Addressing the Contraceptive Funding Crisis

A discussion paper on national advocacy in Kenya, Malawi, Tanzania and Uganda

Background: Framing the funding crisis within a global context

The world is facing a contraceptive funding crisis, and a global shortage of certain methods particularly implants. At the same time, sufficient investment in contraception is not being prioritized at the global, national and subnational levels. The United Nations Population Fund (UNFPA)[1] – the largest supplier of contraceptives in many countries – is facing a US$253 million shortfall between 2016 and 2020. Projections show this is the largest gap in funding for contraception since governments committed to prioritising family planning at the 2012 London Summit on Family Planning. The UNFPA shortfall in funding will affect the procurement of contraceptives at the national level. This will have an impact on the ground as it's expected that by 2020 more than 400 million women will want to use modern methods of contraception in over 130 developing countries.[2] An estimated additional US$750 million investment in contraceptive supplies will be required to meet the demand.[3]

The success of family planning programmes can only be achieved if the necessary contraceptive supplies are accessible, available, affordable and high quality enough to meet the growing demand for contraceptives. Donors, governments and civil society organisations all have a role to play to ensure family planning programmes are adequately funded at all levels. The commitment and leadership of national governments is key to contraceptive security. All governments, even those heavily reliant on donors, are encouraged to prioritize the allocation of domestic resources to contraception, and ensure an enabling environment for family planning programmes.

National and subnational governments need to prioritise family planning by allocating dedicated funds for contraceptive commodities. Urgent action at the country level is needed by civil society to build political will and identify critical advocacy entry points.

This discussion paper highlights contraceptive commodity security concerns in FP2020 countries in East Africa that will likely experience a reduction in global funding support for contraception from 2016 to 2020. It will highlight achievements from Kenya, Malawi, Tanzania, and Uganda's advocacy efforts to address national contraceptive commodity funding, procurement, and provision. The paper also provides advocacy tips and key messages for advocates at the national and sub-national levels. The primary audience is civil society organisations (CSOs) advocating for increased financial support for family planning at the national and subnational level.

What does CSO advocacy entail at national and subnational level?

There is no standardised process or approach to advocate for increasing domestic resources for family planning and contraceptive commodities. Each context, national and subnational process and CSO approach will be different. However, it is worth mentioning a few entry points for CSOs advocating for sustained funding for contraceptive supplies. Advocates will want to adapt these goals into workable solutions for each context they work in:

Increase domestic resources for contraceptive supplies

1. Ensure that family planning programmes have their own budget lines with contraceptive security, to be distributed on time and in full
2. Coordinate the contraceptive supplies funding mechanisms of national governments, private sector, and donor governments to correctly forecast and procure commodities, avoiding stock-outs of some supplies while flooding clinics with others
3. Systematically collect and coordinate public (national and subnational) and private reproductive health data sources to guide countries' forecasting and enactment of matching policies

Enact crucial financial and funding policy shifts at national and subnational levels for contraceptive security

1. Review and eliminate as necessary: reliance on out-of-pocket (OOP) expenses, taxes and levies placed on contraceptive supplies
2. Include contraceptives in the National Essential Medicine Lists for mandatory budgeting and procurement by governments
3. Integrate supply chain policies for improved efficiencies in stock management
4. Include information and provision of a range of contraceptive methods delivered through high quality channels reaching all sectors of society in Universal Health Coverage (UHC) schemes

Financing innovations for contraceptive supplies, like these above entry points, must be locally owned and led initiatives. Advocates at national and subnational levels would benefit from building on past family planning advocacy gains specific to local contexts, such as existing budget lines for family planning or UHC schemes, to tailor their own strategies. Fostering partnerships between the international community, governments, CSOs, the private sector and local communities is paramount to accelerating responses to this financing gap.

CSO involvement in Kenya, Malawi, Tanzania and Uganda: designing context-specific advocacy

To increase financial support to contraceptive supplies and streamline current procurement systems, CSO advocates can turn to these examples of locally owned and led advocacy as successful steps towards contraceptive security.

Kenya: Budgeting and allocation are part of a larger solution for contraceptive security

The Government of Kenya has implemented a dedicated budget line for family planning, estimating needs for FY 2015/16 at US$42,908,650, increasing year-by-year. Within this budget line, the contraceptive supply plan is US$10,307,079, also increasing annually. The commodities committed to the supply plan this year are worth US$7,846,026. The funding gap is therefore US$2,461,052, projected to rise to an alarming US$12,814,620 in FY 2016/17. This gap will widen as the demand for supplies expands. Advocates in Kenya are taking the following immediate actions, using their government's dedicated budget line and contraceptive supply plans as intervention opportunities: (1) prompt resource mobilization covering this financial year's gaps and establishing a solid future funding plan; (2) monthly supply plan monitoring and regular updates from procurement agencies ensuring an uninterrupted supply pipeline, (3) accessing downstream data for national planning; (4) joint resource mobilization for condom procurement led by national organizations like the National AIDS & STI Control Programme (NASCOP) and CSOs like the Reproductive and Maternal Health Services Unit (RMHSU); and (5) advocacy for county forums to discuss procurement, distribution and reporting of family planning commodities.

Malawi: Responding to an immediate need for supply chain mobilisation

In FY 2015/2016, the Government of Malawi allocated US$80,000 to the family planning budget line and donors committed US$21.7 million to family planning. Together, these allocations would cover Malawi's projected contraceptive prevalence rate (CPR) increase of 60%. However, supply chain inefficiencies illustrate that financial commitments are not enough to ensure contraceptive security. In its 2016 contraceptive supplies forecasting, Baja La Mtsoglo (BLM), Malawi's biggest contraceptive commodities supplier, requested 112,000 implants, among other methods. The requested amount was not fully supplied and, as implants are the most popular contraceptive method in Malawi, the amount shorted demand. Simultaneously, the Ministry of Health (MoH) shifted implant brands from Implanon to Nexplanon, offering to pass on surplus Implanon. Lack of coordination shows how supply chain inefficiencies impede contraceptives from reaching users. Significant and immediate communication between the Government of Malawi, BLM, MoH, Marie Stopes International (MSI) and UNFPA, located and routed the excess Implanon to BLM. Through immediate mobilisation, one supplier secured one contraceptive method. However, through efficient forecasting and communication, suppliers and governments must work together to secure multiple methods for multiple suppliers.

Tanzania: Addressing contraceptive stock-outs caused by procurement

In August 2013, the Government of Tanzania approved a major change in how it purchases contraceptives to ensure a consistent supply-flow reaches contraceptive users. The National Contraceptive Security Committee—a technical group led by the Ministry of Health and Social Welfare—recommended the switch to a framework contract system to expedite ordering and improve contraceptive availability. The Advance Family Planning (AFP) initiative, along with government officials and family planning providers, collaborated with the committee to enact the September 2013 change. Previously, family planning commodities were purchased through annual tendering, taking months to request bids, identify suppliers, meet government funding cycles, and make payments, which resulted in contraceptive stock-outs and barriers to contraceptive access for many Tanzanians. Under this new system, suppliers are identified once and contracts can last up to three years. The framework contract system should greatly reduce delays in consignments delivery and provide timely responses to emergency commodity needs.

Uganda: Finding alternative pathways for contraceptive commodities to reach users

In Uganda, the private sector, including CSOs like IPPF Member Association Reproductive Health Uganda (RHU), provides 60% of contraceptive services. Building on previous advocacy gains, with technical support from AFP, RHU and other family planning stakeholders collaborated to address the supply chain bottleneck. Together with the Ministry of Health (MoH) and donors, they developed an innovative strategy called 'alternative distribution' to provide supplies more consistently and efficiently to private sector facilities. At first the system worked well, but with no formal agreement in place, by 2014 its future looked uncertain. A sustained advocacy effort over a period of six months led to a Memorandum of Understanding (MOU) between the Government of Uganda and the Uganda Health Marketing Group (UHMG) to formalise the alternative distribution strategy. The MOU was a critical step to validate roles and responsibilities to ensure the programme continues, commodities remain available and Uganda is able to meet the demand of its contraceptive users.

Advocacy goals

The Kenya, Malawi, Tanzania and Uganda country experiences yield lessons to help other advocates engage more effectively on this issue of funding for contraceptive commodities. As each country context is different, kindly treat the following points as tips only:

Advocating at every level	Suggested approaches
National advocacy	**Position the importance of contraceptive security in national development plans.** Without sustained investment in contraceptive supplies, country-specific development visions, Kenya Vision 2030, Malawi Vision 2020, Tanzania Vision 2035, Uganda Vision 2040, that aim to transition them from lower income to middle-income-countries (MICs) will be difficult to realise.[4] **Eliminate OOP expenses, taxes and levies placed on contraceptive supplies towards affordable and accessible contraceptives.** OOP medical expenditure results in poorer health of communities. As individuals strain to pay for their health care, the economic burden rises to the national and global levels. Subnational structures now vested with the responsibility of health care delivery have limited budgets to make the much-needed financial contribution to the gap. **Encourage sustainable funding for contraceptives, with a specific line item for contraceptives included within national health budgets.**
Subnational advocacy	**Work in collaboration with civil society and government organisations to coordinate and strengthen national and subnational action around contraceptive supplies procurement processes.** Planning and needs quantification are implied in policy frameworks, but they are often not implemented practically. The compromised position of subnational level governments to demand resources to match their needs places them as recipients of whatever is agreed upon at the national level. This highly politicised process is difficult to manoeuvre and results in frequent forecasting failures.
Global advocacy	**Coordinate procurement of contraceptive supplies with donors and national and subnational governments.** Donors should communicate to provide a greater method mix of contraceptives and ensure a range of high-quality methods are procured in the right quantities, and delivered on time to the users. Currently, a lack of coordination between donors often results in scarcity of some methods, while other methods are overstocked at service delivery points.
All levels	**Adequately fund family planning programmes.** Governments have a responsibility to ensure adequate and sustained domestic resources are allocated and released on time. Family planning should have a separate budget line in the national and sub-national budgets. **Build on a rights-based approach.** Access to safe, voluntary family planning is a human right. Barring access to methods that suit the specific health concerns and preferences of women and girls is a violation of rights as conferred in constitutional frameworks and international human rights charters. 54% of all women in East Africa who would like to space and limit their pregnancies are unable to do so.[5] Commodity security is essential to ensure a rights-based approach to a woman's right to choice.

Key messaging around global funding gap

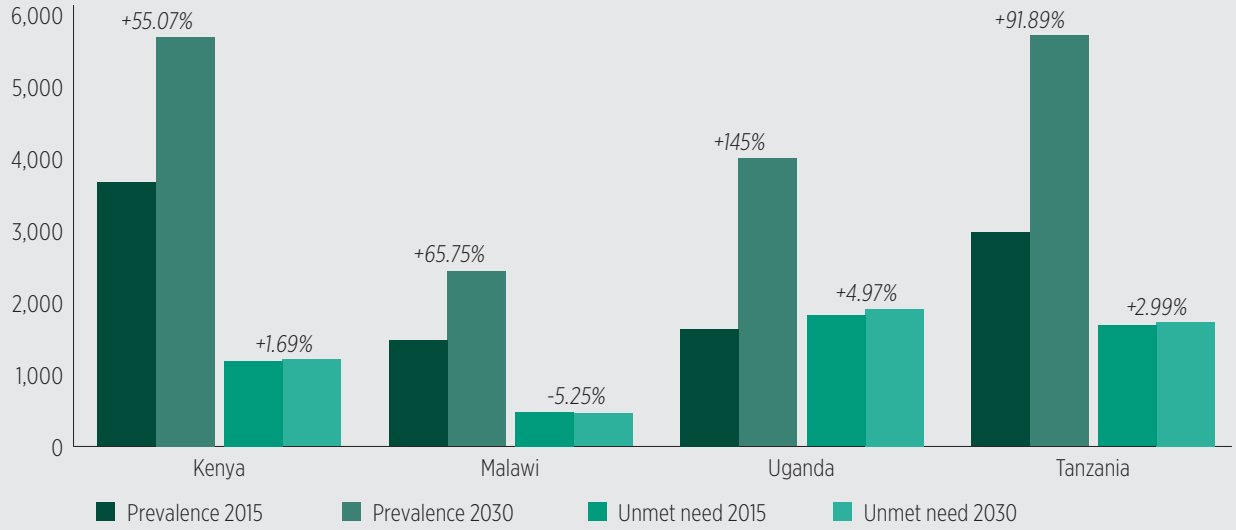
As family planning advocates, we suggest that CSOs consider the following key global factors when advocating for increased domestic resources for contraception:

A. There is a global funding gap for contraception. The global funding gap is illustrated by UNFPA Supplies' US$273 million shortfall. In 2016, immediate reductions will be made to national programmes, with estimated reductions of 45% in Malawi; 54% in Kenya; 70% in Uganda; and 79% in Tanzania.[6] The availability of contraceptives relies on funding from donor countries and sufficient investments from national governments.

B. Additional investments in contraceptive commodities are needed to meet the growing demand for family planning by 2020. Between 2011 and 2015, donor funding declined by 4% annually each year increasing the likelihood of stock-outs and decreasing the number of users supported by donor funding to 7%.[7] Projections show that an additional US$750 million is required to meet the growing need for contraception.

C. Donor funding alone will not solve the funding gap. Traditional donor funding is changing and diversifying. Blended financing models are emerging, and significant emphasis is being

Growing demand for contraceptives: 2015 to 2030 in thousands



placed on domestic resource mobilisation. Contraceptives are underfunded and a significant proportion are covered by individual OOP payments.[8] Domestic resources should be dedicated to contraception, fostering an enabling environment to ensure sexual and reproductive health and rights for women and girls everywhere. The prioritisation of sexual and reproductive health services within national and district-level governments is just as important as the support of international stakeholders.

D. Contraceptive supplies must be included in Universal Health Coverage (UHC). UHC is growing on the global agenda and contraceptives need to be included especially if they are to be funded. Coverage must be designed to include meeting the reproductive health needs of the poor, marginalised and underserved, including contraceptive choice. Contraception should be available as part of all maternal health packages and services must be provided by quality providers. Provider payment must also be designed to balance contraceptive choice for clients, and overcome provider bias.

Conclusion

Now is a critical time to take action to increase domestic resources for contraceptives, especially in light of a growing funding gap at the global level. CSOs have an important role to play in calling for increased political and financial priority for contraceptives. Advocates at all levels – global, national and subnational – must urgently examine the implications of the global funding gap for contraceptive supplies. The commitment and leadership of national governments is the lynchpin to contraceptive security. Without their leadership, we cannot meet the growing demand and need for contraceptives.

Notes

1 UNFPA Supplies provide approximately 40% of donated RH commodities to low and middle-income countries. In: Couture, T. (2016) *Humanitarian summit closes amidst looming crisis in funding for contraceptives.* Available at: http://pai.org/blog/humanitarian-summit-closes-amidst-looming-crisis-funding-contraceptives/

2 According to preliminary estimates by the Reproductive Health Supplies Coalition (RHSC): *Proposal to Population connections from Reproductive Health Supplies Coalition on behalf of the Advocacy and Accountability Working Group* (2016) 23 August.

3 RHSC (2016) *Take Stock Campaign.* Available at: http://noemptyshelves.org/the-issue/

4 Specific investment in contraceptive supplies is proven to yield high social and economic returns. Singh et al. (Guttmacher, 2014)

5 Guttmacher Institute (2013) 'Unmet Need for Contraceptives in Developing World Has Declined, But Remains High in Some Countries', *International Perspectives on Sexual and Reproductive Health,* 39(3), pp. 163–164.

6 PAI, MSI, RHSC, IPPF. *Contraceptive Supplies Crisis Messaging* (2016) 19 September 2016

7 Clinton Health Access Initiative (CHAI) and Reproductive Health Supplies Coalition (RHSC) (2016) *Family Planning Market Report.* Available at: www.clintonhealthaccess.org/content/uploads/2016/08/CHAI_Family_Planning_Market_Report.pdf

8 International Planned Parenthood Foundation (2016) *Financing Demystified.* Available at: www.ippf.org/sites/default/files/ippf_financingdemystified.pdf

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