



## PROGRAM BRIEF

# Shaping the Family Planning Market by Strengthening the Public Sector



PSI makes it easier for people in the developing world to lead healthier lives and plan the families they desire by marketing affordable products and services.







## ACRONYMS

ASF	Association de Santé Familiale	PASMO	Pan American Social Marketing Organization
CYP	Couple-years of protection (against unintended pregnancy)	PPFP	Post-partum family planning
DRC	Democratic Republic of Congo	PPIUD	Post-partum intrauterine device
FP	Family planning	PSI	Population Services International
FP2020	Family Planning 2020	SIFPO2	Support for International Family Planning Organizations 2
IUD	Intrauterine device	SFH	Society for Family Health
LARCs	Long-acting reversible contraceptives	TMA	Total market approach
mCPR	Modern contraceptive prevalence rate	USAID	United States Agency for International Development
MoH	Ministry of Health	WHO	World Health Organization



# Introduction

Total market approaches (TMA) are critical for achieving universal health coverage, which is the goal of ensuring that all people have access to quality health care, including voluntary family planning, without facing undue financial hardship. The term “TMA” is often associated with efforts to direct clients who can pay for services to the private sector to allow subsidies in the public sector to better reach the clients with the greatest financial need. However, Population Services International’s (PSI) approach to TMA involves solutions that involve both the public and private sector players at the levels of supply, demand and the enabling environment.

This program brief presents cases, supported by several different donors, which take into consideration the total family planning market. The TMA lens helped PSI to prioritize interventions that strengthen service delivery in the public sector. Each case began with consideration of two key TMA questions:

**1. Who is the family planning market failing?** As a first step to understand the market, PSI analyzes contraceptive use and unmet need for family planning by age, gender, geography, risk behavior and other factors—segmenting the population to inform the rest of the approach.

**2. How is the family planning market failing those groups?** This step requires consideration of the total health market and incentives for performance from the perspectives of direct players across the value chain as well as indirect players who influence the enabling environments. Examples of direct players are pharmaceutical manufacturers and providers in the public and private sectors who influence supply and demand. Indirect players include regulatory and financial actors, among others.

With the support of multiple projects and donors, PSI’s technical and global marketing teams conduct a market landscape to analyze entire health markets, including markets for voluntary family planning. This highlights where gaps or weaknesses exist at the intersection of market players and market functions.

Once market failures have been identified, PSI assesses and prioritizes them according to:

- **Impact:** Would an intervention at this level affect our goal-level commitment?
- **Scale:** Can the intervention really change the market? Or just band aid it?
- **Partnerships:** Do partners exist to address these failures?
- **Feasibility:** Do we have the budget, organizational alignment and appropriate skillset to intervene?
- **Synergies:** Does the intervention tap into existing strengths (ours or others)?

PSI then develops context-specific solutions to fix priority market failures in partnership with others. These targeted interventions complement the work of national health leaders and other international actors to support a holistic market-strengthening response.

As demonstrated in this program brief, a total market approach can lead to solutions involving public sector service delivery to expand family planning access and choice. In a number of low- to middle-income markets, the public sector remains a very important source of family planning services with a reach beyond the current private sector. In these contexts, building the capacity of the public sector, strengthening cross-sector collaboration and improving the enabling environment can make markets healthier.

While PSI works to strengthen both the private and public sectors, the purpose of this brief is to showcase six country-level examples of PSI’s collaborative work to specifically strengthen the public sector as a part of the total market for family planning. These cases demonstrate how PSI identifies market failures that can be addressed in the public sector; how PSI’s in-country network members collaborate with stakeholders to develop sustainable solutions; and how these solutions are delivered in the form of programs that improve family planning services.



**FIGURE 1.** Making a healthy market: PSI maps all players directly involved in getting a product or services from it's producer to its consumer.



### CORE FUNCTIONS: DEMAND AND SUPPLY

Direct market players across the value chain, from manufacturers to consumers, perform the core functions of demand and supply. PSI measures these core functions through the 4Ps of marketing:



PRODUCT



PRICE



PLACE



PROMOTION

### ENABLING ENVIRONMENT

The enabling environment is made of factors, institutions and players who come together to shape the market. The most common and impactful market players fall under two categories: rules and supporting functions.

#### RULES



POLICY



REGULATION



TAXES & TARIFFS

#### SUPPORTING FUNCTIONS



INFORMATION



GUIDANCE



COORDINATION



FINANCING



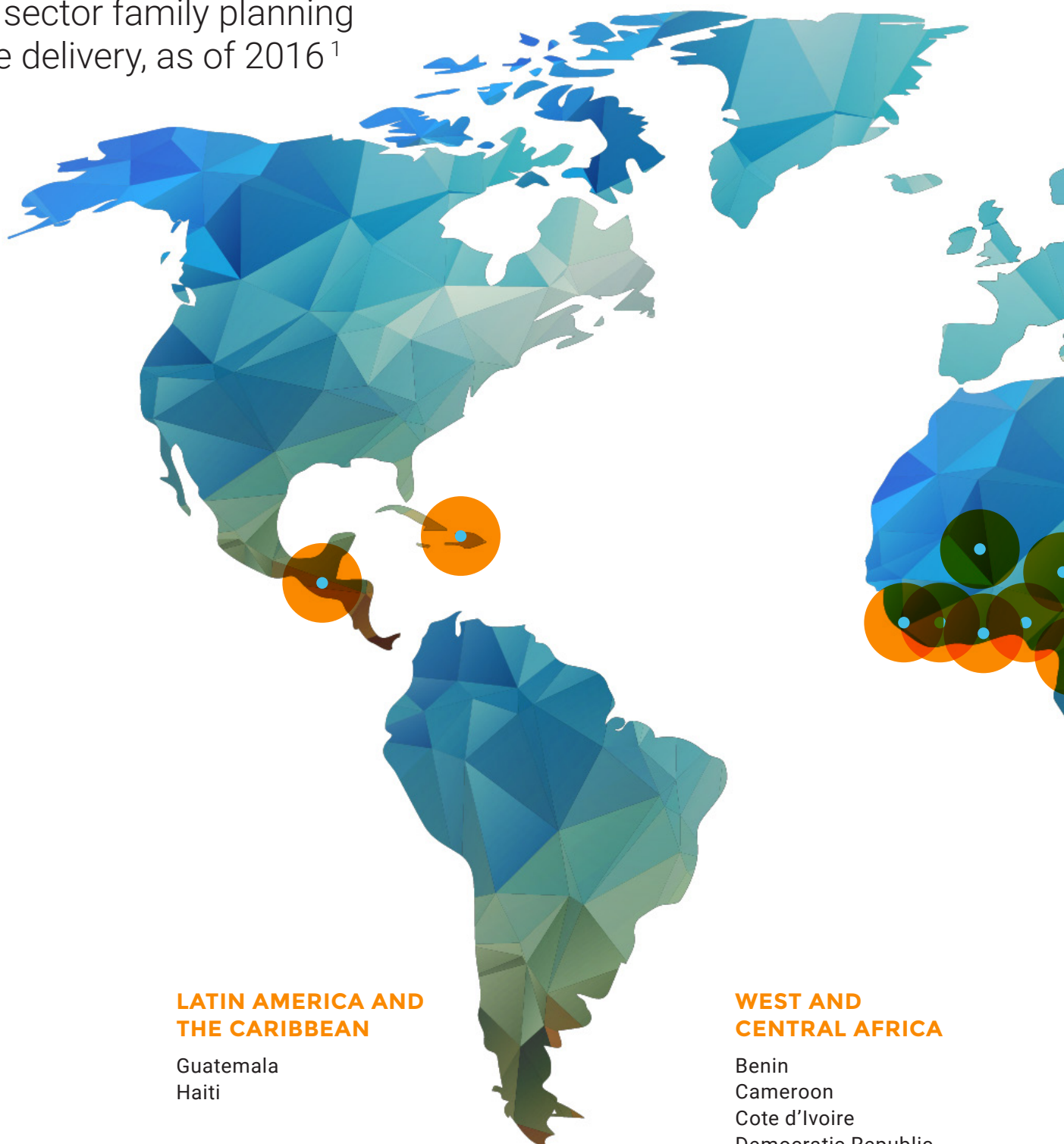
QUALITY  
ASSURANCE



LABOR  
CAPACITY

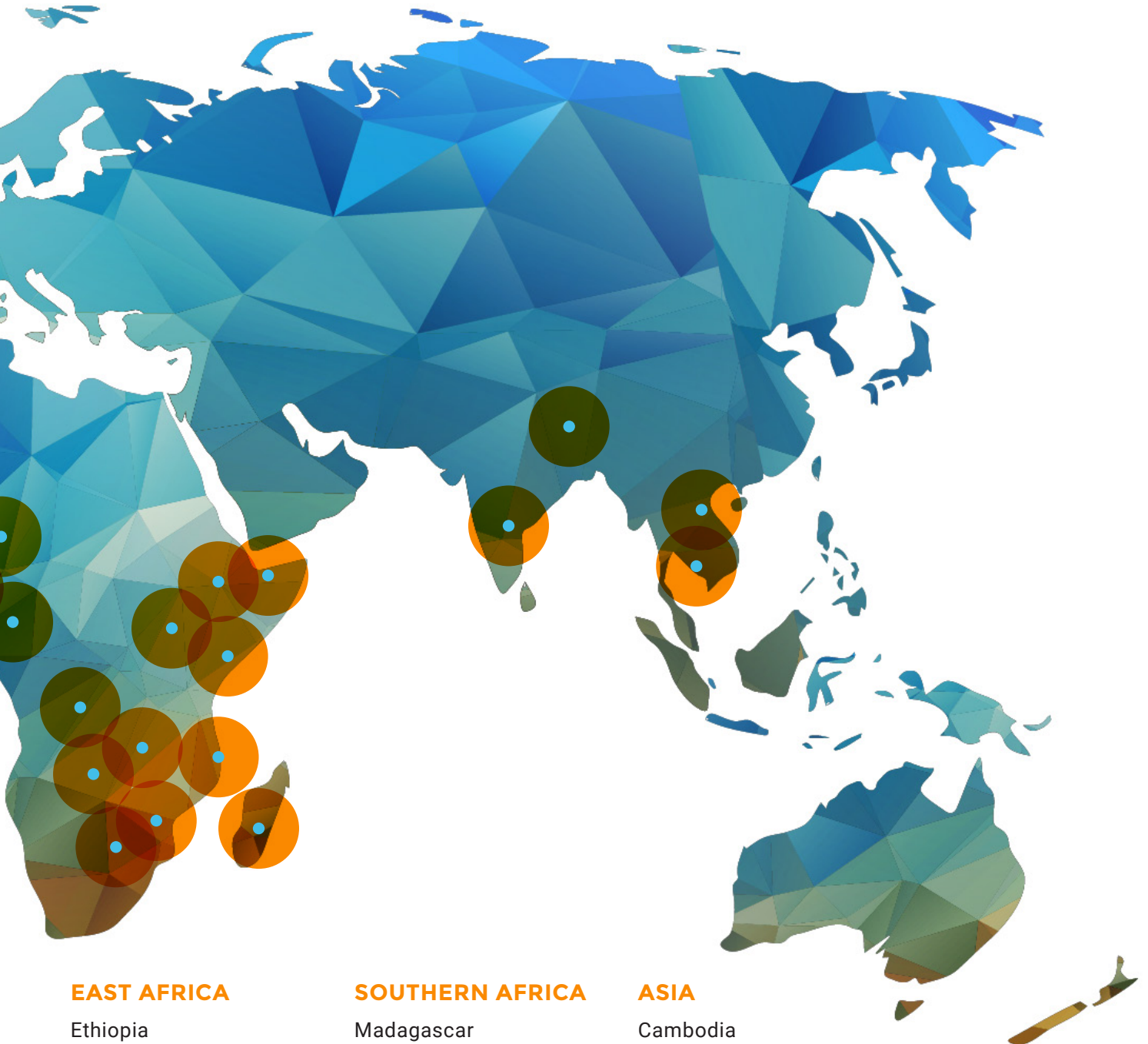


Map of where PSI strengthens  
public sector family planning  
service delivery, as of 2016<sup>1</sup>



<sup>1</sup> These countries are supported through various donors





### **EAST AFRICA**

Ethiopia  
Kenya  
Malawi  
Mozambique  
Somaliland  
Tanzania  
Uganda

### **SOUTHERN AFRICA**

Madagascar  
Zambia  
Zimbabwe

### **ASIA**

Cambodia  
India  
Laos  
Nepal



# Why family planning?

This brief looks at public health sector strengthening through the lens of one health area—voluntary family planning. PSI works in multiple health areas and prioritizes service integration to more efficiently and comprehensively meet clients' needs. According to the World Health Organization (WHO), integrating service delivery in this way can benefit individuals (providing increased satisfaction with and improved access to timely care), communities (generating greater levels of health seeking behavior), health professionals (expanding workforce skills and reducing burnouts), and health systems (improving equity and resources).<sup>2</sup> The approaches presented are relevant and applicable to other health areas, from HIV testing services to malaria treatment and more.

More than 220 million women and girls in developing countries want to avoid pregnancy, but are not using modern contraception. According to the WHO, increasing access to voluntary modern family planning methods can reinforce women's ability to determine

the number and timing of children they desire, while improving maternal and child health outcomes. Giving women this power to delay, space, and limit their pregnancies allows families and communities to thrive.

In light of this unmet need, the global Family Planning 2020 (FP2020) Initiative aims to enable 120 million more women to access voluntary contraception by 2020 and the Sustainable Development Goals call upon the global community to meet 75% of demand for contraception by 2030. As part of FP2020, PSI's goal is to reach 10 million people under the age of 25 with modern contraceptive methods by the end of December 2020,<sup>3</sup> as well as expand access to long-acting reversible contraceptives (LARCs).<sup>4</sup> Achieving these goals will require the engagement of the public and private health sectors alike and a focus on advancing universal health coverage.



<sup>2</sup> World Health Organization. (2015). WHO global strategy on people-centered and integrated health services. Available from: <http://www.who.int/servicedeliverysafety/areas/people-centred-care/global-strategy/en/>

<sup>3</sup> PSI Pledges Increased Access to Contraception for 10 Million Youth by 2020. (July 8, 2016). Family Planning 2020 Web Site. Available from: <http://www.familyplanning2020.org/articles/15573>

<sup>4</sup> Commitments, Progress & Transparency: Program & Service Delivery. (July 11, 2012). Family Planning 2020 Web Site. Available from: <http://www.familyplanning2020.org/entities/209>

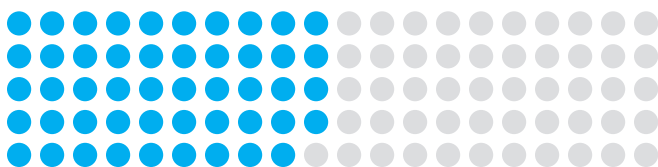
# Task Sharing to Strengthen the Family Planning Workforce in Guatemala<sup>5</sup>



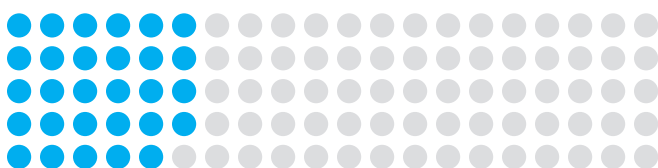
## BACKGROUND

Guatemala has the lowest health worker density in Central America and a high unmet need for family planning, particularly in the Western Highlands.

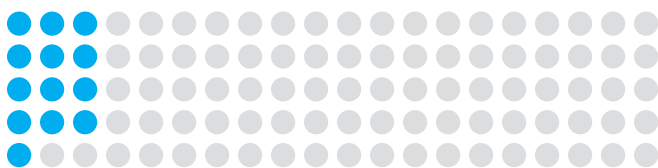
Modern contraception prevalence rate (mCPR): 49%<sup>6</sup>



mCPR in the Western Highlands: 29%



12.5 health workers (defined as Medical Doctors and Registered Nurses) per 10,000 population.



## In this context, who was the market failing?

Low-income, rural women of reproductive age in the Western Highlands.

## Which market failures were prioritized and addressed?

Labor capacity was insufficient to meet demand for family planning. Policies prevented effective use of the skills and competencies of auxiliary nurses in the health workforce.

## Where did PSI work in the market?

PSI's network member in Guatemala, Pan American Social Marketing Organization (PASMO) demonstrated to the Ministry of Health (MoH) how task sharing with auxiliary nurses to provide LARC insertions as part of the range of methods offered in public facilities could fill the gap.

In Guatemala, access to voluntary LARC services, which include implants and intrauterine devices (IUDs), is limited by a lack of providers with the necessary knowledge, skills, and motivation—especially in rural areas. Guatemala has the lowest health worker density in Central America at 12.5 health workers per 10,000 population. Most of the country's health care providers in rural areas are not doctors or nurses, but auxiliary nurses who have an elementary school education or higher, and a 10- to 11-month training.

To address this, the MoH and PASMO work to expand the total market for voluntary family planning by enabling auxiliary nurses to offer all of the methods they can safely provide. In the private sector, clients pay health providers for services, which can create an inherent motivation to deliver quality services and provide good customer service in order to sustain and grow one's business. Without a performance-based payment structure in the public sector, along with a host of other challenges, quality can vary. To model that sense of motivation in the public sector, PASMO encourages providers to meet the highest quality standards through recognition and support: Auxiliary nurses were trained in family planning counseling on informed choice, WHO medical criteria, and voluntary LARC (primarily hormonal implant)

<sup>5</sup> USAID funded this work in Guatemala.

<sup>6</sup> Ministerio de Salud Pública y Asistencia Social (MSPAS), Instituto Nacional de Estadística (INE), ICF Internacional, 2015. Encuesta Nacional de Salud Materno Infantil 2014-2015. Ciudad de Guatemala, Guatemala.



provision, and received ongoing supportive supervision and reinforcement to improve the quality of services. Furthermore, clients chose a provider to recognize for their excellent quality of care, and then presented the certificate of recognition to the provider herself, increasing the desire of providers to provide high-quality service delivery.

Auxiliary nurses work under certain limitations. National guidelines do not allow them to provide LARCs, but the WHO guidelines on task sharing indicate that auxiliary nurses can insert and remove hormonal implants under specific supervisory requirements, and that their role in performing IUD insertions and removals can be considered in the context of rigorous research.<sup>7</sup>

With the support of the MoH, PASMO selected auxiliary nurses in public facilities where there were three to five doctors, and were equipped with all the necessary supplies, and designed a training curriculum for insertion of IUD and hormonal implants, which included the development of skills and competencies, medical eligibility criteria, initial management of complications, and management and reporting of adverse events. PSI's experience developing service delivery protocols and training its franchise networks of private sector providers enabled it to support the public sector to do the same.

While previously only nurses and doctors were authorized to provide LARCs, the project worked with 69 of the 133 facilities (52% of total facilities) in the rural Western Highlands to enable more than 300 auxiliary nurses to provide these services in addition to the short-acting methods and counseling they offered before. Nurses and doctors in the same facilities remained responsible for LARC removals. As the numbers of providers who could offer LARC services grew, so did the percentage of clients choosing them.

Quality assurance visits to the health facilities showed that WHO-based quality standards for IUD and implant insertion are above 95% on average. Quality assurance audits led by PASMO and the MoH found a balanced process of family planning counseling, including information on contraceptive effectiveness, and informed and voluntary decision-making by clients. While the MoH depends on financial assistance from donors to maintain this training and certification process, the project's goals for sustainability are being

initially realized through the transfer of ownership of supervision and quality assurance by introducing new approaches, implementing proof of concept, and then facilitating handover. PASMO is currently working on transferring the processes of supervision and quality assurance audits to the MoH.

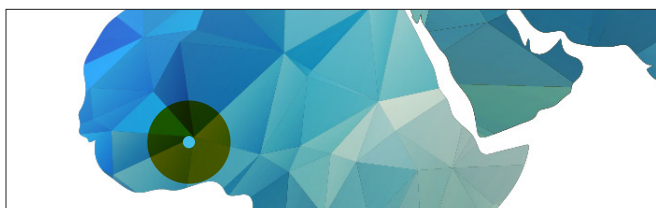
## Results

- From 2012 to 2014, more than 6,000 IUDs and more than 8,000 hormonal implants were inserted across all intervention facilities, providing over 59,000 couple-years of protection (CYPs) against unintended pregnancy in the context of informed choice.
- Guatemala's Ministry of Health agreed that the 2017 update to the national family planning guidelines may include voluntary LARC provision by auxiliary nurses.



<sup>7</sup> World Health Organization. 2012. Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva, Switzerland.

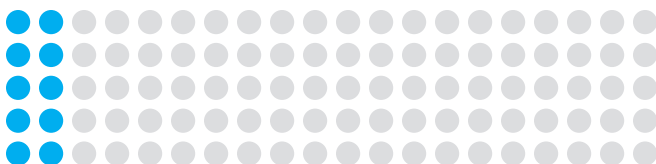
# Integrating family planning with immunization through dedicated providers in **Mali**<sup>8</sup>



## BACKGROUND

In low-income areas of Bamako, community health centers often lack the contraceptive products and access to training and equipment in order to include voluntary LARCs in their method offering. Where LARC options are available, many women are unable to afford the out-of-pocket user fees.

mCPR: 9.6%



Unmet need: 26%<sup>9</sup>



## In this context, who was the market failing?

Low-income Malian women in their first year post-partum.

## Which market failures were prioritized and addressed?

PSI-Mali addressed labor capacity in Mali's public sector hospitals, where health providers were often too busy to offer family planning services. While Malian mothers rarely have the chance to seek services for themselves, most bring their children to hospitals for vaccinations. Immunization days presented an opportunity to reach post-partum women in a place that was more convenient to them, while promoting information about the healthy timing and spacing of pregnancy, and making voluntary family planning services (including LARCs) available on the spot.

## Where did PSI work in this market?

Dedicated family planning providers offered services during immunization event days at public health facilities, then coached and mentored public sector providers to do the same.

In Mali, contraceptive use is rare, maternal death rates are high, and one in 10 children die before his or her fifth birthday.<sup>10</sup> Since 2001, PSI-Mali has leveraged the total market in Mali to contribute to reproductive health and child survival. PSI-Mali's social franchise of private clinics, branded under the name ProFam, works to expand access to high-quality, subsidized health services including family planning.

As of 2006, only 7% of postpartum women were using any method of family planning, including lactational amenorrhea, in spite of an expressed desire by the great majority to avoid giving birth in the next two years. During the first year after a birth, 79% of women were left with unmet need, exposing them to the elevated maternal and infant health risks of closely spaced pregnancies.<sup>11</sup> The family planning market was failing to reach women in their first year postpartum.

Many Malian women lack the financial means, social support and opportunities to seek health services for themselves, but manage to access vaccinations for their infants. Childhood immunization providers in the

<sup>8</sup> USAID funded this work in Mali.

<sup>9</sup> Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT et ICF International, 2014. Enquête Démographique et de Santé au Mali 2012-2013. Rockville, Maryland, USA : CPS, INSTAT, INFO-STAT et ICF International.

<sup>10</sup> Ibid.

<sup>11</sup> ACCESS-FP. (2007.) Family planning needs during the extended postpartum period in Mali. Available from: [http://pdf.usaid.gov/pdf\\_docs/pnaea351.pdf](http://pdf.usaid.gov/pdf_docs/pnaea351.pdf)



private and public sectors saw waiting rooms full of young mothers with small children and an unmet need for family planning. However, these providers were busy with the important task at hand: vaccinating children.

To reach the large numbers of mothers in waiting rooms with an unmet need, PSI-Mali utilized a dedicated family planning provider model, which places a dedicated family planning provider in a setting that typically offers another service. There, a PSI-Mali midwife would attend private sector clinic event days, such as an immunization day, to present a 30-minute group talk to mothers waiting for their children to be vaccinated. Subsequently, the PSI midwife offered free family planning counseling and subsidized services, including voluntary LARCs.

However, because the majority of maternal and child health services are delivered through the public sector in Mali, PSI-Mali and the Malian Ministry of Health saw the need to bring their dedicated provider work to the public sector. In order to establish such a partnership between ProFam and the public sector, PSI sought approval from the MoH and worked to generate commitment and buy-in at both the Ministry and clinic levels.

PSI-Mali representatives met with the Director of the Bamako Regional Department of Health to discuss a potential partnership between PSI-Mali and the MoH's primary health care system. PSI-Mali proposed a partnership that would allow the MoH to expand the contraceptive offerings of community health centers to include the two LARC methods, IUDs and implants, reaching more women in need at minimal additional cost. By expanding the ProFam brand and outreach model to the public sector, PSI-Mali hoped to leverage the ProFam name and reputation to inspire client confidence in the services provided. Additionally, PSI-Mali hoped to demonstrate to public sector providers the latent demand for these services, while training and coaching public sector providers to provide the services—effectively linking quality supply and latent demand at the service delivery points where most Malian women seek care.

The Bamako Regional Department of Health recognized both the need for increased access to LARC services within the public health care system, as well as the successes of the ProFam outreach model in the private sector, and agreed to pilot a partnership

to generate increased capacity within the public health care system.

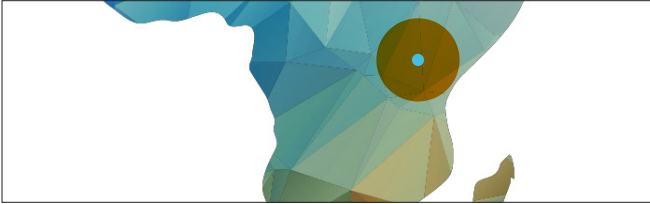
With this agreement, PSI-Mali expanded the successful model from private franchise clinics to public sector community health centers in Bamako. First, PSI-Mali added more midwives to the core staff of dedicated family planning providers for event day activities. PSI-Mali provided trainings, quality assurance and equipment for outreach events, such as immunization days. Over time, these public sector providers increased provision of voluntary family planning services, including LARC methods, with monthly supportive quality insurance and supervision from PSI-Mali. With a standardized package of quality services, the public community health centers became a part of the ProFam social franchise.

In addition, in concert with its partners, PSI-Mali successfully advocated for the reduction in price of LARCs at the government's central medicines store. The expansion of voluntary LARC services was designated as the top priority in Mali's national strategic plan for family planning. PSI-Mali has continued to work to increase government ownership and future sustainability, by ensuring the supervision and monitoring activities were included in the district annual plan and budget.

## Results

- Between 2009 and 2011, trainers from PSI-Mali and the MoH worked hand-in-hand to train and certify 149 public sector providers from 73 community health centers to provide voluntary LARC services in addition to short-acting methods.
- PSI-Mali reached 166,383 women with interpersonal communication messages about voluntary family planning during urban outreach events from 2010 through 2011. Of these women, 25% chose and received a LARC method.
- Between 2013 and 2015, more than 53,000 IUDs and 84,000 implants were offered by trained and qualified health providers in Mali, which represents a 25-fold increase over the 5,543 women estimated users of LARC in 2006.

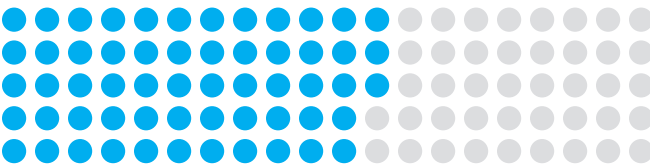
# A mobile outreach model to expand contraceptive choice and access in **Malawi**<sup>12</sup>



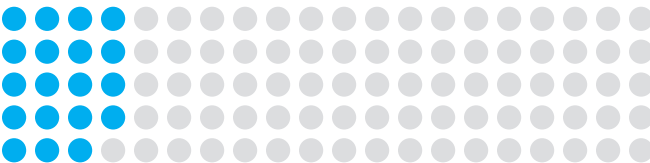
## BACKGROUND

In hard-to-reach rural areas of Malawi, women have low access to health facilities and a high unmet need for family planning, including birth limiting.

mCPR: 58%



Unmet need: 18.7%<sup>13</sup>



## In this context, who was the market failing?

Rural women in Malawi who wanted to limit births.

## Which market failures were prioritized and addressed?

Place and labor capacity: Limited access to modern methods of contraception, such as voluntary LARCs and PMs, in rural areas.

## Where did PSI work in this market?

PSI-Malawi partnered with the MoH to use dedicated providers in public health centers and to provide mobile outreach to rural areas.

In Malawi, where 85% of the population lives in rural areas,<sup>14</sup> PSI-Malawi has collaborated with the MoH since 1994 to extend the reach of the health system and to improve reproductive health. As of 2010, more than a quarter (27%) of rural married women expressed an unmet need for family planning, including 12% who wished to limit births but were using no modern method. In rural areas at the time, the average woman wanted to have four children, but gave birth to six.<sup>15</sup>

In 2014, PSI-Malawi and Malawi's Ministry of Health Reproductive Health Unit, designed a solution: Five collaborative teams made up of one PSI-Malawi clinical officer and five nurse midwives developed a mobile outreach plan to conduct monthly visits to rural areas that were not well served by other service delivery channels, and offer free family planning products and services, including voluntary LARCs and permanent methods. The teams worked to address the family planning market failures in two ways: by using a dedicated provider model to improve labor capacity, and by using mobile outreach in rural areas to provide services where women needed it most.

These nurse midwives also brought public health nurses and nurse midwives with them to provide on-the-job training. They used tents, churches and schools, not only bringing the services closer to rural women but also offering to pick up clients who are too sick to walk to the clinic themselves. Clients who chose to

<sup>12</sup> USAID and KfW funded this work in Malawi.

<sup>13</sup> National Statistical Office (NSO) [Malawi] and ICF International. 2016. Malawi Demographic and Health Survey 2015-16: Key Indicators Report. Zomba, Malawi, and Rockville, Maryland, USA: NSO and ICF International.

<sup>14</sup> Malawi Department of Population and Development. 2012. Why Population Matters to Malawi's Development. Available from: <http://www.prb.org/pdf12/malawi-population-matters.pdf>

<sup>15</sup> National Statistical Office (NSO) and ICF Macro. 2011. Malawi Demographic and Health Survey 2010. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.



receive permanent methods were given transportation to the public health center where the clinical officers provided those services. A week before the nurses and nurse midwives arrived in each rural area, PSI-Malawi used community-level mobilization agents to raise awareness of the timing of the dedicated outreach teams' visits and to generate informed demand for their services.

On average, PSI-Malawi dedicated provider/mobile outreach teams covered up to 20 remote and hard-to-reach sites per week. While PSI-Malawi continued to deliver services at the health centers and through mobile outreach, more responsibilities were given to the MoH staff at the hard-to-reach sites to deliver family planning services themselves. Ultimately PSI-Malawi providers returned every one to two months to provide supportive supervision and to offer help delivering services when needed. This combined approach reduced the burden for public sector providers in the short term and built their capacity to offer an expanded method mix in the long term.

While PSI-Malawi continued to deliver services at the health centers and through mobile outreach, more responsibilities were given to the public sector staff to deliver an expanded method mix of family planning services over time. To move towards embedding this work within the public system, PSI-Malawi has begun

piloting a mentorship program with these public sector providers to continue their work and improve their abilities to deliver voluntary family planning, with the ultimate goal of six districts incorporating this training and service provision into their own budgets.

## Results

At program inception in 2013, no LARC and permanent method services were being offered in the intervention areas. By the end of 2015, PSI had trained six MoH clinical officers to offer permanent methods and 19 medical assistants and 87 nurses to provide LARC insertions and removals. Within the context of access to a broad method mix, the program provided:

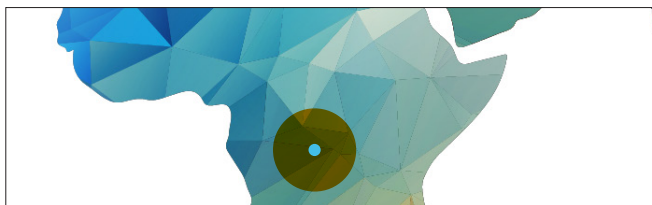
- 568 tubal ligations
- 216 10-year IUD insertions (with 13 removals)
- 4,271 three-year implant insertions (with 318 removals)
- 4,775 five-year implant insertions (with 661 removals)
- For rural, married women in Malawi from 2010 to 2015-2016, the mCPR increased from 41% to 58% and unmet need for family planning declined from 27%<sup>16</sup> to 19%<sup>17</sup> thanks to the contributions of many actors.



<sup>16</sup> National Statistical Office (NSO) and ICF Macro. 2011. Malawi Demographic and Health Survey 2010. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

<sup>17</sup> National Statistical Office (NSO) [Malawi] and ICF International. 2016. Malawi Demographic and Health Survey 2015-16: Key Indicators Report. Zomba, Malawi,

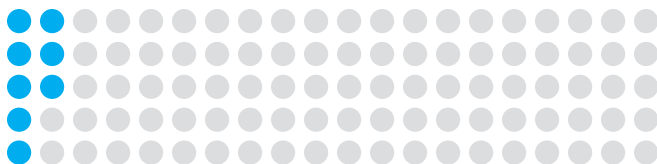
# Introducing Post-Partum Family Planning in the Public Sector in Democratic Republic of Congo<sup>18</sup>



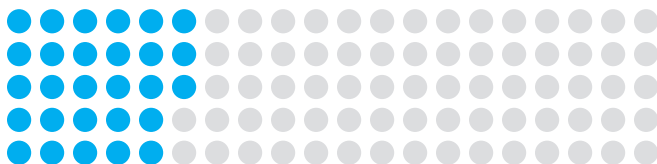
## BACKGROUND

In the DRC, 26% of births take place less than 24 months after a preceding birth, even though only 8% of women in the first year postpartum desire another birth within two years. In the six to 12 months after a birth when the lactational amenorrhea method is no longer effective and most postpartum Congolese women have returned to sexual activity, only one in 10 uses a modern method of family planning.<sup>19</sup>

mCPR: 8%<sup>20</sup>



Unmet need: 28%<sup>19</sup>



## In this context, who was the market failing?

Post-partum women in DRC who desire birth spacing.

## Which market failures were prioritized and addressed?

Coordination, product and labor capacity: While public hospitals, where most women deliver, offered a few family planning methods, post-partum LARCs were not available and post-partum family planning (PPFP) counseling was not integrated into antenatal care.

## Where did PSI work in this market?

PSI and its network member, Association de Santé Familiale (ASF) worked with the MoH to build capacity of public providers in hospitals to provide PPFP and offer post-partum LARC options.

The DRC's public health system faces severe shortages in qualified health staff and quality health care services. In close collaboration with the National Program for Reproductive Health, ASF launched a social franchise network in 2003 called Confiance to increase the private health sector's contribution to meeting the need for family planning in the DRC.

In 2012, the market was failing to reach the great majority of postpartum women with the family planning information they needed and services they desired. In the first year postpartum, two thirds of Congolese women have an unmet need for contraception—a far higher percentage than women in other phases of life. Most of this unmet need among postpartum women is for birth spacing, rather than limiting, signaling a need for improved access to reversible PPFP methods like LARCs.<sup>21</sup>

Recognizing this need, ASF and the MoH agreed to build capacity for PPFP in public health facilities, where most deliveries take place. The program aimed to improve access to and expand the range of family planning choices available to include postpartum IUDs and, more recently, postpartum implants.

Starting in December 2012 in partnership with the MoH<sup>22</sup>, ASF strengthened PPFP counseling during

<sup>18</sup> USAID funded this work in DRC.

<sup>19</sup> ACCESS-FP. Family planning needs during the extended postpartum period in the Democratic Republic of Congo. Available from: [http://reprolineplus.org/system/files/resources/accessfp\\_dr%20congo\\_analysis\\_2009.pdf](http://reprolineplus.org/system/files/resources/accessfp_dr%20congo_analysis_2009.pdf)

<sup>20</sup> Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) and ICF International. 2014. Democratic Republic of Congo Demographic and Health Survey 2013-14: Key Findings. Rockville, Maryland, USA: MPSMRM, MSP et ICF International.

<sup>21</sup> ACCESS-FP. Family planning needs during the extended postpartum period in the Democratic Republic of Congo. Available at: [http://reprolineplus.org/system/files/resources/accessfp\\_dr%20congo\\_analysis\\_2009.pdf](http://reprolineplus.org/system/files/resources/accessfp_dr%20congo_analysis_2009.pdf)



antenatal care and added PPIUD services in public sector facilities in Kinshasa. All participating facilities had at least 100 deliveries per month, providers who were motivated to add PPIUD services, and a family planning unit where clients could return for follow up visits.

ASF trained 10 trainers from the National Reproductive Health Program, the Congolese and Obstetrics and Gynecology Society, the Association of Delivery Nurses, ASF, and 15 public sector providers to offer PPFP that included PPIUD services. In 2013, the National Reproductive Health Program integrated PPIUD services into training modules for family planning providers throughout DRC, and in 2014, ASF introduced PPIUD services in a second province within the context of informed choice. The support of champions in the MoH and health facilities was crucial to the success of this service integration.

Now, in the catchment areas around the 10 public hospitals in the Confiance network where this work is being done, public providers hold information sessions on the wide range of contraceptive methods, and birth attendants counsel through the lens of informed choice during the third trimester of pregnancy. Labor and delivery wards are now stocked with the necessary PPIUD equipment, and PSI provides supportive supervision to help reinforce public sector staff skills and to encourage positive attitudes about PPIUDs.

The WHO's 2015 update to the family planning medical eligibility criteria allowed the use of implants in the postpartum period. Following this important update, ASF advocated for policy change within DRC and has received authorization to introduce postpartum implants. ASF plans to continue building the capacity of the public sector to expand the range of quality family planning services available to women at the critical time of need following childbirth, when so many Congolese women wish to return to their pre-pregnancy health status before becoming pregnant again.

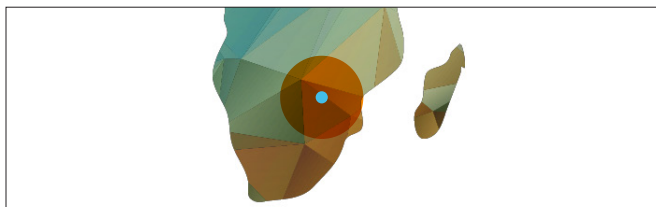
## Results

- From December 2012 to March 2014, 2,976 women received IUDs (30% post-placental, 59% immediate post-partum, 11% intracesarean)
  - Of those 2,976 women, 2,857 women followed up in 15 days, 97% reporting no problems, 0% had infections, and only 3% had experienced expulsion of the IUD.
- Since 2015, the Programme National de Santé de la Reproduction has finalized a country action plan which includes the introduction of post-partum implants. This plan has been approved by the MoH.
- PPIUD and post-partum implant sites expanded from five public hospitals to 10 public hospitals.



<sup>22</sup> This work was funded by USAID.

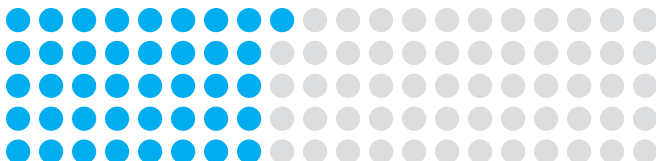
# Public Sector Social Franchising in **Zimbabwe**<sup>23</sup>



## BACKGROUND

With 70% of women in Zimbabwe seeking healthcare through the public sector, there is a high need for more high-quality, standardized voluntary family planning methods and services, as well as increased capacity for providers to remain motivated and trained to offer a range of family planning methods with a limited ability to pay.

mCPR: **40.5%**



Unmet need: **12.8%**<sup>24</sup>



## In this context, who was the market failing?

Low-income women who seek health services in the public sector, but have an unmet need for family planning.

## Which market failures were prioritized and addressed?

Quality, guidance, and labor capacity: Insufficient resources, skills and motivation in the public sector limited access to quality family planning.

## Where did PSI work in this market?

PSI-Zimbabwe applied private sector social franchising elements to the public sector to provide public sector clinics with consistent support, improved standardization and a clear relationship with the MoH in order to increase public sector client access to high quality family planning.

PSI-Zimbabwe has been operating in partnership with the Ministry of Health and Child Care in Zimbabwe since 1996. With an initial focus on HIV/AIDS prevention, the program has grown to include services such as HIV testing and counseling, voluntary medical male circumcision, tuberculosis screening, antiretroviral provision, family planning, and cervical cancer screening.

Since the late 1990s, PSI-Zimbabwe has used principles of social franchising to manage private clinics and strengthen the quality and reach of health services in Zimbabwe. Social franchising brings health care providers together into a branded network that delivers health services according to established quality standards.

In more recent years, with 70% of women in Zimbabwe seeking health care from the public sector, and financing for public health services severely affected by recent economic challenges besetting Zimbabwe, PSI and partners recognized the value of replicating successful social franchising models to the public sector. Seeing this through a market development lens, the relatively limited capacity of the public sector to deliver quality family planning—caused by lack of resources, skills and motivation—was among the most critical market failings that if addressed, would enhance access to quality family planning in Zimbabwe.

<sup>23</sup> DFID funded this work in Zimbabwe.

<sup>24</sup> Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2012. Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland: ZIMSTAT and ICF International Inc.

<sup>25</sup> Cissé, B., Coolen, A., Hayes, B. (2014). Public sector social franchising: the key to contraceptive choice for women? Marie Stopes International, Mali. Retrieved from: <http://sf4health.org/conferences/2014-conference/presentations>



Growing evidence suggests that applying social franchising approaches to the public sector can expand the quality of care, client satisfaction, and uptake of family planning.<sup>25</sup> This relatively new approach goes beyond the training of public sector providers to add additional value of being part of a trusted brand, having access to standardized services and operating procedures, learning motivational techniques, and maintaining a clear agreement between franchisers and the MoH. Since 2013, PSI-Zimbabwe has integrated these approaches within the public sector across nine provinces into a branded network called “ProFam,” delivering a full range of voluntary family planning methods to clients, free of charge.

With the goal of expanding access to quality family planning services to the poor, PSI-Zimbabwe partnered with the MoH to increase the capacity of 28 district mission hospitals and city health clinics to offer a wide range of contraceptive options. Within this ProFam network, PSI-Zimbabwe trained 150 providers to offer balanced counseling and to provide male and female condoms, oral contraceptives, injectables, and Jadelle implants. PSI-Zimbabwe continues to work closely with the MoH to monitor the quality of these services and to ensure effective integration within public sector facilities, helping to build the capacity of the public sector to offer sustained, quality family planning services for clients who have a low ability to pay.

Successes of this model included reliable and free supply of commodities and consumables, well-trained staff, increased client and provider satisfaction, increased method choice and provision of CYPs, and very importantly, the ability to reach lower wealth quintile clients.

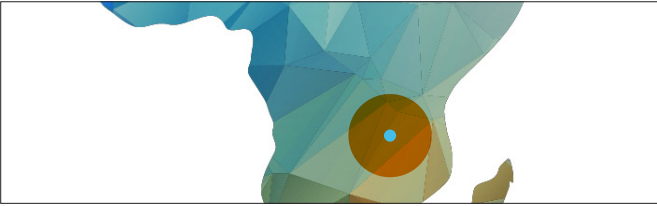
Though this model has been successful in Zimbabwe, PSI recognizes that it works best in environments where public sector provision is prevalent and service quality is in need of strengthening. As with all social franchise models, maintaining motivation for providers and developing both short- and long-term partnerships with the government are essential.

## Results

- Since program inception in 2013, a total of 1,120,912 CYPs were provided.
- 56,067 clients received family planning methods through the public sector Profam Network.



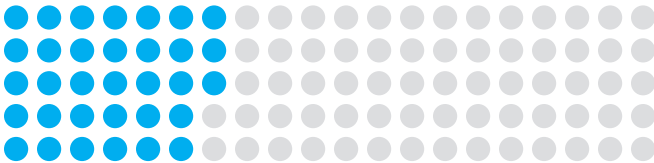
# Mainstreaming Youth-Friendly Health Services in Zambia<sup>26</sup>



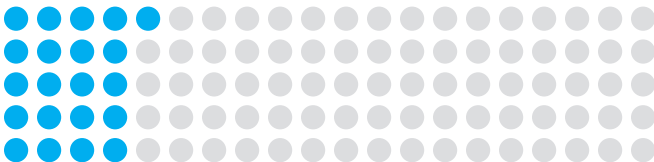
## BACKGROUND

In Zambia, adolescent pregnancy is common: Nearly one in three women now in her twenties gave birth to a child by the age of 18 and 59% gave birth by age 20. Among married women, adolescent girls are the least likely to use contraception and the most likely to report an unmet need for contraception.<sup>27</sup>

mCPR: 32.5%<sup>28</sup>



Unmet need: 21.1%<sup>29</sup>



## In this context, who was the market failing?

Sexually active adolescent girls and young women—married and unmarried—with a desire to delay or to space births.

## Which market failures were prioritized and addressed?

Quality: Providers were acting as a barrier, furthering misconceptions about LARCs, and dissuading young women and girls from using methods that may be the best suited to their needs and desires.

## Where did PSI work in this market?

PSI's Zambian network member, Society for Family Health (SFH) supported the public sector to mainstream youth-friendly service delivery.

Since 1992, SFH, has worked to advance the Government of Zambia's health priorities. Following an ambitious FP2020 commitment by the MoH in 2012, the national budget for family planning commodities doubled and the country saw significant growth in contraceptive use by married women. Yet over the same period, unintended pregnancies and unsafe abortions have remained common among adolescent girls.<sup>30</sup>

The obstacles that young Zambian women face often include providers themselves. SFH and Population Council conducted a 2015 study in Lusaka, Zambia's capital, using simulated client visits in government health centers and provider interviews to identify barriers to IUD use. Even though the WHO confirms that IUDs are safe and suitable regardless of a client's number of children,<sup>31</sup> the study found that many providers dissuade younger, unmarried and nulliparous women from using the method, often due to a prevailing assumption that IUDs would be "wasted" on women whom they viewed as likely to ask for removal prior to 10 years after insertion.<sup>32</sup>

Global evidence shows that family planning services are more effective when they are welcoming and

<sup>26</sup> USAID funded this work in Zambia.

<sup>27</sup> Central Statistical Office (CSO) [Zambia], Ministry of Health (MoH) [Zambia], and ICF International. 2014. Zambia Demographic and Health Survey 2013-14. Rockville, Maryland, USA: Central Statistical Office, Ministry of Health, and ICF International.

<sup>28</sup> Ibid.

<sup>29</sup> Ibid.

<sup>30</sup> FP2020. (2014). FP2020 Progress Reports: Zambia Official Report. Available from: <http://www.familyplanning2020.org/entities/150>

<sup>31</sup> WHO. (2015.) Medical eligibility criteria for contraceptive use: Fifth edition. Available from: [http://www.who.int/reproductivehealth/publications/family\\_planning/MEC-5/en/](http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/)

<sup>32</sup> Dennis M., Nalubamba M., Mweemba O., Owolabi O., & Zama, M. (2015.) Provider and Client Determinants of IUD Usage in Lusaka, Zambia: A Mixed-Method Study. Washington DC, PSI.

<sup>33</sup> High-Impact Practices in Family Planning (HIPs). Adolescent-friendly contraceptive services: mainstreaming adolescent-friendly elements into existing contraceptive services. Washington (DC): USAID; 2015. Available from: <https://www.fphighimpactpractices.org/afcs>



responsive (or “friendly”) to adolescents and youth in addition to older clients.<sup>33</sup> Making services youth-friendly means training and supporting providers to offer balanced counseling and nonjudgmental services to adolescents and youth, ensuring privacy and confidentiality, and offering all medically eligible clients their choice of a wide range of contraceptive methods, including LARCs.

In 2015, PSI co-developed the global consensus statement *Expanding Contraceptive Choice for Adolescents and Youth to Include LARC*, which has more than 250 endorsers including the American Congress of Obstetricians and Gynecologists. The statement makes the case for providing youth with access to the widest available range of methods, including IUDs and implants, which are more effective, cost-effective, and tend to have higher continuation rates than short-acting methods.<sup>34</sup>

SFH initiated a collaboration with the MoH to address provider bias and to improve contraceptive access for youth. In 2015, SFH joined PSI network members from 10 other African countries to learn how PSI has mainstreamed youth-friendly health services in social franchise clinics.

In 2016, SFH and the MoH oriented local partners on the components and value of youth-friendly services, co-designed an action plan with adolescent girls, and trained 36 public sector nurses to ensure that their voluntary family planning services--including LARC services--are youth-friendly. Post-training supervision visits showed that the public sector nurses expressed supportive attitudes and demonstrated that they offer adolescents and youth balanced counseling and an informed choice of contraceptive options. Providers also discuss HIV with youth, encourage dual protection, and make referrals for services they cannot provide themselves.

To link potential clients with youth-friendly services, the providers trained by SFH now conduct health education for youth in the surrounding communities and provide mentorship to youth groups. With training and support from SFH, 133 adolescents act as family planning champions: They educate their peers about sexual and reproductive health and make referrals to sites with

youth-friendly services.

To further increase access and choice, SFH is working with the MoH to scale up community-based distribution of family planning products in the hard-to-reach areas where many youth live. Following a key policy change in 2016 that authorized community-based distributors to provide contraceptive injections, SFH trained 181 community-based distributors in the public sector to add three-month injectables to the range of voluntary family planning methods they offer to adolescents and adults.

In collaboration with the MoH, SFH will continue scaling up youth-friendly services in government health centers and comprehensive sexuality education for adolescents, expanding the reach and institutionalization of evidence-based strategies for improving young people’s sexual and reproductive health.

## Results

- In 2016, SFH trained 36 public sector nurses to offer youth-friendly health services using a curriculum that blended training activities from the MoH and PSI.
  - After the training, 87% of the nurses reported supportive attitudes and correct knowledge regarding use of voluntary contraception by adolescents and youth
- Post-training supervision visits found that providers demonstrated respect for young clients and offered them an informed choice of contraceptive methods, including LARCs.

<sup>33</sup> Pathfinder International, E2A, PSI, MSI, & FHI360. (2015.) Global Consensus Statement: Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception. Available from: <http://www.familyplanning2020.org/resources/10815>

# Lessons learned: Applying a total market lens to strengthen the public sector

Functioning family planning markets require an array of factors related to supply, demand and an enabling environment to align for diverse groups of clients. On the supply side, common market failures include shortages in labor capacity, inadequate service quality, missed opportunities to bring services to the places where clients are, a limited range of family planning options that fails to meet the needs of all clients, and policies that need updating based on the latest evidence. The case studies in this brief illustrate how those market failures manifested, and how collaboration with the public sector helped to address them.

**Addressing market failures related to labor capacity:** PSI-PASMO's work in Guatemala saw this in its training of task sharing with auxiliary nurses to increase method choice, and in Mali and Malawi, where dedicated providers supported professional growth and abilities for public sector staff—ultimately providing increased access to family planning.

**Addressing market failures related to service quality:** In Zimbabwe, improved quality was realized in part by improved guidance. Through the standardized approach of social franchising, public health facilities developed more consistency and reliability for clients. In Zambia, SFH improved the quality of provider interactions with young clients through capacity building for youth-friendly service delivery.

**Addressing market failures related to place:**

PSI learned this in Mali, where there was an opportunity to better coordinate family planning services with immunization days, making methods more conveniently available. Similarly, in DRC, when PSI-ASF began offering post-partum family planning methods in the labor and delivery wards of public hospitals, women gained access to the method of their choice in a more opportune time and place. In Malawi, bringing service delivery to new places through rural mobile outreach units increased method choice and access to LARCs.

**Addressing market failures related to products:** Some market failures can be addressed by making a wider range of products available. For example, in DRC, where few post-partum family planning methods were offered at public hospitals, PSI-ASF linked with public health facilities, where most deliveries take place, to expand the narrow range of PPFP choices available to include IUDs and implants

**Addressing market failures related to policies:** In Guatemala, working upstream with the MoH to change national policy was critical to ensure that the solutions identified will last and be scaled up. As a result, voluntary LARC provision by auxiliary nurses may be included in the 2017 update to the national family planning guidelines. Due to the potential scale of impact, collaboration with the public sector to address policy and regulatory barriers can be among the most important solutions that may flow from an analysis of the total market.



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