



Family Planning (FP) Method Mix Pilot Implementation Overview

Somalia and Somaliland Context

Women in Somalia and Somaliland have a one in 22 lifetime risk of maternal death making the maternal mortality rates in Somalia and Somaliland amongst the highest in the world. Most of these deaths (94%) occurred in low-resource settings, and most could have been prevented (WHO, 2019). It is estimated that the maternal mortality ratio is 699 deaths per 100,000 live births in Somalia (SHDS 2020). In addition, one in 12 women die of childbirth and pregnancy related reasons (UNICEF, 2019). Accordingly, the lifetime risk of maternal death in Somalia and Somaliland is among the world's highest, 1 in 22, exceeded by only Chad and Sierra Leone.

FCDO (formerly DFID) is implementing a health system strengthening programme under the name Somali Health and Nutrition (SHINE) from 2016 to 2021. This program has both a supply side strengthening and demand creation components. PSI is implementing the demand creation for health services, called SAHAN (Somali Advocates for Health and Nutrition) component which aims to increase utilization of reproductive, nutrition, child, and maternal health services and to promote healthy behaviour change.

SAHAN is using an adaptive, evidence-based, participatory design process to better understand the persistent barriers to uptake of health services and health-seeking behaviour and develop and test innovations to increase demand. These strategies target both internal factors to an individual, social, and physical environment factors that influence or constrain health seeking behaviours.

Family Planning (FP) Method Mix Intervention Summary

The term FP Method Mix refers to the range of contraceptive choices available to a population and the pattern of use of these methods¹. It is widely understood that as method choice and access expands, so does contraceptive uptake and usage. Nonetheless, in many countries, the availability of a diverse method mix is highly constrained². Other factors that affect method mix include National Policies, availability of health facilities and trained medical personnel, provider bias, cost, and user preferences.

Somalia/Somaliland was signatory to Family Planning 2020 (FP2020³) commitments. The Government of Somalia updated its commitment at the Family Planning Summit in London, UK on July 11, 2017 with following anticipated Impact:

1. To reach 20,000 new users by 2020.
2. Increased uptake of FP services leading to increased CPR from 2.6 to 5% by 2020.

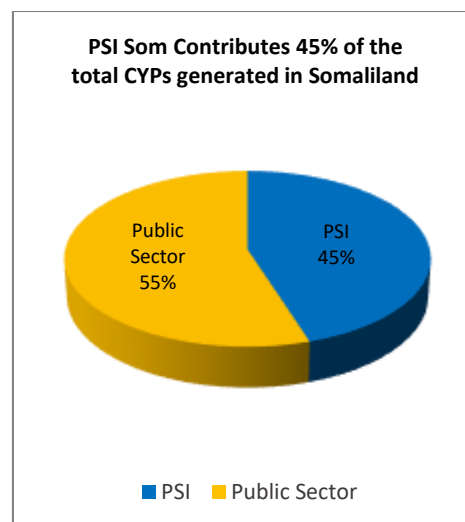
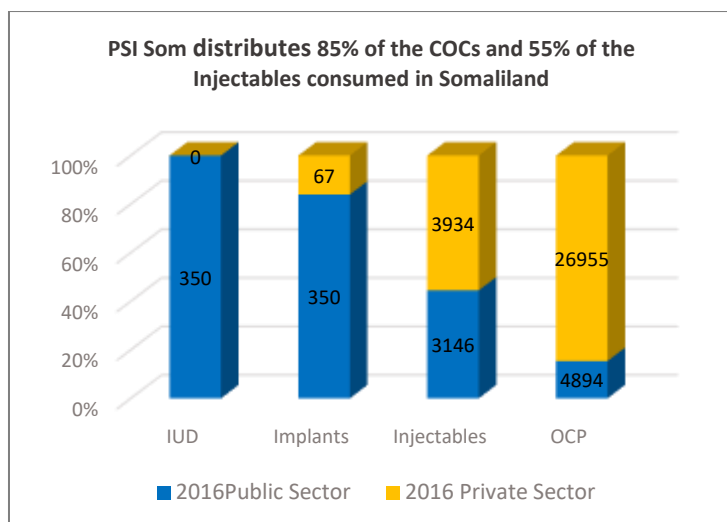
However, there had been little traction in improving uptake of modern family planning demonstrated by the fact the Somaliland's modern contraceptive prevalence rate (mCPR) remained 1.5% while unmet need for FP was 20.2%. (MICS, 2015). PSI remained the only private sector player in the Family Planning market across Somaliland. Insights generated from the immersion phase of the SAHAN program inspired the need for PSI to re-evaluate the Somaliland Family planning landscape. The Diagnose and Decide components of the Keystone Design Framework⁴ found that the private sector (mainly PSI) contributes 45% of the total Couple Years of Protection (CYPs) generated in Somaliland.

¹ Contraceptive Method Mix, Guidelines for Policy and Service Delivery, WHO 1994.

² <http://evidenceproject.popcouncil.org/expanding-contraceptive-method-mix-and-method-choice/>

³ Family Planning 2020 (FP2020) is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

⁴ In 2018, PSI evolved a new approach that marries a relentless focus on consumer and social behavior change with market development. This is underpinned by the rigorous application of commercial marketing principles and deep public health expertise. The approach is built



The health impact indicated was further supported by user insights which show significant preference for FP services provided through the private sector. Some of the reasons include: quicker services; afternoon services are available with a method mix that encourages choice; and spousal consent is not requested as is the case with public facilities. Although spousal consent is not a requirement of the birth spacing guidelines, the practice persists in most public facilities.

Under the SAHAN programme, PSI planned to continue distributing, through social marketing in Somaliland, combined oral contraceptives and depot-medroxyprogesterone acetate (DMPA) injection contraceptives under the brand name 'Nasiye'.

Pilot Implementation of FP Method Mix

Through the SAHAN program, PSI explored partnerships or funding opportunities that would ensure that consumers in Somaliland continued to have the choice on the FP products they preferred through channels the preferred. Such partnerships included: working with UNFPA to explore potential of securing UNFPA products for private sector distribution; and sourcing for donors and new business opportunities willing to invest in the private sector market for Family planning distribution.

A proposal was submitted to DFID (now FCDO) to utilize program income generated from previously DFID-funded PSI social marketing activities as seed revolving fund that would guarantee the continued availability of FP commodities in the Somaliland private sector. With approval of the proposal secured, PSI commenced the procurement of combined oral contraceptives and DMPA injections for the Somaliland market. Despite delays occasioned by the covid-19 pandemic, 25,667 COC cycles and 8,400 DMPA vials were delivered to Hargeisa, Somaliland in the first half of 2020. As part of reducing the unit cost of the contraceptive to the lowest cost to the consumer, the packaging of the Nasiye contraceptive were modified to take advantage of economies of scale. The Nasiye COCs were changed to 3-cycle packs (initially only one cycle per pack) while the Nasiye MPA injections, which are provider administered were changed to 10 vial packs (initially packed in single units).

Recruitments for 2 Medical Sales Representatives (MSR) was also done. The use of Medical sales representatives was also a shift away from PSI's previous model where trade market representatives had

on consumer and market insights, informed by behavioral theory with focus on the vision of a sustainable market. We apply a user-centered, creative approach to design, with knack for value for money and leading through learning.

the responsibility of product distribution. The Medical sales representatives added more value to the distribution process and the quality of family planning services provided by the pharmacies and clinics. Their medical background was a skill leveraged upon for them to carry out medical detailing and mentorship of the providers on family planning provision as part of their duties. Upon recruitment, the medical sales representatives were trained on the product knowledge and Provider Behaviour Change Communication (PBCC) skills. They were thereafter deployed to Maroodijex and Todhdeer regions of Somaliland to commence product distribution.

Distribution channels:

The contraceptives were distributed through 180 pharmacies and private sector clinics in Somaliland. The 2 medical detailers carried out trade marketing and quality assurance responsibilities, leveraging on the distribution through wholesale outlets and the network of clinics which had previously been trained by PSI on the provision of short-term Family Planning methods.

Geographic Coverage:

Product distribution primarily covered Maroodijex and Togdheer regions of Somaliland. However, private sector distribution in nearby regions of Sahil and Awdal was also done through wholesaler channels.

Pricing and cost recovery

One of the objectives of the proposed distribution model was to work towards full cost recovery to ensure a sustainable model. To this end, the landed costs of the contraceptive were reduced by changing the packaging configuration and by slightly adjusting the market prices, effectively increasing the cost recovery percentage. These two actions increased the cost recovery from 62% to 95% for Nasiye injection and from 77% to 100% for Nasiye CoCs.

Nasiye Injection Price List			
Category	Margins	Price of Dispenser (25 Vails)	Price per vail
Wholesaler	30%	\$ 25.00	\$ 1.00
Retailer	54%	\$ 32.50	\$ 1.30
Consumer			\$ 2.00

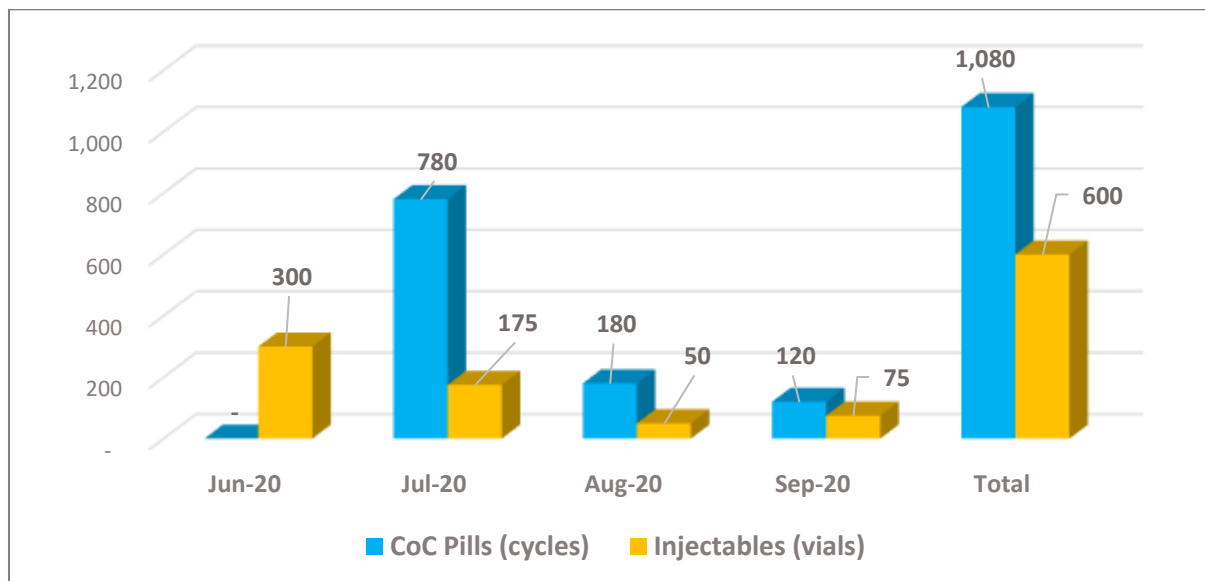
Nasiye COC Price List				
Category	Margins	Price of Dispenser (10 packs)	Price per pack (3 cycles)	Price per cycle
Wholesaler	33%	\$ 15.00	\$ 1.50	\$ 0.50
Retailer	50%	\$ 20.00	\$ 2.00	\$ 0.67
Consumer			\$ 3.00	\$ 1.00

Pilot distribution figures

During the pilot period, June to September 2020, a total of 1,080 cycles of oral contraceptives and 600 vails of injectable were distributed as shown in the table below.

	Jun-20	Jul-20	Aug-20	Sep-20	Total
Nasiye-COC (Cycles)	0	780	180	120	1,080
Nasiye-Injection (Vails)	300	175	50	75	600

The relatively high figures in the first month of distribution of both contraceptives was occasioned by the fact that there was a widespread stockout and the distribution pipeline had to be 'filled' in that initial month. The distribution figures stabilized in the months thereafter.



Distribution beyond SAHAN programme

Beyond the SAHAN programme project period, PSI intends to continue distribution in the private sector and aim to achieve the intervention goal of having a sustainable distribution model into the future. This is in line with PSI global and PSI Som strategic objectives. PSI Som will continue to source for funding to continue implementation of this intervention, especially to finance the sales team required to support the distribution of contraceptive and to support and fund associated marketing plans of the same.

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