TMA workstream

Jane Hutchings

Director
Reproductive Health

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PATH
A catalyst for global health

Our definition of total market approach

Government engaged in intentional coordination of an entire market for family planning commodities, by supporting a range of partners to reach the segments of markets that they have comparative advantage to reach, in order to enhance equity and sustainability.

Adapted from Market Development Approaches scoping report, HLSP, 2006

ILLUSTRATIVE ACTIVITIES

- Primer – based on country experiences
- Retrospective analysis (submitted as article for TMA supplement of Cases in Public Health Communication & Marketing)
- Regional coordination
  - Eastern Europe / Central Asia
  - SECONAF

RETROSPECTIVE ANALYSIS

Objectives of retrospective analysis

- Determine specific **practices** or **contextual factors**, if any, help to foster equity and sustainability of family planning
- Understand whether deliberate, proactive, coordinated approaches to total market planning **by government** are necessary to meet demand

Background

Total market work in 5 countries during 5 distinct time periods

- Indonesia: Promoting the private sector through self-reliant family planning at the individual level (1988-2001)
- Mexico: Targeting highest-need clients in the public sector and working with innovative NGOs (1992-1999)
- Romania: Targeting vulnerable groups and integrating family planning into primary health services (1990-2002)
- Thailand: Prioritizing the national family planning program while enabling the private sector to innovate (1970-1984)
- Turkey: Increasing national contraceptive self-reliance through an increased national budget, voluntary donation policy, and inclusion in social insurance (1994-2004)

Methods

- Country selection considerations
  - Known FP total market work
  - USAID graduation
  - SPARHCS assessment
  - Availability of data and information
- Policy framework for analysis
  - Contextual factors
  - Good practice hypotheses
- Data collection on contextual factors and policy practices
  - Literature review
  - Data review
  - Expert consultants

Good practice hypotheses

1. Problem recognition occurs among key stakeholders.
2. Clear priorities are set, with national government leadership.
3. Data are collected about health markets to help clarify options/advocate.
4. Policy and programmatic options evaluated through pilots.
5. Government-led coordinating group oversees total market work and all sectors are considered.
6. Implementation is guided by an action plan.
7. Planning and implementation involves every level of the health system.
8. Sufficient resources available for evaluation and learning.

Results: context and practices

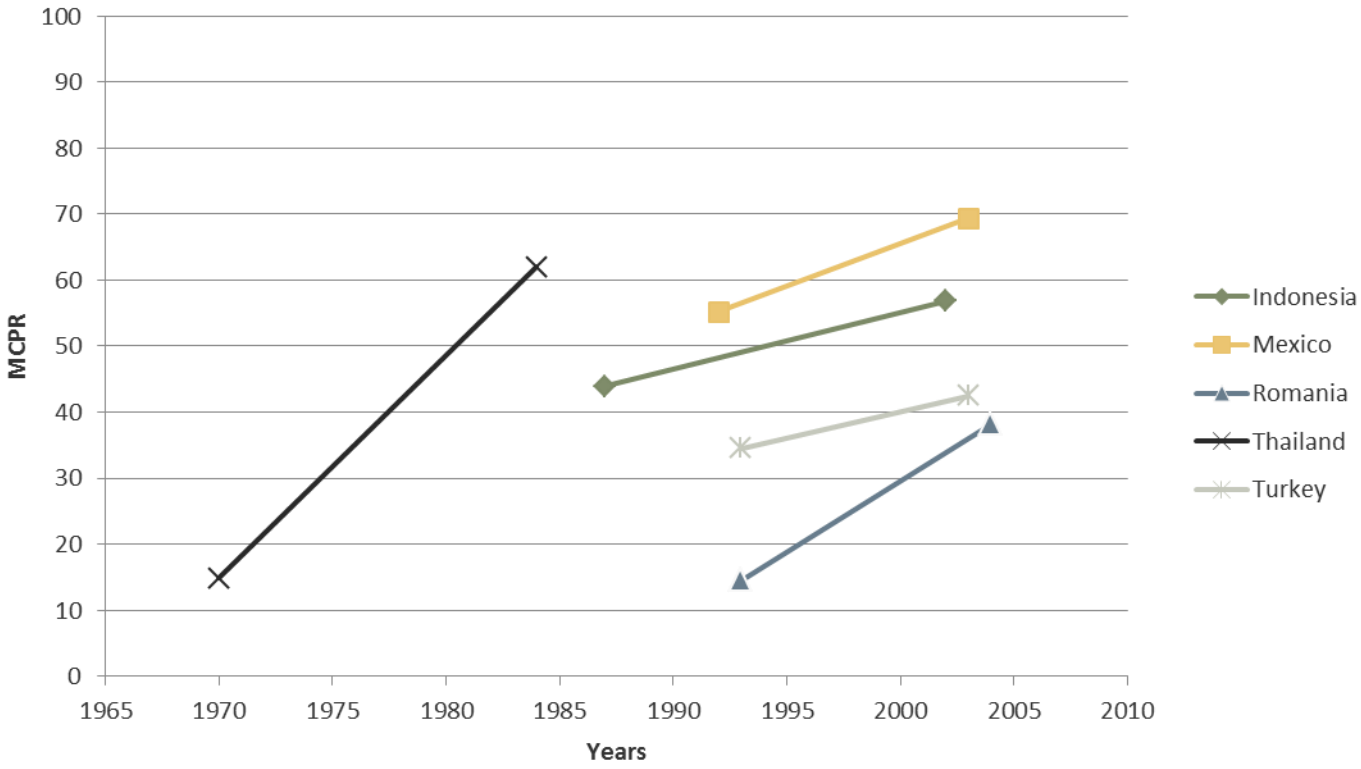
Contextual factors varied significantly across the five countries

- **Government support** clearly present in 3/5 countries (Indonesia, Mexico, Thailand)
- All countries experienced **MCPR** growth during the periods in question, especially Thailand
- Linkages with **broader health sector reforms** in Romania and Turkey
- Variability in **operating environment for the commercial sector**
  - Indonesia – strong, deliberate government engagement with private commercial sector
  - Romania and Thailand – commercial growth facilitated indirectly
  - Mexico and Turkey – challenging operating environment

Most, but not all, good practices applied across settings

Results: MCPR

MCPR increased in all countries during total market periods



Results: equity

FP use among lowest wealth groups increased over time in all countries; income differentials in FP use remained

Country	Year	MCPR, lowest wealth group	MCPR, highest wealth group
Indonesia	1987	37	52
	2002-3	49	58
Mexico	1992	36	68
	2009	60	75
Romania	1993	8	28
	2004	23	49
Thailand	**1987**	**60**	**65**
Turkey	1993	21	46
	2008	38	54

Conclusions

Which contextual factors shape the success of total market work?

- Prominence of and support for family planning in government seems especially important
- Indonesia, Mexico, and Thailand all experienced high levels of FP prominence/support—countries with relative TMA "success"

Conclusions

Which good practices shape the success of total market work?

Good practice hypothesis	Results
Problem recognition	**All countries but Romania**
Priority-setting with gov't leadership	**All countries set priorities; gov't leadership in Indonesia, Thailand**
Market research	**All countries but Thailand**
Pilot projects	**All countries, helped establish TMA feasibility**
Coordinating group	Limited commercial participation, except Indonesia
Clear action plan	Only Mexico
Involve all levels of health system	**All countries**
Evaluation	**All countries but Romania**

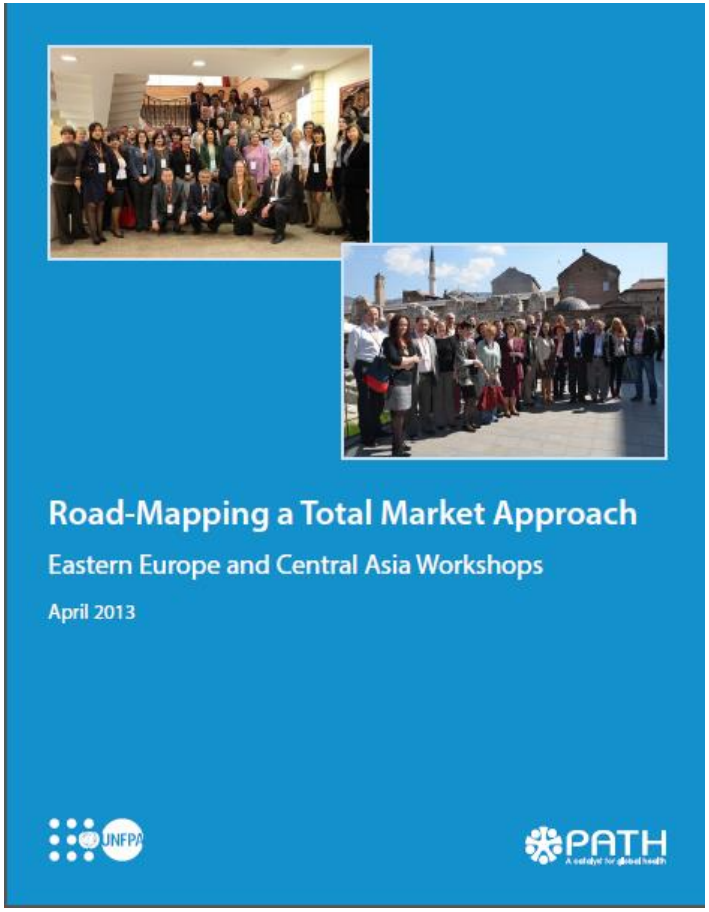
Conclusions

Is deliberate government planning and action that reaches beyond the public sector necessary for total market success?

- Yes: Experiences in Indonesia, Mexico, and Thailand underscore that strong government leadership and coordinated action on family planning—rather than fragmented private-sector projects—strengthen the success of total market implementation

Regional coordination

- Eastern Europe



Common themes of EECA country action plans

- **Engage stakeholders:**
  - Identify new stakeholders.
  - Strengthen existing coordination bodies
  - Advocate to government agencies, parliamentarians, and subnational government authorities.
  - Integrate TMA into national strategy development.
- **Gather and apply evidence:**
  - Determine current contraceptive and service sources including private markets.
  - Collect evidence about the extent and identification of low-income, vulnerable populations.
  - Identify which populations are best suited to pay for contraception.
  - Review/revise EDLs to include contraception (including devices).
  - Evaluate legislative and regulatory changes needed.
  - Determine costs of family planning service provision.
  - Determine quality indicators to monitor quality of service provision in both public and private sectors.

TMA next steps

- SECONAF regional coordination
- Public financing benefit analysis
- Other?
  - Demand building for specific products
  - Longitudinal analysis of TMA

QUESTIONS?

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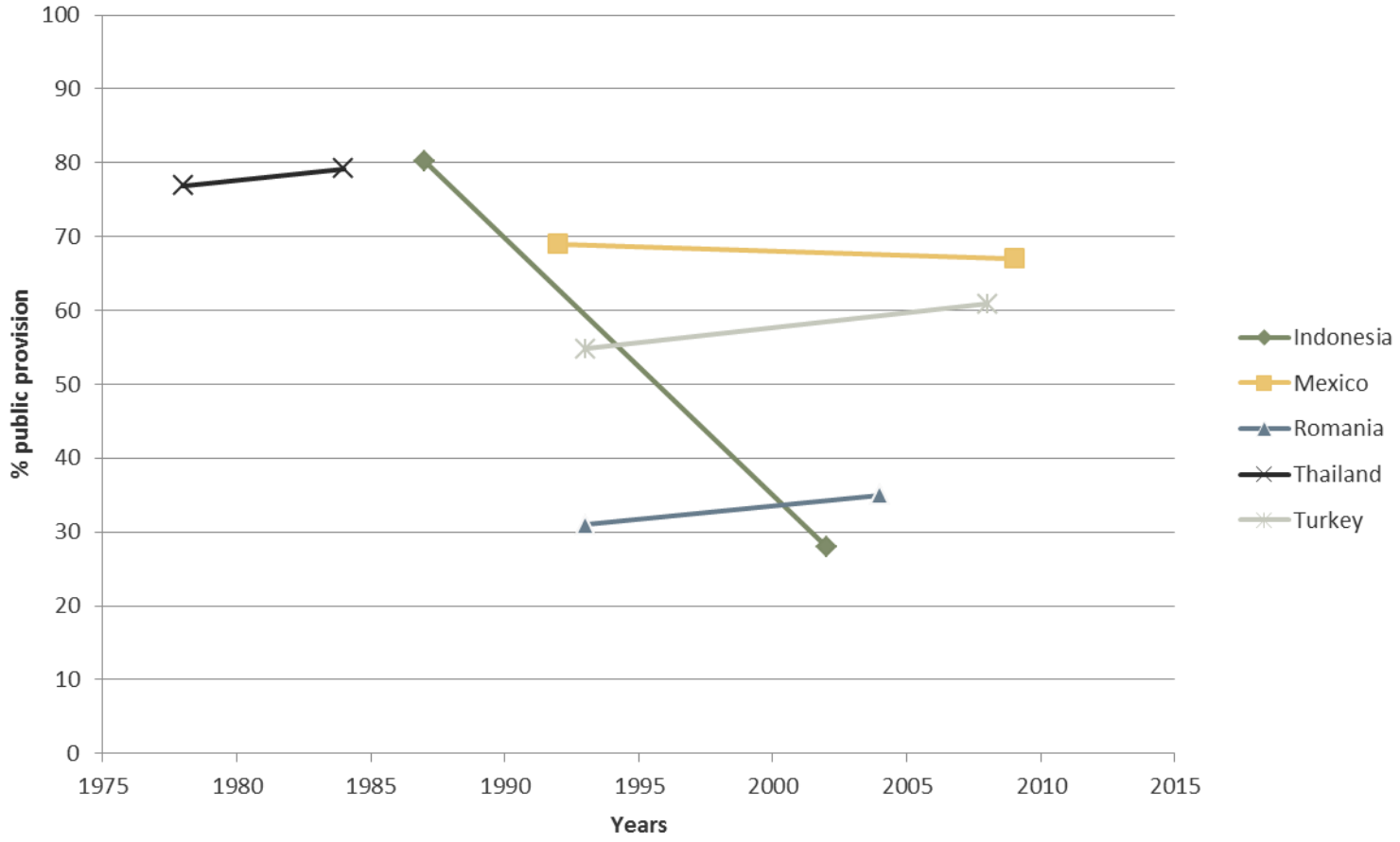
Supplemental slides

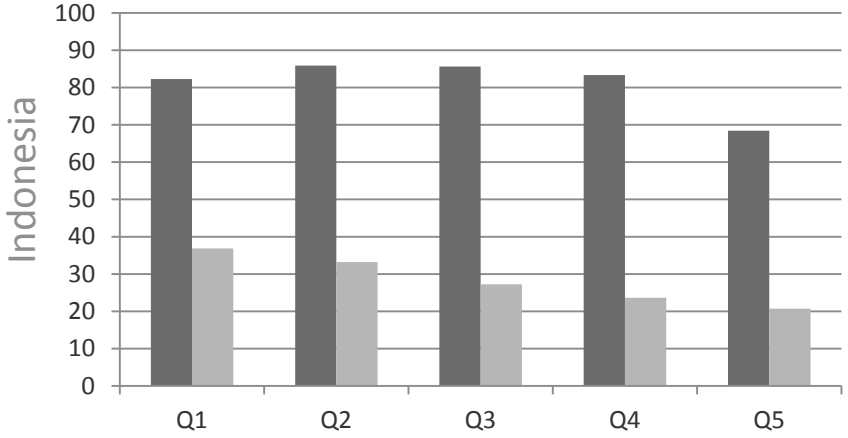
Results: sustainability

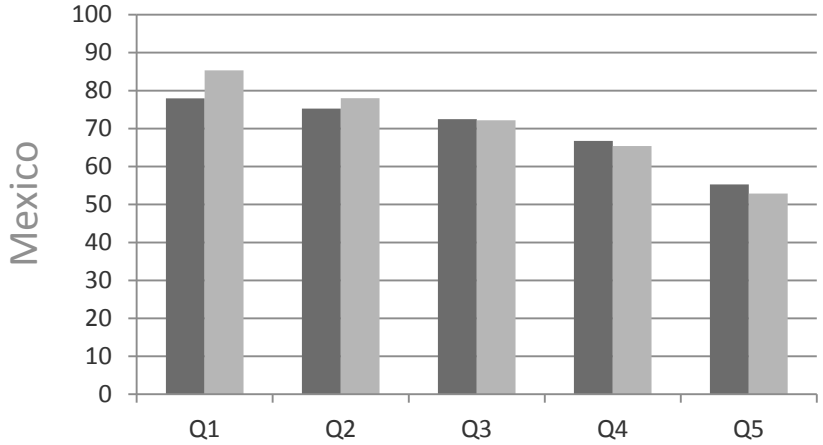
Public-sector provision of FP decreased markedly in Indonesia.

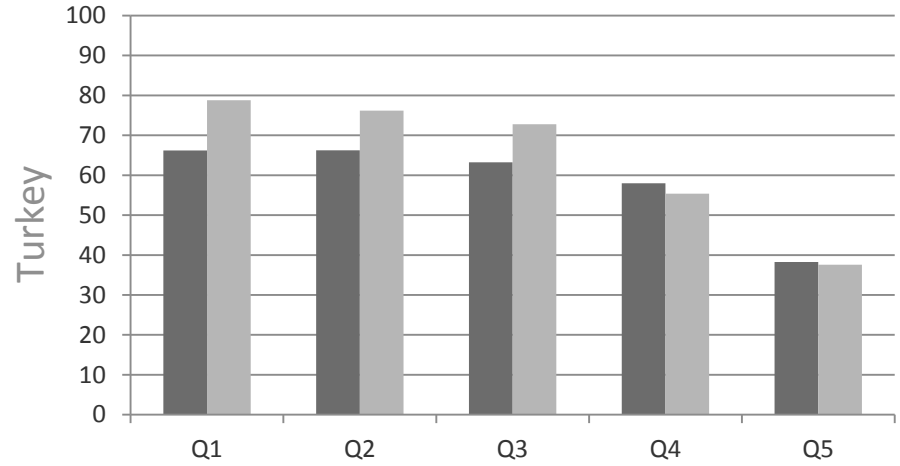


Results: equity/targeting

In countries with data, the proportion of consumers accessing contraceptives through public sources decreased as wealth increased.







Percent of public sources by wealth quintiles at beginning/end of TMAs

Indonesia: 1987, 2002

Mexico: 1992, 2009

Turkey: 1993, 2008

Background

Indonesia total market work (1988-2001)

- National Family Planning Coordinating Board (BKKBN) aimed to shift 50% of FP users to private sector by 1994, due to increasing demand and decline in donor support
- Clients encouraged to seek services in the private sector or pay in the public sector
- Close collaboration with USAID to strengthen the private sector
  - Build capacity of private midwives and doctors
  - Create demand for products and services
  - Ensure supply of low-cost products in private sector

Background

Mexico total market work (1992-1999)

- Close coordination of USAID and government in context of impending phaseout
- Goal: Replace USAID funding with national resources
- Support to NGOs, MEXFAM and FEMAP, to reach underserved and vulnerable groups
- Public resources targeted in nine rural states with highest need
- 1999: All public-sector agencies financing 100% of contraceptive commodities

Background

Romania total market work (1990-2002)

- 1990: Government initiates involvement in FP service provision, SECS (NGO) establishes private family planning clinics
- Policy changes
  - General practitioners can provide FP services
  - NGOs can charge for contraceptives on a not-for-profit basis
- Integration of family planning in primary health care, basic package of services
- Increased efforts to target free products to vulnerable groups

Background

Thailand total market work (1970-1984)

- Government family planning leadership enabled innovation in the private sector critical to the growth of family planning
  - Auxiliary midwives permitted to provide FP services, enabling community-based distribution by NGOs
  - Commercial pharmacies permitted to provide OCs without prescription
  - Free contraceptives supplied by government to NGOs who agreed not to charge users
- 1982: Government increased budget for contraceptives from US$750,000 to US $6 million per year; funding continued to increase

Background

Turkey total market work (1994-2004)

- Government and USAID focused on expanding contraceptive self-reliance
  - Increasing public-sector budget for contraceptives (previously non-existent)
  - Implementing donation policy
- Donation policy – those willing and able to pay for services could electively contribute to the costs of FP products to subsidize products for the poor
- Simultaneous investments by USAID in increasing FP capacity of Turkey's social insurance organization SSK
  - SSK covered ~60% of population
  - Previously only focused on curative services