Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2007

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 Management Branch. Also within UNFPA, special thanks goes to Kabir Ahmed and Howard Friedman for editing manuscript drafts and coordinating with donors and other stakeholders to collect, compile and clean data. Contributions from Erica Hagen, consultant, and Antti Kaartinen of UNFPA's Procurement Services Branch in Copenhagen undoubtedly strengthened the final product. Finally, UNFPA would like to thank Brian Lutz, consultant, for analyzing the donor support data and synthesizing the results into this report.

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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. EXECUTIVE SUMMARY

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 2007 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 2000-2007. 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 2000-2007 and provides projections of contraceptive needs through 2015.

Highlights of the 2007 report include:

- Total donor support in 2007 was slightly more than US$ 223 million, a 5% increase over support in 2006. Donor support, however, has remained fairly constant since 2001.

- Ninety percent (90%) of donor support in 2007 was allocated to three types of commodities: male condoms (43%), oral contraceptives (23%) and injectables (24%).

- Sub-Saharan Africa received 60% of total support in 2007. The Asia and Pacific region received 27%. Latin America and the Caribbean and Arab States/Eastern Europe received 7% and 5%, respectively.

- Sub-Saharan Africa witnessed the largest increase in percentage and absolute terms in donor support, which nearly tripled from US$ 45 million in 2000 to US$ 134 million in 2007.

- Total contraceptive need in developing countries in 2007 was estimated at US$ 873 million. This figure rises to $1.4 billion when condoms for HIV prevention are included.

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, progress toward the ICPD goals and 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]

Skilled birth attendance—another indicator of maternal health in the ICPD goals and MDGs—also shows uneven progress among regions. On average, developing countries increased skilled birth attendance from 43% in 1990 to 57% in 2005, but much of that increase has been driven by impressive gains in southeastern and eastern Asia as well as northern Africa.[5] Rates in sub-Saharan Africa have only increased 3% over the same period, a rate far too low to achieve ICPD goals and the MDGs.

Similarly, contraceptive prevalence rates (CPRs) vary tremendously among regions. In 2005, sub-Saharan Africa had the lowest CPR of 15%, less than half the rate of Western Asia, the developing region with the next lowest CPR at 35.8%, and far below North Africa's CPR of 53.8%.[6] The linear annual increase of less than 1% in sub-Saharan

[1] *The Millennium Development Goals Report 2007 [MDG Report 2007].*
[2] WHO, UNICEF, UNFPA, World Bank 2005. *Maternal Mortality in 2005*.
[3] WHO, UNICEF, UNFPA, World Bank 2005. *Maternal Mortality in 2005*.
[4] WHO, UNICEF, UNFPA, World Bank 2005. *Maternal Mortality in 2005*.
[5] *MDG Report 2007.*
[6] UN Population Division 2008.

Africa since 1990 puts the region well off-track to achieving universal access to RH services by 2015.

Globally, nearly 137 million women have unmet need for family planning; an additional 67 million are using traditional methods with high failure rates.[7] Rapidly increasing demand will only exacerbate current gaps. Latest figures from the United Nations Population Division projects an increase of 13% in the reproductive age population in less developed regions between 2000 and 2015.[8] Over the same period, the number of contraceptive users is projected to increase more than 28% due to population growth and increased demand for contraception.[9] Without a concerted redoubling of efforts at the international and national levels toward established goals, millions will be unable to exercise their RH choices, health outcomes will continue to stagnate and the ICPD and MDGs will not be achieved.

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.

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.[10] 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.[11] 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,

[7] *MDG Report 2007*.
[8] UNPD 2006. *Population Projections, Medium Variant, 2006 Revision.*
[9] UNFPA 2006. *Achieving the ICPD Goals: Reproductive Health Commodity Requirements 2000-2015*.
[10] (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*
[11] UNAIDS/WHO 2007. *2007 AIDS Epidemic Update*. Published December 2007. http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

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 national governments, and mobilize the resources needed to ensure sufficient progress toward universal access to SRH.

III. INTRODUCTION

This report represents the 2007 installment of the Donor Support Report series. In addition to including the latest year (i.e., 2007) for which data are available, the report also updates data from previous years where new information is available. Consequently, data prior to 2007 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 2000-2007. 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 2000-2007 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 $7.6 million. World Bank contraceptive financing, which amounted to just over US$ 3 million in 2007, is not included either.
- 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. Some records, for example, may not specify procurement by 'gross,' which equates to 144 individual condoms—a mistake that can lead to under-reporting by two orders of magnitude for individual records. UNFPA periodically 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 2000-2007. 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 2000-2007. Figure 1 represents these data pictorially. Since 2001, male condoms have constituted the single largest donor expense as tracked in the donor support database. The bulk of the remainder is fairly evenly split among oral contraceptives and injectables. Driven largely by a doubling of expenditures on most commodities except oral contraceptives, donor support jumped from $155 million in 2000 to $224 million in 2001. Donor expenditures have remained roughly constant since 2001. Nor has absolute spending for most commodity types changed significantly since 2001. Female condoms, however, have seen the largest increase in expenditure in absolute and percentage terms, followed by that for implants. These gains are partially offset by recent declines in spending on IUDs.

Table 1. Trend in Donor Expenditure by major Commodity Method, 2000-7

	Expenditure, in US$ Millions									
Method	2000	2001	2002	2003	2004	2005	2006	2007	2000-7	
Male Condoms	46.1	91.0	76.7	63.2	74.3	76.0	72.4	83.5	**583.2**	36%
Oral Contraceptives	71.1	58.1	46.8	58.2	50.7	54.0	58.2	52.3	**449.5**	28%
Injectables	29.5	57.7	36.5	70.4	62.9	57.6	58.4	53.3	**426.3**	27%
Implants	2.8	5.1	5.9	4.0	3.2	5.5	7.2	16.2	**50.0**	3%
Female Condoms	0.0	2.0	2.9	2.5	6.2	5.3	9.0	12.8	**40.6**	3%
IUDs	3.2	6.5	6.4	5.7	6.0	3.9	4.0	2.5	**38.4**	2%
Other*	1.9	3.5	2.6	2.1	1.6	1.8	2.8	2.6	**18.9**	1%
Total	**154.6**	**223.9**	**177.8**	**206.2**	**205.0**	**204.2**	**212.1**	**223.2**	**1606.9**	

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

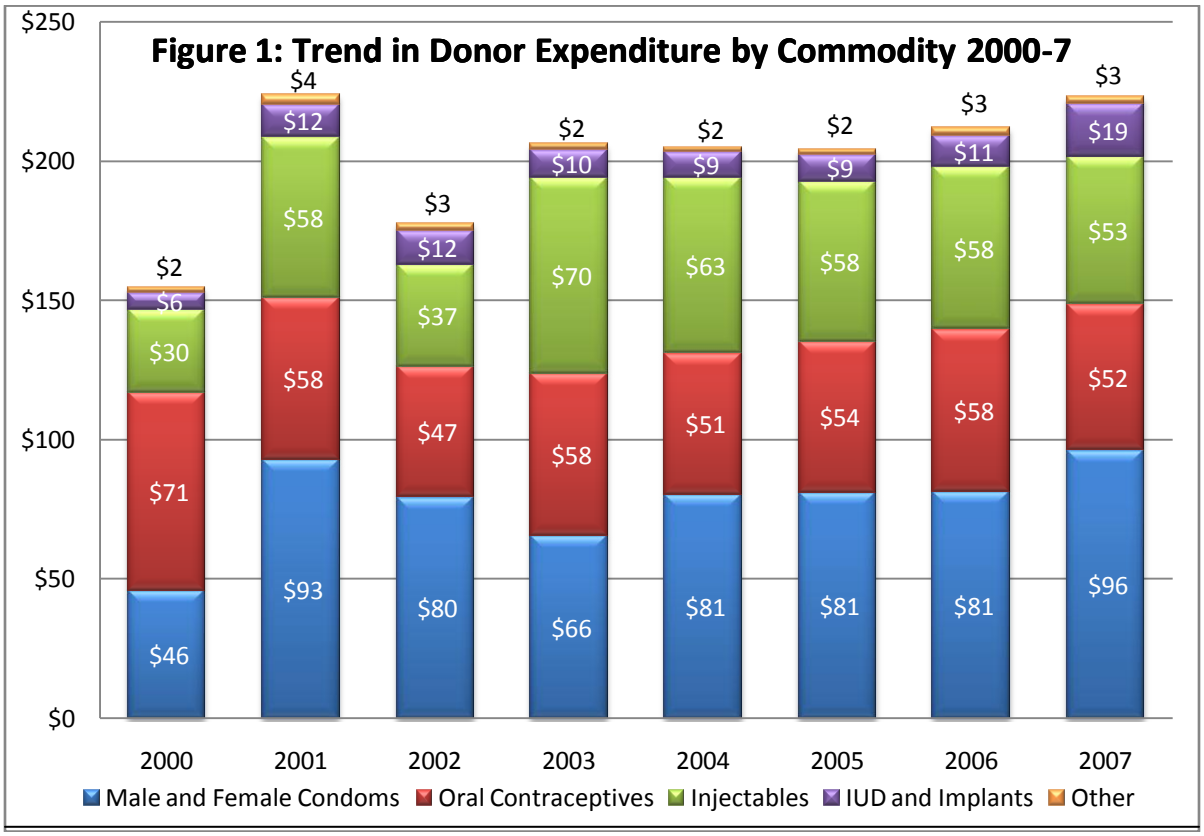


Figure 2 (next page) reflects trends in the quantities of major commodities procured by donors from 2000-2007. With the notable exception of vaginal tablets, whose donor procurement has dropped precipitously, the quantities of donor-procured commodities have remained roughly constant since 2001. Quantities of male and female condoms procured by donors have risen slightly since 2001 after more than doubling between 2000 and 2001 (see Section 5 for an analysis that disaggregates male and female condoms). Quantities of oral contraceptives, on the other hand, have fallen by nearly 50% since 2000.

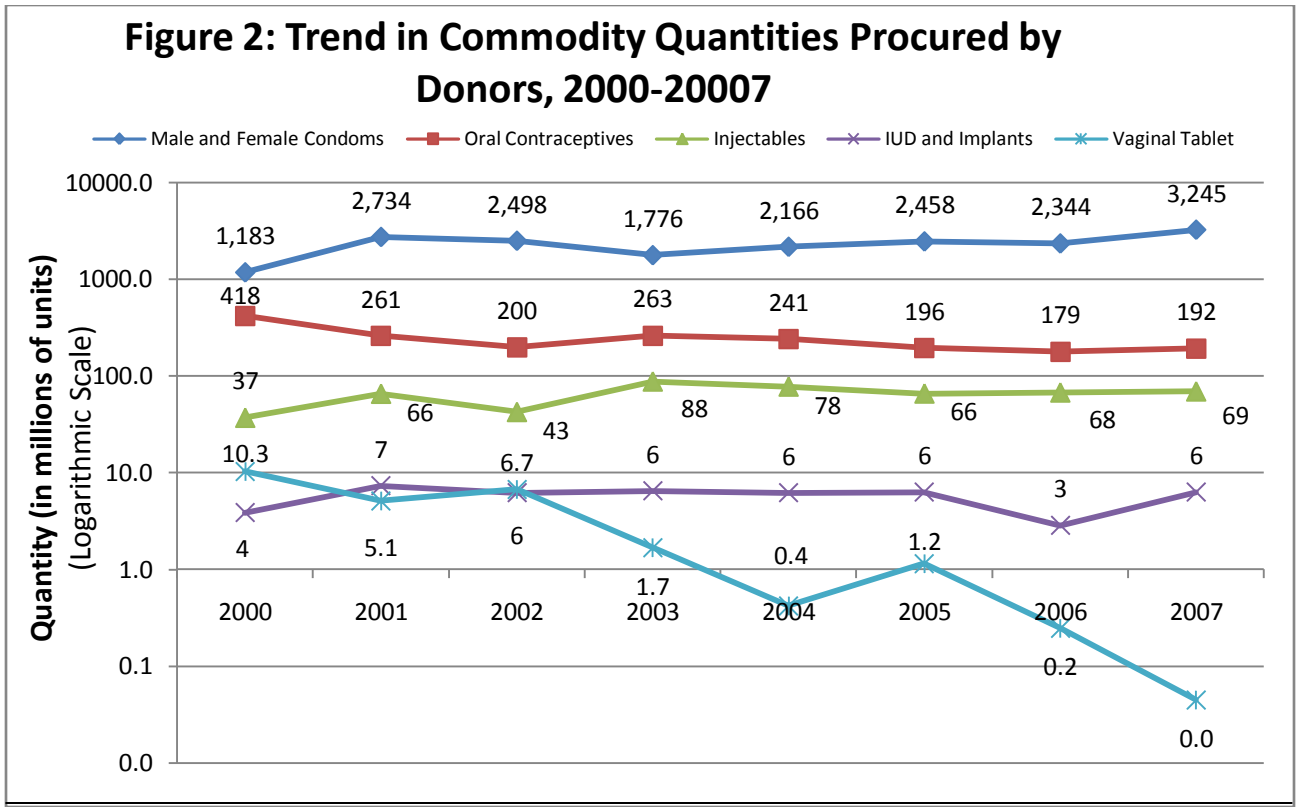


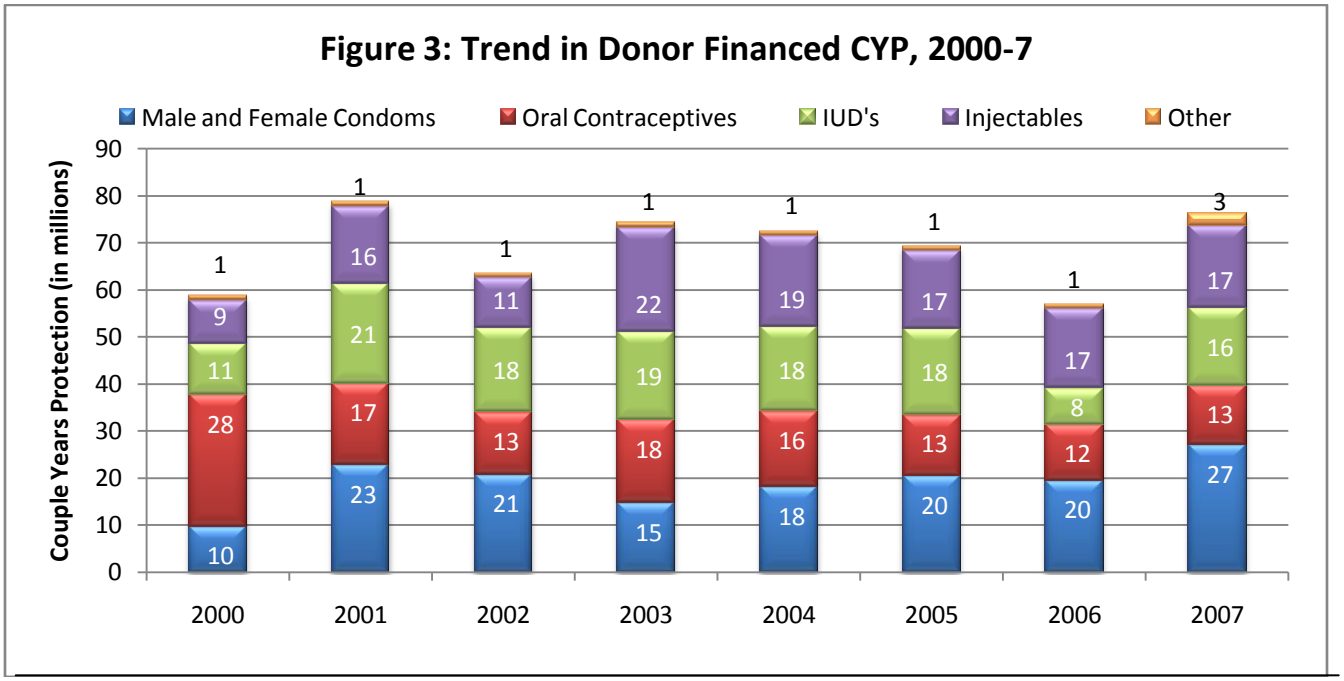
Table 2 and Figure 3 (next page) estimate the number of couple years of protection (CYP) afforded by donor-financed commodities. CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives distributed during that period. The 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 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. Based on these calculations, four major commodities—male condoms, oral contraceptives, IUDs, and injectables—represent nearly equal quarters of total CYP provided by donor-financed commodities over the entire period. In 2007, male condoms provided the largest share, with the remainder distributed fairly evenly among oral contraceptives, IUDs and injectables.

CYP Conversion Ratios

Commodity	Ratio	Ratio value
Male Condoms	# units/CYP	120
Oral Contraceptives	# units/CYP	15
Injectables	# units/CYP	4
Female Condoms	# units/CYP	120
IUDs	CYP/unit	3
Vaginal Tablets	# units/CYP	150
Foams/Jellies	# units/CYP	4.75
Implants	CYP/unit	3
Diaphragms	CYP/unit	1

Table 2. Trend in Donor-Financed Couple Year Protection (CYP)
By Major Commodity methods, 2000-2007

	CYP, in thousands									
Method	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2000-7**	
Male Condoms	9,862	22,749	20,780	14,760	17,980	20,426	19,418	26,904	**152,880**	27.8%
Oral Contraceptives	27,891	17,375	13,317	17,513	16,094	13,039	11,911	12,813	**129,951**	23.6%
Injectables	9,295	16,410	10,653	21,952	19,460	16,502	16,922	17,353	**128,546**	23.4%
Implants	779	815	695	465	423	651	860	2,586	**7,274**	1.3%
Female Condoms	-	33	34	39	72	58	112	137	**485**	0.1%
IUDs	10,756	21,134	17,834	18,911	18,074	18,292	7,714	16,397	**129,112**	23.5%
Foam/Jellies	20	82	15	246	380	238	-	68	**1,048**	0.2%
Diaphragms	2	1	0	360	-	1	1	-	**365**	0.1%
Vaginal Tablets	69	34	45	11	3	8	2	0	**171**	0.0%
Total	**58,673**	**78,634**	**63,371**	**74,257**	**72,485**	**69,215**	**56,939**	**76,258**	**549,833**	



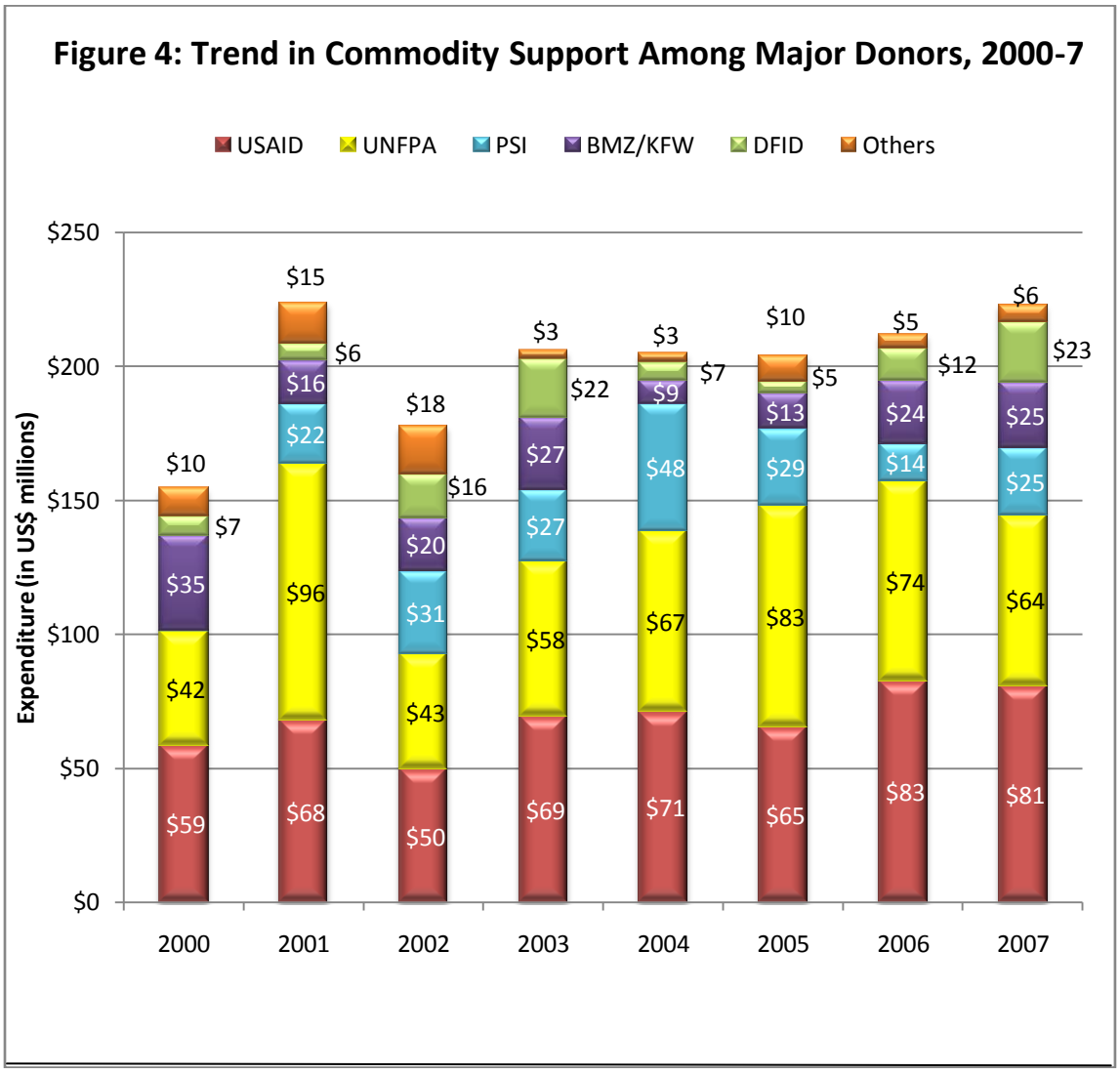
Patterns and Trends by Donor

Table 3 and Figures 4-6 (next page) illustrate trends in commodity expenditures among major donors from 2000-2007. Consistently the largest two donors over the period, USAID and UNFPA together account for nearly two-thirds of overall donor support for contraceptives and condoms for STI/HIV prevention. USAID also accounts for the largest absolute increase in commodity expenditures over the period, contributing nearly half of the overall increase in donor support.

Table 3. Trend in Commodity Support Among Major Donors, 2000-2007

	Expenditure, in US$ Millions									
Donor	2000	2001	2002	2003	2004	2005	2006	2007	2000-7	
USAID	$ 58.7	$ 67.9	$ 49.6	$ 69.4	$ 71.2	$ 65.4	$ 82.7	$ 80.9	**$ 545.8**	34%
UNFPA	$ 42.4	$ 95.9	$ 43.0	$ 58.1	$ 67.3	$ 82.6	$ 74.4	$ 63.9	**$ 527.4**	33%
PSI	$ 0.5	$ 22.4	$ 30.9	$ 26.5	$ 47.8	$ 28.8	$ 14.2	$ 24.9	**$ 196.1**	12%
BMZ/KFW	$ 35.5	$ 16.4	$ 20.1	$ 26.9	$ 8.7	$ 13.1	$ 23.6	$ 24.6	**$ 168.9**	11%
DFID	$ 7.3	$ 6.1	$ 16.4	$ 22.3	$ 6.7	$ 4.6	$ 12.1	$ 22.5	**$ 98.1**	6%
Others*	$ 10.4	$ 15.2	$ 17.7	$ 2.9	$ 3.3	$ 9.6	$ 5.1	$ 6.4	**$ 70.6**	4%
Total	**$ 154.6**	**$ 223.9**	**$ 177.8**	**$ 206.2**	**$ 205.0**	**$204.2**	**$212.1**	**$223.2**	**$1,606.9**	

*Includes IPPF, DKT, MSI, Japan, Netherlands, GFATM, OCEAC, UNDP, CDC, Hewlett Foundation



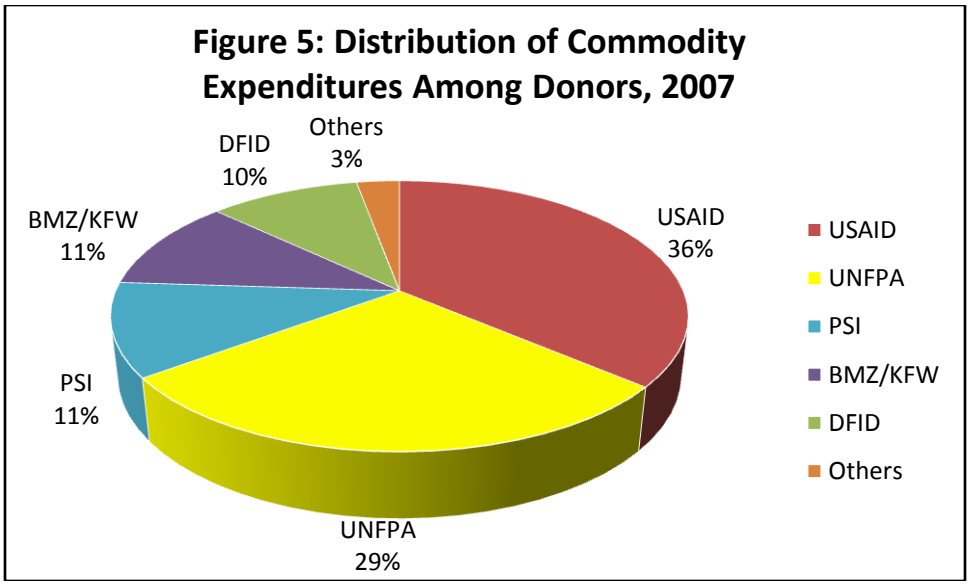


Figure 5: Distribution of Commodity Expenditures Among Donors, 2007
Others 3%
DFID 10%
BMZ/KFW 11%
USAID 36%
PSI 11%
UNFPA 29%
USAID
UNFPA
PSI
BMZ/KFW
DFID
Others

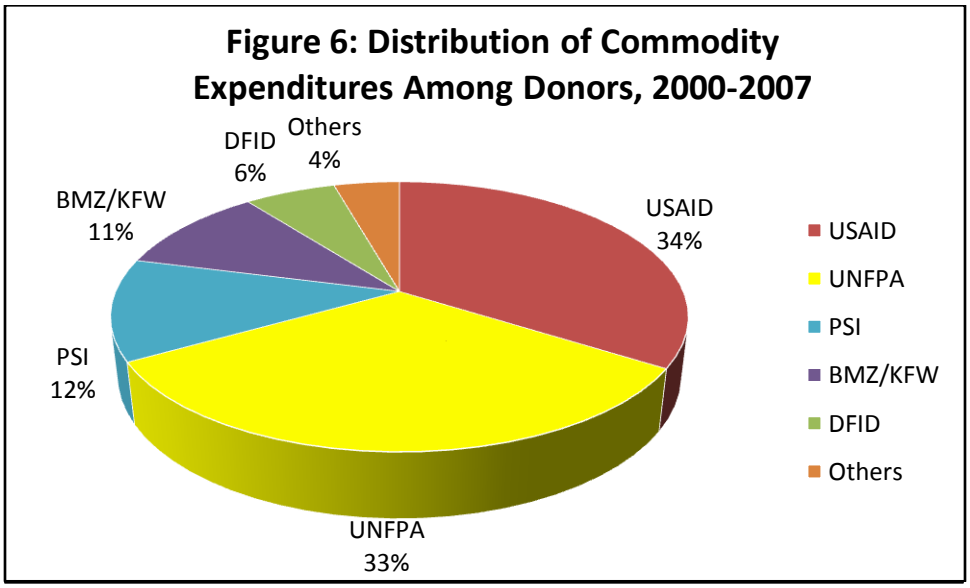


Figure 6: Distribution of Commodity Expenditures Among Donors, 2000-2007
DFID 6%
Others 4%
BMZ/KFW 11%
USAID 34%
PSI 12%
UNFPA 33%
USAID
UNFPA
PSI
BMZ/KFW
DFID
Others

Figures 7-12 illustrate the quantities of contraceptives, including condoms, provided by donors for 2007. USAID was the largest supplier of female condoms (54%) and oral contraceptives (53%). UNFPA was the single largest procurer of injectables (56%) male condoms (24%) and implants (73%). BMZ/KFfW provided most of the donor-financed IUDs (59%).

Figure 7: Quantity of Male Condoms Supplied by Donor, 2007

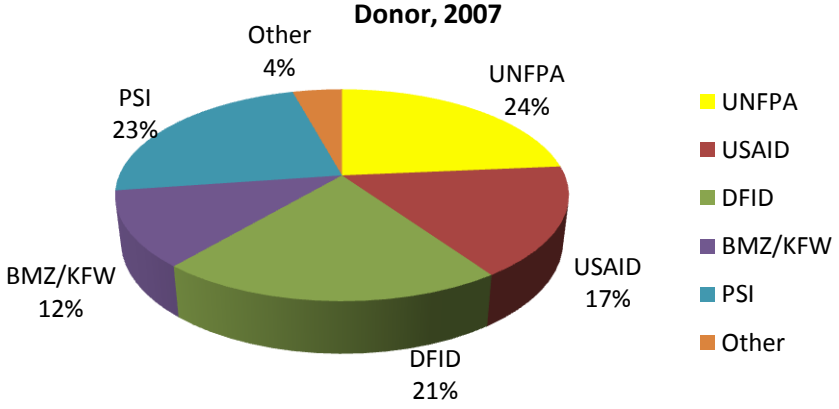


Figure 8: Quantity of Oral Contraceptives Supplied by Donor, 2007

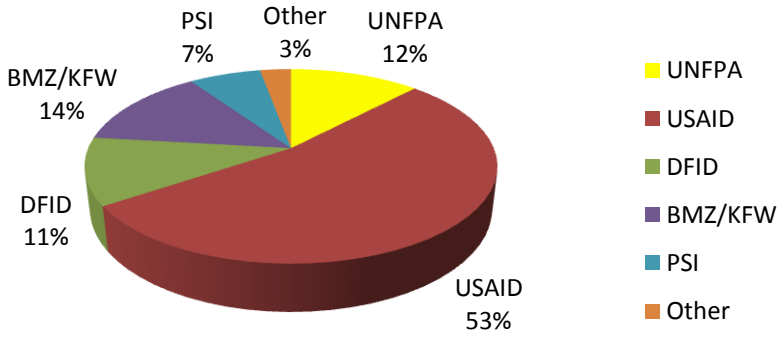


Figure 9: Quantity of Injectables Supplied by Donor, 2007

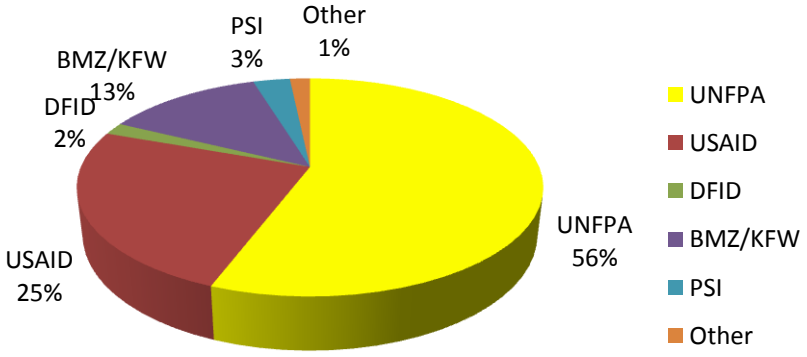


Figure 10: Quantity of Female Condoms Supplied by Donor, 2007

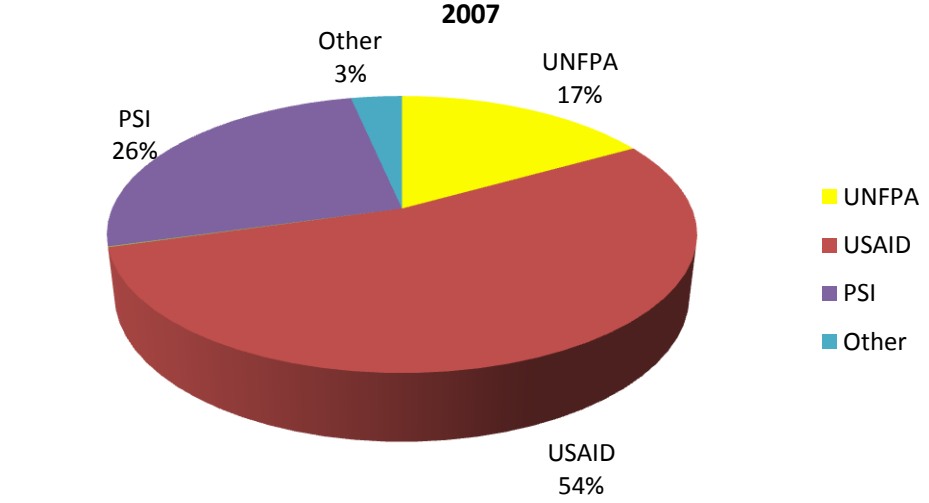


Figure 11: Quantity of IUDs Supplied by Donors, 2007

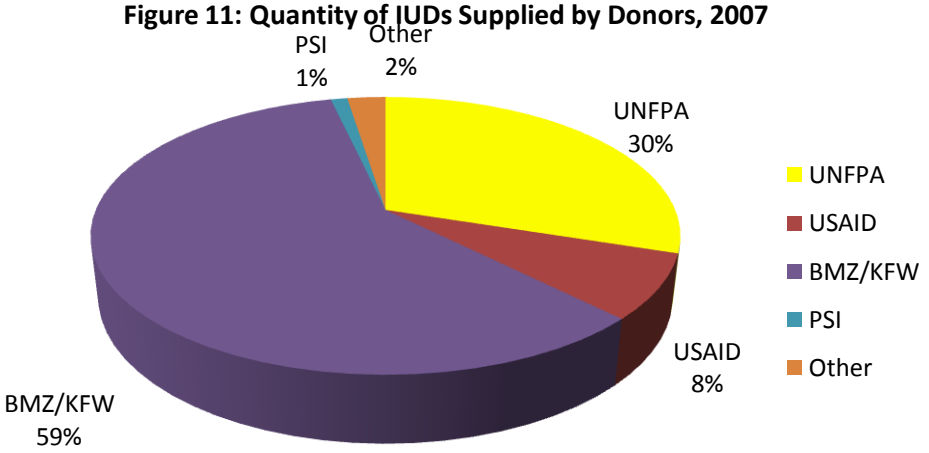


Figure 12: Quantity of Implants Supplied by Donors, 2007

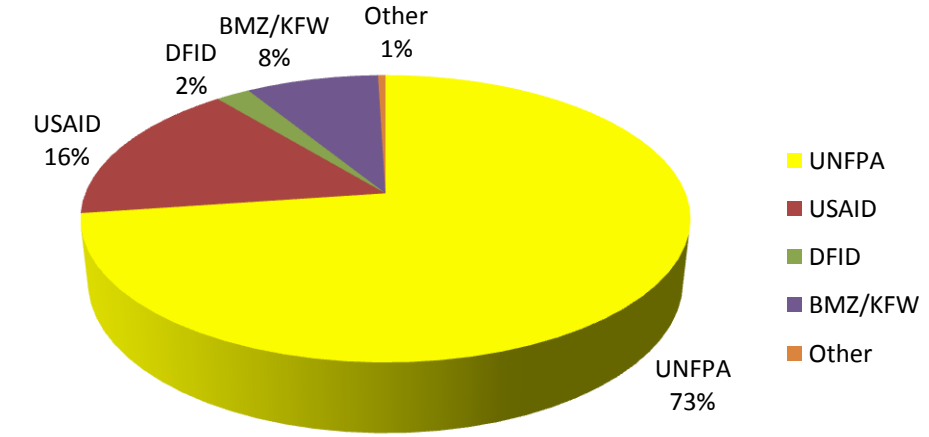


Figure 13 depicts the distribution of donor support for three major commodities in terms of expenditures in 2007. Not unexpectedly, the largest procurers of each commodity type are the same as when analyzed by quantity.

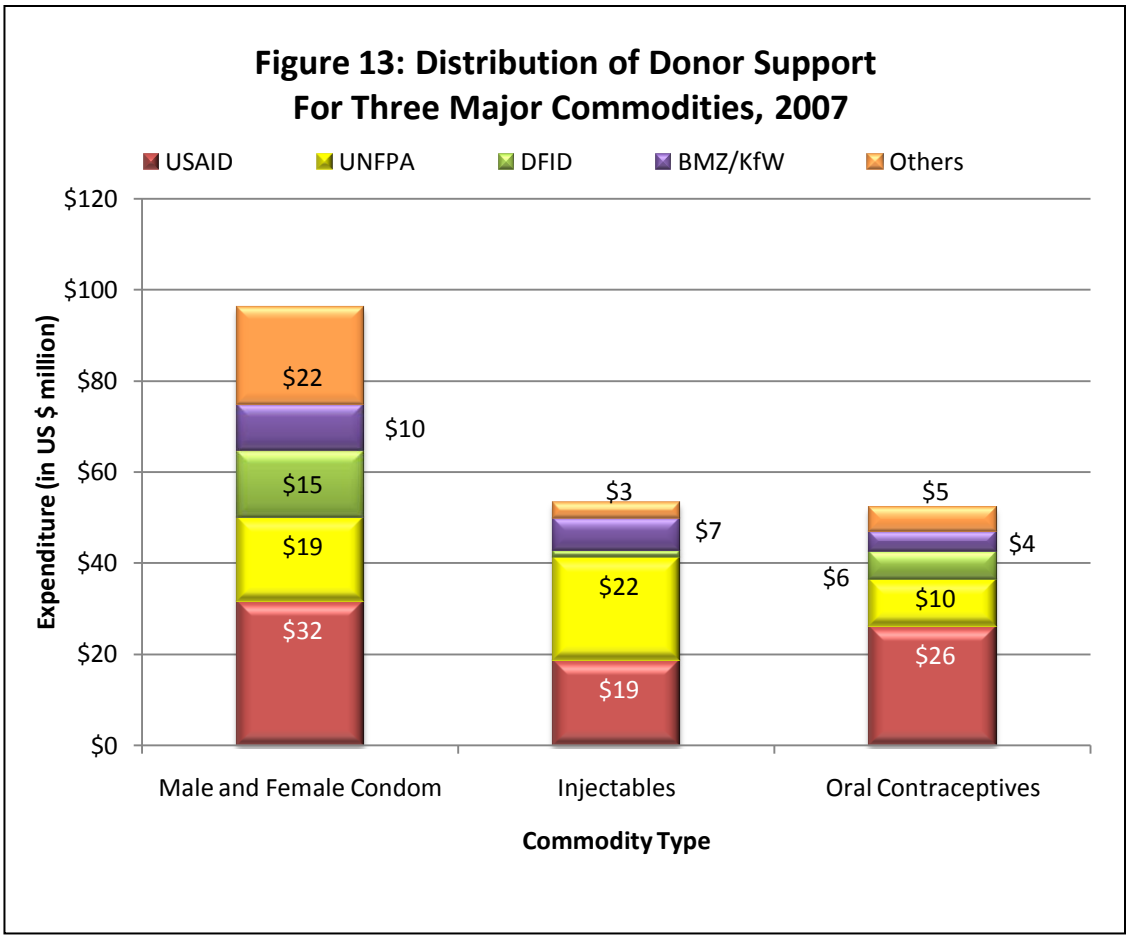
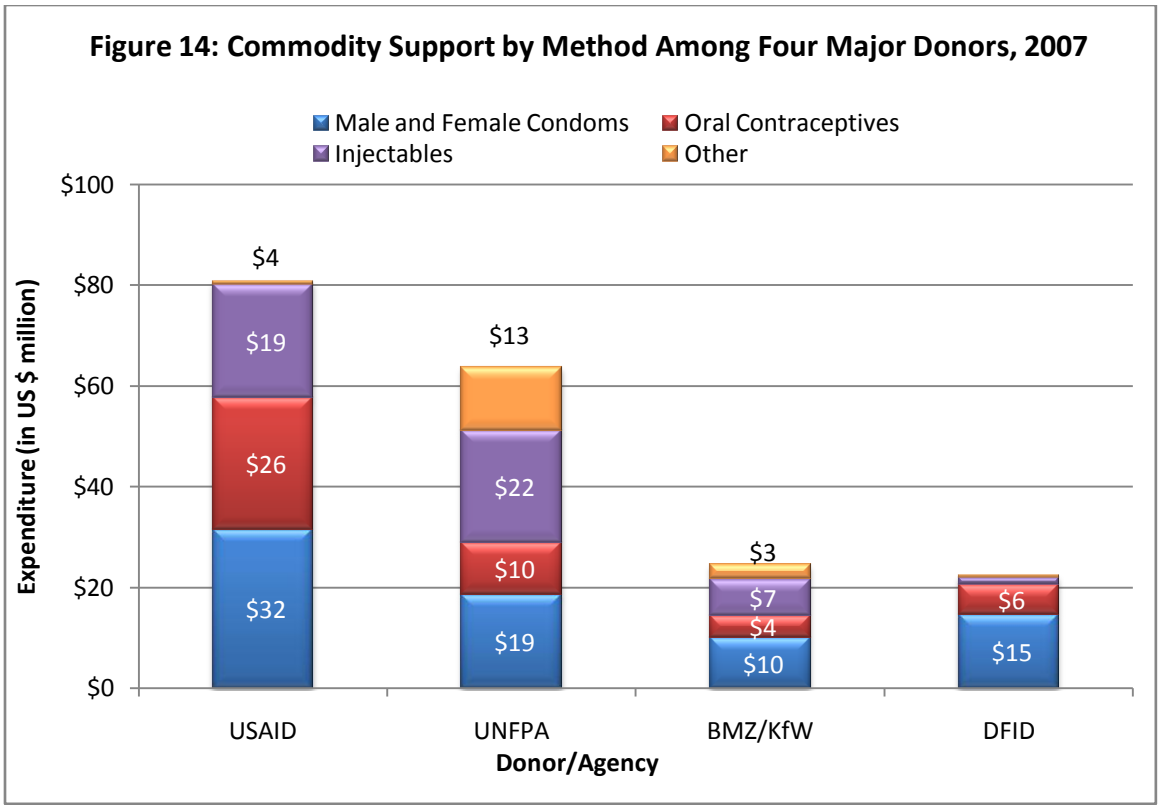


Figure 14 illustrates the expenditure patterns of four major donors in 2007. USAID's expenditure of US$ 32 million on male and female condoms was nearly equal to the combined expenditure of UNFPA (US$ 19 million), BMZ/KfW (US$ 10 million) and DFID (US$ 15 million) on condoms. Similarly, USAID's expenditure of US$ 26 million on oral contraceptives was more than that spent by the other leading donors combined. Funding distributions differed among donors. The majority of USAID and DFID funds were allocated to male and female condoms, while UNFPA's single largest expenditure was on injectables (US$ 22 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 2000-2007. 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). Note that the data reported in this subsection may be slightly lower than as reported in previous subsections, owing chiefly to entries in the global donor support database that lack information on recipient country and, therefore, region. Sub-Saharan Africa is the largest single recipient of donor support for all years except 2000. The most striking trend is the near tripling of donor support to this region since 2000. In absolute terms and as a percentage of total donor support, expenditures to the Asia and Pacific region fell over this period. Support to LA held steady. Arab States/Eastern Europe saw gains in absolute terms, but the region's percentage of total donor support remained fairly constant.

Table 4.Trend in Commodity Support Among Recipient Regions, 2000-2007

	Expenditure, in US$ Millions									
Region	2000	2001	2002	2003	2004	2005	2006	2007	2000-7	
AE	$7.5	$21.4	$15.2	$12.6	$14.8	$14.5	$10.8	$11.0	**$107.6**	7%
AF	$45.3	$94.2	$84.3	$89.16	$101.6	$98.0	$89.7	$133.9	**$736.1**	46%
AP	$88.0	$86.8	$59.3	$86.99	$67.2	$58.4	$74.9	$60.2	**$581.7**	36%
LA	$13.3	$21.5	$19.0	$16.47	$17.0	$20.9	$22.6	$16.1	**$146.9**	9%
Other/Unknown	$0.6	-	-	$1.0	$4.5	$12.4	$14.1	$2.0	**$34.5**	2%
Total	**$154.6**	**$223.9**	**$177.8**	**$206.2**	**$205.0**	**$204.2**	**$212.1**	**$223.2**	**$1,606.9**	

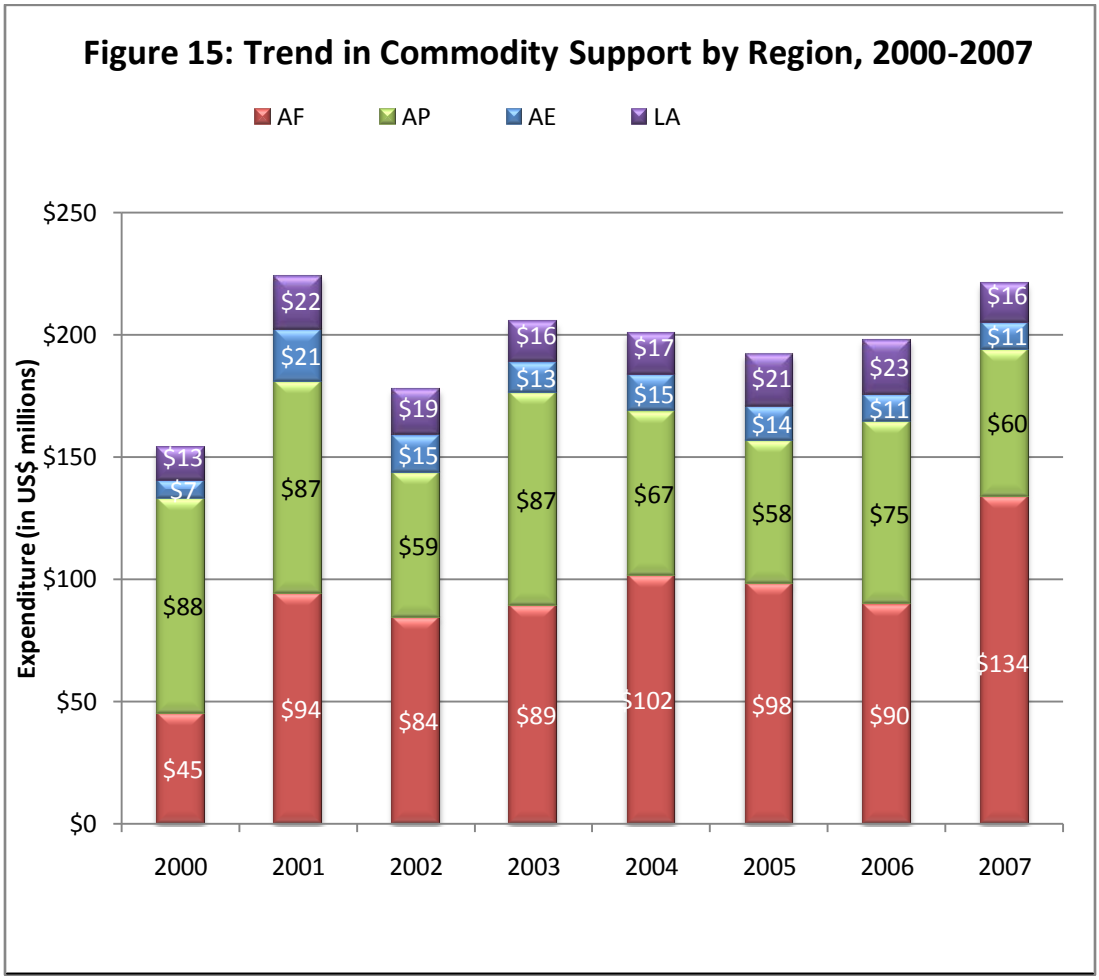


Figure 16: Distribution of Commodity Support Among Regions, 2007

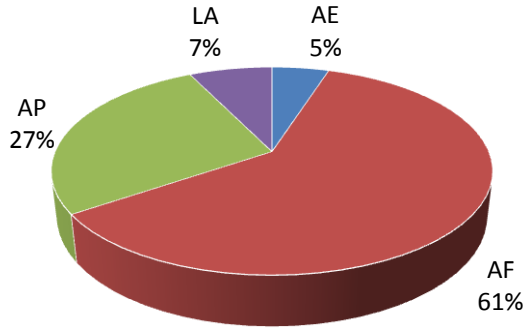
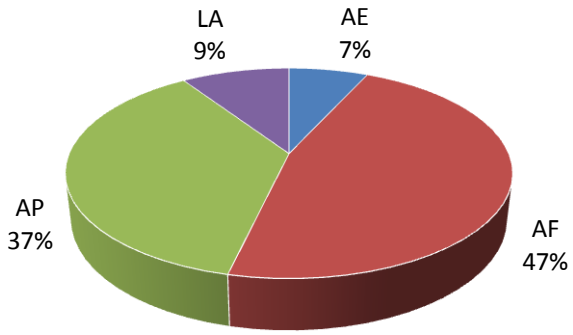


Figure 17: Distribution of Commodity Support Among Regions, 2000-2007



To account for differences in population sizes among the four 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 2007 (US$ 0.17 per capita). Arab State/Eastern Europe received the least (US$ 0.02 per capita).

Table 5. Per Capita Donor Support By Region, 2007

Region	Population	% of Total Population	Donor Support	% of Total Support	Support Per Capita
AE (excl. Russian Federation)	707,673,442	16%	$ 10,972,074	5%	$ 0.02
AF (excl. S. Africa)	810,562,914	19%	$ 132,043,269	60%	$ 0.17
AP (excl. China)	2,435,178,680	57%	$ 60,181,809	28%	$ 0.02
LA (excl. Brazil)	338,305,964	8%	$ 15,460,087	7%	$ 0.05
Total	4,291,721,000		$ 218,657,239		

Tables 6 and 7 show the top ten recipients of donor support for contraceptives and condoms on a total and per capita basis, respectively.

Table 6. Top 10 Recipient Countries By Total Expenditure

	2000	2001	2002	2003	2004	2005	2006	2007	2007 Total (US$ Million)	% 2007 Total
1	Bangladesh	Bangladesh	Nigeria	Bangladesh	Bangladesh	Ethiopia	Bangladesh	Zimbabwe	$ 23.0	10.3%
2	Ethiopia	Ethiopia	Bangladesh	Zimbabwe	Pakistan	Nigeria	Pakistan	Ethiopia	$ 22.1	9.9%
3	Philippines	Nigeria	Philippines	Pakistan	Nigeria	Bangladesh	Zimbabwe	Bangladesh	$ 17.5	7.9%
4	Pakistan	Philippines	Ethiopia	Nigeria	Uganda	Pakistan	Vietnam	Nigeria	$ 15.6	7.0%
5	Indonesia	Pakistan	Pakistan	Egypt	DRC	Vietnam	Ethiopia	Pakistan	$ 14.8	6.6%
6	Ghana	Zimbabwe	Ghana	Ethiopia	Nepal	Kenya	Madagascar	Kenya	$ 11.3	5.0%
7	Uganda	Egypt	Egypt	Malawi	Ethiopia	Uganda	Tanzania	India	$ 7.8	3.5%
8	Nepal	Ghana	Sri Lanka	Philippines	Zimbabwe	Tanzania	India	Uganda	$ 6.9	3.1%
9	Peru	Peru	Côte d'Ivoire	Nepal	Egypt	Egypt	Ghana	Ghana	$ 5.8	2.6%
10	India	Uganda	DRC	Vietnam	Tanzania	Nepal	Uganda	Tanzania	$ 5.4	2.4%

Table 7. Top 10 Recipient Countries By Per Capita Expenditure

	2000	2001	2002	2003	2004	2005	2006	2007	2007, Per Capita
1	Namibia	Fiji	Nicaragua	Zimbabwe	Zimbabwe	Nicaragua	Zimbabwe	Zimbabwe	$ 1.57
2	Lao PDR	Republic of Congo	Fiji	Haiti	Swaziland	Fiji	Swaziland	Bhutan	$ 0.81
3	Bangladesh	Cape Verde	Sao Tome & Principe	Malawi	Lesotho	Republic of Congo	Republic of Congo	Lesotho	$ 0.66
4	Bhutan	Zimbabwe	Vanuatu	Togo	Nepal	Guinea	Lesotho	Swaziland	$ 0.56
5	Gambia	Albania	Zambia	Namibia	Uganda	Zimbabwe	Madagascar	Fiji	$ 0.41
6	Ghana	Swaziland	Eritrea	Lesotho	Cambodia	Central African Republic	Haiti	Haiti	$ 0.34
7	Sao Tome & Principe	Namibia	Zimbabwe	Bangladesh	Zambia	Cape Verde	Fiji	Zambia	$ 0.33
8	Zambia	Nicaragua	Cape Verde	Suriname	Namibia	Bhutan	Suriname	Cambodia	$ 0.31
9	Uganda	Ghana	Lesotho	Madagascar	Malawi	Ethiopia	Cape Verde	Botswana	$ 0.31
10	Honduras	Haiti	Benin	Sao Tome & Principe	Ghana	Mongolia	Lao PDR	Sao Tome & Principe	$ 0.30

Figures 18-23 illustrate the quantities of major contraceptives, including condoms that donors provided to regions in 2007. 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 condoms and implants. Arab States/Eastern Europe was the chief recipient of IUDs. The Asia and Pacific region was the largest recipient of units of oral contraceptives.

Figure 18: Regional Distribution of Units of Male Condoms, 2007

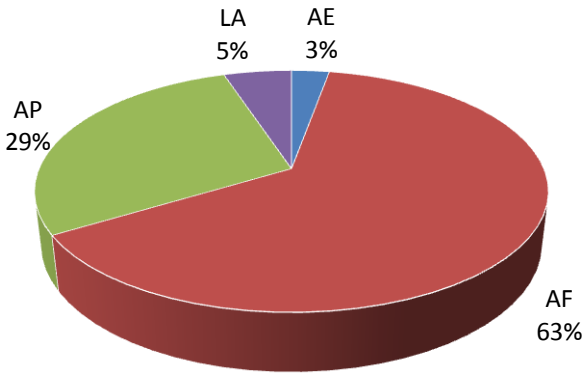


Figure 19: Regional Distribution of Units of Female Condoms, 2007

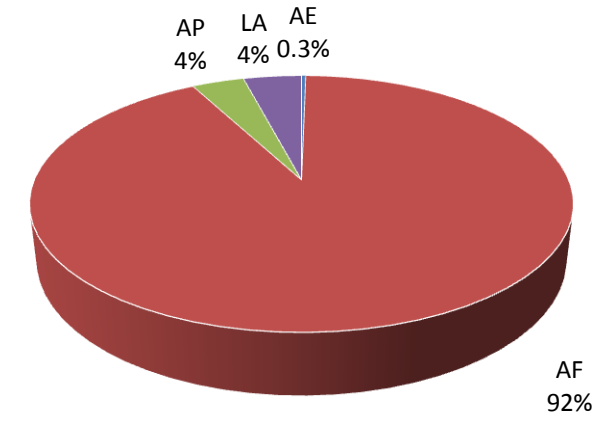


Figure 20: Regional Distribution of Units of Oral Contraceptives, 2007

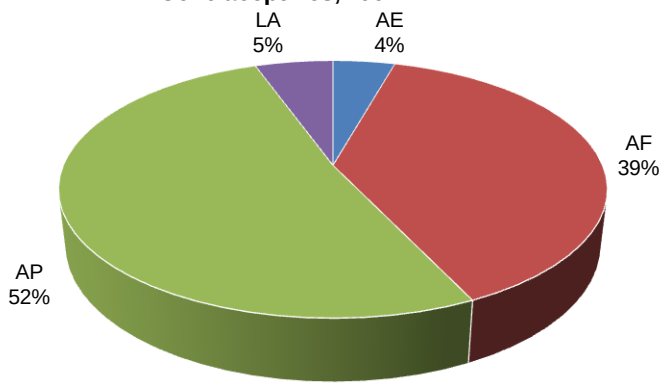


Figure 21: Regional Distribution of Units of IUDs, 2007

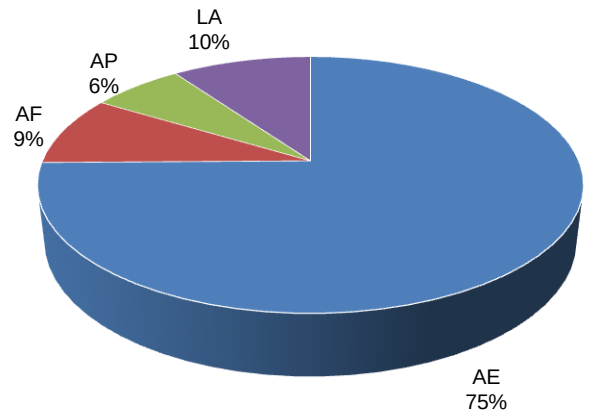


Figure 22: Regional Distribution of Units of Injectables, 2007

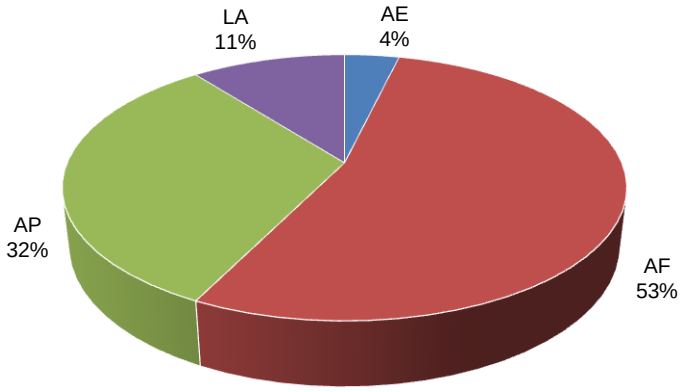


Figure 23: Regional Distribution of Units of Implants, 2007

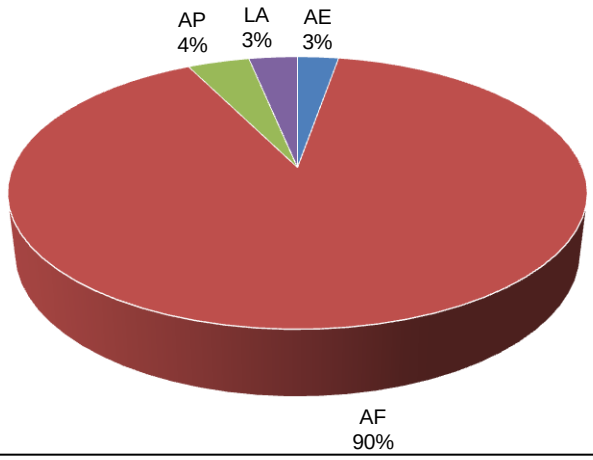


Figure 24 depicts the regional distribution of commodity expenditure by commodity type in 2007. Regions with less than US$ 1 million in expenditure by commodity type were excluded from the graph for ease of visual representation. Regional patterns in terms of expenditure mirror the patterns in terms of quantities procured.

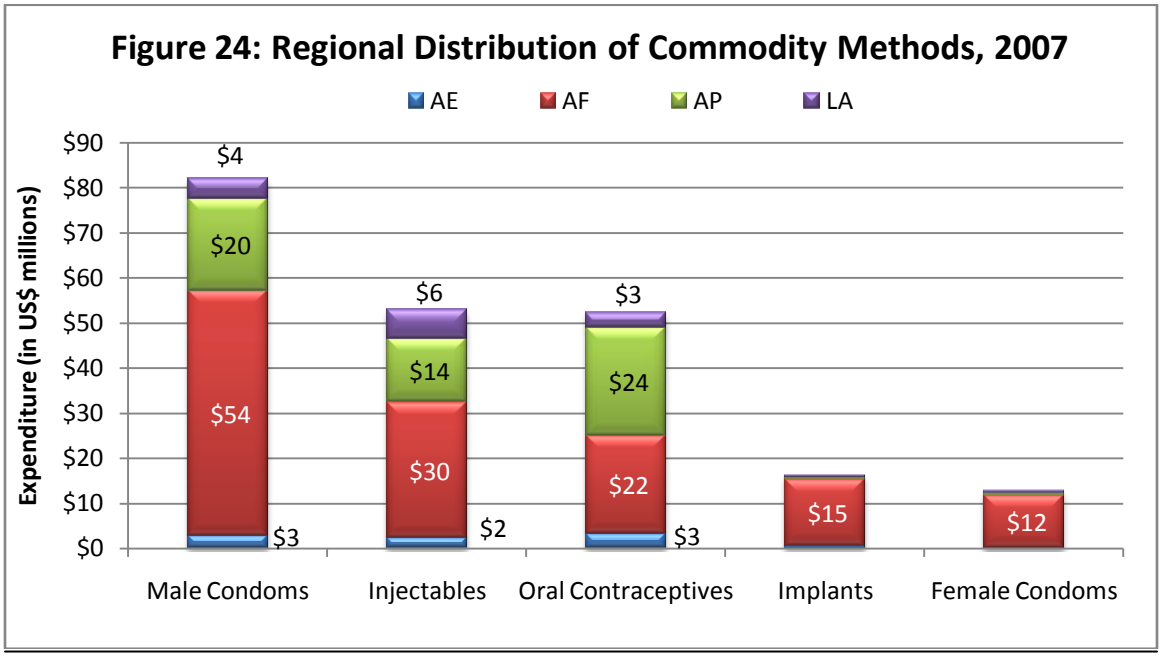
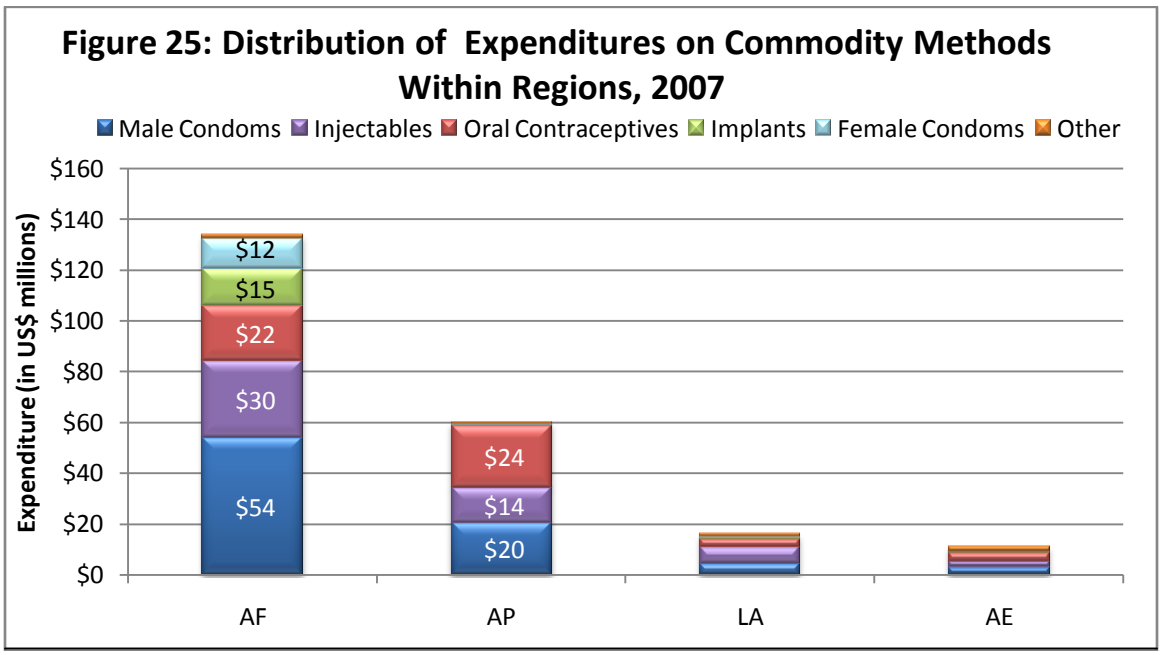


Figure 25 illustrates the expenditure patterns in the four regions in 2007. Sub-Saharan Africa received twice the amount of support for male condoms (US$ 54 million) and about 50% more for injectables (US$ 30 million) than the other three regions combined. Sub-Saharan Africa also received nearly all of the donor support for implants (US$ 15 million) and female condoms (US$ 12 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 closely by male condoms. Largest donor expenditures in LA split evenly between male condoms and injectables.



V. DONOR SUPPORT FOR MALE AND FEMALE CONDOMS

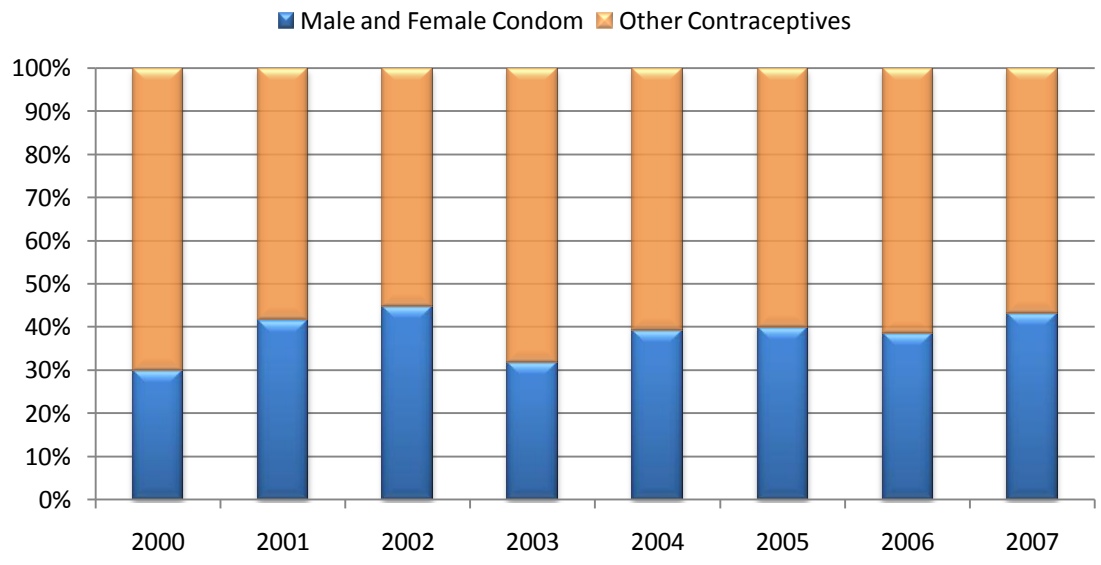
Male and female condoms, when used consistently and correctly, are highly effective at preventing STIs, including HIV. Indeed, male and female condoms are central to efforts to halt the spread of HIV as recognized at the ICPD in 1994 as well as by the UNGASS Political Declaration on HIV/AIDS, adopted 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.

Patterns and Trends in Donor Support for Condoms versus Other Contraceptives

Figure 26 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. According to the graph, the percentage of total donor contraceptive support allocated to condoms has remained essentially constant since 2001, following a sizeable increase from 2000 to 2001. It is important to note that most condoms are provided and utilized for STI/HIV prevention rather than contraception.

Figure 26: Donor Support for Condoms vs. Other Contraceptives, 2000-20007



Male Condoms

Figure 27 depicts trends in donor expenditures on male condoms by region over the period 2000-2007. Total donor expenditure doubled from US$ 46 million in 2000 to US$ 91 million in 2001, dropping slightly to US$ 83 million in 2007. Sub-Saharan Africa received its highest levels of donor support (US$ 54 million) for male condoms in 2007.

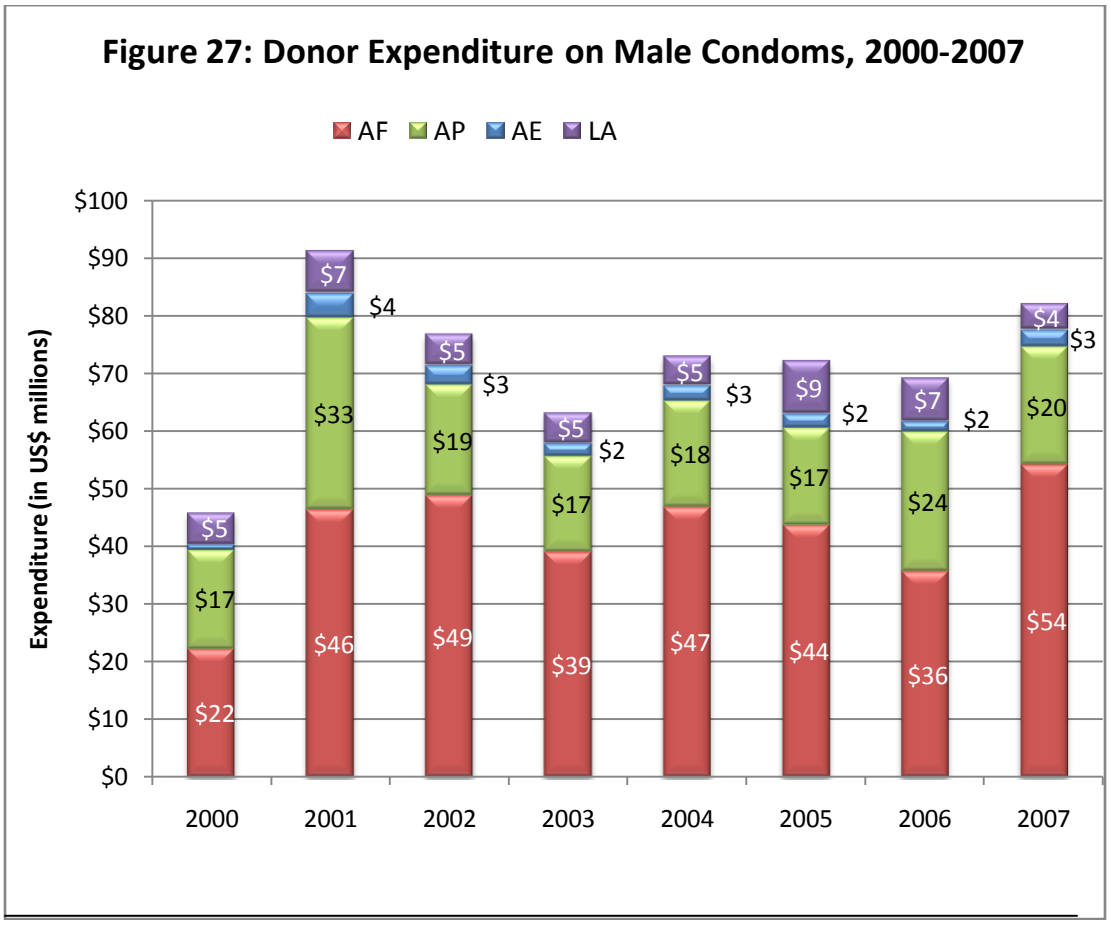


Table 8 summarizes the quantity of male condoms procured by donors in each region from 2000 to 2007. Donors provided a record high of over 3.1 billion male condoms in 2007, representing a near tripling of procurement since 2000 as well as a sharp increase from 2006. Most of these increases have been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

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

Region	2000	2001	2002	2003	2004	2005	2006	2007
AF	422	1,302	1,569	1,031	1,354	1,297	1,038	2,004
AP	638	1,066	667	559	590	584	838	900
LA	102	208	139	121	117	337	263	161
AE	21	153	118	60	42	86	53	90
Total	1,182	2,730	2,494	1,771	2,103	2,305	2,193	3,155

Female Condoms

According to the Female Health Company, the largest supplier of female condoms, global procurement of female condoms from all sources, not just from donors, has doubled from 12.2 million in 2004 to 25.9 million in 2007 (Figure 28).

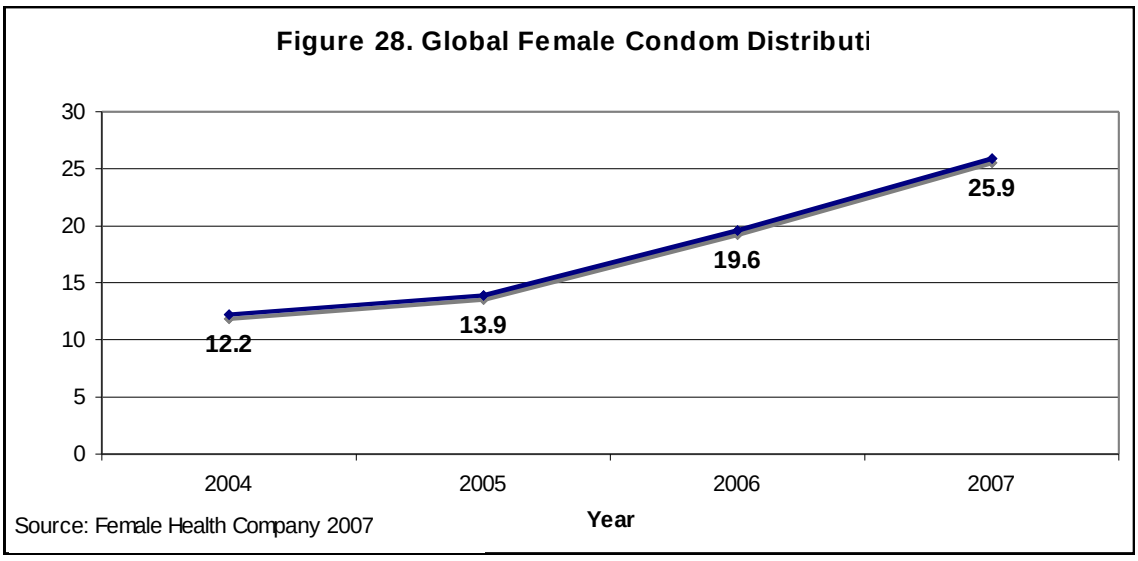


Table 9 summarizes donor expenditures for female condoms by region. Since 2001, donors have increased their support dramatically, from nearly US$ 2 million in 2001 to almost US$ 13 million in 2007. While most of that increase has been directed to sub-Saharan Africa, which received US$ 11.8 million in 2007, the Asia and Pacific region and Latin America and the Caribbean have also seen sizeable increases in donor support for female condoms. Table 10 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 16.5 million in 2007. Most of this increase has been driven by dramatic increases in support to sub-Saharan Africa, which received over 15 million female condoms from donors in 2007. As a percentage of total global procurement (see Figure 28), donors have considerably increased their support since 2001. In fact, by 2007, donors provided over 60% of all female condoms.

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

Region	2001	2002	2003	2004	2005	2006	2007
AF	$1,909	$2,713	$2,265	$5,196	$3,800	$5,965	$11,798
AP	$4	$38	$93	$173	$358	$590	$465
LA	$67	$100	$104	$129	$92	$325	$501
AE	$14	$6	$7	$7	$11	$36	$43
Total	$1,994	$2,857	$2,470	$5,505	$4,261	$6,917	$12,807

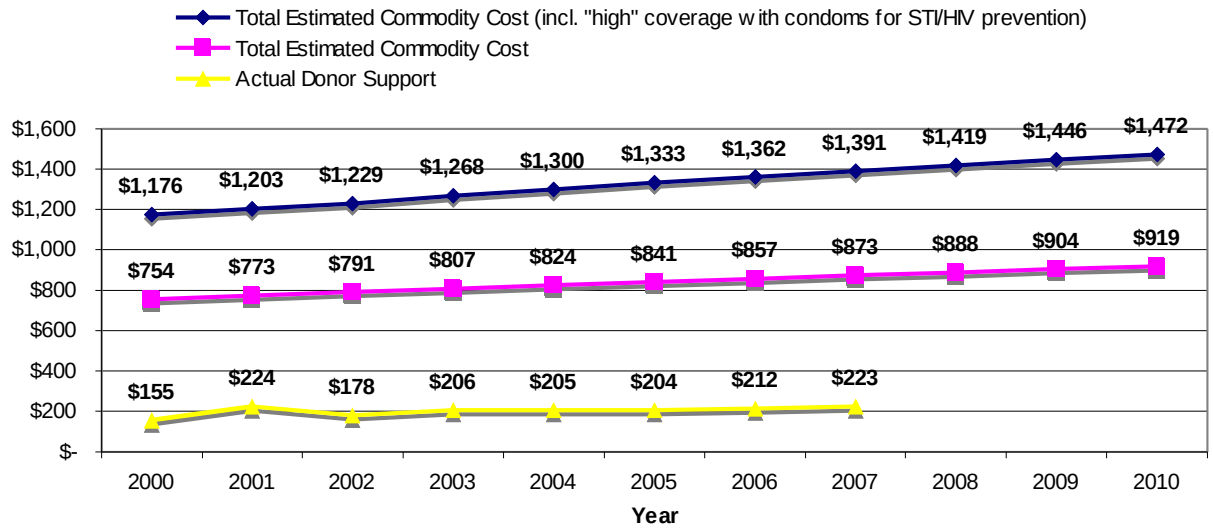
Table 10. Quantities of Female Condoms (in thousands) Provided By Donors

Region	2001	2002	2003	2004	2005	2006	2007
AF	3,810	3,853	4,256	7,275	4,907	8,681	15,108
AP	17	61	216	235	481	848	611
LA	102	146	248	181	115	433	679
AE	21	11	8	9	14	44	49
Total	3,950	4,070	4,729	7,700	5,518	10,006	16,448

VI. COMPARISON OF CONTRACEPTIVE NEEDS AND DONOR SUPPORT

This section compares aggregate donor support with estimated costs of contraception from 2000-2007 in developing countries. Figure 29 illustrates this comparison. Assuming that approximately 655 million women or their partners used contraceptives in 2007, the estimated cost of the needed commodities was $873 million. When condoms for HIV prevention are included, total requirements rise to $1.4 billion. In 2007, donors provided $223 million – or 16% of the total required – in commodities and condoms for HIV prevention.

Figure 29. Comparison of Estimated Costs of Contraceptive Commodities Actual Donor Support



Sources: UNFPA 2006. *Donor Support Report 2006;* UNFPA 2008. *Global Donor Support Database*

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 the main factors that influence the estimated requirements.

Unmet Need

The above projections of family planning users do not take into account the large number of women with so-called "unmet needs" for family planning. 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.[12] The cost of these contraceptives alone, at standard UNFPA prices, would cost an additional $263 million.[13]

Standard Costs
The above projections of commodity requirements were made using standard UNFPA prices. These prices are at the very low end of the cost spectrum, which means that the actual costs might be substantially higher.

Programming Costs
In this context, it is also important to note that supplying contraceptives alone is not sufficient. Ensuring that women and couples actually have access and can use the contraceptives entails substantial programming costs. These systems costs, which are essential for quality service delivery in developing countries, are estimated to amount to a minimum additional cost of four times the cost of the commodities themselves.

Varying Degrees of Donor Dependency
There are also factors that effectively reduce the presented needs. The numbers shown in the graph were calculated for all developing countries regardless of their actual dependency on donor assistance. When countries such as India and China, which do not generally depend on donors for contraceptive and condom supplies, are excluded, the estimated needs decrease dramatically. For example, when China and India are excluded, estimated contraceptive costs fall by $318 million in 2007; the estimated total with condoms for HIV prevention decreases by nearly $505 million.

Sterilization
Another factor that needs to be taken into account is the fact that a large proportion of contraceptive users in developing countries rely on sterilization as their contraceptive method. As this report does not track commodities used for sterilization, current donor support should be compared only to commodity needs for other contraceptive methods.

Other Providers of Contraceptives
Finally, the public sector is not the only sector responsible for providing contraceptive supplies. According to a study on contraceptive projections and distributions, the public sector was responsible for slightly less than half of all oral pill supplies and only about one third of condoms in approximately 90 countries that depend on donor support. The remainder was provided by the private sector, including commercial enterprises as well as NGOs.

[12] 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.
[13] UNFPA estimate.