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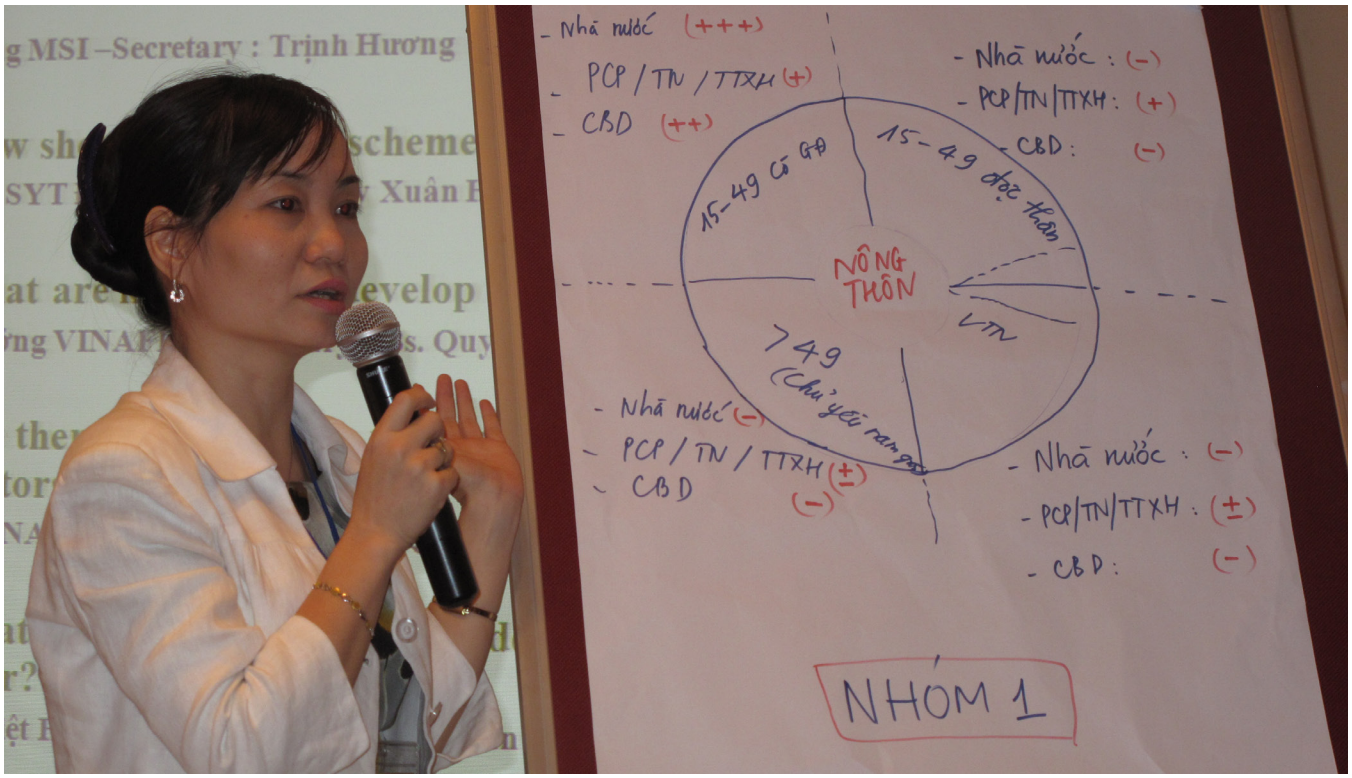
Total Market Initiatives for Reproductive Health



PRIMER

Reproductive Health Supplies Coalition

PATH

SHOPS
Strengthening Health Outcomes *through* the Private Sector

Summary: This primer documents the work of members of the Market Development Approaches Working Group of the Reproductive Health Supplies Coalition in defining and implementing total market initiatives (TMI). A TMI in reproductive health is a process in which the suppliers and financers of reproductive health products and services from across sectors—public, nonprofit, and commercial—develop a common strategic framework for maximizing use of reproductive health products and services to improve equity, efficiency, and sustainability in the health system. In addition to defining the concept and providing practical examples, the paper discusses when TMIs should be implemented, the process for implementation, and what indicators should be used to measure their success.

Keywords: family planning, reproductive health, total market approach, whole market approach

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Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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Total Market Initiatives for Reproductive Health

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1: Background

Policymakers and managers in reproductive health are increasingly aware that the most effective strategies for meeting the reproductive health needs of consumers must engage all sectors that supply reproductive health products and services: the public sector, the private nonprofit sector, and the private commercial sector. Having the public and nonprofit sectors provide subsidized services for needy consumers while maintaining sustainable commercial provision for consumers who are able to pay is often referred to as a "total market" or "whole market" approach. Many reproductive health organizations have adopted a total market approach for their sourcing of products and provision of services. Adopting such an approach more widely would lead to more rational use of limited resources, ensuring access to reproductive health products and services for all consumers.

Since 2007, the Market Development Approaches Working Group of the Reproductive Health Supplies Coalition has strongly advocated for the total market approach as an alternative to almost exclusive reliance on the public sector. However, even as MDAWG members supported the total market concept, they debated the form that an ideal approach would take, and realized there were no examples of how a country had moved from a single sector approach to a total market approach in its reproductive health planning and programming. To address this gap, the MDAWG members and the organizations they represent began to operationalize the total market theory by designing and implementing total market initiatives (TMI) intended to reorient government health policymakers and reproductive health program managers from a single sector focus to a total market perspective and thus increase access to reproductive health products and services efficiently and equitably.

The purpose of this primer is to document the TMI experiences of several countries and thereby inform policymakers and program managers about TMIs: what they are, which are appropriate for different country contexts, and what the steps are in implementation. The lessons learned from the country case studies can be used to advocate for stronger government stewardship of TMIs and to guide implementation of future TMIs. The primer draws on the many discussions of the MDAWG as well as the operational experiences of different member organizations.

2: The TMI Concept

A TMI in reproductive health is a process in which the suppliers and financers of reproductive health products and services from across sectors—public, nonprofit, and commercial—develop a common strategic framework for maximizing use of reproductive health products and services to improve equity, efficiency, and sustainability in the health system.[1] Throughout this primer, the authors use terms such as "approach," "framework," "initiative," and "plan." The total market concept remains the same throughout, but each term refers to a different aspect of the concept. For example, a total market approach involves an implementing organization using total market

[1] In this primer, we refer to the health system, which includes the market for reproductive health products and services. Where public health professionals see a health system, marketers and commercial suppliers see a market. Each refers to the same set of players, processes, and regulations.

concepts to identify which suppliers of products, services, or information in the health system could increase its role or improve its targeting and then design a technical assistance package to use those suppliers to best serve consumers in the market. A total market framework establishes broad principles and objectives to guide all health system actors, but does not specify operational activities. A TMI is a project (or activity within a project) funded specifically to implement total market activities (e.g., conducting market segmentation analysis, stakeholder engagement, developing a whole market framework and plan). Lastly, a total market plan is often an output of a TMI; it outlines which activities will be conducted by which actors in order to achieve specific framework objectives, and it includes some level of commitment to adhere to the framework principles.

A TMI will orient reproductive health financers and suppliers to the consumer segments in the reproductive health market that they are most suited to serve. (See Section 4 for more information about the TMI process.) Each sector has a comparative advantage that enables it to meet the needs of different consumer segments and facilitate policies and strategies that relate suppliers and consumers in a way that increases efficiency and sustainability. A consumer segment can be defined by various factors including socioeconomic level, age, geography, parity, cultural and religious beliefs, product preference, and other psychographic or behavioral features. Modern marketing techniques have demonstrated that these factors define consumers' preferences for different products and services, their willingness to pay for them, their preferred place to obtain them, and their susceptibility to brand and promotional messages. For example, consumers who want to obtain their contraceptives conveniently and discreetly, and who are influenced by professional branding and willing to pay for branded products, are likely to be served most effectively by commercial suppliers.

In order to apply this core principle, information on financing sources, suppliers, and consumer segments must be available and understood. This means that to the extent possible, TMI strategies should be informed by up-to-date, accurate data about the consumer segments in the market and the resources and capacity of the suppliers as well. As seen above, there are numerous ways to segment consumers in a market. Government priorities will dictate how this is done in an individual TMI.[2]

Indeed, the MDAWG recognizes the centrality of government in engaging all players in the reproductive health market, and recommends that TMIs be implemented under government stewardship.[3] This is because the state is the natural owner and steward of national health strategies and because it has the convening power to bring all stakeholders together. Also, the state enacts regulatory functions that influence implementation by private actors. The state may provide products and services through its own public sector-financed and managed programs or may rely on the private sector for some or all of the services it supports, for example, through a voucher system, national insurance scheme, or government-contracted services.

[2] The MDAWG helped produce a primer on market segmentation that summarizes many of the ways to segment consumers (Private Sector Partnerships-*One* Project, 2009).

[3] This vision of a total market approach led to the design and implementation of two TMIs that were supported by the RHSC Innovation Fund and are documented on the RHSC website (http://www.rhsupplies.org/working-groups/market-development-approaches/facilitating-public-private-collaboration/total-market-initiative.html). Other MDAWG members have experimented with TMIs in countries of Latin America and the Caribbean, West Africa, and Vietnam.

Or, the state may simply enact policies that allow nonprofit organizations to operate and support an active commercial market.

While the state may be the leader and convener of the TMI, private entities must play an active and facilitating role. In some cases, they may have to be the catalyst that encourages the government to effectively assume its role as steward. The private sector entity could be a reproductive health supplier or a technical assistance organization that specializes in data analysis, policy dialogue, or demand forecasting and planning. As shown in the case of Ivory Coast in Box 1, the greatest need for a TMI often occurs where governments are weak, under-resourced and/or lacking information needed to lead policy initiatives. In such circumstances it may be both necessary and desirable for one or more private sector partners to help the government play its stewardship role.

It should be noted that there are other types of government-private sector engagement, such public-private partnerships, but these differ from the total market approach in that their scope typically looks beyond the needs of a specific health market. Public-private engagements usually address regulatory issues affecting the broader health system, or strategies to leverage private investment in the health sector.

Box 1. Ivory Coast Case

Under ideal circumstances, the total market approach involves rigorous data analysis of consumer use, preferences, willingness, and ability to pay for reproductive health products and services. This analysis informs a government-led policy dialogue around the optimal targeting of various consumer segments by different suppliers of reproductive health products and services. However, in many countries, decisionmakers lack reliable data to inform policy and programming decisions and may have limited operational capacity to oversee private sector actors. In the Ivory Coast in 2010, the local social marketing organization, AIMAS, was struggling to improve its contraceptive sales under a grant from the German development bank, KfW. One of AIMAS' major challenges was the impact on its sales of free distribution of products from other HIV prevention and family planning programs to residents in urban areas who might otherwise be AIMAS customers. AIMAS did not have consumer data to prove this, but other organizations faced the same challenge, also due to lack of coordination of suppliers. Charged with providing technical support to AIMAS, Abt Associates suggested that AIMAS help the government play a greater role in coordinating different funding and implementing partners in reproductive health.

AIMAS organized a one-day workshop for donors and implementers involved in the procurement, distribution, and promotion of contraceptives including the Ministry of Health's Division of Reproductive Health, the Ministry of HIV/AIDS, the United Nations Population Fund, the local affiliate of the International Planned Parenthood Federation, other local nongovernmental organizations, and commercial contraceptive suppliers. The objective was to promote a more coordinated approach to contraceptive programming, one that takes into account players from the public, private nonprofit, and private commercial sectors. The meeting included some sharing of available data and a review of total market principles. The practical exercises involved sharing among the partners of recent and planned activities for contraceptive procurement, distribution, and promotion.

This exchange immediately led to opportunities to improve efficiency and sustainability through cost saving and better targeting. The IPPF affiliate realized it could procure some of the Ministry of Health's excess supplies of injectables instead of conducting its own international procurement. The Global Fund prime recipient realized that it needed to better coordinate condom distribution activities with the social marketing organizations because there was an imbalance of condom distribution and promotion activities in the large

southern cities and towns and no organization providing similar efforts in northern towns. Significant changes made to partners' plans based on the information learned at the workshop resulted in a better use of resources for contraceptive programming. The outcome of the meeting was a plan to create working groups that would exchange information on existing stocks, procurement plans, distribution strategies, and communications strategies. While government leadership has still not been as strong as desired, it has sanctioned coordination efforts that have led to reduced duplication of efforts.

3: The TMI Process

A TMI is essentially a government-led intervention to improve efficiency, equity, or sustainability in the financing and provision of health products and services in a defined market such as reproductive health. While the focus of this paper is on the market for reproductive health products and services, the TMI concept can be applied to other health markets. For example, Roll Back Malaria has provided guidance on defining the roles of the public sector, the private nonprofit, and the private commercial sector with respect to provision of insecticide-treated nets and antimalarial drugs and supported country planning that follows total market principles.

From the experiences observed, the need for a TMI is most likely to be felt by key stakeholders in one or more of the following circumstances:

1. A number of donor-supported suppliers exist in the health market but there is little coordination of investments or activities, leading to oversupply for some population segments and undersupply for others.

2. Subsidized suppliers (using donor or public sector resources) are undercutting and displacing commercial suppliers or each other in the health market, reducing sustainability of reproductive health provision. Subsidies are reaching consumers who are willing and able to pay for commercial sources of supply, while low-income groups may be underserved.

3. Subsidized provision of reproductive health products and services is being phased out by donors or government and there are concerns that some population segments will be underserved as a result of subsidy removal.

The likelihood of these circumstances occurring often depends on how developed the market is for reproductive health products and services. The stage of market development is determined by the size of the market (both in numbers of consumers and the value of products sold), the number of suppliers, and the variety of consumer tastes that demonstrate different market segments. Although market development is a continuum, to illustrate the differences, Annex A shows the kinds of differences that exist between early, developing, and mature stages and what types of interventions may be appropriate for each stage.

In a mature market, TMI strategies are likely to involve what are often referred to as "market development approaches" (Gardiner et al., 2006), which involve increasing the role of commercial and financially sustainable reproductive health provision. For market development approaches to be successful, a market has to have sufficient size regarding the number of women of reproductive age, contraceptive prevalence rate, current users, intent to use, and product volumes distributed and sold. A market also must have a potential for profit (for example, ability to pay and general business climate). See Annex B for a detailed description of total market indicators and the issues regarding their interpretation and measurement.

Despite differences in market development, the key criterion for determining whether a TMI is appropriate is the degree to which the different providers of reproductive health products and services (government, nongovernmental organizations, social marketing organizations, commercial manufacturers, and distributors) feel the need to coordinate their efforts to maximize coverage, minimize duplication, and efficiently serve different market segments. As with any policy process, when there is strong interest and a felt need among stakeholders, it is easier to facilitate dialogue and produce reform. This seems to occur most often when a country has experienced problems of coordination and duplication. However, policymakers should ideally champion a TMI before there are problems or before the market has developed to a level where coordination and duplication issues are likely to occur. Wider adoption of total market principles in policymaking at an early stage of market development will go a long way toward preventing inefficiencies or inequities.

The key criterion for determining whether a TMI is appropriate is the degree to which providers of products and services feel the need to coordinate efforts.

4: Implementing a TMI

The process for implementing a TMI is not a science, and different country situations will influence the steps that are needed. The experience of the MDAWG members is captured in the process outlined below. Note that the steps may overlap or occur in a different order; regardless, it is important for the government and its partners to engage and convene diverse stakeholders (steps 1, 5, and 6), collect appropriate evidence (steps 2, 3, and 4), and apply it to develop a total market plan (steps 7 and 8). The country examples provided throughout the primer demonstrate how these steps have been applied differentially—sometimes with only a few of the following steps.

Step 1: Assess or catalyze government interest in and capacity to pursue a TMI under its leadership.

Because a successful TMI depends on the government providing leadership and convening the process, it is critical for the government to demonstrate ownership of the process. The government must see the potential of a TMI to resolve problems that it feels are important. In some cases, the government may already know the benefits of engaging the private sector, or it may already be facing phase-outs of donor-supported products. Government officials responsible for family planning

programming may be facing budget concerns. In other cases, impetus for a TMI may be from donors or other partners working in the country.

If a private technical agency is supporting the government to build capacity in leading the initiative, both would benefit from a formal agreement. A written document enables discussion and agreement on objectives and potential TMI activities, as well as responsibilities and timelines. In addition, the discussion while drafting an agreement is useful as it can reveal government understanding and sensitivities about total market concepts and concerns. Finally, government partners and leaders change over time—because of elections, restructuring, coups, or reassignment and retirement of individuals—thus greatly influencing the ability of family planning authorities to convene stakeholders and implement plans. Attention to these potential shifts is a critical part of any TMI planning and implementation.

Linking TMI plans to government health strategies and processes can help ensure that the plans will be sustainable.

It is helpful to have a clear understanding of broad family planning policies, strategies, and plans and where the government is in its planning cycle (e.g., midway through a 10-year plan, drafting a new 10-year plan, etc.). Linking and integrating the project to these documents and processes from the start can help ensure that any final TMI plans will be actionable and sustainable.

Step 2: Collect available data on the current family planning market and its potential, as well as additional data on supply chains, consumer behavior, and major stakeholders.

To conduct a TMI, background information is needed about the current family planning market as well as future projections of need and demand. Data availability varies significantly by country, but most developing countries will have recent demographic and health surveys or similar population-based surveys that document consumer knowledge, attitudes, and practices related to reproductive health products and services. This provides information about the size of the market—the number of users, the CPR (including modern contraceptive methods or the modern CPR), use by contraceptive method, and intent to use. Such surveys usually provide information about socioeconomic status of contraceptive users; this is important since it can help show which groups have unmet demand and where different categories of users (by wealth quintile) source their products. For an example of application of such data, see Box 2.

Social marketing sales statistics and research are another source of information that demonstrates the extent that clients are willing to pay for products. Commercial sales and pricing data are often more difficult to obtain because they are often proprietary information, but survey reports can sometimes be purchased for particular methods and channels, such as oral contraceptive sales in pharmacies. Such commercial surveys can demonstrate product price ranges, the size of the total market, and the market share of unsubsidized brands. These surveys may also be

used to determine which manufacturers may be important stakeholders in developing a total market plan. Leveraging data available through private actors who are partners or suppliers to the government can also be useful in helping policymakers understand the broader market and relative importance of different players in the market.

Box 2. Using DHS Data: Paraguay

Data from Paraguay's Reproductive Health Survey show an increase in contraceptive prevalence among women in union of reproductive age, from 73 percent in 2004 to 79 percent in 2008.

During the same time period, government support for family planning improved and USAID invested in strengthening the national family planning program. Consequently, the public sector played a greater role in providing family planning services and products—from 36 percent of the market in 2004 to 42 percent in 2008. Factors in the expansion of the public sector's family planning program included Ministry commitment to national family planning coverage, a protected line item in the national budget for contraceptives, and improvements in family planning logistics.

The SHOPS project analyzed the market segmentation of the Paraguayan contraceptive market with emphasis on sustainability of progress against family planning indicators. Given USAID's graduation of Paraguay health programs in 2012 and the rapid growth of the public sector, the objective of the analysis was to determine if the growth had negatively affected the private sector. This analysis concluded that:

- Between 2004 and 2008, Paraguay experienced an influx of users from the lowest income quintiles, rural areas, and the northern region. All three segments were more likely to use the public sector and may have been encouraged to do so by increased availability of products and services in this sector.
- The overall increase in the use of pills and injectables compared to longer-term and traditional methods reflected a sourcing pattern that favors sources such as health centers, but also pharmacies, which continued to attract most users from the higher-income quintiles.
- Users from the lower two quintiles were more likely to source from the public sector in 2008 than in 2004. At the same time, a larger portion of the middle and upper two quintiles sourced from the private sector, specifically from pharmacies. Therefore, in terms of sourcing patterns, segmentation improved as the public sector grew.

This double effect—a **larger** proportion of a **larger** user population from the lower two quintiles sourcing from the public sector—explains how rapid growth in the public sector could happen without detrimental effects to the private sector.

USAID/SHOPS is providing technical assistance to the Social Security Institute to increase its role in family planning; to the multisectoral contraceptive security committee which will assume the leadership role in continuing the total market approach; and to the local IPPF affiliate, the Paraguayan Center for Population Studies, to become more self-sufficient.

Analyzing data for a total market analysis of family planning services, particularly for long-acting and permanent methods, can present special challenges. In many countries, these methods are the least used, so the market size and the demand level in a given catchment area can be difficult to quantify. Moreover, the presence of commercial service providers who are qualified to offer these services does not mean that the providers are able or interested in providing these services. If the public sector offers

intrauterine devices, implant insertion, or sterilization services at no or low cost, then commercial providers may not feel it is worth their while to develop the skills to offer these services. Even when commercial providers are trained to offer these services, there may be too little demand in their market to maintain their skills and they will no longer be able to provide the services. Another complication occurs when providers work in both the public and private sector and clients are counseled in one sector and referred to another sector for service provision by the same provider. Analysis of the availability of service provision must take into account provider scopes of practice and possible differences between official scopes and what is actually practiced. For example, regulations may require that doctors insert IUDs, but the reality may be that nurses and midwives are also providing these services. Finally, analyzing provision of IUDs and implants involves determining the availability of commodities *and* service providers, adding a layer of complexity to the analysis.

Policies that affect the supply of and demand for reproductive health products and services affect participation of the private sector.

Surveys may have already been conducted on willingness to pay for specific contraceptive methods. If not, data are needed to determine if cost-sharing is feasible and among which categories of clients.

Data availability may also vary by regions within each country.

Step 3: Review relevant policies that affect contraceptive procurement, financing, distribution, promotion, and the general business environment.

In addition to data on consumers, procurement, commodity forecasts, sales, and distribution, it is important to collect and review policies that affect supply of and demand for reproductive health products and services. These policies can affect not just participation of the private sector and thus the success of TMI implementation, but also flexibility within the state sector to shift tasks and product provision within its system. Policies that may affect the supply of and demand for reproductive health products include import and tariff regulations, price controls, pharmaceutical regulations determining whether products can be sold over the counter, product registration, local industry preferences, quality control mechanisms, and professional medical regulations on who can dispense reproductive health supplies and services and how. Pharmaceutical regulations also restrict brand promotion and product packaging and can therefore impact product uptake. For an example of how policy can affect the total market, see Box 3.

Box 3. Policy Review: Madagascar

With a fertility rate of 4.8 children per woman, Madagascar's population continues to grow. In September 2007, the government declared that all contraceptives would be provided free of charge to clients in the public sector. This resulted in some impressive gains: total fertility rates decreased, CPR increased, and unmet need decreased. However, the policy change also resulted in a number of challenges for contraceptive security.

Marie Stopes International and Futures Group collaborated to use data from the Madagascar DHS 2009 for market segmentation analysis. The project used the asset-based wealth index developed by ORC Macro and the World Bank to classify currently married women of reproductive age according to socioeconomic status. The analysis revealed the following issues:

1. Although the government had a line item for procurement of contraceptives, the overwhelming majority of contraceptives were provided by donors. District authorities were still obligated to cover the costs of transporting contraceptives to health facilities, but no longer had the funds to cover the costs, putting districts at risk of stockouts.
2. Introduction of free contraceptives in the public sector resulted in declining sales in the commercial sector, resulting in greater reliance on limited public sector resources.
3. Clients who could pay used contraceptives provided by the public sector; unmet need for family planning persisted across all socioeconomic groups.
4. The policy environment posed challenges for the private sector. Taxes on contraceptives discouraged private sector participation and free public sector contraceptives discouraged scale-up of commercially priced products.

After a TMI consultation process, stakeholders from the Ministry of Health and Ministry of Finance agreed to:

1. **Increase public sector funding for contraceptive procurement and transportation.** The MOH would develop objectives for funding.
2. **Strengthen public-private partnerships.** The MOH together with stakeholders would develop an action plan with a formal policy paper on public-private partnerships for family planning services.
3. **Segment the market to appropriately target clients with public and private sector resources.** The advisory group, in partnership with the MOH, would determine where the resources should be targeted.
4. **Remove taxes on contraceptives.** The MOH, in consultation with the Director of Finance and Budget, would propose a law amendment.
5. **Promote social marketing initiatives.** The Director of Safe Motherhood would frame a social marketing policy and disseminate it at the Council of Ministers meeting to demonstrate the role of the private sector and potential for social marketing.

Step 4: Perform market segmentation analysis.

There are many different approaches to grouping and analyzing the market segments using the data collected in Step 2. The primer produced by the Reproductive Health Supplies Coalition and the Private Sector Partnerships-*One* project (PSP-*One* Project, 2009) provides information on the different approaches, advantages, and disadvantages to each approach. As noted in the primer, market segmentation is a tool to learn more about existing and potential clients in order to reach them, effectively meet their needs, and increase demand. In terms of TMIs, it can provide policymakers with information about the needs of different

population segments, which segments of the private sector could serve, and how to target public resources to address market inequities.

For an example of market segmentation data collection and analysis, see Box 4.

Box 4. Segmentation Analysis: Honduras

The CPR in Honduras grew steadily from 41 percent in 1987 to 62 percent in 2001, an increase of 21 percentage points in 14 years. However, growth slowed from 2001 to 2006, when the CPR grew to 65 percent, only three percentage points in almost five years. During the same time period (2001 to 2006), unmet need grew from 11 percent to 17 percent. In an effort to address unmet need using a whole market of actors and their respective resources, Abt Associates launched a TMI in Honduras in April 2009 with funding from the Reproductive Health Supplies Coalition, and later from USAID through the SHOPS project.

Abt Associates and John Snow, Inc. conducted market segmentation analysis using 2005/2006 DHS data and IMS* retail pharmacy data from 2005 to 2010. Four preliminary market segments were defined:

1. Young women in union with an average of two children and want to space
2. Young women in union with an average of three children and think they want to limit
3. 30-somethings with an average of four children and are sure they want to limit
4. 40-somethings who have on average 5.6 children and don't want more children but are not using a family planning method

Following quantitative analysis, the team conducted qualitative research by segment. Additionally, in-depth stakeholder interviews with over 20 stakeholders were conducted. The activity concluded with a large stakeholder workshop in March 2010 to present the findings of the segmentation analysis and discuss ways to address unmet needs through improved coordination and segmentation. The workshop was attended by more than 45 participants from 30 organizations from the public sector, nongovernmental organizations, social marketing organizations, the donor community, professional associations and academia, and the commercial sector.

The TMI project achieved the following results:

1. Reactivated the Honduran Contraceptive Security Committee.
2. Engaged new members, especially from the commercial sector, including two condom distributors and five drug companies (including two regional drug manufacturers).
3. Established working groups within the Contraceptive Security Committee: monitoring and evaluation, market segmentation and targeting, policy, and procurement and forecasting.
4. Began discussions of introducing new products to the new market, such as Jadelle implants.
5. Facilitated MOH acknowledgement of the need to strengthen family planning programs in rural areas where unmet need was highest.

**Intelligent Marketing Solutions, a global marketing company that provides market research data, merchandising services, and auditing of product and promotion activities at retail level.*

Step 5: Interview stakeholders.

Stakeholders are defined as service providers, government bodies (for health, financing, and planning), donors, product manufacturers and distributors, professional associations, and beneficiary representatives. Determining the purpose of the interviews is a critical step in building an initiative and identifying supporters and opponents, and those who can develop or influence policy. Often, a TMI is described in terms of political will; a stakeholder analysis can yield information about the limits of authority and resources, and what is needed to change viewpoints and ultimately policy. For example, stakeholder analysis can determine why decisionmakers have implemented the program, reasons for opposition, overlapping roles of various stakeholders, and activities and messengers who can influence those in power. Previous experiences with stakeholder analysis have helped identify the relationships and depth of networks that family planning stakeholders have with each other, and identify stakeholders who should be invited to join coordinating bodies (see Step 6). Stakeholder interviews can also serve to identify key obstacles and opportunities to implement a TMI. At a minimum, a stakeholder analysis can also serve as an initial point of contact with many key groups and provide an opportunity to introduce TMI principles.

For an example of engaging stakeholders and applying evidence, see Box 5.

Box 5. Engaging Stakeholders: Vietnam

As Vietnam transitioned to middle-income status, donors ceased donations of clinical contraceptive supplies, causing a large projected shortfall in the family planning budget. At the same time, the number of women of reproductive age is increasing, with an expected peak of 27 million in 2015, remaining at that level until 2025. This is the largest-ever generation of young people in the demographic history of Vietnam. Increasing demand and scarce resources therefore motivated the government to develop a total market plan for family planning. In addition, the national strategy for population and reproductive health from 2010 to 2020 called for the government to prioritize free contraceptives for poor and vulnerable groups, while enhancing social marketing and sales of contraceptives in commercial markets to those who can afford to pay. This motivation was an important success factor in the development of the plan.

PATH signed an agreement with the family planning division of the MOH to support creation of a coordinating mechanism and develop a total market plan for family planning. Since a coordination committee did not exist, a technical advisory group was created to engage stakeholders. Despite the language in the national strategy to engage commercial channels, an early lesson learned was the importance of finding acceptable terms to describe and translate a total market approach, since the concept of markets in the health sector was not widely understood. One concept that was more accepted was the notion of diversifying financing sources to sustain family planning.

Interviews with 38 stakeholders confirmed strong support for public sector leadership of public-private coordination (Drake et al., 2011). When stakeholders were asked what information was needed to implement a total market approach, most reported data about ability and willingness to pay for clinical contraception, products available in the commercial sector, and their prices. To obtain this information, PATH engaged the Futures Institute to reanalyze and compare two pre-existing data sets about ability and willingness to pay. This reanalysis identified groups for whom private services might be appropriate, where the services should be offered, and for which contraceptive methods. This was an example of pre-existing data being reanalyzed relatively inexpensively. IMS data were

commissioned about oral contraceptives and emergency contraception sales and prices in pharmacies, and these were compared to pre-existing data about out-of-pocket expenditures for medicines by wealth quintile. Because the government wanted to provide free services for the poor, these groups were identified using the population lists from the health insurance program (which does not include family planning). Finally, family planning service costs at different levels of the public system were collected and calculated to develop budget projections and fees to be introduced in the public sector for clients who can afford to pay.

These data were then shared with stakeholders at the national and provincial levels to gauge their interest and obtain input on developing an operational plan. At the first meeting of more than 70 stakeholders from 35 organizations, the government committed to private sector involvement in family planning policy and programming, private sector stakeholders expressed interest in participating, a potential list of key steps to develop a total market plan was generated, and participants suggested how the Vietnamese family planning market might be segmented. Goals and objectives of the plan and an outline were then developed and shared again with a smaller group of 30 participants. This second meeting was helpful to prioritize that the family planning division wanted initially to focus on a plan for clinical contraception (IUDs, injectables, implants) rather than oral contraceptives and condoms. The family planning division established a small internal working group, with support from the Ministry of Finance and the Ministry of Planning and Investment, to draft and approve a plan. The timeline and content of this plan were developed with the goal of integrating with implementation of Vietnam's 2011–2020 Population and Reproductive Health strategy. On June 27, 2011, the Vietnamese MOH officially approved the Operational Plan for the Contraceptive Total Market—a significant step for the country and for the family planning field.

Step 6: Convene a coordinating group under government leadership.

Many countries already have contraceptive security coordinating committees that have been supported under the USAID | DELIVER PROJECT to bring together government, donors, and technical agencies to address contraceptive supply needs, reduce overlapping efforts, promote information sharing, and promote joint action planning. Therefore, forming a separate group for a TMI may be duplicative. At the same time, existing committees may not include participation from the private sector, especially commercial sector representatives. Two things are needed from the group—government, rather than donor leadership, and commercial sector participation. Ad hoc or working group mechanisms may be a way to garner commercial engagement productively, especially in a setting where the government might initially be resistant to or skeptical of official involvement of the commercial sector. The TMI may be a means to strengthen an existing coordinating group as one of its planned activities. An advantage of working with an existing coordinating committee is that the TMI can become part of existing strategic plans and activities that the committee may already have.

For an example of the participation and purpose of coordinating committees, see Box 6.

Box 6. Working with Coordinating Committees: Nicaragua

PATH signed an agreement with the Ministry of Health, and at the MOH's request, focused a stakeholder analysis on 24 nongovernmental stakeholders, such as nongovernmental organizations and private distributors. The results of the stakeholder analysis confirmed that stakeholders supported total market principles, but identified a lack of ongoing government engagement with the commercial sector. A coordinating group, the contraceptive security committee (DAIA), already existed, as did the DAIA strategy that included improving access to family planning via the private sector. The stakeholder analysis resulted in an expansion of the DAIA to include three nongovernmental organizations that were considered to be influential in family planning. This experience suggested that formal stakeholder analysis was a powerful tool enabling DAIA members to look at the family planning community in a new way. When results of the stakeholder analysis were shared with the DAIA, a senior MOH official called for a national campaign to increase awareness of family planning and to design a communication plan between the DAIA and interested stakeholders.*

Some data to support a total market plan were already available. With overall modern CPR at almost 70 percent, analysis by the USAID | DELIVER PROJECT of the 2007 DHS survey revealed gaps and inequalities among population groups. It also showed the MOH, the main service provider, delivering services to individuals already covered by social security. IMS data highlighted extensive use of emergency contraception.

Private sector stakeholders identified barriers of product registration: condom import taxes; lack of information about medical eligibility criteria, method selection, correct use, and side effects; services for adolescents; and rural coverage. This input is being fed back into the DAIA to develop a plan for how to communicate and link to the providers in future.

**For results of the stakeholder analysis in Nicaragua, see Drake et al. (2011).*

Step 7: Develop a plan for implementing targeted and coordinated supply strategies.

At this point in the process, stakeholders are engaged and evidence for decisionmaking is available. Key stakeholders can be convened in workshops or working groups to develop plans for what interventions they can commit to implement, over what time period, and how they will evaluate their success. Critical components of a plan are identifying who is responsible for what, what resources will be mobilized, and how the plan will be monitored. While participating organizations may have individual plans, there should be an overarching plan that consolidates each sector so that it is clear which organizations will serve the neediest populations, how commodity procurement will be coordinated, or what regulatory changes might be needed to ensure quality, availability, and affordability. Based on results from segmentation or willingness-to-pay studies, interventions may be implemented on a pilot basis or in one location to gain marketing experience. Plans may also include capacity-building activities, such as training private sector providers on national family planning guidelines or introducing a new contraceptive method. Plans should be realistic about the ability of public health officials to achieve policy change in the short term. Advocacy to influential authorities (such as those with financing allocation authority or with government authorities responsible for economic growth and industry that can affect reproductive health supply) may also need to be built into plans for future policy changes.

Plans should recognize existing contractual arrangements between governments and nongovernmental organizations, and the need for commercial players to earn profits. TMI plans should not seek to control all market players, but provide a road map to allow market players to reach a greater number of consumers more efficiently with reproductive health products and services. For example, in the Caribbean, the Caribbean Social Marketing Programme for HIV Prevention and the Promotion of Reproductive Health project worked with a regional policy body, Pan Caribbean Partnership against HIV and AIDS, to establish a total market framework that member countries could use as a basis for national plans for condom programming. Finally, integrating the plan into broader policy documents or frameworks can help ensure that it will be implemented and evaluated over time.

Step 8: Periodically monitor and revise the plan.

TMI plans should not seek to control market players, but provide a road map to reach a greater number of consumers more efficiently.

In order to maintain momentum and ensure effectiveness, TMI plans should be monitored periodically to see how well different consumer segments are being reached; whether improved coordination is bringing about great efficiencies in distribution, procurement, and promotion; and most importantly, to determine if unmet need is being reduced. In some cases, if commitment and funding are available, a TMI could develop a performance monitoring plan to monitor progress in implementing the TMI plan and measuring its effect on efficiency, equity, and sustainability. One way to establish continuity in monitoring the plan would be for the government or financial partner to engage a local university or civil society organization to monitor progress over an extended period. Ideally, market segmentation analysis could be performed at some future point in time, for example, three to five years after the plan is agreed upon, to measure results further along in the input-output-outcome-impact continuum. However, there are many alternative indicators to measure progress of the total market without a complete market segmentation analysis. Some suggested indicators are included in Annex B.

If during the monitoring process it is discovered that problems persist, the plan should be altered and specialized working groups may need to be created to address gaps.

5: Future Directions for TMIs

The TMI tool can become one of several policy tools available to decisionmakers in the reproductive health field. The TMI concept is still being developed and tested. As experience with TMIs is accumulated and documented, more formalization of some of the processes can take place. This should allow for easier replication of the TMI process. More experience and research are also needed in medium- and long-term monitoring of TMI processes to assess their impact in improving efficiency, sustainability, and reach of reproductive health programs. Although expanded reach of programs can be documented in a typical project period through estimations of contraceptive prevalence and numbers of users,

sustainability and long-term efficiency may require longer-term evaluation that extends well beyond the period of the TMI strategy implementation and more challenging analyses of cost efficiency and financial self-sufficiency. Since a TMI as defined in this paper treats an entire country as the intervention area, establishing appropriate counterfactuals to show the relative advantage of total market approaches over other approaches may also be challenging. To overcome this challenge, it may be useful to compare similar countries that have adopted total market approaches in graduating from donor support with countries that have relied exclusively on public sector investment. Comparing costs between programs is also very challenging, but more studies focused on specific issues such as the reduction in costs to public sector financing by leveraging investment in the nonprofit and commercial sectors may help demonstrate advantages of total market approaches. Finally, as noted above, total market principles can be applied to the market for any number of health products and services, not just those in the reproductive health field. Applications of the TMI concept to malaria, maternal and child health, and other issues may offer others opportunities to refine the TMI approach and generate global lessons learned.

Annex A: TMI for Different Stages of Market Development

Stage of the Contraceptive Market	Characteristics	Key Issues	Focus of a Total Market Intervention
Early	Low use of reproductive health products and services (modern CPR < 25%*) Market share dominated by public sector or other sources of subsidized supply Low willingness to pay for RH Supplies are consistently irregular	Need to build demand Need to increase access Need to ensure good coordination of reproductive health programs	General coordination of donor-supported RH efforts in the areas of communications, service delivery, procurement, and distribution to minimize duplication and maximize efficiency while expanding access Ensure that policies encourage investment in commercial markets Address policy barriers to increase access and demand
Developing	Increasing numbers of users and more consistent use (CPR 25–54%*) Increasing numbers of service providers and sales points More commercial provision of products and services, but share of subsidized products is still > 50%	Continued need to build demand, supply, and access Need to target subsidies to low-income consumers Need to target communications to specific behavioral barriers	Continued coordination of reproductive health efforts Matching subsidized products and services to consumers who need them Transitioning consumers with ability to pay to the private sector
Mature	Medium to high numbers of RH users (CPR > 54%*) Multiple sources of services and product supply Good access to RH services and products Free or subsidized provision is below 30% of the total market share. If the subsidized market exceeds this level, the policy is supported with evidence that the segmentation is appropriate and the public sector has a strong commitment to continue providing subsidies to lower-income segments.	Need to understand consumer segments well (preferences, barriers to use, willingness and ability to pay, etc.) Need to ensure that RH products and services are sustained and remain highly accessible as subsidies are reduced or phased out	Continued coordination of RH efforts and targeting subsidies to appropriate populations Using public-private partnerships or other market development strategies to introduce new RH products and services that better meet the needs of consumer segments Transitioning consumers from subsidized sources of supply to private or sustainable sources of supply.

**25% and 54% modern CPR corresponds to the average CPR for least-developed and developing countries, respectively (Population Reference Bureau, 2011)*

Annex B: Total Market Indicators

The indicators below were developed over the course of MDAWG discussions, in response to questions about how to judge whether a strategy was helping or hurting the total market. Historically, the tendency of reproductive health programs was to evaluate results in isolation, with a particular focus on couple years of protection (CYP) supplied. Because the MDAWG was created to support a broader vision of reproductive health program success, it was important to develop new ways of looking at the broader market and the indicators that could be used to show that success.

The focus of total market indicators is on growth and maturity of the overall market for reproductive health products and services, not the performance of individual reproductive health programs in the market. Some of the indicators below may be appropriate for tracking program performance, but others are not, as they are likely to be beyond the control of a single project. Some of the indicators may be more relevant to measure commercial market development rather than state-led coordination of the total market.

There are four broad areas for judging market health: market size, market equity, market accessibility, and market sustainability. For each of these criteria, multiple indicators need to be considered because all indicators are limited in reliability, feasibility, and cost.

- Market size: The market potential as measured by the units of contraceptive products sold or distributed, the rate of use, or the numbers of users.
- Market equity: The ability of consumers in the market from all income quintiles to find products and services at prices they are willing to pay.
- Market accessibility: The ease of access to a contraceptive product in different geographical regions of a country or market.
- Market sustainability: The ability of the market to serve a critical mass of consumers with well-established demand and willingness to pay with minimal government or donor support. When the market achieves this degree of viability, the number of market entrants will increase and market shares will be divided among a wider number of suppliers. Market sustainability is higher where the market share of subsidized products is low and competition drives the division of the market among many suppliers.

The table on page 20 gives more specific indicators and summarizes the various issues with each one.

Total Market Indicators

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
1. Market Size		
1.1 Units of product sold or distributed	When the data can be obtained, sales or distribution are reliable in that they can be verified against stock movements or revenues. However, because sales can leak out of the market one is trying to measure and because significant percentages of units sold or distributed may be wasted, they are not a reliable proxy for use. Sales can be difficult to compare because they may be collected at various points in the supply chain—units imported, units sold to a national distributor, or units sold to retail level. The closer the level of sale to the consumer, the better the indicator of use.	Typically, sales from social marketing programs can be obtained easily and verified. Units distributed through public sector programs may be difficult to obtain. Sales from commercial suppliers are very difficult to come by, unless the country has market reading services such as Nielsen or IMS. The cost of obtaining sales data is comparatively low, except for Nielsen or IMS reading services that charge significant fees.
1.2 Number of users	To obtain this indicator, one would typically have to project from nationally representative surveys on reported use and model the number of users from population data. In terms of assessing profit potential, the number of users in the market is as important as understanding the average rate of use and the segments of heavy, medium, and light users of products. Estimates of the number of users are only as reliable as the survey data and census on which the estimates are based.	Determining this requires nationally representative surveys and relatively recent census information. In most markets of interest, these data would be available without needing further investment. Where national surveys have not been done or where the specific product information is lacking, obtaining it would be very costly.
1.3 Consumption of product per capita	This indicator would have to be obtained by dividing units of product sold or distributed by the total population. This indicator is another way of weighing the overall potential of the market since profitability depends not only on the total consumption but also on how concentrated that consumption is in geographic areas and how many heavy users there are. This indicator provides a rough proxy for those factors.	If total units sold or distributed is available, then this indicator is easily available at no cost.

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
1.4 Number of products/brands in the market, and number of product/ brand launches in the last year	On the principle that supply increases as market potential increases, tracking the number of market entrants and market offerings is another proxy. Conversely, if commercial products drop out of the market, it could be a sign that market potential is being hurt by subsidized or free competition. These are not perfect indicators because many economic and regulatory factors drive market entrants. However, all other factors being equal, supply will follow demand and market potential. If the number of products or brands is dominated by free or subsidized brands, that still represents a market potential, albeit one that is dependent on increasing willingness to pay over time.	This information is readily available from retail audits at minimal cost. Even small samples of retail outlets will usually capture all the brands in a market.
2. Market equity		
2.1 Number of brands in the market determined to be affordable to lowest wealth group	Most affordability measures rely on arbitrary rules of thumb (e.g., 1% of gross national product per capita should buy 1 CYP). More sensitive measures of affordability need to be developed.	Establishing the number of brands and prices is easy. Determining their "objective" affordability may require new tools.*
2.2 Percentage of consumers (current users and non-users) in each wealth group who report that the product is affordable or that the price is not a barrier to use	Willingness-to-pay indicators are more reliable indicators of equity than ability-to-pay indicators, which involve arbitrary rules set by outsiders to decide on behalf of the consumer what the consumer "should" be able to pay. Perceptions of affordability or willingness to pay are obtainable through surveys. The higher the percentage and the more even the percentages are across income quintiles, the more equitable the market.	Nationally representative surveys that include significant numbers of people from all income categories are long and costly to do. However, it may be possible to add willingness-to-pay questions to an existing household survey. Or, it may be possible to collect this information from a targeted population (e.g., low- and middle-income) on a smaller scale. Respondents must know and understand the product or service and its costs and benefits to be able to reliably answer questions on willingness to pay.
2.3 Share of the lowest wealth group served by public funds	Given that public funds can be applied to both public and private service provision, tracking the funding targeted to the lowest wealth group will show that public funds are equitably targeted. This measure also shows those in the lowest wealth group who are not served by public funds.	DHS will not be able to provide data because they only show provision of service rather than funding of the service. Data would have to be collected by examination of government funding accounts.
2.4 Inclusion of family planning in national health insurance	This measure makes the assumption that national health insurance is provided equitably and in a manner affordable to all. If this is the case, then inclusion of family planning services in the plan would show market equity.	Examine national health insurance inclusion of family planning and equitable application for the poor (such as coverage of premiums for the poor).

** One resource is by the World Health Organization and Health Action International (2008).*

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
3. Market accessibility		
3.1 Percentage of consumers in a defined geographic area of the market who report knowing where to obtain the product or who report that distance to a delivery point is not a barrier to use	Markets that show strong growth and offer prices accessible to all consumers may still have gaps for consumers in selected regions or in rural areas. The higher this percentage is for an area, the less effort and investment should be made in opening delivery points, managing distribution channels, etc. Low-percentage areas require more attention to stockouts, opening of delivery points, and communication to consumers about where to find the product.	This information can be collected through surveys, provided the survey sample includes sufficiently large samples in the areas of interest. The smaller the analytical unit of area, the more expensive it will be to provide statistically significant samples for all areas of the market. The larger the analytical area, the less guidance the data provides on improving accessibility.
3.2 Percentage of product delivery points reporting a stockout in the past 3–6 months	When appropriate systems are established to collect these data (including retail outlet surveys), the indicator is a highly reliable predictor of accessibility. Knowing what to do about the indicator is more problematic since stockouts may reflect poor resupply systems, a sudden increase in demand, poor forecasting by the retailer, cash flow constraints by the retailer, etc.	Within a closed system such as the public sector, there may be reliable management information systems producing data on rates and duration of stockouts. In commercial retail outlets, this may be available from Nielsen or IMS readings or through retail outlet surveys.
3.3 Number of delivery points in a given area or for a given population	Some product or service delivery points may be registered with government authorities such that it is possible to analyze the number of service delivery points in specific districts with known populations. The higher the ratio of delivery points to consumers, the higher the accessibility. Some social marketing programs also track numbers of outlets and where they are located. There is a large margin of error, however, since the indicator represents a "point in time" image of accessibility, and the data are often out of date and difficult to keep up to date. Outlets that closed are typically not taken off the registration lists in a timely manner and, even in a social marketing database, outlets that still exist may have chosen to stop carrying the product.	If in-country references sources exist (provider registration lists, social marketing databases), this indicator can be obtained at low cost. If not, conducting a census of commercial retail outlets can be expensive. Typically, however, pharmacies and clinics are limited enough in number that registration lists, combined with some on-the-ground verification, can provide a fairly accurate picture.

Indicator	Interpretation and Reliability Issues	Measurability and Cost Issues
4. Market sustainability		
4.1 Market leader's market share	Dominance of market by one provider is typically a sign of a weak, unsustainable market. When the government or a social marketing program provides 80–90% of a product type, it means that the market is dependent on a single source of supply and the subsidy that finances the source of supply. In a healthy, sustainable market, there are multiple sources of supply, many of which are unsubsidized and no one provider has more than 30–40% of the market share.	As long as number of units can be estimated and the source of each seller/distributor of product units can be identified, then market share can be calculated through a percentage of each provider's units over the total units distributed or sold.
4.2 Number of unsubsidized brands in the market and market share of unsubsidized brands	Although the overall number of brands/products in the market is representative of market potential, market sustainability should only take account of the unsubsidized brands—these may be commercial or sold at full cost recovery from government or nongovernmental organization providers.	Number of brands in the market is easily available through small retail audits. Knowing the source of supply and the retail price should be sufficient to determine which of the brands are unsubsidized.
4.3 Number of sources of supply serving the market	A market that is supplied from one source is less sustainable than one that is supplied from several sources. A market may have several brands supplied by a single nongovernmental organization, in which case it is less sustainable than a market that has the same number of brands, but supplied by several sources (government, nongovernmental organization, commercial).	Retail audits and background research on the suppliers of each brand will be sufficient to establish this indicator.

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