

What is the Supplies Gap? A New Look at the Data

October 22, 2007

Meeting Minutes

Meeting Participants:

- Stan Bernstein, UNFPA
- Alan Bornbusch, USAID/CSL
- Paul Dowling, USAID | DELIVER PROJECT
- Margot Fahnstock, Constella Futures, USAID Health Policy Initiative
- Jane Feinberg, JSI, RHInterchange
- Pam Foster, DSW
- Carolyn Hart, JSI
- Ali Karim, USAID | DELIVER PROJECT
- Steve Kinzett, RHSC Secretariat
- Elizabeth Leahy, PAI
- Kevin Pilz, USAID/CSL
- Katie Porter, PAI
- Tanvi Pandit-Rajani, Constella Futures, USAID Health Policy Initiative
- Mark Rilling, USAID/CSL
- Suzy Sacher, USAID | DELIVER PROJECT
- John Skibiak, RHSC Secretariat
- John Stover, Futures Institute
- Carolyn Vogel, PAI
- Mimi Whitehouse, JSI, RHInterchange

Carolyn Vogel and Paul Dowling served as moderators. Paul explained that the USAID | DELIVER PROJECT was asked to look into updating the original funding gap analysis presented in *Meeting the Challenge: Securing Contraceptive Supplies*.

Purpose and Uses of Gap Statistics

Carolyn Vogel facilitated a brainstorm regarding the purpose and uses of the donor gap analysis. Highlights of the brainstorm follow, as well as the related decisions that were arrived upon during the course of the meeting.

Uses of gap analysis:	Target audiences:
Create alarm.	Complacent governments
Raise money.	Donors (bilateral, multilateral)
Media	Reporters/policy makers
Influence policy.	National governments
Private sector potential	Manufacturers, other private sector
Internal organization commitment (helps organizations focus their strategies)	Advocacy organizations, other orgs
Create consensus.	Stakeholders
	Researchers (to accept methodology and

What does “the statistic” mean?

- Donor gap
- Gap between supply and demand
- Which supplies does it cover? (**Decision:** Gap refers to contraceptives but new contextualization will put it in the broader context of other sectors/estimates.)
- Which sectors (public, NGO, subsidized etc.?) (**Decision:** needs more thought, but just presenting total demand for all sectors probably not the way)
- Which countries are included? (**Decision:** Tweak the current 87, but essentially donor dependent developing countries (so no China, India))
- Which people?
- Refers to quantities or money? (**Answer:** Money (but derived from quantity calculations).)
- Yearly or cumulative over another time frame? (**Answer:** yearly)
- Is it an estimate or actual? (**Answer:** mix – actuals when can)
- Broad context or specific issue focus? (**Decision:** Gap refers to contraceptives but new contextualization will put it in the broader context of other sectors/estimates.)
- Worldwide or country focus? (**Decision:** Gap is global but will also have a country focus providing information for all countries used in our analysis as well as a phase 2 with more specific information for certain countries.)

Other aspects of an updated gap analysis:

- Short-term vs long-term projection (**Decision:** Project out another 10 years or so. Maybe don't have to go back all the way to 1990 though.)
- Realism vs aspiration (**Decision:** Use median variant and possibly unmet need.)
- Global, regional, vs country statistics (**Decision:** Gap is global but need to provide country information as well.)
- Need to contextualize the gap in the context of general health system needs and other estimates.
- Whether should compare donor funding with total demand or with what is an appropriate percentage for donors to fill (public sector demand) (need vs unmet need)

History of the Gap Calculations and Review of Past Methodologies

John Stover led a discussion about the gap calculations. He began by explaining how the gap was calculated last time and then raised issues related to calculating a new estimate.

Key points:

- Calculations were done at a country level and then aggregated for the region.
- Used UN population figures for TFR

- Employed correlation between CPR and TFR
- Method mix from DHS and from how method mix changes over time as CPR changes (Requirements for condoms also take into consideration HIV.)
- Determined commodity requirements for country by method and year.
- This approach is between aspirational and realism. The gap is not calculated to meet unmet need or desired TFR or replacement fertility. By using the UN median TFR projection there is not much argument, but it is obscure as to what is included and requires making an estimate for countries that haven't yet started their demographic transition.
- Method mix patterns are based on country data over the last 30 years, so low CPR countries don't contribute much to the pattern, and countries that have gone through transition did so years ago, when the method mix was different. It would be good to include source mix too (where users obtain the commodity – whether through the private sector, NGOs, or government). There is good data for most methods in the DHS. There is not a good way to predict change in source mix though, so we could assume the current source mix continues, even though this assumption is problematic.
- We could publish the country-level data. Publishing the gap by country though would be trickier because this would require estimating the funding available by method by country and projecting this into the future.
- Issue with the approach – even though gap has been getting worse, contraceptive prevalence hasn't decreased, but instead has been increasing. It would be helpful if we could address and explain this.

Moving Forward – Harmonizing Approaches

The group then reviewed a handout which compares the methodology used by *Meeting the Challenge* with UNFPA's *Achieving the ICPD Goals* and *Donor Support for Contraceptives and Condoms for STI/HIV Prevention* (2005). (See annex) While the differences in methodology were discussed, it was also noted that some of the same people did the analyses, and that the methodologies were for the most part pretty similar.

A discussion then followed. Key points that were raised include:

Importance of the gap analysis and rationale for a new estimate:

- While there have been somewhat similar exercises by other groups to estimate spending or aspirational needs, the gap analysis is a unique contribution since the other analyses do not attempt to show the gap.
- A new estimate creates an event to get donors' attention again. And global pricetags are being published for other health issues, so it would be good to produce a new estimate.
- Rationale for new estimate – the thought that donor focus on commodities has eroded over the years and the move towards basket funding. We want to draw people's attention back to commodities. Also, one of the assumptions behind the current graph is that donor funding wouldn't change much, but this hasn't been true. It has increased slightly, but as percentage of need it probably has been decreasing.

- Further rationale – to show governments how much the private sector is contributing. Often the private sector doesn't get a seat at the table regarding contraceptive security. This could be an advocacy tool to show what the private sector is providing. In the past there has been a government reaction when they see how little they themselves are contributing. Also, with basket funding this could provide useful advocacy to have a component for commodities. At the global level it could provide competition between the donors (peer pressure). It could also do so at the country level.

Need for providing proper contextualization of estimate:

- Estimates have often been criticized because they don't account for the program costs to support an increase of commodities (such as health workers, mass media to increase demand, marketing, training, etc.) We need to present the commodity gap and contextualize it better than has been done in the past. We can defend commodity gap methodology more robustly though alone than if we included program costs into the gap as well.
- Since reproductive health commodities are not just contraceptives, a question was raised regarding whether the gap should include commodities for basic and emergency obstetrics care as well. Discussion ensued, and it was decided that the focus would be on family planning commodities since budgets are done this way. We do, however, want to put this gap in the context of other needs. We will also mention that by investing in family planning, benefits will be felt in other health programs and other sectors (such as education).

Importance of country focus:

- While we still need more donor funding, the real challenge is convincing the Ministers of Health and Planning and Finance. If this is in fact the case, it is more important to have a country gap (instead of a global gap).
- The focus needs to be at the country level. But we have less confidence in the estimates and are not sure people at the country level will buy into it since they didn't help produce it. So it might not be as helpful as global data.
- We have country-level data on the cost of commodities needed. There was a suggestion to compare this to the total national health budget to show the country cannot pay for what is needed given the country's other health needs.
- It would be great to build data up from the ground level with input from country people and from there to build up to global estimates. This way we would ensure more buy-in from the country level and better global estimates. This would be much more expensive and time-consuming though.
- We could go ahead with the global analysis and then think of country workshops as a follow-up. Or we could just develop a tool and encourage people to use it at the country level.

Methodology:

- We need to agree on what the need for commodities is and also say approximately how much donors, the private sector, and the country is giving. Given trend to use basket funding though, there was a question regarding

whether we can obtain donor funding estimates or should instead just look at governments (who are making the allocations). It was explained though that we have enough information to obtain extrapolations of donor funding.

- Two new areas of money need to be included – national budgets and pocketbooks. Maybe this could be done regionally or sub-regionally.
- Desire to be able to break down the public sector need since it doesn't capture everything. Can we get at projected need based on income level (instead of total need)? There's better data now about who can and cannot pay. Also governments have their own ideas about who should pay and who shouldn't have to. Extrapolating from current use patterns can be helpful too. (Sometimes the poor are paying more though because they don't know how to access subsidized commodities.)
- Wouldn't have to compare new graph to graph from 10 yrs ago since the methodology will change.
- Current methodology uses a single projection – the median variant. We could use an alternate projection, such as meeting current unmet need. Or a gap but without saying who fills it.
- What countries should we include? Do we want non-donor-dependent countries (like China) in this analysis since this is meant to have broader use than just to drum up donor support? Should we focus on the UN category of low-income countries instead? **Decision:** tweak the 87 used in the current gap analysis.
- Suggestion: use a more absolute measure of poverty than the Sine methodology in order to compare countries better.

Consensus

Carolyn then summed up the consensus for moving forward. These can be found here and in the decisions noted on p.2:

- There is a need for an updated global gap figure and for it to be contextualized as well (based on other costing exercises, new financing environments, etc.).
- We should project the gap at the country level as well – in a few countries to begin with since data collection will be intensive at country level.
- Possible alternate projections in addition to using UN medium variant as a target:
 - Unmet need
 - Country targets
 - Universal access
- Need vs donor gap: We can emphasize a donor gap or a need gap
- Potential sources of funding

Annex – handout

Comparison of “Meeting The Challenge” Analysis and UNFPA “Achieving the IPCD Goals” (2005) and “Donor Support for Contraceptives and Condoms for STI/HIV Prevention” (2005) (Latter is based on the former)

Topic	Meeting The Challenge	UNFPA
Year	2001 (latest data 1999)	2005
Period	1990 – 2015 (2000 -2015) for projections	2000 -2015
Published by	JSI (FPLM)	UNFPA
Funded by	USAID	UNFPA
Authored by	John Ross, Randy Bulatao	Randy Bulatao (principal author)
Country Scope	87 developing countries only. Excludes China, India, Caucasus, Russia, Ukraine (Eastern Europe) Criteria for exclusion: not donor dependent	All developing countries (not explicit on criteria)
Demand Scope	Public sector only Excludes social marketing, subsidized private sector	All
Commodity Scope	Contraceptives, condoms for STI Include sterilization?	Contraceptives, condoms Does not include cost of commodities for sterilization (part of a larger piece for all RH commodities)
Commodity Costs	UNFPA prices? (not 100% clear) No allowance for inflation	Weighted averages of UNFPA & USAID prices Inflation? (not clear)
CPR	Based on meeting UNDP TFR projections	Based on meeting UNDP TFR projections
Method mix	Based on DHS and other surveys (for 87 countries)	Based on DHS and other surveys
Population projections	UNDP	UNDP
Financial support	Donors (UNFPA data) Note: Excludes Global Fund, is there some double counting? (e.g PSI) some counting of govt money (UNFPA)	Donors (UNFPA data) Note: Excludes Global Fund, is there some double counting? (e.g PSI) some counting of govt money (UNFPA)
Condom Projections		