Access to contraceptives in Argentina and Brazil

Evangelina Martich
Introduction

- Why Argentina and Brazil?

Similarities and differences between them

- Why the period 2003-2015?

In that years Argentina and Brazil implemented medicines policies and sexual and reproductive health programs as well.

- Why Contraceptives?

Health- Human Right-State Responsibility
Contraceptives - Essential Medicines (WHO)
Access barriers= Negative indicators for Women’s health
Methodology

How did I conduct the comparison and analysis?

- Carried out a literature review
- Developed 3 analyses matrix with specific dimensions: 1) to compare the health systems; 2) to compare the national sexual and reproductive health programs, 3) to compare the medicines policies with focus in contraceptives.
- Collected data (secondary sources), analyzed and compared both countries
- Analyzed how this issue reached the public agenda
- Mapped the key-actors and stakeholders
- Conducted 6 semi-structured interviews with stakeholders from both countries
Findings

Six key elements in the creation of ways to access to contraceptives:

- Political Processes
- Health System
- Outsiders
- Feminization
- Lack of Knowledge
- Medicines Policies and SRH
The influence of the political process

SRH reached the public agenda in 1984

SRH reached the public agenda in 2002
The relation between the ways of access and the institutional design of the health system

Argentina
- Public
- Social Insurance (46%)
- Private (16%)

Brazil
- Public
- Private (28%)
The participation of actors (outsiders from the sanitary sector) in the design and implementation of these strategies

IN FAVOUR

Women’s movements (Civil Society)

Religious and conservative groups

AGAINST
A feminization of contraception

Emergency contraception: conflicts

Misoprostol: in Argentina not in the EML
The lack of knowledge on the right to free contraception

Despite the fact that both countries implemented public supply strategies, the main way to access contraceptives is through commercial/private pharmacies (the population pay the full price)

(IEPS, 2009; PEREIRA VONK et al., 2013; RODRIGUEZ DE MEDEIRO et al., 2016; ROCHA FARIAS et al., 2016; UNFPA, 2016b)
### Medicines policy and Sexual and Reproductive Health

<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>SUBDIMENSIONS</th>
<th>ARGENTINA</th>
<th>BRAZIL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SANITARY</strong></td>
<td>Public supply</td>
<td>Yes</td>
<td>Irregular</td>
</tr>
<tr>
<td></td>
<td>Co-payment</td>
<td>Soc Security and Private</td>
<td>PFPB</td>
</tr>
<tr>
<td><strong>ECONOMIC</strong></td>
<td>Price control</td>
<td>No</td>
<td>CMED</td>
</tr>
<tr>
<td></td>
<td>Generic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>INDUSTRIAL</strong></td>
<td>Public Production</td>
<td>Incipient</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Incentives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Average unit price of hormonal contraceptives in Argentina and Brazil (in dollars PPA)

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>Drospirenone + Ethinylestradiol</th>
<th>Levonorgestrel + Ethinylestradiol</th>
<th>Levonorgestrel</th>
<th>Ethinylestradiol + Gestodene</th>
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</thead>
<tbody>
<tr>
<td>ARGENTINA</td>
<td>1,919</td>
<td>0,738</td>
<td>13,051</td>
<td>1,238</td>
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<tr>
<td>BRAZIL</td>
<td>1,016</td>
<td>0,301</td>
<td>9,404</td>
<td>0,557</td>
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</tbody>
</table>

Source: UNFPA, 2016
Lessons learned

- There is a need to understand the health system as a whole in order to analyze specific health policies’ interventions

- Analyze the participation of key-actors and stakeholders in public policy design

- Know the political context where the implemented health strategies emerge.

Next Steps

- Translating research results into practice (researchers and policy makers)

- Improve communication
Thank you very much!
Muchas gracias!

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