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The Global Contraceptive Shortfall: U.S. Contributions and U.S. Hindrances

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Getting family planning services to people in developing countries requires the availability of clinicians, counselors, information and educational materials, some sort of facility and, of course, the contraceptives themselves. Indeed, without an adequate and reliable supply of contraceptives, programs simply cannot succeed in responding to the growing demand for services worldwide.

Yet, there is a huge financial gap between the amount international donors contribute to the global reproductive health supplies initiative and the cost of meeting the needs of the approximately 561 million women and their partners in developing countries who, according to estimates from the United Nations Population Fund (UNFPA), are currently using modern contraceptives. And that gap does not even account for the additional 200 million women who wish to avoid or delay pregnancy but are not using modern methods.

The U.S. Agency for International Development (USAID) has been and remains the single largest contributor of funds for family planning and reproductive health services worldwide. In addition, it is the single largest donor of contraceptives globally. President Bush, however, is proposing a severe funding cut to USAID's family planning program for next year that would undermine the program's reach and reduce the amount available for procuring and distributing contraceptive supplies.

Moreover, the strict antiabortion litmus test known as the "Mexico City" global gag rule policy, which applies to all U.S. family planning assistance overseas, is also an impediment to supplying contraceptives to struggling programs around the world and to the people they serve. Thus, U.S. policy—purportedly aimed at reducing abortion—only exacerbates the already daunting challenge of ensuring that all people in the developing world who want to time and space their childbearing without resorting to abortion can actually obtain the contraceptives they need to do so.

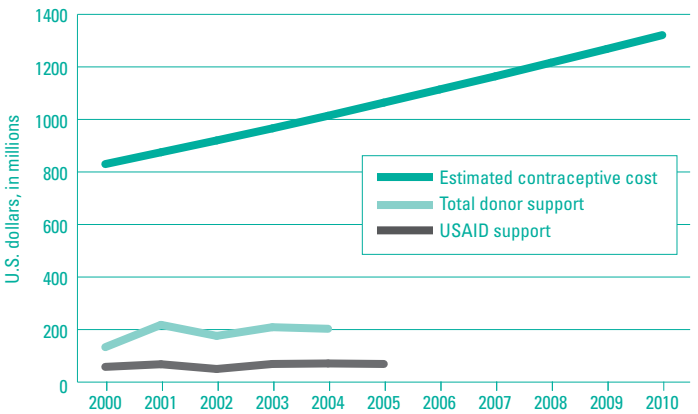
Insufficient Funds

As USAID describes the issue, if there is no product, there is no program. Therefore, a key goal of USAID's program is attaining "contraceptive security." USAID defines this as the ability of providers to rely on a steady supply and an appropriate mix of contraceptives to ensure that individuals are able to choose, obtain and use high-quality modern contraceptive methods (including condoms) to prevent pregnancy, as well as condoms to prevent HIV and other sexually transmitted infections (STIs).

In the United States, subsidized family planning program providers use their public grant funds to purchase contraceptives for their low-income clients; however, in developing countries, international donors supply and distribute a large bulk of the contraceptives themselves to programs. USAID, for example, spent about $69 million last year on almost 90 million cycles of oral contraceptive pills, 19 million doses of injectable contraceptives and about one million each of IUDs, female condoms and contraceptive implants, as well as about 444 million male condoms. In addition to the costs of purchasing the supplies, USAID and other donors participating

INCREASING COSTS

The escalating cost of contraceptives and condoms is far outpacing total donor support, including the significant support from the United States.



Source: UNFPA and RHInterchange, 2006.

in the global reproductive health supply initiative must address the costs and the logistical challenges of ensuring a smooth supply chain down to the client level. This involves not only striving to create a steady and adequate supply of a particular method, but maintaining an appropriate mix of methods so that individuals can choose the method they consider most appropriate for them.

USAID provides more than one-third of the total donor support for contraceptive commodities worldwide; UNFPA provides roughly another third. The remainder comes from a combination of other country donors and from social marketing organizations that sell contraceptives at reduced prices and then apply the proceeds to subsidize the purchase and distribution of more supplies. As of 2004, all of these donors combined had contributed about one-fourth toward the actual cost of the contraceptives dispensed in developing countries; they provided about one-fifth of the combined cost of contraceptives and condoms for STI prevention. The gap between the amount of donor support and the amount expended is made up largely by recipient country government contributions, the commercial sector and individuals' out-of-pocket expenses. Although the ultimate goal is that all developing countries achieve self-sufficiency in terms of their contraceptive supplies, it is clear that most will need to rely heavily on donor support for the foreseeable future. It is up to the donor community, then, to muster adequate financial resources to provide enough supplies and to support efficient systems for delivering them to programs and people.

UNFPA's most recent report detailing global donor support for contraceptives indicates that donors contributed about $203 million for reproductive health supplies in 2004. Although overall donor support (including the United States' share) has increased by about 50% since 1994's landmark International Conference on Population and Development in Cairo, contributions peaked around 2001 and have remained roughly level since then. The cost of the supplies, however, has risen steadily since 2000 (see chart). Moreover, the global demand for contraceptives has risen even faster.

In a sense, family planning and reproductive health programs are a victim of their own success, by having successfully increased knowledge about and demand for contraceptives over the past four decades. Although contraceptive prevalence in developing countries hovered at about 10% in the mid-1960s, it is about 60% today. Moreover, about one billion adolescents—the largest cohort in history—are now entering their reproductive years. According to UNFPA, the increase in the number of women of reproductive age combined with an increase in the proportion of such women using contraceptives is likely to lead to a 26% increase in the overall number of contraceptive users between 2000 and 2015 (see chart, page 17).

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Finally, this estimate does not reflect the sharp escalation in demand for condoms for disease prevention. For example, the global supply of male condoms doubled between 2000 and 2004 to more than two billion; however, that only averages to about 3.7 condoms per man per year.

And although Sub-Saharan Africa—the region where the HIV/AIDS epidemic is most severe—received more than half of that supply, the average annual number of condoms per man in South Africa, for example, is still only 1.7.

Insult to Injury

As if the resource limitations affecting the supply of contraceptives were not challenging enough, the situation is exacerbated by the fact that the United States conditions the provision of its supplies on the willingness of foreign nongovernmental organizations (NGOs) to comply with its strident antiabortion policy. The global gag rule prohibits foreign NGOs, in exchange for any U.S family planning assistance, from providing any abortion services or information and from engaging in any efforts to liberalize their own country's abortion laws. This restriction applies even to an NGO's eligibility to receive USAID shipments of contraceptives.

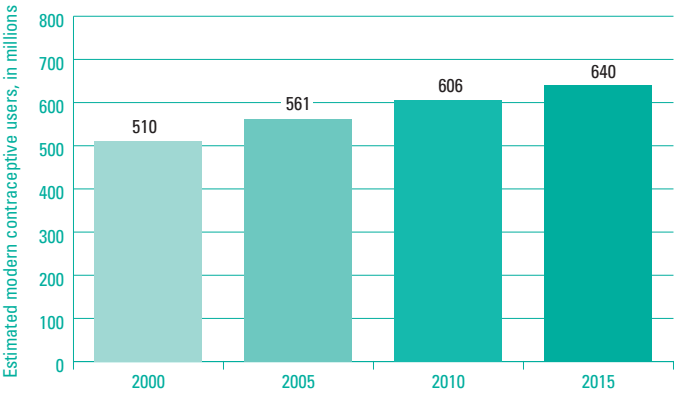
In specific countries and areas around the world, the effect has been disastrous. The London-based Marie Stopes International (MSI), for example, has been disqualified from any U.S. family planning assistance—including contraceptive supplies—because it could not accept the terms of the global gag rule. Getachew Bekele, MSI's Ethiopia country director, explained to the *Ottawa Citizen* in April that the U.S. policy is at least partly responsible for the fact that Ethiopia is facing a severe shortage in contraceptive supplies. In the article, Bekele recounts the story of a client named Esther, who was married at 16 and had had three children by age 21. She was exhausted and resisted her husband's desire for more children. MSI helped her to avoid another pregnancy for three more years with three-month injections of Depo-Provera. Last year, she came back numerous times for her shot, but each time learned there was none to be had. The next time she saw the MSI worker, she was pregnant and charged, "This is your child. I didn't want this child and you forced me to have it because you promised me I could stop pregnancy, then you let me down."

Despite the significant financial role the United States plays in providing contraceptives to poor countries, then, the global gag rule is an obstacle that impedes the availability of contraceptives at least in certain parts of the world. *Access Denied,* a report produced by the Population Action International–led Global Gag Rule Impact Project, terms it "a crisis within a crisis." The project found that defunded NGOs in Kenya and Ghana, for example, have had to terminate or curtail their community-based distribution programs, which are often the only means for getting contraceptives to women and men in rural and remote geographic areas.

According to the project's analysis, 16 developing countries in Africa, Asia and the Middle East had lost their USAID supply of contraceptives as of 2002: Burundi, Cape Verde, Chad, Comoros, Gabon, the Gambia, Lesotho, Mauritius, Sierra Leone, Solomon Islands, Sri Lanka, Swaziland, Tonga, Vanuatu, West Samoa and Yemen. In each case, the local International Planned Parenthood Federation affiliate was the only recipient of USAID contraceptives, but refused to accept the U.S. gag rule. (Four of the 16—Burundi, Lesotho, Sierra Leone and Swaziland—are now receiving USAID condoms through the U.S. global HIV/AIDS program, which the president explicitly deemed to be exempt from the gag rule.) The gag rule can be blamed for the loss of contraceptive supplies to leading NGOs in 12 other countries.

GROWING DEMAND

The demand for contraceptives in developing countries has been rising steadily and is expected to continue rising as the number of reproductive-age women grows and more of them want to control their fertility.



Source: UNFPA, 2005.

Beginnings of a Response

Earlier this year, a bipartisan group in Congress representing both sides of the abortion-rights divide coalesced to develop legislation to redress some of the financial challenges and the ideological constraints affecting the availability of U.S.-supplied contraceptives overseas. The resulting Ensuring Access to Contraceptives Act of 2006, sponsored by prochoice Reps. Rob Simmons (R-CT) and Dennis Moore (D-KS) and antiabortion Reps. James L. Oberstar (D-MN) and Tim Ryan (D-OH), would double the amount that USAID currently spends on contraceptives to $150 million each year in FY 2007 and FY 2008. In addition, the legislation would exempt the distribution of contraceptives from the gag rule funding restrictions, which would remove an important obstacle to getting them to some key, especially remote areas. In the words of the legislation, "reducing the need for abortion and reducing the spread of HIV/AIDS are unlikely to be achieved when United States–donated contraceptives are subject to policy restrictions, such as the Mexico City Policy, that limit access to such contraceptives."

Proponents of the gag rule assert that providing any kind of U.S. family planning aid to NGOs that are unwilling to distance themselves from abortion is tantamount to providing U.S. support for abortion. They argue that even providing a supply of contraceptives to an NGO that is also involved in abortion-related activities "frees up" other resources for those activities.

The bill's sponsors, however, maintain that whatever one thinks of the so-called fungibility argument, there is nothing fungible about the supplies themselves. After all, contraceptives can only be used for contraception. Furthermore, they say that greater—not reduced—access to contraceptives is integral to making abortion less necessary, even if that access is provided by local family planning organizations that are supportive of abortion.

Although this is not a new message, it is noteworthy that both prochoice and antiabortion members of Congress are getting behind it. It is too soon to know the prospects for advancing this idea in the legislative process, but this is an important start. **www.guttmacher.org**

Correction: Please note this article has been changed slightly from the print version. On the bottom of page 16, data have been corrected regarding the global supply of condoms.