TMA STUDY FOR FAMILY PLANNING IN FOUR EAST AND SOUTHERN AFRICAN COUNTRIES

REGIONAL REPORT

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Mann Global Health

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ACRONYMS, FIGURES, TABLES & BOXES

ADS	Alternative Distribution System
CO	Country Offices
COGS	Cost of Goods Sold
DFID	UK Department for International Development
DTTU	Delivery Team Topping Up
EC	Emergency Contraception
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
FP	Family Planning
IUD	Intra Uterine Device
LARC	Long Acting and Reversible Contraception
M4P	Markets for the Poor
MGH	Mann Global Health
MIC	Middle Income Country
MOH	Ministry Of Health
MOHCC	Ministry Of Health and Child Care
MSI	Marie Stopes International
NGO	Non Governmental Organisation
NR	No Response
OCP	Oral Contraceptive Pill
PAC	Post Abortion Care
PACE	Programme for Accessible Health Communications and Education
PMA	Performance Management and Accountability
POP	Progestin Only Pills
PPP	Public Private Partnerships
PSI	Population Services International
RH	Reproductive Health
RHCP/CCP	Reproductive Health Care Provider / Comprehensive Condom Programming
RMHSU	Reproductive and Maternal Health Services Unit
SBCC	Social and Behavioural Change Communications
SMO	Social Marketing Organisation
SPARCHS	Strategic Pathway to Reproductive Health Commodity Security
SRH	Sexual and Reproductive Health
SWOT	Strengths, Weaknesses, Opportunities, Threats
TMA	Total Market Approach
TOR	Terms of Reference
UHC	Universal Health Coverage
UHMG	Ugandan Health Marketing Group
UIS	United Nations Educational, Scientific and Cultural Organization Institute for Statistics
UK	United Kingdom
UNCoLSC	United Nations Commission on Life Saving Commodities
UNFPA	United Nations Population Fund
UNFPA CO	United Nations Population Fund Country Office
UNFPA ESARO	United Nations Population Fund East and Southern Africa Regional Office
URHVP	Ugandan Reproductive Health Voucher Programme
WRA	Women of Reproductive Age
ZAPS	Zimbabwe Assisted Pull System

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GLOSSARY [FROM BRADY, JANUARY 2016]

Commercial sector
The commercial sector is a subset of the private sector and is synonymous with for-profit entities. The commercial sector is used to distinguish for-profit from nonprofit entities.

Government stewardship
In government stewardship, the government takes a lead role in mobilizing and coordinating all sectors and stakeholders toward a goal, such as to improve family planning services. This includes government oversight to ensure the high quality, availability, and affordability of nonstate providers of family planning. Stewardship does not mean "control", however; it is important for multiple voices to inform TMA development and implementation.

For-profit
A for-profit company can earn a profit, which is defined as revenues in excess of expenses. A for-profit health care organization has wide discretion on how to spend its profit. This distinguishes it from a nonprofit organization, which can spend profits only on the purpose for which it was formed.

Non-governmental
A nongovernmental organization (NGO) is an organization or institution that is entirely or largely independent of any national government. Although an NGO can technically be a for-profit organization, the term is generally used to describe an organization whose primary goal is social and supports a public good.

Nonprofit
A nonprofit health care provider does not have profit maximization as a goal. Instead, it uses all revenues available after normal operating expenses to accomplish its purpose. Although nonprofits are allowed to generate extra revenue, they must be retained by the organization for its self-preservation, expansion, or plans, and not released as profits or dividends. Many nonprofits use the model of a double bottom line because furthering their cause is a more important priority than making a profit, although both are needed to keep the organization sustainable. Nonprofit organizations involved in health care are typically NGOs, community- or faith-based organizations, or other charitable organizations.

Private medical or health sector
The private medical or health sector is a large and diverse community comprising both for-profit and nonprofit entities that lie outside the public health sector. The private sector includes a wide range of health sector entities, and may include individual private practitioners, clinics, hospitals, and laboratories and diagnostic facilities; nongovernmental organizations; faith-based organizations; shopkeepers and traditional healers; pharmacies; and pharmaceutical wholesalers, distributors, and manufacturers.

Private provider network
A private provider network is an affiliation of health service providers grouped together under an umbrella structure or parent organization. Networks may be organized according to a variety of arrangements. The details of the arrangements vary widely but often include monitoring by a parent organization and commitment by members to standards, high quality, a given service mix, and prices. Private provider networks include professional associations as well as franchises.

Public-private partnership

A public-private partnership is any explicit joint program or project involving both public and private collaboration. Public-private partnerships to provide health services and products can take the form of public-sector subsidies to the private sector. Public-sector government or development agencies can also contract with private service providers or producers and distributors of products and commodities.

Social marketing
Social marketing is the use of commercial marketing techniques to achieve a social objective. Social marketers combine product, price, place, and promotion to maximize product use by specific population groups. In the health arena, social marketing programs in the developing world traditionally have focused on increasing the availability and use of health products, such as contraceptives or insecticide-treated nets.

Social franchising
Social franchising is the use of a commercial mechanism for replicating a successful business strategy to achieve a social objective. Key components generally include a common business format, a branded identity, and a quality assurance system. A franchise is a business arrangement whereby a franchisor develops a system of conducting an activity and provides franchisees with the "know-how" to conduct the activity. A franchise operation offers additional benefits, ranging from a defined and exclusive territory and the use of a common name to a full-fledged operational structure with centralized management services such as advertising, financial accounting, marketing, and procurement. In the case of health care service providers in a clinic franchise system, a network of private practitioners offers a uniform set of services at a predefined cost and standard of care.

Total market initiative
A total market initiative (TMI) is a project (or an activity within a project) that is funded specifically to implement total market activities such as conducting a market segmentation analysis and engaging stakeholders to develop a five-year contraceptive procurement forecast that incorporates historical data from all three sectors.

EXECUTIVE SUMMARY

This regional Total Market Approach (TMA) report compares and contrasts key findings of four TMA studies on the modern Family Planning (FP) markets conducted between October and December 2016. The four countries participating in the regional study were: Kenya, Madagascar, Uganda and Zimbabwe.[1]

The aim of the TMA is to design more targeted, efficient and sustainable FP programs through participation of all sectors – public, NGO, commercial and traditional– to meet the contraceptive needs of all women (and men) in the region, and contribute to universal health coverage. The study was financed by the United Kingdom's Department for International Development (DFID), through UNFPA's East and Southern Africa Regional Office, under the leadership of Dr Kanyanta Sunkutu, RHCP/CCP Technical Specialist.

The goal of the TMA studies was to generate an understanding of the total market for modern contraceptive commodities by assessing the current family planning (FP) landscape and available market data, and identifying market constraints and programmatic gaps that prevent universal, sustainable use of FP commodities in each of the four target countries.

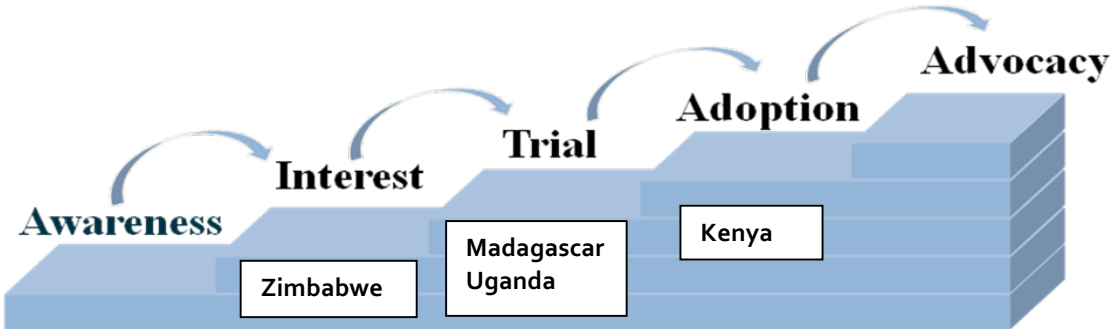
Key objectives of the studies were to: (i) understand the national FP environment, rules, resources and capacity; (ii) map public, NGO and commercial sector players and products in the market system, and assess their performance and core roles in terms of procurement, distribution, access and demand generation; (iii) analyze whom the FP market is failing (iv) describe how the FP market is failing to meet the needs of population segments, and (v) assess national support and possible coordination mechanisms for the implementation of a TMA initiative for FP products.

The roadmap, methodology and tools for the study were based on market systems frameworks and pioneering work from various organizations, including Abt Associates, PATH, the Springfield Centre, and Population Services International (PSI). National consultants based their analysis of FP markets on available market and other data collected by means of a desk review and through key informant interviews conducted with main FP stakeholders to assess each FP market. TMA findings were presented and discussed at the national consensus generation meetings organized in most countries in December 2016. During these meetings, key policy and advocacy recommendations and action points were formulated jointly by participating FP stakeholders. Consensus generation meetings were held in Madagascar and Uganda in December 2016 and in Zimbabwe in January 2017. In Kenya, the national consensus-building workshop was replaced by smaller FP TMA Technical Working Group meetings, held in Dec 2016 and March 2017.

Interestingly, three countries - Kenya, Madagascar and Uganda -- have prior experience in carrying out TMA studies either for male condoms only or for the full range of modern FP methods. Of those countries, Kenya is most advanced in TMA implementation: a TMA working group with representatives from public, NGO and commercial sector entities is housed within the MOH and meets on a regular basis. A concrete output of their work was the development of an overall TMA plan for 2017. The figure below illustrates the stage of change in which each country finds itself, along the path to adoption and advocacy of TMA in its reproductive health sector.

[1] A 5th country, Zambia had planned to participate but due to time constraints, the UNFPA Zambia Office postponed their TMA Study to 2017.

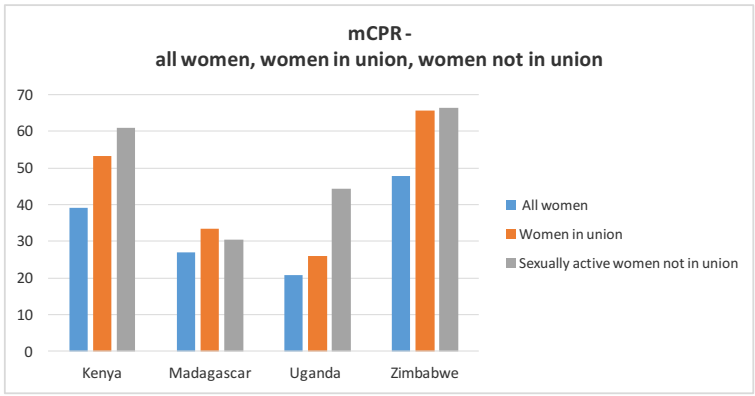
Figure: Stages of change from awareness to adoption and advocacy for TMA

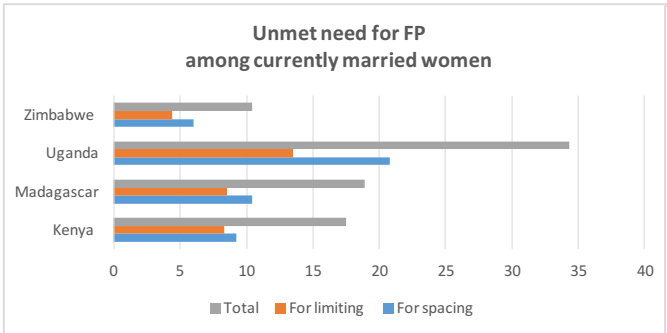


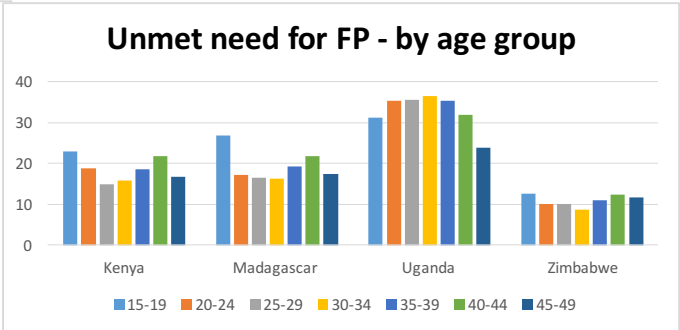
Main Findings from the FP TMA Studies

The main findings from the FP TMA studies in the four focus countries are listed below.

- FP is integrated in national strategies and policies in all focus countries, and all countries have dedicated commitments to FP 2020.
- The FP markets, uptake, demand and unmet need however vary considerably in these countries.
- Zimbabwe and Kenya have by far the highest proportions of women using modern contraceptives, whereas Uganda and Madagascar have much lower modern contraceptive prevalence rates (mCPR). As a consequence, Uganda and Madagascar have higher unmet needs for FP, in particular for birth spacing, but also for limiting births.
- Unmet need for FP varies with the age group, with adolescents (15-19 years) in most countries having a higher unmet need for FP. There are considerable differences in met and unmet need in all countries depending on place of residence, female education and wealth quintile.







All country reports include findings regarding the key questions for TMA: whom the market is failing? And how the market is failing? Summarizing findings are presented in the following sections of the report.

Analysis of target audience insights revealed that despite an overall high general knowledge and awareness of FP, uptake and continuous use of modern methods is hampered by a variety of barriers. Such barriers include supply side as well as demand side factors, e.g., lack of method mix, low supply of

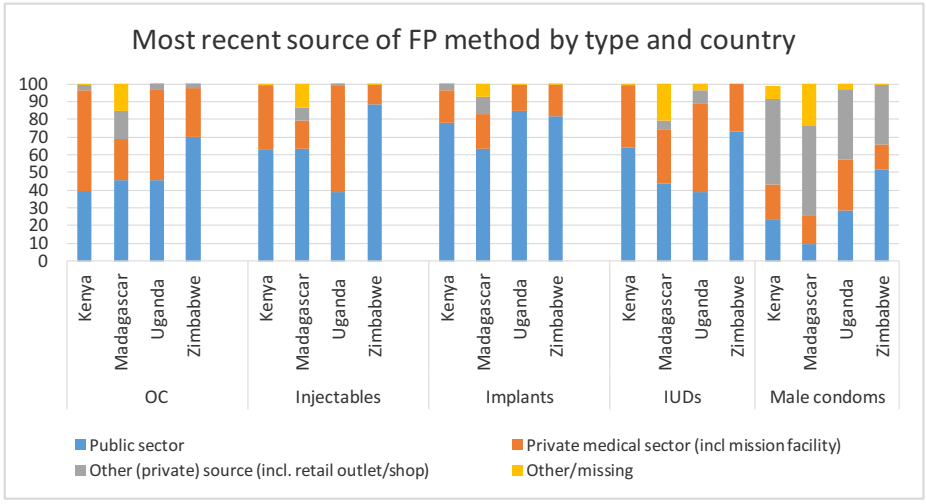
long-acting reversible contraceptives (LARCs), and myths and misconceptions about different product categories.

Cost-related barriers play a less important role, in particular for urban women and those living near a public health facility, because all four countries offer FP products and services in the public sector free of charge. However, the out of pocket payments and opportunity costs, as well as certain fees charged even in countries with "free access to FP," represent a burden for low income populations in all four countries.

For demand side factors, all four national studies document individual and social barriers, including lack of social support to access and use FP. National data also pointed out that discontinuation rates of modern FP methods are quite high: ranging from 22.0% in Zimbabwe, to 30.5% in Kenya and 42.6% in Uganda. The main reasons for discontinuation (other than fertility related reasons) were method-related health concerns and side effects. Given that the quality of FP counseling is directly correlated with satisfaction and continued use, the level of discontinuation attributed to side effects may indicate a market failure on the part of FP providers, who have too little method information and poor counseling approaches.

The FP markets of the four countries share similar pattern:

- The majority of all contraceptives are supplied by the public and Social Marketing/NGO sector; the private pharmaceutical sector plays a limited role.
- Most FP products are distributed for free or subsidized, with little or no targeting of these subsidies, leading to market distortion and an expectation even among wealthier population segments that FP products will continue to be available at low or no cost.
- As indicated in the figure below on the most recent source of FP methods, according to DHS data, the private medical sector plays an important role in Kenya, Madagascar and Uganda. Private medical facilities, including clinics, hospitals and providers and pharmacies in all countries, are a main source of OCs, injectables and IUDs. In Uganda, for example, 51.5% of OCs, 60.1% of injectables and 50.4% of IUDs. While it is not possible to clearly differentiate whether the FP method was sourced through an NGO or through social marketing or franchising, in this context it is noteworthy that the private medical sector as described above includes social franchising networks operated by NGOs such as PSI, MSI and others, and therefore private providers benefit from training, ongoing support and assistance in FP and in particular for the service provision of long acting reversible FP methods. The private medical sector stands out for IUD service provision, accounting as the most recent source for 34.5% of users in Kenya, 30.3% in Madagascar and - as mentioned - 50.4% in Uganda. Retail outlets or shops (reported under "other private sources") are used to access male condoms in all four focus countries, representing the most recent source for between 33.9% (Zimbabwe) and 50.5% (Madagascar) of all users.



FP commodities are mostly donor funded; all countries have national reproductive health commodity security strategies in place and commitment to FP2020 goals. However, according to the Contraceptive Security Index 2015, only Madagascar and Uganda have dedicated budget line items in the national budgets for procurement of contraceptives. In all four countries, there are diverse problems in the supply chain and distribution, which differ depending on the country and lead to inefficiencies including stock-outs of FP products and/or a lack of funding to transport the products from central to community levels.

All four countries have policies and regulations in place to coordinate the supply and delivery of FP commodities. These are generally developed, implemented and supervised by different MOH departments.

Legal age restrictions applied to contraceptive use by young people are in place with varying age limits: in Madagascar and Uganda, except for condoms, a person must be 18 years old or older to purchase a contraceptive; otherwise consent from a parent, adult tutor or adult spouse is compulsory. In Zimbabwe, contraceptives are not for sale to young people under 16. However, youth can access EC in the case of sexual abuse or related circumstances. Kenya has the lowest legal restrictions: adolescents from 15 years on can have access to FP products and services.

All four countries channel products from manufacturing and importation to the end users using different and somewhat parallel supply chains for publicly- versus commercially- distributed and social marketed FP commodities. Distribution of social marketed FP commodities may use both channels depending on the country and the product category. Short-term FP methods are generally integrated into existing commercial distribution systems, whereas longer-term methods may be supplied for social franchising, social marketing or to NGO facilities through public and commercial sector channels. Private sector supply chains are generally based on pull-systems operating on demand from the client up to the dispensing entity (clinic or pharmacy), to the wholesaler and importer level. On the other hand, public sector supply chains, which channel the largest proportions of FP commodities, are sometimes employing active "push systems" to increase access to and uptake of FP.

Key findings from stakeholder interviews regarding supply chain issues as reported in the country studies are:

- Kenya: unanimous agreement that commercial outlets, especially those serving middle- to high-income segments of the population, should not access the free public sector FP commodities. There is widespread concern that the current system, where public providers serving people who can afford either subsidized or full commercial prices, is not sustainable.
- Uganda: With respect to potential crowding out of the commercial sector in FP commodity supply and service provision, the overriding opinion by stakeholders was that this was unlikely to happen. This view was, in their minds, supported by the fact that there was a niche for the commercial sector within the general population, a proportion of which is willing to pay for services despite availability of subsidized or free services.
- Madagascar: The last-mile transport issue at the health centre level remains unresolved and may lead to lack of availability and access to FP in more remote areas.
- Zimbabwe: Stakeholders on one hand felt there is generally no competition between subsidized FP commodities and commercial ones, with only two key stakeholders interviewed citing the existence of competition. On the other hand, there is consensus that the current donor-dependent supply and distribution system needs to be changed to be more cost effective and sustainable.

Stakeholder perceptions regarding the current FP programmes revealed the there are major challenges in all focus countries to guarantee government financing of a sustainable supply of FP commodities, and to ensure free and subsidized FP commodities reach the populations that need them. Stakeholders

also report major or moderate challenges in accessing FP methods among all target groups, particularly rural women, urban poor and young people. Availability of FP commodities to all target groups is a barrier in three of the four countries, excluding Zimbabwe, where the majority of health facilities have most FP methods in stock.

Regarding the Total Market Approach, most stakeholders shared positive perceptions regarding the implementation of a TMA in their countries. The TMA was seen as laying a pathway towards reducing donor dependency and wastage of resources. Stakeholders cited numerous benefits, including:

- increasing the sustainability, equity, and efficiency of FP programmes,
- prioritizing public sector funds towards the poor,
- improving choice and affordability of contraception, access and uptake, and
- enhancing coordination and partnerships across sectors.

FP stakeholders agreed that implementation of a TMA required stewardship from the MOH and wide participation from all FP market sectors – public, NGO/SMO, commercial and donors. In general, findings suggest that the government's readiness to steward a TMA is greater in Kenya and Madagascar in comparison with Zimbabwe or Uganda, where stakeholders perceive a need for more TMA advocacy and education efforts to persuade government of the urgency to implement TMA initiatives.

The national studies describe the FP market failures and show *whom* the markets are failing and *how* the markets are failing in the respective countries. The overall pattern indicates that in general, poor, rural women with low education, as well as adolescents and youth, and populations in hard to reach zones of the countries lack access to information, products and services.

The detailed analysis of how the market is failing indicates failures of core functions, support functions, and regulatory functions at all levels in the value chain from production to use. Market failures concern all product categories, to varying extents in the four countries. Illustrative examples are:

- Kenya is a middle-income country, has a vibrant market of male condoms which is dominated by subsidized SMO products; this leads to crowding out of the commercial sector.
- In Madagascar, a socially marketed emergency contraceptive brand is sold at a higher price than an equivalent commercial brand, which represents a market distortion and inefficiency.
- In Uganda, the oral contraceptives market grows, with a high proportion of free distribution despite willingness to pay by certain segments.
- In Zimbabwe there is a high demand for injectables, mainly sourced for free through the public sector, which leads to crowding out of the commercial sector.

<u>Follow-Up to This Report:</u>
The analysis of the national TMA studies led to an initial set of conclusions and recommendations to improve the overall FP market systems, according to the different stages of market development for each product category in the respective countries.

The TMA study process included the organization of UNFPA-led consensus generation meetings in each country with FP stakeholders representing all sectors – public, NGO and commercial, including donors and multilateral organizations. Consensus generation meetings provided opportunities to share and discuss findings from the TMA studies and generate key issues and/or recommendations for moving TMA initiatives forward. All four national TMA studies will be fully completed in early 2017, providing countries with an evidence-based assessment of their respective FP markets, indicating

market failures, and including suggestions and recommendations on how to address imbalances and sustainability of FP markets through total market Initiatives.

The TMA work conducted in the four countries to date will need to be followed up by the development of national TMA plans, which in turn need to be endorsed by national governments and stakeholders. There is general consensus among stakeholders in the four countries that these next steps require strong commitment and firm engagement not only from the Ministries of Health, but also from Ministries of Finance and other relevant government departments. In addition, the process requires an alignment of diverse stakeholders and donors to support and implement national Total Market initiatives.

I. INTRODUCTION

A. Purpose and Objectives of the TMA Study on FP

The purpose of this regional study was to apply Total Market Approach (TMA) principles and methodologies to a range of contraceptive commodities in four East and Southern Africa (ESA) countries. The target countries[2] for the regional TMA study were**:** Kenya, Madagascar, Uganda and Zimbabwe.

The TMA aims to design more targeted, efficient and sustainable programmes through participation of all sectors – public, NGO, commercial and traditional[3] – to meet the contraceptive needs of all women (and men) in the region, and contribute to universal health coverage (UHC). Applying a well-coordinated TMA for contraceptives can address access and equity imbalances, and help improve financial sustainability of family planning (FP) programs through better targeting of subsidies. Its application furthermore takes into account the achievement of global FP2020 and national commitments[4] to expand access to FP information, services and supplies by 2020 in each country.

The study was financed by the United Kingdom (UK) Government Department for International Development (DFID), through UNFPA's East and Southern Africa Regional Office (ESARO), under the leadership of Dr Kanyanta Sunkutu, RHCP/CCP Technical Specialist.

The Consultant's Terms of Reference (TOR) requested *a review of the market for reproductive health (RH) supplies, including condoms, other contraceptives and RH commodities in target countries.* Following consultation with UNFPA ESARO, the commodities to be considered under the study were limited to modern contraceptive commodities procured by each UNFPA CO. They included:

- Male condoms
- Female condoms
- Progestin-only pills (POP)
- (Combined) Oral contraceptive pills (OCPs)
- Emergency contraceptive (EC) pills
- Injectable contraceptives
- Subdermal implants
- Intra-Uterine Devices (IUD)
- New contraceptive products: self-injectables, for example.

The objective of the TMA Study was to generate an understanding of the total market for modern contraceptive commodities by assessing the current FP landscape and available market data, and identifying market constraints and programmatic gaps that prevent universal, sustainable use of FP commodities in each of the four target countries. This meant specifically:

1. Understanding the national FP environment, rules (policies and regulations), resources (financing, institutional) and capacity (programme, coverage and reach).
2. Mapping public, NGO and commercial sector players (and related products) in the market system, their performance and core roles in terms of procurement, distribution, access and demand generation.

[2] The assignment originally listed 5 ESA countries, including Zambia. Due to a restricted timeframe, the UNFPA CO in Zambia has postponed their TMA Study to 2017 (to be confirmed).
[3] The traditional sector refers to unqualified, informal and traditional networks that provide health care within countries. Traditional/informal providers may include traditional birth attendants, drug sellers, etc.
[4] For more information: http://www.familyplanning2020.org/ (Accessed: December 7, 2016)

3. Analysing whom the FP market is failing – through the quantification of *needs* versus *use*, and the identification and size of underserved segments of the population in need of contraceptive commodities as well as its potential to increase/decrease.
4. Describing how the FP market is failing to meet the needs of population segments, especially those that are underserved, and how underserved population segments are coping with market failures.
5. Assessing national support and possible coordination mechanisms for the implementation of a TMA initiative.

B. Clarifying current gaps and future needs, and making recommendations for advocacy, policy dialogue and action,[5] to the TMA Study Implementation Team

A team of regional and national consultants carried out this study. The work was highly collaborative, with distinct roles played at regional and national levels.

Table 1. Responsibilities of regional and national TMA consultants

Regional consultants	National consultants
• Wrote the inception report, including a detailed roadmap, data collection tools and a standard TMA reporting template to guide the work of national consultants. • Provided the overall study approach, including framework and tools for data collection, as well as technical guidance and support. • Coordinated regular update calls with national consultants and UNFPA CO focal points to monitor study progress and provide technical support. • Informed UNFPA ESARO of the progress of the TMA Study and any challenges in implementation. • Organised and facilitated a virtual regional meeting to share findings, recommendations and lessons learned from the TMA study implementation in the four focus countries. • Wrote a final regional consolidated consultancy report with recommendations generated from the country-specific reports and consensus generation meetings.	• Worked with UNFPA COs to ensure smooth implementation of the country-specific TMA studies. • Collected and analysed data on existing market systems for selected FP commodities using guidance from the inception report, frameworks and associated tools. Data collection included desk reviews and in depth interviews with key stakeholders. • Wrote a country-specific TMA study report based on analysed data, frameworks and the standard TMA reporting template. • Organised and facilitated the consensus generation meetings with national FP stakeholders. • Documented recommendations generated from the market analysis and consensus generation meetings within final country-specific reports. • Presented TMA study findings and recommendation during a virtual regional meeting hosted by UNFPA ESARO at the close of the project.

C. Limitations of the TMA Study

Country-specific and regional work was time-bound – the scope and depth of the study were defined according to the study timeframe, which varied in each country depending on when national consultants were recruited, and the availability of stakeholders. *Due to time constraints, no new population-based data were collected, nor was a new statistical analysis of available raw data carried out*. The consultants' work was limited by available documentation and data in each ESA country. In some cases data were available from different sources and were not aligned; more time would have been required to uncover these discrepancies. Previous TMA work in FP was available in some countries (Kenya, Madagascar and Uganda) making data more readily available. All consultants expressed difficulties in collecting sales data from the commercial sector.

[5] Country specific TMA reports provide insights on outlets for certain populations segments.

II. DESCRIPTION OF THE TOTAL MARKET APPROACH FOR FAMILY PLANNING

FP policymakers and managers increasingly recognise that the best way to sustainably meet the FP needs of consumers is through strategies that engage all market sectors that supply FP commodities: the public sector, the private non-profit (or NGO) sector, and the for-profit, commercial sector.[Barnes, 2012] Heavy reliance on donor funding for contraceptive commodities, too frequently provided as a short-term solution to emergency situations, is preventing decision-makers from asking questions that address the root-cause of the problem: "why isn't the market providing solutions to these problems?" and "how can we facilitate the health market to work for the poor?" [The Springfield Centre, 2015] Answering these questions entails the implementation of new approaches, such as Markets for the Poor (M4P) or the TMA, which strive to establish inclusive, equitable and sustainable market systems to address health problems based on a thorough understanding of how existing health markets are working and failing. [Hanson, 2001; Barnes, 2012; The Springfield Centre, 2015]

Box 1 : Market system
A **market system** is defined as *a multi-function, multi-player arrangement comprising the core function of exchange by which goods and services are delivered and the supporting functions and rules which are performed and shaped by a variety of market players.* [The Springfield Centre, 2015]

A. Total Market Approach – Definition

A TMA in FP is a process through which suppliers and financiers of FP commodities from all sectors – public, NGO and commercial - build a common strategic framework to improve equity, efficiency and sustainability in the health system, in order to better target FP subsidies and to maximize use of FP products. [Barnes, 2012] TMA employs total market system frameworks and tools to a) understand the underlying causes of persistent challenges faced in use of FP commodities, b) identify system-level interventions to mitigate those challenges, and c) guide initiatives that promote sustainable change.[The Springfield Centre, 2015]

B. Frameworks for Understanding the FP Total Market System

This study sought to create a comprehensive understanding of the total FP market system in each selected country. A total market system is comprised of both demand and supply mechanisms for FP commodities, as well as the contexts in which these mechanisms are at play. These contexts have a supportive function, by providing information, infrastructure, skills and technology, and related services. They also define the rules (both formal and informal) by setting laws, standards and regulation (including tariff structures and taxes), and taking into account social norms. (***Figure 1***) Unravelling the pieces of the total market system helps to identify where there are *opportunities*, *market failures*, *how* and *whom* the market is failing, and which interventions might address them.

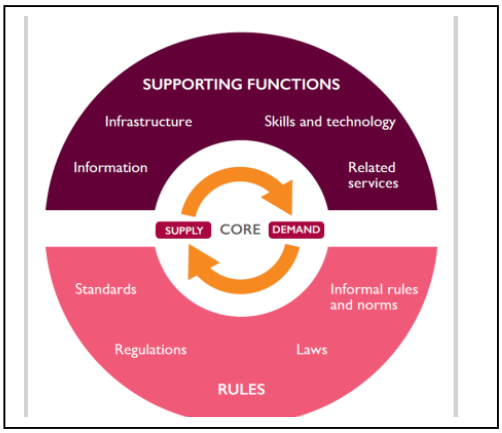


Figure 1: The Market System
[Source: The Springfield Centre, 2015]

Thinking around total market systems for FP is drawn from pioneering work led by Abt Associates, PATH, the Springfield Centre, and Population Services International (PSI). The Springfield Centre and PSI offer a number of practical frameworks and resources that can further guide the present TMA study. [Barnes, 2012; The Springfield Centre, 2015; PSI Market Development Approach, 2016; PSI TMA

for FP In Cambodia, 2011; Pallin, 2013.] Similarly, the conceptual model at the core of the Strategic Pathway to Reproductive Health Commodity Security (SPARCHS) presents programmatic and environmental components required to achieve contraceptive security, placing client demand and use at its centre. (***Figure 2***)

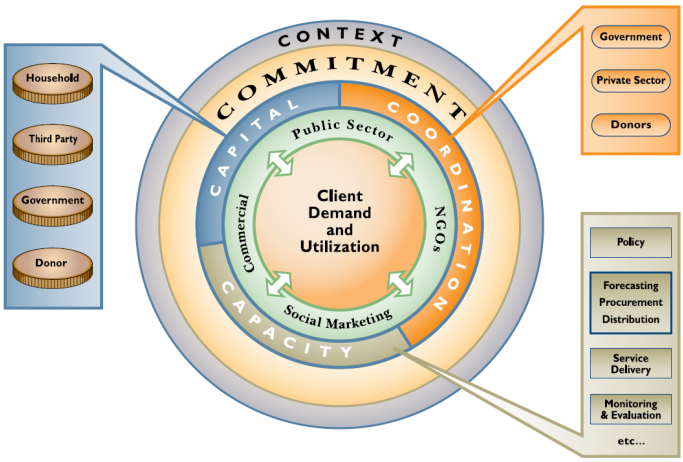


Figure 2. SPARCHS Framework for Reproductive Health Commodity Security [USAID, DELIVER Project 2015]

The process of understanding the FP market system explores information around two main areas: demand and supply, which are further divided into sub-sections. (***Figure 3***)

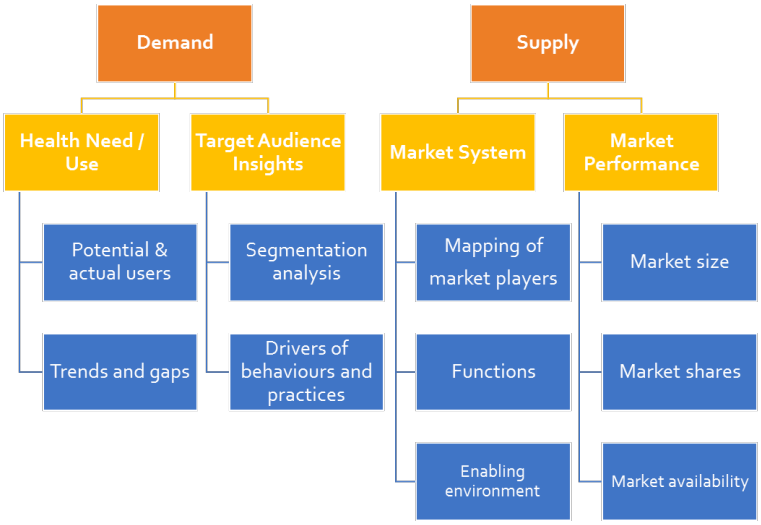


Figure 3: Areas for understanding the market system
[Source: Adapted from The Springfield Center 2015 and PSI Market Development Approach, 2016]

Understanding demand requires:

- An analysis of health *need* and *use*, in terms of:
  - Potential and actual FP users.
  - Trends in need and use over time, and gaps between the two.
- Target audience insights, which explore information on:
  - Target audience segments based on age, gender, place of residence, income and behaviours, for example.
  - Drivers of FP behaviours and practices, including the role of influencers.

Understanding supply requires:

- Mapping the market system, particularly:
  - FP market players involved in the supply of and demand for FP commodities. This includes - manufacturers, importers, distributors, providers and consumers.
  - The functions of each player and the relationships between them. An analysis using the traditional 4 "Ps" of marketing (which products are offered? At what price? Through which outlets (place)? How are they promoted?) is helpful here.
  - The enabling environment, both the supportive elements and the rules that are provided within.

- Assessing market performance, which is related to:
  - Total market size for FP commodities –in terms of both volume and value.
  - Market competition and shares, considering all market sector players and the extent to which they are meeting FP needs and demand
  - Market availability of a range of FP product categories and brands.

III. METHODOLOGY: MODULES AND ASSOCIATED STEPS

A. Four Modules of the TMA

"The Planning Guide for a Total Market Approach to Increase Access to Family Planning" was developed under the USAID-funded EVIDENCE Project. It recommends a roadmap for conducting a TMA in four modules. [Brady, 2016] ***Figure 4*** below, "Planning a total market approach for family planning," illustrates these four modules. It highlights that the first module of a TMA study – landscaping -- should be followed by analysis of further evidence, stakeholder engagement (through a coordination mechanism), decision making, capacity building and action (implementation and monitoring).

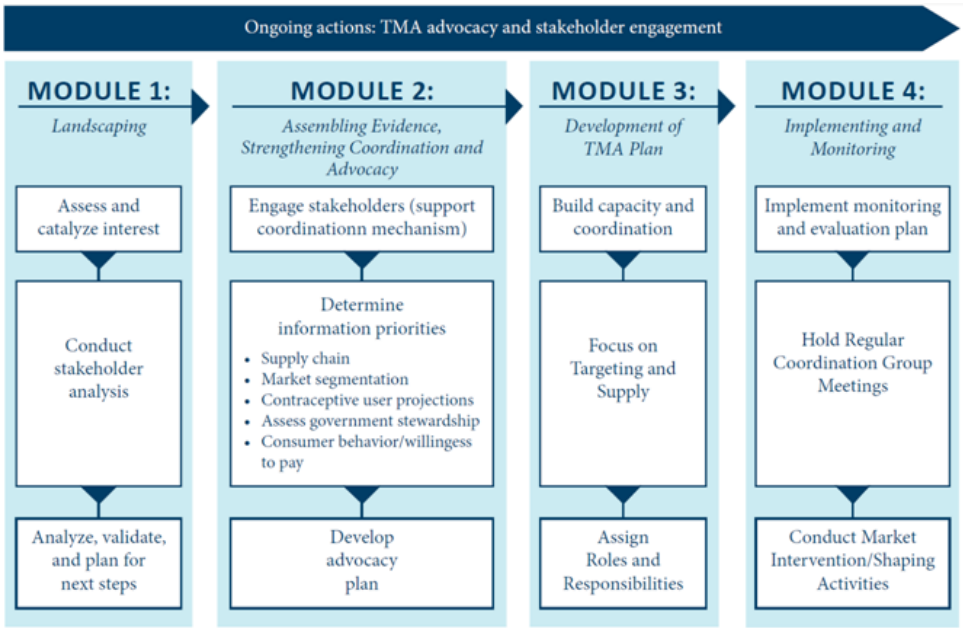


Figure 4: Planning a total market approach for family planning [Brady, 2016]

B. TMA Study Focus on Landscaping and Understanding the FP Market

The present TMA study focused on Module 1 and Module 2 (in part) of the TMA presented in ***Figure 4*** above.

Module 1, landscaping assessment, aims to understand the important issues affecting equitable and sustainable FP and to generate interest among stakeholders for implementing a TMA initiative. There are three main steps required for a TMA landscaping assessment. [Brady, 2016]

- Step one analyses and seeks to catalyse stakeholder interest. It shares information about TMA, gauges stakeholder interests and concerns, and examines existing information on the FP market as part of a desk review.

- Step two requires conducting an analysis of stakeholders and their roles, visiting providers and other outlets to gather consumer level data, and identifying issues, gaps, obstacles and opportunities. It explores the feasibility of a TMA initiative and updates the desk review with this information.

- Step three summarises the analysis of all information, validates the findings and lays out a plan for next steps. During this step, TMA "snapshots" of FP markets and market failures are developed. Stakeholders are brought together in consensus generation meetings to validate findings and prioritise issues and concerns. Finally, a course is charted for future TMA initiatives.

Consultants conducting this landscaping assessment noted the following during this part of the TMA study:

- The role of the public sector is critical.[6]
- Because the concept of a TMA may not be well understood by stakeholders, it was helpful to provide a description of the TMA before discussing issues related to it (see Tool #1: Background on the TMA). Referring to concepts such as health systems strengthening (HSS) and/or public private partnerships (PPP) helped to generate an understanding of the TMA concept.
- It was important to identify TMA "champions" (public, NGO and commercial) at an early stage. TMA champions help disseminate information on the value and benefits of a TMA and advocate for the implementation of policy-level changes and initiatives in this area.
- The engagement of the commercial sector was sometimes challenging. Narrative tools that articulate the advantages of a TMA for commercial sector partners were provided for consultants to use when communicating with commercial sector partners (see Tool # 1: Background on the TMA, which includes commercial sector pitches).

Each step had certain activities to be completed. These are described in **Annex 1.**

Module 2 looks closely at available **data to assess the FP market**[7]. Patterns and key trends in TMA assessment criteria are analysed when possible in view of stratifying and segmenting the market. Technical guidance was provided to all country teams by the regional consultants. There were five broad areas explored for assessing FP market health [Barnes, 2012; The Springfield Centre, 2015; Meekers, 2016):

(1) Market size
(2) Market equity
(3) Market accessibility
(4) Market sustainability
(5) Market systems

[6] Abt Associates offers a framework for assessing government stewardship capacity, which regional consultants will review for guidance on this question. (See Barnes, 2012 pp 9-10)

[7] Data sources from secondary sources were identified. This module also requires the collection of primary data, however this was not included in the present TMA Study.

The tables in **Annex 2** present the assessment criteria, their definitions, calculations and sources of data for each of these areas. [*adapted* from: Meekers, 2016]

During both phases, policy dialogue and advocacy recommendations were developed. Government and other FP partners' stewardship capacity was also assessed.

In practice, both of the modules described above overlapped. Once fully completed, they are intended to lead into the development of a TMA plan for FP (**Module 3**), its implementation and monitoring (**Module 4**). ***In the course of this TMA study, some countries held country consensus generating meetings. However, modules 3 and 4 were not part of the assignment.***

IV. OVERVIEW OF THE FOUR COUNTRIES: KENYA, MADAGASCAR, UGANDA, ZIMBABWE

A. Socio-Demographic, Health, Economic and Political Context

Table 2 below provides a snapshot presentation of the socio-demographic, health, economic and political contexts of each of the four focus countries.

Table 2. Main characteristics of each of the four ESA focus countries.

Characteristics	Kenya	Madagascar	Uganda	Zimbabwe
Demography, health and family planning				
Population size (WB, 2015)	46.1 M	24.2 M	34.9 M	15.6 M
Average annual population growth rate (WB, 2015)	2.9%	2.8%	3.3%	2.3%
% population < 15 years (WB, 2015)	42%	42%	48%	42%
Adult literacy rate women 15 and above, 2015 UIS estimates	75%[f]	62.2%	66.8%	85.5%
Median age at first sexual intercourse (women)	18 years[a]	17 years (2013)	17 years[c]	18.9 years (2011)
Median age at first marriage(women)	20.2 years[a]	19 years (2013)	18.1 years[c]	19.7 years (2011)
Total fertility rate	3.9 live births[a]	4.4 (WB, 2014)	5.96	4.0 (2015)
Maternal mortality rate (/100,000 live births)	510 (WB, 2015)	353 (WB, 2015)	438	614 (UNICEF, 2014)
Infant mortality rate (/1,000 live births)	36 (WB, 2015)	35.9 (WB, 2015)	38 (WB, 2015)	47 (WB, 2015)
Family Planning				
mCPR (married women)	53.2%[a]	33.3%[b]	26%[c]	65.6%[d]
Unmet need among married women	18%[1]	14.9%[b]	34.3%[c]	10.4%[d]
HIV/AIDS prevalence (UNAIDS, 2015)	5.9%	0.4%	7.1%	14.7%
Previous TMA experience	Yes	Yes	Yes	No
Socio-cultural dimensions				
Social structure, norms, taboos	Multi-ethnic, 42 ethnic languages	Multi-ethnic, 7+ main ethnic groups	Multi-ethnic	Two main ethnic groups (Shona: 70% & Ndebele:

Characteristics	Kenya	Madagascar	Uganda	Zimbabwe
				20%)
Economy				
Per capita GNI 2014 (PPP $2011)[f]	2.762 USD	1.328 USD	1.613 USD	1.615 USD
GDP growth (WB)	5.9% (2016)	3% (2015)	5% (2015)	1.1%
Income status	Middle income	Low income	Low income	Low income
Poverty rate (% living below the national poverty line, UNDP 2015 report)[f]	45.9%	75.3%	19.5%	72.3%
Political structure				
Conflict or instability	None	Politically unstable	Politically stable with pockets of insecurity in western Uganda	Difficult Political situation - economic situation is increasingly fragile
Total health expenditure per capita (WB, 2015)	78 USD	14 USD	52 USD	58 USD

[a] Kenya DHS 2014.
[b] Madagascar Enquete OMD 2012-2013
[c] Uganda DHS 2011
[d] Zimbabwe DHS 2015
[e] http://wdi.worldbank.org/table/2.8
[f] http://hdr.undp.org/sites/default/files/2015_human_development_report_1.pdf, (2004-2014 most recent data)

B. FP2020 Commitments and Policy Context

Kenya, Madagascar, Uganda and Zimbabwe have created supportive policy environments for FP and position FP as an important factor in population pressures and economic development. FP- related strategy and policy documents state specific objectives to strengthen both demand for and supply of quality FP commodities and services through increased government financing, public private partnerships (PPP), commodity security, demand generation and the provision of FP services to youth/adolescents and underserved segments in both urban and rural settings.[8]

The four countries in this TMA assessment are among the 39 countries to have pledged commitments to FP2020 -- the global partnership that supports the rights of women and girls to decide freely whether, when and how many children they want to have. FP2020 drives new initiatives to enable an additional 120 million women in the world's poorest countries to use modern contraception by 2020.[9] Among the four countries, Madagascar's FP2020 commitments, pledged in 2015, are the most recent, as Madagascar's earlier progressive position on FP was put on hold due to the 2009 coup and ensuing political instability. Table 3 below gives a brief description of FP 2020 commitments pledged by each TMA country.

Table 3. FP2020 commitments by TMA country

Kenya (since 2012)	Madagascar (since 2015)	Uganda (since 2012)	Zimbabwe (since 2012)
• Increase CPR to 56% (2015) and 70% (2030)	• Increase mCPR among married women to 50%	• Increase mCPR among married women from 26% to	• Increase CPR from 59%-68% • Reduce unmet need

[8] Lists and descriptions of FP-related strategy and policy documents are available in each country-specific TMA report.
[9] http://www.familyplanning2020.org/ (Accessed 9 December 2016)

• Increase budget for FP • Strengthen PPP • Scale up voucher system • Include Youth Empowerment Centres in each constituency (*progress update provided 8/2016*)	• Increase mCPR among women aged 15-24 to 46% • Reduce unmet need to 9% • Reduce overall TFR to 3 children per woman • Reduce NMR to 17/1,000 live births • Reduce MMR to 300/100,000 live births (*Commitments signed in 2015; ISP_FP_RHCS 2016-2020, progress update 5/2016*)	50% • Increase mCPR among sexually active unmarried women from 44.3% to 68.3% • Reduce unmet need from 40% to 10%	from 13% to 6.5% • Reduce adolescent girls' unmet need from 16.9% to 8.5% • Double % of FP budget within health from 1.7% to 3% • Remove user fees for FP • Promote FP among underserved groups, including adolescents, and focus on LARCs. • Strengthen PPP. (*progress update provided in 7/2016)*

C. Previous TMA Experiences

Three of the four focus ESA countries -- Kenya, Madagascar and Uganda -- have prior TMA experiences, which have been documented. [Cardno Emerging Markets, 2015; PATH, Futures Group and Marie Stopes Madagascar, 2010 (report not available); PACE, 2016]. Total market studies were previously carried out in the three countries to understand supply- and demand-side characteristics in view of assessing the equity, efficiency and sustainability of the market and potential crowding out of commercial sector players: in Kenya and Madagascar on FP and in Uganda on FP [PACE, 2016] and condoms only [Pallin, 2013].

Some common recommendations emerging from these prior studies were related to 1) increasing public funding for procurement of FP commodities and condoms, 2) strengthening collaboration between private (NGO and commercial) and public sectors, and 3) improving market efficiencies through better segmentation and increased availability of commercial FP commodities and condoms. Table 4 below offers a brief description of previous TMA experiences in each focus country.

Among the three countries having conducted TMA studies, **Kenya** emerges as having the most recent and most advanced experience in TMA. To date, there is an active TMA working group, which brings together representatives from public-, NGO- and commercial-sector entities active in the FP market on a monthly basis. The TMA working group is stewarded by the national Reproductive and Maternal Health Services Unit (RMHSU) housed within the MOH. At the time of this report, the TMA working group was deciding upon its work plan for 2017.

Programme for Accessible Health Communication and Education (PACE), a **Ugandan** NGO affiliated with PSI, has recently conducted a TMA study for FP methods that provides a robust analysis of the FP market. This study was made available to the consultants and was used to inform the present TMA report. Key elements of the TMA study were: use/ need analysis, detailed description of the market and supply chains, market depth and breadth of all major FP product categories, and indications on market inefficiencies and market constraints. These results were presented to the Uganda FP technical working group.

Table 4. Previous TMA experiences in the three focus ESA countries

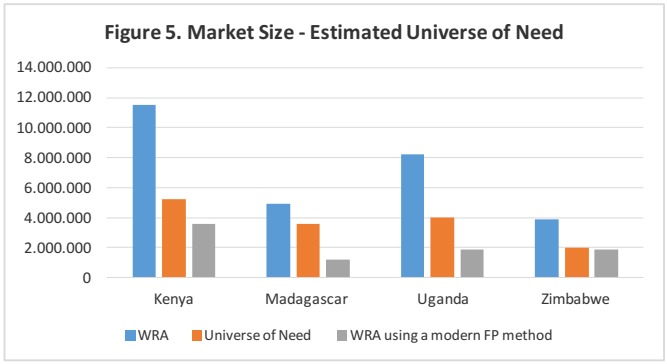
	Kenya	Madagascar	Uganda
Previous TMA experience?	Yes, for FP	Yes, for FP	Yes, a) condoms and b) all FP products
Year	Since 2015	2010 (after 2009 Coup)	a) 2013 b) 2016
Organisations involved	DFID -- Enhancing Sustained Health Equity (ESHE) project through Palladium	DFID-funded TMI study, implemented by PATH and Marie Stopes Madagascar (MSM)	a) UNFPA-funded TMA for condoms, implemented by PSI b) PACE/PSI
Description	Diagnostic assessment of FP market to assess market dynamics and feasibility of greater private sector participation.	Study assessed FP market demand and supply to identify market failures.	a) Study assessed supply and demand for condoms in the context of HIV/AIDS b) Study assessed FP market demand and supply to identify market failures
Recommenda-tions	TMA working group TOR and participation established, stewarded by RMHSU. TMA work plan developed. The FP market assessment report analysed the question and provided recommendations on what could be done if subsidies were removed a) Develop and implement BCC campaigns to raise awareness about contraceptive side effects and prepare women for possible side effects. b) Review policy on free commodities going to commercial outlets. c) Better market segmentation and targeting of subsidies. **Further research** regarding whether some of the manufacturers would have strong enough incentives to play a more proactive role in market development if this free distribution policy were to change.	Increase public sector funding for contraceptive procurement and transportation. Strengthen public-private partnerships. Segment the market to appropriately target clients with public and private sector resources. Remove taxes on contraceptives. Promote social marketing initiatives. (*Few of these recommendations were implemented.)*	a) Inefficient condom subsidy programmes with wealthy class benefiting. Erratic condom supply owing to lack of collaboration between public, non-profit and commercial sectors. Limited demand and thus growth of condom market. Potential crowding out of commercial sector condoms due to presence of 3 social market condom brands. b) Inefficiencies of market, due to high volume of free products (in particular for condoms and OC), inhibiting commercial sector; poor forecasting of supply. Overall erratic supply of FP products, free products leaking into commercial sector. Lack of harmonized national demand generation strategy. High discontinuation rates, due to poor counselling and side effect management.

V. FP MARKET: UNIVERSE OF NEED AND DEMAND FOR FAMILY PLANNING

This chapter compares and contrasts information collected on **demand-side aspects** of the total market for modern FP commodities and related services in Kenya, Madagascar, Uganda and Zimbabwe. It considers data on market size for FP, FP uptake, inequities in the FP market and target audience insights.

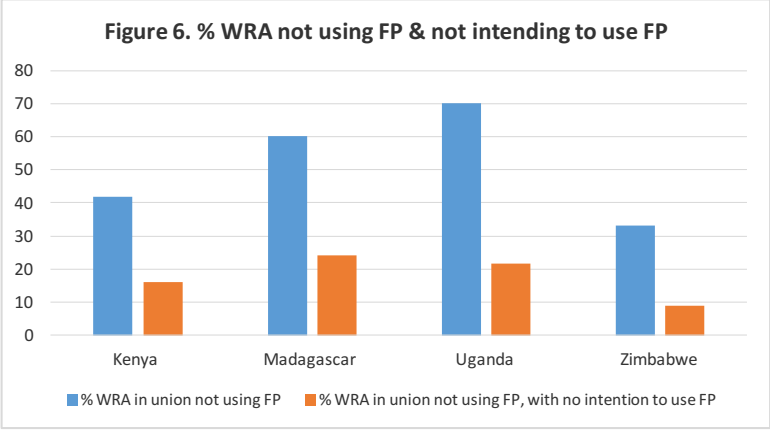
A. Market Size

Market size for FP examines three indicators: total number of women of reproductive age (WRA), total number of WRA using a modern FP method, and an estimation of the universe of need for FP. Universe of need calculations (Tool #9) estimate the number of women in union (currently married or living with a man) and the number of sexually active[10] women not in union who want to delay, space or limit birth. Universe of need assesses the number of FP products or services needed to reach universal coverage in the market. The sizes of FP markets vary considerably in the 4 countries (**Figure 5**), both in terms of total numbers of WRA and actual number of FP users compared with the estimated universe of need. Kenya has the greatest population of WRA and universe of need for FP, with close to 5.2 million women estimated to be in need for FP.



[Kenya DHS 2014, Madagascar ENSOMD, 2012-2013, Uganda PACE, 2016; Zimbabwe DHS, 2015]

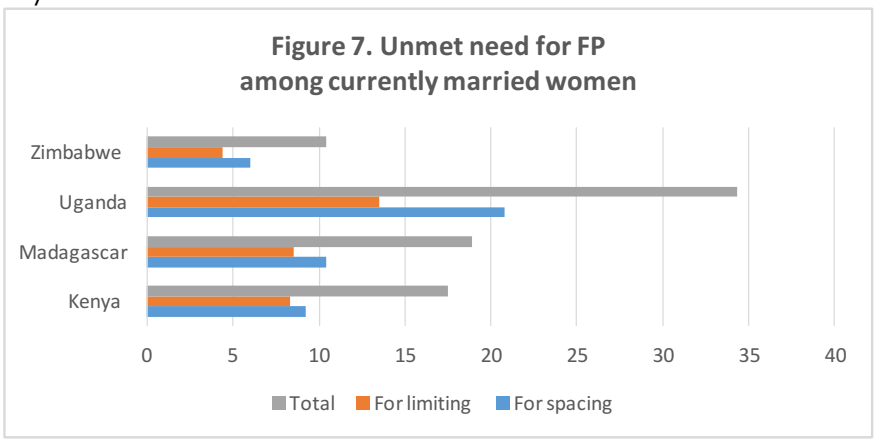
However, while national survey data confirm that considerable percentages of women in union in the 4 countries are not using any FP method, ranging from 33.2% in Zimbabwe (2015) up to 70% in Uganda, the data also reveal that many of these women do not *intend* to use FP in the future. These proportions range from 27.2% in Zimbabwe up to 40% in Madagascar. This finding may point to market failures on the demand side to be addressed, particularly Uganda and Madagascar.



[Kenya DHS 2014, Madagascar ENSOMD, 2012-2013, Uganda DHS, in 2011, Zimbabwe DHS, 2015]

[10] We used DHS definitions to measure sexual activity: these are currently unmarried WRA who do not live with a man and report having had sexual intercourse in the last 30 days.

Gaps in demand for FP can be estimated using survey calculations for unmet need. Unmet need reflects the number of WRA who are sexually active, but are not using any FP method and report not wanting any more children or are unsure as to whether or when to have another child.

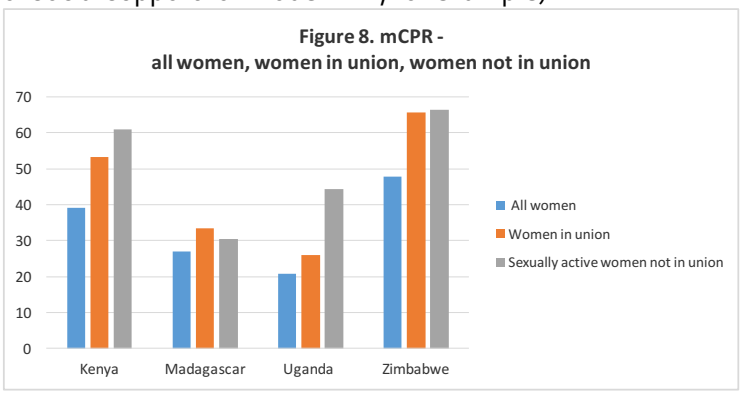


[Kenya DHS 2014, Madagascar DHS 2008-2009, Uganda DHS, 2011; Zimbabwe DHS, 2015)]

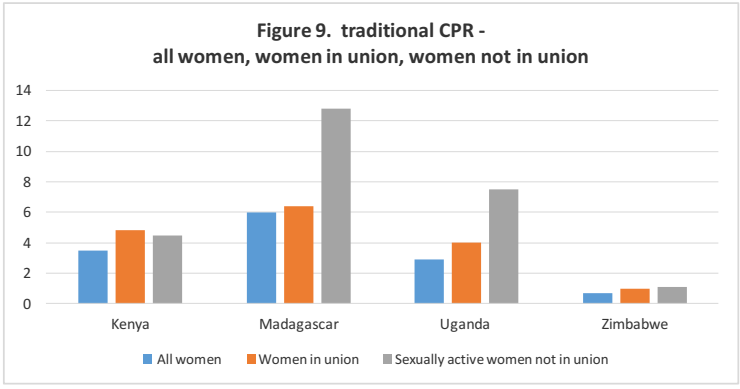
Unmet need (***Figure 7***) is highest in countries with lower CPR, such as Uganda (34.3%). Unmet need among women in union is more important for spacing than for limiting births, particularly in Uganda.

B. FP Uptake

Figures 8 and 9 below present the CPR for modern and traditional FP methods for all women -- women in union and sexually active women not in union. Modern method use is highest in Zimbabwe and Kenya overall. In **Figure 9**, traditional methods are used by fewer women, except in Madagascar and Uganda where 12.8% and 7.5% of sexually active women not in union rely on them. This points to potential market failures on the supply side (lack of access to FP) and/or to demand-side obstacles (lack of social support for modern FP, for example).



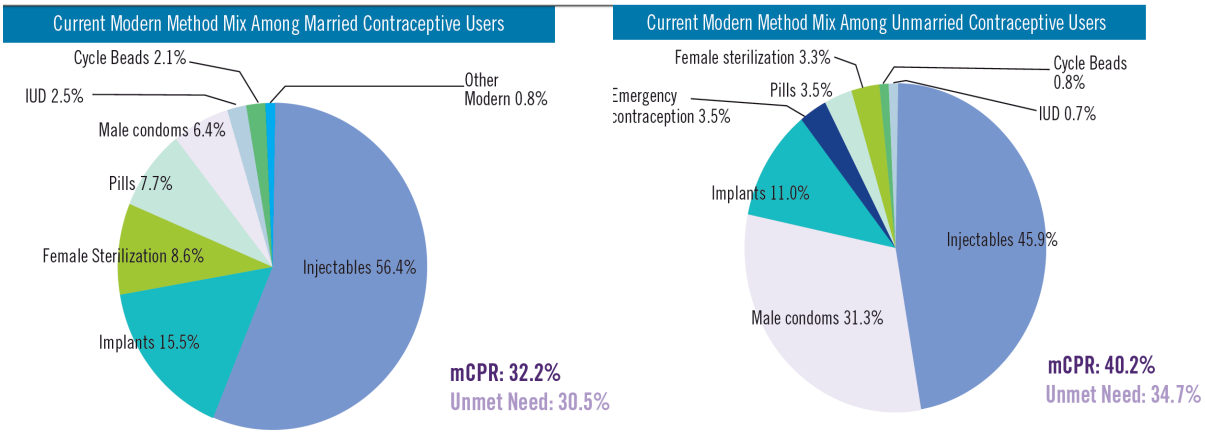
[Kenya DHS 2014, Madagascar ENSOMD, 2012-2013, Uganda DHS, 2011; Zimbabwe DHS, 2015]



[Kenya DHS 2014, Madagascar ENSOMD, 2012-2013, Uganda DHS, 2011; Zimbabwe DHS, 2015]

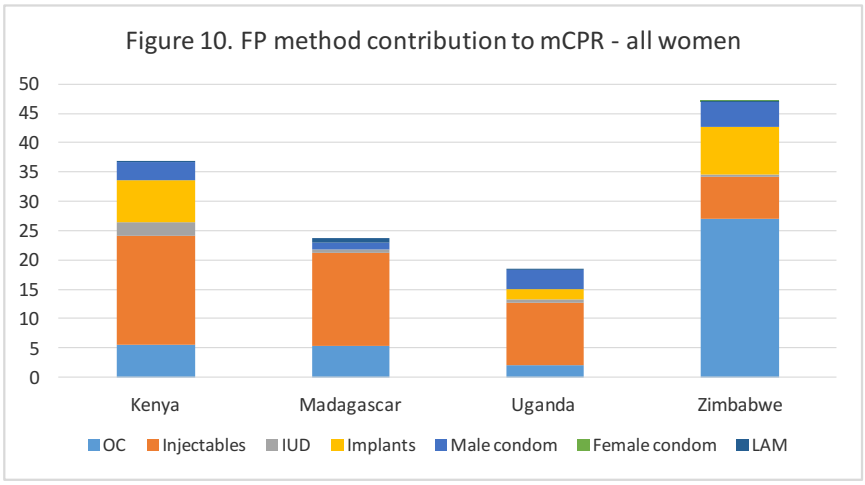
Box 2: Uganda - increase in modern FP uptake since Uganda DHS, 2011.

More recent data collected by Performance Management and Accountability (PMA) in 2016 indicate an overall increase in modern FP uptake in Uganda rising to 32.2% among married women and 40.2% among unmarried sexually active women. Injectables are by far the most popular modern method for all women; followed by implants among married women, and male condoms among unmarried women.



[PMA2016/Uganda-R4]

A review of the contribution of each type of modern FP method to mCPR (**Figure 10**) shows that OCs and injectables are by far the most commonly used modern methods in all countries.



[Kenya DHS 2014, Madagascar ENSOMD, 2012-2013, Uganda DHS, 2011; Zimbabwe DHS, 2015]

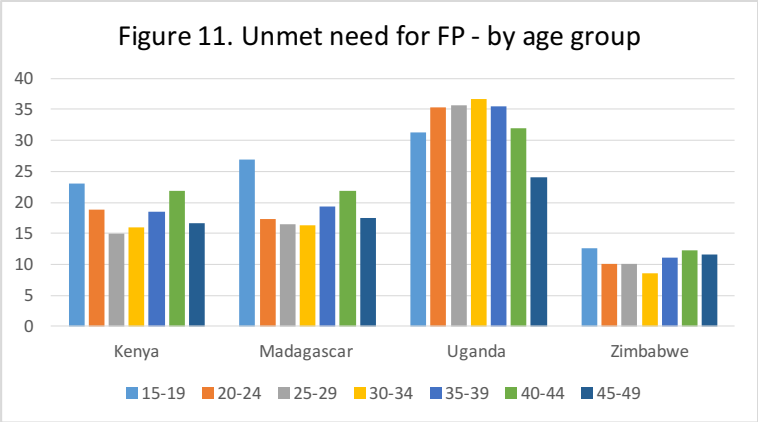
Implants are also becoming more widely used, such as in Kenya where 7.1% of all women use them. In Zimbabwe the mCPR of implants rose from 2.4% in 2011 to 9.6% among women in union and 14.4% among sexually active women out of union in 2015.Uganda also increased the mCPR for implants from 2011 (DHS) to 2016 (PMA R4) among married women from 2.7% to 15.5% and among unmarried women from 2.4% to 11.0%.

C. Market Equity

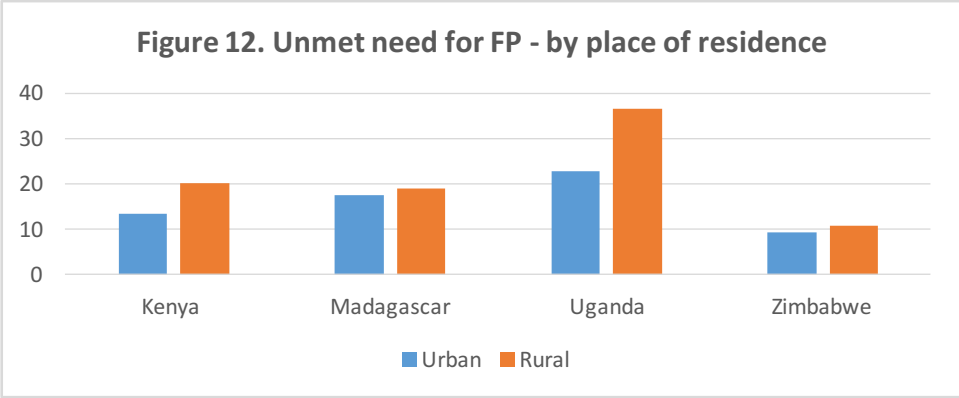
Market equity examines which population segments are disadvantaged in terms of uptake of FP, and whether the market's ability to meet these needs is increasing. An analysis of satisfied and unsatisfied demand for modern FP, measured according to modern method use and unmet need, by age, place of residence, education levels and wealth quintiles, can help highlight inequities in the total FP market.

The figures used below compare the four focus countries, using two sources: Countdown to 2015 data (UNICEF/WHO, 2015) and the most recent and complete national DHS data. Across the four countries, unmet need is especially prevalent among younger women (15-19), women residing in rural areas, women with less than secondary education, and women in the lowest wealth quintiles.

Comparison of unmet need by age groups (***Figure 11***). The comparison of unmet need by age group reveals that in Kenya, Madagascar and Zimbabwe, the highest unmet need is among young women in the 15-19 age group, followed by women in older age groups (40-44). Unmet need is comparatively higher across all age groups in Uganda in comparison with the other countries.



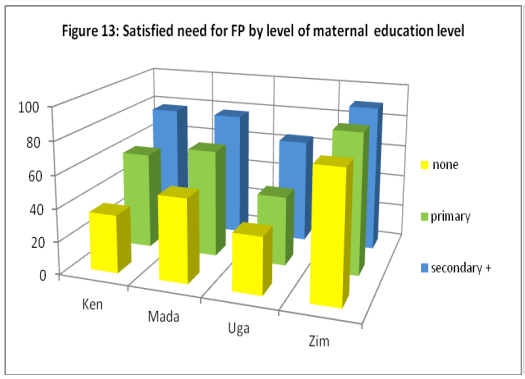
[Kenya DHS 2014; Madagascar DHS 2008-2009; Uganda DHS, 2011; Zimbabwe DHS, 2015)]



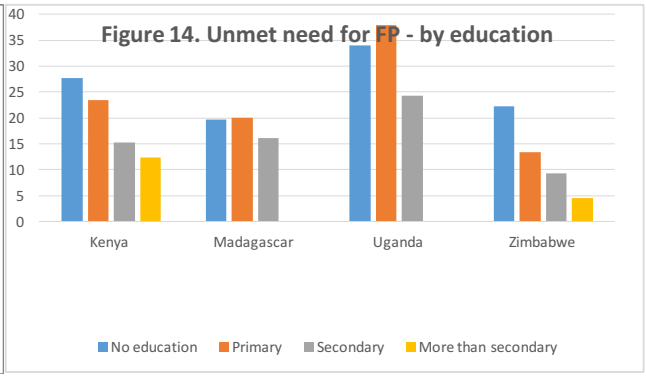
[Kenya DHS 2014, Madagascar DHS 2008-2009, Uganda DHS, 2011;Zimbabwe DHS, 2015)]

Place of residence: urban vs rural (***Figure 12***). Unmet need is higher among women in union living in rural areas in all 4 countries. Uganda – the country with the lowest mCPR - shows the highest inequity with respect to place of residence. Zimbabwe, on the other hand, has the lowest gap between rural and urban women and the highest mCPR among the 4 countries.

Level of education (***Figures 13* and *14***): Across the four countries, need is most satisfied among women with higher education levels (secondary and above), and most unmet need is found among married women with lower levels of education (none and primary). This trend is more striking in Kenya and Uganda.

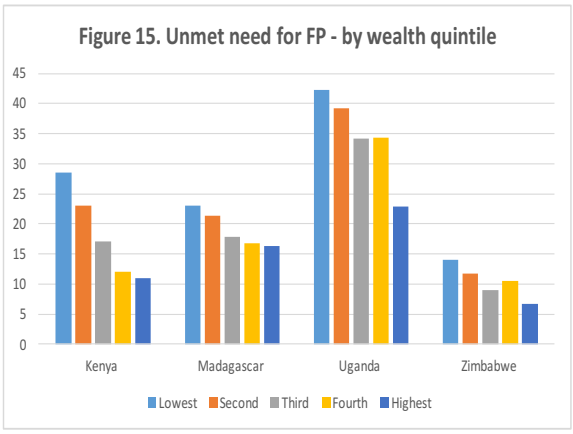


[Source: Countdown to 2015]

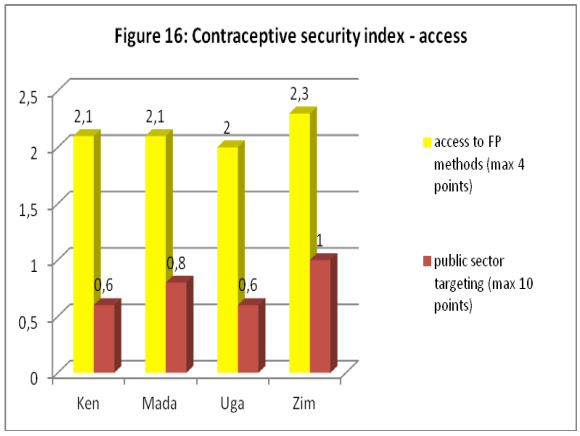


[Source - same as Figure 12]

Wealth quintile (***Figures 15*** and ***16***): ***Figure 15*** reveals socio-economic inequities in satisfying need for FP. Not surprisingly, unmet need decreases the higher the wealth quintile, with women in the lowest wealth quintile having the highest levels of unmet need. This finding is consistent with Contraceptive Security Index 2015 findings in ***Figure 16***, which gives an overview of the accessibility and targeting of modern FP methods. The yellow bar shows the level of access to a broad range of at least three contraceptive methods. The red bar indicates the proportion of the country's contraceptives distributed through public sector channels that go to poor and near-poor FP clients. Zimbabwe scores best in both indicators, however the level of targeting is still low in absolute terms, as the vast majority of subsidies are not well targeted.



[Kenya DHS 2014; Madagascar DHS 2008-2009; Uganda DHS 2011; Zimbabwe DHS 2015)]



[USAID Deliver Project, CS Index 2015]

Stakeholder perceptions of underserved populations. Echoing (in part) the findings from the above analysis of unmet need, national stakeholders in the four focus countries identified the following population segments as being underserved:

- Adolescents and young people (all 4 ESA countries)
- Rural, geographically hard-to-reach communities (all 4 ESA countries)
- Urban poor (Madagascar)
- People with disabilities (Uganda and Zimbabwe)
- PLHIV and key populations (Uganda and Zimbabwe)
- Migrants (Zimbabwe)
- Post-partum women (Zimbabwe)

FP programmes have in response developed targeted policies and interventions to better serve some of these population segments. The Kenyan and Zimbabwean TMA studies document the development

of recent sexual and reproductive health (SRH) policies or strategies for adolescents and young people. All report on the presence of interventions specially designed to improve the reach of FP commodities and services to underserved populations, including youth-friendly corners or services in public and NGO health centres, and community-based or mobile outreach to hard-to-reach, and rural and urban poor communities. Three countries – Kenya, Madagascar and Uganda - have targeted voucher schemes for adolescents and poor women. Marie Stopes Madagascar, for example, offers FP vouchers to young people and urban poor for free or at a very low cost, at *Blue Star* franchised clinics. Voucher schemes in the same countries also exist to facilitate demand for long acting and reversible contraceptive (LARC) methods, such as IUDs and implants.

When asked to share their perceptions regarding what role the NGO and commercial sectors could play in reaching underserved population segments, stakeholders shared numerous ideas. These are documented in the table below. The below comments represent views from stakeholders from all sectors.

Table 5. Stakeholder perceptions regarding role of NGO and commercial sectors

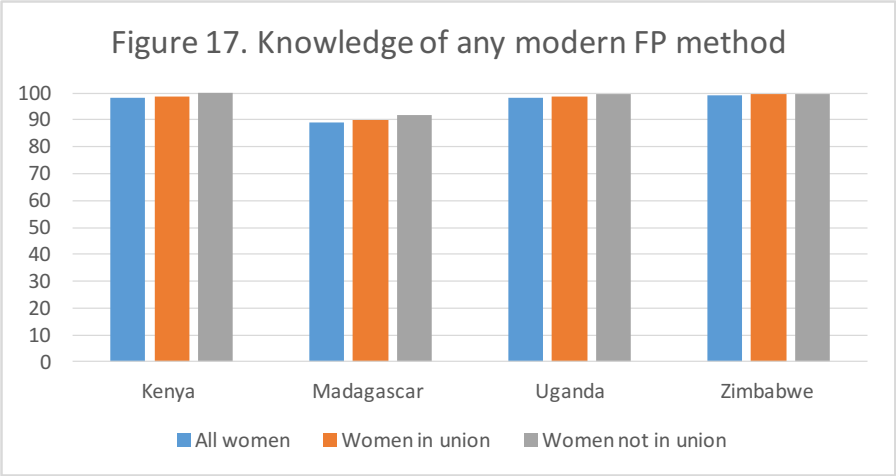
NGO sector	Commercial sector
• Complement public sector service delivery. • Establish and strengthen public-private partnerships. • Targeted outreach to adolescents/young people, urban and rural poor and hard-to-reach populations. • Target demand generation / social and behavioural change communications • Skills transfer and capacity building to FP providers. • Social marketing of subsidized products to socio-economic segments with ability and willingness to pay, but cannot afford full-priced FP commodities or services. • Communications for long acting reversible contraceptive methods. • Investigate FP user perspectives and needs.	• Stakeholders are divided on the role that commercial sector can play. • Some stakeholders perceived the commercial sector's role to be limited to serving the high end market with the ability and willingness to pay. • Others saw the sector playing a special role for underserved groups, through: ➢ Provision of affordable access to high quality, convenient and confidential services for young people, e.g. emergency contraceptives. ➢ Implementation of corporate social responsibility strategies to reach to the poor with services.

D. Target Audience Insights

National survey data and country-specific TMA reports provide additional insights into the target audiences for modern FP commodities and related services.

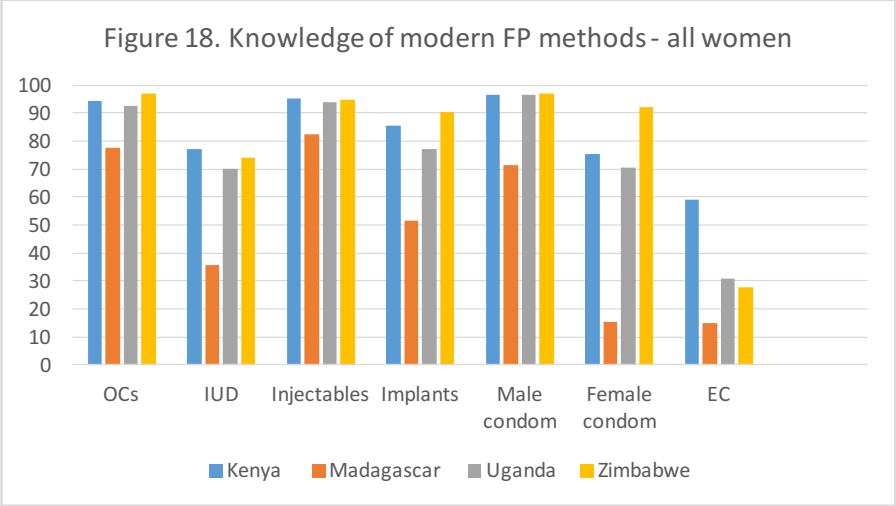
Knowledge of modern FP methods.

A review of knowledge of modern FP methods among all women shows variations depending on the country and the type of modern method. (***Figure 17***). Knowledge of any modern FP method is high in the four ESA focus countries, and close to universal in Kenya, Uganda and Zimbabwe.



[Kenya DHS 2014, Madagascar ENSOMD, 2012-2013, Uganda DHS, 2011; Zimbabwe DHS, 2015]

With regard to different types of FP methods, knowledge is highest for OCs, injectables and male condoms in the four focus countries, and is generally lower for IUD, implants, EC and female condoms. (***Figure 18***). Madagascar scores the lowest rates in all product categories. Higher rates of knowledge of female condom in Kenya, Uganda and Zimbabwe in comparison with Madagascar attest to national efforts to promote female condom as a method for dual protection against unwanted pregnancy and HIV.



[Kenya DHS 2014; Madagascar ENSOMD, 2012-2013; Uganda DHS, 2011; Zimbabwe DHS, 2015]

Barriers to uptake of modern FP methods. There are multiple and often co-existing reasons for low FP method uptake and for high unmet need. Though these were not the focus of this TMA study, some of these reasons were documented in the four individual TMA country studies and provide important insights into target group attitudes, behaviours and practices. Discontinuation rates and reasons from DHS and other surveys also shed light on barriers to FP uptake. Barriers presented below are related to access, social support and FP-related beliefs and experiences.

Barriers to access are related to the availability of modern FP methods, geographic distance to FP source, cost and FP provider attitudes.

With regard to *availability*, in general

- Short-term contraceptive methods (male condoms and OCs) were reported to be widely available through public, NGO and commercial sector outlets at a range of consumer prices.

- LARC methods such as implants and IUDs were relatively more restricted, owing to shortages of skilled and/or qualified providers. For example, in Madagascar, IUDs are available in only 9% of public health facilities; implants are available in 60%. On the other hand, training and task shifting efforts could result in both increased availability and uptake of FP methods, as in Uganda where task shifting of injectables to Village Health Teams proved to be a viable option.
- Stock outs of FP methods – in this case female condoms and implants – were only reported in Uganda.
- Overall, there was a gap in information on female condom, which appeared to be available only in selected outlets.

FP stakeholders agreed that *distance* and travel-related *costs* were barriers to women (and men) who live far from a health facility and where outreach efforts are irregular or infrequent.

Cost-related barriers can be considered both in terms of out-of-pocket cash expenditures and opportunity costs, including, for example, time away from jobs or farms. In Kenya, the national report documented out-of-pocket expenditures related to FP, referring to a 2015 Performance Management and Accountability (PMA) study and citing that 49% of Kenyan women paid for FP services, with fees charged in 7.4% of public facilities and 72.6% in private health facilities surveyed[11]. TMA study respondents emphasized the role of cost as a major deterrent to FP uptake particularly for poor families and, in the absence of generalized health insurance coverage in the countries, the importance of the public sector's role in providing free FP commodities to vulnerable populations.

The role of negative *FP provider perceptions* was cited by stakeholder respondents as a barrier, particularly when considering FP needs of adolescents and young, unmarried women and men.

Country-specific TMA reports included *individual and social barriers* to accessing FP, including *lack of social support*. In Kenya, in some of the areas where FP usage is low, gender-based cultural and religious barriers play an important role in determining whether women will use a method of FP or not. In such cases, changing the negative perceptions about FP requires the involvement of both the cultural and religious leaders and other opinion leaders in the communities. In Uganda, gender inequalities and male attitudes towards women in the household were mentioned as affecting women's ability to make household decisions including regarding use of contraception.

The Zimbabwe Family Planning Council lists a number of common FP-related *myths and misconceptions* in Zimbabwe. Misconceptions are that FP is:

- *only meant to reduce the number of children per person;*
- *bad for women's health;*
- *a ploy to curb population growth, and reduce economic development;*
- *a cause of infertility;*
- *culturally abominable, and a religious apostasy;*
- *a cause of reduction in libido.*

(Source: http://www.znfpc.org.zw/index.php/news-pr/news/77-family-planning-myths-and-misconceptions*)*

Reasons for discontinuation shed light on barriers to continuing use of a specific FP method. In all countries, high discontinuation rates are reported to be mainly *product and service-delivery related*. Discontinuation rates of modern FP methods range from 22.0% to 42.6 % in the studied countries and vary across different methods, with highest discontinuation rates among users of implants and injectables. The main reasons for discontinuation (other than fertility related reasons) in all countries were method-related health concerns and side effects. Because quality of FP counseling is directly

[11] As reported in the Kenya national TMA report, December 2016.

correlated with client satisfaction and continued use, the level of discontinuation due to side effects and health concerns can indicate a market failure related to the knowledge and skills of the FP provider, including provider capacity to offer good counseling.

Table 6. Discontinuation rates of modern FP methods[a]

	Kenya (KDHS, 2014)	Uganda (UDHS, 2011)	Zimbabwe (ZDHS, 2015)	
12 months discontinuation rates, women 15-49 in past 5 years (%)				
All women	30.5	42.6	22.0	
Main reasons (%)				
health concerns/side effects	10.5	15.8	6.9	

[a] Data unavailable for Madagascar

Demand generation activities. Demand generation activities exist in all four countries, and are primarily led by NGO/social marketing partners that support public sector promotion of FP commodities and services. However, these campaigns are often limited in scope, reach and timing. This leaves room for improvement, with significant gaps in generating demand for FP. There are considerable discrepancies between *potential demand* and *perceived demand*, where in countries such as Uganda the majority of women in union do not use FP, and many of them have no intention to use FP. Thus there is a need to design and implement SBCC strategies to address the underlying bottlenecks that inhibit adoption of FP.

VI. FP MARKET: SUPPLY OF FAMILY PLANNING COMMODITIES

This chapter presents findings from the TMA studies in the four focus countries on supply side dynamics of FP markets. It includes a comparative analysis of:

- Contraceptive funding and procurement
- Market volume, value and subsidies
- Market systems and players, and their respective roles
- Policies, regulations and support guiding the FP market
- Description of supply side systems and their challenges.

A. Contraceptive Funding & Procurement

The Contraceptive Security Indicator Survey developed by the USAID-funded Deliver Project provides a snapshot of the four focus countries in terms of FP leadership and coordination, financing and procurement, commodities, policies and supply chain dynamics. Table 7 presents key aspects from the 2015 survey of FP markets in Kenya, Madagascar, Uganda and Zimbabwe.

Table 7: Snapshot of Contraceptive Security Index comparison

Contraceptive Security Index comparison - 2015 data of the *4 ESA focus countries*				
Aspects	**Kenya**	**Madagascar**	**Uganda**	**Zimbabwe**
Does a national committee exist that works on contraceptive security?	yes	yes	yes	yes
Were regular meetings held (how many times/year)?	1-2 times	1-2 times	3-5 times	1-2 times
Does a government budget line item for procurement of contraceptives exist ?	no	yes	yes	don't know
Were government funds allocated for contracptives in recent FY?	no	yes	yes	don't know
Were government funds spent on contraceptive procurement ?	no	$14,274		don't know
Were In-kind donations of contraceptives provided ?	$19,570,876 (7/13-6/14)	$1,0530172	$24,175,175	$13,295,730
What are the main sources of in kind donatations ?	USAID; UNFPA; DFID; KFW	DFID, UNFPA, USAID	USAID, UNFPA	DFID, USAID, UNFPA
Does a contraceptive security or RH commodity security strategy exist?	2013-2017	2015-2019	2010-2015	2011-2015
Is the strategy formally approved by the Ministry?	yes	yes	yes	don't know
Is the contraceptive security strategy being implemented?	yes	yes	yes	don't know
Are FP commodities subject to duties, import taxes, or other fees?	no	yes	yes	no
Are there policies that hinder the ability of the private sector in FP services?	no	yes (product registration and tax law)	don't know	no
Are there policies that enable the private sector ?	yes	yes	don't know	yes
Are there laws, regulations, or policies that make it difficult for certain sub-populations to access effective family planning services?	NO	NO	NO	yes
Were there stockout of contraceptives offered in public sector facilities in the past 12 months at the central level ?	yes	yes	yes	no
If yes, what contraceptives had stock outs ?	POPs, IUDs, FC, EC	Cycle beads	POPs , implants	n/a

Key findings from the Contraceptive Security Indicator Survey are:

- All four ESA countries have national strategies for contraceptive security and coordinating committees or working groups in place.
- However, political commitment was not translated into budgetary allocations, except in Uganda and Madagascar, which has a dedicated budget line item to procure FP commodities.
- In the other countries, in-kind donations and financial support from donors represent the predominant source of commodity supply.
- Overall, there are policies in place to enable private sector engagement. In Madagascar, however, commercial sector players face challenges in registering new products and due to import duties and taxes on contraceptives.
- The public sector supply chain supplies the vast majority of FP commodities in all countries. Stock outs of different commodities occurred in the last 12 months in Kenya, Madagascar and Uganda. These point to supply-side market failures.
- In Kenya, the devolution of public health services and related commodity budgets from national to county governments poses a significant threat to contraceptive security. Although the national government does not have resources for contraceptive procurement, warehousing and distribution, county-level governments have yet to adopt new procurement systems and continue to look to the national program for their supply of FP commodities. There are advocacy efforts at both levels, but so far no resources have been committed from the national or county governments.
- In Madagascar, there is a lack of funding for contraceptive transportation from the central level to the community level. This is one reason for FP commodity stock outs at the service delivery points level.
- In Uganda, the heavy focus on the supply of contraceptives at the expense of demand generation contributes to the maintenance of a low mCPR.

B. Market Volumes and Values

National consultants collected sales and financial data on their respective FP commodity markets. The results presented in the tables below provide these data. Some figures, such as market volumes, are estimations based on available data, which omit commercial data. Costs of commodities were estimated using the UNFPA Contraceptive Price Indicator 2015; they are unweighted[12] estimates.

FP markets in all countries rely heavily on public sector provision of services and products. This consumer dependence on public supply represents a major funding/budget challenge for the sector and also inhibits the development of the commercial sector market to its full potential. Particularly in countries with increasing economic growth, levels of subsidies should be reduced and better targeted.

Table 8: Market volumes, values, brands and leader by FP product category

a) Male condoms (*including brand extensions)

Aspects	Kenya	Madagascar	Uganda (PACE, 2016)	Zimbabwe
Market Volume	**92.4 M**	**37.9 M**	**55 M**	**89.0 - 114.6M***
Number of brands*	**> 55**	**>24**	**>26**	**> 29**
Cost of commodities in dollars (COGS /$0.034)	**$3.14 M**	**$1.28 M**	**$1.89 M**	**$3.0 - 3.9M**
Market share of leader	**68% public**	**50.8% private/SM**	**>40% free**	**52% public**

[12] These estimates do not take into account the differences in contribution of each sector: public, commercial and NGO.

b) OC and POP

Aspects	Kenya	Madagascar	Uganda	Zimbabwe
Market Volume	**4.1 M**	**3.6 – 4.3 M**	4.8 M	**6.6 - 16.1 M***
Number of brands	**>15**	**9**	**7**	**/**
Cost of commodities (COGS/ $0.58)	**$2.37M**	**$2.0-2.4M**	**$2.7M**	**$3.8 - 9.3M***
Market share of leader	**74% Private/SM**	**45.7% public**	**62% free, public/SM**	**66% public**

c) EC

Aspects	Kenya	Madagascar	Uganda	Zimbabwe
Market Volume	**not reported**	**0.41 M**	**not reported**	**0.2 M**
Number of brands	**not reported**	**5**	**3**	**3**
Cost of commodities (COGS/$0.50)	**not reported**	**$0.2 M**	**not reported**	**$0.1 M**
Market share of leader	**not reported**	**>90% private/SM**	**not reported**	**64% private/SM**

c) Injectable contraceptives

Aspects	Kenya	Madagascar	Uganda	Zimbabwe
Market Volume	**6.6 M**	**3.1-5.0 M**[a]	**4.0 M**	**0.9 M**
Number of brands	**>3**	**5**	**4**	**2**
Cost of commodities (COGS/$1.2)	**$7.9 M**	**$3.7 -6.0 M**	**$5.2 M**	**$1.08 M**
Market share of leader	**93% public**	**63.6% public**	**62% free, public/SM**	**85% public**

[a] see **Box 3** below

e) Implants

Aspects	Kenya	Madagascar	Uganda	Zimbabwe
Market Volume	**0.525 M**	**0.59 M**	**0.050** M	**0.14 M**
Number of brands	**>3**	**3**	**3**	**2**
Cost of commodities (COGS/$11.0)	**$5.7 M**	**$6.49 M**	**$0.55 M**	**$1.54 M**
Market share of leader	**69% public**	**63.1% public**	**65% private/ SM**	**48 % public**

f) IUDs

Aspects	Kenya	Madagascar	Uganda	Zimbabwe
Market Volume	**0.147 M**	**0.28 M**	**0.4 M**	**0.014 M**
Number of brands	**>3**	**1**	**3**	**1**
Cost of commodities (COGS/1.08$)	**$0.15 M**	**$0.30 M**	**$0.438 M**	**$0.015 M**
Market share of leader	**64% public**	**43.8% public**	**68.6% free, public/SM**	**48% public**

***** Estimations based on data collected from different sources (importation/distribution/use) showed significant variations and are therefore presented as "range".

Table 9 below provides a snapshot of the FP commodity market system in the four focus countries with respect to the different sectors: public, NGO, SM, private commercial and informal sectors.

Table 9. Key characteristics of market systems and players in the 4 ESA countries

Kenya	Madagascar	Uganda	Zimbabwe
Public sector			
The MOH through the Reproductive and Maternal Health Services Unit (RMHSU) provides technical leadership for the FP program. Public sector provides FP products/ service for free.	MOH is overall coordination entity; dedicated *FP Service* exists within *Family Health Department.* FP was made into a Vice Ministry in 2003, and then downgraded in 2009 to a FP division. MOH is perceived as lacking influence on policy and strategic orientations. Since 2007, FP products are free in public sector facilities.	The MOH is overall coordination entity and provides policy and programming regulatory frameworks, public funding, advocacy for FP. Health system and service delivery are decentralized. Shortages in human resources for health severely hamper the scale-up of FP service delivery. The numbers of skilled medical staff are too few in comparison with the need. Public sector provides all FP products and services, for free.	MOHCC is responsible for policy and administrative guidance, determining funding allocation, approving staff hires at district and provincial levels and overseeing central-level hospitals. Public sector provides FP products/ service for free. Zimbabwe National Family Planning Council (ZNFPC) - parastatal institution under the MOHCC, mandated to coordinate provision of FP/RH services. Operates FP clinics, implements CBD system (300 agents) with limited coverage across the country. 9 FP clinics and outreach teams.
Multilateral/donor organizations			
The main donors are UNFPA, USAID, DFID, and KfW. Funding is mostly geared towards addressing commodity gaps.	UNFPA and USAID are the main financial partners. Global Fund provides funds for condoms. A private US donor funds a social franchising project (focus on IUDs). IPPF finances contraceptives.	USAID, DFID and UNFPA are main donors for FP and commodities. World Bank supports a Health Voucher Project, which includes FP.	DFID, USAID and UNFPA are main donors for FP and commodities.
SMOs and NGOs			
Population Services Kenya focuses on SBCC, social franchising (329 clinics), FP social marketing through commercial pharmacies and supports GOK in hard to reach areas **Marie Stopes Kenya** (MSK) provides RH services through 22 static clinics, 1 nursing home and 406 franchised clinics. Free FP	**Marie Stopes Madagascar (MSM)** focuses on FP service delivery, (20 RH clinics, 22 Mobile Teams, 1 urban bus), *Blue Star* network of 150 private doctors; 150 MS Ladies/midwives, 100 *Star public* Health centers are supported, MSM is highly important (84% of LARC distributed in 2015).	SMO include: **Marie Stopes** (226 social franchising clinics), **UHMG**, **PACE** (329 social franchising clinics), **Reproductive Health Uganda**; they provide alternative distribution mechanisms for FP commodities to increase access and use. NGOs acting in FP are: **Pathfinder**, **Engender**	**PSI** operates social franchising program offering integrated SRH services through 13 New Start, 12 New Life Centres, 28 PROFAM Public Sector Facilities, and 19 Outreach teams. PSI implements social marketing program for FP products through private sector outlets. **Population Services Zimbabwe** (PSZ), an

Kenya	Madagascar	Uganda	Zimbabwe
services are offered by 15 outreach teams in partnership with GOK facilities. MSK runs a toll free call-in centre. **Family Health Options Kenya** is engaged in advocacy for FP, service provision through their 15 static clinics and outreach activities where free FP services are offered. **Palladium** implements the DFID-funded ESHE project to increase use of modern FP with support to 500 private facilities. Conducts market systems research and technical support for TMA and for commercial sector to introduce new FP products. **Jhpiego** focuses on systems strengthening, community-based demand generation, distribution, including the introduction of hormonal IUD. Implements Tupange Project to increase access and uptake of FP services among urban poor in certain areas. Part of the Advance FP program, implements CBD project providing injectables contraceptives	**PSI**- nationwide social marketing of FP products and Social franchising (*Top Reseau* Network of 300 private outlets). Very active in creating demand for FP. **Fianakaviana Sambatra** (FISA), IPPF affiliate runs 6 clinics. **Protestant medical services** offer FP products.	**Health**. Other NGOs and CSOs working in FP (**Straight talk**, **Family Health 360**, **PATH**) carry out advocacy for funding and effective programming of FP and also SBCC interventions to create demand and mobilize communities for uptake of FP services.	affiliate of MSI, offers FP services through 3 channels: 9 Outreach teams; 11 Static sites and 124 Social Franchise – Blue Star Healthcare Network.
Private commercial sector			
Vibrant for-profit commercial sector that provides health services including FP. Six clinical franchise networks with over 1,000 private providers since 2013, the Association of Social Franchises in Health (AFSH). 4 pharmacy networks with over 318 outlets.	Wide span commercial sector with 36 Drug Wholesalers (225 pharmacies, 1642 drug selling outlets)	Private wholesale and retail pharmacies (477) and drug shops (4,370) are concentrated especially in the urban areas and serve especially the wealthiest quintile. Total of 1,488 private facilities (different levels)	287 registered pharmacies mainly located in urban areas while distribution outlets under social marketing and private sector cover the rural areas, peri-urban and hard to reach areas.
Community based agents			
MOH-Community Health	34,000 community based	Effective task shifting in	VHWs, CBDs and lay

Kenya	Madagascar	Uganda	Zimbabwe
Unit implements CBD to supply pills and condoms at community level. Jhpiego, as part of the Advance FP program, implements a CBD project providing injectables.	agents (CA) are delivering FP information & products (Projects funded by USAID, and UNFPA supervise half of CAs)	place: Village Health Teams provide oral contraceptives, condoms, injectables (Depo-Provera and Sayana Press)	providers supply FP products - mainly condoms in private sector outlets
Traditional, informal sectors			
Informal sector stocks FP commodities and provides certain FP service however overall less important	Black markets for drugs exist, selling counterfeited or fake products at low prices. These escape any regulation or control.	Traditional birth attendants provide traditional FP service especially to the rural poor communities.	

D. Market Policies, Regulations and Support for FP

All studied countries have policies and regulations in place to coordinate the supply and delivery of FP commodities to the different market segments. These are generally developed, implemented and supervised by different MOH departments.

In most countries, the MOH have dedicated departments that are responsible for the **registration and licensing of pharmaceutical products**. In Madagascar, however, a semi-autonomous "Drug Agency" attached to the Secretary General is mandated by the MOH to oversee the regulation of new drugs and outlets through the provision of drug licenses and authorization of pharmacy openings and their inspection. In practice, there are contentious issue between the Drug Agency and commercial stakeholders who complain of the complexity and lack of clarity of the required procedures, which are perceived as hindering commercial sector players.

Some countries have **legal age restrictions** to contraceptive use by young people. In Madagascar and Uganda, except for condoms, a person must be more than 18 years old to purchase a contraceptive, otherwise consent from a parent, adult tutor or spouse is compulsory. In Zimbabwe, contraceptives are not for sale to young people under 16 years. However, youth can access EC in the case of sexual abuse or related circumstances. Kenya has the lowest legal age restrictions, where adolescents from 15 years on can have access to FP products and services.

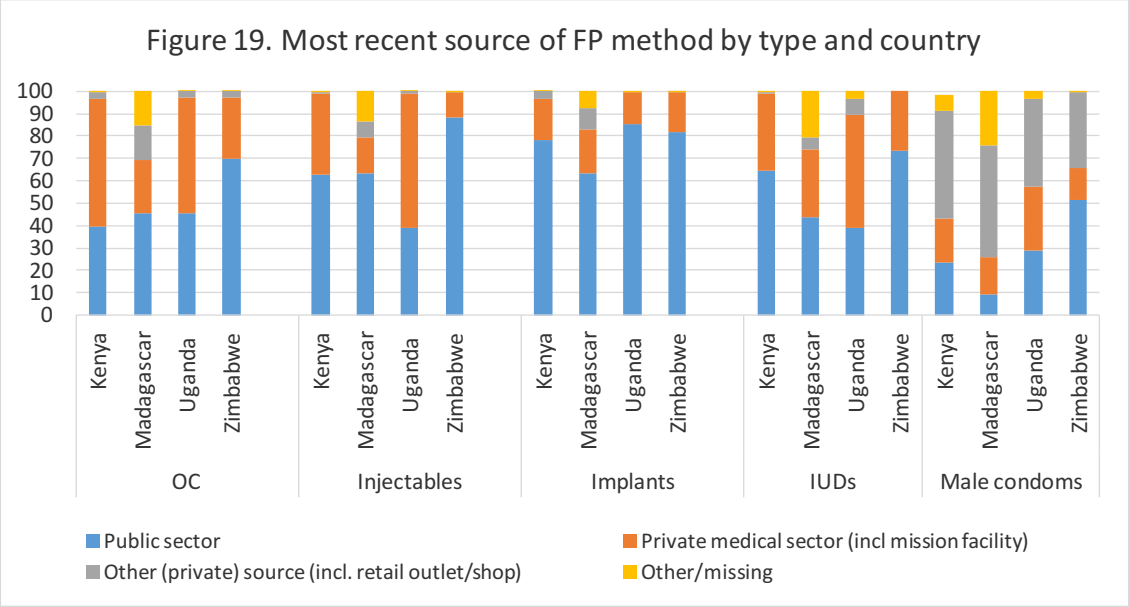
Importation taxes and tariffs on FP commodities represent important barriers for commercial sector players in Madagascar. Interestingly, all other drugs -- generics as well as branded -- are exempt from tax and custom duties, while FP commodities alone are not. The only modern FP commodity that can be imported free of duty and taxes is EC. In Uganda also, taxes represent an obstacle for greater commercial sector engagement as witnessed by a commercial sector stakeholder: "*The taxation process is instructive, (there are) no consultations, no forum to air our concerns. The MoH technical working groups do not effectively link up with Ministry of Finance and the end result are taxes on FP commodities, which translates in high cost of services.*"

In most studied countries, regulations do not allow **mass media advertising of prescription medicines**, such as hormonal contraceptives, which limits demand creation activities to generic messaging only. In Uganda, however, there are no specific restrictions in place concerning advertising for contraceptives, sex aids, or other sexuality-related products. This fact represents a clear advantage and opportunity for commercial and social marketing demand creation interventions using mass media.

E. Supply-Side Descriptions and Challenges

Source of modern FP methods. Data on the source of modern FP commodities and related services give important insights into where demand for and supply of FP meet in the FP market place. DHS surveys report on sources of modern FP methods by measuring the percentage distribution of users of modern contraceptive methods, aged 15-49, by most recent source of method. ***Figure 19*** below describes the breakdown by source, by type of modern contraceptive method.

The public sector remains an important source of supply for all types of modern FP methods in all 4 ESA countries. This is the case for OCs and especially for long acting reversible contraception (LARC) like implants, injectables and IUDs, where public sector FP providers may be among the first to be equipped with the skills in new FP method delivery. More than 60% of users in the 4 focus countries source implants through public sector facilities. In Zimbabwe, the public sector is the predominant source of supply for all modern contraceptive methods, including male condoms (51.6% of users source male condoms from the public sector) according to the 2015 ZDHS.



[Kenya DHS 2014, Madagascar (ENSOMD, 2012-2013), Uganda DHS, 2011;Zimbabwe DHS, 2015)]

The private sector[13] plays an almost equally important role in Kenya, Madagascar and Uganda, where private medical facilities and providers are important sources for OCs, injectables and IUDs. In Uganda, for example, 51.5% of OCs, 60.1% of injectables and 50.4% of IUDs are sourced in the private medical sector. In this context it is noteworthy that the private clinical sector as described above includes social franchising networks operated by NGOs such as PSI, MSI and others, and therefore private providers benefit from training, ongoing support and assistance in FP and in particular for the service provision of long acting reversible FP methods. The private medical sector

[13] According to DHS, the private medical sector includes private hospitals, clinics and providers and pharmacies in all countries. It also encompasses: in Uganda- outreach and village health teams; in Kenya- faith-based clinics and family planning clinics; in Madagascar- family planning clinics, and in Zimbabwe- community-based distributors. Other private sources include: retail outlets such as shops, churches and friends and relatives depending on the country. With DHS findings, it is not possible to identify if the source is through NGO or social marketing, and if the product was accessed for free or at a subsidised cost.

stands out for IUD service provision, accounting as the most recent source for 34.5% of users in Kenya, 30.3% in Madagascar and - as mentioned - 50.4% in Uganda.

Retail outlets or shops (reported under "other private sources") are used to access male condoms in all 4 focus countries, representing the most recent source for between 33.9% (Zimbabwe) and 50.5% (Madagascar) of all users.

Share of FP commodity procurement

Data and graphs that present the share of FP commodity procurement are available for certain countries, such as Madagascar and Kenya. These graphs, which were developed by the national consultants, are presented in ***Figures 20* to *23*** below.

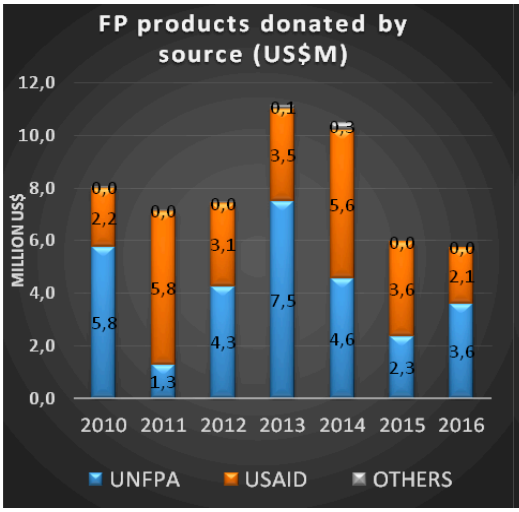


Figure 20: Madagascar Share of FP

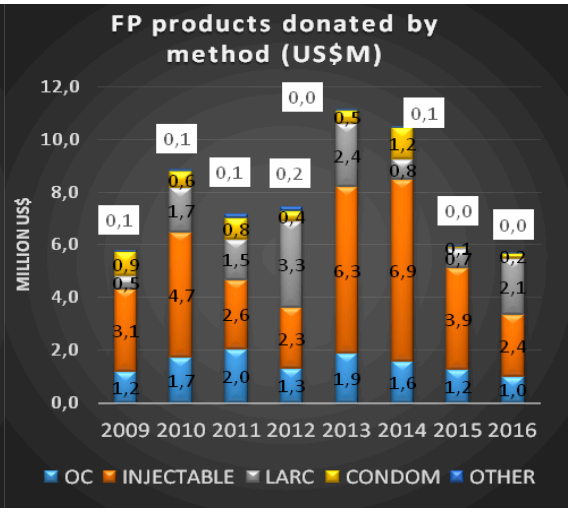


Figure 21 Procurement by Source and by Method

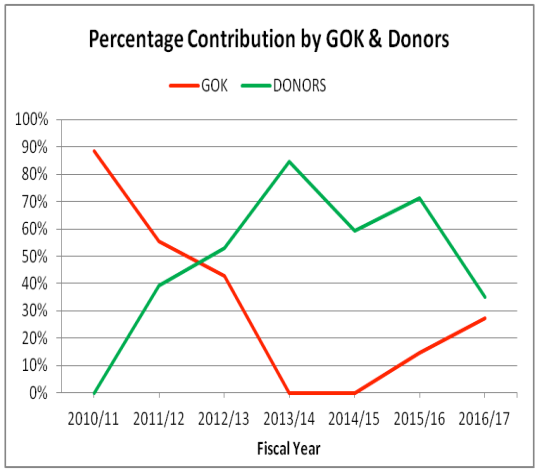


Figure 22 Kenya -Trends in FP Funding

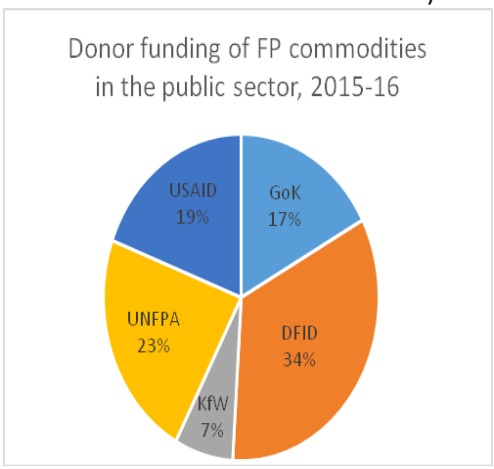


Figure 23 Kenya - Source of Funding

The ***Figure 23*** illustrates the contrasting evolution of donor and Government of Kenya contributions to FP: when donor funds increased, Government of Kenya funds for FP commodities decreased.

Description of the supply chain for FP commodities

Procurement processes and supply chains are presented in all national reports using a range of different diagrams and with varying levels of detail. (See **Annex 3**- for Kenya, **Annex 4** for Madagascar and **Annex 5** for Uganda and **Annex 6** for Zimbabwe.)

All four of the focus countries channel products from manufacturing and importation to the end users using different parallel supply chains for publicly versus commercially distributed FP commodities. Private sector supply chains are generally based on pull-systems operating on demand from the client up to the dispensing entity (clinic or pharmacy) to the wholesaler and importer level. On the other hand, public sector supply chains, which channel the largest proportions of FP commodities are sometimes employing active "push systems" to increase access to and uptake of FP.

In Zimbabwe, for example, the Delivery Team Topping Up (DTTU) system a has a rolling warehouse approach using an informed push to about 2,000 public sector service delivery points nationwide to prevent stock outs and manage health supplies. The DTTU system has been in place thanks to technical and funding support from USAID and DFID from 2003 to 2015 and has achieved 99% coverage of the public health facilities. Recently, a new integrated distribution system, Zimbabwe Assisted Pull System (ZAPS) has been piloted with the intention to progressively replace the DTTU system. ZAPS has been evaluated and recommended for adoption in FP commodity distribution, and will slowly phase out the DTTU distribution system. The change is being driven by the need for a more cost-efficient, integrated "pull" supply chain system.

Key stakeholders interviewed in Zimbabwe confirmed their willingness to change the systems and raised the following issues for consideration:

- Need for a non-donor dependent and thus sustainable FP commodity distribution system.

- Limited understanding of the ZAPS system, with fears of lost gains given that the DTTU system has been very efficient with minimal stock outs.
- Existence of a vertical supply chain and the move towards integration of all commodity distribution systems may be cost effective.

Box 3 - Opportunities and challenges regarding implants

Contraceptive implants are increasingly available in all focus countries. In some countries, they have become the fastest growing modern method, as in Kenya, where implant use among all women aged 15 to 49 has increased rapidly from 7.8% to 10.4% in just 18 months (PMA2015). There are similar trends in Zimbabwe, where the use of implants among married women rose from 2.2% in 2011 to 9.6% in 2015 (DHS).

Implants clearly offer opportunities to expand contraceptive choice, increase FP uptake and reduce unmet need. However, they are also mostly provided by the public sector for free or at subsidized costs, which calls for considerable funding from donors and governments to sustain access to implants. An annual 1% increase in implant users corresponds to an additional funding requirement of roughly 1.0 million USD in Kenya and 0.35 million USD in Zimbabwe[14].

Growing FP markets require sustainable solutions. TMA can play an important role in creating sustainable and equitable access to implants and other FP products.

In Uganda, the MOH developed the Alternative Distribution Strategy (ADS), to make free public sector FP commodities available in the non-profit, NGO sector and for-profit, commercial sector. The strategy provides for inter warehouse transfers between National Medical Stores and Uganda Health Marketing Group (UHMG) to ensure regular availability of FP commodities. The strategy emerged out of lessons learnt from implementing FP interventions, which were characterized by high levels of stock outs, policy restrictions that limited the National Medical store to only supply commodities to Government health facilities, failure of FP commodities to reach the lowest levels, and weak forecasting and procurement capacities in the lower level health facilities. The initiative has been important in achieving equity by reaching clients who go to the private sector; and has helped minimise supply chain risks (stock outs, expiry, redundancy and obsolescence). An evaluation of the ADS showed that there was a general increase in uptake of FP commodities and services by an average of 53% over the period 2011/12 and 2014/15.

Another innovative distribution approach implemented in Uganda is the Ugandan Reproductive Health Voucher Project (URHVP), a MOH programme implemented in partnership with Marie Stopes Uganda with support from the World Bank. The project goal is to reduce maternal and perinatal mortality and morbidity through increased access to skilled care using voucher-based services, which include post-natal FP services. The project provides youth corners set up in the health facilities to provide Sexual and Reproductive Health services. It trains community midwives who conduct door-to-door visits offering FP services at community level and mobilizing clients for various services.

Another example is from Madagascar, where vouchers allowing a free consultation at either Blue Star or Top Reseau franchise networks are sold at a symbolic low price by urban Health or Peer Educators, to poor and/or youth. A young person can get an e-voucher on his/her cell phone through calling a free line.

[14] Kenya has 11.5 Million WRA, 1% new user =115.000 women x 9$ = 1.0 M $; Zimbabwe has 3.9 Million WRA, 1% new user =39.000 women x 9$ = 0,35M$

Table 10: Supply chain issues for FP commodities

Aspects	Kenya	Madagascar	Uganda	Zimbabwe
Presence of logistics management information systems	Yes	yes	Yes, with detected weaknesses	Yes
High quality of warehouses	Yes	yes	yes	Yes
Push- or pull-type distribution styles	Pull type systems	Pull type systems in all 3 sectors	Push and pull systems	Push and pull systems
Presence of shipping/transport companies	Yes	Yes	Yes	Yes
Information on frequency and product type of stock outs, by sector	Yes	Yes, Stock-outs in public sector remain an issue also because of lack of a financial solution to transport of contraceptives.	Yes	yes
FP commodity cross-border leakage or exchanges	At times when stock outs occur for condoms and injectables	No cross border leakage but leakage to agriculture sector (livestock breeding)	NR	NR
Presence of any innovative distribution methods for FP commodities	NR	Several voucher systems (including digital vouchers) are in place.	Yes, ADS and voucher systems	Yes, DTTU and ZAPS
Desire and willingness among FP stakeholders to modify current supply and/or distribution mechanisms	NR	General awareness of last mile transport issue - however mixed willingness to change current mechanisms.	Yes, This would require changing existing policies that regulate the distribution of LARC, and strengthening the capacity of health workers in lower-level health facilities to provide them.	Yes, Key stakeholders cited an ongoing process to change the current FP commodities distribution systems.
Competition between subsidised FP commodities and commercial ones	Yes, SM products and free distribution compete with commercial sector.	Yes, SM products and free distribution compete with commercial sector.	Yes, SM products and free distribution compete with commercial sector.	Yes, Competition exists for condoms - free public sector condoms being distributed in private sector outlets.

Key findings from stakeholder interviews regarding supply chain issues are reported for each country:

- **Kenya –** unanimous agreement that commercial outlets, especially those serving middle to high income segments of the population, should not access the free public sector FP commodities. There is widespread concern among a cross section of stakeholders that the current system, where public providers serving people who can afford either subsidized or full commercial prices, is not sustainable.
- **Uganda:** With respect to crowding out of the commercial sector in FP commodities supply and service provision, the overriding opinion by stakeholders was that this was unlikely to happen. This view was, in their minds, supported by the fact that there was a niche for the commercial sector within the general population, a proportion of which is willing to pay for services despite availability of subsidized or free services. Consultants believe that this perception may convey a lack of understanding of the TMA and that further education of TMA is needed among FP stakeholders.
- **Madagascar:** While many of stakeholders were aware of the last mile transport issue, they had a different view regarding the current distribution mechanism. Some would opt for charging a small fee at HC level including for the transport from the public sector regional warehouses.
- **Zimbabwe:** Stakeholders felt there is generally no competition between subsidised FP commodities and commercial ones, with only two key stakeholders interviewed citing the existence of competition. As above, this finding may point to the need for further understanding of how total market approaches work, and how to reduce a reliance on subsidy and thereby increase sustainability.

VII. ASSESSMENT OF THE FP MARKETS AND TMA READINESS

This chapter reports on stakeholder perceptions collected during interviews with FP stakeholders from donor agencies, and the public, commercial and NGO/SMO sectors. Stakeholder interviews were conducted by national consultants using Tool #5, *Stakeholder Scoping Interview Guide,* in November and December 2016. During these interviews, FP stakeholders shared their thoughts regarding FP market challenges, TMA benefits, facilitators and barriers, government capacity to steward a TMA, and the role of other agencies in coordinating a TMA.

The chapter also compares and contrasts each country's analysis of market failures by function, player and FP commodity, and provides a TMA-related SWOT analysis of the four countries.

A. Stakeholder Perceptions Regarding Current FP Programmes

With regard to current FP programmes, stakeholders from all countries said that there are major challenges in guaranteeing government financing of a regular supply of FP commodities, and ensuring sustainability of levels of free and subsidized FP commodities. Stakeholders also report major or moderate challenges in the accessibility of FP commodities for all target groups, and particularly for underserved populations and young people. Availability of FP commodities to all target groups is an issue in three of the four countries, excluding Zimbabwe.

Other noteworthy findings include:

- The Ugandan FP programme is perceived to face major challenges in all of the aspects surveyed, apart from NGO availability of FP commodities.
- There are major challenges in provider skills and capacity in the private sector (particularly among those providers not included in social franchising networks) and/or the public sector depending on the country.
  The need to improve provider confidence and capacity in delivery of LARC was also mentioned across the four countries.
- Lack of FP leadership and support are noted as a major challenge in Uganda and at the county-level in Kenya.
- There is room to improve FP counselling and informed contraceptive choice.

Table 11 indicates stakeholders' average rating of different aspects of the national FP programmes.

Table 11 Assessment of stakeholder perceptions regarding aspects of FP programmes

Average rating	NOT A CHALLENGE	MINOR CHALLENGE	MODERATE CHALLENGE	MAJOR CHALLENGE	NOT REPORTED

No.	ASPECT (statement)	Kenya	Madagascar	Uganda	Zimbabwe
1.1	Public-sector FP commodities are of high quality.				
1.2	Non-profit, private sector (NGO) FP commodities are of high quality.				
1.3	For-profit, Commercial sector FP commodities are of high quality.	EC brands			
1.4	Public sector FP commodities are available.	Remote areas			
1.5	Nonprofit, private-sector (NGO) FP commodities are available.	Provider bias			
1.6	For-profit, commercial sector FP commodities are available.	If stock-outs			Many don't know
1.7	Government financing of public sector guarantees regular supply of FP commodities.	Donor reliance			
1.8	The current levels of provision of free and subsidized FP commodities are sustainable.				
1.9	National policies for FP are supportive.	Focus on how			
1.10	There is strong leadership and support for FP programmes.	National = minor, county= major			
1.11	FP providers have skills and capacity to deliver quality FP commodities and related services.	LARC	NGO yes, less in public sector, lack in private sector		Divided: NGO sector yes, weak public sector, less private sector
1.12	FP commodities are accessible to all target groups.	LARC< youth, remote			
1.13	FP commodities and related services are accessible to underserved populations.				
1.14	FP commodities and related services are accessible to young people.				
1-15	FP commodities and related services are affordable for underserved populations	free			

1.16	The choice of FP commodities available meets the needs of target populations.				
1.17	FP target audiences are informed of their contraceptive choices.				
1.18	FP target audiences receive sufficient information or counselling when choosing a FP method.	misconceptions			divided
1.19	FP discontinuation rates are acceptable.				DK

B. Stakeholder Perceptions Regarding TMA

Most FP stakeholders shared positive perceptions regarding the implementation of a TMA in their countries. The TMA was seen as laying a pathway towards reducing donor dependency and wastage of resources. Stakeholders cited numerous benefits, including:

- increasing the sustainability, equity, and efficiency of FP programmes
- prioritising public sector funds towards the poor
- improving choice and affordability of contraception, access and uptake, and
- enhancing coordination and partnerships across sectors.

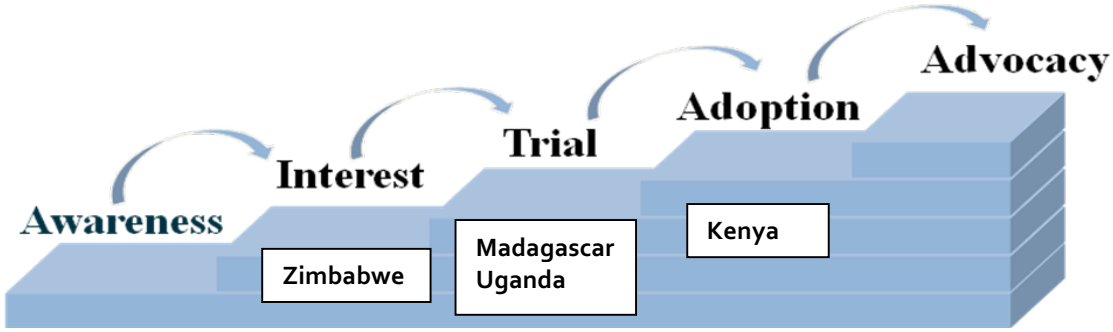
In Uganda, however, a number of stakeholders also voiced caution regarding what a TMA could promise. They perceived TMA as the new semantic of the moment and an approach that would be likely to fail in the Ugandan context, due to the lack of human resources and lack of overall motivation within the MOH. Ugandan stakeholders underlined the need to strengthen the Ugandan MOH stewardship capacity and health care system first before embarking on a new approach.

FP stakeholders agreed that implementation of a TMA required stewardship from the MOH and wide participation from all FP market sectors – public, NGO/SMO, commercial and donors. TMA coordination was perceived to be possible through a TMA secretariat housed within the unit or department responsible for leading the national FP programme, such as it is presently with the RHSMU in Kenya. It was also agreed that high-level involvement of Ministries of Health and Finance, as well as entities holding the purse strings (related to revenue, taxation) and with planning abilities, would be necessary. Stakeholders expressed that engaging and maintaining the involvement of commercial sector partners was vital for a TMA initiative to succeed.

In general, findings suggest that the government's readiness to steward a TMA is greater in Kenya and Madagascar in comparison with Zimbabwe or Uganda, where stakeholders perceive a need for more TMA advocacy and education efforts to persuade government of the urgency to implement TMA initiatives.

Figure 24 below illustrates stakeholder perceptions in terms of where countries are located in the "stages of change" pathway towards adoption of and future advocacy for TMA.

Figure 24: Stages of change from awareness to adoption of and advocacy for TMA



TMA facilitators, barriers and expectations expressed by FP stakeholders during interviews are presented in **Table 12** below.

Table 12. Perceived facilitators, barriers, expectations and concerns regarding a TMA

TMA Facilitators	TMA Barriers	TMA Expectations & Concerns
• Support from national governments (Kenya and Madagascar) • Support from donors (all countries) • NGO/SMO support (all countries) • Supportive FP strategies & policies (all countries) • Increased sharing of FP market data (Madagascar) • Existing TMA initiative (Kenya) • Ability of commercial sector to reach into rural areas (Uganda)	• Lack of political will or prioritisation (Uganda, Zimbabwe) • Lack of specific TMA policy (all countries) • Lack of resources for TMA (all countries) • Lack of donor alignment due to conflicting targets and interests (Kenya) • Absence of TMA cost-benefit analysis (Kenya, Zimbabwe) • Low understanding of TMA in all countries (especially in Uganda, Zimbabwe) • Existing taxes and custom duties on contraceptives (Madagascar) • Fear/risk of taxation among commercial sector players (Uganda, Zimbabwe) • Fear of loss of control over FP by public sector (Zimbabwe)	• Risks of decreasing mCPR uptake (all countries) • Risks increasing inequities in FP access and uptake (all countries) • Concerns regarding quality of FP commodities entering the market (Need for quality monitoring and quality assurance across FP market) (Kenya, Zimbabwe) • Need for better understand of FP segmentation and willingness/ability to pay data (all) • Challenges in how to identify users' ability-to-pay (all) • Weakness in MOH coordination structures (Uganda) • Need to strengthen weak public sector health care delivery system and resources, which are currently weak (Uganda) • Concerns about availability of funding and sustained commitment to TMA (all) • Gaps in participation of non-health sector entities (MoF/ Ministry of Gender) that would be involved (all) • Questions about benefits to private/commercial sector (all)

C. Market Failures: Who & How?

Market failure is a situation where free markets fail to allocate resources efficiently. With respect to FP, market failures can occur when there is a monopoly of suppliers or when there is failure to produce enough commodities that are of merit and meet the needs of consumers. In situations where government provides free or subsidized products that flood the market, the market becomes skewed, where commercial-sector entities are faced with unfair competition that threatens their long-term financial viability.

Whom is the market failing? Based on the findings from the national studies, several segments of the population can be clearly identified. Table 13 below lists whom the market is failing in each of the TMA focus countries.

Table 13: Market failure - whom are the markets failing?

Countries	Whom is the market failing?
Kenya	Women 15-49 with no or low education Adolescents, unmarried youth 15-24 Women aged 45-49 years Rural women Women in Northern Kenya Poorest half of wealth quintiles
Madagascar	Married and unmarried women 15-49 (especially educated women) Adolescents (especially girls from outer regions), unmarried youth 15-24 Extremely poor women (lowest quintile) both urban and rural Rural women (especially poor women) Urban middle class women Sex workers (limited access to female condoms)
Uganda	Married and unmarried women 15-49, particularly: • Adolescents 15-24, unmarried youth 15-24 • Rural women • Women in Northern and Eastern Uganda • Poorest half of wealth quintiles (lowest, second and middle wealth quintiles.)
Zimbabwe	Rural women (especially in resettlement zones) Women 15-49 with no education, Adolescents, unmarried youth 15-19, Older women 45-49; Poorest half of wealth quintiles (lowest, second wealth quintile)

Table 14 below presents an assessment of market failures by type of function, market player and country, based on findings from the country-specific TMA reports.

Table 15 that follows presents market failures by type of FP commodity, supportive evidence and related recommendations.

Table 14. Assessment of market failures by type of function, market player and country

Type of function	Market Participants	Kenya	Madagascar	Uganda	Zimbabwe
Core functions (supply and demand)	**Importers**	Few commercial importers of FP, who are crowded out and have low interest due to free and subsidised FP products. No demand creation for FP by importers.	Few commercial importers of FP, crowded out and low interest due to free and subsidised FP products and tax burden on contraceptives. Need to coordinate with donors and NGOs to prevent duplication of efforts, such as with EC. (see table below on market failure by product category.)	Few commercial importers of FP, crowded out and low interest due to free and subsidised FP products. Long waiting time for inspection of FP commodities increases commercial sector costs. Low margins for FP product serve as a disincentive. No national strategy for FP demand generation.	Few commercial importers of FP, crowded out and low interest due to free and subsidised FP products.
	Distributors	Free and subsidised distribution plus the combination of low margins and low volumes for commercial FP products deter distributors from increased engagement in FP.	Free and subsidised distribution plus the combination of low margins and low volumes for commercial FP products deter distributors from increased engagement in FP. Problem with cost of transportation of free FP commodities over last mile to HCs yet to be resolved.	Combination of low margins and low volumes for commercial FP products deter distributors from increased engagement in FP. (wholesaler bias towards condoms because more lucrative) Subsidized products are rerouted from low SES to higher SES areas. Overall low coverage of distributors/wholesalers (only 5/9 regions)	Free and subsidised distribution plus the combination of low margins and low volumes for commercial FP products deter distributors from increased engagement in FP.

Type of function	Market Participants	Kenya	Madagascar	Uganda	Zimbabwe
	Providers	Mostly stock public or SM FP commodities. Little incentive to procure commercial FP products. Do not actively promote FP or engage in demand creation activities. FP provision for adolescents is suboptimal, and reliant on youth-friendly health centres; provider opinion (negative attitude and bias towards use of FP among adolescents).	Limited supply of IUDs (9% of public health facilities) and implants (60% of public health facilities) limited to certain public and NGO health care structures and providers. FP provision for adolescents is suboptimal, and reliant on youth-friendly health centres; negative provider opinion; availability of methods. Disconnect between youth friendly FP policy and regulations limiting access to FP to youth under 18	Lack of capacity and confidence in provision of *all* FP methods. Provider bias towards easier to provide methods and products with higher margins. Disconnect between youth friendly FP policy and regulations limiting access to FP to youth. Limited public sector infrastructure and providers in rural areas to provide wide range of FP services. Low availability of condoms and OCs in shops and pharmacies.	Limited public sector infrastructure in hard to reach, rural areas to provide wide range of FP services Disconnect between youth friendly FP policy and regulations limiting access to FP to youth.
	Consumers	Consumer are used to getting FP for free, which creates a habit and limits sources of supply. Large universe of need for FP, and high unmet need: 18% among married WRA (26% among 15-19 and 52% among 40-44 years); higher among unmarried sexually active women (55% among 15-19; 52% among 30-34; 64% among 45-49). 30% discontinuation rate among WRA. Stock outs reported in Contraceptive Security Index	Lack of contraceptive choice depending on point of care. High unmet need among married and unmarried women. Fear of hormonal side effects among more educated clients.	Stock outs reported in CS Index particularly in public health facilities. Limited product diversity resulting in high discontinuation instead of switching when experiencing side effects. High unmet need = 34.3%, across all age groups. Limited FP promotion targeting key influencers (male, cultural and religious leaders) 42.6% discontinuation rate among WRA.	Method choice depends on point of care. Myths and misconceptions about FP side effects Recent stock out of EC (in country-specific report). Some rural areas remain underserved. 22.0% discontinuation rate among WRA.

Type of function	Market Participants	Kenya	Madagascar	Uganda	Zimbabwe
		[2015].			
Support functions (information, infrastructure, skills, technologies)	**Importers**	Very little support for FP (demand creation or training). Lack of access to information on the national contraceptive market (forecasting, market and survey data).	Very little support for FP (demand creation or training). Lack of access to information on the national contraceptive market (forecasting, market and survey data).	Very little support for FP (demand creation or training). Lack of accurate forecasting / Quantification and LMIS not done in tandem with the budgeting cycles. Low capacity of National Drug authority. Market data/ DHIS 2 data not shared with commercial importers. Lack in quality control of imported products.	Very little support for FP (demand creation or training). Lack of access to information on the national contraceptive market (forecasting, market and survey data).
	Distributors	Absence of training or marketing support for FP. Lack of road or facility infrastructure in rural areas.	Absence of training or marketing support for FP. Lack of roads in most rural areas with catastrophic situation during rainy season.	Absence of training or marketing support for FP. Lack of road or facility infrastructure in rural areas. Limited involvement of commercial sector in FP supply chain management.	Absence of training or marketing support for FP. Donor reliance for supply chain systems (DTTU, ZAPS) is not sustainable. Lack of road or facility infrastructure in rural areas (in particular in resettlement communities). Private sectors not sufficiently informed and involved in the national FP program despite procuring FP from public sector.
	Providers	Lack of and inequitable coverage of skilled providers relative to population. Lower level facilities lack adequate skills and equipment.	Lack of and inequitable coverage of skilled providers relative to population - this resulted in large cadre of community agents. Low level of formal education of community agents hampers the quality of services at the periphery level.	Shortages of human resources for health, which hampers the scale-up of FP service delivery. Lack of skills and competencies among health workers especially to provide long-term FP methods; bias towards injectables.	Lack of and inequitable coverage of skilled providers relative to population. Lack of skills and competencies among health workers especially to provide long-term FP methods in most public sector facilities.

Type of function	Market Participants	Kenya	Madagascar	Uganda	Zimbabwe
		Inadequate counselling and service provision skills may explain high rates of discontinuation. Limited youth friendly services infrastructure.	Need to develop provider skills in provision of IUDs and implants in public and private clinics. Inadequate counselling and service provision skills. Limited youth friendly services infrastructure.	Inadequate counselling and service provision skills may explain high rates of discontinuation. Health concerns/fear of side effects are not prioritized in BCC/ communication efforts, leading to limited demand for and uptake of services. Limited youth friendly services infrastructure.	Limited youth friendly services infrastructure
	Consumers	Insufficient consumer knowledge about FP choices and what to expect. Fear of side effects & health concerns major contributors to non- or discontinued use of FP.	Insufficient consumer knowledge about FP choices and what to expect. Fear of side effects & health concerns major contributors to non- or discontinued use of FP.	Insufficient consumer knowledge about FP choices and what to expect. Fear of side effects & health concerns major contributors to non- or discontinued use of FP. Clients not being provided with FP options and are forced to get whichever products are available at the time of visit to health facility.	Insufficient consumer knowledge about FP choices and what to expect especially in rural areas.
Regulatory functions (standards, laws, informal rules and norms)	**Importers**	Limited capacity to control quality. Branded advertisement of FP products not allowed in mass media.	Tax and import duty burden on contraceptives except EC. Limitations on regulations. Except for condoms, branded advertisement of FP products not allowed in mass media	No mechanism to maintain consistent quality among imported FP commodities (PACE 2016) CS Index 2016 - Some sectors are charged a 2% verification fee on imported products by the National	Costly and highly stringent quality standards. Non-adherence to importation regulations by some private sector entities.

Type of function	Market Participants	Kenya	Madagascar	Uganda	Zimbabwe
				Drug Authority (NDA). Donations charged about $200 per shipment for verifications. Uganda Revenue Authority is charging withholding tax on contraceptives and condoms (further clarification needed)	.
	Distributors	.	Import duties and VAT on active ingredients discourage local manufacturing. Limitations on regulations. Except for condoms branded advertisement of FP products not allowed in mass media		Advertising regulations may limit demand creation. Private sector reluctant to participate in External Quality Assurance processes.
	Providers	Laws relating to injections may need to change based on *Sayana Press* pilot. Legal age restrictions to FP prescription/access (15 years)	Sales of injectables suspended at drug stores (DM). Legal age restrictions to FP prescription/access (18 years)	Policy restrictions by government on access to FP services to adolescents in school. Some provider cadres are not allowed to administer some methods; Village Health Teams not fully integrated in health system. Provider bias against FP for youth. Legal age restrictions to FP prescription/access (18 years)	Unclear policies on age of consent and access to FP by young people. *Legal age restrictions to FP prescription/access* (16 years).
	Consumers	Habit to source FP from public sector. Purchase of contraceptives is restricted to 15 and older.	Since July 2016, medical prescription is required to purchase OCs and injectables. Purchase of contraceptives is restricted to 18 and older.	Lack of access to health information and products in schools. Religious and cultural barriers, low male involvement as well as	Young people/adolescents face limited access to FP due to prevailing social cultural norms Purchase of contraceptives is restricted to 16 and older.

Type of function	Market Participants	Kenya	Madagascar	Uganda	Zimbabwe
				negative attitudes among men limit women's FP uptake Purchase of contraceptives is restricted to 18 and older.	

Table 15. Market failures detected by type of FP commodity

Product	Failures	Kenya	Madagascar	Uganda	Zimbabwe
Male condoms	**Failure detected?**	Yes	Yes	Yes	Yes
	Evidence	Vibrant market, dominated by SMO sector (96%). Crowding out of commercial sector.	Crowding out of commercial sector	Free commodities /subsidies are not well targeted, resulting in a) limited financial accessibility and geographical availability (in particular for youth and hard to reach populations) - and b) crowding out commercial and SM sectors.	*Free Panther* condoms are sold in some private sector service delivery points. Crowding out of commercial sector
Female condoms	**Failure detected?**	Yes	Yes	Yes	Yes
	Evidence	Targeted product for groups at high risk for HIV, with insufficient availability, acceptability, and ability to use.	Targeted product for groups at high risk for HIV, with insufficient availability, acceptability, and ability to use.	Targeted product for groups at high risk for HIV, with insufficient availability, acceptability, and ability to use. Inefficient promotion and management of distributing of FC have caused wastage and concerns about use.	Targeted product for groups at high risk for HIV, with insufficient availability, acceptability, and ability to use.
OC/POP	**Failure detected?**	Yes	Yes	Yes	Yes
	Evidence	SMO brands account for 95% of market. Few mid-priced brands available but lack marketing support.	POP restricted to public and SMO clinics. Absence of commercial POP brand.	OCs market grows, with high proportion of free distribution despite WTP by certain segments.	Supply chain is mostly donor and NGO driven. Poor in-depth knowledge about side effects, poor quality of

Product	Failures	Kenya	Madagascar	Uganda	Zimbabwe
		Crowding out of commercial sector. Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates (DHS 2014 45%).	One compulsory medical prescription per cycle forces clients to consult a FP provider at a cost each month. Crowding out of commercial sector. Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates.	Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates. (DHS 2011 54%).	service / counselling and high discontinuation rates (DHS 2015, 20.5%).
Injectables	**Failure detected?**	Yes	Yes	Yes	Yes
	Evidence	Market dominated by public sector and SM. SM injectable (*Femiplan*) accounts for 93% of the sales volume. Crowding out of commercial sector. Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates (DHS 2014 30%).	Ban on injectable at drug outlets because of the "hormone pig issue" limits access for relatively well-off clients not willing to attend a health facility. Crowding out of commercial sector. Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates	Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates (DHS 2014 46.5%). Overall decline of market volumes due to inaccurate forecasting; commercial sector share declines - likely due to overstocked free product. Crowding out of commercial sector.	Highly in demand and mainly sourced through the public sector. Crowding out of commercial sector. Poor in-depth knowledge about side effects, poor quality of service / counselling and high discontinuation rates. (DHS 2015, 30.0%of which 15.6% is due to side effects/health concerns).
IUD	**Failure detected?**	Yes	Yes	Yes	Yes
	Evidence	Public sector the main source of IUDs. Lack of sourcing of wealthier quintiles in private sector, lack of skilled IUD providers in public - sectors. Limited coverage of high quality IUD services in NGO/SF sector.	Only 9% of public sector HC deliver IUD services.	Limited skills and availability of IUDs in public sector, high market share (50.4%) of private sector for service provision linked to high cost.	Lack of access in rural areas.
Implants	**Failure detected?**	Yes	Yes	Yes	Yes

Product	Failures	Kenya	Madagascar	Uganda	Zimbabwe
	Evidence	Only two brands in the market and only available through public sector and social marketing channels. Prices are negotiated at global level between manufacturers and donors and are relatively high. Public sector supplies most of the market. Growth and demand for implants may lead to more availability of commercial implant brands.	Lack of coverage for implants: Only 60% of public sector HC deliver *Implanon* services. In private sector, Implant provision limited to franchised providers.	Limited skills among health workers to provide implants and high cost Market transition ongoing since donors in 2015 dropped support for free implants, and commercial sector is growing. Growth and demand for implants may increase availability of commercial implant brands.	Method mid mix has grown from 5% in 2011 to 14.5% in 2015. Market sector dominated by free and subsidized supply. Growth and demand for implants may provide availability of commercial implant brands.
EC	**Failure detected?**	Yes	Yes	Yes	Yes
	Evidence	Concerns of quality of private sector EC brands due to limited quality control. Lack of targeted access to subsidized EC for underserved populations (rural areas, youth)	Market distortion due to presence of a SM EC brand that is more expensive than commercial equivalent.	Limited availability and use reported (Lack of information)	High EC stock out rates; (Lack of information), existence of access barriers among young people

D. Analysis of Strengths, Weaknesses, Opportunities and Threats (SWOT)

The table 16 below proposes a combined SWOT analysis for TMAs in the four countries. Detailed country specific SWOT analyses are available in each country TMA report.

Table 16: SWOT analysis for TMAs in the four countries

Strengths	Weaknesses
• Presence of policies and strategies that are supportive of FP • Desire to meet FP2020 targets and commitments (some countries have made either new or renewed commitments) • Functioning FP-related working groups exist in all countries (in Kenya, a TMA-specific working group was created) • Agreement that high donor dependency is unsustainable • Markets where public, NGO/SMO and commercial sectors are active • Existence of regulatory frameworks and systems for importation, storage and distribution of FP commodities • Reported knowledge of any FP method high as per DHS findings • Availability of relatively recent DHS data, as well as other surveys to inform FP	• Heavy reliance on donors • Lack of administrative/organizational/financial support for TMA at national and at sub national level (for example, county level support for FP in Kenya) • Insufficient communication and coordination between different FP sectors, entities and stakeholders • Low level of involvement of commercial sector in FP • Limited capacity of public sector/MOH to monitor commercial sector activities • Lack of quality control mechanisms • Limited health capacity (clinics, human and financial resources and capacity) to provide a wide range of FP commodities and related services in countries like Uganda • Limited capacity to provide FP in private sector • Lack of brand choice for many FP commodities (other than male condoms) • High level reported knowledge does not mean that there is a good understanding of FP methods- rumors and misconceptions persist
Opportunities	**Threats**
• Willingness to be part of current/future TMA discussions • Growing FP markets based on increasing need for FP, leaving room for private commercial engagement (mid and higher price ranges) • High unmet need and interest in/potential for new FP commodities, particularly implants • Wide community-based distribution systems in some countries, like Madagascar • Growing middle class (Kenya) • Existence of active NGOs, including SMOs with vast distribution channels (outlet and provider-based)	• Competing health priorities • Frequent changes in leadership and priorities • Perceived inability of MOH to steward TMA (Uganda) • Conflicting interests of different FP players (donors, government, NGO/SMOs, commercial) • Lack of TMA policy • Risk of fatigue in providing continuous support for TMA in the long-term • Lack of exit plan for donors to manage gaps in FP commodities while reducing commodity support

• Opportunity to include FP in growing commercial and private medical sectors • Donor interest in TMA (and need to develop more sustainable FP markets)	• Slow or unstable economy hindering a far-sighted vision for change • Lack of business and/or public health incentives to pursue a TMA • Need to build and regulate private sector capacity in FP commodity and related service provision to ensure national FP standards • Resistance to changing the public sector ethos of free service delivery • Lack of interest among commercial partners, and lengthy process to facilitate entry of new commercial FP commodities • Fears related to quality of FP commodities and related services in case of increasing private sector engagement

VIII. CONCLUSIONS AND RECOMMENDATIONS

A. Stages of Market Development by Focus Country and FP Product Category

The USAID/SHOPS Project primer *Total Market Initiatives for Reproductive Health* (Barnes, 2012) proposes a framework with key characteristics for assessing the stage of the contraceptive market development, identifying issues to consider, and making recommendations for a TMI. (Please see details of this Framework in the **Annex 7).** This framework was used to help categorize each of the four focus countries' FP markets, including by FP product category, and guide recommendations for further action.

The four focus countries in this study can be categorized as early (Uganda), developing (Madagascar, Zimbabwe), and developing/mature (Kenya) stages of market development. (**Table 17)**

Table 17. Stage of market development of each focus TMA country using the SHOPS Plus framework

Country	Stage of Market Development	Characteristics
Kenya	Between Developing and Mature depending on the FP commodity	mCPR 53.2% among married women (KDHS,2014). Market share of public and SM sectors of subsidized supply > 50% (depending on the FP commodity). Commercial sector provision of some FP commodities. Willingness to pay for FP products among higher wealth quintiles. Increasing number of service providers and sales outlets. Middle-income country.
Madagascar	Developing	mCPR 33.3% among married women (ESOMED, 2012-2013). Market dominated by public and SM sectors of subsidized supply. Commercial sector provision of some FP products (condoms, EC). Low willingness and low ability to pay. Tax and import duties on contraceptives. Politically-fragile, low-income country.
Uganda	Early to Developing depending on the FP commodity	mCPR 32.2% among married women (PMA R4, 2016). Market dominated by public and SM sectors of subsidized supply. Commercial sector provision of some FP products (condoms). Low willingness to pay. Irregular supply of FP commodities. Fragile public health care system, with insufficient coverage of skilled FP providers. Low-income country.
Zimbabwe	Developing	mCPR 57.3% among married women (ZDHS,2015). Market dominated by public and SM sectors of subsidized supply. Commercial sector provision of some FP products. Willingness to pay for FP products among higher wealth quintiles.

		Increasing number of service providers and sales outlets. Good access to FP commodities and related services. Low-income country.

During the analysis of country-specific TMA findings, national consultants were asked to assess each FP product category's stage of market development and readiness for a TMA initiative, based on extensive conversations with local stakeholders. The tables below document the results of this analysis. The recommended next steps formulated after each product category are proposed by the regional consultant.

Table 18. Male condoms: stage of market development and TMA initiative recommendation

Category	Aspect	Kenya	Madagascar	Uganda	Zimbabwe
Male condoms	*Stage of market development*	(Almost) Mature	Developing	Developing	Developing
	Recommended for a TMA initiative?	Yes	Yes	Yes	Yes
	Supporting Evidence	Multiple brands in 3 sectors widely available at different price points. SMO sector accounts for over 90% of sales volume. Consumers source condoms mainly in commercial sector.	Multiple brands in 3 sectors widely available at different price points. Increasing share of high-end condoms sales. (For example, 457,260 of PSI's high-end *Yes* condom sold when launched in 2015.) Consumers source condoms mainly in commercial sector.	Multiple brands, however majority of those are subsidized and leaked free condoms, representing 73% market share.	Multiple brands in 3 sectors widely available at different price points. Free or subsidized provision accounts for over 96% of the total market share. (PSI MAP, 2014)

Recommendations for male condoms:

- Ensure coordination of condom market shaping initiatives across donor, public, NGO/SMO and commercial sectors.
- Conduct or use findings from market segmentation and ability to pay studies to better understand different condom consumer segments.
- Encourage introduction and use of sustainable condom brands, where needed and where promising, to move consumers away from subsidies..
- Better target subsidies to low-income, vulnerable consumers and adolescents/young people.
- Explore and address leakage of public sector FP into commercial sector.
- Target SBCC to specific behavioural barriers.

Table 19. Female condoms: stage of market development and TMA initiative recommendation

Category	Aspect	Kenya	Madagascar	Uganda	Zimbabwe

Female condoms	*Stage of market development*	Early	Early	Early	Early
	Recommended for a TMA initiative?	No	No	No	No
	Supporting Evidence	Low and targeted demand. Subsidized product warranted for vulnerable groups at HIV risk or for dual protection.	Low and targeted demand. Subsidized product warranted for vulnerable groups at HIV risk or for dual protection.	Low and targeted demand. Subsidized product warranted for vulnerable groups at HIV risk or for dual protection.	Low demand, but highly targeted due to promotion as dual protection method in high HIV prevalence context. Subsidized product warranted for vulnerable groups at HIV risk. No commercial brands on the market.

Recommendations for female condoms.

- Maintain subsidies for female condoms given low demand limited to specific target groups at higher HIV risk, or groups requiring dual protection.
- Increase coordination of donor-supported service delivery efforts in the areas of procurement.
- Increase access in targeted outlets and focus on demand generation, community awareness and competency-based training in how to use female condoms.

Table 20. OCs/POP: stage of market development and TMA initiative recommendation

Category	Recommendations	Kenya	Madagascar	Uganda	Zimbabwe
OCs/POP	*Stage of market development*	Mature (OCs) Developing (POP)	Developing	Developing	Mature
	Recommended for a TMA initiative?	Yes	Yes	Yes	Yes
	Supporting Evidence	Current market dominated by subsidized products. Commercial brands are available in market.	Current market dominated by subsidized products (98%) If tax and duties lifted, it is possible that new generic OCs could be launched (like EC). Low POP prescription may be linked to lack of provider skills.	Current market dominated by subsidized products. Growing market with increased share of free products but also market value holding steady, which suggests willingness to pay and opportunity for commercial	High market coverage with multiple sources of services and product supply and opportunities for increased brand mix.

				sector.	

Recommendations for OCs/POP.

- Encourage introduction and use of sustainable brands, where needed and where promising, to move consumers away from subsidies.
- Better target subsidies to low-income, vulnerable consumers and adolescents/young people.
- Improve capacity of health workers in counselling for FP as well as knowledge about the side effects of the different FP methods.

Table 21. EC: stage of market development and TMA initiative recommendation

Category	Recommendations	Kenya	Madagascar	Uganda	Zimbabwe
EC	*Stage of market development*	Mature	Developing	Developing	Developing
	Recommended for a TMA initiative?	Yes	Yes	Yes	Yes
	Supporting Evidence	Commercial sector is main source of supply. Several brands available. Affordability is not a barrier.	Ready for maturity. Illustrates the fact that tax suppression can tilt the balance for a relatively recent product	NR	Increased commercial provision of EC, 3 brands available, sold at different price points.

Recommendations for EC.

- Facilitate access to adolescents/young people by aligning policies/strategies, introducing a wide range of outlets including through community-based distribution, and targeting communications to specific behavioural barriers and population segments.
- Better target subsidies to low-income, vulnerable consumers and adolescents/young people.
- In cases where social marketed brands compete against cheaper commercial EC brands, remove social marketed brand from market and use social marketing to increase informed demand for EC.

Table 22. Injectables: stage of market development and TMA initiative recommendation

Category	Recommendations	Kenya	Madagascar	Uganda	Zimbabwe
Injectables	*Stage of market development*	Developing	Developing	Developing	Developing
	Recommended for a TMA initiative?	Yes	Yes	Yes	Yes
	Supporting Evidence	Popularity means it needs to be widely available. Public and NGO sectors share market.	The most used FP method. Deserves TMA attention because: (i) MoH's measures taken after hormone-pig scandal; (ii) reluctance to	Downward trend of commercial sector sales due to crowding out by public sector- better inclusion of private sector is needed.	Increasing commercial provision of products and services.

			have CA making injection; and (iii) current acceleration to shift to *Sayana Press*.		

Recommendations for Injectables.

- Encourage introduction and use of sustainable brands, where needed and where promising, to move consumers away from subsidies.
- Better target subsidies to low-income, vulnerable consumers and adolescents/young people.
- Increase access to injectables, through capacity building of providers including task shifting to community-based agents and accelerating shift to *Sayana Press*.
- Improve capacity of health workers in counselling for FP as well as knowledge about the side effects of the different FP methods in an effort to reduce discontinuation rates and rumours about injectables.
- Case of Madagascar: Resume injectable supply to drug outlets, whilst controlling for leakage to livestock breeding.

Table 23 Implants: stage of market development and TMA initiative recommendation

Category	Recommendations	Kenya	Madagascar	Uganda	Zimbabwe
Implants	*Stage of market development*	Early or Developing	Developing	Early/ Developing	Developing
	Recommended for a TMA initiative?	Yes	Yes	Yes	Yes
	Supporting Evidence	Public sector has bulk of market share. Growing popularity encourages growth in NGO and commercial sectors.	Although currently a small potential, starting with pharmacies, private providers and insurance-based/NGO networks of private medical services.	PACE reports since 2015 decline in donor support for free implants and in implant market volumes, which may suggest a reduction in the availability of free implants. More investigation is needed.	A market with opportunities for growth. Market share dominated by subsidized supply.

Recommendations for implants.

- Facilitate commercial provision of implants to ensure easy access for urban women with willingness to pay.
- Target subsidized implants to underserved women, including those living in rural areas, and adolescents/youth and urban women in the lower wealth quintiles.
- Increase access to implants in all sectors through capacity building of providers, and increase participation of NGO and private medical sector in service provision.
- Scale up training in public sector, insurance-based/NGO networks of private medical providers, and other private medical providers and train more than one staff per health center.

- Improve information to consumers and HC provider counselling and care in an effort to reduce discontinuation rates based on rumours, fears and misconception of side effects about implants.
- Given interest and growth in, and high cost of implants, sustain advocacy with manufacturers for global price reductions of implants beyond 2020.

Table 24. IUD: stage of market development and TMA initiative recommendation

Category	Recommendations	Kenya	Madagascar	Uganda	Zimbabwe
IUDs	*Stage of market development*	Early	Early	Early	Early
	Recommended for a TMA initiative?	Yes	Yes	Yes	No
	Supporting Evidence	Shared between public and NGO sectors.	IUD access limited to 9% of service delivery points.	Free and commercial sectors growing, market value growing quickly.	Low uptake.

Recommendations for IUD.

- Improve availability to IUDs by training qualified FP providers in all sectors: public, NGO and commercial, train more than one staff member per health facility.
- Need to expand availability of product and quality service provision in commercial sector for consumers with willingness and ability to pay.
- Improve information and counselling in an effort to reduce discontinuation rates and rumours, fears and misconception of side effects about IUDs.
- Target subsidized IUD services to underserved women, including those living in rural areas.
- Support interventions through social franchising and mobile outreach teams to increase access to IUDs.
- Incentivize IUD provision through third party payments.

B. Recommendations for Policy Dialogue and Advocacy

The TMA studies included the organisation of UNFPA-led consensus generation meetings in each country with FP stakeholders representing all sectors – public, NGO and commercial, including donors and multilateral organisations. Consensus generation meetings provided opportunities to share and discuss findings from the TMA studies and generate key issues and/or recommendations for moving TMA initiatives forward. Consensus generation meetings were held in Madagascar and Uganda in December 2016. Policy dialogue and advocacy recommendations generating from these meetings are reproduced below.

An initial stakeholder meeting was organised in Kenya to share and discuss findings from the TMA study, with the plan to host the final consensus generation meeting in January-February 2017. In Zimbabwe, the consensus generation meeting will be held in January 2016. Recommendations from Kenya and Zimbabwe are therefore provisional.

B.1. Recommendations from Kenya:

1. **Issue**: High dependency on ***external financing*** for commodities.

Recommendation: High-level advocacy is required to increase government budget allocations for FP including at county level.

2. **Issue**: Policy of ***"free" FP commodities*** for the whole market and ***lack of market segmentation***. Consequently, subsidies and free commodities are not targeted to those who need them the most.

Recommendation: Review policy on provision of free commodities to private sector outlets where clients subsequently pay for them. Subsidized commodities by NGOs should focus on low income areas where clients cannot afford to pay commercial prices for FP.

3. **Issue**: Lack of a ***TMA policy*** and health in general to guide implementation.

Recommendation: TMA should be embedded in key policy documents. Stakeholders recommended embedding it in the Reproductive Health Policy that is currently under review and in the new FP Costed Implementation Plan, to ensure TMA remains a strategic focus. Without policy direction, the efforts are dependent on the goodwill of the current TMA for FP TWG and donor support for the process and efforts are unlikely to be sustained over time.

4. **Issue**: ***Declining FP budget allocations*** following ***devolution***. The budget proportion for FP commodities in the county health budgets either does not exist or does not match the needs. Previously, national government was taking on an increasing share of the FP budget, financing approximately 40% of the commodities budget in FY2012/13. Furthermore, distribution of FP commodities to counties is dependent on counties' ordering from KEMSA. Therefore, if counties don't order for commodities KEMSA may not deliver to them resulting in stock outs.

Recommendation: Stakeholders need to carry out advocacy efforts with Council of Governors (COG) and health committee of the COG to ensure county level health budgets exist and are sufficient to meet FP needs. Advocacy is also needed to ensure more proactive prioritization of FP by Counties including development of FP CIPs in all counties

5. **Issue**: Lack of ***TMA for FP cost versus benefit analysis*** to guide and inform stakeholders' decision making. Stakeholders want to know what the cost of implementing a TMA would look like, and whether the potential benefits outweigh such costs. This would include detailed modeling to determine what the potential market sizes are for each segment of the market – free, subsidized, and commercial. Such information would also be key in convincing commercial sector to invest in bringing new products into the market.

Recommendation: Conduct a TMA cost vs benefit analysis. This is needed to inform policy dialogue and to convince policy makers of why the country needs to implement a TMA for FP.

6. **Issue**: ***Divergent stakeholder interests*** may impede TMA implementation.

Recommendation: Map key stakeholders and their interests and identify incentives for each stakeholder group to support a TMA. Stakeholders indicated that this is necessary because TMA will need market wide support to succeed. MOH stewardship is critical to the success of TMA in order to hold stakeholders accountable to the country's TMA road map.

7. ***Issue: Quality of the FP program*** throughout the supply chain including the quality of FP products. Stakeholders hold the view that the FP program owes its success largely due to the quality of FP products that clients have come to trust over time, essentially because there is one credible source of FP products used in the country, the MOH. They worry that opening up the market may compromise the quality of the program, especially the products coming in which may erode client confidence resulting in high rates of discontinuation and subsequent decline in CPR.

Recommendation: Stakeholders need to engage on how the quality of products would be monitored and ensured throughout the supply chain so that CPR gains are not lost.

Suggestions for further study and analysis:

- Willingness to pay studies
- Analysis of the cost vs benefit of implementing a TMA for family planning including the cost of targeting subsidies to deserving populations.

B.2. Recommendations from Madagascar:

1. **Issue:** The tax and import duties selectively applied to contraceptives are unduly increasing FP product prices in the commercial sector, hampering FP initiatives;

Recommendation: MoH should urgently request Government to lift the selective taxation of FP products.

2. **Issue:** Crowding out the FP market with highly subsidized SM FP products deters DWs and pharmaceutical firms from launching new contraceptives.

Recommendation: Once PF taxes will be eliminated, similarly to EC (the only contraceptive not imposed), which is a commercial success, donors, for the sake of sustainability, may consider partnering with the private sector, like what has been done by the Global Fund for Antimalarials.

3. **Issue**: The weak FP unit's institutional status hinders strong leadership of a TMA by the MoH;

Recommendation: Strengthen FP Unit's institutional position and provide Technical Assistance to improve its leadership & managerial capacities.

4. **Issue**: The problems some drug wholesalers and/or foreign pharmaceutical firms face with the drug registration and licensing procedures overviewed by the Drug Agency.

Recommendation: The Drug Agency to benefit from technical support to elaborate, communicate and apply transparent registering and licensing rules.

5. **Issue**: Despite expanding scope and coverage of FP methods including LARCs, FP users remain hugely biased in favor of injectable;

Recommendation: Accelerate LARC training countrywide, both in the public and the private sector.

6. **Issue**: Behaviour change communication (BCC) targeting FP users through the various media channels is not always optimal mainly because of significant behaviour differences among regions;

Recommendation: Given the very different cultural and behavioral characteristics between regions, BCC content must be specifically tuned to the regions.

7. **Issue:** Although the new FP Law when voted should allow a flexible application of texts regulating access to FP by adolescents, uncertainties persist regarding MoH leaders' view on this issue;

Recommendation: MoH should elaborate FP Law application taking into account all FP stakeholders' views while respecting Madagascar's cultural norms.

8. **Issue**: Lack of financial solution to transport costs of FP products between District pharmacies and peripheral public health centers

Recommendation: MoH and FP donors should consider: (i) a specific budget line to cover these costs; and (ii) selling FP products to CAs for a fee as is done at PSI supply points, and use these funds to finance the FP transports costs.

9. **Issue**: Doctors outside public sector, NGO and franchised networks are sometimes excluded from the provision of FP services and products, particularly LARCs. Pharmacies' staff are not trained to provide FP counselling.

Recommendation: The various health professional bodies should address, with NGOs' support, the FP training needs of private practitioners, midwives and pharmacy staff.

10. **Issue**: Due to the injectable leakage for pig fattening, MoH halted injectable supply to drug outlets and enforced stricter prescription requirements in pharmacies, compelling women to consult a doctor for a fee ten times more expensive than the SM contraceptive.

Recommendation: The MoH should assess to what extent injectable users were penalized by the restrictions and discuss possible solutions with the professional bodies like extending the prescription validity duration.

B.3. Recommendations from Uganda:

1. **Issue**: There is currently no TMA framework to guide the different actors in reaching out to populations in need in an effective and sustainable manner.

Recommendation: Develop a TMA strategy and implementation plan that takes into account all stakeholders' perspectives through a multi stakeholder approach including social marketing organisations, manufacturers, private commercial sector, development partners and civil society organisations to ensure buy in and ownership. The MoH should secure funding to implement the TMA plan. Take advantage of the SMO, private commercial and public sectors' comparative advantages for promotion of TMA.

2. **Issue**: There are no deliberate demand generation interventions by government within the different population segments in order to increase FP service uptake. This lack of demand activities has contributed towards the current low mCPR.

Recommendation: Government should take lead in community FP awareness creation so as to increase demand and use of FP services.

3. **Issue**: There is not sufficient stewardship at the MoH for the TMA initiatives. The current technical staff at MoH are insufficient in numbers and have limited knowledge about TMA.

Recommendations: Development partners should accredit a technical staff to sit in at MOH and coordinate TMA initiatives. Development partners should support efforts in creating awareness about TMA among all stakeholders.

4. **Issue**: There is limited government funding for FP services with the bulk being borne by donors. This makes FP service delivery unsustainable.

Recommendation: Step up evidence-based advocacy for increased government allocations for FP services in order to minimize donor dependency.

5. **Issue**: There are policy constraints in accessing FP services especially for in-school adolescents. This contributes to high levels of unwanted pregnancies and school drop-outs.

Recommendation: High-level advocacy for policy reviews should be undertaken to address gaps in FP service access by in-school adolescents.

6. **Issue**: There is limited knowledge about TMA, how it works and its benefits, which is likely to create resistance for its adoption

Recommendations: MoH should take lead in TMA education for government, private commercial sectors, NGOs, and religious and cultural leaders to increase awareness and support adoption of TMA. MoH should have an e-platform for information sharing on TMA.

7. **Issue**: Participation by the private commercial sector in TMA is very minimal. This contributes to suspicions about TMA by the private commercial sector, which can fail the initiative.

Recommendation: MoH should get the private commercial sector to play an active role in the TMA initiative, initially through participating in the TMA technical working group.

B.4. Recommendations from Zimbabwe:

1. **Issue**: *Low knowledge on TMA*- FP stakeholders' knowledge of Total Market Approach initiatives is limited, pointing to the need for sensitisation of all key stakeholders involved in the FP program. It is important to note that operationalising a TMA is a substantial task that can take up to 2 years, with intensive stakeholder engagements and participation.

Recommendation: The following are recommended steps in setting up a TMA for family planning in Zimbabwe:

- Establishment of a TMA committee led by MOHCC, co- chaired by ZNFPC and representatives of implementing donors and implementing partners

- Establish high level support, through TMA committee, for MOHCC leadership to lead policy engagements towards creating an enabling environment for a TMA initiative
- Carry our extensive stakeholder mapping across Zimbabwe (providers and outlets) across public, NGO and commercial sector, documenting challenges, gaps and recommendations
- Engagement of donors/multilateral organisation for strengthening TMA management and coordination

2. **Issue**: *Diversification for family planning financial sustainability* - FP program is almost entirely dependent on external funding for commodities. Government support has gone down considerably with the current support mainly addressing salaries and administrative costs, resulting in the program's being donor driven and unsustainable.

Recommendation: There is a need for high-level advocacy for increased budgetary allocation to family planning to reduce donor dependency. Alternative innovative financing mechanisms should be explored to sustain FP financing in Zimbabwe. This could include matched financing mechanisms to guarantee whatever minimum amount the government allocates towards the health sector budget and FP commodities, better targeting of subsidies towards the underserved, rural and lower wealth quintile users and increasing role and market share of private sector in meeting the FP needs of users with willingness and ability to pay.

3. **Issue**: *Private-sector participation in family planning*- current private sector membership to the family planning forum in Zimbabwe is too low, with mainly two commercial sector providers (PSMAS & CIMAS) representing commercial sector issues in the forum.

Recommendation: The MOHCC should consider high-level efforts to increase engagement and participation of the commercial sector entities in the FP forum so as to explore opportunities for growing the private sector FP market. This could be achieved by establishing public-private partnerships with commercial sector entities located in peri-urban and rural settings, for free or highly subsidised access to FP services and commodities.

4. **Issue**: *Market equity*- Zimbabwe's underserved vulnerable populations are poor, living in remote locations and mostly young people/adolescents of reproductive age. It is therefore the responsibility of the Government of Zimbabwe to ensure that the needs of underserved population are met. FP users in the top 60% wealth quintile may still be accessing subsidised services despite ability and potential willingness to pay for FP services.

Recommendation: MOHCC should initiate high level engagements with private for profit and non-profit entities to create and strengthen Public Private Partnerships for FP service delivery appropriate FP services to the right target market. Supply and service delivery channels should be reviewed to facilitate/move up FP users with willingness to pay from free to subsidised services and from subsidised to commercial services.

5. **Issue**: The shift in method mix towards LARCS amongst WRA 15-49 years between 2011 & 2015, suggests growing demand for LARCS particularly amongst rural women. However current discontinuation rates on LARCS suggest the need for health worker training in LARC insertion and removal in the public sector to ensure informed and quality service delivery.

Recommendation: MOHCC and ZNFPC should review best practices in LARC service delivery by the NGO and commercial sector and recommend scaling up across the FP market, particularly the public sector. Such scalable interventions have proven to be effective in FP service delivery in the

public sector, as in the case of the public sector social franchising program *(PROFAM)* supported by PSI.

6. **Issue**: Myths and misconceptions about FP planning may present barriers in equitable access to FP. The launch and publication of the book "Genetically Modified Organisms (GMOs) and Population Control Drugs in Developing Countries" may have changed perception on FP amongst current and potential users given the popularity of the author. This may negatively affect demand for FP, ultimately leading to failure in attaining Fp2020 commitments.

Recommendations: High level advocacy and communication efforts by MOHCC and ZNFPC should continue in order to counter the impact of FP demand on the Zimbabwean market. Demand creation efforts should be strengthened and targeted towards rural population given current existing disparities by residence, education, age and wealth.

7. **Issue**: The current tax system and registration process are regarded by the commercial sector as highly stringent and cumbersome with the process taking too long. The current FP market may not be lucrative enough to promote commercial sector importers and wholesalers to register and introduce new products on the market.

Recommendation: MOHCC should take a lead in engaging the Government of Zimbabwe in efforts toward creating an enabling environment for commercial sector service providers to grow the commercial FP markets. Such an environment could be created by providing import tax cuts and waivers on commercial sector procurement of FP commodities.

C.5.1 Way forward: Emerging Issues and Recommendations [Consensus Generation Meeting outcomes)

- The following emerging issues and recommendations, discussed at the consensus generation meeting, were agreed as a high level direction and the basis of development of more specific and detailed operational plan.
- Short, Medium and long-term recommendations were agreed for the 1-2, 3-4 and 5-7 years respectively.
- No contributions were made by donors yet, with regards to financing the planning, inception and implementation of a TMA initiative in Zimbabwe.
- However recommendations were made to leverage existing resources and platforms to kick start TMA activities amongst relevant responsible entities.
- Donors and NGOs were also encouraged explore ways of support the TMA initiative in Zimbabwe.

C. Recommendations regarding the Smart Condom Dispensers

Table 25: Conclusions and recommendations regarding Smart Condom Dispensers

Findings/conclusions (What?)	Recommendations (so what?)
Condoms to be widely available and very convenient to access	Target smart condom dispenser in risky areas (night clubs, bars and red district neighborhoods) as well as around universities and tertiary schools.
Condoms to be available at a range of prices, to serve all segments based on ability to pay.	Include representatives from public, subsidized and commercial markets to ensure that all brands are included in smart dispensers.
Quality control standards and vending maintenance to be respected according to national	Develop quality standards for smart condom dispensers to ensure adherence to storage and maintenance standards, and uninterrupted supply of condoms.

guidance (storage).	
High levels of unmet FP needs due to legal restrictions and limited FP responsive services	Provide condom dispensers in places of entertainment, Advocate for policy review to address limited access to FP services by adolescents in school
Particularly vulnerable are young girls who are at risk of unwanted pregnancies and STI/HIV due to limited bargaining power for safer sex, and limited information about FP choices and service availability	Segment youth population to provide age appropriate condoms/brands.

IX. LESSONS LEARNED & RECOMMENDATIONS IN TMA ANALYSIS IN EAST AND SOUTHERN AFRICA

A. Lessons Learned

This final section of the regional report lists lessons learned from the regional consultant's experience in facilitating a TMA study for FP across four ESA countries, as well as recommendations for future TMA studies.

1. The regional study was led by the regional consultant (Chastain Mann, from Mann Global Health) and her team, in close collaboration with locally based consultants, who were responsible for conducting in-depth country studies with support from the national UNFPA offices. National consultants applied the methodology and tools developed by the international consultant and her associates.
    a. The regional consultant was not involved in the selection or recruitment of the national consultants and had no line-management authority over the national consultants. National consultants reported to the UNFPA focal points.
    b. The overall workload to be tackled in the short implementation period (October - December) was intense, and could only be managed by a dedicated team. Two of the Mann Global Health team members were based in the same or nearby time zones as the national consultants, and were available for ongoing and frequent support to the country teams.
    c. Managing logistics and communication flow with all four countries from a distance was a challenge; lack of reliable high-quality internet access posed difficulties in most countries for both skype and webinar calls.
    d. The quality and timeliness of the national reports varied considerably across the four focus countries.
    e. The level of involvement and support from UNFPA focal points also varied across the four countries.
    f. Senior national consultants with social marketing experience needed the least assistance and guidance from the regional consultants and developed the highest quality reports.

2. Good analysis depends on the availability of good data, and good data are often hard to obtain. The quality of data was variable across market sectors.
    a. Personal relationships and good networking with health professionals and organizations were important for regional and national consultants to successfully

approach stakeholders and gather insights, and to collect information on national and regional levels.
    b. Little data are available from the commercial sector, so that leadership from MOH, UNFPA and other influential organizations is needed to persuade commercial players to share their information.

3. The TMA landscaping exercise represents the first step and the easier part of TMA, where each country assembles the evidence for a TMA and begins to engage with stakeholders. The application of total market initiatives is far more complex.
    a. The translation of the national recommendations into practice requires alignment of key stakeholders from all sectors around a TMA plan designed to shape FP markets. This assumes that clear roles and responsibilities are assigned to all actors to implement, monitor and evaluate the plan.
    b. Stakeholders may have their own agendas, and in some cases, there are overlaps in funding from different donors and or implementers for the same or similar activities.

4. The virtual regional meeting that was held mid-December 2016 using the *bluejeans* application to replace the face-to-face workshop constituted a promising experience for this type of regional TMA study.
    a. It is possible to use virtual platforms to share and discuss TMA progress and findings.
    b. For this to be successful, a well-planned facilitated agenda should be agreed upon beforehand.

B. Recommendations

1. The regional consultant must be involved in the selection, recruitment and management of national consultants, and ideally have line-management authority and/or be the contracting entity.
2. It is helpful to select national consultants who live and work in the country they assess for TMA, so that they have knowledge of the local context and connections with key stakeholders. However, even more important than hiring locally is to hire experienced "boots-on-the-ground" consultants who are well versed in total market approaches and techniques. Ideally, the consultant should have both sets of qualifications.
3. Implementing the TMA studies simultaneously in four countries with distance support from regional consultants worked and could be improved with innovative approaches to be tested in the future, such as pairing 2 countries together, to enable mutual exchanges and support amongst the national teams.
4. All national consultants need to have reliable internet access and/or phone accessibility.
5. Active involvement and support from national UNFPA COs and teams needs are required for a smooth implementation of the national studies. Advocacy from UNFPA ESARO should be reinforced to assure relevant availability and support of national UNFPA CO teams to provide data, information, and political support for the data collection, stakeholder interview planning, and workshop preparation and coordination.
6. And finally, predictably, more time should be allocated to the TMA process to ensure the quality of the data and the depth of stakeholder involvement. Ideally, UNFPA support would stretch to include not just the initial steps of documentation/assessment and stakeholder workshops, but also the more complex work of achieving stakeholder alignment and leadership, to begin the hard work of market shaping.
7. UNFPA ESARO and regional consultants should use virtual platforms like *bluejeans* for the inception, implementation and sharing of findings and lessons learned for future regional TMA studies.

REFERENCES

Barnes, Jeffrey, Janet Vail, and Dawn Crosby. 2012. *Total Market Initiatives for Reproductive Health.* Bethesda, MD: Abt Associates, Strengthening Health Outcomes through the Private Sector Project. Retrieved from: http://abtassociates.com/AbtAssociates/files/1e/1e8e3ce0-e800-4b27-bc4f-c40ed8efcd95.pdf

Brady C, Weeden L, Hutchings J., Parks, J. 2016. *Planning Guide for a Total Market Approach to Increase Access to Family Planning. Module 1: Landscape Assessment*. Seattle, WA: PATH and Washington, DC: The Population Council, Evidence Project. Retrieved from: https://www.path.org/publications/files/RH_tma_icfp_module1.pdf

Brady C, Weeden L, Hutchings J., Parks, JR. 2016. *Planning Guide for a Total Market Approach to Increase Access to Family Planning. Toolkit and Glossary*. Seattle, WA: PATH and Washington, DC: The Population Council, Evidence Project. Retrieved from: www.path.org/publications/detail.php?i=2575

Cardno Emerging Markets (EA) Ltd; *Diagnostic Assessment of Kenya's Family Planning Market:* Support to the ESHE Programme; Prepared for Palladium Group; September 2015.

Hanson, Kara , Lilani Kumaranayake and Ian Thomas. *Health Policy and Planning*. 2001. 16 (2): 125-136: "Ends versus means: the role of markets in expanding access to contraceptives". Oxford University Press.

Meekers, Dominique, Sarah C. Haynes, and Kathryn Kampa. 2016. *Handbook for Research on the Family Planning Market. Volume 1: Using Data to Inform a Total Market Approach to Family Planning*. Chapel Hill, NC: MEASURE Evaluation, University of North Carolina. Retrieved from: https://www.measureevaluation.org/our-work/family-planning/tma-resources

Pallin, S.C., D. Meekers, K. Longfield, O. Lupu. November 2013. *Uganda: A Total Market Approach. PSI/UNFPA Joint Studies on the Total Market for Male Condoms in 6 African Countries*. Retrieved from www.psi.org/total-market-approach

Population Services International. 2016. *PSI's Market Development Approach: Fact Sheet*. Washington, DC: PSI. Retrieved from: www.psi.org

Population Services International. 2011. *Total Market Approach to Family Planning in Cambodia: A Case Study*. Washington, DC: PSI. Retrieved from: www.psi.org and http://pdf.usaid.gov/pdf_docs/PBAAC073.pdf

Programme for Accessible Health, Communication and Education (PACE), *Total Market Approach. Ugandan FP-Condoms Total Market*, August 22, 2016. Social Marketing Activities. USAID. PACE. UHMG. (*unpublished presentation*)

The Springfield Centre. 2015. *The Operational Guide for the Making Markets Work for the Poor (M4P) Approach.* 2nd edition funded by SDC & DFID. Retrieved from: http://www.enterprise-development.org/wp-content/uploads/m4pguide2015.pdf

UNICEF, WHO. 2015. Countdown to 2015: *A Decade of Tracking Progress for Maternal, Newborn and Child Survival*.The 2015 Report.

USAID | DELIVER PROJECT, Task Order 4. 2015. *Contraceptive Security Index 2015: Global Efforts Yield Significant Dividends* in Contraceptive Security Arlington, Va.: USAID | DELIVER PROJECT, Task Order 4.