

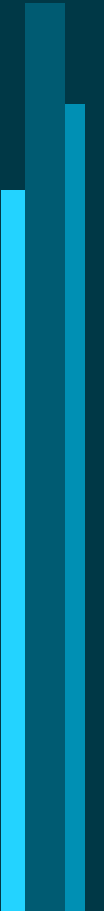


Diagnose and Decide

Somaliland FP

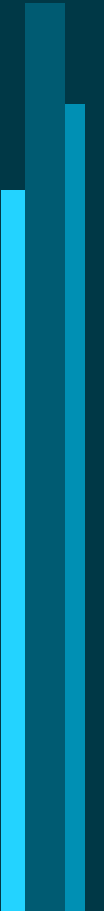


Diagnose



Use/Need and Quality of Use Analysis

Somaliland FP

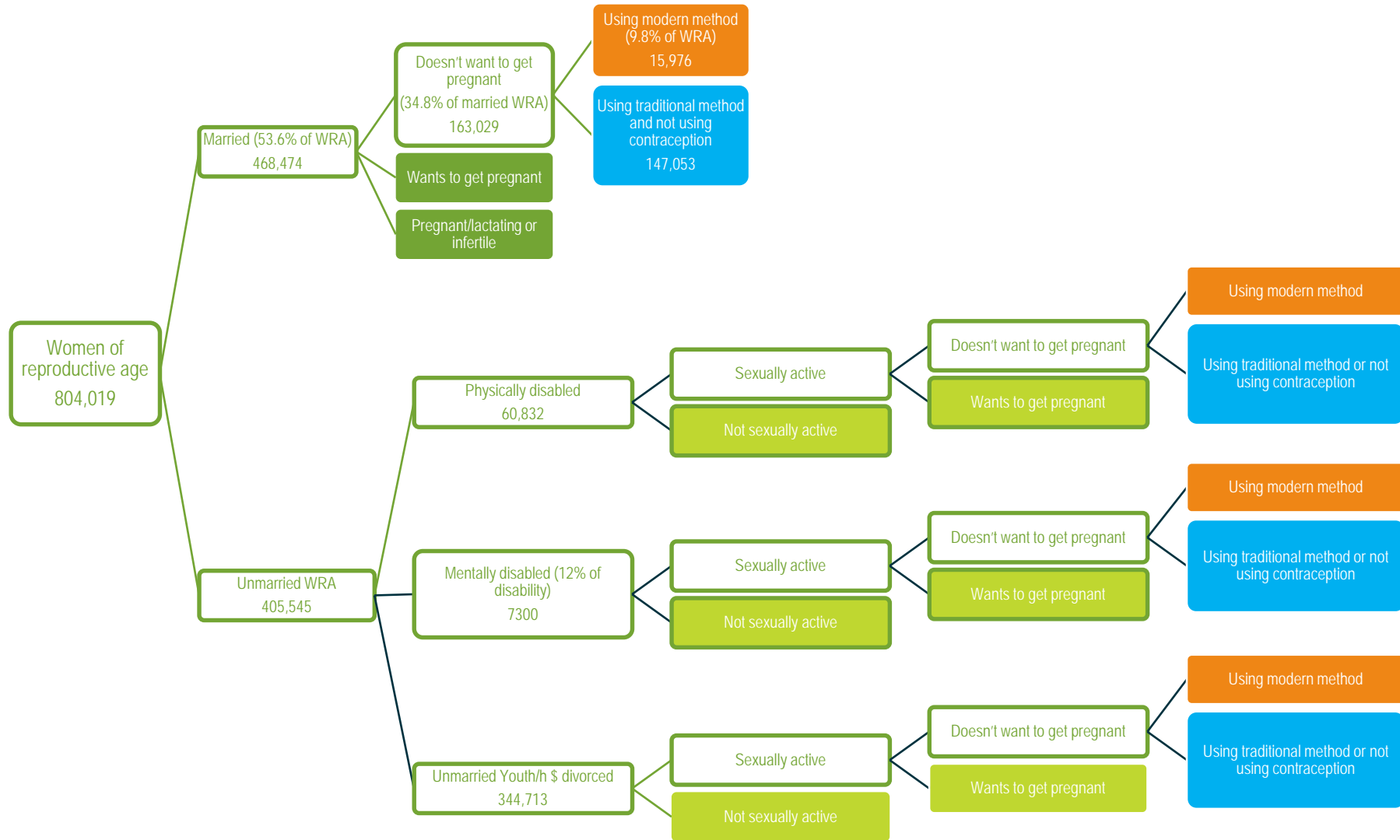


Use/Need and Quality of Use

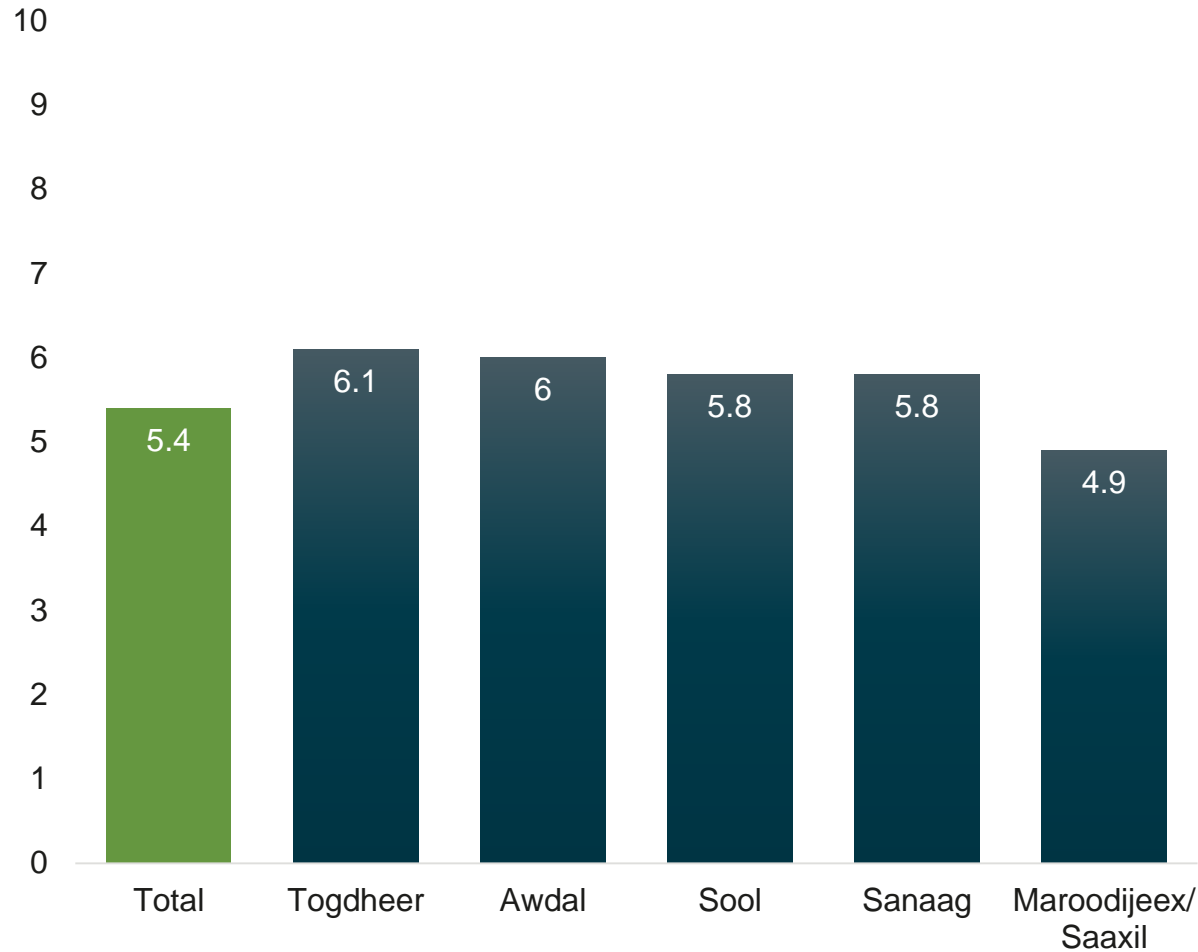
Somaliland population as per 2014 census was 3,508,180. Estimated population at 2017 based on annual population growth rate of 2.7% is 3,800,084

Women of reproductive age based on a global standard of 23% comes to 804,019

Disability based on global average of 15%. In Somaliland, 12% of all disability is mental (Ref K4D)

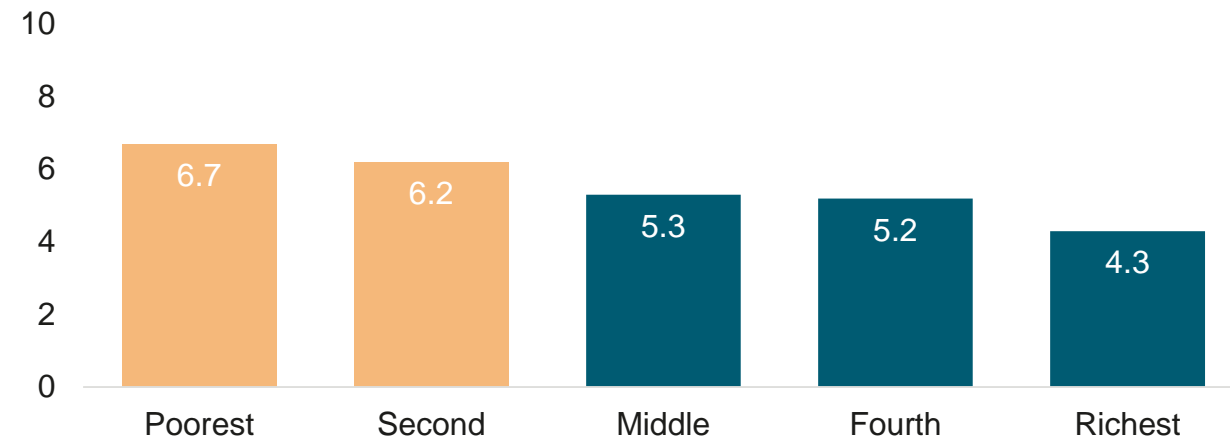
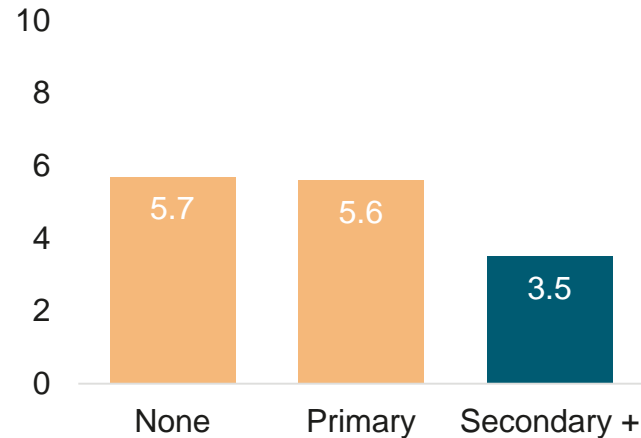
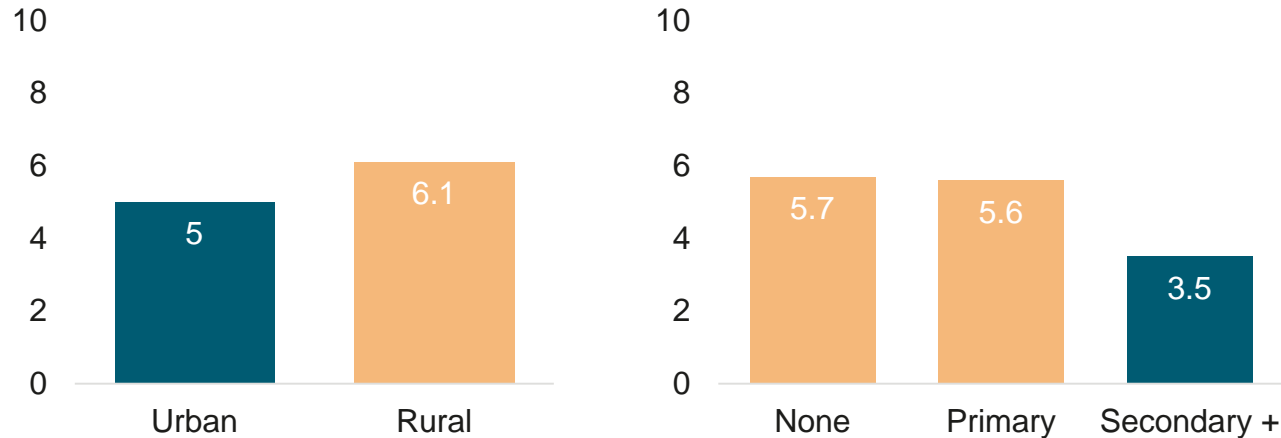


Total fertility rate (TFR)



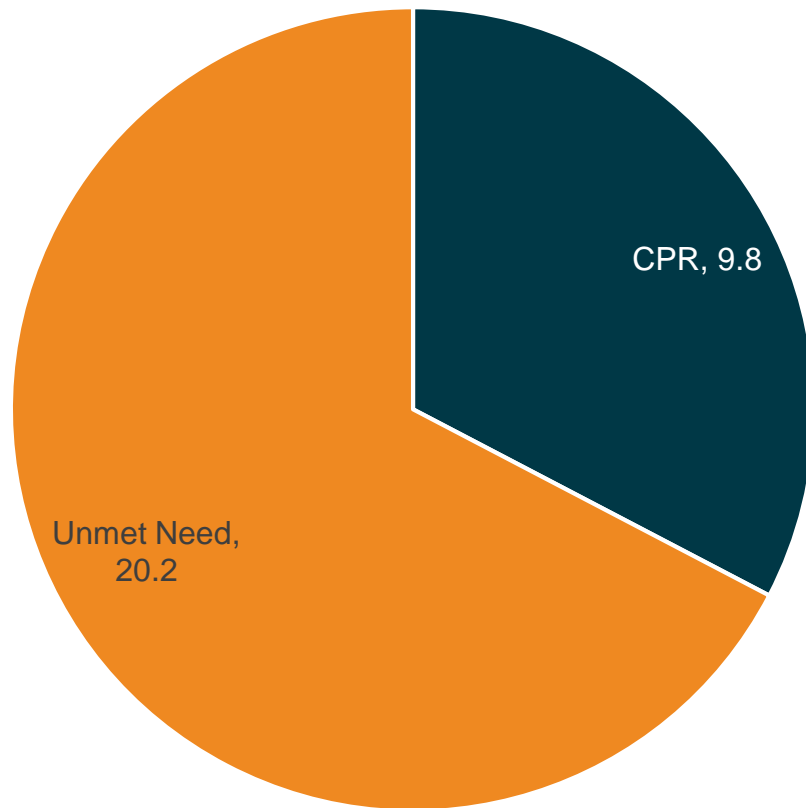
- Fertility is generally high in all regions but slightly lower in Maroodijeex and Saaxil.
- Early child bearing is more common across the country but higher in rural areas.
- The percentage of women with a live birth before age 15 in rural areas is 4 percent compared to 2 percent for those in urban areas.

TFR by urbanisation, education and wealth quantiles



- Fertility is considerably higher in rural areas (6.1 births per woman) than in urban areas (5.0 births per woman).
- Education level of a woman aged 15 – 19 influences fertility and women with no education have higher fertility (5.7) compared to women with secondary or higher education (3.5).
- Moreover, wealth status is associated with the adolescent birth rate and women from the poorest quintile have a considerably higher fertility rate (6.7 births per woman) compared to women in the richest quintile (4.3 births per woman).

Contraceptive prevalence rate (CPR)



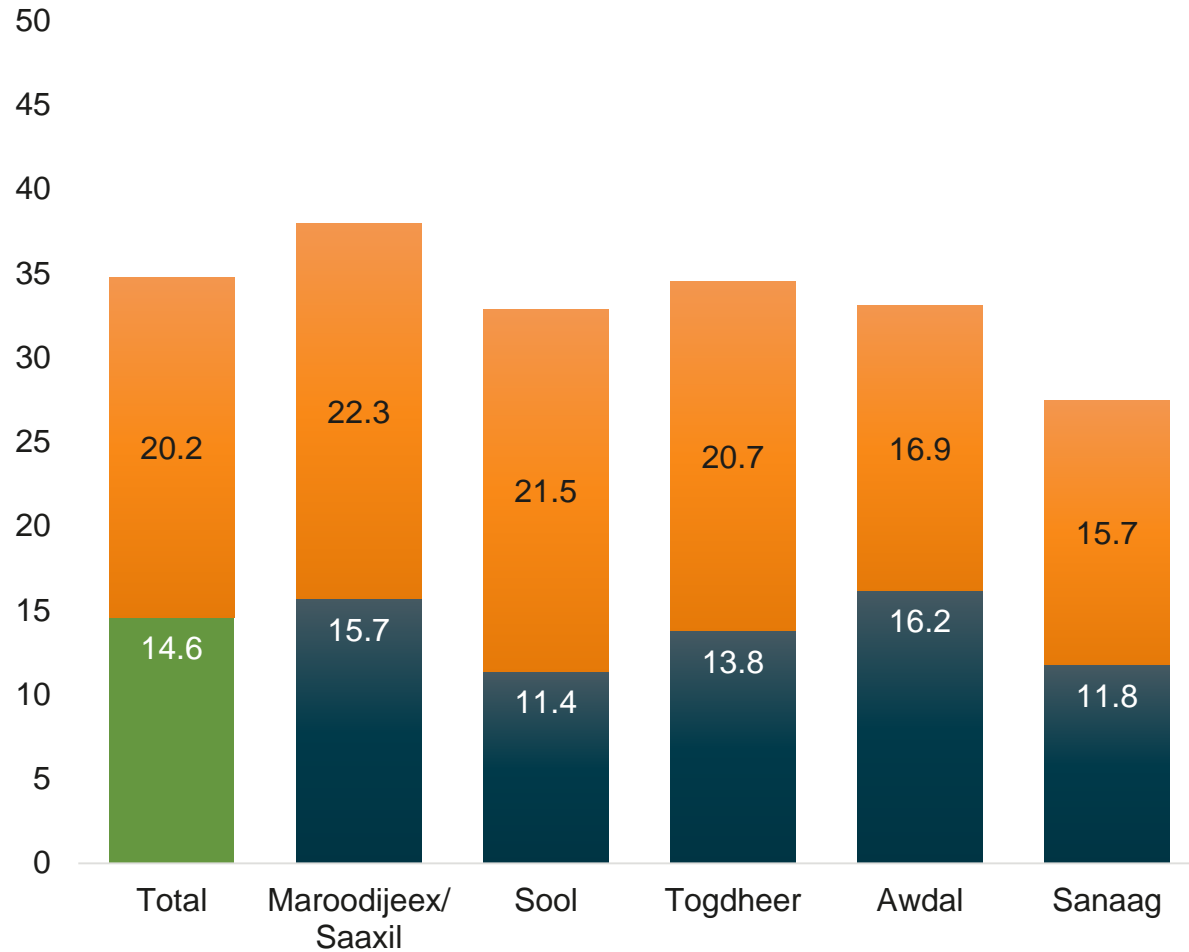
- Only one in ten married women are using any method of contraception.
- The unmet need for contraception is 20 percent.

Met versus unmet need - FP methods used

Region	Not using a method	Injectables	Pill	Female condom	Lactational Amenorrhea Method (LAM)	Withdrawal	Any modern method	Any traditional method	Any method
Maroodijeex/Saaxil	90.2	0.6	1.5	0.1	7.3	0.1	2.4	7.5	9.8
Awdal	88.1	0.8	1.6	-	9.2	0.2	2.6	9.4	11.9
Togdheer	90.1	-	-	-	9.9	-	-	9.9	9.9
Sool	92.4	-	0.9	-	6.7	-	0.9	6.7	7.6
Sanaag	91.8	-	-	-	8.2	-	-	8.2	8.2
Total	90.2	0.4	1.0	0.1	8.2	0.1	1.5	8.3	9.8

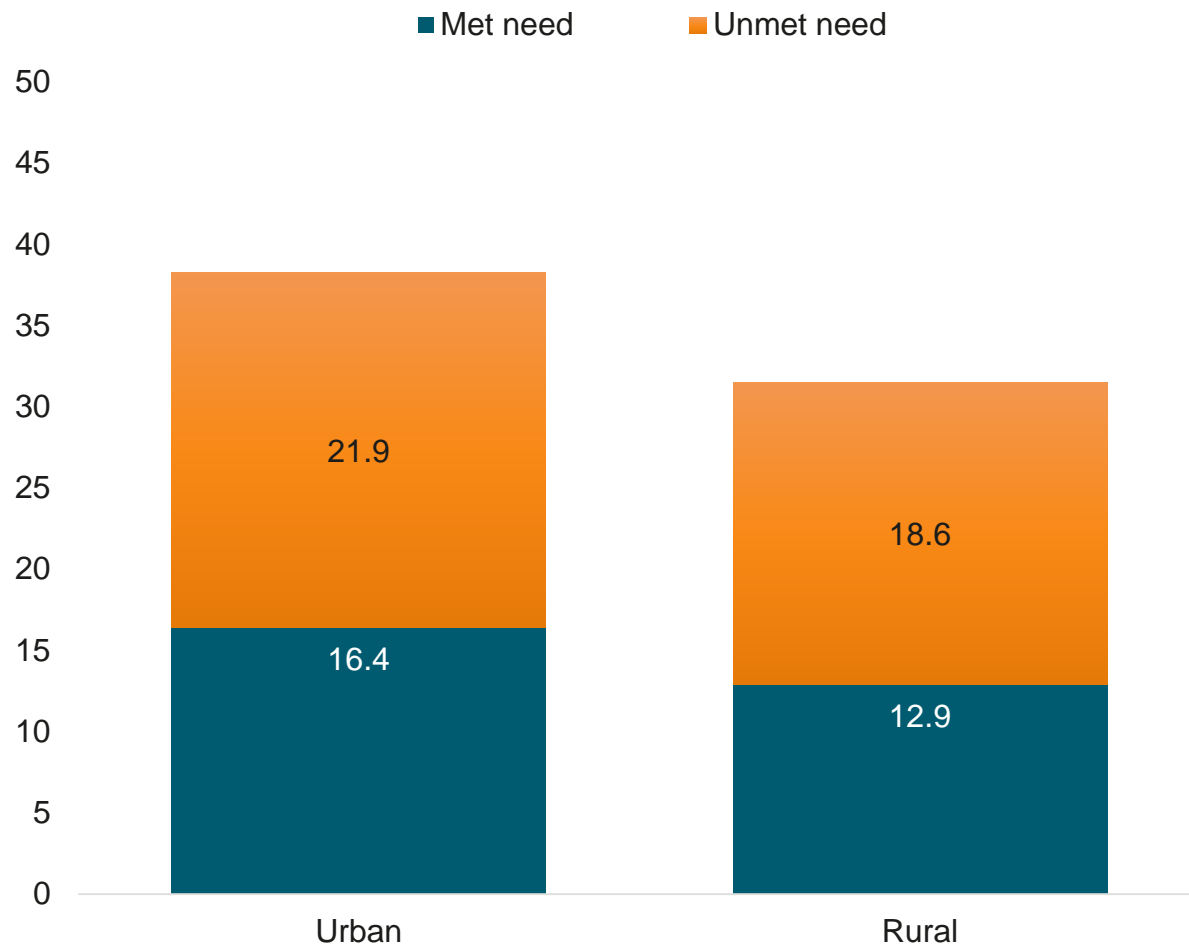
- Low penetration of modern contraceptive methods overall; Tagdheer and Sanaag are regions where modern methods are practically inexistent.
- The pill is the most common modern method though its use is very low.
- The most common non modern method is Lactational Amenorrhea Method (LAM)
- Lack of proper counselling on Side effects is the major reason for discontinuation of MBS

Met versus unmet need by region



- The lower the TFR, the higher the unmet need for contraception becomes. Maroodijeex and Sahil which are the regions with the lowest TFR have slightly higher unmet need.
- Sool and Togdheer follow closely.

Met versus unmet need by urbanisation



- Urban areas have both a higher met and unmet needs compared to rural areas.
- Awareness and acceptance of FP is likely to explain the lower numbers in rural areas.

Summary of Use/Need analysis

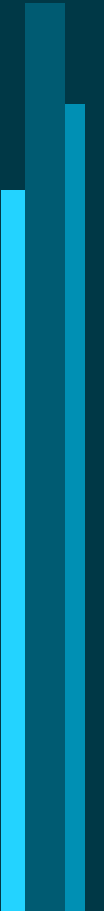
- Fertility is inversely related with modern contraceptive use.
- Utilisation of modern contraception is low across the entire country but with a slightly higher utilisation amongst urban, more educated, wealthier WRA.
- Fertility is high across most regions in Somaliland with a skew towards rural, low education and poorer WRA. This is the category that the market is mostly failing even though the general market performance is low.
- The other category that the market is failing is the unmarried WRA. Because of lack of data on them, initial research is recommended. A policy framework after the research would be required to guide the formulation of interventions.

Policy

Somalia Government Commitment overview FP2020

- To ensure that legal policy and strategic framework for FP in Somalia are in place by 2020
- To increase understanding of barriers to access, demand, and uptake of FP services in Somalia by 2020
- To ensure access to quality reproductive health services including FP in emergency and crisis settings from 50% of facilities offering FP services in 2017 to 80% by 2020
- To decrease stock outs by 30% by 2020 by ensuring continuous availability of quality FP commodities at all levels of the pipeline
- To explore and leverage PPP in FP service delivery by 2018
- To strengthen the existing monitoring of FP programs through routine HMIS and Demographic Health Survey (DHS).

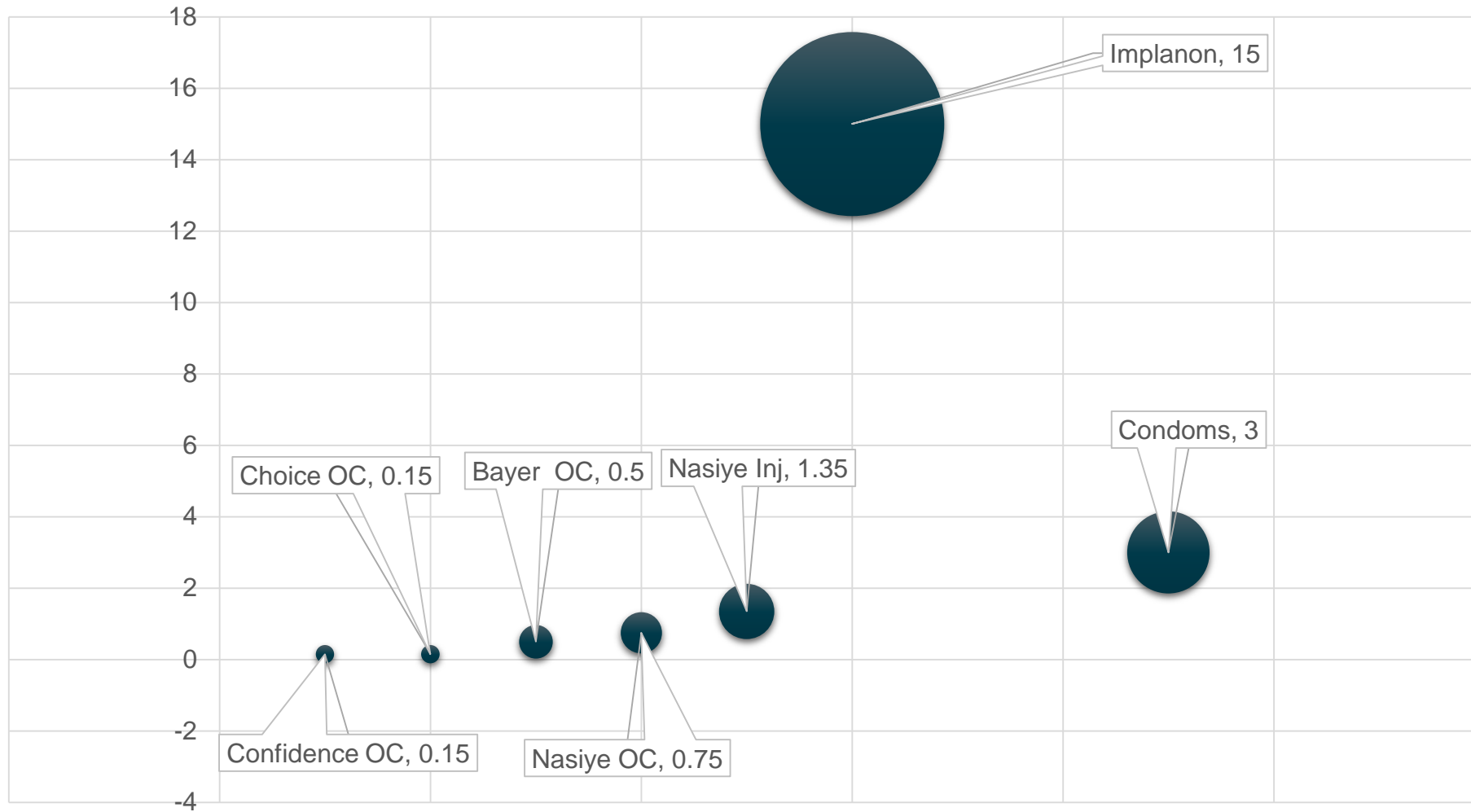
Market Analysis



Market Players

Product	Private Sector	Public Sector
Oral Contraceptive	<ul style="list-style-type: none"> • Nasiye – PSI Brand, • Bayer (Generic) • UNFPA (Generic Public sector leakage) • Choice (Ethiopian) • Confidence (Ethiopian) 	UNFPA Generic
Injectables	<ul style="list-style-type: none"> • Nasiye – PSI • Confidence 	UNFPA - Depo Provera
	<ul style="list-style-type: none"> • Implanon NXT – PSI products in 10 PSI Facilities and few private hospitals 	Implanon and Jadel
IUD –	Only in few private hospitals Only	IUD Present in some public facilities
ECPs	Not available	VCT Centers only
Condoms	available but rare.	Not Available

Private Sector Commodity Prices (\$)

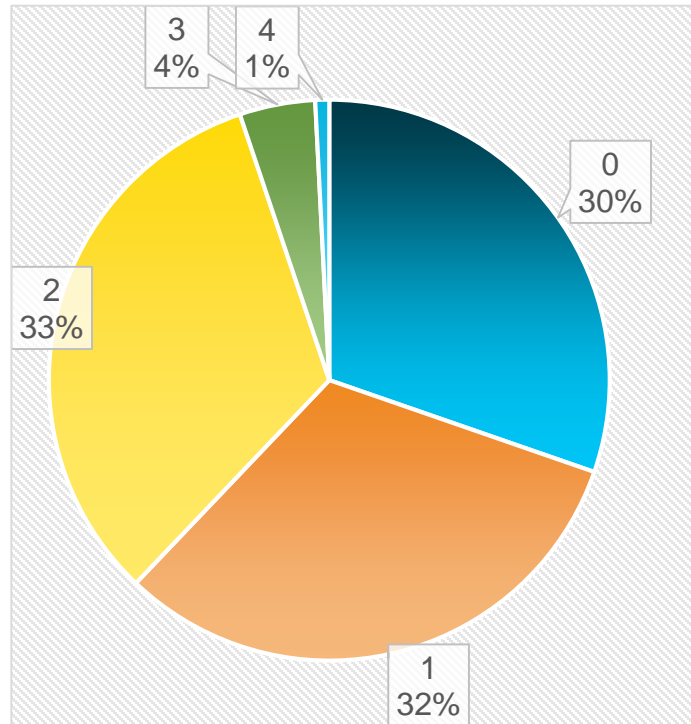


Market Gap

- Distributors find the contraceptive business unattractive due to low profit margin and low clientele. Stigma also exists in the pharmaceutical industry as association with birth spacing products can limit the distributor's range of customers. However, PSI currently has one distributor who still requires a lot of marketing support and capacity building.
- Though there is stigma in the retail end of the market, existing demand has been a motivation for pharmacies and providers to stock birth spacing products
- Both private and public sectors lack emergency contraceptives except VCTs. PSI is the only registered player in the private sector space for birth spacing. The 12% non PSI products recorded are public sector leakages and parallel imports of Ethiopian products.
- PSI is the only player in the demand creation space for birth spacing with generic marketing and communication strategies ranging from mass media to print and inter personal communication.

Market Penetration

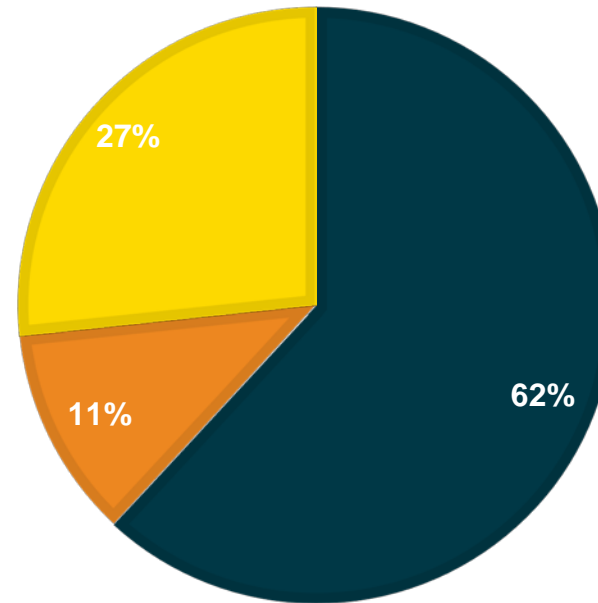
Number of FP Products per Outlets



68 % of 833 private clinics/Pharmacies have at least 1 FP product.

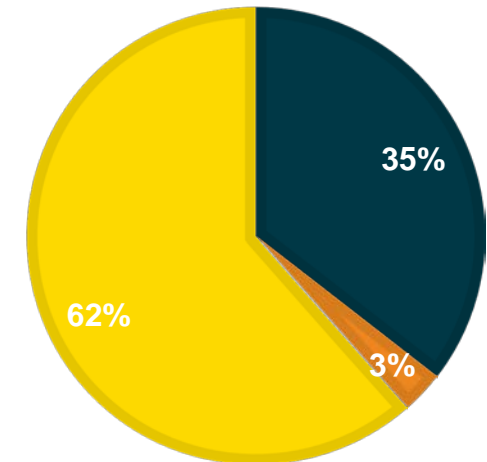
OC Private Sector Penetration

■ PSI OC ■ Non-PSI OC ■ No OC ■



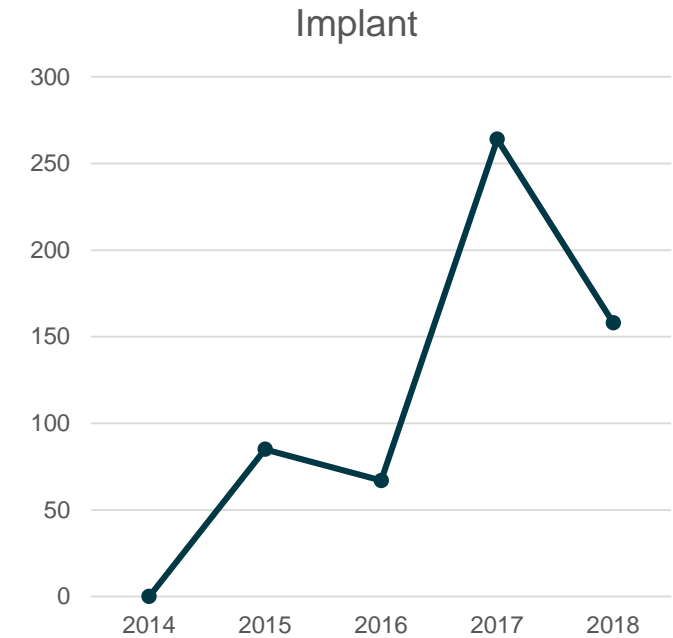
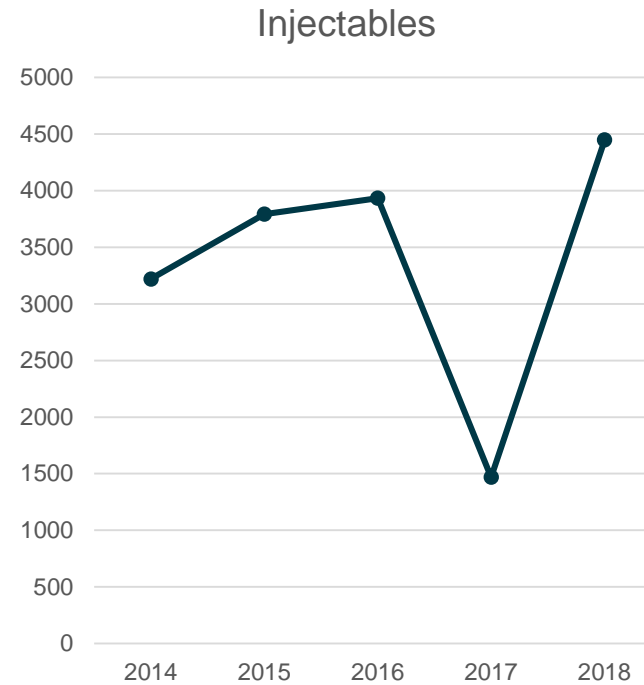
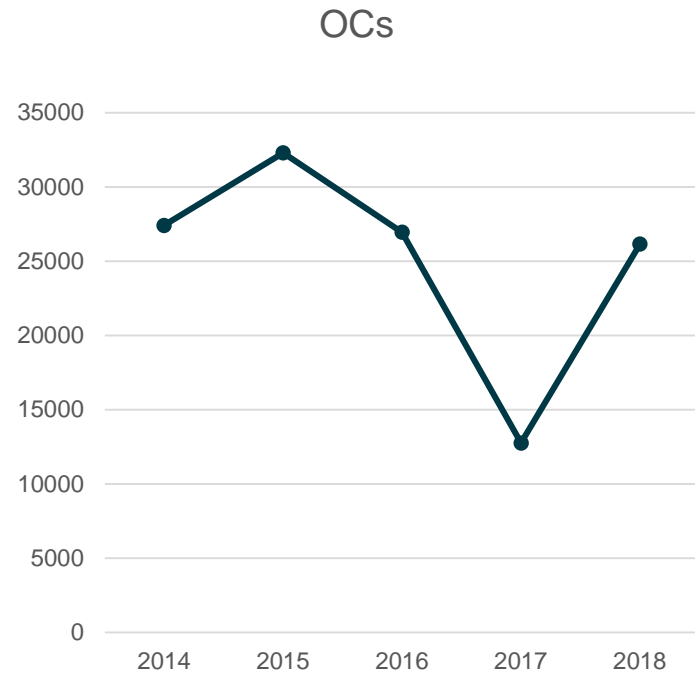
Injectable Private Sector Penetration

■ PSI ■ Non PSI ■ No Injectable ■



Source: 2015 MAP Survey

PSI-SOM FP Distribution Trends



As opposed to increase distribution between 2014 and 2015 of OCs and Injections, in 2016 and 2017 we experienced a reduction in distribution figures. However, these peaked in 2018 as a result of Demand creation and distribution support received from USAID. (Figure 1 and 2)

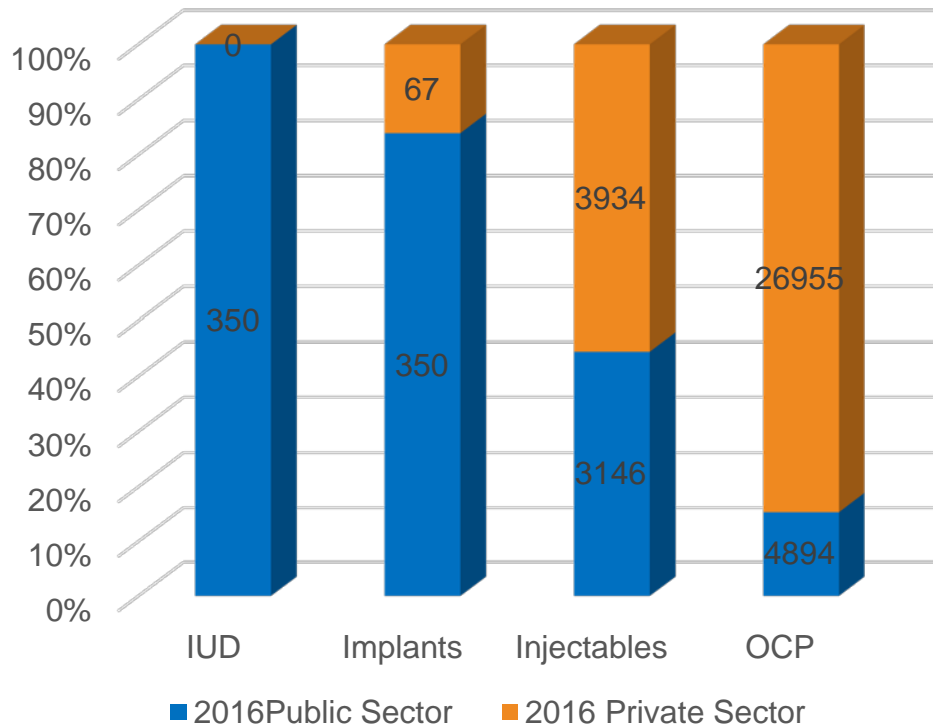
Provider attrition, the lack of refresher trainings and demand creation has been responsible for the decline in the private sector implant performance.

Marketing support

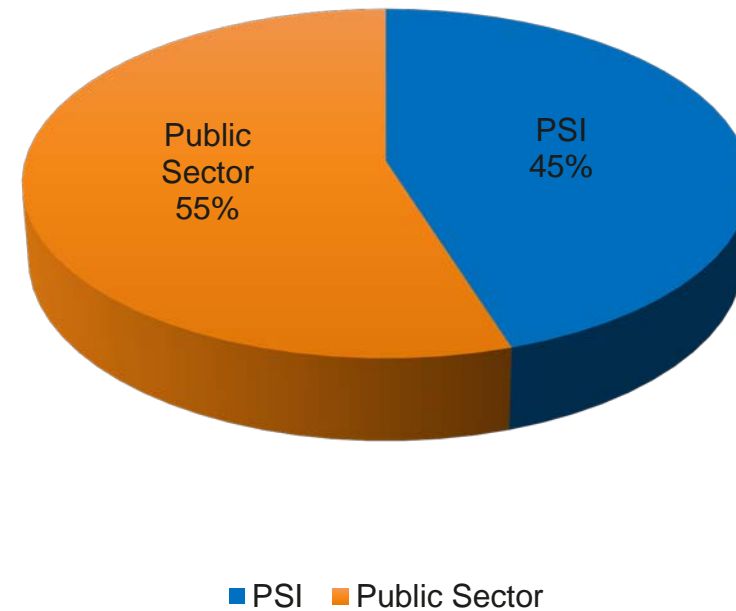
- In 2016, while UNFPA has continued to provide public sector commodities the following major events occurred in the private sector -
 - March 2016: 5-year DFID HCS program ended
 - May 2016: 5-year Dutch FP program ended
 - March 2016: 2-year UNICEF program ended
- The above funding streams were directly or indirectly contributing to FP demand creation and distribution activities in Somaliland. With these coming to an end, the following was the effect: -
 - Zero demand creation activities for FP starting June 2016 to May 2018 when the USAID support for demand creation commenced and expected to end in December 2018.
 - Zero behavior change communication tackling FP myths & misconceptions starting June 2016 to date

Private Sector Service and CYP Contribution

Sector contribution by Product



CYP Contribution



2016 track Survey and 2016 PSI Distribution Data

Audience Profile - Amina



Key Insight

Amina values her reputation as a good wife and mother and will seek health care where quick services are provided, that is affordable and close to her home.

Amina is a 27 year old woman, married with 4 children. She has basic education and lives in semi-urban area with low- income. (Population Size: 875,000). She is most happy whenever she is able to spend time with her friends and husband but she is a busy house wife and has only limited time to socialize.

Amina visits health facilities only when an illness affecting her children becomes severe. Though she considers their services to be expensive, private clinics and pharmacies are preferred because they are close to her house and she perceives their services to be better than those at the public sector. She has to walk long distances to get to the public facilities which usually has long queues with harsh providers. Therefore would only go there when the service she seeks, like immunization is not available nearby.

Amina delivered of her 4 children at home with the help of a TBA and her mother/mother-in-law. She believes breastfeeding is vital for the first six months, but not enough for the baby so she supplements with other traditional baby feeds of maize Sorghum with goat or sheep milk. She also breastfeeds because she believes it will stop her from getting pregnant but fears modern birth spacing because of infertility and cancer

She perceives that the services offered in PHCs are of poor quality. Knows the importance of breastfeeding, immunization, and sanitation, Seeks health information from her neighbors, friends and mother. Is motivated by the acts of other mothers in her community. She has Access to TV, Radio. She fears infertility, values her husband's joy and satisfaction, healthy children and desires affordable health services close to her house.

Motivators, Barriers and Influencers

Motivators	Barriers
<ul style="list-style-type: none"> • Family size and financial needs to cater for the family. • Feels tired from close pregnancies that make her feel fatigued for long periods • Wants to show her motherhood strengths(Caring Nature) • Desire for many healthy children and large family • Service and product is free at the public facility. • Services close to her home offering timely service 	<ul style="list-style-type: none"> • Please her family (Husband and relatives) • Modern methods perceived side-effects • Limited range of choices available close to her. • Lack of husband consent - Husbands are against modern BS methods • Societal stereotypes about FP product and users • Fear of family problem – husband and wife conflict (fear to be divorced) • Fear of side effects associated with Modern methods.-Perception that this method lead to infertility or cancer. • Providers discouraging FP use.
Influencers	Sources of Information
<ul style="list-style-type: none"> • Peers • Husband • Family members (e.g. sisters, Mother, Mother inlaw) • Providers they are familiar with • Religious Leaders 	<ul style="list-style-type: none"> • TV, Radio • Social peers

Source: 2018 Immersive Research

Customer Journey Map

Market Interaction	
Public	Private
<p>Preferred due to:</p> <ul style="list-style-type: none">• Free service• Preference for female providers• 	<ul style="list-style-type: none">• Quicker services• No regulatory procedures (asking husband consent)• Afternoon services available• No stock-out for products• MCH is for children
Product choice	
<ul style="list-style-type: none">• Pills they are cheaper it's an entry level and we can stop anytime• Implants hard to get off• Implants for convenience and less repeating to take the product compared to others	

Opportunities and Constraints

Strengths:

- Availability of range of FP products Different options/mix of methods (short and long term)
- Market presence/share
- Brand trust
- Existing channels-Networks of facilities (pharmacies, clinics, MCHs, hospitals etc.)
- Strong collaboration and engagement of stakeholders (public and private) and partners.
- Human resource and expertise Technical expertise (FP programming, HCD...) Products, strategy, market presence
- Availability of FP guidelines
- RHG forums

Weaknesses:

- Inadequate coverage of FP products/health education –by geography- Low access in rural and nomadic areas
- Limited options/choices of FP
- Lack of Male Health education approaches for behavior change
- Inadequate value proposition
- Costly products
- HP(VCAT) Value clarification
- Diminished funding for FP demand creation activities
- Inadequate Market tracking (no up-to-date information collection system)

Opportunities and Constraints

Opportunities	Treats
<ul style="list-style-type: none">• The Willingness to uptake the FP methods and range of products• Stock-outs in public sector• Inadequate coverage of FP products/health education –by geography Low access in rural and nomadic areas• Government of Somalia has made an FP2020 commitment• Public-private partnerships present new opportunity• Opportunity to reaching youth, currently more than 60% of the population.• Recently ratified the revised Reproductive Health Strategy to include family planning.• Integrated reproductive health outreach activities ongoing already bearing positive results• Commitment of UNFPA to provide quality contraceptives	<ul style="list-style-type: none">• Public to private sector leakages• Unsupportive Policies and regulations• Distributers are not willing to take up our products

Decide

Demand vs Supply



Demand

- **Design Interventions to target:**

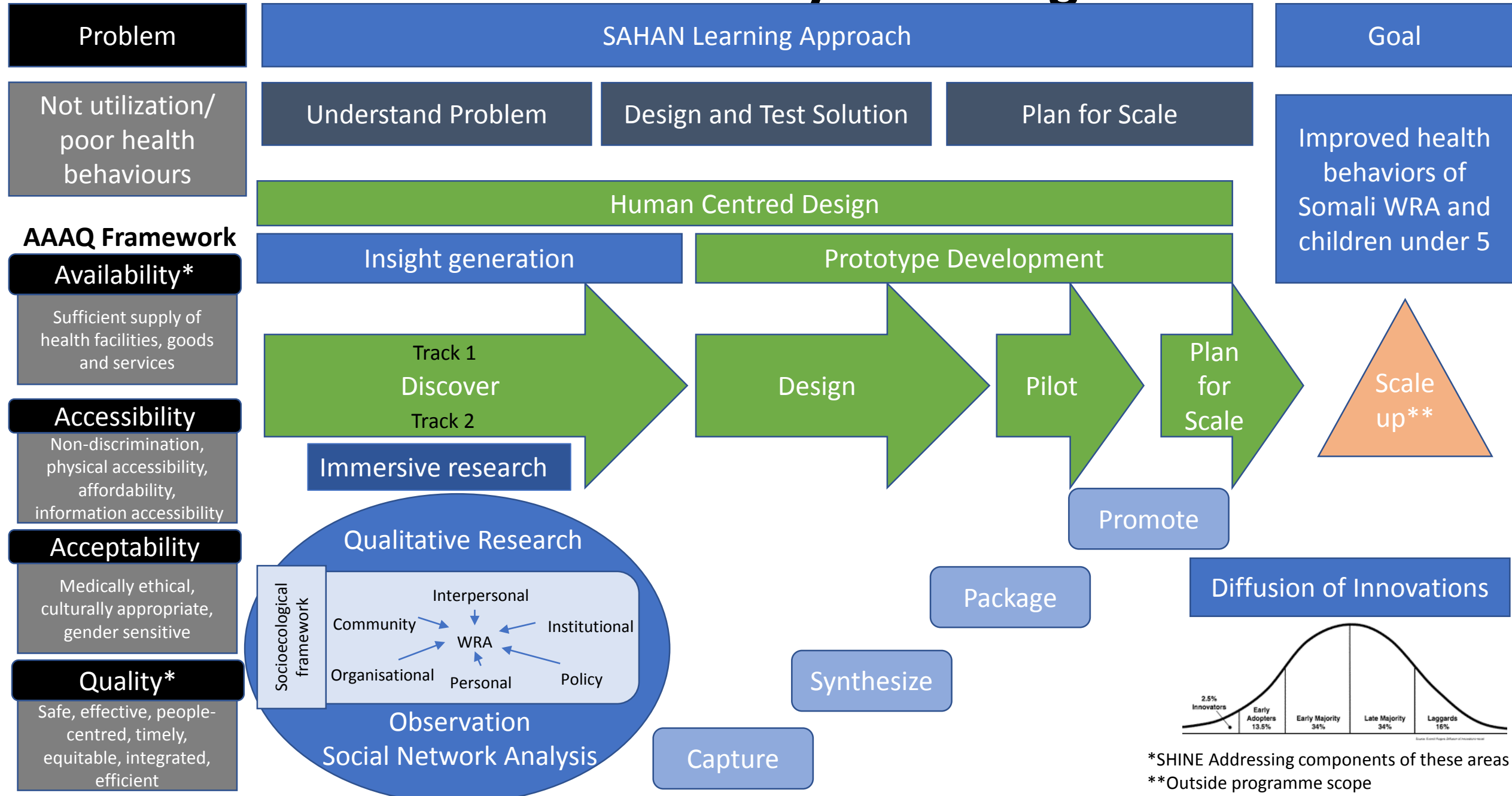
- Religious leaders
- Husband
- Mothers/Mother in-laws and sisters

- **Key Barriers to Address**

- Social cultural / religious
- Husband: wants a large family, **fears infertility and side effects**
- Knowledge: Fear of side effects and Misconceptions associated with Modern FP.

- **Leveraging SAHAN which is applying HCD** to Design a wide range of user centered demand creation interventions targeting WRA and their influencers (Religious leaders, husbands, mothers/in laws, etc) as indicated in the Log frame and TOC. These are in line with the Keystone framework Design and Deliver Objectives.

SAHAN Theory of Change



*SHINE Addressing components of these areas
**Outside programme scope

SAHAN Log Frame

	Indicator 1	Indicator 2	Indicator 3	Indicator 4
IMPACT: IMPROVED HEALTHY BEHAVIOURS OF SOMALI WOMEN OF REPRODUCTIVE AGE AND CAREGIVERS OF CHILDREN UNDER 5	Maternal Mortality rate	Under 5 Mortality rate	Sever malnutrition	Contraceptive Prevalence Rate
OUTCOME 1: Increased utilisation of quality essential health services	Health Facility Utilization	Healthy Behavior uptake		
SAHAN OUTPUT 1: Develop and support scale up of proven behaviour change interventions (healthy behaviours include health service utilisation)	Number of prototypes designed, tested and ready for piloting stage	Number of piloted Interventions ready for scale	Number of evidence generation and synthesis products (Number of documented insight generation processes, Prototype testing processes, Innovation Labs reports, Discovery days) used in prototype development.	
SAHAN OUTPUT 2: Promotion of a learning culture in SHINE to inform the wider health sector	Practical examples of SAHAN partners sharing knowledge and best practices leading to a new activity/initiative by another stakeholder (may include health sector tools, guidelines, case studies, webinars, event reports,			

Supply

- **Influence Policy Shift:**

- For increased opening hours in the public sector.
- To include excluded groups:
 - Perceived sexually active youth unmarried populations
 - women with disability (mental and physical)
- Increase access to LTM (Implants and IUD) through the private sector
- Leverage Syana press availability for distribution through CHWs
- Approval for increase Product Range: ECP, Syana press, Noristerat, Condoms.

- **Address distribution capillarity** by maximizing the potential of the private sector to Sustain Private Sector 45% CYP contribution

- Explore potentials of securing products for private sector distribution.

- **Service quality and providers skills** in both public and private sector:

- Systemic VCAT

Conclusion

- While SAHAN continues to design and innovate user centered interventions aimed at improving healthy behaviors and lifestyle, sustaining these new behaviors are subject to availability of the products and services this new behaviors require.
- As indicated above, WRA have preferences for products and services for several different reasons and restricting their options to the public sector alone would marginalize a large portion of current users and potential users.
- In addition, the public sector is not growing at a rate that would easily compliment the contributions of the private sector in the near future. It is therefore necessary for the private sector CYP contribution to be sustained and improved upon.