Total Market Assessment for Family Planning in Mozambique

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Acknowledgments

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BACKGROUND

Founded in 1970, PSI is a nonprofit organization dedicated to generating measurable health impact for vulnerable and marginalized populations in the developing world. In 2015, PSI estimates that 44,894,996 million Disability Adjusted Life Years (DALYs), a measure of the burden of disease, were averted by its programs in sexual and reproductive health, malaria, childhood illnesses, and nutrition. . Through its interventions in 2015, PSI averted an estimated 10,237,228 HIV cases, 9,246 maternal deaths, 3,896,671 million unintended pregnancies, nearly 72,564 malaria deaths, and over 2,732 diarrhea deaths averted and provided 19.1 million Couple Years of Protection (CYPs) and a provided a total of 3,066,043 services referrals.

With fifteen years of social marketing experience in Mozambique, PSI/Mozambique is established as a leading player in delivering innovative preventive health care options to Mozambicans nationwide PSI/Mozambique has a permanent presence in six of the 10 provinces of Mozambique and ongoing activities and infrastructure in all 10 provinces. Our field structure is built around core competencies that include: distribution, logistics, sales, communication, marketing and clinical. PSI/Mozambique is known in Mozambique primarily as the leader of social marketing condoms. The Jeito brand is synonymous condoms and PSI has sold 33,906,000 in the last 20 years.

In 2014, PSI/Mozambique introduced TEM+ (pronounced “Tem Mais”, which means “we have more”) - a network of nurses and community health promoters that offer family planning counseling and a wide range of voluntary contraceptive services in both public and private sector. Each TEM+ clinic is staffed with a family planning nurse, who provides a range of basic health services, including a comprehensive overview of family planning options. Currently, TEM+ has 18 clinics operating in 6 provinces (Maputo, Gaza, Inhambane, Sofala, Zambezia, and Nampula), and several different program models.

To generate demand for the services social franchises offer, PSI deploys community health promoters who are affiliated with specific TEM+ clinics. The promoters are health agents selected, trained, and working in the communities from which they come. They are the backbone of health programs at the community level, and work to generate demand and provide basic, essential information, services, and referrals to higher-level health providers. The promoters visit communities and provide introductory family planning information and, for those interested, a Movercado voucher for a counseling session with a TEM+ nurse.

As part of the Support for International Family Planning Organizations (SIFPO) 2 project and in discussion with the United Nations Population Fund (UNFPA), PSI/Mozambique undertook a landscaping of its family planning market in March and April of 2015. The landscape sought to identify market constraints that were barriers to meeting the family planning needs of Mozambican women. The exercise was conducted with support from the SIFPO2 team in headquarters and the regional marketing team.

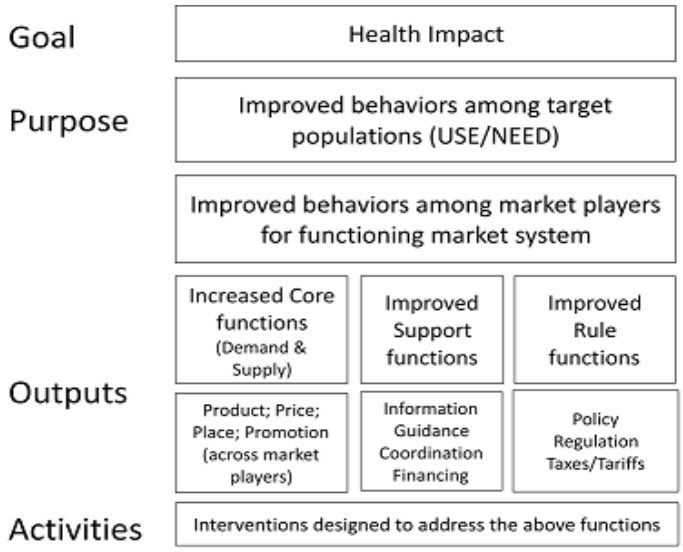
This landscape analysis provides PSI and other partners in Mozambique clear outline of how different actors can reinforce their efforts to meet the needs of the women in Mozambique taking into account policy level constraints, cultural barriers, and perceived risk of family planning methods on the user level. This analysis will be shared with different donors and discuss how PSI will leverage efforts with different stakeholders.

Theory of Market Change

PSI's theory of market change demonstrates how changes in the market can lead to improvements in population health, and is based off its PERForM framework and logistical frameworks. It shows how market activities can influence market outputs in core (demand and supply), support, and rule functions, which in turn improves the functioning of the market and market players as well as the behavior of the target population, with the goal of improving the health status of the population.

For example, an advocacy activity may lead to a change in law (an improved rule function) that allows private providers to carry a product, which in turn leads to private providers stocking the product and increased availability of the product in the market, which results in increased use and improved health status in the target population.

Figure 1. PSI's Theory of Market Change



For Mozambique's family planning market, when informed demand for products and services is met with quality supply, this will result in an increase in the modern contraceptive rate and reduce maternal and child mortality.

The Total Market Approach

The public health community has recently focused on improving the health of market systems to better serve consumers. The Total Market Approach (TMA) or "whole market approach" is a lens for viewing how the public and private (including commercial and social marketing) sectors can coordinate to maximize market efficiency, equity, and sustainability. Greater efficiency in the market increases sustainability by better targeting public and social marketing subsidies, decreasing "crowding out" of the commercial sector. A more efficient market also increases equity by ensuring all groups can access products and services. TMA's fundamental goal is to have a functioning market that increases use among the population at risk while also promoting equity across groups such as age, gender, geography, and wealth.

While TMA is a way of viewing the market and its players rather than a prescribed approach or process, the first step in applying this market lens is to assess the performance of the current market and to identify the market strengths as well as where the market is failing to meet the target population's needs.

One measure of the performance of the current market is coverage of the universe of need. The universe of need is the number of persons needing a product or service and/or the number of products or services required to meet the total health needs in the population at risk; coverage represents the number of people's needs who are being met and/or products or services that are currently being used. TMA's goal of increased use can be captured by assessing if coverage of the universe of need is increasing.

The second key measure of the functioning of the market is the number of people using products or services by the equity groups, specifically wealth. Market improvements should seek to ensure that all groups have equal awareness of and access to and products and services.

In addition to these key measures, an initial TMA assessment captures information about the drivers and barriers of health behaviors among the target population as well as the market landscape including its players (e.g., product distributors) and system functions (e.g., policies).

Background of the TMA exercise

In order to assess the current performance of the family planning market, PSI conducted a market landscaping which included a literature review, analysis of secondary data to assess the universe of need, coverage, and wealth equity, and collection of primary data with consumers and players in the supply chain using in-depth interviews (IDIs) and focus group discussions (FGDs).

Among the supply chain players, no manufacturers were included as no family planning manufacturing is done in-country, and importers, wholesalers, and distributors were combined as these functions are not diversified into separate companies. Public and private sector providers were identified and interviewed separately.

For consumers, three specific groups were selected based on the data: women under 20 years who had not yet had a child and did not have a primary partner, women under 30 who had a primary partner and had had at least one child in the last two years, and women over 30 with a primary partner and one or more children. These categories were chosen to reflect specific family planning needs: for delaying childbearing, for spacing children, and for spacing or limiting, respectively. They were also chosen to

reflect age categories generally. Consumers were interviewed in several geographic locations and in urban and rural areas.

Province	Urban	Rural
Maputo	Maputo city	Marracuene and Boane
Nampula	Nampula city	Namialo
Zambézia	Quelimane city	Mocuba

The primary data collection conducted is summarized in the table below.

Market player	Interviews
Importers/wholesalers/distributors	12 interviews
Pharmacists	15 interviews
Retailers	14 interviews
Private sector doctors	3 interviews
Public sector nurses	5 interviews
Public sector nurses	1 FGD
Private sector nurses	1 FGD
Public sector doctors	10 interviews
Women under 20 with no children/partner	3 FGDs in rural and 3 in urban
Women under 30 with at least one child in the last two years and a regular partner	3 FGDs in rural and 3 in urban
Women over 30 with at least one child and a regular partner	3 FGDs in rural and 3 in urban

In addition, the Ministry of Health (MISAU), donors, and implementing organizations were interviewed about the state of the family planning market using a structured quantitative and qualitative questionnaire; the quantitative questions were adapted from a questionnaire on TMA developed by UNFPA. The donors interviewed included USAID, UNFPA, DFID, the Swiss Embassy, the Belgian Embassy, and the Dutch Embassy. The implementing organizations interviewed included ADPP, AMODEFA, Coalizão, the Clinton Foundation, ICRH, DKT, and Pathfinder. An interview was also conducted with the representative from the Ministry of Health (MISAU).

The secondary and primary data collected was analyzed through a collaborative four-day workshop including program, research, and marketing staff at PSI/Mozambique. The outputs of the workshop included a review of the background information, archetypes of the target population, an assessment of the market landscape including its key constraints and their root causes, and summarized quantitative and qualitative findings from the donor and implementing interviews.

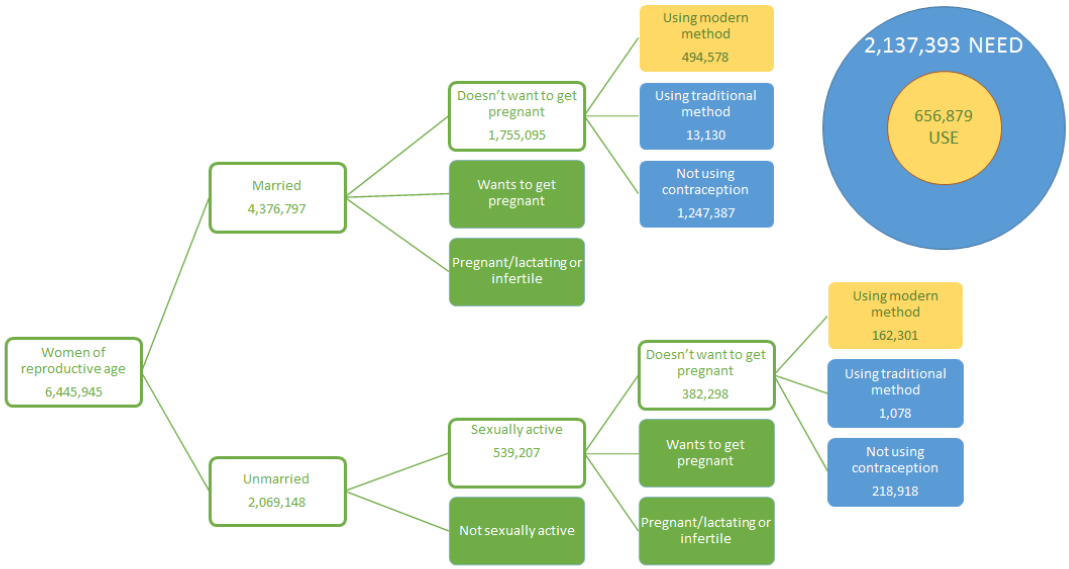
SUMMARY FINDINGS

Market Information from Secondary Sources

Family planning use and equity

The calculation of the universe of need and coverage were calculated using the modern contraceptive prevalence rate (mCPR) derived from the 2011 Mozambique Demographic and Health Survey (DHS) as well as the population projections for 2016. The universe of need and coverage are captured in the graphic below.

Figure 2. Universe of need and coverage

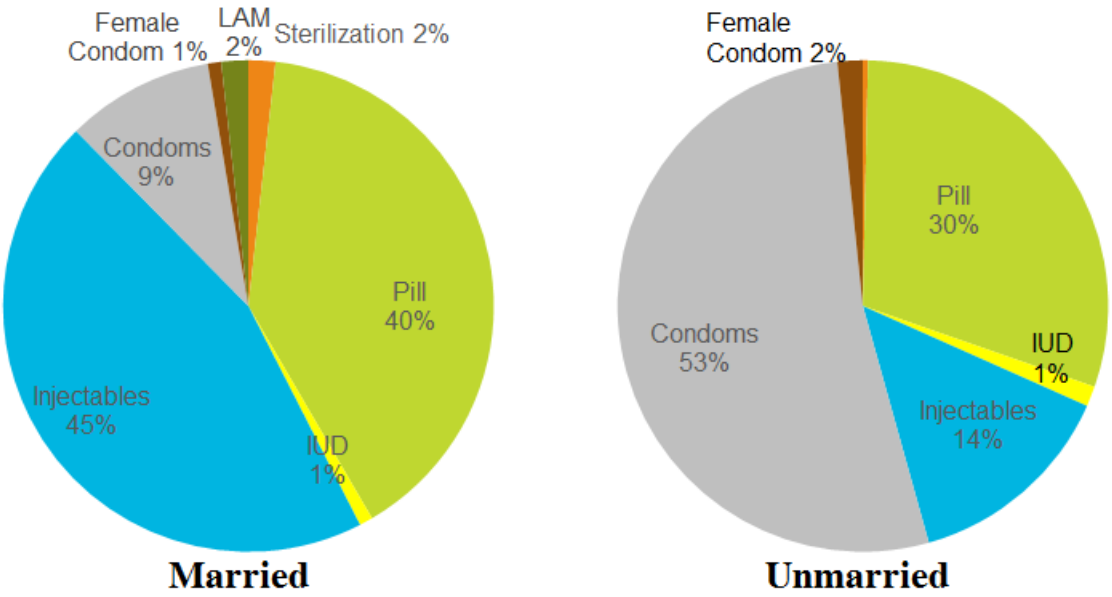


It was estimated that there are about 6.5 million women of reproductive age in Mozambique in 2016. These were divided into those married and those unmarried (and those unmarried were divided into sexually active and not sexually active). Of the married women and unmarried women who are sexually active, a total of 2,137,393 (about one-third of the women of reproductive age) were estimated to be fertile but not wanting to get pregnant at this time; this represents the universe of need.

Coverage was calculated from the CPR (11.3% for married women and 30.1% for unmarried women, according to the DHS 2011). Of the more than 2 million who are fertile but do not want to get pregnant at this time, just 656,879 are using modern contraception. This indicates that there are nearly 1.5 million women whose needs are not being met by the current family planning market.

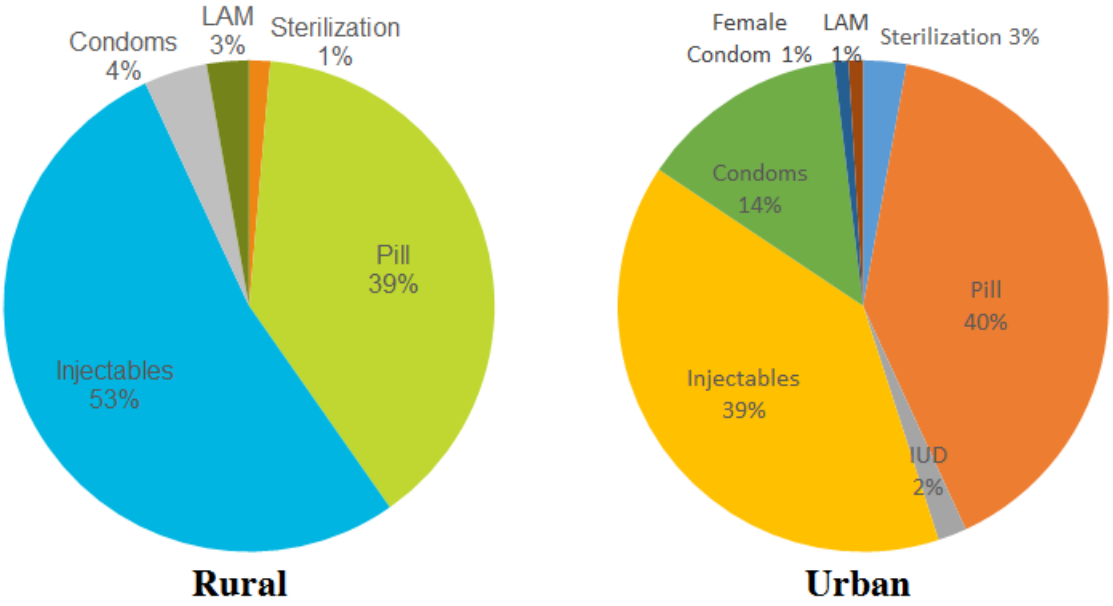
Method use and mix was also examined by two groups: married vs. unmarried and urban vs. rural. Fewer married women than sexually active unmarried women were using modern contraception (11.3% vs. 30.1%), and method use varied by marital status. Married women were most likely to use injectables (45%) and pills (40%) whereas unmarried women were most likely to use condoms (53%) and pills (30%).

Figure 3. Method mix by marital status



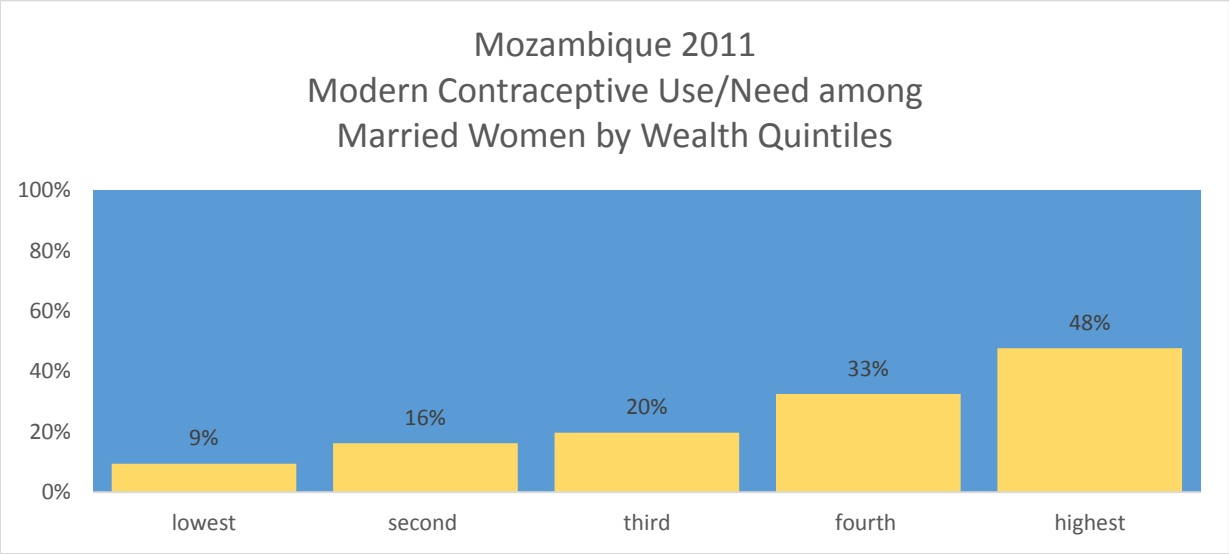
Among married women, those in rural areas were much less likely to be using contraception than those in urban areas (7.2% vs. 21.1%). Rural women had a higher total fertility rate (TFR) than urban women (6.6 vs. 4.5). Method mix was similar, with pills and injectables as the most common methods for both groups, but with many more urban women using condoms as opposed to rural women.

Figure 4. Method mix by residence



In addition to urban and rural differences, mCPR varied by provinces. Use was highest in Maputo city and province (35.9% and 33.6%, respectively) and lowest in Cabo Delgado (2.9%), Zambezia (4.7%), and Nampula (5.0%).

Equity in use over need across socioeconomic status was assessed by assessing how many married women in each quintile needed family planning and of those what percentage were currently using (as per the DHS). As shown below, use increased with socioeconomic status, with nearly five times as many users among those with need in the highest quintile as among those in the lowest quintile.



An additional group identified as having heightened need are women within two years post-partum. A reanalysis of DHS data found that almost half of births occur within two years of a previous birth and 69% of post-partum women have an unmet need for family planning (MCHIP & MCSP, 2013).

In addition to discrepancies among women, fertility intentions differed by sex according to the 2011 DHS. Women's ideal number of children was 4.8 whereas men's ideal number of children was 5.9. For women, desire for more children decreased rapidly after having 4 children, whereas men's desire for children remained high even with many children.

Drivers and barriers of family planning use among women

Lack of knowledge did not appear to be a significant factor in influencing youth, as 95.5% of women know a modern method of family planning, and more than 80% spontaneously named pills, condoms, and injectables as means of family planning (MISAU 2011).

Factors that were associated with use of family planning in the literature included: older age and higher education (Yao, J., Murray, A. T., Agadjanian, V., & Hayford, S. R., 2012); higher socioeconomic status and monogamy (Agadjanian, V., Hayford, S. R., Luz, L., & Yao, J., 2015); Christianity and regular church attendance (Agadjanian, 2013); HIV positivity or perceived HIV positivity and not wanting children in the next two years (Agadjanian, V., Hayford, S. R., Luz, L., & Yao, J., 2015).

Identified barriers to family planning use included lack of current employment and reporting that one's husband makes the healthcare decisions (Mboane & Bhatta, 2015). Distance was a frequently cited barrier to program personnel (Pathfinder Technical Highlight, 2014), however a study measuring the effect of distance from clinics on family planning uptake showed no effect (Yao, J., Murray, A. T., Agadjanian, V., & Hayford, S. R., 2012).

In addition to barriers to contraceptive uptake, discontinuation of methods is an obstacle to maintaining coverage of the universe of need. Of those who discontinued a method, nearly one-third did so due to side effects of a modern method. Just one half of women reported knowing what to do in case of side effects of pills and injectables (MISAU 2011).

Despite barriers to use, many women express a desire to use contraception. Of those not using a method of contraception in a 2013 Omnibus survey on family planning commissioned by PSI and conducted by GFK, 37% were interested in using a method. The methods they were most interested in using were pills, condoms, and implants. Pathfinder noted in their endline survey for Extending Service Delivery – Family Planning Initiative that there is increasing demand for family planning, particularly among youth.

Sector sourcing

Of the women who use family planning, the vast majority get their method from the public sector (75.6%); just 16.1% of women get their method from the private sector (MISAU 2011). In the 2013 family planning Omnibus, the most commonly cited sources of family planning were hospitals and health centers. A similar Omnibus conducted around perceptions of pharmacies in 2013 found that women who used pharmacies generally chose them based on proximity rather than brand or other factors and usually visited once a month.

The main source of information about family planning was reported to be medical staff and friends. Health information was primarily sought in public hospitals and private clinics (Family Planning Omnibus, 2013). Just 7.5% heard health messaging from a community health worker (CHW) (MISAU 2011).

Service quality

While consumers reported high satisfaction with family planning services in the Omnibus survey, assessments of health systems have found areas of improvement for service quality. An evaluation of the family planning situation prepared for USAID in 2012 found that health facilities were not well equipped, there was a shortage of nurses, and there was a need for better commodity delivery, more CHWs, and more family planning in the private sector.

A study of user and provider perspectives found that providers felt rural women couldn't make informed family planning choices and were likely to recommend oral contraceptives to women with fewer children and other options for women with more children (Agadjanian, V., Hayford, S. R., Luz, L., & Yao, J., 2015). The use of oral contraceptives for spacing and injectables for limiting was similarly found in the reanalysis of the DHS 2011 data (MCHIP & MCSP, 2013). The emphasis on short-term methods was also noted by USAID as a way in which women's needs may not be being met (USAID, 2012). The users and providers study also found that women had many misgivings about adverse effects of family planning that were not resolved by their interaction with the provider (Agadjanian, V., Hayford, S. R., Luz, L., & Yao, J., 2015).

Archetypes

To begin the workshop, the participants developed archetypes – personality and lifestyle profiles – for the women the market is intended to serve. The workshop participants identified characteristics, traits, and themes about women's lives and perceptions and use of family planning that consistently emerged in the focus group discussions. Across the three groups interviewed (women under 20 without a regular partner or children; women under 30 with a regular partner who had a child in the last two years; and women over 30 with a regular partner and children), two clear archetypes emerged: women without children or a regular partner (a youth profile) and women who had a regular partner and at least one child. Two profiles, Rosalina and Josina, were developed to represent the voices of the women interviewed and provide a portrait of how consumers interact with the family planning market.

Youth archtype: Rosalina

My name is Rosalina and I live in Namialo in Nampula Province. I am 17 years old and a student. The most important thing for me in life is to finish school and fulfill my dream of becoming a nurse. Once I become a nurse, I can help to support my family. My parents and family are the most important people in my life because they take care of me and support my education. In five years, I want to have finished my education and be able to travel. I want to see Maputo and Brazil.

My biggest challenge day-to-day is transportation to school; the cost and difficulties cause many people to drop out. The travel time means that I am often too tired to study at night or to help my family. I often don't have enough money to pay for school supplies, clothing, and shoes. Disease and poor health is also an issue in my community.

Right now, I'm single and I want to stay single for now, because getting married and having kids can make it difficult to live your dreams, though maybe I will get married in the future.

I went to the hospital to get family planning information, but the nurses did not want to counsel me. Instead, they asked me what I wanted family planning for and said it was not suitable for a woman who hasn't had a child to use the products. I have heard of other methods including pills, implants, injections, and IUDs, and I've heard that the pill is good for younger women, but I'm not sure how to use it. My older sister is using the implant and has talked to me about it, but has advised me not to tell my parents as they would not be willing to talk about it with me as I am not married. I mostly talk to my sister and grandmother about these things.

I use condoms as this method is suitable for single women and I can hide it from my parents. I recommend to all my friends to use condoms, even if their boyfriend doesn't want to, as condoms protect from pregnancy and diseases. My boyfriend and I agreed to use condoms because we both have dreams and don't want to have children now.

My boyfriend gets condoms at the pharmacy or in retail stores, and they are affordable. Family planning is free at the health center and they have good information; however, there are often no medicines available there and the service is not always good. At the health center, there is a back door and there is a front door: if you have money or you know someone, you will not wait and you will get the best medicines through the back door, but if you don't you will have to wait a long time for less good medicine. I know that private clinics always have drugs but it is very expensive there and the nurses aren't willing to explain anything, they just want to sell you something. I would be willing to go to a pharmacy to get other family planning methods, but it depends on what it would cost.

Recently a friend of mine got pregnant and went to the hospital for an abortion, but they sent her to the Central Hospital. As that was too far away, she decided to go to the local healer. This can be unsafe as sometimes the abortion works but then you can't get pregnant again. I am not sure what I would do if I got pregnant now.

Adult archetype: Josina

My name is Josina and I live in Boane. I'm 28 years old and I have two children that are five and two years old. I live with my husband, who I've been with for six years. The most important things to me are taking care of my family and my children's health. Right now in my life, with the cost of living I'm struggling to support my family and make sure my children and healthy and well. I would like to go back and finish school so I can get a better job but that's hard because my husband would prefer that I stay at home to care for the children.

Initially my husband was not in favor of me using a contraceptive method, but I convinced him over time that this is best for us for now, and we should wait for my youngest to get older before we have more. Not all of my friends are so lucky. For many of them, their husbands would not accept that they use family planning and are even more abusive to them, saying that they pay to support the woman and should be the one to make decisions for the family.

I know about family planning for spacing births and limiting the number of children, and have heard of several methods including pills, condoms, injectables, and IUDs, and the advantages and disadvantages of each of these. I've heard about these methods from my friends and also from nurses at the hospital. However, I've never heard of emergency contraception.

In my opinion, the better methods for young women are pills and condoms, whereas women with at least one child can use the injectable. I've tried different methods, and I did try the injectable, but I went three months without my period and that scared me. I've heard from friends that you can also have a lot of bleeding, so I didn't go back for my next injection. I'm using the pills now and they work fine for me, though they make me a little tired and it's hard to remember to take them every day.

I get my family planning from the hospital, and although the service is not always the best. Once I went there with my son and he was sick and the nurse refused to see us until I cleaned him up. Still, I feel more comfortable there because if something goes wrong they have medical services and could help me in an emergency. I use the pharmacy sometimes but I don't prefer it because the costs are high, the technicians don't always give advice on medicines, and they don't have emergency services. I can't afford the services at the private clinic.

I love my children but I hope that I can wait to have another child so that I can make our situation better for the future.

Production to use spectrum

To understand the total market, the team identified a wide range of market players including importers and distributors, public and private doctors and nurses, pharmacies and retailers, and consumers. (Other supply chain actors that are generally included in a market landscape analysis are not relevant in this context: there are no local manufacturers and the importers and distributors often play both functions as well as wholesaling their products.)

Key informants were identified within each of these groups and interviewed via in-depth interviews or focus group discussions. In addition, secondary data (e.g., laws and policies) was reviewed for these market actors. The team then went through the data and conducted a landscape mapping in which the market situation for each group was captured, including core functions (product, price, place, and promotion), support functions (information, guidance, financing, and incentives), rule functions, quality, commodity security, and capacity of the workforce.

The main findings were summarized in a production to use spectrum, which was then used as a basis of identifying key market constraints. The market constraints identified are bolded in the table below.

Importers and distributors

Players	**The main importers/distributors are: Sidat Medical Solutions, Hospilab e servicos, Mocambique Agencias, Mobiserv Lda, Paramedicos, Kambeny, Medimoc, MedimPort, Mais Saude, MEDIS FARMACEUTICA, Farmac, and Central de Medicamentos** **They sell primarily to MISAU; they also sell to: PSI, Jhpiego, Noleid, clinic in Alto Mae, Ministries, Blue Cross, clinics, Ariel, Glaser, Clinic 22, Institute of the Heart or ICOR** **Products are received directly from pharmaceutical distributor** **There is a lot of competition for contracts among a few major players who import and distribute; if they don't have the government contract for FP products they are minor players (less than 1% of the market)**
Product	Of those who supply to the public sector, there are pre-specified brands and products; those who supply pills to both public and private sector generally provide Minigest, Microgynon, Yasmin, Yaz, Dain 35, Qlaira, and Try Ginera; condoms are generally imported and branded by the social marketing sector Other products sold: medical and hospital equipment, equipment to NGOs, consumables, kits, tests, furniture, digital equipment, gloves/disposables Future investment: consumable products and disposables because these sell a lot FP products are 1-2% of total sales for importers; of the FP products recommended by the WHO they represent a small proportion; they are only perhaps 5-10% of sales for public pharmacies Some do not sell FP products because they don't have appropriate storage conditions for medicines; those who do prefer to import from Europe rather than Asia as they trust the storage conditions more Importers participate in business fairs to find future investments

	Some report being reactive to their clients and ordering what products are requested directly; they add new products only when there is demand
Price	Importers ask the prices from the manufacturer, agree on the margins, then present the final price to the client; sometimes with the process of importing, tariffs, costs, etc. they will only make a 5-10% profit on any given item **For medicines, there is a preset profit margin of 12.6%, which incentivizes sale of more expensive medicines as opposed to oral contraceptives** Most operate on a tender system as they are selling directly to the health system or NGOs and there is a lot of pressure to put in competitive bids, thus they are priced accordingly When unsure of profit, they will only bring in a small amount; they also frequently import based on request from clients with a preset contract as otherwise they may not be able to compete against other importers **They are hesitant to invest in family planning products as there is a limited market for paid products** **Current market fluctuations mean that profit margins for private sector provision are uncertain, coupled with lower perceived demand**
Place	Based in Maputo and the bulk of sales are in Maputo and Nampula Products available in public and private clinics, pharmacies, and retail shops (condoms); demand is perceived to be low in pharmacies for family planning products Whom they sell to is dependent on the contracts they win with companies **Distant pharmacies make orders centrally, but sometimes the suppliers dispatched are unable to reach certain issues due to rain or poor road conditions**
Promo	Most importers/distributors were unfamiliar with the concept of B2B and B2C and did little direct promotion of any product **Warehouses work with representatives from pharmaceutical companies who go out and promote their brand; not allowed to promote via mass media and are not allowed to offer promotional items above a certain value** Flyers and catalogues are available
Support: Information, Guidance, Coordination, Financing, Incentives	CMAM (the Center for Medicines and Medical Supplies) is the coordinating entity looking at the drugs and supplies used in the national health service, and does the tendering process for the national health service's commodities There is a commodification subgroup that meets to discuss the scope of need for family planning commodities A 7% subsidy on family planning products is specified by MISAU **One of the main disincentives for carrying products is that the state controls the vast majority of the family planning market and competition to provide for major contracts is fierce** **The government is perceived by some as a poor client in terms of payment, further disincentivizing entry into the family planning market**
Rules: Policy and Regulations **Taxes and Tariffs**	In order to distribute FP products, you need a license from MOH in addition to the license to import **Importers have exclusive importing rights for the products registered under their company, limiting any fair competition.**

	Local laws stipulate that there are 30 days for local payments and 60 days for international payments **The government has not decentralized purchasing of health products, so companies must have a presence in Maputo and be known, thus smaller importers are unlikely to be able to compete leading to monopolies; the centralization of product procurement can also lead to logistical issues with supply chain** In the past, the government did not have as many set tendering rules, but now has improved processes for this; however, there are cases of the government overpaying for less than quality products **The main risk associated with importing FP products is the potential for delays; one importer noted that PSI policies about expiry dates of products can lead to product being returned to them if its end of validity is too close and huge losses of money** No taxes or customs for importing medicines, though tariffs can affect prices
Quality	All materials are provided with essential treatment guidelines Only one distributor noted that private pharmacies may carry unlicensed medications; the scope of this problem is unclear Stocks are transported in sealed cars so as to prevent any contamination of medical supplies
Commodity Security	Most importers don't keep stocks for more than 48 hours **For the public sector, the government maintains stock and supplies centrally; stock-outs at provincial level are due to logistics issues of poor estimation of stock needs, lack of communication, storage, and transport rather than actual absence of stock** **Most importers are reactive to client orders so they don't order what they don't hear a demand for; insufficient communication of demand can lead to shortages in the private sector**
Capacity of Workforce	-

Public and private doctors and nurses

Players	**The main provider of services is the public health system. Doctors tend to take a supervisory role while nurses do most of the direct patient interface in terms of FP counseling and provision. The hospital pharmacies handle the supply chain and product issues.** **Interact with activistas: ADPP; PAITO; ARIEL; PATH; DPS** **CCS provides materials; all other materials come from the government** **Receive product from DKT**
Product	Most public health facilities offer the standard suite of FP products: pills (microgynon and microlut for breastfeeding mothers), implants, IUDs, injectables, and condoms; the products are provided via the hospital pharmacy Private facilities tend to mostly prescribe pills, implants, and IUDs (injectable users go to the public sector); the products are provided via private pharmacies **The most preferred method is the injectable because it is easy to use and longterm; the largest concerns cited are bleeding/lack of a period** **Second most preferred method is the pill** **Some women like implants, but others express concerns and side effects (weight gain, fear it is moving in the arm, obviousness to husband, bleeding)** **Having to remove clothing for the insertion can be a barrier to IUD uptake** **Some husbands oppose particular longterm methods and report penile discomfort with IUD** Both doctors and nurses report that patients come to the clinic with a method in mind (based on a personal recommendation from friends/family/peers) and regardless of counseling are set on this particular method **Method switching is an issue; patients don't give time for their bodies to adjust to side effects and switch to other brands or products** **Some nurses report refusing contraceptives to young women (under 18)/questioning why they want the product**
Price	Cost is free in the public sector; many providers are unaware of the private sector cost including the cost of products because they are charged at the pharmacy **There is a perception that the private sector is motivated by profit and will push whatever method is most expensive (e.g., implants), whereas the public sector cares about the well-being of women.** However, some private sector providers report prescribing whatever is cheapest regardless of incentives. Reported prices for implants and pills are 50 MTs; implant removal is 50 MTs; condoms can be 10-50 MTs Contraceptives are subsidized by DKT
Place	Generally public clinics are located close enough for women to reach them; distance does not seem to be an issue for most women, just those in very remote areas Private clinics are not available in rural areas Some providers report that women want to receive more services at home
Promo	Community education via activistas is reported, as are radio and TV campaigns **Doctors not very involved in promotion, and nurses only somewhat, via linkages with NGOs (Pathfinder)**

	Limited opportunities to educate women about FP options given long wait times and expressed client preference for a particular method Providers express a desire for more education sessions in schools, community education sessions, etc.
Support: Information, Guidance, Coordination, Financing, Incentives	Some public health nurses have worked with NGOs on health promotion; others report minimal interaction All data is reported to the MOH **No concerns about supplies or equipment. Transportation would be appreciated to bring services to remote communities.** **Lack of space can be an issue for counseling/privacy**
Rules: Policy and Regulations **Taxes and Tariffs**	Complete policies exist for FP, SRH, adolescents and youth, and male involvement; there are clear FP guidelines to providing FP services free of cost **Most report that they are aware that there are laws that mandate that FP is free, but otherwise low awareness or questioning of policies** Awareness in the private sector that government commodities cannot be provided through private clinic pharmacies **Private clinic providers seemed generally unaware of government policies** Some public providers stated that there is a new policy about providing FP counseling to post-partum women, but unclear if this is an internal directive or law
Quality	**Public sector providers perceive the private sector as better as private sector providers get more time with clients due to less wait time. However, they are also perceived as focusing on increasing the volume of clients rather than providing the correct service.** **Public sector recommends avoiding stockouts and "palestras" to reduce waiting time and to improve customer service** Many providers seem unaware of what is happening within the hospital overall
Commodity Security	No awareness of stockouts in the public sector; MISAU controls the stocks **Any lack of product in the public sector is due to poor management from the hospital supply chain, not MISAU insufficiency** **In the private pharmacies, lots of pill stockouts that lead to brand switching**
Capacity of Workforce	**Public providers report few training needs, but their knowledge (describing incorrect prescribing practices) and attitudes (appropriateness of methods for different types of women and youth, client service orientation) show room for improvement** **Lack of nursing staff can be an issue in some public sector facilities** Private clinics want more training on IUD insertion, implant removal, and government regulations

Pharmacists and retailers

Players	**Main players in private sector provision: pharmacies for pills, injectables, and condoms; retailers for condoms; black market for pills and condoms** **Pharmacies interact with hospitals and have arrangements for injectables to be provided in the health center** **Pharmacies get stock from/work with: DKT; Medimporte; Geracao BIZ; MedAfrica; Maputo HealthCare; NatuFarm; Medis(port); Farmacetique** **Outlets that sell condoms get these mostly from promoters who come by or from larger markets; very little pull and lots of push for small retailers**
Product	Products usually available: -condoms – Kama Sutra, Way, Fiesta, Prudence, Jeito -oral pills – microgynon (Indian), microlut, Intimos, Progestin, Microlin, Yasmin, Diane 35, Extra Diol, Minigeste **→available brands are limited because few are imported** -emergency pills -depo-provera -(at least one pharmacy was working with DKT to sell implants but lack the trained staff) Most popular FP product in pharmacies is the pill; of these, the most popular is microgynon as it is the least expensive If the preferred brand of pill is not available, consumers may switch to another brand. However, there is a fair amount of brand loyalty. Pharmacies are resistant to stocking new brands of condoms. They generally stock what customers request by name, which is what was suggested to them by a health provider. Condoms have low turnover in pharmacies **Pharmacists have a resistance to selling FP products other than the pill due to the risk of side effects with other methods and the lack of a competitive incentive given that these are provided free in the public sector** **Retailers report no efforts taken to appropriately conserve condoms** Some say Prudence sells more than Jeito, others say J3 is the top seller for its comfort
Price	**No financial advantage to most FP products as they are undercut by the free market – they are selling the same product (including packaging) that is given for free in hospitals** Cheapest pills are those from India, costing ~50 MTs; these often sell out Most expensive pills are microgest and diane 35 (~500 MTs) and minigest and Yasmin (700-900 MTs); these sell less Emergency pills cost around 100 MTs Female condoms have low turnover Most pharmacists believe products, especially pills, should be cheaper and more accessible Condoms are not a major source of revenue – food, alcohol, and beauty products are; some retailers carry them more as a social good than as a source of revenue or only carry them when there is a direct pull from consumers or push from distributors

Place	Distributors come directly to the pharmacist to sell; on these visits, they also order what brands the customers are requesting (pharmacies note which brands are requested that they do not currently carry)
Promo	**Pharmacists will recommend FP methods (pills and condoms) to those purchasing emergency contraception** **Most have no active promotion and don't want to promote**; some have shopping bags or posters and want t-shirts/caps **Some believe they cannot sell FP products to women under 18** Distributors provide health information but not promotional materials
Support: Information, Guidance, Coordination, Financing, Incentives	**Few pharmacists or outlets reported any interaction with government or other regulatory bodies outside of initial licensing** **Some report knowledge of regulations, others don't; some would like information on it** Outlets and pharmacies get some support from DKT and promoters
Rules: **Policy and Regulations** **Taxes and Tariffs**	**Pharmacists are not allowed to sell most FP products and need authorization to sell injectables (most don't administer)** Some pharmacists know the FP policies; most don't Retail outlets are aware they are not allowed to sell contraceptives
Quality	**Pharmacy technicians have pharmaceutical training, but no specific training on FP counseling** **Some feel comfortable talking about pill administration or side effects, but in case of any issues they refer women back to hospitals** Many would like training on FP counseling
Commodity Security	**Stockouts of pills reported, usually of microgynon – this is the most demanded and it is often not available; they will substitute with other brands** In case of stockout, they call the supplier Sometimes they can go a month or two without stock
Labor/Capacity of Workforce	Pharmacy technicians; shop owners **Many people working in pharmacies and shops are salespeople (not pharmacists or doctors) and have limited medical knowledge**

Consumers

Players	**Factors associated with use:** **-urban vs. rural (21.1% vs. 7.2% CPR)** **-higher education** **-highest vs. lowest SES (48% vs. 9%)** **-unmarried vs. married (30.1% vs. 11.3%)** **-monogamous** **-Christian/regular church attendance** **-does not want children in the next two years** **-does not say that husband makes healthcare decisions** **-currently working**
Product	Method mix: -Unmarried women: 53% condoms, 30% pills, 14% injectables -Married women: 45% injectables, 40% pills, 9% condoms -very little difference between rural and urban in terms of method mix High knowledge of contraceptive types with the exception of emergency pills Lots of method switching reported, especially between injectables and pills and between pill brands Perceptions of oral contraceptives: -best method for older women -second best method for young women, following condoms -best method for spacing births -fewest side effects **-uncomfortable side effects (nausea, weight gain, bleeding)** **-confusion about appropriate administration** Perceptions of injectables: **-causes problems with bleeding** -good for young women who don't want children as they won't forget to take it -**providers are unlikely to recommend this to women who don't have children yet** Perceptions of condoms: -best option for young, unmarried women and men **-however, some young women don't trust it for pregnancy prevention as condoms can break** **-married women cannot use because their husbands will not accept it** **-free condoms are not "sophisticated"** Perceptions of IUDs: **-can hurt the uterus** **-causes too much bleeding** Perceptions of implant: **-too longterm, providers may refuse to remove it before five years** **-can be absorbed by the body** -not advised for those with hypertension -**concerned that this will lead to temporary infertility**
Price	Most women receive products free of cost from the health sector **However, there are additional costs to the public health sector, mainly in the form of bribes (50-1,000 MTs) to reduce wait times** Transport costs are not considered an issue Women report paying 20-50 MTs for a condom; 50 MTs for injectables

	Pharmacies and the private sector are considered expensive If condoms became too expensive, women may switch to a different FP method
Place	Distance and transport are not a factor in choosing healthcare options The primary source of healthcare for women is the hospital because services and products are free; this is especially true for the older and youngest women. The second choice is the pharmacy Women don't have a preference generally for particular pharmacies, whatever is close and available **Younger women express some interest in using the pharmacy for FP services, but older women would not due to cost and lack of care**
Promo	Sources of information: -Nurses (in the maternity ward) -Doctors -Generation BIZ – peer education project -Youth centers -Hospital/health center -Community promoters -Friends -Sisters/Aunts **Although parents are an important influencer and respected, they do not talk to their children about FP** **There is a lack of coordination of messaging across partners**
Support: Information, Guidance, Coordination, Financing, Incentives	Total lack of awareness of healthcare financing/insurance Generation BIZ condom vouchers
Rules: Policy and Regulations **Taxes and Tariffs**	Products at pharmacies may be taxed but this cost is included in the price
Quality	**Hospitals are the primary source of care and the quality of counseling is appreciated as are the free services. However, the wait times, hygiene, and lack of privacy are issues** **Women may lose interest in waiting for an FP method and abandon it entirely** **Pharmacies and private clinics are seen as good quality but as too expensive and actively seeking to take money from patients**
Commodity Security	**Sometimes hospitals lack medicines** Pharmacies are often stocked out of pills
Labor/Capacity of Workforce	N/A

Market barriers for Rosalina and Josina

Most groups from whom data was collected (stakeholders, providers, pharmacists, retailers, and women themselves) were also asked about barriers that women (and youth specifically) face overall to accessing family planning in the current market, beyond the set categories of core, support, and rule functions.

Women themselves reported that the primary barriers they faced to adoption of modern family planning include:

- Lack of partner support
- Lack of parental support (youth)
- Side effects
- Myths
- Provider attitudes about acceptability of family planning methods according to age/fertility
- Quality of care: long wait times, lack of privacy in the public sector, insufficient information from pharmacists, etc.

Of the others interviewed, the key barriers they identified for women include:

- Lack of partner support
- Myths
- Method switching
- Private sector costs
- Poor provider training for counseling
- Provider attitudes about acceptability of family planning methods according to age/fertility
- Quality of care: lack of space and lack of time for service delivery
- Stock-outs
- Religion
- Lack of information
- Lack of access

While there is overlap between the two lists, the last two items were frequently cited by the other interviewees but rarely by women themselves. They generally had high awareness of methods (if incorrect knowledge about their administration) and felt that family planning products were generally available and accessible.

An additional way of conceptualizing market access from the standpoint of the consumer is to review the 5 As: affordability (including prices, taxes, tariffs, and financing); availability (shortages, stockouts, presence of suppliers and retailers); assured quality (product quality); appropriate design (appropriateness of choices and cost); and awareness (knowledge and promotion). The 5 As are summarized below for Rosalina and Josina.

Rosalina

Affordability	**Rosalina mostly uses condoms or pills. The condoms are free from public health centers or socially marketed condoms that are sold affordably in pharmacies and retail shops. Rosalina gets her pills free from the public health center. Generally, Rosalina perceives the cost of these products to be affordable, though she cannot afford non-subsidized products or services within private health clinics. This can pose a problem as, though affordable, public health facilities may limit her access to family planning methods due to her age.**
Availability	Condoms are consistently available to Rosalina at set outlets (fixed retail stores, pharmacies, public health centers), but not available in all areas, particularly very rural areas. Pills are available most of the time in the public health center but are often stocked out in the pharmacy, which can lead to brand switching.
Assured quality	Due to strong policy controls on product imports, Rosalina has access to safe and tested products. The only quality concerns she may encounter is in appropriate storage of condoms by retailers.
Appropriate design	The existing products on the market are designed appropriately to meet family planning needs. However, for Rosalina her choice set is often limited by family and provider attitudes which prevent her from using contraceptives at all or from using injectables and longer term methods.
Awareness	Rosalina is aware of most modern methods available to her, though much of her knowledge about the methods is not from trusted sources, as not much education is provided in schools (other than Generation BIZ), her parents are uncomfortable discussing sex with her, and providers refuse to counsel young women about contraception. As such, she relies on conversations with other family members (sisters, grandmothers, aunts) and friends and learns about methods from their personal experiences and perceptions.

Josina

Affordability	**Josina mostly uses pills and injectables. Josina gets her methods mostly from the public health center, which is free. However, there are hidden costs associated even the free services, including transport, bribes paid for services, and the opportunity cost of long wait times. For Josina, products sold in pharmacies are affordable, but the private health facilities are too expensive.**
Availability	Family planning methods are available most of the time in the public health center but pills are often stocked out in the pharmacy, which can lead to brand switching.
Assured quality	Due to strong policy controls on product imports, Josina has access to safe and tested products.
Appropriate design	The existing products on the market are designed appropriately to meet family planning needs. However, for Josina her choice set may be limited by her knowledge and provider perceptions around the most appropriate method for her.
Awareness	Josina is aware of most modern methods available to her, and her trusted source of information is health providers. However, despite knowledge of the products themselves, there can be confusion about administration of the product, namely for the pill.

Market constraints and root causes

Once the market performance had been landscaped, the overall landscape was assessed for weaknesses using a "traffic light" system to show the degree of market failures. Red signifies that there is current neither the motivation for the capacity for the market player to perform this function or the supporting function is absent. Yellow signifies sub-optimal performance, either lack of capacity or motivation.

Figure 5. Traffic light production to use spectrum

	Importers/distributors	Public and private providers	Pharmacists and retailers	Consumers
Product				Myths and misperceptions about the appropriateness of certain products Lack of access for youth
Price	Minimal financial incentive to import or distribute products with little private sector demand		Minimal financial incentive to sell products that are provided for free	
Place				
Promo		Lack of time or capacity for quality counseling		
Support: Information, Guidance, Coordination, Financing, Incentives	Tendering process for government contracts encourages monopolies and reduces competition	Poor awareness of laws and policies surrounding family planning		
Rules: Policy and Regulations **Taxes and Tariffs**	Importers have exclusive rights to certain products which limits negotiating power for those seeking to procure products	Law prohibits private providers from selling many contraceptives Poor licensing and oversight of private providers	Law prohibits private providers from selling many contraceptives	
Quality				Poor quality of counseling and customer service received in the public health clinics
Commodity Security		Occasional stockouts	Frequent stockouts	
Labor/Capacity of Workforce		Public sector is understaffed and lacks capacity	Pharmacy employees are perceived as lacking training	

The team also reviewed each specific market constraint and conducted a scoring exercise to prioritize them. The criteria for scoring the constraints were: 1) feasibility of addressing the constraint; 2) potential for impact on the market (coverage of the universe of need); and 3) whether a market actor is well-positioned to address this issue. Each constraint was scored on a scale of 1-3 for each criteria and those with the highest composite scores were identified.

For importers and distributors, no constraints were prioritized given low feasibility or motivation to change procurement policies.

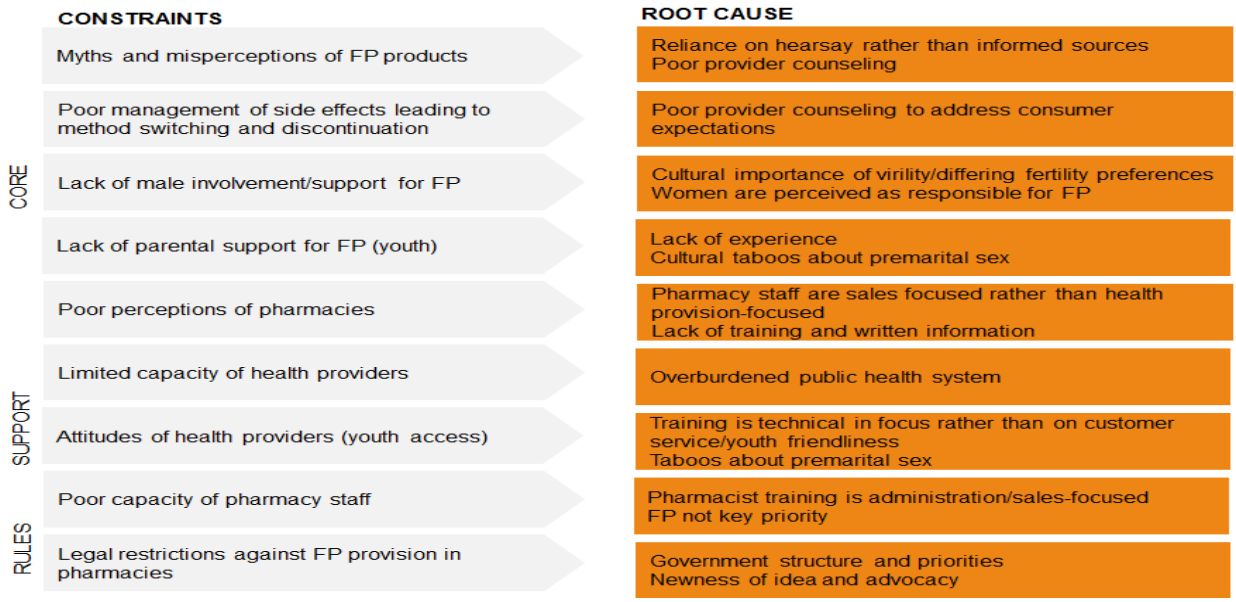
For public and private providers (doctors and nurses), two constraints were identified: lack of provider capacity (time and technical skill) and poor attitudes of providers for family planning provision (preconceived notions about appropriateness of methods, youth access, and respect for clients).

For pharmacists and retailers, three constraints were identified: poor capacity of pharmacists and pharmacy employees in family planning counseling; perceptions of pharmacies as commercially-driven and lacking medical training; and laws limiting contraceptive provision in the private sector.

For consumers, four constraints were identified: myths and misperceptions about methods (including miseducation about method administration and appropriateness); limited access for youth in the public sector due to provider refusal; poor management of side effects, which leads to method switching and/or discontinuation; lack of partner support for family planning use; and lack of discussion with parents for youth.

Once the key constraints had been identified, a root cause analysis was conducted, in which the whys behind each constraint were explored with supporting evidence. The goal of this exercise is to get to the root of the problem in order to address more appropriate strategies to solve it. The root cause analysis is summarized in the figure below.

Figure 6. Main constraints and root causes

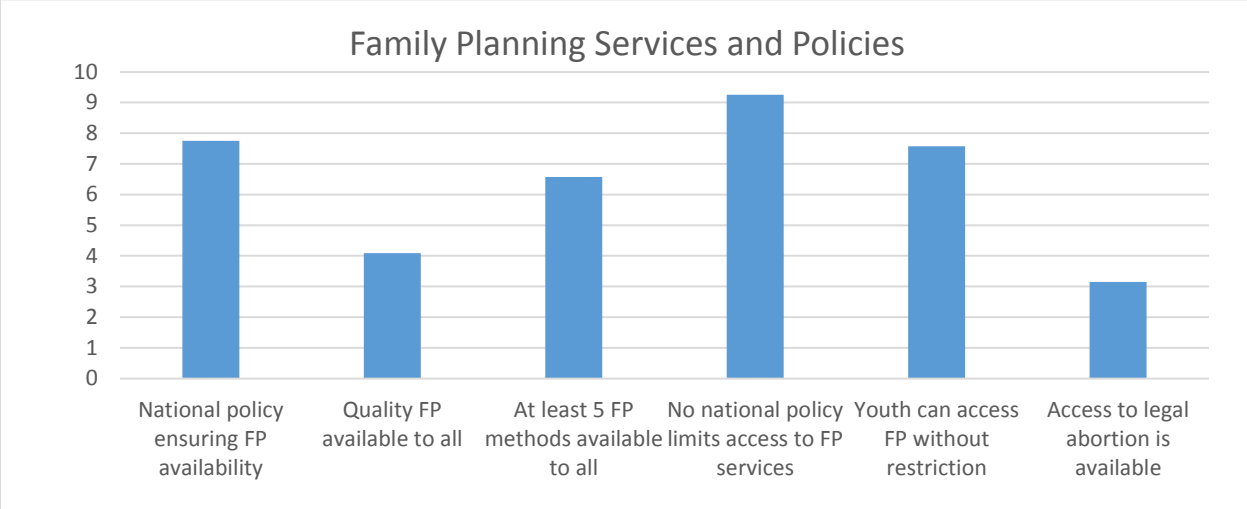


Stakeholder interviews

Donors, implementing organizations, and the Ministry of Health (MISAU) were interviewed on family planning service and policies, financing, and the total market approach using both close-ended (statements that were rated on a scale of 1-10 indicating no agreement to total agreement) and open-ended questions. The workshop summarized the major themes that emerged from the qualitative to complement the quantitative findings.

Family planning services and policies

Overall, most agreed that there were national policies in place that ensured family planning availability without limits, including for youth. However, there was less agreement that quality family planning and a varied method choice was available in practice to all, and likewise that abortion was accessible.



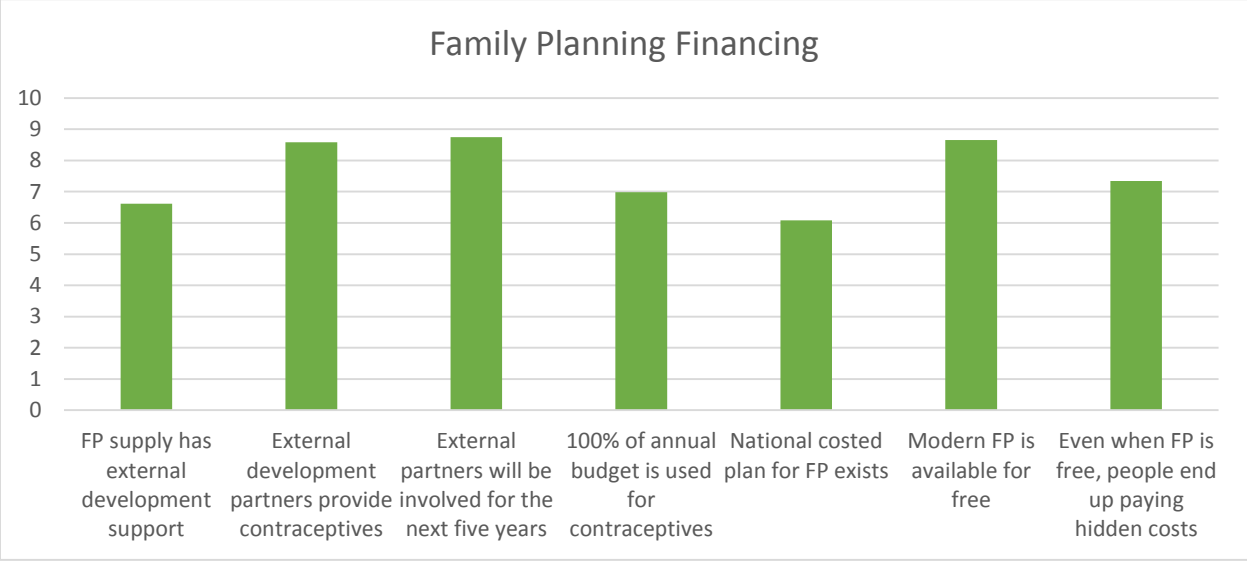
In the qualitative findings, most stakeholders stated that the Government had clear policies for family planning and sexual and reproductive health. However, many of these policies are not always implemented as envisioned due to a lack of communication from central level to the provinces, low capacity of staff to operationalize procedures, and lack of buy-in from the local level. Policies were characterized as top down and often receive very little feedback from the provincial level. There were existing policies that were favorable to providing services to young people. However, according to the Youth Program Coordinator from a local organization, “There is an approved a policy on sexual and reproductive health, but even health care providers don’t know about these policies.”

Thus, most felt that there was no change required to the majority of policies, but that there should be clear guidelines on how to translate policies into action and with specific steps for improving availability of family planning services and products for all. The one policy that was specifically mentioned that could be changed to improve access was the limiting family planning product provision to the public sector; particularly for short-term methods, implementing organizations felt that adherence to methods could be improved by increasing access to these methods through other outlets.

In contrast, it was perceived that there was no specific policy around condom use. It was noted that though that there was government coordination around procurement and logistics for condoms, and that this collaboration should be continued and improved.

Family planning financing

In general, there was high agreement that family planning has support from external partners and it is expected that they will continue to support family planning going forward. Though modern family planning is as being available for free, most also agreed that people could pay hidden costs. Some were also not sure if 100% of the annual budget was used as intended for contraceptives.

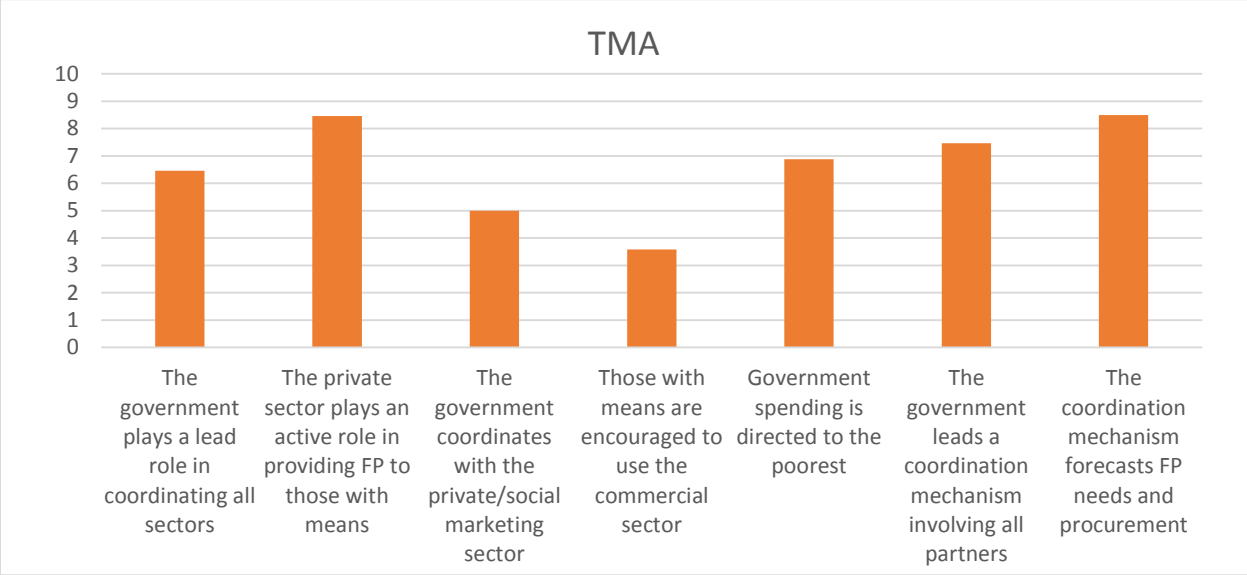


Donors had mixed perceptions around the level of financing that would continue to be provided. Most acknowledged the system at present relies very heavily on donor subsidies and that they would not be able to exit the market in the near future without its collapse. However, some indicated that donors were pulling back and reappraising their role in the family planning market, and that the future of funding would be dependent on the politics of both Mozambique and the funding countries. A few expressed concerns about strains on the existing public health system and whether the government would be able to continue to be the main provider of family planning services with the costs of training, infrastructure, and salaries.

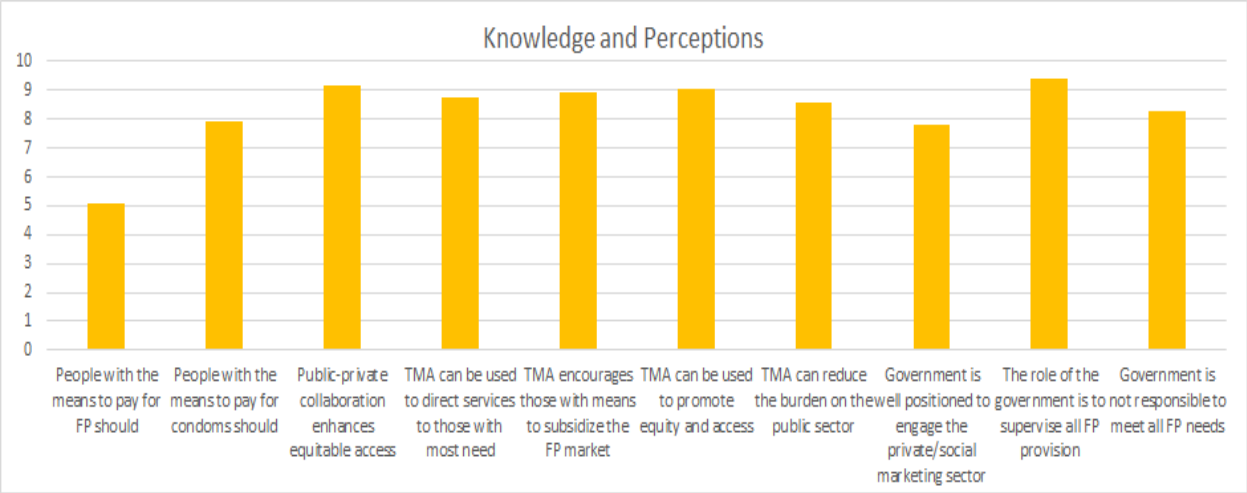
The Ministry of Health (MISAU) indicated that they cost out their needs and the donors support pieces of the funding package according to their ability and priorities. They noted a trend of MISAU covering more gaps in funding, though they appreciated the assistance as well of the private sector in reaching areas that they were not able to cover well, such as remote areas.

TMA situation and perceptions

Generally, stakeholders agreed that the government was coordinating with partners and forecasting family planning needs. However, fewer agreed that they were effectively coordinating with the private and social marketing sectors. While they felt that spending was directed to helping the poorest, they generally disagreed that those with means were encouraged to seek care within the private/commercial sector.



In addition to the current market situation, stakeholders were also asked about their knowledge and perceptions of the total market approach. Generally, people tended to agree with the concept of TMA: that an efficient market would improve equity and access while reducing the burden on the public sector. They also felt that the government did not have to play the role of supervising and meeting all market needs for family planning. However, there remained strong resistance to the idea that people who could should pay for family planning. There was also less agreement about the government's readiness to engage the private sector and social marketing.



Most of the stakeholders had not previously heard of the term "total market approach," but were familiar with the concept and felt that there was space for the market to exist and change, particularly to shift its focus away from the public sector as the only sector for family planning provision. As one implementing organization said, "I'm not familiar with the term but I assume it is not to look only to the national health system as the sole provider…but look for different types of providers in private sector, social marketing…things like that can perhaps be other alternatives for the supply of family planning beyond the national system and are also directed to other segments of the population."

Some noted that at present there was a competition rather than collaboration between public and private sectors and that this is a key factor hindering an efficient market and that the government has a hard time engaging the private sector and also tracking what it is doing. Likewise, a few people indicated that collaboration between non-governmental organizations and MISAU could be improved. However, stakeholders also stated that in working groups there has been increasing discussion on the role of TMA and collaboration between sectors, and the government specifically noted a desire to bring the private sector into these discussions.

When asked specifically about the role of the private sector, most felt that the private sector could play an important role in family planning provision, particularly in the provision of condoms to supplement existing shortages of free condoms. They also felt that the private sector's strengths were innovation and logistics and that there was an opportunity to work with the government on novel approaches for family planning promotion as well as on improving supply chain and distribution. The private sector was also specifically noted by the government as a way to reach rural areas, though one donor felt that they could be doing more education at a community level rather than just providing products.

One implementing organization stakeholder noted that there was a growing demand for family planning services as the economy grows. However, another felt that long-term private sector provision of family planning was uncertain given current economic conditions paired with a lack of demand. "The conditions in the market are not favorable…the country still doesn't understand the importance of family planning…and people do not want to pay."

In addition to market conditions, a donor noted policy restrictions around free provision that limit private-public partnership. DFID felt that the policy of free provision should be examined in light of the future sustainability of the market.

At least one implementing organization noted that the Ministry of Health (MISAU) should be "more involved" with the activities of the private sector, particularly in product and service provision. Another noted a lack of oversight of the private sector (for example, not knowing how many private providers there are) and adherence to regulations.

Future of Family Planning

Donors and implementing organizations spoke of a hope that there will be growth in the family planning market via provision of more services, expanding the geographic reach of products and services, improvement in people's perception towards family planning services and products, and greater donor support.

Among specific strategies mentioned by donors and implementing organizations for improving the contraceptive landscape were changing of policies to allow non-public health centers to provide a range of contraceptive options, increasing the involvement of the private sector in family planning provision and specifically social marketing of condoms, targeting youth in education, including family planning promotion in more routine health activities, increasing community outreach, and engaging parents and men in family planning promotion. The Ministry of Health (MISAU) specifically noted the success of community distribution strategies and the intent to scale up these programs.

One donor called for a more multi-sectoral approach, engaging other ministries such as education and agriculture to be involved in family planning promotion. Implementing organizations also expressed a desire for more coordination in the areas of messaging, transportation, and coordination of activities. UNFPA specifically called for more coordination to reduce "message confusion" for the target population and bringing together the markets to make products more accessible via improved procurement and distribution of commodities. There was also a call for more education and demand generation activities, particularly in rural areas.

Funding constraints were cited on several occasions as a barrier to family planning scale up in Mozambique as many local and international organizations were heavily dependent on donor priorities and donors themselves expressed concern that progress was moving too slowly. However, the government and implementing organizations working in this space reported that progress was being made on uptake of family planning in Mozambique and hope to see successful initiatives continued.

Annex A: List of interviewees

Organization	Name(s)
USAID	Lilia Jamisse and Raquel Zaqueu
UNFPA	Arsénia Nhancale
DFID	Etelvina Mahanjane
Swiss embassy	Christina de Carvalho Erikson, PhD
Dutch embassy	Monique Kamphuis
ADDP	Helen Hallstrom
AMODEFA	Manuela Dalas, Ester and Estevão
Clinton Foundation	Beatriz Rocha, Custódio Mondlane and José Augusto de Jesus
Coalizão	Maria Feliciana
DKT	Júlio Baptista
ICRH	Sally Griffin and Joelma Joaquim
Pathfinder	Rita Badiani