Contraceptive (In)Security in South-East Asia[i]

In South-East Asia sexual and reproductive health needs remain substantial and are not adequately met by the current supply of contraceptive products and services. While financial and technical scarcity persists, it is the facilitation of the policy environment and the fulfilment of equity principles in the delivery of contraceptive methods that present the greatest challenges in achieving contraceptive security. A regional advocacy agenda should address ideological objections to modern contraceptives and to people's contraceptive choices and ensure that contraceptive security is meant for all and not only for privileged groups and countries.

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The late 1990s saw the concept of "contraceptive security" defined as the ability of every person "to choose, obtain, and use quality contraceptives and condoms for family planning (FP) and for protection from sexually transmitted infections (STIs), including HIV" (USAID, 2008). The concept re-emphasizes the notion that contraceptive supplies[ii] are the cornerstone of family planning and STI/HIV prevention and that ensuring and maintaining the availability of contraceptive commodities — comprising hormonal methods (contraceptive tablets, injectables, implants, rings or patches), intrauterine devices (IUDs), barrier methods (condoms and diaphragms) and supplies to perform vasectomies and tubal litigations — is instrumental not only to attain better sexual and reproductive health (SRH), but also to reduce poverty and foster development (Finkle, 2003; PATH & UNFPA, 2006; IPPF, 2008).

The conceptualization of contraceptives as essential commodities for human well-being brought new urgency in addressing supply gaps

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caused by increasing demand in the face of insufficient funding and inadequate service delivery and logistics systems. Financing of commodities is being tackled through high-profile initiatives at the global level, but many challenges in building national capacity for commodity forecasting, procurement, financing, and delivery still remain. There is also recognition of the fact that efforts to provide contraceptives and other SRH supplies and services could not be separated from a broader socio-political environment and the overall functioning of the health system.

To better understand how the interaction of global and local processes affect contraceptive use and choices at the regional and country levels, the status of contraceptive security in South-East Asia,[iii] a region that has received relatively little attention despite its substantial SRH needs, is explored in this article. The material presented is based on a synthesis review of published material, gray literature and internet sources, conducted in 2009 and published as a report a year later (Sciortino, 2010), and updated here.

The article is arranged in four main sections. In the first two sections, an overview of SRH in the region and the related contraceptive gaps are presented, while the third section deals with current efforts to provide contraceptive services in various South-East Asian countries. The article argues that existing needs are not yet fully met for reasons that are only partly of a financial nature. In the final section of the article, a regional advocacy agenda is proposed to enhance the delivery of contraceptive services and commodities and realize contraceptive security in South-East Asia.

SRH: a regional overview[iv]

In South-East Asia, SRH differentials are intertwined with socio-economic disparities. Thus, the relatively more advantaged countries – Brunei Darussalam, Malaysia, Singapore, Thailand and, to a certain extent, Indonesia, the Philippines, and Viet Nam – have better SRH indicators than resource-poor countries such as Cambodia, the Lao People's Democratic Republic, Myanmar and Timor-Leste.

In general, maternal mortality and morbidity rates are high, with six countries in the region having maternal mortality ratios (MMR) of over 200 deaths per 100,000 live births. The disparities between regions inside each country are substantial. In the Philippines, for instance, MMR estimates are 50 deaths per 100,000 live births in the National Capital Region, 160 deaths per 100,000 live births in region eight, and 320 deaths per 100,000 live births in a more disadvantaged autonomous region of Muslim Mindanao (Rosell-Ubial, 2008, p. 53). More generally, access to

skilled attendants is lower among the poorest quintiles and MMR is higher in rural areas because of weaker infrastructural development, lower literacy levels and higher levels of poverty when compared to urban areas. Maternal morbidity has not been recorded properly, but the estimation of it being thirty times the number of maternal deaths (UNFPA, 2006, p. 2) implies a substantial burden of pregnancy-related illnesses in the region.

Table 1. Maternal health indicators for South East Asia, 2005

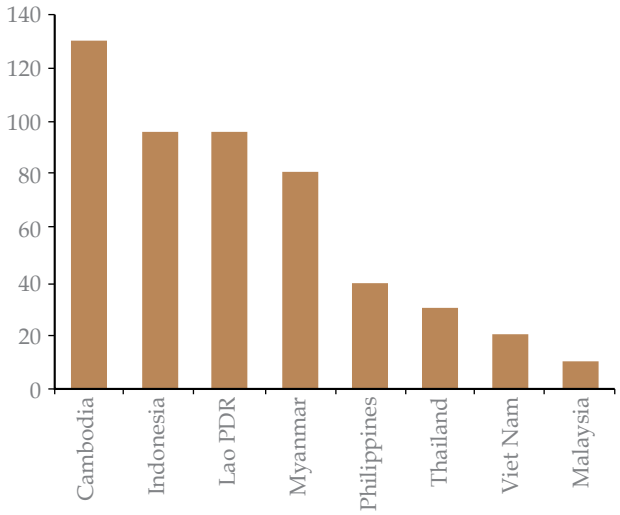
	MMR (per 100,000 live births)	Range of MMR estimates	Lifetime risk of maternal death (1 in)	Number of maternal deaths
Lao PDR	660	190-1 600	33	1 300
Cambodia	540	370-720	48	2 300
Indonesia	420	240-600	97	19 000
Timor-Leste	380	150-700	35	190
Myanmar	380	260-510	110	3 700
Philippines	230	60-700	140	4 600
Viet Nam	150	40-510	280	2 500
Thailand	110	70-140	500	1 100
Malaysia	62	41-82	560	340
Brunei Darussalam	13	3-47	2 900	1
Singapore	14	14-27	6 200	5

Source: World Health Organization et al (2007, p. 23-27)

In South-East Asia, in line with global patterns, 60 to 80 per cent of all maternal deaths can be attributed to obstetric haemorrhage, sepsis, obstructed labour, hypertensive disorders and unsafe abortions. Abortion-related mortality, however, is thought to be higher than the global average of 13 per cent, reaching 19 per cent of all maternal deaths in the region (UNFPA, 2006 p. 1-2, 11). Cambodia, Indonesia, the Lao People's Democratic Republic and Myanmar have the highest number of abortion-related deaths, while Malaysia, Thailand and Viet Nam have the lowest (see figure 1).

Although the region's post-abortion care is limited and, often, with no contraceptive provision (Warriner and Shah, 2006), except for Cambodia, Singapore and Viet Nam, abortion is illegal or officially limited to a few conditions. Abortion rates are still high, with Viet Nam and Indonesia having among the highest figures in the world. In Viet Nam, about 504,377 abortions or 38.7 abortions for every 100 live births were recorded in 2003 (Do Thi Hong Nga, 2008); and in Indonesia, 2 million induced abortions were performed in 2000, implying that the annual

Figure 1. Unsafe abortion-related deaths per 100,000 live births



Source: UNFPA, 2006 p. 11 (Adapted from IPAS Policy Fact sheet).

abortion rate is higher than that of Asia as a whole (37 and 24 abortions per 1,000 women of reproductive age respectively) (Sedgh and Ball, 2008, p.1).

STIs are widespread in the region. South-East Asia is a high-prevalence area for hepatitis B, and the World Health Organization (WHO) estimates that the largest proportion –almost 50 per cent – or about 340 million of new STI infections occurring each year happen in South and South-East Asia, especially among the youth (WHO 2007, p. 3). The regional estimate of HIV prevalence among adults aged 15-49 years old is relatively low, in the range of 0.2-0.4 per cent, but the absolute numbers are significant with about 1.7 million people in 2007 living with HIV/AIDS in South-East Asia (UNAIDS 2008). Thailand, Cambodia, Viet Nam, Myanmar and Indonesia are among the top six countries in Asia in terms of adult cases per 1,000 of population (ADB 2010, p. 96). While in Cambodia and Thailand the epidemic is slowing down, this is not yet the case with Indonesia and Viet Nam.

The major identified sources of HIV transmission are unprotected sex with irregular partners and the use of contaminated instruments for injecting drugs. More and more, however, new cases of infections are women who have acquired HIV from unsafe sex with their stable partners. In Thailand, this group accounted for more than 4 in 10 (or 43 per cent) of new infections in 2005 (UNAIDS and WHO, 2008, p. 16). In

Cambodia, husband-to-wife transmission has become the main transmission route accounting for two-fifths of new infections (Chaya, 2006, p. 5). In Malaysia, the largest proportion of infected women is married (CCR & Arrow, 2005, p. 20).

Contraceptive reach and demand

South-East Asia's reproductive health picture, with its high numbers of unwanted pregnancies, abortions and STIs, reflects the insufficient reach of contraceptive commodities and services. Although the region as a whole has a relatively high contraceptive prevalence compared to other parts of the developing world (Harvard Gazette, 2007), the absolute use of contraceptives in certain countries and groups remains low in spite of high unmet need. Moreover, traditional methods often account for a considerable proportion of the Contraceptive Prevalence Rate (CPR). The share of contraceptive users opting for periodic abstinence, withdrawal or country-specific methods range from 2 per cent in Thailand to 25 per cent in Malaysia (PRB, 2008, p. 76), and these official statistics do not include single adolescents and adults who often resort to traditional methods having limited access to modern methods.

As table 2 shows, contraceptive prevalence is the lowest in the poorest countries of South-East Asia. CPR in Timor-Leste is as low as 10 per cent while in Cambodia, the Lao People's Democratic Republic and Myanmar it is between 30 and 40 per cent. The Philippines and Malaysia, countries that have restrictive policy environments, demonstrate slightly higher CPRs of around 50 per cent, more than a third of which are traditional methods. At the other end of the spectrum, the middle- and high-level income countries of Indonesia, Singapore, Thailand and

Table 2. Contraceptive prevalence rates in South East Asia

	CPR any methods	CPR modern method
Brunei Darussalam	--	--
Cambodia	40	27
Indonesia	61	57
Lao PDR	32	29
Malaysia	55	30
Myanmar	37	33
Philippines	51	36
Singapore	62	55
Thailand	72	70
Timor-Leste	10	9
Viet Nam	78	67

Source: National DHS and other sources in PRB 2008, 13.

Viet Nam, which have had long-standing family planning programmes, boast high CPRs in the 50-70 per cent range and, with the exception of Viet Nam, a small proportion of traditional methods.

Within countries, contraceptive use increases with women's education and wealth status. In Cambodia, non-users and users of traditional methods are concentrated in the poor quintile, especially in rural areas (Cambodia et al, 2005). Disparities also occur along geographical and ethnic boundaries. In 2003, the CPR of married women in Thailand was estimated to be as high as 83 per cent in the northern region, but around 70 per cent in the southern region where the Malay population is concentrated (CCR and ARROW, 2005, p. 14). In Viet Nam, the Central Highlands, with their diverse ethnic minority population, show the lowest CPR in the country (Teerawichitchainan, 2008; UNFPA, 2009). Supply and demand side barriers hampering access and use of contraceptives among disadvantaged groups are many, such as costs, distance to service delivery points and lack of information and knowledge, as well as cultural and social values (Sciortino, 2008).

The gap between women's fertility preferences and their use of contraception, albeit reduced in recent years, has still to be closed. According to estimates, in South and South-East Asia in the 2000-2005 period 11 per cent of married women of reproductive age had an unmet need for contraception both for spacing and limiting births. These figures overshadow great inter- and intra-country variance, with rates of unmet needs for family planning varying from 40 per cent in the Lao People's Democratic Republic and 30 per cent in Cambodia and the Philippines to 9 per cent in Indonesia and 5 per cent in Viet Nam (Sonfield, 2006; PRB, 2008). In the Philippines—a country, where more than half of all pregnancies are unintended—the percentage of married women with unmet needs averages 18 per cent in the National Capital Region of Metro Manila, but reaches 60 per cent in the autonomous region of Muslim Mindanao (ARMM) and 87 per cent in the ARMM poor quintile (Darroch et al, 2009, p. 2).

Information about the unmet need of never-married women of all ages is not readily available as they are not included in CPR data, reflecting the official position of most South-East Asian Governments that contraception is a need for married couples only. The exclusion of this vulnerable group is also reflected in their not being counted in forecasting of commodity demand, in management information systems and in outreach efforts. Not-yet-married young people of both sexes are also overlooked in information gathering as well as services (Hull and Mosley, 2008; Khuat Thu Hong, 2003). Still, based on the increasing number of single, sexually active, adult women in South-East Asia, the many who decide not to marry (Jones 2005) and the growing number of young people of both sexes having pre-marital relations, it can be deduced that unmet needs are high in this population group. Other underserved

populations include ethnic communities, migrants, refugees and displaced people, marginalized urban communities and people living with HIV, to name a few.

It also needs to be noted that, discouraged by entrenched gender values, the role of men in fertility reduction remains minimal, with negligible numbers of male sterilizations, limited condom use and a widespread preference for withdrawals. In particular, there is an unmet need for condoms. Socio-cultural barriers hamper open condom promotion and family planning programs prefer long-lasting methods from a population control perspective. When national AIDS programs promote mainly male condoms to prevent HIV transmission, they limit their provision to groups considered at risk such as sex-workers, injecting drug users and men who have sex with men (MSM). In Indonesia, even in government programmes, differentiated branding and packaging of condoms is envisaged in social marketing efforts for those groups as if to keep them apart from the "safe" general population.

As a result of this dual approach, condom use is widespread in these so-called risk-groups but remains low overall. In Cambodia, for instance, from 1997 to 2003, consistent condom use among police officers grew from 65.6 to 94.2 per cent in commercial sex interactions, but only from 11.4 to 41.2 per cent in intimate relationships. More generally, "less than 20 per cent of sexually active Cambodian men and women have ever used a condom, representing an enormous unmet need" (PSI, 2004, p. 2). Inconsistent condom use is also rife, implying opportunities for greater use of condoms if adherence could be increased. In Singapore, in 2004, 45 per cent of the surveyed clients of sex workers used condoms inconsistently (Wee *et al*, 2004) and in Indonesia less than 10 per cent of male clients consistently used condoms though more than 50 per cent were married or had regular partners (Hudiono, 2006). Still, women have no alternative contraceptive methods at their disposal, as female condoms, available in parts of Asia since 1995, remain unfamiliar and poorly accessible (Vijerasa, 2009).

If the existing gaps are addressed, it could be expected that the already large demand for contraception in South-East Asia will expand. In Indonesia, for instance, it has been calculated that satisfying the unmet need of married women for spacing (4 per cent) and limiting (5 per cent) births would result in an increase in CPR from 61.4 to around 71 per cent (BPS and Macro International, 2008,). The increase would be greater if excluded groups such as single men and women are included, and if prevention of STI/HIV is integrated in reproductive health programmes for the general population. Growth in demand can also occur if the switch from traditional to modern methods increases, discontinuation of modern contraceptive use is reduced, and adherence in contraceptive use, including consistent use of condom use, is enhanced (see Cleland and others 2006).

An additional driver of future demand for contraceptive services and commodities is South-East Asia's expanding population, with large numbers of young people entering reproductive age. Although fertility in the region started to decline in the 1960s and is now reaching the replacement level of about two births per couple, the overall population is expected to grow from 586 million in 2008 to 826 million in 2050 as the demographic momentum continues to build (Hirschman, 2001; PRB, 2008). Nevertheless, countries are at different stages of demographic transition. As table 3 shows, while Singapore and Thailand are well below replacement levels, Cambodia, the Lao People's Democratic Republic, the Philippines and Timor-Leste have total fertility rates in the range of 3.0 to 6.5 children per woman. Consequently, while in Singapore and Thailand the share of people below 15 years is around 20 per cent and declining, in other countries in the region it is in the 25 to 45 per cent range and generally growing. How these rates translate into absolute numbers depends on the population of various countries, especially since population distribution in South-East Asia is very unequal. The least populated country in the region, Brunei Darussalam, is expected to grow from 400,000 people in 2008 to 600,000 people in 2050, while Indonesia, the most populous country in the region and the fourth most populous country in the world, is projected to increase from 239 million in 2008 to 341 million in 2050 (PRB, 2008). In terms of population below 15 years of age, and thus potential future contraceptive users, even if their share in both countries is around 30 per cent, Brunei Darussalam would account for about 120,000 while Indonesia for more than 69 million contraceptive users.

Table 3. Selected demographic data and estimates for South East Asia

	Births per 1,000 population	Total population (millions) (2008)	Projected population (millions) (2050)	Total fertility rate (TFR)	Per cent of population of ages	
					<15	65+
Brunei Darussalam*	19	0.4	0.6	2.0	30	3
Cambodia	26	14.7	30.5	3.5	36	4
Indonesia	21	239.9	343.1	2.6	29	6
Lao PDR	34	5.9	12.3	4.5	44	4
Malaysia	21	27.7	40.4	2.6	32	4
Myanmar	19	49.2	58.7	2.2	27	6
Philippines	26	90.5	150.1	3.3	35	4
Singapore	11	4.8	5.3	1.4	19	9
Thailand	13	66.1	68.9	1.6	22	7
Timore Leste	42	1.1	3.0	6.7	45	3
Viet Nam	17	86.2	112.8	2.1	26	7
South East Asia	20	586.0	826.0	2.5	29	6

Source: PRB, 2008; *UNFPA, 2008:8.

Considering these and other factors, an augment in contraceptive use and demand is projected for most of the region. Incremental increases are expected rather than great leaps, with a possible exception in the use of condoms, if the environment becomes more enabling. Still, numbers of additional contraceptive users will be great, requiring a greater financial and political commitment by countries in the region in the realization of contraceptive security.

A typology of contraceptive landscapes

In South-East Asia, the degree to which governments are uncommitted to contraceptive security varies according to religious, demographic and economic reasons. Thailand stands out in the region as coming close to contraceptive security, while all other countries have more insecure environments. Based on diverse contraceptive landscapes, a typology can be construed consisting of: (a) countries taking a pro-natalist stance for moral or demographic reasons that oppose or reduce access to modern contraceptives, namely Brunei Darussalam, Malaysia, the Philippines, and Singapore; (b) countries, like Indonesia and Viet Nam, with strong family planning programs that emphasize the methods considered more effective in achieving population control, yet neglecting short-term contraceptives; and (c) countries such as Cambodia, the Lao People's Democratic Republic, Myanmar and Timor-Leste, hampered by a lack of resources in the provision of contraceptive supply and services, with some countries also not fully supportive of contraception.

Countries with pro-natalist policies

In the first category of pro-natalist countries, Brunei Darussalam, Malaysia and the Philippines view the use of modern contraceptives as against their religious tenets, either because of strict Islamic interpretations in Malaysia and Brunei Darussalam or because of conservative Catholic views in the Philippines. In Singapore, selective procreation policy is considered essential to long-term development because the country has one of the "lowest-low" fertility rates in the world (Yap Mui Teng, 2007). Conservative ideologies in all these countries further condemn condom promotion for HIV/STIs prevention as being against "family values". Even in Malaysia, South-East Asia's second major producer of condoms, including female condoms, thanks to its ready supply of rubber (Howe, 2005, p. 6), the Ministry of Health avoids direct procurement and distribution of condoms out of concern that it could be "misinterpreted as advocating promiscuity", leaving the necessary task to NGOs and the for-profit sector (Medical News Today, 2007).

Interestingly Malaysia, the Philippines and Singapore all had strong population control policies in the 1960s and 1970s and later took the current stand of abandoning modern contraceptives and instead promoting traditional methods. In Malaysia, use of the contraceptive pill, as the most popular method of contraception, dropped almost by half in the last three decades from 50 per cent in 1974 to 27 per cent in 2004, with many switching to the rhythm method (now the second-most popular method accounting for about 18 per cent of users) (Nai Peng Tey, 2007, p. 2). In the Philippines, emphasis on female sterilization has given way to the promotion of natural family planning, and only 33 per cent of married women in 2003 used modern contraceptives, of which, in a reflection of the past, 10 per cent were sterilizations (Connell, Cisek and Robertson, 2005, p. 9). A clear reduction in the use of modern contraceptives (and especially of sterilization) and a parallel increase in the use of traditional methods were also observed in Singapore after the introduction of pro-natalist policies in the 1980s (see Ross and others, 2005).

Table 4. Contraceptive use among currently married women 1982 and 1997 in Singapore

Date	Total prev.	Modern methods	Sterilization		Pill	Injectable implant	IUD	Male condom	Vaginals	Traditional
			Male	Female						
1982	74.2	73.0	0.6	22.3	11.6	-		24.3	14.2	1.2
1997	62.0	53.0	0.2	15.8	10.0	-	5.0	22.0	-	9.0

Source: MOH, Population Planning Section Data in Yap Mui Teng, 2007:213).

There is minimal updated information available on contraceptive use and supplies for Malaysia and Singapore from either governmental or non-governmental sources and no accessible data for Brunei Darussalam[v]. This lack of information reflects the reduced financial support for the promotion and provision of modern contraceptives in public services. In the Philippines, the central government has opted not to directly finance and procure modern contraceptives, tasking instead decentralized local government units (LGU). However, LGUs do not allocate sufficient resources, lack the capacity to forecast, procure or deliver contraceptives and/or oppose performing this task on religious grounds (Rauhala, 2008). A large percentage of total requirements (skewed towards contraceptive pills and sterilization kits) have historically been provided by the United States Agency for International Development (USAID), but since its phase-out in 2008, the United Nations Population Fund (UNFPA) has provided pills and injectables as a stop-gap measure on a cost-share arrangement with local governments.

Worries remain that the needs of the very poor, who are being estimated at around 30 per cent of the existing users of donated contraceptives, are not being met (Darroch et al, 2009, p. 6; Deliver, 2007, p. 4; Connell et al, 2005, p. 24). Commercial suppliers focus on the top end of the market, while social marketing organizations, often supported by USAID to reduce the burden on LGU budgets and ensure availability of contraceptives, are interested in lower-middle and upper-low income families, leaving the low-priced segment less well served (Connell et al, 2005).

In Malaysia, under the current reproductive health policy focusing on birth spacing (following the slogan "not to soon, not too late, not too close"), contraceptive methods in public health facilities are only accessible to married couples; there are limits for contraceptive advertising and educative programmes have been discontinued (CCR and Arrow, 2005). It is the NGOs, mostly the Federation of Reproductive Health Associations, Malaysia (FRHAM) and its 13 state members associations that have taken upon themselves a task of making contraceptives available at a subsidized cost. Private outlets sell a wide variety of contraceptives, including emergency contraceptives, but this option is reserved for those who can afford higher prices. Similarly, in Singapore, with a decrease in subsidies to commodities and the closure of government family planning clinics in the mid-1980s, private sources (pharmacies and drugstores) have substituted public sources (Yap Mui Teng, 2007, p. 206). The need for contraceptives to prevent unwanted or unintended pregnancies, however, remains, especially among women with economic constraints. AFP reported that abortions, legal in Singapore, increased during the financial crisis from 11,933 in 2007 to 12,222 in 2008 (Bristow, 2009).

Countries enforcing family planning programmes

At the other extreme end of the population policy spectrum, Indonesia and Viet Nam have taken an anti-natalist stand, enforcing a two-child policy to stem population growth. Initiated in the 1960s, the Indonesian Family Planning Program has been hailed as a demographic success contributing to the expansion of modern contraceptive use and halving the total fertility rate. Today, Indonesia is close to replacement level while the program has been scaled back, but the maintenance of the small family norm remains a priority in view of the still significant increase in population discussed in the previous section. Similarly Viet Nam, after decades of strong population control, relaxed the two-child policy in 2003, but is continuing the thrust of previous policies to address the "demographic bonus" characterized by an age dependency ratio of under 50 per cent as derived from having just achieved below-replacement levels (UNFPA, 2009).

The policy focus approving family planning, however, does not necessarily imply "full availability" of contraceptive methods, and thus contraceptive security. Both countries have in fact emphasized long-acting and permanent methods of family planning (LAPMs) and discouraged non-use as well as the use of less reliable temporary methods (as perceived by governments), attracting criticism for their disregard of women's choice and of quality of care concerns. Both countries have also opposed condom promotion for HIV/STIs among the general population having taken a conservative stand when it comes to sexuality. More particularly, Indonesia's family planning programme initially promoted IUD and sterilization (mainly tubal litigation). In the early 1980s it introduced implants – even if at the time still untested– and remains one of the few countries in the world to have used them in large numbers, notwithstanding the lack of a proper support system (Smyth, 1991; Hull and Mosley, 2008). Viet Nam has provided hormonal implants, IUDs, female sterilization, and vasectomies through its public health system (NCPFC and ORC Macro, 2003). IUDs, in particular, have been a permanent feature, making Viet Nam the only country in South-East Asia, on par with a handful of countries in the world, where IUDs are the most used contraceptive method.

In both countries, while the public sector has remained centred on LAPMs, contraceptive choices are expanding in the private sector. This is especially true of Indonesia where provisions for contraception have been privatized in the last decade and where, in 2007, 69 per cent of married women purchased contraceptives from private sources, while in Viet Nam, 86 per cent of acceptors are still served by the public sector (BPS and Macro International, 2007, p. 86; NCPFC and ORC Macro, 2003). Private practices and clinics in Indonesia have opted for a "cafeteria-contraceptive basket" approach selling to their clients more diverse and branded products. Still providers' biases remain, this time leaning towards hormonal injections, recurrent shots being perceived as "an ideal way to lock in a flow of payments" (Hull and Mosley 2008, p. 18-19). In Viet Nam, the source of supply varies depending on the type of method used with an increasing number of private pharmacies and outlets opting for pills, three-month injectables and condoms. Their sales are expected to grow as the market liberalizes further, in line with the 2006-2015 national strategy on contraceptive commodity security developed with the support of UNFPA and other international agencies, which advocates for more involvement of non-governmental sectors and social marketing to encourage greater diversity in contraceptive supplies, at least for those who can afford it. Moreover, the Governments of Viet Nam and Indonesia have preferred to defer distribution of condoms for STIs and HIV prevention to international and local NGOs.

In view of the large consumer base, Governments in both countries favour local production of contraceptive commodities. Indonesia has the capacity to produce all modern contraceptive methods, thus

ensuring a sustainable supply at low cost. Ten contraceptive producing factories operating in the country have a reputation for being reliable manufacturers (Armand 2006, p. 22), although not all meet international export standards as defined in the World Health Organization Good Manufacturing Practices and the Pharmaceutical Inspection Cooperation Scheme. With the major donor USAID completing its phase out in 2006, Indonesia has become self-reliant in the funding of contraceptive supplies for its now much-reduced public sector (Hull and Mosley, 2008). External support is still received for use of condoms for STIs/HIV prevention among sex-workers and other groups considered at risk under the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Viet Nam has supported local production of contraceptives and import from other Asian countries since the 1990s (Feuerstein 1994), but, due to economic constraints, has not yet achieved self-reliance, and in 2006 was among the 10 top recipients of donor support (UNFPA, 2008, p. 22). Other donors, especially of contraceptive pills and condoms, include the European Union (EU) and bilateral agencies such as German's Gesellschaft für Technische Zusammenarbeit (GTZ) and the United Kingdom's Department for International Development (DFID).

Resource-poor countries

Irrespective of their views on family planning and STI/HIV prevention, the poorest countries of South-East Asia simply do not have the means to address the great SRH needs of their people. Cambodia, the Lao People's Democratic Republic, Myanmar and Timor-Leste are largely dependent on foreign aid, including for their contraceptive delivery systems. Although these systems vary, management of family planning activities at the national and local levels is particularly weak, funding is segmented, personnel and equipment are insufficient; and the processes of clearing, storing and delivering commodities for the public sector inefficient. Stock-outs are not uncommon and facilities, especially in rural areas, are scarce and lack basic requirements such as clean water, waste disposal and energy systems. Product safety and efficacy are a concern as fake and outdated smuggled products commonly circulate to fill the void. As a result, contraceptive services are not only limited, but also of poor quality, with method failure a common problem.

In Cambodia and Myanmar large private sectors compensate somewhat for the failing public system, providing contraceptive services at a cost throughout the country. In Cambodia, the public sector is the main provider of female sterilization and injectables, while the commercial private sector is the lead provider of IUDs and social marketing accounts for a majority of condoms and pills (UNFPA, 2007; 2007a). In Myanmar,

the private sector is composed mostly of providers' private practices. NGOs and social marketing outlets sell male and female condoms, pills as well as one- and three-month injectables, IUDs and emergency contraception (UNFPA, 2002). In the other two countries, the public sector is the major provider of contraceptive services, offering in Lao People's Democratic Republic two types of combined pills, a mini-pill, three-month injectables, IUDs, male condoms and female sterilization, and in Timor-Leste mainly injectables, but also IUDs, pills and implants are offered (UNFPA, 2001; 2007b; 2008).

Irrespective of the public-private mix, the very poor are dependent on public services, when they can access and afford them, a cheaper option in comparison with the private sector. Even if the very poor get free services or a cost exemption, the targeting and waiver system is inefficient and providers often charge fees in order to compensate for budget shortcomings, whereas subsidies and other pro-poor financial schemes, when available, are fragmented and insufficient (Sciortino, 2008).

International aid is crucial to enhance contraceptive security. In Cambodia, foreign donors finance most contraceptives and have formed a Commodity Security Working Group (CSWG) to project and address future contraceptive supply needs. The German government-owned development bank Kreditanstalt für Wiederaufbau (KfW) has been the major donor since 1993 and provided contraceptive supplies for public health services and social marketing until 2011. In addition, USAID and UNFPA provide pills and injectables and GFATM condoms for social marketing efforts (UNFPA, 2007; 2007a). There are concerns that the purchase of Western-manufactured brands, such as those procured with KfW funding, is unsustainable because, as is shown in table 5, the gap in resources will increase once donors gradually phase out, and it is suggested that donor agencies rather procure cheaper reliable generic contraceptives (Hall and Chhuong, 2006:4; UNFPA, 2007). More sustainable strategies are also needed for Lao People's Democratic Republic and Timor-Leste, where contraceptive services are fully dependent on international aid. In both countries, UNFPA funds most supplies and GFAMT and USAID support social marketing of condoms among groups considered at risk (UNFPA, 2008; USAID, 2008a). In Myanmar, despite economic sanctions, support has been provided on humanitarian grounds, with DFID and UNFPA as the primary source of generic commodities (condoms, pills, injectables and IUDs) for the public sector, and bilateral donors and foundations investing in social marketing and outreach work of NGOs (UNFPA 2002; PSI 2010). Still, foreign aid remains insufficient to cover the total unmet need for contraception and for STI /HIV prevention.

Table 5. Projected resources needs, committed resources and gaps 2007-2015, Cambodia (in $100,000)

Year	Total projected resources need	Resources need in 6-month buffer stock	Expected committed resources	Gap (unmet need)
2007	2 270	3 405	3 258	147
2008	2 520	3 780	3 488	292
2009	2 780	4 170	3 488	682
2010	3 050	4 575	1 168	3 407
2011	3 330	4 995	1 168	3 827
2012	3 630	5 445	150	5 295
2013	3 930	5 895	200	5 695
2014	4 240	6 360	200	6 160
2015	4 570	6 855	200	6 655

Source: UNFPA 2007a:11.

Scarcity of means is compounded by a political inclination to ignore or discourage contraception, with governments preferring to invest their few resources into other development areas. In Timor-Leste, modern contraceptives are not well-accepted by the Catholic Church (Hayes 2010), and there is a reluctance to promote safe sex and condom use among the general population.

A special case

Compared to the other countries in the region, Thailand stands out for its long-standing commitment to contraceptive security for both family planning and STI/HIV prevention. Since the beginning of family planning efforts in the late 1960s, Thailand took a unique path in controlling population growth by: integrating family planning activities into the health system; using auxiliary personnel in the provision of contraceptives; adopting a cafeteria approach inclusive of short-term methods and methods for men such as condoms and non-scalpel vasectomies; promoting local production of contraceptives; and engaging NGOs in mobilizing communities and integrating family planning into community development (Rosenfield, & Min, 2007; WHO, 2003).

Today, as shown in table 2, Thailand has the highest CPR in South-East Asia thanks to an almost exclusive use of modern contraceptive methods, foremost contraceptive pills, followed by female sterilization and injectables. Public contraceptive services are highly accessible to adult women and men and there are plans to provide services for married and unmarried male and female youth, to further expand coverage and specifically reduce adolescent pregnancy. Contraceptive methods are

provided "conveniently, largely free of charge, without incentives, and with controls for quality and safety" (WHO, 2003). Family planning is part of the preventive and promotive SRH services covered under Thailand's universal insurance scheme, as are condoms for STI/HIV prevention, while abortion in cases of rape and risk to maternal health is covered under the curative services package (Teerawattananon and Tangcharoensathien, 2004). Many contraceptive brands, including emergency contraceptives, are also on sale at affordable prices at pharmacies, and other outlets.

Initially with foreign support, Thailand's family planning efforts have become self-sufficient. Contraceptive commodities are produced in locally developed formulation and brands for internal use and export. Thailand is a supplier to UNFPA, various developing countries in Africa and its neighbours and often provides technical assistance internationally in the different aspects of manufacturing, quality control, storage, marketing, and distribution of contraceptive commodities (Hall, 2006).

Towards a regional advocacy agenda

In South-East Asia, governments remain challenged to fulfil the many urgent reproductive health needs of their populations. Great strides have been made toward achieving contraceptive security, but they are still not sufficient to guarantee universal access to a wide range of quality contraceptives for family planning and disease prevention, nor are they adequate to meet the expected increase in demand as the regional population continues to grow and a large number of young people enter reproductive age. While tailored strategies should take into account the specific contraceptive landscapes of each country, there are common issues that should be identified as central to a regional advocacy and intervention agenda, as they present the greatest challenge in achieving contraceptive security, namely the realization of an enabling policy environment and the promotion of greater equity across and within countries.

More particularly, efforts at the regional and national levels should address the ideological opposition to modern contraceptive services and commodities, and to people's SRH choices grounded in religious as well as demographic objections, as it disables contraceptive security and precludes the gathering of information, accurate planning and effective logistics and delivery systems. For South-East Asia as a whole, the exclusive focus of contraceptive services on married couples and the sensitivities around condom use and sexuality should be questioned. In particular, governments should recognize that the unmet need for contraceptive supplies exists not only in marriage, but also among the growing number of single women and girls. What Hull and Mosley (2008, p. 8) wrote about Indonesia, actually applies to many countries in South-East Asia:

> "national family planning program[s] explicitly excludes unmarried women (and men), therefore these women receive little attention… This policy may have been rational 40 years ago when the family planning program began and most women, with no opportunity for education, married and began childbearing early. But with development and urbanization, times have changed dramatically, as has the demographic picture and sexual behaviour of unmarried women, yet the old policies remain."

Much still needs to be done to emphasize the male role in contraception and HIV prevention, assuring promotion of male contraception methods (vasectomies and condoms) in SRH services. At the same time, female condoms should be promoted more vigorously so that girls and women, in regular as well as non-regular relationships, could control the means of protection from HIV and unwanted pregnancies.

In view of the ongoing demographic transition in the region, it is further important to emphasize that fertility decline does not justify a neglect of contraceptive services that should rather transform into more comprehensive SRH services that integrate family planning and HIV/STIs prevention and include linkages with safe abortion. Integration, demonstrated by Thailand, should be seen as a strategy to optimize resources, enhance universal access to contraceptive supplies and improve SRH outcomes. To achieve the desired integration, barriers that keep family planning and HIV prevention programmes apart ought to be addressed, including de-stigmatizing sexual behaviour and eliminating the common practice of differential branding and packaging of condoms depending on their ascribed purpose.

Parallel to efforts directed at fostering an enabling environment, efforts should be directed at promoting equity concerns across and within countries. Cambodia, the Lao People's Democratic Republic, Myanmar and Timor-Leste deserve continued attention by the foreign aid community in view of their poorer SRH indicators and lack of resources. However, strategies should be directed at diversifying funding so as to reduce dependency from major sources and allow more negotiating power in deciding procurement parameters, including advocating for contributions from the wealthier countries in the region, especially Singapore. Mechanisms could also be developed for joint regional procurement and storage of contraceptive commodities, preferably less expensive generic products of good quality, maximizing the opportunities that may be derived from the fact that three countries in South-East Asia – Malaysia, Indonesia and Thailand – are significant producers of contraceptive supplies, and that South-East Asia is close to both India and China, two of the largest producers of cheaper goods.

An equitable perspective is also crucial to avert the creation of an underclass of people excluded from essential health commodities and services or having access to services of lesser quality, which is currently the case. An evidence-based discussion should be promoted about the distributional impact of privatization and decentralization efforts on contraceptive supplies, access to services, costs and standards of care and SRH outcomes for diverse groups in society. While, as discussed before, the involvement of the private sector, and especially social marketing organizations, appear to compensate for the weaknesses of the public sector and expand the reach of services and access to commodities and contraceptive choices, unregulated privatization may not fulfil the universality and equity principles implicit in the concept of contraceptive security. Greater government stewardship is needed in determining the "right" mix of private (both commercial and not-for-profit) and public services and in regulating the market in a way that endorses equitable services. As the majority of the poor rely on the public sector for their health needs, it will be crucial to ensure that public services, especially when decentralized, are of a comparable standard to private services to avoid inefficiencies of creeping market segmentation.

Moreover, the access to and affordability of contraceptive supplies and services should be enhanced. More efforts should be directed at expanding the outreach of activities to rural areas and other less-served areas, addressing supply and demand side barriers to reduce socio-economic disparities in contraceptive security. Payment systems, especially in the public sector, also require reform. The experience of Thailand shows that a universal coverage system contributes to the affordability as well as the wide availability of contraceptives in an effective manner. Countries with a similar level of economic development as Thailand should work towards establishing national insurance schemes comprising a reproductive health package that ensures that contraceptive commodities essential to the population's welfare and the development of the country are covered. After all, contraceptive security in its broad sense of availability of a wide range of quality contraceptives is meant for all and not only for the advantaged groups of society.

Endnotes

i This article is based on a synthesis report prepared by the author to sustain advocacy efforts of the Asia Pacific Alliance (APA), which was published by APA in collaboration with the Institute for Population and Social Research, Mahidol University in 2010 with the title "Achieving Contraceptive Security and Meeting Reproductive Health Needs in Southeast Asia". The views presented in this article are those of the author and do not reflect those of the organizations she is or has been associated with.

ii In the following, "contraceptive supplies/commodities" as a category will include condoms for both contraception and HIV prevention unless specifically distinguished for clarity purposes.

iii South-East Asia is composed of Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste and Viet Nam.

iv Please note that the figures presented are not always consistent as different sources use different calculations and criteria. The same source may also have inconsistencies as it derives figures from disparate studies. Also when comparisons of countries are made, numbers are only approximately comparable due to variation in the timing of the surveys and in the details of the questions.

v For this reason Brunei Darussalam is barely discussed.

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