



MINISTRY OF HEALTH
PRIMARY HEALTH CARE DIRECTORATE
REPRODUCTIVE HEALTH UNIT

National Contraceptive Security Strategy

June 2003



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Acronyms

| | |
|----------------|--|
| ICPD | International Conference on Population and Development |
| UNFPA | United Nations Fund for Population |
| USAID | United States Agency for International Development |
| LMIS | Logistics Management Information System |
| CPR | Contraceptive Prevalence Rate |
| ICMH | International Center for Migration and Health |
| MOH | Ministry of Health |
| NCSC | National Commission for Contraceptive Security |
| ASMA | Albanian Social Marketing Association |
| NGO | Non Governmental Organization |
| KfW | German Bank for Development |
| NESMARK | Social Marketing Unit for Contraceptives |
| CYP | Couple Years of Protection |

Major Questions Related to Contraceptive Security and the Future Policy of Family Planning in Albania

1. How will Albania define "contraceptive security" and "contraceptive independence?" How will we know when contraceptive security and/or contraceptive independence have been achieved?
2. How and when are the family planning programs in Albania (social marketing and public sector) to achieve contraceptive security? What role should donors play in the short and medium term to ensure long-term contraceptive independence?
3. How will the NCSC's Secretariat functions be handled once the JSI/TASC project ends in 2003?
4. How is Albania to build political support for contraceptive security so that an MOH budget allocation for contraceptives is eventually forthcoming?
5. Should the development of a national Reproductive Health Policy be a priority for the MOH? Is it possible to achieve contraceptive security without an overall national Reproductive Health Policy?
6. Should the status quo regarding the contraceptive method mix be accepted? Discussions of the method mix will lead to a number of subsidiary questions, including:
 - a. Should the public program reduce (or stop) supplying condoms, or even oral pills, and leave these methods to the social marketing and commercial sectors?
 - b. Should there be more emphasis on IUDs, perhaps expanding access by authorizing nurses to insert IUDs?
 - c. Should method choice be expanded in Albania, e.g., implants and female condoms. Should more emphasis be placed on permanent methods?
7. How should the contraceptive market in Albania be segmented among public, social marketing and commercial sectors? How can family planning services in Albania be better targeted? What is the best process for achieving this segmentation? How and by whom will the segmentation be monitored and adjusted? What implications does segmentation of the contraceptive market have for MOH contraceptive procurement?
8. How is the "contraceptive security constituency" in Albania to be expanded? How might the NCSC reach out to women's groups, consumer groups, etc.
9. How will we assure success in the continued collection of information from the commercial and social marketing sector?

A. Definition of Contraceptive Security

For family planning programs, the vital importance of contraceptives is often summed up by the slogan: *No Product, No Program*. Without contraceptive security, families will be unable to space their births, limit their family size, and time pregnancies.

Contraceptive Security

A guaranteed long-term supply of quality contraceptives for every Albanian who wants them, in accordance with the ICPD goal of universal access to reproductive health services.¹

Contraceptive Independence

Complete self-reliance in maintaining contraceptive security, with no need for external donors to fund contraceptives or related logistics technical assistance.

Once having achieved contraceptive security, partly with donor assistance, Albania like any European country will strive for contraceptive independence. **Contraceptive independence is the surest form of contraceptive security.**

At a minimum, Albania will declare that contraceptive security has been achieved when it is able to do the following:²

- Accurately estimate its contraceptives requirements in a way that prevents national shortages and/or stock-outs;
- Effectively mobilize financial resources (either from the government budget or elsewhere) to cover the cost of contraceptives;
- Timely procure or arrange procurement of the required contraceptives in an efficient and cost effective manner;
- Guarantee the delivery and availability of contraceptives to all users and potential users in the country.

B. Contraceptive Security: A Global Challenge

Contraceptive security is a global challenge as well as a challenge for Albania. The goal of the international community, led by major contraceptive donors such as UNFPA and USAID, is to mobilize stakeholders and resources worldwide to pursue security for contraceptives and other reproductive health products. Globally, the gap between the cost of the contraceptives required in the world and the funding available for purchasing them is projected to reach hundreds of millions of dollars by 2015. Four major factors are contributing to the growing gap between global contraceptive funding and contraceptive requirements:

¹ 1999 ICPD+5: "Governments should strive to ensure that by 2015 all primary health-care and family planning facilities are able to provide, directly or thorough referral, the widest available range of safe and effective family planning and contraceptive methods: essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases; and barrier methods, such as male and female condoms and microbicides, if available, to prevent infection." UN General Assembly, July 1999.

² Criteria adapted from *Programs That Deliver: Logistics' Contribution to Better Health in Developing Countries*, USAID Publication prepared and published by FPLM/John Snow, Inc., 2000.

1. More People Using Contraceptives. The worldwide success of family planning and reproductive health programs is enabling more and more couples to choose to manage their fertility, and this results in a demand for more and more contraceptives. Globally, the number of contraceptive users will rise by 28 percent in the next five years, and by 79 percent by 2015, representing an increase of 105 million users.³ This trend is evident in Albania, with contraceptive use continuing to rise.⁴

2. More People of Reproductive Age. Rapid population growth in the last decades of the 20th century means that many people are now entering their reproductive years, and an even larger group of adolescents will soon follow. Globally, the number of women of reproductive age is projected to grow 36 percent by 2015. Albania has a relatively young population. The average age is 29 years old⁵ which means that the number of women of reproductive age will increase substantially in coming years, thus increasing the demand for contraceptives.

3. Insufficient, Poorly Coordinated Donor Funding for Contraceptives. Donors do not provide enough money to meet the global need for subsidized contraceptives. The problem is made worse by a lack of coordination between governments and donors, and among contraceptive donors themselves. Worldwide, by 2015, it is estimated that the contraceptive funding gap will exceed US\$100 million if current donor trends continue.⁶ In Albania, both the public and social marketing sectors are totally dependent on donor-funded contraceptives, with no guarantee that these donations will continue.

4. Inadequate Logistics Capacity in Developing Countries. Countries with the fastest growing number of contraceptive users are often the ones with the poorest logistics infrastructures for delivering contraceptives to users. Although it successfully established a nationwide LMIS in 2002, the MOH in Albania depends on UNFPA funding for central storage facility for contraceptives, and a delivery system to move contraceptives from Tirana to the districts. This UNFPA support is not certain beyond 2005.

C. Current Status of Contraceptive Security in Albania

Family planning was legalized in Albania, with government order no.226, in May 1992.⁷ Since January 1996, based on an order from the MOH, contraceptives have been distributed for free in all government health centers. Currently family planning services are offered in 283 woman consultancy rooms, maternity hospitals, and health centers at commune level. Today a variety of modern contraceptive methods⁸ are available from public (free), social marketing (subsidized) and commercial sources. In 2000, two separate surveys⁹ estimated the contraceptive prevalence rate (CPR) for modern methods to be between 15% and 17% (a comprehensive Reproductive Health Survey due in late 2003 will provide a more precise

³ Ross, J. and R. Bulato. "Contraceptive Projections and the Donor Gap." Washington DC: The Futures Group International for John Snow, Inc., 2001.

⁴ Between the 3rd calendar quarter of 2002 and the 1st calendar quarter of 2003, the estimated couple years of protection provided by contraceptives distributed in the public sector increased by seven percent.

⁵ INSTAT, *Statistical Yearbook*, 2003, page 28.

⁶ Population Action International, "Meeting the Challenge," April 2001.

⁷ Act of Parliament no 226.

⁸ Modern contraceptive methods available in Albania: condoms, oral contraceptives, injectables, IUDs, and voluntary surgical contraception.

⁹ ICMH, *Albania Knowledge, Attitudes, Beliefs and Practices Survey 2000*, and the UNICEF, *Multiple Indicator Cluster Survey Report: Albania*, 2000.

CPR estimate.) While actual unmet need for contraception is unknown¹⁰, low Contraceptive Prevalence (CPR), together with the reportedly high abortion rate, suggests that unmet need for contraception is high.¹¹ This situation reflects the socio-cultural difficulties and barriers that exist, lack of information to the population, and the low quality services that are still offered.

In 2001, a major stock-out of contraceptives in the public sector threatened the family planning gains made during the 1990s. One positive outcome of this crisis was the acceptance of "contraceptive security" as the conceptual framework for ensuring reliable contraceptive availability in the future. The Ministry of Health (MOH) has responded by 1) arranging an emergency supply of contraceptives (provided by USAID); 2) establishing a reliable, nationwide contraceptive Logistics Management Information System (LMIS) that allows for accurate contraceptive forecasting, procurement and distribution; and 3) establishing a National Contraceptive Security Commission of all contraceptive stakeholders (public, social marketing and commercial) to work collaboratively toward contraceptive security in Albania.

| Contraceptive Donors in Albania, 2001-2003 | | | | |
|---|--------------------|---------------------------|----------------------|-----------------------|
| | <i>IUD (piece)</i> | <i>Injectable (vials)</i> | <i>Orals (piece)</i> | <i>Condom (piece)</i> |
| UNFPA | 4,730 | 20,200 | 256,667 | 417,600 |
| USAID | 6,600 | 24,000 | 0 | 594,000 |

D. National Contraceptive Security Commission

The National Contraceptive Security Commission (NCSC), which first met in October 2001. Members include representatives from the public sector, the two social marketing programs, the private commercial sector, a local family planning NGO, and donors/international agencies contributing to contraceptive security in Albania.

Members of the Contraceptive Security Commission

Deputy Minister and Chair of the Commission
 PHC Director/Ministry of Health
 Reproductive Health Unit/Ministry of Health
 Statistics Unit/Ministry of Health
 Pharmaceutical Directorate/Ministry of Health
 Director, Albania Family Planning Association (AFPA)
 Director, SCHERING Pharmaceuticals
 Director, NESMARK
 Director, PSI/ASMA
 Health Team Leader, USAID
 Chief of Party, JSI/TASC
 Deputy Chief of Party, JSI/TASC
 General Director of the Obstetrical-Gynecological University Hospital
 Chief of Obstetrical-Gynecological Department
 UNFPA

¹⁰ Lothar Springen in a 1996 UNFPA Evaluation Report estimated unmet need at 40% of women of reproductive age

¹¹ Reproductive Health Survey results to be published in December 2003 will provide the first accurate estimate of CPR in Albania, and also quantify the unmet need for contraception. These survey results will be very useful to policymakers in guiding Albania toward contraceptive security.

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The National Contraceptive Security Commission is now accepted as the focal point and policy-designing authority for contraceptive security in Albania. At its fourth meeting in February 2003, the Commission authorized the immediate drafting of this Contraceptive Security Plan as a first step toward developing 1) a National Family Planning Strategy by 2004, and 2) a comprehensive Reproductive Health Strategy for Albania by 2005.

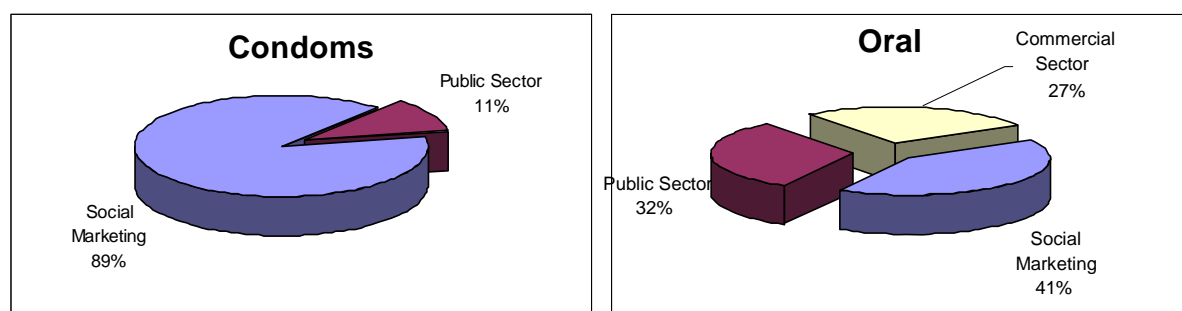
Brief Stakeholder Analysis of the National Contraceptive Security Commission (NCSC)

The **public sector**, and in particular the MOH, sets national reproductive health policy and is a major provider of "free" contraceptives. From the MOH/public sector's perspective, the NCSC serves three main purposes:

- 1) It serves as a multi-sectoral policy advisory group that provides valuable insight and information on family planning, and especially on contraceptives. It provides an opportunity to review current evidence on contraceptive methods not yet introduced in Albania.
- 2) It serves as a convenient mechanism for communicating national policy and exercising the MOH's national policy oversight authority and responsibility;
- 3) It serves as an advocacy group that assists the MOH in designing, preparing and reviewing policy (especially with regard to allocating public funds to procure contraceptives.)

The **social marketing programs** (ASMA, NESMARK) are already the main providers of condoms and oral contraceptives in Albania. Social Marketing groups identify their target populations, choose the suitable products, assess the price, then advertise and promote these products which are, in turn, distributed through a defined distribution network.

Figure A: Market Share for Condoms and Orals in Albania 2003



Source LMIS/MOH data for the first quarter 2003

Both ASMA and NESMARK depend on donor funding to be able to sell their contraceptives at subsidized prices (both also envision a more self-reliant future in which they will be less dependent on donors). From social marketing's perspective, the NCSC serves three main purposes:

- 1) it provides social marketing with a national commission where its interests can be articulated and protected, and where social marketing is able to influence national policies affecting the future of social marketing in Albania;

- 2) it provides a mechanism for raising the profile of social marketing as a key provider of contraceptives in Albania, thus lending legitimacy to social marketing and strengthening their negotiating position vis-à-vis the donors who support them;
- 3) it provides insight and information on the plans and activities of other Albanian contraceptive stakeholders and providers.

The private **commercial sector** (international pharmaceutical firms) currently supplies an insignificant quantity of contraceptives in Albania (except for 27% of oral contraceptives) but plans to increase sales in the future. From the commercial sector's perspective, the NCSC serves two main purposes:

- 1) it provides insight and information on the contraceptive market in Albania that may help the commercial sector with future marketing strategies;
- 2) it demonstrates corporate social responsibility and a commitment to improved health in Albania.

Local NGOs involved in family planning currently provide a small quantity of contraceptives, but there is the potential for expansion as civil society develops in Albania and the number of NGOs grows. From the NGO's perspective, the NCSC serves three main purposes:

- 1) it provides NGOs with a national commission where NGO interests can be articulated and protected, and where NGOs can influence national policies;
- 2) it provides a mechanism for raising the profile of NGOs as providers of contraceptives in Albania, thus lending legitimacy to NGO programs and assisting in fund-raising;
- 3) it provides insight and information on the plans and activities of other Albanian contraceptive providers.

Donors and international organizations, particularly USAID, UNFPA and KfW, have invested substantially in the FP program in Albania, and are committed to continued support. From the donors' perspective, the NCSC serves three main purposes:

- 1) it demonstrates MOH commitment to contraceptive security goals and objectives;
- 2) it provides a national forum for coordinating contraceptive donations, reducing waste and inefficiency, and fostering transparency;
- 3) it represents a step toward sustainability and eventual contraceptive independence in Albania.

E. Contraceptive Security in Albania: Major Strengths

1. Contraceptive stock-outs are now rare, due primarily to recent improvements in the contraceptive logistics information and distribution systems.

-
2. Adequate contraceptive supplies are ensured for the short-term:
 - the public sector (MOH) currently has approximately a two-year supply (already in-country) of all required contraceptives (based on current usage patterns.)
 - ASMA currently has UNFPA funding for approximately a three-year supply of condoms (based on ASMA sales projections.)
 - NESMARK is re-negotiating its current agreement with KfW to obtain a five-year supply of contraceptives (based on NESMARK sales projections.)
 3. Albania has an effective, multi-sectoral National Contraceptive Security Commission (NCSC), chaired by the Deputy Minister, which meets regularly to deal with the contraceptive security issues facing the country.
 4. Two strong social marketing programs are actually the major supplier of condoms and oral pills in Albania, and in the future have potential for expansion.
 5. The commercial sector, poised for a major expansion of its role in the Albania health sector, has the potential to increase its contribution to contraceptive security by supplying contraceptives to those who are able to pay.
 6. A reliable nationwide Logistics Management Information System (LMIS) became functional in mid-2002 and currently provides timely data for contraceptive decision making (policy, procurement and distribution.) By combining contraceptive sales and distribution data from the public, social marketing and commercial sectors, the LMIS allows for effective and timely contraceptive decision-making that reduces stock-outs and helps ensure universal access to contraceptives. This helps the FP program to better meet client needs.
 7. The MOH is committed to making the necessary policy and budget adjustments to achieve contraceptive security, and key donors (USAID, UNFPA) are committed to supporting contraceptive security.
 8. Market segmentation for contraceptives has evolved in Albania, with the social marketing sector providing the bulk of the re-supply methods (condom and pills), and the MOH providing the longer-term methods (IUDs and injectables). The stage is set, therefore, for a more formal market segmentation strategy based on the comparative advantages of the various sectors and services.
 9. The current practice of reimbursing some of the costs of essential drugs for those unable to pay may provide a future distribution channel for contraceptives.

F. Contraceptive Security in Albania: Major Weaknesses

1. Albania lacks a tradition of public/private partnership of the type needed to achieve genuine, long-term contraceptive security and contraceptive independence.
2. The public sector currently depends heavily on donors for contraceptives and logistics support. The MOH relies entirely on donor-supplied contraceptives, as well as donors to fund central-level contraceptive storage (UNFPA), MOH contraceptive distribution from Tirana to the 36 districts (UNFPA), and major LMIS and logistics technical assistance (USAID.)

3. The MOH has never procured contraceptives, and therefore has no contraceptive procurement expertise or experience. Contraceptives are not, and have never been, included in the MOH pharmaceutical budget.
4. There is no formal market segmentation strategy for contraceptives in Albania. The commercial sector, for example, has been relegated to an insignificant role as a source of contraceptives due to the widespread availability of free and/or subsidized contraceptives. Likewise, the social marketing programs often see themselves as competing with the public sector's "free" contraceptives.
5. Albania lacks a national Reproductive Health Strategy that would provide a framework within which to work toward contraceptive security. A Reproductive Health Strategy would address issues such as contraceptive method mix, market segmentation, and better targeting of services -- all of which have potentially large impacts on long-term contraceptive security.
6. The key mechanism for contraceptive security in Albania - The National Contraceptive Security Commission - is a relatively new institution, and the roles and responsibilities of members require further clarification..

G. Contraceptive Security Goals and Challenges

Long-Term Goal for the Public Sector: Contraceptive Independence by 2010

The public sector's long-term goal is contraceptive independence in 2010. This will be achieved incrementally in a manner already used by the GOA to assume the costs of vaccines. GOA financial participation will increase according to the following schedule:

| | |
|------|------|
| 2005 | 10% |
| 2006 | 20% |
| 2007 | 40% |
| 2008 | 60% |
| 2009 | 80% |
| 2010 | 100% |

The following tables present the quantities of contraceptives required for the period 2005-2010 and the financial contribution of the MOH and Donors to cover the need for contraceptives

Total Quantity of Contraceptives Forecasted

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|----------------------|--------|--------|--------|--------|--------|--------|
| Orals (cycle) | 84164 | 94263 | 105575 | 118244 | 132433 | 148325 |
| Condom (piece) | 438214 | 386359 | 444313 | 510960 | 587604 | 675744 |
| IUD (piece) | 0 | 3726 | 4323 | 5014 | 5816 | 6747 |
| Depo-Provera (vials) | 15078 | 23321 | 27052 | 31381 | 36402 | 42226 |

| Year | Total | Existing Stock on Hand | GoA | | Donors | |
|------|-----------|------------------------|-----------|------|-----------|------|
| 2002 | \$93,056 | \$93,056 | \$0 | 0% | \$93,056 | 100% |
| 2003 | \$106,732 | \$106,732 | \$0 | 0% | \$106,732 | 100% |
| 2004 | \$122,429 | \$91,754 | \$0 | 0% | \$122,429 | 100% |
| 2005 | \$140,450 | \$6,280 | \$14,045 | 10% | \$120,125 | 90% |
| 2006 | \$161,140 | \$0 | \$32,228 | 20% | \$128,912 | 80% |
| 2007 | \$184,896 | \$0 | \$73,958 | 40% | \$110,938 | 60% |
| 2008 | \$212,175 | \$0 | \$127,305 | 60% | \$84,870 | 40% |
| 2009 | \$243,502 | \$0 | \$194,802 | 80% | \$48,700 | 20% |
| 2010 | \$279,482 | \$0 | \$279,482 | 100% | \$0 | 0% |

Ministry procurement of the Depo-Provera required for 2005 would correspond to the 10% proposed under the phased approach. Injectables are a medical method. About $\frac{3}{4}$ of injectables are provided by the public sector. This means that GoA should include the cost of the procurement in the 2004 budget. At the same time the MOH has to ask for the Donors' support to cover the other part of the cost (e.g. 2005-90%, 2006-80%,.....2010-0%)

Long-Term Goals for Social Marketing Sector

NESMARK hopes to cover 100% of operational costs by 2008, and continue to rely on donor-supplied commodities beyond 2008

ASMA already recovers the full cost of the condoms that it sells, but will continue to rely on donors for operating costs. ASMA funding is currently secured only through 2005

Medium Term Goal: Contraceptive Security in 2004

Albania's **medium-term goal is contraceptive security** by 2004 (reliable, universal access to contraceptives.) Access to contraceptives is now widespread in Albania, but not yet universal. Rural districts especially suffer from limited access. Some remote rural communities have access to social marketing but not yet access to public sector outlets.¹² Contraceptive security will thus be achieved by

- 1) expanding FP services and contraceptive availability to commune – level health centers in all 36 districts;
- 2) enhancing the current national LMIS to provide the data required for contraceptive procurement and distribution based on strategic market segmentation;
- 3) monitoring and coordinating public, social marketing and commercial sector contraceptive sales/distribution through the National Contraceptive Security Commission. This will require the commission to use existing and supplemental information in the conduct of a market segmentation analysis.

¹² The MOH currently provides full FP services (including contraceptives) in 20 districts. In the remaining 16 districts, only a few designated MOH facilities provide FP services and contraceptives.

Immediate Challenges Facing Contraceptive Security in Albania

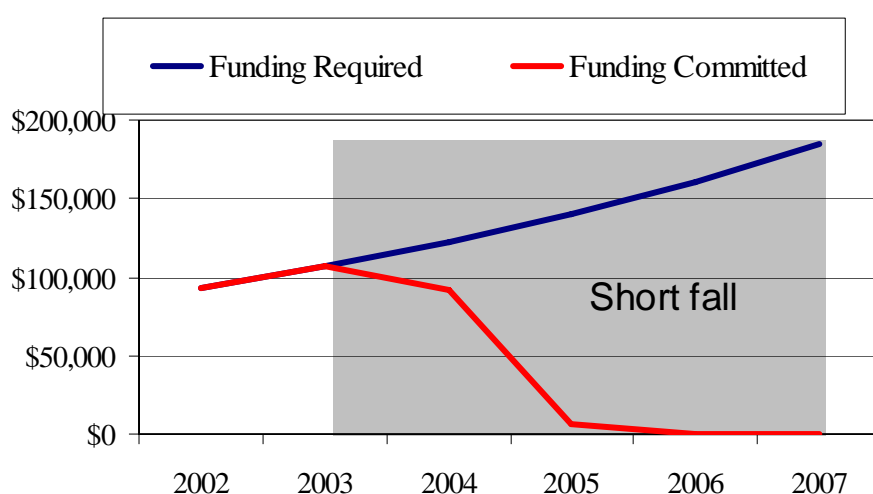
- Challenge 1: Mobilizing stakeholders. Action is needed now because 1) international contraceptive procurement pipelines are typically 1-2 years; 2) the required policy and budgetary changes may need several years to complete; and 3) social marketing programs must begin now to gradually increase their cost recovery and become more self-reliant. The challenge is to use 2003-2004 when contraceptive stocks are high as an opportunity for moving rapidly toward contraceptive security and contraceptive independence.
- Challenge 2: Government funds are limited. Donors and other stakeholders will need to support the MOH in its efforts to achieve Contraceptive Security.
- Challenge 3: Strengthen and further institutionalize the National Contraceptive Security Commission. The NCSC needs to further define the roles and responsibilities of its members, better articulate its mission, norms and procedures, and agree on problem identification and problem solving approaches.
- Challenge 4: Engage donors in ways that ensure short and medium term availability of contraceptives while simultaneously ensuring long-term contraceptive independence. The NCSC should carefully review the role of donors and seek to tailor donor inputs to meet Albania's long-term goal of contraceptive independence.
- Challenge 5: Achieve consensus on the major contraceptive issues facing Albania, and convince all stakeholders that contraceptive independence (no reliance on donors) is a realistic goal for the public sector by 2009. .
- Challenge 6: Develop a national Reproductive Health Strategy for providing universal access to FP services and contraceptives in Albania, ultimately without donor assistance.
- Challenge 7: Mobilize the commercial sector to play a prominent role in contraceptive security by developing a true public/private partnership that includes, among other things, expansion of the commercial sector's contraceptive market share in Albania. Encourage private companies to import contraceptives directly to the commercial market. This requires not only changes in government policies and procedures, but also the development of goodwill, trust and flexibility on both sides.
- Challenge 8: Develop and implement a market segmentation strategy for contraceptives that shifts poor clients to the public sector and all other clients to the social marketing and commercial sectors.

H. Contraceptive Funding Shortfall

The size of the shortfall depends on how rapidly contraceptive consumption rises in the next five years -- the more rapid the increase in contraceptive use in Albania (CPR), the larger the funding shortfall becomes.

Figure B: Estimated Contraceptive Funding Shortfall in Public Sector

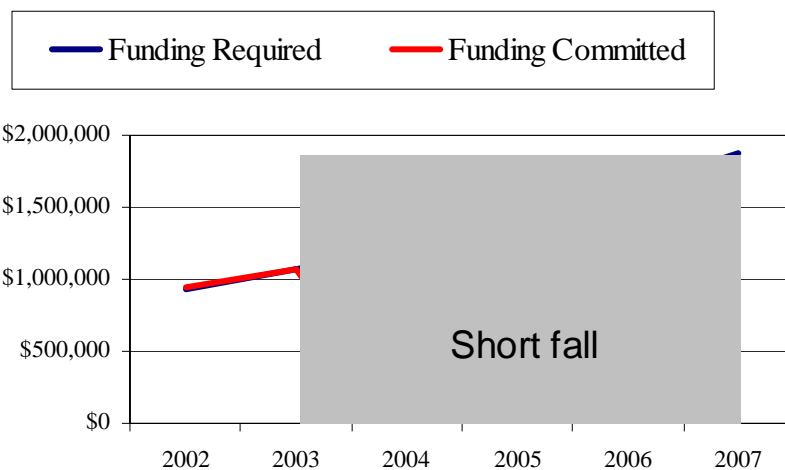
| | | Funding Required | Funding Committed |
|-------------|------|------------------|-------------------|
| Actual | 2002 | \$93,056 | \$93,056 |
| Projections | 2003 | \$106,732 | \$106,732 |
| Projections | 2004 | \$122,429 | \$91,754 |
| Projections | 2005 | \$140,450 | \$6,280 |
| Projections | 2006 | \$161,140 | \$0 |
| Projections | 2007 | \$184,896 | \$0 |



Contraceptives already in country (supplied by USAID and UNFPA) are estimated to meet all public sector requirements until 2004. Based at the long-term strategy for contraceptive security presented at this document, the MOH will need to arrange additional funding from Donors to cover the uncovered part of the total cost required (e.g.2005-90%, 2006-80%,.....2010-0%)

Figure C: Contraceptive Funding Shortfall in Social Marketing Sector

| | | Funding Required | Funding Committed |
|-------------|------|------------------|-------------------|
| Actual | 2002 | \$928,635 | \$937,665 |
| Projections | 2003 | \$1,068,088 | \$1,068,088 |
| Projections | 2004 | \$1,228,498 | \$0 |
| Projections | 2005 | \$1,413,014 | \$0 |
| Projections | 2006 | \$1,625,262 | \$0 |
| Projections | 2007 | \$1,869,413 | \$0 |



Unlike the public sector, the social marketing sector does not have a multi-year supply of contraceptives in-country. Funding shortfalls begin in 2004 and are projected to grow larger with each passing year.

ANNEXES

ANNEX 1

Checklist for Monitoring Contraceptive Security

Financing

- Funding shortfall? Based on accurate projections?
- Funding requirements well communicated to decision-makers?
- Local contraceptive procurement experience/expertise?
- Transparency in projecting requirements, costs, and procurement decisions?
- Over-dependence on donors? Potential for local cost-recovery?
- Government spending on contraceptives? How much now? How much in future?
- Social Marketing/commercial sector prices for contraceptives as a barrier?

Efficiency

- Supply chain efficiency?
- Procurement efficiency?
- Market segmentation? Service delivery efficiency?
- Subsidies and targeting?

Logistics Management

- LMIS provides accurate and timely data? Data used for decision-making?
- Procurement and distribution?
- Logistics skills? Logistics training?

Access

- Are contraceptives easily available? To whom? Which methods?
- Gender/age access barriers? (males, adolescents, etc.)
- Financial barriers to access? (poverty, youth without income, opportunity costs)
- Provider attitudes? (bias for/against certain contraceptive methods)

Quality

- Full range of contraceptive available to maximize choice?
- Standardization of products? (WHO standards, Albanian standards)
- Local quality testing?
- Packaging?
- Client acceptance of product? Client attitudes toward product?

Partnerships and Political Commitment

- Genuine public/private partnership to achieve contraceptive security?
- Donor coordination for contraceptive security?
- Involvement of private pharmaceutical firms?
- Contraceptive security consensus among public/social marketing/commercial sectors?
- Advocacy and mutual support for contraceptive security?
- How large is the contraceptive security constituency? How influential?
- Inter-ministerial partnerships (Customs Service, Ministry of Finance, etc.)
- Community partnerships?

ANNEX 2

Sample Short-Term Action Plan for Contraceptive Security

| | Action | Date | Responsible |
|---|--|-------------|-----------------------------|
| 1 | Conduct a formal Market Segmentation Study for contraceptives | Oct '03 | NCSC (assist from donor) |
| 2 | Hold a Contraceptive Security Workshop to reach consensus among stakeholders on market segmentation strategies (based upon recommendations in the Market Segmentation Study) | Nov '03 | NCSC (assist from donor) |
| 3 | Review results from the Reproductive Health Survey, compare these with LMIS results, note differences and similarities, and possible explanations for any variations | Dec '03 | NCSC (assist from donor) |
| 4 | Conduct ad hoc meetings on issues related to the Family Planning Program: <ul style="list-style-type: none"> • Method mix • Trend Analysis • Relative Performance • Market Segmentation Intervention tools • Introduction of new FP methods | Continuing | NCSC (assist from donor) |
| 5 | (other activities to be added in response to suggestions from NCSC members) | | |
| 6 | | | |

ANNEX 3

Projected Contraceptive Demand, All Sectors, Years 2003-2007

| | | IUDs | Injectables | Orals | condoms |
|-------------|------|------|-------------|--------|---------|
| Actual | 2002 | 2134 | 17812 | 179968 | 3244146 |
| Projections | 2003 | 2466 | 20415 | 201152 | 3730768 |
| Projections | 2004 | 2850 | 23408 | 225386 | 4290383 |
| Projections | 2005 | 3295 | 26849 | 253138 | 4933941 |
| Projections | 2006 | 3812 | 30808 | 284954 | 5674032 |
| Projections | 2007 | 4411 | 35363 | 321462 | 6525136 |

*Projected contraceptive demand is based on the following annual percentage increase in contraceptive consumption in Albania.

| | IUD | Injections | Orals | Condom |
|------------------|-----|------------|-------|--------|
| Public Sector | 16% | 16% | 12% | 15% |
| Social Marketing | | 11% | 17% | 15% |
| Commercial | 3% | | 3% | |

ANNEX 4

Estimated Contraceptive Costs, All Sectors, Years 2003-2007

UNFPA Unit Costs in US\$

| IUDs | Injectables | Orals | condoms |
|------|-------------|-------|---------|
| 0.5 | 0.93 | 0.23 | 0.3 |

| | | IUDs | Injectables | Orals | condoms | total |
|-------------|------|----------|-------------|-----------|--------------|--------------|
| Actual | 2002 | \$ 1,067 | \$ 16,565 | \$ 41,393 | \$ 973,244 | \$ 1,032,269 |
| Projections | 2003 | \$ 1,233 | \$ 18,986 | \$ 46,265 | \$ 1,119,230 | \$ 1,185,714 |
| Projections | 2004 | \$ 1,425 | \$ 21,769 | \$ 51,839 | \$ 1,287,115 | \$ 1,362,148 |
| Projections | 2005 | \$ 1,648 | \$ 24,970 | \$ 58,222 | \$ 1,480,182 | \$ 1,565,022 |
| Projections | 2006 | \$ 1,906 | \$ 28,652 | \$ 65,539 | \$ 1,702,209 | \$ 1,798,306 |
| Projections | 2007 | \$ 2,205 | \$ 32,888 | \$ 73,936 | \$ 1,957,541 | \$ 2,066,570 |

ANNEX 5
Projected Contraceptive Requirements:
Public, Social Marketing and Commercial Sectors, Years 2003-2007

| | | IUDs | | |
|-------------|------|-------------|------------------|------------|
| | | Public | Social Marketing | Commerical |
| Actual | 2002 | 2058 | 0 | 76 |
| Projections | 2003 | 2387 | 0 | 78 |
| Projections | 2004 | 2769 | 0 | 81 |
| Projections | 2005 | 3212 | 0 | 83 |
| Projections | 2006 | 3726 | 0 | 86 |
| Projections | 2007 | 4323 | 0 | 88 |

| | | Injectables | | |
|-------------|------|--------------------|------------------|------------|
| | | Public | Social Marketing | Commerical |
| Actual | 2002 | 12880 | 4932 | 0 |
| Projections | 2003 | 14941 | 5475 | 0 |
| Projections | 2004 | 17331 | 6077 | 0 |
| Projections | 2005 | 20104 | 6745 | 0 |
| Projections | 2006 | 23321 | 7487 | 0 |
| Projections | 2007 | 27052 | 8311 | 0 |

| | | Orals | | |
|-------------|------|--------------|-------------------|------------|
| | | Public | Social Marketing* | Commerical |
| Actual | 2002 | 59906 | 74240 | 45822 |
| Projections | 2003 | 67095 | 86861 | 47197 |
| Projections | 2004 | 75146 | 101627 | 48613 |
| Projections | 2005 | 84164 | 118904 | 50071 |
| Projections | 2006 | 94263 | 139117 | 51573 |
| Projections | 2007 | 105575 | 162767 | 53120 |

| | | Condoms | | |
|-------------|------|----------------|------------------|------------|
| | | Public | Social Marketing | Commerical |
| Actual | 2002 | 220902 | 3023244 | 0 |
| Projections | 2003 | 254037 | 3476731 | 0 |
| Projections | 2004 | 292143 | 3998240 | 0 |
| Projections | 2005 | 335964 | 4597976 | 0 |
| Projections | 2006 | 386359 | 5287673 | 0 |
| Projections | 2007 | 444313 | 6080824 | 0 |

Note: Actual value=(4th quarter 2002 + 1st Quarter 2003)*2

*not included emergency contraceptive pills (39,260)

ANNEX 6
Estimated Contraceptive Costs:
Public, Social Marketing and Commercial Sectors, Years 2003-2007

| | | IUDs | | | |
|-------------|------|-------------|------------------|------------|---------|
| | | Public | Social Marketing | Commerical | Total |
| Actual | 2002 | \$1,029 | \$0 | \$38 | \$1,067 |
| Projections | 2003 | \$1,194 | \$0 | \$39 | \$1,233 |
| Projections | 2004 | \$1,385 | \$0 | \$40 | \$1,425 |
| Projections | 2005 | \$1,606 | \$0 | \$42 | \$1,648 |
| Projections | 2006 | \$1,863 | \$0 | \$43 | \$1,906 |
| Projections | 2007 | \$2,161 | \$0 | \$44 | \$2,205 |

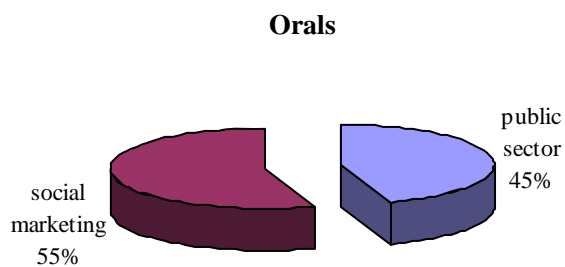
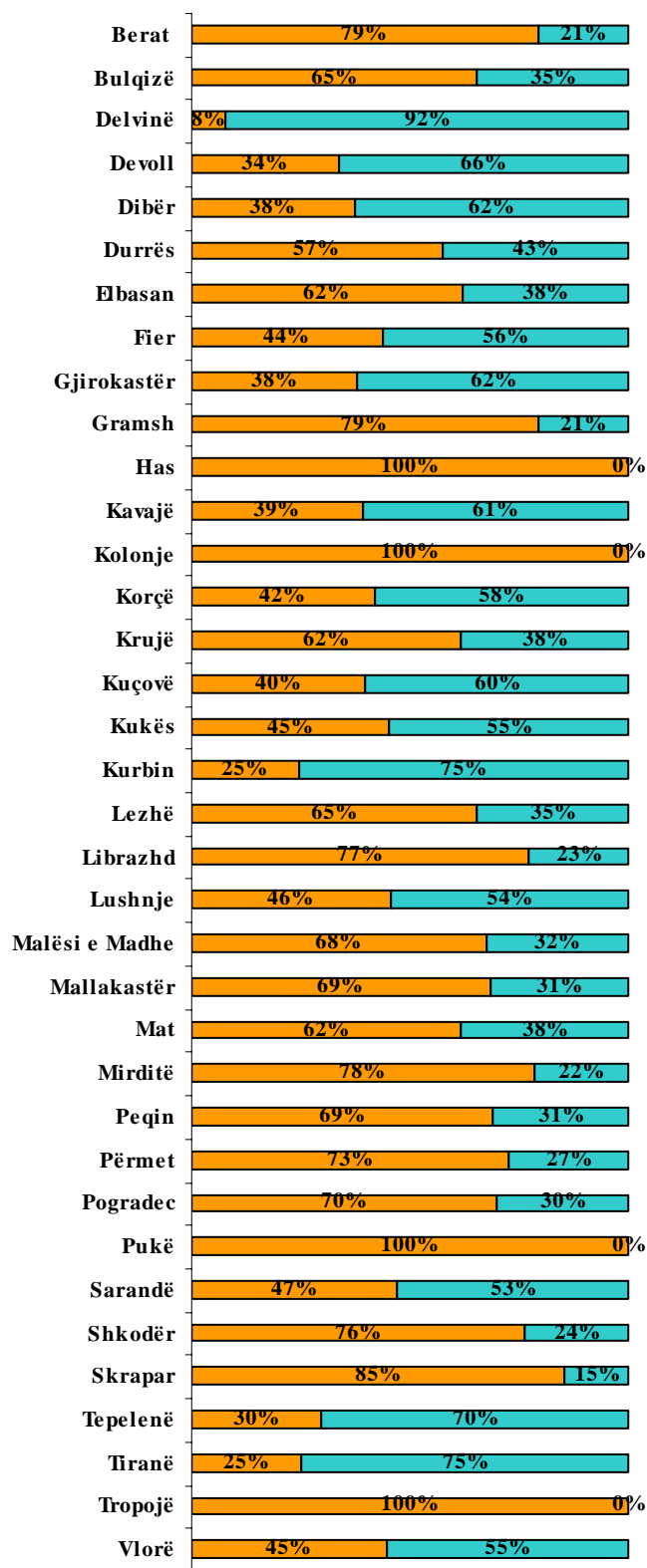
| | | Injectables | | | |
|-------------|------|--------------------|------------------|------------|----------|
| | | Public | Social Marketing | Commerical | Total |
| Actual | 2002 | \$11,978 | \$4,587 | \$0 | \$16,565 |
| Projections | 2003 | \$13,895 | \$5,091 | \$0 | \$18,986 |
| Projections | 2004 | \$16,118 | \$5,651 | \$0 | \$21,769 |
| Projections | 2005 | \$18,697 | \$6,273 | \$0 | \$24,970 |
| Projections | 2006 | \$21,689 | \$6,963 | \$0 | \$28,652 |
| Projections | 2007 | \$25,159 | \$7,729 | \$0 | \$32,888 |

| | | Orals | | | |
|-------------|------|--------------|-------------------|------------|----------|
| | | Public | Social Marketing* | Commerical | Total |
| Actual | 2002 | \$13,778 | \$17,075 | \$10,539 | \$41,393 |
| Projections | 2003 | \$15,432 | \$19,978 | \$10,855 | \$46,265 |
| Projections | 2004 | \$17,284 | \$23,374 | \$11,181 | \$51,839 |
| Projections | 2005 | \$19,358 | \$27,348 | \$11,516 | \$58,222 |
| Projections | 2006 | \$21,681 | \$31,997 | \$11,862 | \$65,539 |
| Projections | 2007 | \$24,282 | \$37,436 | \$12,218 | \$73,936 |

| | | Condoms | | | |
|-------------|------|----------------|------------------|------------|-------------|
| | | Public | Social Marketing | Commerical | Total |
| Actual | 2002 | \$66,271 | \$906,973 | \$0 | \$973,244 |
| Projections | 2003 | \$76,211 | \$1,043,019 | \$0 | \$1,119,230 |
| Projections | 2004 | \$87,643 | \$1,199,472 | \$0 | \$1,287,115 |
| Projections | 2005 | \$100,789 | \$1,379,393 | \$0 | \$1,480,182 |
| Projections | 2006 | \$115,908 | \$1,586,302 | \$0 | \$1,702,209 |
| Projections | 2007 | \$133,294 | \$1,824,247 | \$0 | \$1,957,541 |

ANNEX 7 Oral Contraceptives, Market Segmentation by District, 2002

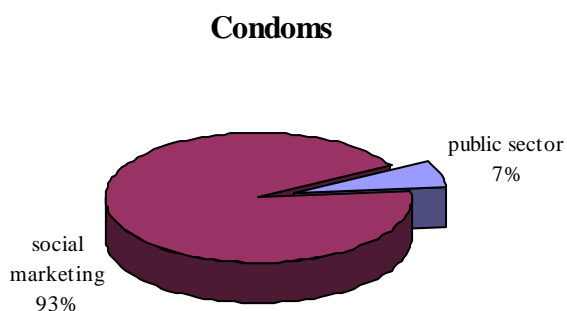
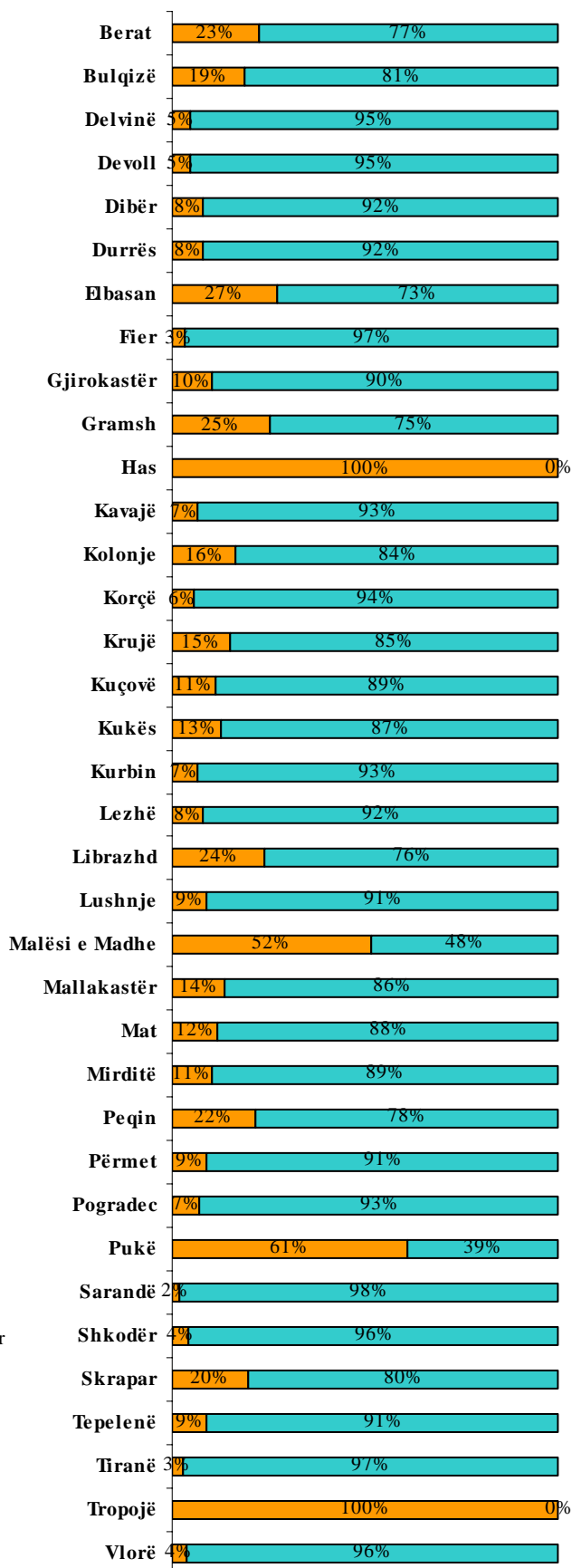
| District Name | public sector | social marketing |
|----------------|---------------|------------------|
| Berat | 79% | 21% |
| Bulqizë | 65% | 35% |
| Delvinë | 8% | 92% |
| Devoll | 34% | 66% |
| Dibër | 38% | 62% |
| Durrës | 57% | 43% |
| Elbasan | 62% | 38% |
| Fier | 44% | 56% |
| Gjirokastrë | 38% | 62% |
| Gramsh | 79% | 21% |
| Has | 100% | 0% |
| Kavajë | 39% | 61% |
| Kolonje | 100% | 0% |
| Korçë | 42% | 58% |
| Krujë | 62% | 38% |
| Kuçovë | 40% | 60% |
| Kukës | 45% | 55% |
| Kurbin | 25% | 75% |
| Lezhë | 65% | 35% |
| Librazhd | 77% | 23% |
| Lushnje | 46% | 54% |
| Malësi e Madhe | 68% | 32% |
| Mallakastër | 69% | 31% |
| Mat | 62% | 38% |
| Mirditë | 78% | 22% |
| Peqin | 69% | 31% |
| Përmet | 73% | 27% |
| Pogradec | 70% | 30% |
| Pukë | 100% | 0% |
| Sarandë | 47% | 53% |
| Shkodër | 76% | 24% |
| Skrapar | 85% | 15% |
| Tepelenë | 30% | 70% |
| Tiranë | 25% | 75% |
| Tropojë | 100% | 0% |
| Vlorë | 45% | 55% |
| Total | 45% | 55% |



public sector social marketing

ANNEX 8 Condoms, Market Segmentation by District, 2002

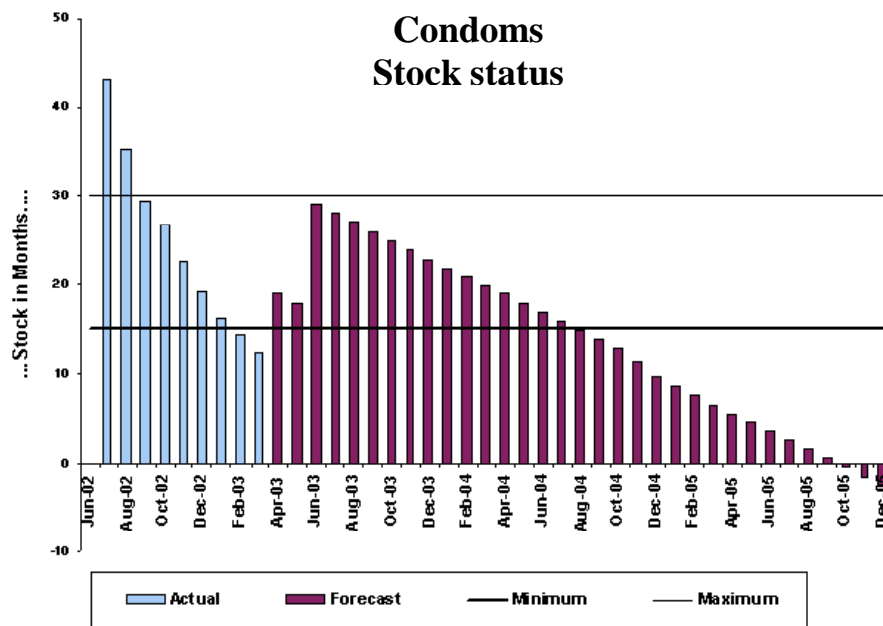
| No | District Name | public sector | social marketing |
|----|----------------|---------------|------------------|
| 1 | Berat | 23% | 77% |
| 2 | Bulqizë | 19% | 81% |
| 3 | Delvinë | 5% | 95% |
| 4 | Devoll | 5% | 95% |
| 5 | Dibër | 8% | 92% |
| 6 | Durrës | 8% | 92% |
| 7 | Elbasan | 27% | 73% |
| 8 | Fier | 3% | 97% |
| 9 | Gjirokastrë | 10% | 90% |
| 10 | Gramsh | 25% | 75% |
| 11 | Has | 100% | 0% |
| 12 | Kavajë | 7% | 93% |
| 13 | Kolonje | 16% | 84% |
| 14 | Korçë | 6% | 94% |
| 15 | Krujë | 15% | 85% |
| 16 | Kuçovë | 11% | 89% |
| 17 | Kukës | 13% | 87% |
| 18 | Kurbin | 7% | 93% |
| 19 | Lezhë | 8% | 92% |
| 20 | Librazhd | 24% | 76% |
| 21 | Lushnje | 9% | 91% |
| 22 | Malësi e Madhe | 52% | 48% |
| 23 | Mallakastër | 14% | 86% |
| 24 | Mat | 12% | 88% |
| 25 | Mirditë | 11% | 89% |
| 26 | Peqin | 22% | 78% |
| 27 | Përmet | 9% | 91% |
| 28 | Pogradec | 7% | 93% |
| 29 | Pukë | 61% | 39% |
| 30 | Sarandë | 2% | 98% |
| 31 | Shkodër | 4% | 96% |
| 32 | Skrapar | 20% | 80% |
| 33 | Tepelenë | 9% | 91% |
| 34 | Tiranë | 3% | 97% |
| 35 | Tropojë | 100% | 0% |
| 36 | Vlorë | 4% | 96% |
| | Total | 7% | 93% |



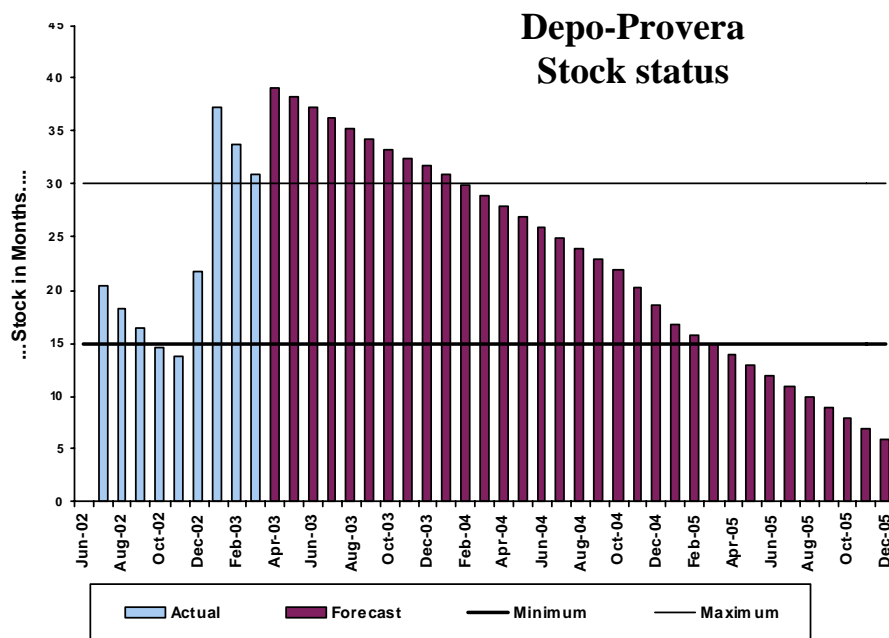
■ public sector
 ■ social marketing

ANNEX 9

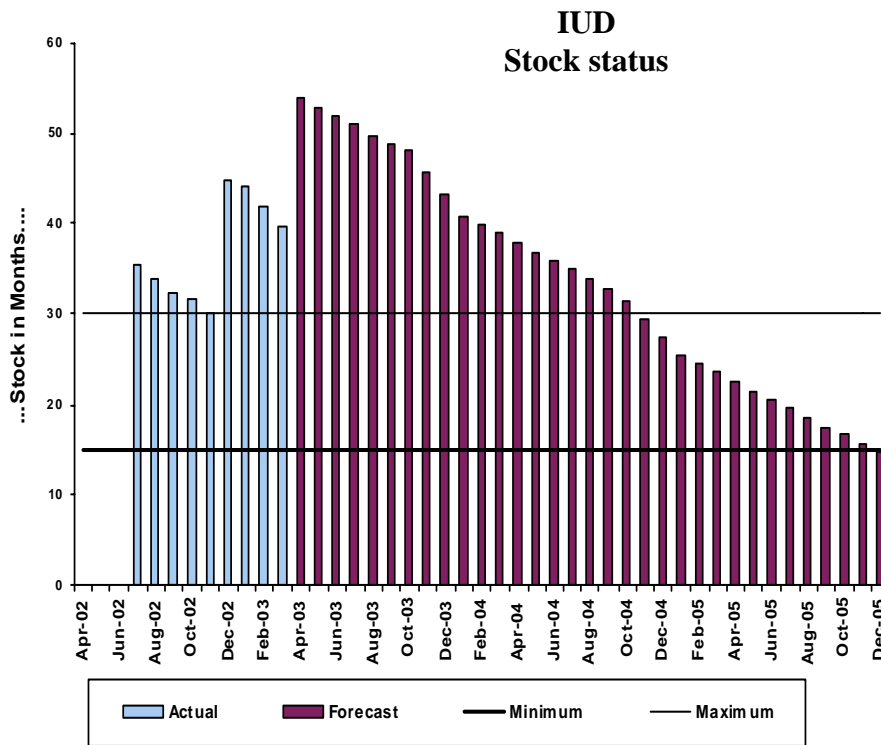
Stock status for Condoms



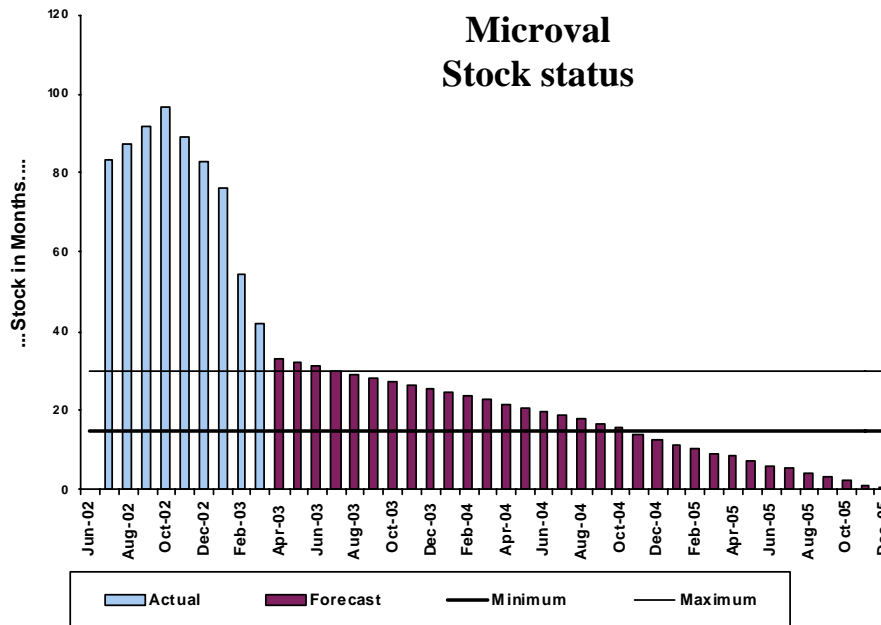
Stock status for Injectables



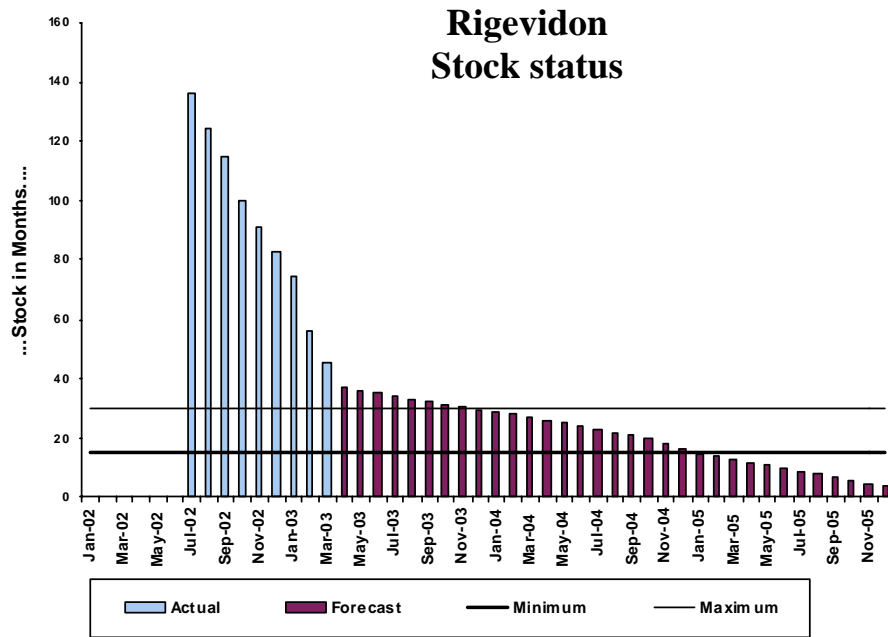
Stock status for IUD



Stock status for Orals



Stock status for Orals



ANNEX 10

Preliminary Market Segmentation Analysis for Contraceptives

Background

Family planning was illegal in Albania until the early 1990s. Today, contraceptives are available from the public sector (MOH facilities), two social marketing programs, and the commercial sector. A *de facto* market segmentation exists among these three sectors: the MOH – while a provider of all methods - is the key provider of longer-term methods (IUDs and injectables) and social marketing the re-supply methods (condoms and pills). Unable to compete with free (public sector) and subsidized (social marketing) contraceptives, the commercial sector currently has an insignificantly small market share (except for 27% of orals).

Albania would benefit from a comprehensive Market Segmentation Study once the results of the Reproductive Health Survey are published in late 2003. Such a study should look at the comparative advantages of the public, social marketing and commercial sectors in providing contraceptives, and recommend a market segmentation that maximizes access to contraceptives, and hence contributes to contraceptive security. In the meantime, this market segmentation analysis is meant to stimulate policy-makers' interest in market segmentation as a useful tool for moving the country toward contraceptive security.

Methodology and Data

This preliminary market segmentation analysis stratifies contraceptive users into five groups based on the prevalence of poverty in the districts where they reside. Poverty is defined as "receiving government financial assistance."¹³ By determining the source of contraceptive supply for each group, the following questions may be answered:

- Where do current contraceptive users, stratified according to poverty, obtain their contraceptives?
- What does this analysis suggest about an appropriate market segmentation strategy for Albania, and about the most effective and efficient way of achieving long-term contraceptive security?

Data from the public sector (LMIS), plus sales statistics from the private sector (social marketing), were used as the basis for this analysis. The nationwide LMIS data comes from three quarters (Jul-Sep 2002, Oct-Dec 2002, and Jan-Mar 2003). Private sector sales data include two quarters (Jul-Sep 2002, Oct-Dec 2002.) Commercial sales data¹⁴ are not available by district, therefore, commercial sector data are not included in this analysis (clearly a limitation to be overcome in a future Market Segmentation Study). A last source of data is the population projection prepared by INSTAT using 2000 census data.

¹³ "Receiving government financial assistance" is the best indicator of poverty currently available for this analysis. INSTAT is reportedly preparing a poverty index, by district, based on 2000 census data, that will be published at the end of 2003. Such a poverty index is likely to provide superior data for a future market segmentation analysis.

¹⁴ For example KRKA or Schering

Table 1 Districts Ranked by Percent of Population Receiving Government Assistance¹⁵

| District | % of Total Population | % of Population Receiving Government Assistance | User Group |
|----------------|-----------------------|---|------------|
| Kukës | 2% | 46% | G1 |
| Dibër | 3% | 45% | G1 |
| Pogradec | 2% | 41% | G1 |
| Pukë | 1% | 38% | G2 |
| Has | 1% | 36% | G2 |
| Shkodër | 6% | 36% | G2 |
| Tropojë | 1% | 35% | G2 |
| Mirditë | 1% | 34% | G2 |
| Bulqizë | 1% | 31% | G2 |
| Mat | 2% | 31% | G2 |
| Librazhd | 2% | 29% | G3 |
| Skrapar | 1% | 28% | G3 |
| Kurbin | 2% | 25% | G3 |
| Berat | 4% | 24% | G3 |
| Malësi e Madhe | 1% | 24% | G3 |
| Gramsh | 1% | 21% | G3 |
| Elbasan | 7% | 19% | G4 |
| Lezhë | 2% | 15% | G4 |
| Kavajë | 3% | 14% | G4 |
| Tepelenë | 1% | 14% | G4 |
| Peqin | 1% | 12% | G4 |
| Kuçovë | 1% | 12% | G4 |
| Korçë | 5% | 11% | G4 |
| Krujë | 2% | 10% | G5 |
| Tiranë | 17% | 10% | G5 |
| Përmet | 1% | 9% | G5 |
| Fier | 7% | 9% | G5 |
| Vlorë | 5% | 9% | G5 |
| Kolonje | 1% | 8% | G5 |
| Mallakastër | 1% | 8% | G5 |
| Lushnje | 5% | 7% | G5 |
| Durrës | 6% | 5% | G5 |
| Delvinë | 1% | 4% | G5 |
| Gjirokastër | 2% | 4% | G5 |
| Devoll | 1% | 3% | G5 |
| Sarandë | 1% | 2% | G5 |

Table 2

| Groups | Percentage of Total Population | Percentage of Population Receiving Government Assistance |
|---------|--------------------------------|--|
| Group 1 | 7% | >40% |
| Group 2 | 13% | >30% but <40% |
| Group 3 | 12% | >20% but <30% |
| Group 4 | 20% | >10% but <20% |
| Group 5 | 48% | <10% |
| Total | 100% | |

¹⁵ source: *National Strategy for Socio-economic Development*, Council of Ministers, Tirana, November 2001

Based on the percentage of the population receiving government assistance (indicator of poverty), districts were divided into five groups. Group 1 includes districts where 40% or more of the population receives assistance; Group 2 where 30-40% receive assistance; etc.

Market Segmentation Results

Figure 1 shows Couple Years of Protection (CYPs) by the source where the five groups obtained contraceptives. For Groups 3, 4 and 5, we see an apparently efficient segmentation, i.e., the poorer the group, the more reliance on free public sector contraceptives. This pattern breaks down, however, with Groups 1 and 2 (the poorest groups), whose members are not obtaining free public sector contraceptives as frequently as the more affluent Groups 3 -5. This indicates poor segmentation and should be further investigated.

Figure 1: CYPs by Source of Contraceptives and by User's Poverty

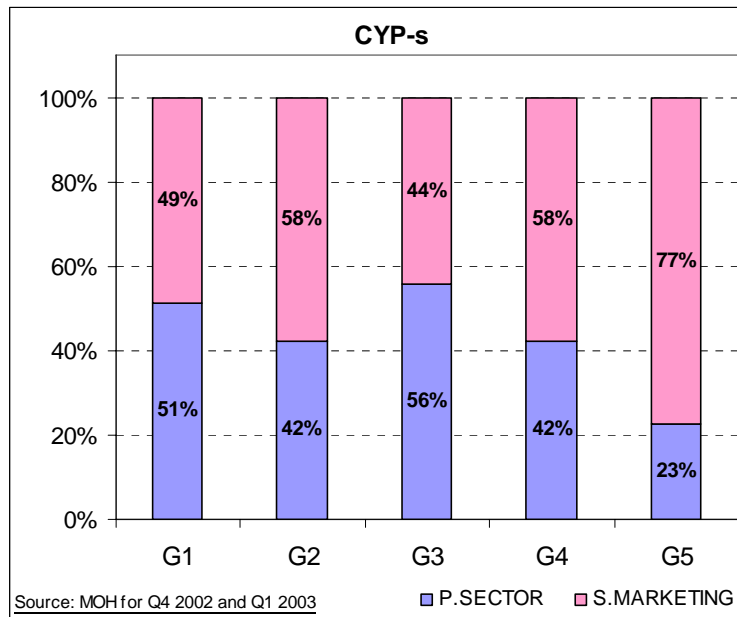
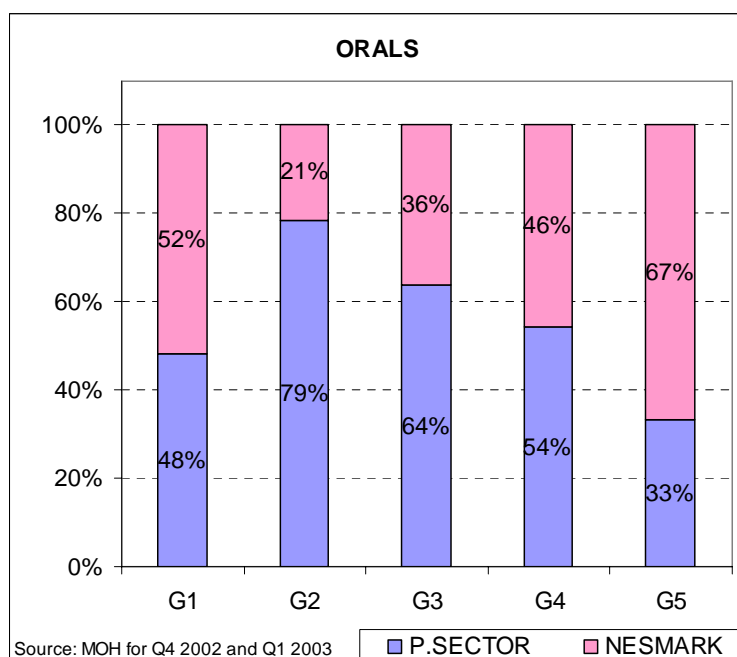


Figure 2: Source of Oral Pills Related to User's Poverty



Figures 2, 3 and 4 show similar patterns, i.e., efficient market segmentation for the better off groups but with the poorest group not accessing free public sector contraceptives.

Figure 3: Source of Condoms Related to User's Poverty

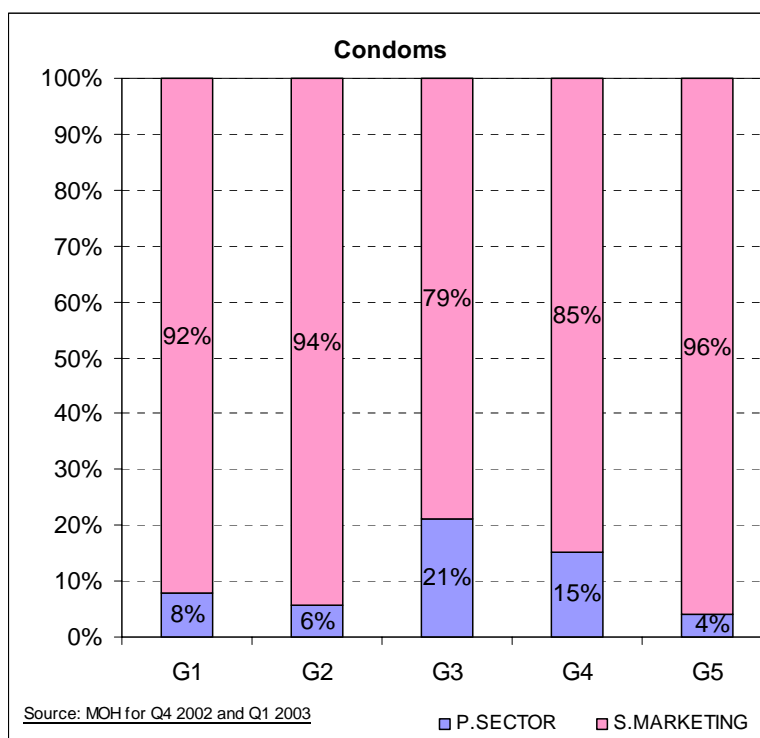
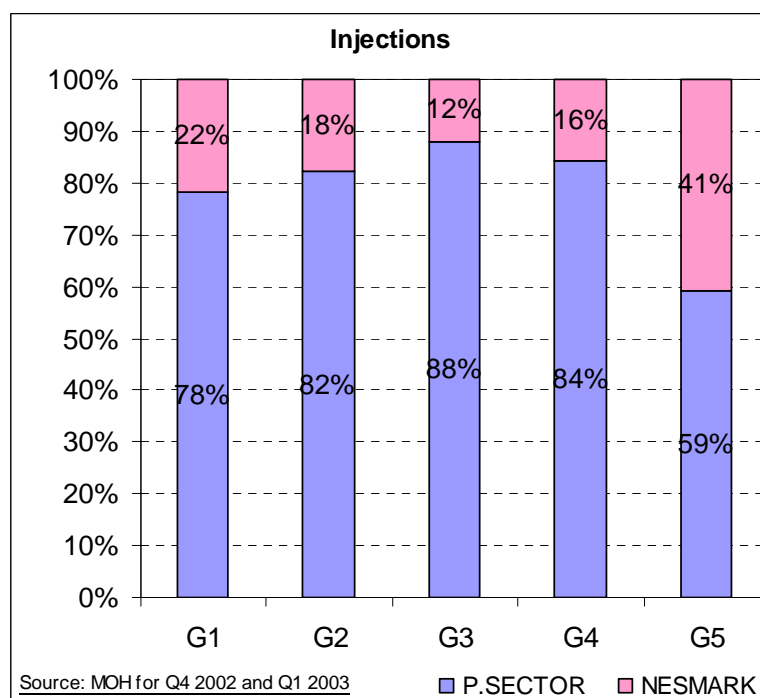


Figure 4: Source of Depo-Provera Related to User's Poverty



Conclusion

Market segmentation is a useful analytical tool for the National Contraceptive Security Commission. In its policy role, the MOH can use market segmentation to assess the adequacy contraceptive access throughout the country; in its provider role, the MOH can use it to target public resources on vulnerable groups. Market segmentation helps to identify and examine options for using resources more efficiently and moving Albania toward contraceptive security. The social marketing and commercial sectors can use market segmentation to identify opportunities to expand their niches within the overall contraceptive market.

It will require additional data and further research to fully explain the patterns observed in Figure 1-4 above. Some variables are known to affect access (ability-to-pay) but other potential variables will need to be investigated, e.g., method preferences, service proximity, service differentials at public and private outlets. A comprehensive Market Segmentation Study will further divide the five groups into subgroups, and also look at additional groupings based on other criteria that will assist in arriving at a more effective market segmentation strategy for contraceptives in Albania.