

Distorting the market

Changing the conversation on contraceptive security

We are halfway to 2020 – the year the global community promised to have delivered modern contraception to more than 120 million women and girls who wanted them, but lacked access to them in 2016. To deliver this commitment, we must ensure contraceptive security.

On 26 October 2016, Countdown 2030 Europe, in partnership with Marie Stopes International (MSI), Plan International UK and the International Planned Parenthood Federation (IPPF), brought together key stakeholders and technical leaders in the field working to promote contraceptive security. Together, they discussed the challenges of a dysfunctional system for contraceptives and explored achievable responses to these challenges. Panellists included: Sandra Jordan, Family Planning 2020 (FP2020), James Droop, UK Department for International Development (DFID), Brian McKenna, Reproductive Health Supplies Coalition (RHSC), and Simon Cooke, Marie Stopes International (MSI).

Introduction

If FP2020 commitments are met, an additional 550 million contraceptive users in 135 low-income and middle-income countries will require contraceptive supplies by 2020.¹ Women will rely on dysfunctional systems to supply their contraceptive method of choice, systems which are currently failing to reach that all important ‘last mile’, the poorest, most vulnerable and marginalised women. The reasons for these failures are multiple: systemic weaknesses, vulnerabilities at different points in health systems, inconsistent flows and bottlenecks of contraceptives at different stages of the supply chain. These difficult issues are so well-known that they have earned the title ‘wicked problems’: recognition of an ominous combination of complexity and the absence of technical certainty or political agreement.²

The roundtable acknowledged that if the sector was going to solve the contraceptive security

impasse, it must find new ways to address the factors that contribute to stock-outs in both public and private facilities. Thus, the roundtable initiated a new question around contraceptive security: **‘As public and private funding fails to keep pace with demand in an area so critically linked to women’s rights, to what extent is the sector complicit in institutional discrimination and the inequitable distribution of resources?’** Participants discussed a range of factors that fall within the control of the sector itself, including erratic and insufficient or late funding flows, systemic inefficiencies, corruption, distorted market dynamics, vested interests, informal fees and political apathy.

Panellists agreed that the sector needed to concretely address the foundational problems of the dysfunctional system. This paper is intended for reproductive health advocates to:

Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever they need them.

1. Recognise the systemic problems that are failing contraceptives in reaching the ‘last mile’;
2. encourage critical thinking on the challenges and possible solutions; and
3. inspire pragmatic and strategic advocacy strategies to promote contraceptive security.

This paper aims to encourage discussion about solutions to the most urgent problems the sexual and reproductive health and rights (SRHR) sector is facing.

Contraceptive security

Main discussion points

The roundtable focused on the three following areas: (1) funding facilities and financing; (2) generic contraceptives and contraceptive market distortions; and (3) rights-based barriers. These topics aimed to guide solutions and interventions that target the complex issue of contraceptive security.

Financing for contraceptives

Contraceptives remain underfunded. Decreases in resource flows at the global level have not been matched by increases at the national level. New innovative financing modalities do not hold promise for delivering additional funding for contraception.

Between donor fatigue and insufficient national funding, who will step up to fill the gap?

Globally, we are facing a contraceptive funding crisis. As demand for contraceptives increases along with reaching the goals of FP2020, increased investment in contraceptives will be required to meet women and girls’ needs and desires to realise their reproductive rights. To meet the growing demand by 2020 investments in contraception will need to increase. An additional US\$132.2 million will be required from donors, US\$67.2 million from national governments, and US\$238 million from the private sector.³

Meanwhile, bilateral donors, who have in the past prioritised funding for family planning, have moved away from funding contraceptives in the past ten years. Increasingly, emphasis is being placed on domestic resource mobilisation, and the need for

national governments to fund national family planning programmes. A government increasing funding to national health budget lines is not enough. Governments should prioritise specific budget lines for contraceptives and ensure that the funds are released on time and spent appropriately. This will require a drastic attitude change. The gap between global and national resource allocations is leaving a shortfall to be filled by global procurement mechanisms. However, UNFPA Supplies, who supply 35 per cent of the donated contraceptives to low-income and middle income countries, are themselves facing the same funding trends and projected shortfall.

Ambitious innovative financing modalities are not delivering for contraception

Traditional donor funding is changing and diversifying. Blended financing models are emerging and significant emphasis is being placed on domestic resource mobilisation. There are concerns over the sustainability of blended mechanisms, which initially presented great ambition to deliver for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). The Global Financing Facility (GFF), for example, links grants to loans, a modality that donors and governments anticipated would lead to an increase in dedicated funding for family planning. However, in practice, the GFF supports a cycle of indebtedness among national governments in low-income and middle-income countries, and the priority and costing for contraceptives in the GFF Country Investment Cases has been minimal. Current research shows that the GFF will deliver very little for contraceptives in DRC, Kenya, Tanzania and Uganda.⁴ The deficiencies of the new funding landscape are realities the family planning sector must work within.

Case Study: Prioritising national family planning programmes

Using a cost-effectiveness strategy, South Africa has made strides towards a self-funded national family planning programme by investing in male and female condom programmes as part of its fight against the HIV/AIDS epidemic. Recognising that providing the male condom as the only method to protect against HIV and other STIs limits choice and ignores gender biases, the South African government and a private sector partner, The Female Health Company, worked together closely to improve the method mix and give women, men and young people the autonomy to decide how to protect themselves. A cost-

effectiveness analysis suggests that expanding female condom distribution in South Africa may avert hundreds to thousands of HIV infections annually, at an incremental cost to the government less than the potential cost of antiretroviral therapy. Using the Female Health Company's integrated model of providing supplies and training support, the South African government has become largely independent from donor support for female condoms and, by adding female condoms to their method mix, they now include an additional method that offers the important dual function of combined STI prevention and contraception.⁵

Women shoulder the burden of out-of-pocket expenses

If FP2020 goals are to be met, private sector financing will need to cover the highest proportion of increased investment in reproductive health commodities, an additional US\$238 million. This will largely comprise of out-of-pocket (OOP) payments⁶ by women, men and young people using contraception. In order to exercise one of their most basic human rights, women will be confronted with high prices for contraceptives that many of them cannot afford. Still, there are substantial middle class and affluent populations in countries like Kenya, Tanzania and Uganda, who can and do want to purchase their contraceptives. These people need to have access to a sustainable contraceptive supply chain. Contraceptive security will ensure that contraceptive procurement satisfies all women, regardless of income.

Discussion question

How do we make new funding mechanisms effective for contraceptive security while low income economies grow sufficiently to make a meaningful investment in contraception?

Recommendations from the panel:

- **Universal Health Coverage.** Civil society organisations (CSOs) should advocate for contraceptive supplies to be included in Universal Health Coverage (UHC), the international goal to ensure that all people and communities be able

to obtain the health services they need without suffering financial hardship while paying for them.⁷ Contraception should be available as part of all maternal health packages and services must be provided by quality providers.

- **Beyond vertical funding.** The reproductive health sector must recognise that the GFF will not fill the contraceptive funding gap. Panellists recommend that the SRHR sector engage in discussions around new financing modalities beyond the GFF, and look beyond vertical funding for contraceptives.
- **Increase domestic resources for contraception.** National governments, particularly from least developed countries (LDCs), have equally failed on their commitments to family planning. National governments must increase budgetary support for family planning and prioritise specific budget lines for contraceptives. National governments should be encouraged to harness the demographic dividend as part of their economic agendas and, as such, increase domestic resources for family planning.
- **Greater coordination among stakeholders.** Coordination strategies between donors, procurement channels and national governments should consider applying innovative approaches like UNICEF's Vaccine Independence Initiative to family planning strategies for contraceptive security.⁸ Donors should disperse their funds earlier in the year so (1) national quantification processes can start earlier and prompt earlier decision making,

and (2) so national governments can confirm allocations and plan contraceptive procurement informed by available financing.

- **Clear donor guidance.** When multilateral donors decide to stop financial support to a country, they should write detailed reports about the funding gap left behind to ensure national governments are briefed.
- **Contraceptive inclusion in emergency response.** Women and children make up 75 per cent of people affected by humanitarian crises and women still need a reliable supply of their choice of contraception in conflict zones. With donors and national governments, leverage the links between humanitarian aid and family planning to ensure that lifesaving reproductive commodities are a standard of care in emergency response.

Inefficient and expensive quality assurance processes are limiting the method mix and distorting markets

Procurement of generic products can have a positive impact on health budgets because governments can procure quality contraceptives at a lower cost than branded products. Generic contraceptives are an important way to maximise the impact of scarce resources. Currently, to ensure quality, donors and UN agencies only procure products that pass stringent regulatory authority processes such as WHO prequalification. National governments are encouraged to only procure products that adhere to these same quality standards. As the WHO prequalification processes can be slow and expensive, many small generics manufacturers cannot afford to have their products WHO pre-qualified. In addition to the manufacturing costs of becoming eligible for WHO approval, from 2017 these manufacturers will also have to pay annual subscriptions to maintain their WHO prequalification status. This increases the cost of their product and makes them less competitive. Currently there are 26 contraceptives that have passed WHO prequalification processes: eight are emergency contraceptives and there are no IUDs on the list. 14 of the contraceptives are generics.⁹ Only one of these generics is a long-acting reversible contraception (LARC), a levonorgestrel implant.

The failure to pre-qualify a range of LARC methods restricts women's choices. The lack of generic pre-qualified implants could be considered a monopoly. Some LARCs are costlier than short acting methods and the lack of generic equivalents therefore places greater strain on public funding to subsidise this segment of the market. Not all procurement forms list methods by formulation, making it harder for procurers to order generics over a brand name. Over time, this creates a further challenge by distorting markets with overstocks of some methods and stockouts of others. To change this, interventions can be made at the point of manufacturing, procurement or funding allocations based on organisational speciality and capacity.

Discussion question

How do we eliminate distortions created by slow quality assurance processes while maintaining a continuous supply?

Recommendations from the panel:

- **Advocacy for generics.** CSOs and coalitions should build and leverage partnerships with manufacturers to increase the efficiency of the route from manufacture to service provision. CSOs should examine the excessive amount of time and costliness of meeting WHO prequalification standards for generics and hold manufacturers accountable to equitably meeting demand for these products.
- **Listing contraceptives by formulation.** Procurement systems operated by the WHO and UNFPA should list contraceptives by formulation rather than brand to reduce biases towards generics. When contraceptives are listed by brand, procurers will often select products they are familiar with despite the facts that their budgets and needs may be better served by cheaper alternatives.
- **Manufacturing closer to the market.** Consider innovative approaches to decreasing costs that will incentivise manufacturers to produce more accessible contraceptives. For example, the sector was challenged to explore the possibility of moving production closer to the markets that need them, which could lower manufacturing costs and involve populations more in the development of products.

Unlike Coca Cola, contraceptive supply is often regulated or legislated against

When discussing contraceptive security, some have looked to the success of Coca Cola's geographic reach and supply chain management. Yet, it is important to recall that contraceptives, unlike Coca Cola, are highly regulated and legislated, as well as politicised. Many countries impose regulatory or legal barriers to the entry of contraceptives into the country, or into the health system, which can increase the cost of contraception for the user. When paired with values-based restrictions, (i.e. barring access to contraception due to age or marital status requirements), this creates an environment where vulnerable and marginalised women are prevented from exercising their full reproductive rights. In Zambia and Bangladesh for example, young people under the age of 16 years require parental consent to access all methods of contraception, including emergency contraception. Regulations also restrict the entry of certain products into the market, thus limiting women's choices. There are increasing restrictions on CSO participation and declining resources for grassroots advocacy, making advocacy around reducing these regulations even more difficult at the local level.

Discussion question

How can we regulate the supply of contraceptives in environments where civil society participation is increasingly restricted?

Recommendations from the panel:

- **Empowering women to have informed choice.** Women should be empowered to create demand for a comprehensive contraceptive method mix and to hold their governments accountable for commitments to rights-based family planning programming and sustainably delivered contraceptives as part of fulfilling sexual and reproductive health and rights. 'Informed choice' requires that women are properly counselled on their contraceptive and STI-prevention options.
- **Coordination with the SRHR sector.** The SRHR sector should organise greater collaboration between donors, national governments, the private sector and civil society to benefit from comparative advantages and existing networks and to decrease programme repetition and wasting resources. The

strength of coalitions and platforms that spearhead collaboration should not be underestimated.

- **The importance of subnational advocacy.** Strengthen the capacity of national CSOs and community-level actors by focusing on context-specific attitude changes. Following local changes that reduce stigma and increase demand, raise advocacy to subnational and national levels around policy frameworks that enable the fulfilment of sexual and reproductive health and rights.

The flow of subsidised or free contraceptives has distorted the market

CSOs in the SRHR sector like IPPF and MSI have attempted to shape the contraceptive market, despite political barriers. Some national governments and manufacturers have made volume guarantee agreements to increase method options for women, whereby manufacturers agree to sell contraceptives at a certain price, as long as governments guarantee a minimum volume purchase. Recent volume guarantees for Jadelle and Implanon (implants) guarantee a lower price for contraceptive users and a minimum sale volume for the manufacturers. This guarantee will yield hundreds of millions of dollars in savings for those buying these products. Increased provision of Jadelle alone could save over 310,000 lives through reduced maternal mortality.¹⁰ However this price is only guaranteed until 2023. Additionally, the volume guarantee offers implants at an incentivised price which is considered sustainable, but still unaffordable for those in the lowest economic quintiles. Though volume guarantees can make methods more affordable, they can also override rights-based approaches to family planning by increasing the prevalence of a single method over others based on price rather than choice. Flooding the market with certain contraceptive methods, while enduring stock-outs of others, diminishes the integral aspect of choice in providing rights-based sexual and reproductive health services.

Discussion question

Do market distortions challenge the basis of our rights-based family planning programming, which aims to guarantee quality, choice, acceptability, appropriateness and agency?

Recommendations from the panel:

- **Forecasting for the ‘last mile’.** In forecasting for contraceptives, use a ‘customer-back’ method to improve supply chains. The ‘customer-back’ method begins by evaluating the needs and demands of customers at the last mile, then tracks access problems backwards along supply chains until they meet manufacturers.
- **Eliminate taxes and levies.** There should be no taxes or levies placed on contraceptives, as they create additional barriers to access. Get involved in the trade negotiations to lift these tariffs.
- **Beware of market distortions.** Consider possible market distortions of contraceptive methods that we advocate for, and ensure that women can freely choose from a comprehensive range of contraceptives, without regard to cost. Always guarantee a method mix and eliminate stockouts on a context-specific basis.
- **Effective and sustainable volume guarantees.** Ensure that volume guarantees for products are effective and sustainable by collaborating with procurement systems, manufacturers and CSOs to make certain volume guarantees are carried out according to a rights-based agenda and will not distort the contraceptives market.
- **Remember STI prevention methods.** In addition to incorporating a rights-based approach, contraceptive procurement must always include male and female condoms, as they are currently the only method to protect against STIs.

Changing the conversation

Turning discussion points into action

The roundtable yielded a consensus on action points to take forward. All stakeholders have a role to play – from civil society, national governments, donors and manufacturers.

The following is a list of key discussion areas to encourage more thorough intra-organisational conversations and action plans to respond to the identified problems. Working multilaterally and considering each organisation’s comparative advantages will allow the family planning community to tackle the complexities of contraceptive security more efficiently and effectively. To ensure contraceptive security and women’s reproductive health and rights down to the last mile, these issues must be addressed. Task sharing can streamline this change process.

Civil society organisations

- **Civil society advocates strengthen their advocacy messages to provide stronger economic evidence**

on the importance of family planning to donors and national governments. Connect the relatively low cost of investing in family planning with high returns on girls’ education, women entering the workforce, ending child marriage, decreasing the of adolescent pregnancy and implementing youth-friendly policies and services. Strengthen the interlinkages of family planning beyond health for inclusion in other sectors, including education, environment and climate change.¹¹

- **Strengthen the capacity of national civil society to advocate for strong political and financial support for family planning in national and subnational budgets, with dedicated budget lines for contraceptives in the upcoming fiscal year.** Government support for family planning as part of development agendas must be backed up by financial commitments. CSOs should hold governments accountable for specific family planning goals like FP2020.

Case study: Graduating from financial assistance to financial crisis

An over-reliance on donor financing can hinder middle income countries (MICs) from sustaining a steady supply of affordable contraceptives. Many MICs in Latin America that have 'graduated' from subsidised donor pricing (e.g. USAID's subsidised contraceptives) see large price increases for certain commodities, mostly Implants and the Levonorgestrel Intrauterine System (LNG IUS, often sold under the brand name Mirena®). These price differences may be as high as ten times the FP2020 price for these contraceptive methods. Though these countries have experienced overall economic development, contraceptive prices are still too high for governments to

procure sustainably and for OOP to cover, leaving the poorest women unable to afford their contraception. Many countries with substantial and growing economies still have large wealth disparities among their populations, and these high prices disproportionately affect lower income populations.

In the next round of commodity price negotiations, it will be important to consider a price scale (either incremental or targeted for lower income populations) for countries that fall outside the FP2020 focus, which may soon include Botswana, Namibia and South Africa.

Bilateral donors

- **Increase donor support to contraceptives and ensure that they are fully funded in line with FP2020 commitments.** It is important that while donors aim to increase political prioritisation of family planning programmes, financial support is given to the contraceptive supplies and provision required to meet the needs and choice of women.
- **Funds must be dispersed on time and in full.** Late procurements cause stockouts; managing grants and disbursing funds must be organised so that countries are not waiting to receive shipments of contraception late in the year.

National governments

- **National governments should eliminate taxes and levies on contraceptive supplies, which can cause unnecessary delays in the supply chain of contraceptive supplies.** Alternatively, pursue, with donors, synchronised and innovative strategies to procurement similar to UNICEF's Vaccine Initiative.
- **Increase domestic investment in family planning programmes and ensure dedicated budget lines for contraceptives.**

Coalition platforms

- **Monitor volume guarantees and other supply chain solutions made by donors, national governments and the private sector to ensure that women and girls have access to a wide range of contraceptive methods.** Solutions designed with donors, national governments and the private sector should not distort the market or violate the principles of choice by eliminating or skewing method mix. Once volume guarantees are in place, advocates should monitor the supply chain to ensure they are sustainable.
- **Ensure that donor governments are held accountable to deliver and implement the political and financial commitments made to FP2020.** Rather than turning to financing facilities like the GFF as remedies in future budget plans, dedicate funds directly to family planning.

Procurement systems

- **Work in collaboration with the WHO's prequalification team to address prolonged prequalification process with a vision to relieve barriers posed to generic contraceptives.** Work in collaboration with the WHO prequalification team to decrease annual and start-up fees for manufacturers to prequalify contraceptive products. By reducing the expenses related with

prequalification, procurement systems staff can incentivise manufacturing.

- **Envision affordable products for women, men and young people: to this end, work with private sector providers to consider volume guarantees for a range of methods over time.** Similar to volume guarantees for implants Jadelle and Implanon, offer sustainable prices to manufacturers while maintaining affordable products for women.

All levels

- **Consider interventions that would relieve and/ or eliminate the burden of out-of-pocket payments, especially for poor, vulnerable and marginalised women, men and young people.** To address the disproportionately high amount of contraceptive financing coming from OOP, work with governments, private sector and civil society to balance a decrease of contraceptive costs and an increase of financial contributions. Current subsidised prices are still too high for many of the most marginalised populations to access.
- **Work in collaboration with contraceptive manufactures to decrease overhead costs and move closer to marginalised markets.** Moving manufacturing plants closer to marginalised markets could decrease cost of transportation and facilitate the coordination of demand for contraception with relevant supply.
- **Consider addressing supply chain inefficiencies using a customer-back approach towards understanding the needs and challenges of the last mile.** Begin with the needs and demands of women, men, and young people and work backwards up the supply chain to influence suppliers.

References

1. RHSC (2016) *Global Contraceptive Commodity Gap Analysis*. Available at: https://www.rhsupplies.org/fileadmin/uploads/rhsc/General_Membership_Meetings/Seattle_2016/2016_09_Commodity_Gap_Analysis_handout.pdf.
2. Hill, M. and Hupe, P.L. (2008) *Implementing public policy: An introduction to the study of operational governance*. 2nd edn. London: SAGE Publications.
3. RHSC (2016) *Global Contraceptive Commodity Gap Analysis*.
4. Sochas, L. and Dennis, S. (2015) Raising the Bar: Recommendations to Strengthen the GFF Minimum Standards for Country Platforms to Enhance Participation, Transparency and Accountability. Available at: <http://pai.org/wp-content/uploads/2015/11/Raising-the-Bar.pdf>.
5. Dowdy, D.W., Sweat, M.D. and Holtgrave, D.R. (2006) 'Country-wide distribution of the nitrile female condom (FC2) in Brazil and South Africa: A cost-effectiveness analysis', *AIDS*.
6. Ibid.
7. WHO (2017) *What is Universal Health Coverage?* Available at: http://www.who.int/health_financing/universal_coverage_definition/en/
8. This UNICEF initiative provides a mechanism to maintain annual group vaccine procurement while encouraging governments to financing and assume increasing responsibility for vaccine procurement. The initiative is structured around a revolving fund acting as a line of credit for the government to pay for vaccines at a later time, after order receipt. Available at http://www.unicef.org/pacificislands/immunization_2881.html
9. WHO (2016b) *WHO list of prequalified medicinal products*. Available at: [<http://apps.who.int/prequal/query/ProductRegistry.aspx?list=rh>]
10. RHSC and Dalberg (2015) *Market Shaping for Family Planning*. Available at: http://www.dalberg.com/documents/Market_Shaping_for_Family_Planning.pdf
11. Progressive investments in family planning (totalling US\$39.2 billion annually) amounts to only US\$7 per person in the developing world, making sustainable family planning programmes achievable and immensely attractive investments. Investing in family planning has additional success in decreasing early and forced child marriage, continuing education for girls, expanding a healthy and productive workforce, all of which are integral to a country's economic development. Available at: https://www.guttmacher.org/sites/default/files/report_pdf/addingitup2014.pdf

Acknowledgements

This paper was written by Elisa Pinto de Magalhães, Erica Belanger (IPPF), Aoife NicCharthaigh (Plan UK), and Sarah Shaw (MSI). It is based on a paper by Sarah Shaw (MSI). Case studies were provided by Juan Jaramillo (IPPF WHR) and Iris Weges (The Female Health Company). With thanks to panellists and participants at the Countdown 2030 event 'Distorting the Market' (26 October 2016).