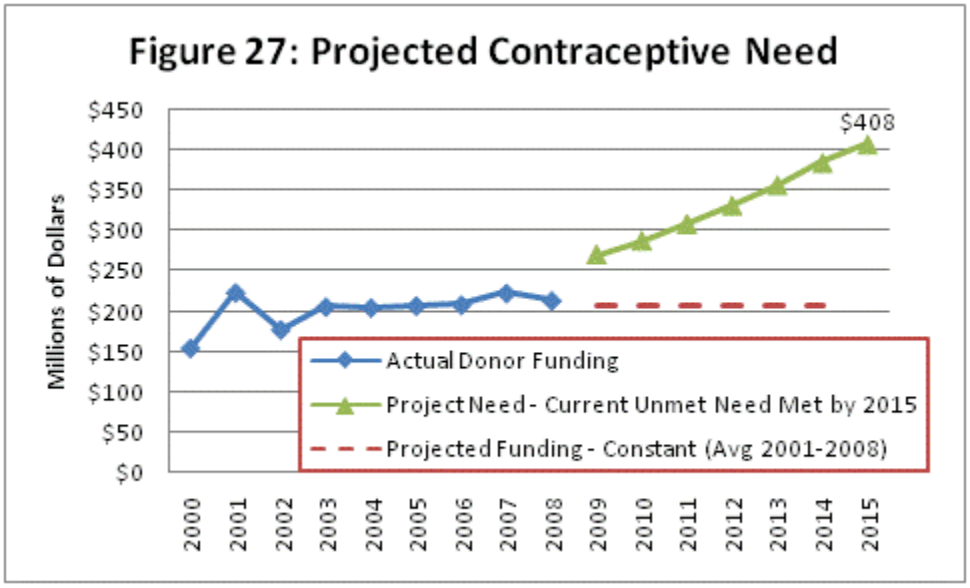
Region	Average 2000 - 2004	2005	2006	2007	2008
AF	4,799	4,907	8,681	15,108	16,531
AP	132	481	848	611	952
LAC	169	115	433	679	490
AE	12	14	44	49	216
Total	5,112	5,518	10,006	16,448	18,189

Table 10 summarizes donor expenditures for female condoms by region. Since 2001, donors have increased their support dramatically. While most of that increase has been directed to sub-Saharan Africa, which received US$ 12.9 million in 2008, the Asia and the Pacific region saw a sizeable increase in donor support for female condoms. Latin America and the Caribbean, however, saw a slight decrease. Table 9 summarizes the quantities of female condoms procured by donors by region. Total donor support in terms of quantities has quadrupled from nearly 4 million pieces in 2001 to around 18 million in 2008. Most of this increase has been driven by dramatic increases in support to sub-Saharan Africa, which received well over 16 million female condoms from donors in 2008.

VI. COMPARISON OF CONTRACEPTIVE NEEDS AND DONOR SUPPORT

This section compares donor support with estimated costs of contraception and condoms for HIV/AIDS prevention (from Reproductive Health Supplies Coalition, "Contraceptives Projections and the Donor Gap", 2009). The donor support requirements were estimated for a set of 88 donor dependent countries by leveraging data sources such as the DHS surveys to estimate the current contraceptive prevalence rate, current unmet need for family planning and the current method mix of different family planning options. The projected number of users was computed using population projections, projected CPR rates for all women and projected method mixes. The population receiving service (the number of women projected to be using each type of family planning service) was multiplied by the cost of a couple year protection to estimate the family planning costs. A separate calculation was performed to estimate the number of condoms need for HIV/AIDS prevention and added to the commodity requirements. Donor funding share was estimated based on historical donor share. It is important to note that this is not meant to indicate that the historical donor share is the "correct share" but rather was used as a basis for asking the question, "what would donor costs be in the future if the donor share remained the same and the current unmet need was reduced to 0 by 2015?"

Figure 27 clearly displays that the donor share requirements would nearly need to double in order for the current unmet need to be met in 2015.



Source: Reproductive Health Supplies Coalition, "Contraceptives Projections and the Donor Gap", 2009

Several factors need to be kept in mind when analyzing resource requirements in the context of available funding. Individuals' unmet needs for family planning, the use of standard costs and the exclusion of programming costs increase the requirements shown above; other factors, however, reduce them. The following provides a brief overview of some of the main factors that influence the estimated requirements.

Unmet Need

The projections of family planning users assumes that the current unmet need for family planning is reduced to zero by 2015. There is no assumption of latent demand.

According to UNFPA estimates, approximately 200 million women worldwide would like to limit or space the number of children they have but are not using contraceptives.[8]

Standard Costs
The projections of commodity requirements were developed assuming unit costs paid by USAID and UNFPA in 2006. Unit costs were weighted according to the quantities procured by the two agencies. An upward adjustment of 15 percent was applied to account for transportation and wastage costs. These prices are at the very low end of the cost spectrum, which means that the actual costs might be substantially higher.

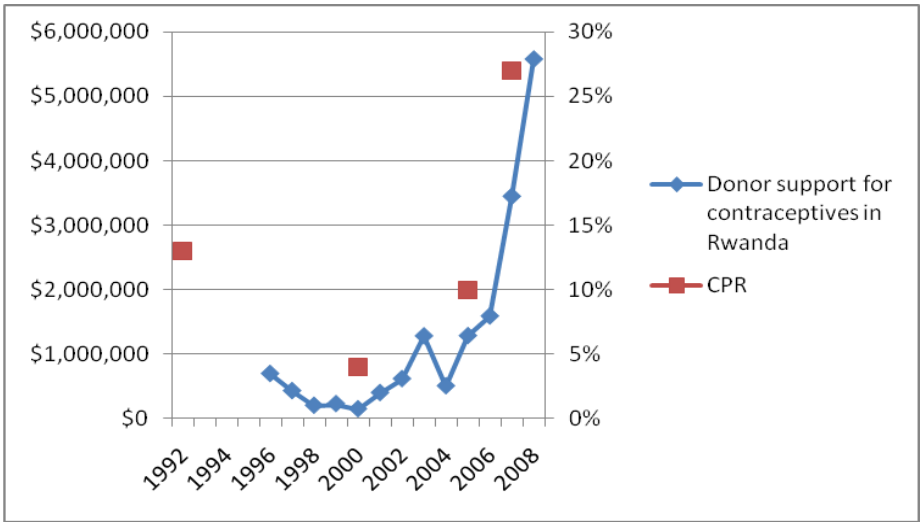
Varying Degrees of Donor Dependency
There are also factors that effectively change the presented donor requirements. The numbers shown in the graph were calculated based on historical donor share which may change in the future.

Linking Donor Support to CPR
Contraceptive prevalence in developing countries has grown dramatically in the past decades. Since the mid-1960s, the contraceptive prevalence rate has increased from approximately 10 per cent to almost 60 per cent. The United Nations Population Division projections show that the reproductive-age population in developing countries will increase some 23 per cent between 2000 and 2015. To meet current growth rates, donor funding for contraceptives will need to increase by 60 percent, from about US$230 million per year today to about US$370 million by 2020, or by more than 80 percent to more than US$420 million by 2020 to eliminate unmet need[9].

Despite rising needs for contraceptive commodities worldwide, however, donor support is declining. While this underscores the need to monitor requirements and potential shortfalls, it also highlights the importance of maintaining, and increasing, donor support so that CPR will not regress.

Case Study: Rwanda
The below graph illustrates the strong relationship between donor support and CPR in Rwanda. As donor support for contraceptives declined during the peak conflict years, the corresponding CPR also declined. Donor support for contraceptives has increased rapidly since 2006 with a correspondingly sharp increase in CPR. By 2008, with support close to US$ 5.6 million, CPR had reached an impressive 27% in Rwanda.

[8] As defined by Demographic Health Surveys, 'unmet need', is the measure of the discrepancy between the number of women in surveys who respond that they would like to limit or space childbirth but are not currently using contraception.
[9] Reproductive Health Supplies Coaltion, *Contraceptive Projections and the Donor Gap: Meeting the Challenge* 2009.



Source: JSI/USAID Project Survey, 2008: Policy, Finance, Coordination and Supply[10]