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Increasing Same-Day Access to FP through Available, Affordable Pregnancy Tests

*Final Detailed Report of SHOPS Plus
Market Shaping Analysis in 5 Countries*



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One step HCG urine pregnancy test



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Overview

- **Premise:** Studies have suggested that women seeking hormonal FP methods outside their menstrual period risk being turned away by providers, and improving access to pregnancy tests can result in improved same day access to FP methods
- **Purpose:** To determine whether market shaping can be used to improve access to same-day hormonal FP methods through PTs.
- **Method:** The SHOPS Plus project conducted market assessments in India, Kenya, Madagascar, Malawi, and Zambia between June-September 2016.
 - Collected information included: price, availability, quality perceptions, use of PTs, use of the Pregnancy Checklist or other protocols, and past procurements in the public, for-profit and NGO sector.
 - The project then analyzed the findings with the CII market shaping framework, and used a consultative process to identify the most promising interventions.

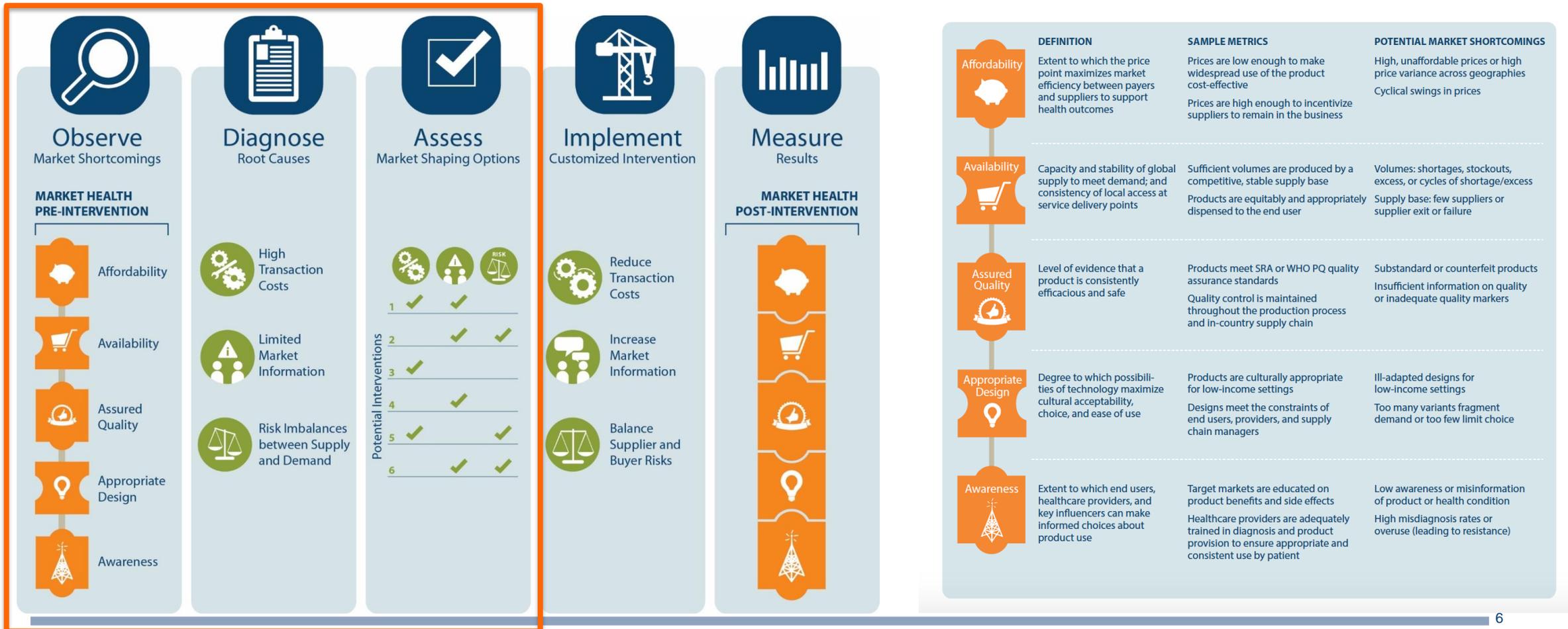


Assessment overview

- **Key questions:**
 - What are market conditions for PTs at the global and local level?
 - What barriers to the use of PTs may cause FP clients to drop out?
 - What interventions might reduce these barriers?
- **Caveats:**
 - The assessment was qualitative, with a small sample of respondents
 - The geographic scope was limited to capital cities or other urban centers
 - Affordability and quality could not be precisely assessed

Project Methodology & Caveats

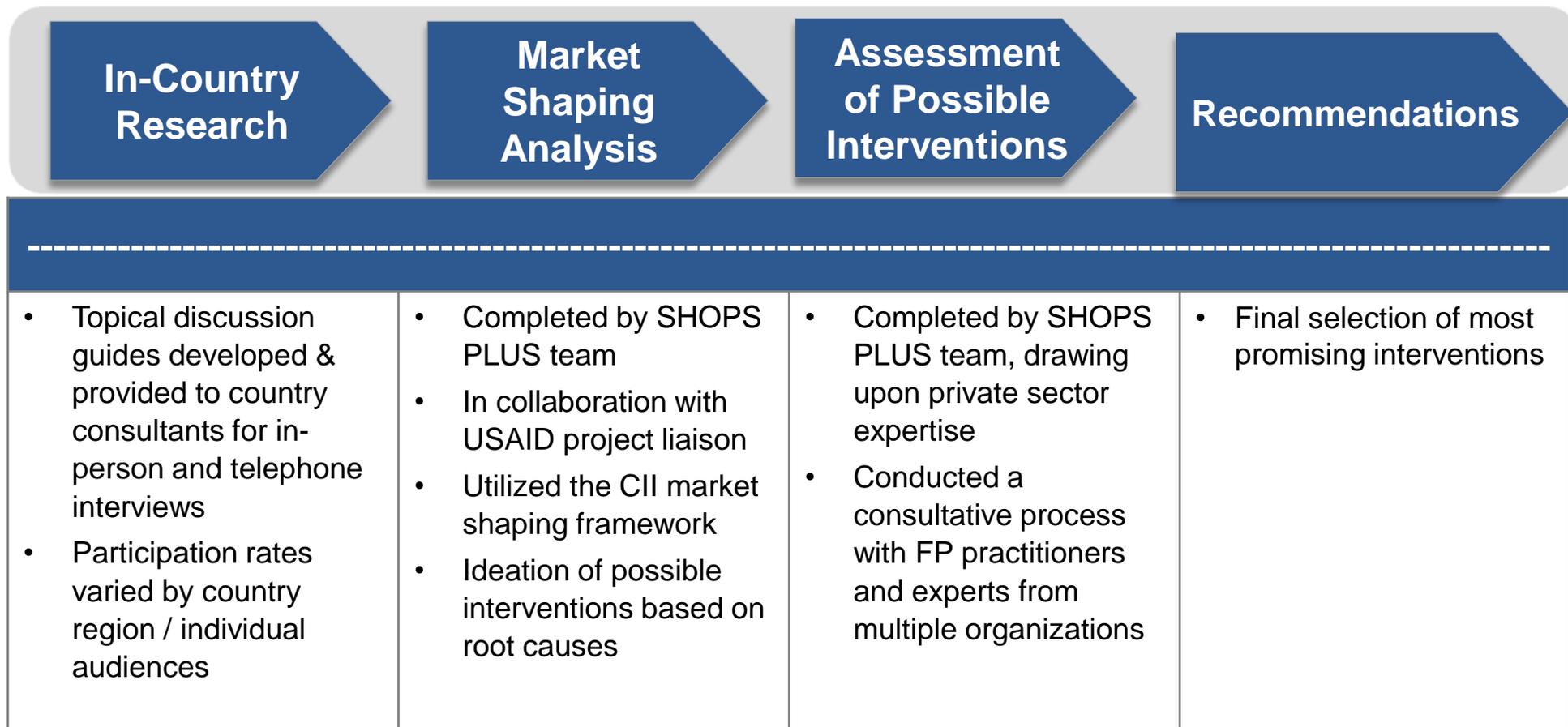
Project Methodology: In-country qualitative research and analysis using the CII market shaping framework





Project Methodology

In-country qualitative research + secondary data review informed the market shaping assessment and intervention ideation; followed by consultative process





Information Sources

- **Global:**
 - IMS Health, public records
 - USAID procurement records
 - Consultation with procurers
- **Local:**
 - IMS Health (India)
 - Local tenders
 - Interviews and site visits
 - Including MOH contacts and NGOs managing private pharmacies

Country	Number of site visits /interviews				
	Public clinics	Private clinics	Distributors Wholesalers	Retailers	Total
India	13	23	2	8	46
Kenya	3	14	3	7	27
Madagascar	2	7	6	11	26
Malawi	13	24	5	18	60
Zambia	13	7	5	22	47
Total	44	75	21	66	206

Abbreviations & Project Caveats

Abbreviations and caveats pertaining to this research are included below:

Abbreviations:

- EML: essential medicines list
- FP: family planning
- KEMSA: Kenya Medical Supplies Authority
- MCH: maternal & child Health
- MOH: ministry of health
- NGO: non-government organization
- OC: oral contraceptive
- PT: pregnancy test

Project Caveats

- This assessment is based on qualitative small sample research; findings should be viewed as directional
- Research represents findings from a single urban region in each of the five countries
- Affordability could not be precisely assessed
- Several respondents declined to share PT purchase price and margin information
- Product quality was not evaluated, therefore any findings on quality refer to user experience as described

PT Market Shaping Assessment Executive Summary



Global Level Findings

Mixed signals to providers; and varying clinical practice

- PTs and Checklist are included in *WHO Decision-Making Tool for Family Planning Clients and Providers**
- However, national guidelines are mixed; and providers do not routinely follow the WHO guidance
- PTs are not included in the WHO Essential Medicines List
- Only nine countries list PTs in their EMLs

Small, local ad hoc procurement

- USAID missions procure PTs locally from wholesalers
- UNFPA orders very small quantities of PTs for a few countries

Low procurement costs due to a competitive market

- Procurement costs range from \$0.04 - \$0.40 (dipsticks)
- There are many manufacturers of PTs, mostly from China, India, the US and EU



PT availability and use is driven by programmatic and procurement failures rather than market factors in these five urban regions

Availability issues are programmatic and procurement-related, rather than market based

- Market supply of PTs was adequate in the five areas studied, relative to manufacturer capacity and participation, based on private sector availability
- Inadequate availability and utilization of PTs in public clinics are due to demand issues deriving from country policy, clinical practice, funding and procurement not market conditions

Affordability may be an issue for sub-segments but was not determined to be a cross-cutting issue based upon this research and assessment

- A range of procurement prices indicate that widespread cost-effective use of PTs is possible
- PT pricing variance across regions and provider types results from:
 - Inefficient public procurement
 - Mark-ups applied at both retail and clinic outlets
- Affordability may be a barrier in under-served and rural areas (not fully represented in this research sample), but requires population research to determine



PT quality and design are not inhibiting use in FP services; the barriers are policy, protocol and behaviorally based

Assured Quality

- Qualitative research in the five country regions did not indicate evidence or a pattern of expressed concern or negative health outcomes due to problems with PT quality and reliability, however...
- A possible market shortcoming is insufficient information and assurance on the quality of available PTs

Appropriate Design

- Across the five regions, PT product design was not identified as a potential market shortcoming, nor as a reason for non-use, nor for any negative impact on health outcomes
- Dipstick and cassette tests were the most common, with midstream tests also available

Awareness

- This research reaffirmed that national policy and healthcare provider behavior (both public and private sector, including training, adherence and motivation) are significant shortcomings and barriers to appropriate and consistent use of PTs as well as the pregnancy checklist



Cultural norms, provider and client behavior all block use of checklist / PTs, and delay initiation of method-start

The practice of turning women away who are not in their menses is deeply entrenched

- Most prominent in India, but evident in other country regions as well
- Clients also self-delay visits to FP providers for this reason

Use of the pregnancy checklist is inconsistent across both public and private sector providers

- Coordinated and sequential use of both the checklist and PT is not routinely occurring

Purchase and use of PTs does not necessarily result in FP counseling or initiation

- Common practice of clients sourcing in the private sector, not demanding provision of PTs at public clinics

Client ability and willingness to pay for PTs is not fully understood

- Not clear whether clients are unable or choosing not to pay for PTs and leaving the clinic

India key findings: clinical practice is the barrier rather than PT availability - opportunity is in provider behavior change

- **PT market**
 - Public clinics carry PTs
 - PT public procurement is conducted through centralized tenders
 - PTs are widely available in the private sector at various prices
 - There is a high incidence of home use of PTs
- **Policy and practice**
 - Providers often do not use checklist or a negative PT result to initiate FP
 - Non-menstruating FP clients are typically asked to return during menses
 - Use of PTs is appropriately reserved for FP clients with delayed menses



Kenya key findings: opportunity is in improving public sector procurement and increasing provider adherence to protocol

- **PT Market**

- PTs are available in public sector (county procurement)
- Private pharmacies carry wide range of brands
- Trade margins are high (see table, next page)

- **Policy and practice**

- MOH supports PT use with checklist/history-taking
- Practice varies across public and private sector providers

Kenya: High trade margins are consistent with PTs as a low-volume, low-cost product

	Distributor	Wholesaler	Retail Price	Public Clinic*	Private Clinic
US\$ per strip	0.06	0.07	0.50	0.99	1.88
Wholesale margin		12.53%			
Retail Margin			85%		
Public clinic margin				93%	
Private clinic margin					96%

(*) FHI360 found that some public clinics did not charge for PTs

Madagascar key findings: continued policy support for both checklist and PTs needed, critical for PT procurement and provider use

- PT market
 - PTs are not currently available in public clinics for FP services
 - USAID funded projects supply PTs at the community level
 - Commercial brands are widely available in pharmacies at various prices
- Policy and practice
 - MOH supports use of the checklist and supported the introduction of PTs for FP through community-based MIKOLO project
 - Inconsistent use of checklist in public clinics
 - FP clients whose pregnancy status cannot be ruled out are given barrier method and asked to return
 - Clients potentially more likely to self-delay FP visit outside menses, when PTs are not available in public clinics



Malawi key findings: policy supports PTs but also client delay, so an opportunity exists to advance new clinical guidance and prioritize PTs

- PT market
 - PTs are not currently available in public clinics for FP services
 - PTs are not on an essential commodities list
 - There is a wide range of brands and prices in private pharmacies
- Policy and practice
 - Malawi RHSD guidelines do support use of PT after checklist, but not more than alternatively delaying the client until her next monthly bleeding
 - Public FP clients with undetermined status must buy PT elsewhere or return during menses
 - Private franchised clinics use own guidelines when using PTs for FP

Zambia key findings: opportunity appears to be predominantly in improving PT supply security through procurement and logistics

- PT market
 - MOH procures PTs for FP
 - Public sector stockouts are routinely reported but availability has been improving
 - PTs are widely available in private pharmacies and clinics
- Policy and practice
 - MOH policy supports the use of PTs in the context of FP services
 - FP clients must buy a PT when they are not available at the public clinic
 - Private franchised clinics use own guidelines when using PTs for FP



Summary

- ***All countries have a vibrant private market for PTs***
 - Market shortcomings do not appear to be upstream or at the sourcing stages before reaching the retailer/provider
 - Wide product variety and availability, range of prices but retail margins can be high
- ***The availability of PTs for FP in the public sector is mixed***
 - Three out of five countries routinely order PTs for use in FP services, but clinics in Malawi and Zambia do not regularly carry PTs
 - Clinical and commodity procurement practices influence actual availability
- ***Issues related to policy and practice are found in all countries***
 - There is variable awareness and use of the checklist for pregnancy screening
 - Ruling out pregnancy with a PT does not always lead to method initiation

Country / Region Findings

PT Types and Costs

PT availability in the marketplace: Many brands, mostly for dipstick format

Country	Number of Products identified	Dipstick	Cassette	Midstream	Number of Manufacturers identified
India	19	0	19	0	14
Kenya	14	14	0	0	9
Madagascar	14	7	4	3	8
Malawi	13	12	0	1	11
Zambia	24	13	2	9	11

Sources: IMS/India. All other data collected in-country in public and private facilities, retail pharmacies, and from wholesalers/distributors.

PT costs (USD) imply likely affordability in private clinics, yet public clinic users may face barriers due to non-availability in clinics and cost in private sector

Country	PT Cost at Public Clinic	PT Cost at Retail Pharmacy	PT Cost at Private Provider	FP Consultation Cost at Private Provider	Other product for comparison (ECP)
India	Free	0.45–0.96	0.75 –1.49	2.99–4.48	0.75–1.49
Kenya	0.99–1.40	0.29–4.17	0.97–1.94	0.99–3.00 ²	0.99–1.48
Madagascar	PTs not available	0.33–3.45	0.49–0.99	0.99–1.66	0.33–3.25
Malawi	PTs not available	0.28–1.80	0.69 –2.08 →	0.14–1.39	0.69–2.08
Zambia	Free	0.10–4.50 ¹	Included	2.00–6.50	0.15

1. Excludes midstream digital test found in two outlets, at a maximum price of \$12.40

2. Typically includes FP method and service.

Comparing SHOPS Plus PT pricing data with IFP and FPWatch data: PT prices were under \$1.00 in all but one country, and as low as \$0.10

Outlet Type	SHOPS PLUS (US\$, range)					IFP (US\$, range)			FPWatch (US\$, range)		
	Kenya	India	Madagascar	Malawi	Zambia	Kenya	Mali	Malawi	DRC	Ethiopia	Nigeria
Private	0.97- 1.94	0.75 - 1.49	0.49 - 0.99	0.69 - 2.08	Incl in consult	0.98-5.87	0.41 - 3.28	0.35 - 1.77	0.55 - 1.10	0.10 - 0.21	0.25 - 1.00
Public	0.99-1.40	Free	NA	NA	Free	0.98 - 4.89	0.82 - 2.46	0.35 - 0.35	0 - 1.10	0 - 0.25	0.25 - 1.00
Pharmacy / Drug Shop	0.29 - 4.17	0.45 - 0.96	0.33 - 3.45	0.28 - 1.80	0.10 - 4.50	0.49 - 1.96	1.15 - 2.46	0.35 - 0.88	0.22 - 0.33	0.10 - 0.25	0.25 - 1.00

Sources: IFP / FHI360, SHOPS PLUS, FPWatch

Observations across the studies

- FPWatch, large sample sizes for private, public clinics, and pharmacies / drug shops
- SHOPS Plus and IFP are both small sample, qualitative in nature; variation in range is not surprising due to geography and question phrasing
- Public clinics charge for PTs in Mali, Malawi, Ethiopia, DRC and Nigeria
 - India and Zambia free, Kenya mixed
- Mali mean prices -- highest across all three studies
- Mali and Kenya data from IFP -- highest for public providers
- Ethiopia -- lower cost range and median across all outlet types
- DRC - 5x higher at private provider than in pharmacy / drug shop



FPWatch: Ethiopia has best PT availability in both public and private clinics, pharmacies generally have better PT availability than drug shops

Outlet Type	DRC			Ethiopia			Nigeria		
	All	Urban	Rural	All	Urban	Rural	All	Urban	Rural
Private	13.3	14.5	10.7	43.7	48.9	40.8	37.7	25.0	41.6
Public	28.9	41.7	21.2	77.5	79.0	77.0	45.0	44.8	45.0
Pharmacy	64.3	64.3	NA	47.0	57.1	37.9	78.3	79.4	72.8
Drug Shop	41.6	51.6	19.5	39.0	40.1	21.5	32.4	32.5	32.4

Source: FPWatch

Observations across the countries

- FPWatch, large sample sizes for private, public clinics, and pharmacies / drug shops
- Comparable availability across urban and rural settings for Ethiopia clinics
- DRC private clinics have the lowest PT availability of all segments
- DRC public urban segment has better than availability than rural
- Nigeria rural private clinics better availability than urban (however a smaller N for rural private clinics)
- Of the three countries, Nigeria has best availability in pharmacies, followed by DRC urban segment

Retail trade margins tend to be high

Country	Total Number of Products identified	Retail Selling Price (USD)		Retailer Gross Margin	Wholesaler Gross Margin
		Min	Max		
India	19	0.45	0.96	69-81%	15-37%
Kenya	14	0.29	4.17	85%*	12%
Madagascar	14	0.33	3.45	25-45%	NA
Malawi	13	0.28	1.80	60-93%	NA
Zambia	24	0.10	4.50**	15-98%	94-95%

*Relevant price information available for only 1 brand.

**Excludes outlier midstream digital test

Sources: Data from products identified by in-country consultants; India number of products supplemented with IMS data. Margins calculated by SHOPS Plus. Country currencies have been converted to USD

Public Procurement of PTs

(Does not include Madagascar and Malawi because they are not procuring)



PTs are not included in the 2015 WHO Model Essential Medicines List, and are included in relatively few country EMLs

Included in 10 country EMLs

- Cape Verde
- Cote d'Ivoire
- DRC (rapid test)
- Guyana (test strips)
- Madagascar*
- Namibia (diagnostic kit (HCG))
- Papua New Guinea (biochemistry assayed serum control, lyophilised)
- Rwanda (Reactifs pour Test de coagulation)
- Trinidad and Tobago (disposable sticks)
- Uganda (HCG pregnancy test strips)

Not included in most country EMLs

- Including the SHOPS PLUS, IFP and FPWatch research countries
 - DRC
 - Ethiopia
 - India
 - Kenya
 - Malawi
 - Mali
 - Nigeria
 - Zambia

*Reportedly added to the EML after [SHOPS 2013 study](#); confirmed by country consultant
Source: <http://www.cecinfo.org/emlsearch/commodity/pregnancy-tests-for-family-planning/>

India PT public procurement utilizes a centralized tender, does not include quality specifications

PTs are part of central procurement process

- Central Medical Services Society (CMSS) conducts centralized procurement, storage and inventory of medicines and essential health commodities for national level programs
- Each state sends annual requirement to Ministry of Health and Family Welfare, forms basis of forecast and procurement
- PTs are received from CMSS at dedicated FP Logistics Management Cell at Lucknow
- No quality specifications

Lucknow Public Supply Chain of PTs



Kenya PT public procurement is decentralized, and even highly localized, resulting in clinics charging for PTs and variable pricing

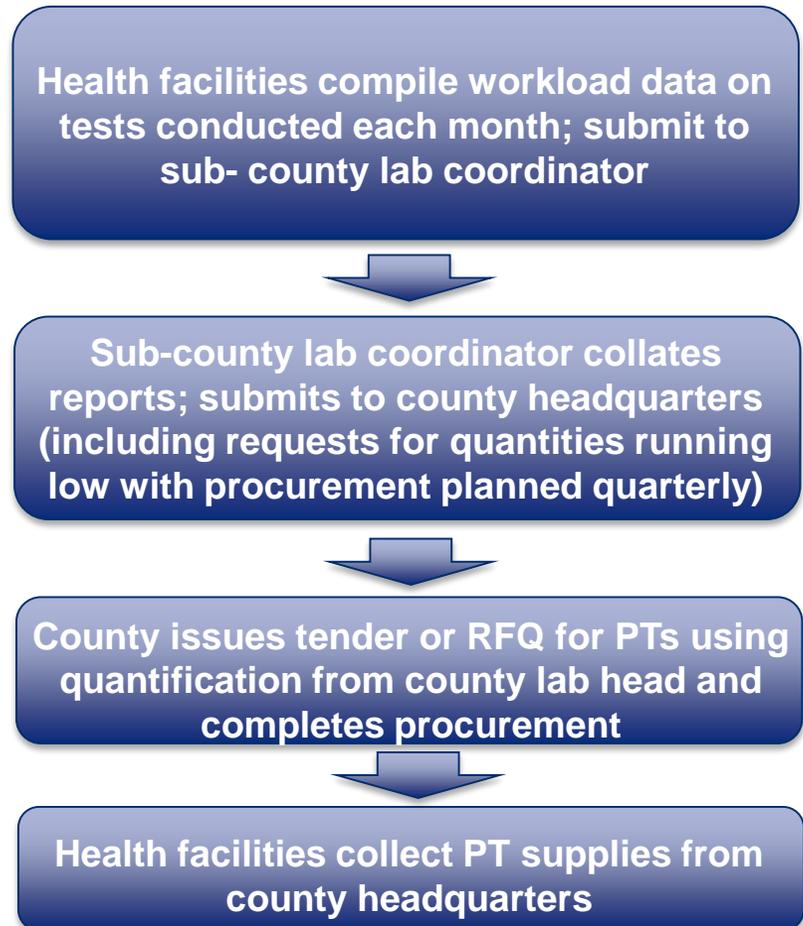
PTs are procured at the county level

- Kenya's devolved system includes two units of healthcare management and responsibility:
 - 1) National
 - 2) County level
- KEMSA does not routinely procure or distribute PTs
- Counties procure PTs for their facilities
- Procurement is done largely from the local market

Policy and Regulation

- PTs fall under Health Products and Technologies
- PTs are regulated under the Pharmacy and Poisons Board (PPB) listing route

One County's Process





Zambia PT public procurement is in place, challenges are capacity and process related

Shift in approach has positively impacted procurement and availability

- Until 2014, accessibility was mainly through facility laboratories
 - Resulted in missed opportunities as clients were sent to lab
 - Did not always get back to MCH
- 2015 forward, deliberate intention to improve FP services
 - Making PTs available in MCH became a priority

Continued challenges

- Bottlenecks in supply chain -- due to reporting problems, lack of awareness on stock availability at central level
- Coming from background of perpetual PT stock outs, situation seems to be improving with MOH continued scale-up of family planning
- With support from cooperating partners, they hope to build awareness in the communities who in turn should demand the services

Clinical Practice, Service Delivery and Client Behavior

Mapping the client journey revealed that multiple drop-off risks contribute to not obtaining same-day start of contraception

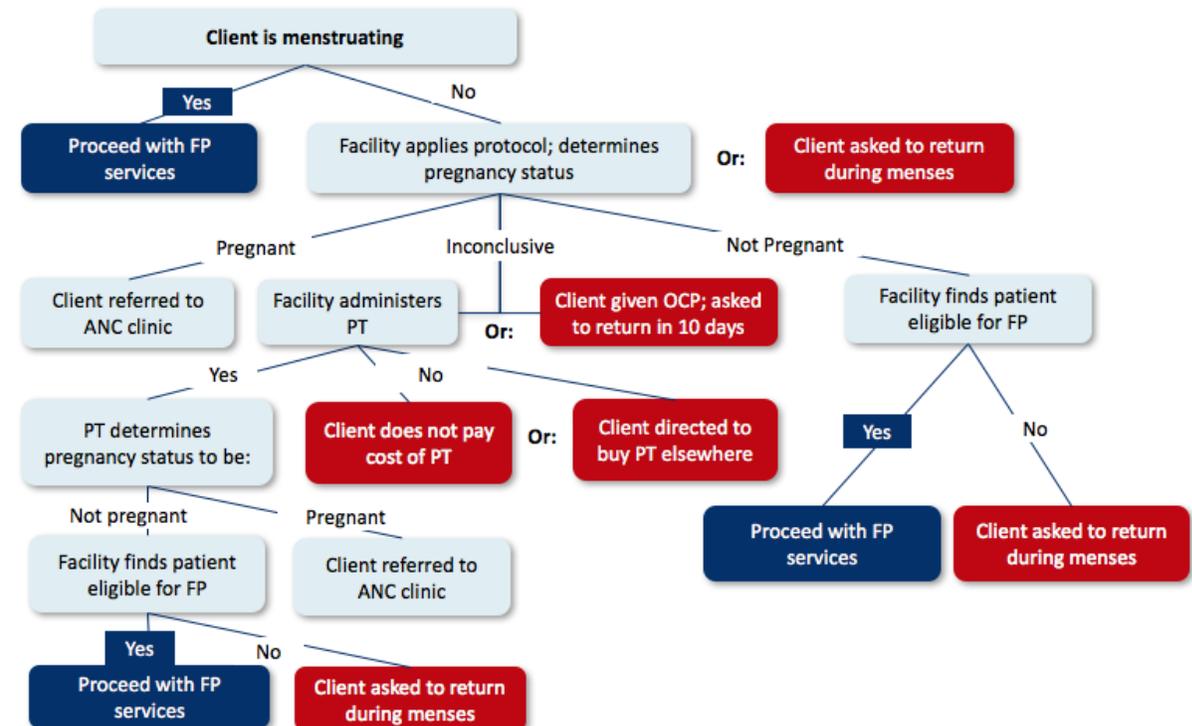
Both Public and Private Sector

- Risks are variously present across FP care delivery sites, although less so in franchised NGO sites

Drop-off Risks Include:

- Application of clinical protocol
- Availability of checklist and PTs
- Cost of PT
- Pregnancy may be 'excluded', yet still does not lead to same-day start of method

Public Sector Client Journey*



*Developed from Country Consultant Interviews, similar flow / risks for private sector

Clinical practice in public clinics appears highly variable with respect to protocol and use of PTs

	India (Lucknow) N = 4	Kenya N = 3	Madagascar N = 2	Malawi N = 13	Zambia (Lusaka Region) N = 13
Country Clinical (Defacto) Policy	Clients are required to present within first five days of menstrual bleeding to be eligible to receive contraception	<ul style="list-style-type: none"> PTs are to be used to when history taking and exam have not ruled out pregnancy 	<ul style="list-style-type: none"> Per the MOH, public sector providers use checklist to rule out pregnancy, PTs would be second-line 	<ul style="list-style-type: none"> Malawi National RH Delivery Guidelines 2014-2019 PTs are to be used after use of checklist 	<ul style="list-style-type: none"> FP protocols followed: FP card (proxy to WHO pregnancy checklist), FP registers, other FP booklets
Use of Checklist	<ul style="list-style-type: none"> Do not use checklist, 1 of 4 reported knowing about it 	<ul style="list-style-type: none"> General awareness of checklist Checklist was available 	<ul style="list-style-type: none"> Checklist is used Providers give score of 3/5 on checklist, as clients may not be truthful 	<ul style="list-style-type: none"> Per some but not all the clinics, checklist is used - two versions - 1) Checklist that is in health passport for every woman (used more often) or 2) checklist from Malawi National RH Delivery Guidelines 	<ul style="list-style-type: none"> FP card (similar to checklist) commonly used at all facilities FP card was considered subjective, not entirely reliable due to either / both staff accuracy in use and client honesty
Use of PTs	<ul style="list-style-type: none"> For clients with delayed or scant menses Do not report use prior to initiating contraception 	<ul style="list-style-type: none"> For antenatal care Family planning School girls as mandated by the institution 	<ul style="list-style-type: none"> No PTs in stock If needed, clients sent to purchase PT @ pharmacy 	<ul style="list-style-type: none"> Just 3 of 13 public clinics had PTs sometimes available No quantification of utilization 	<ul style="list-style-type: none"> All staff indicated they were more comfortable with PT in addition to checklist
Other Notes	<p>55% of clients presenting at FP clinic during menses</p> <p>Estimated % of clients returning during menses Urban = 65%, 40% Rural = 85%</p>	<p>Variable practice:</p> <ul style="list-style-type: none"> PTs are administered at a cost by sending clients to the clinic's lab Clinics without labs send their clients out to get PTs and return 	<ul style="list-style-type: none"> Reported that providers generally find an FP solution, rarely delay to next period PTs provided by UNFPA are mainly to check pregnancy after gender based violence 	<ul style="list-style-type: none"> Estimated that <50% of those referred for PT or to return during menses do <u>not</u> return to clinic PTs are not on EML, not on standard RH quantification list 	<ul style="list-style-type: none"> PT stocks not consistently adequate, although signs of improvement Client-learned behavior to procure PTs at pharmacy prior to visiting public clinic due to inconsistent availability at clinics

Clinical practice in private clinics: India relies on ‘first five days’ practice, Kenya research suggests variable use of pregnancy exclusion protocols

	India (Lucknow) N = 19	Kenya N = 14	
Private Facility Type	Independent private clinics and HLPPT MeriGold ranchisees	Independent clinics	PSI Tunza and MSI Amua franchisees
Use of Checklist	Do not use a physical copy of the checklist, two doctors reported using a checklist to rule out pregnancy and using questions based on their knowledge of the checklist	Facilities reported different tools / protocols	Just one facility (Amua) had checklist
Use of PTs	To rule out or confirm pregnancy in women presenting with delayed or scanty menses, also in lactating mothers and clients with DMPA-induced amenorrhea	Conducted PTs on site, separate service provided at lab Providers largely report that tests are reliable, no constraints in use	
Other Notes	12 / 19 doctors confirm that between 50-98% of women with delayed menses perform a PT at home before coming to the clinic All doctors indicated they would not be comfortable with same-day initiation of contraception outside first five days of menstruation	All private providers indicate they source from commercial market (including Tunza and Amua franchises) Brands vary among suppliers and based on what supplier has in stock at time of order No problem with stock outs, suppliers are responsive	

Clinical practice in private clinics: variable availability and use of both the checklist and PTs

	Madagascar N = 7		Malawi N = 24		Zambia (Lusaka Region) N = 7
Private Facility Type	PSI Top Reseau network and MSM franchisees	FISA and OSTIE	Independent clinics	PSI Tunza and MSI Banja La Mtsogolo franchisees	Independent clinics and MSI BlueStar franchisees
Use of Checklist	Protocols vary by provider and franchise, but generally: checklist for eligibility and method, WHO disk for choosing FP method,	FISA: FP eligibility sheet and decision making tool Ostie: Use checklist issued by USAID/FHI	No description of checklist use for either independent or franchised clinics		<ul style="list-style-type: none"> • 5 of 7 clinics did not have checklist • 4-5 of 7 clinics had other forms of FP cards or protocols
Use of PTs	PTs are used as a final step after use of the checklist, also in some cases clients are asked to come back	PTs are used when clients are: breastfeeding, not menstruating at time of visit, delaying appointment for injectable method	No specifics on use other than they sell and charge for PTs	All had PTs Tunza and Blue star clinics conduct PTs on all new FP clients, as requirement by BLM and PSI	PTs are used if history and physical examination cannot rule out pregnancy.
Other Notes	Estimate that 60% of non-menstruating women who are turned away, return during their menses			Clinics have poor record keeping, only a few are tracking PT use through self-made registers	<ul style="list-style-type: none"> • Facilities source bimonthly from wholesaler/distributor in local market

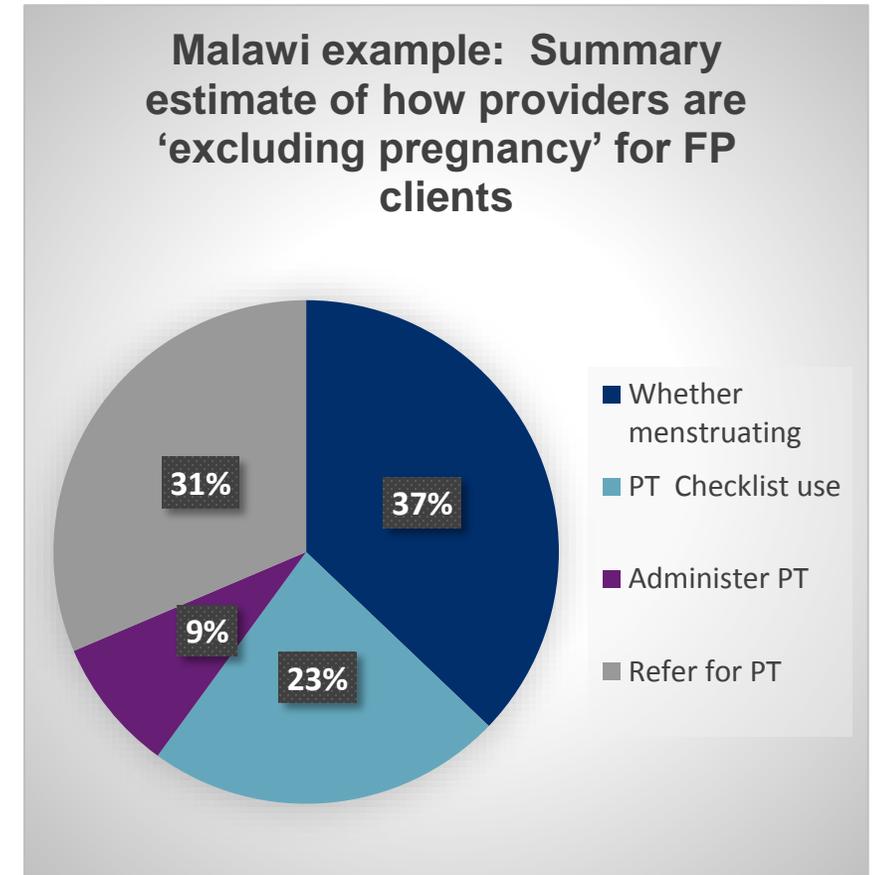
Provider interviews revealed that clinical practice is highly inconsistent with respect to both the pregnancy checklist and PTs

Considerable variation by region studied, and by provider site

- Job aids vary from site to site
- Providers express knowledge of requirements and feel no need to use checklist

Provider practice of relying on evidence of menses rather than checklist and / or PTs

- Most consistently evident in Lucknow region of India, but present in other countries as well



Source: Malawi Country Consultant Report



Clients routinely purchase and use PTs privately, often prior to clinic visits -- not always resulting in FP counseling or initiation

India

- 12 of 19 private sector clinicians indicated that 50% to 90+% of clients with delayed menses perform PT at home before coming to the clinic
 - All clinicians indicated that in some cases they repeat the test
- Six (of eight) retailers indicated that 50% or more of PT purchasers are men

Zambia

- Historically, PTs have been stocked out at public clinics, and clients have become accustomed to procuring from private retailers
- This has led to clients not demanding provision of PTs at public clinics
- Now being addressed with MOH's continued effort to scale-up family planning

PT Pricing Data Comparison



SHOPS PLUS research included pricing as one of multiple components in small sample research

Pricing versus Affordability Distinction

- Utilizing the CII market shaping framework leads to use of term ‘Affordability’ which may be misleading
- Data collected to-date through SHOPS PLUS and other recent efforts has been pricing, not affordability
- Affordability is a subjective measure which requires population data and research

SHOPS PLUS: Summary and Conclusions

- Focused on pricing and indicators of pricing structure within private sector / commercial settings
- While PTs had relatively high markups in percentage terms, not high in absolute value
- PT prices are not abnormally expensive in commercial settings
- PTs are comparably priced relative to emergency contraception, an appropriate analogue
- No evidence in this research that clients are dropping out due to PT cost

Two other studies included for comparative purposes

- Innovation Fund Project led by FHI360
- FPWatch Survey: Contraceptive Commodity and Service Assessment (with PTs included)

Two of the three studies were qualitative with small sample sizes, whereas FPWatch was larger sample, national audit

	SHOPS PLUS	Innovation Fund Project	FPWatch
Overall Methodology	Qualitative, site visits (Public & Private clinics, retailers)	Qualitative, site visits	Quantitative survey, site audit (Public, Private, CHW, NGO, Drug Shop / Pharmacy)
Countries & Overall N (sample size across public & private sector outlet types)	India = 44 Kenya = 24 Madagascar = 20 Malawi = 55 Zambia = 42	Kenya = 45 Malawi = 49 Mali = 34	DRC = 915 Ethiopia = 730 Nigeria = 1664
Research Questions Re: clinic (public and private sector) and retail outlet pricing of PTs	1) Does the facility administer PTs for free or at a cost? If at a cost, what is the average cost?	1) Of the PTs currently / usually available at this facility, which test is the least expensive for the client? 2) How much do clients pay for the least expensive PT currently/usually available at this facility? 3) Is this price just for the test itself or for the test plus fees? 4) What fee do clients pay for pregnancy testing, not including the test itself?	For how much do you sell one pregnancy test kit <of this brand> to an individual customer who would come in today to purchase this <brand of pregnancy test kit>?

In comparing data from each study, it is critical to note that the Ns for each country / outlet type ranged from small qualitative samples to census data

Outlet Type	IFP Data (US\$)			SHOPS PLUS (US\$)					FPWatch (US\$)		
	Mali	Malawi	Kenya	Kenya	India	Madagascar	Malawi	Zambia	Ethiopia	DRC	Nigeria
Private provider	1.99 (0.41-3.28) n=15	0.95 (0.35-1.77) n=27	1.94 (0.98-5.87) n=21	0.97-1.94 n=14	0.75-1.49 n=23	0.49-0.99 n=7	0.69-2.08 n=24	incl. consult n=7	0.10 (0.10-0.21) n=254	1.10 (0.55-1.10) n=70	1.00 (0.25-1.00) n=100
Public provider	1.72 (0.82-2.46) n=2	0.35 (0.35-0.35) n=1	1.86 (0.98-4.89) n=7	0.99-1.40 n=3	Free n=13	NA n=2	NA n=13	Free n=13	0.14 (0.00-0.25) n=233	0.55 (0-1.10) n=190	0.50 (0.25-1.00) n=95
Pharmacy / Drug	2.12 (1.15-2.46) n=7	0.66 (0.35-0.88) n=1	0.84 (0.49-1.96) n=7	0.29-4.17 n=7	0.45-0.96 n=3	0.33-3.45 n=11	0.28-1.80 n=8	0.10-4.50 n=22	0.16 (0.10-0.25) n=233	0.22 (0.22-0.33) n=36	0.35 (0.25-1.00) n=437
CHW/CHW									0.21 (0.10-0.21) n=6	0.55 (0.55-0.55) n=17	0.75 (0.75-0.75) n=3
Not for Profit									0.21 (0.16-0.31) n=4	0.55 (0.33-1.10) n=18	0.75 (0.75-2.50) n=3

All pricing data represents a blend of product types (except for SHOPS PLUS data where India = only cassettes, Kenya = only dipsticks)

Observations across the studies

- FPWatch, large sample sizes for private, public clinics, and pharmacies / drug shops
- SHOPS Plus and IFP are both small sample, qualitative in nature; variation in range is not surprising due to geography and question phrasing
- Public clinics charge for PTs in Mali, Malawi, Ethiopia, DRC and Nigeria
 - India and Zambia free, Kenya mixed
- Mali mean prices -- highest across all three studies
- Mali and Kenya data from IFP -- highest for public providers
- Ethiopia -- lower cost range and median across all outlet types
- DRC - 5x higher at private provider than in pharmacy / drug shop

Sources: IFP / FHI360, SHOPS Plus, FPWatch

FPWatch data: comparable PT pricing across urban and rural areas within the three countries, with exception of private providers in Nigeria

		FPWatch (US\$)					
Outlet Type		Ethiopia		DRC		Nigeria	
		Urban	Rural	Urban	Rural	Urban	Rural
Private (provider)	median (IQR)	0.21 (0.21, 0.31)	0.21 (0.16, 0.31)	1.10 (0.55, 1.10)	1.10 (1.10, 1.10)	2.50 (1.00, 2.50)	1.00 (0.25, 1.00)
		n=160	n=94	n=42	n=28	n=78	n=22
Public (provider)		0.16 (0.10, 0.31)	0.12 (0.07, 0.21)	0.55 (0.1, 1.10)	0.55 (0.05, 1.10)	0.50 (0.25, 0.50)	0.50 (0.25, 1.00)
		n=90	n=143	n=105	n=85	n=51	n=44
Pharmacy / Drug Shop		0.10 (0.10, 0.16)	0.14 (0.10, 0.21)	0.22 (0.22, 0.33)	0.33 (0.22, 0.55)	0.35 (0.25, 1.00)	0.35 (0.25, 1.00)
		n=194	n=39	n=490	n=146	n=1229	n=217
CHW/CHEW		0.12 (0.12, 0.12)	0.21 (0.10, 0.21)	NA	0.55 (0.55, 0.55)	NA	0.75 (0.75, 0.75)
	n=1	n=5	n=0	n=1	n=0	n=3	
Not for Profit	0.14 (0.10, 0.31)	0.25 (0.25, 0.25)	0.55 (0.33, 1.10)	0 (0, 0.55)	2.50 (2.50, 7.50)	0.75 (0.75, 0.75)	
	n=3	n=1	n=11	n=7	n=4	n=1	

Observations

- N's vary across the comparator groups, often considerably larger for urban (exception of Ethiopia public providers)
- Ethiopia relatively consistent for urban versus rural (public sector, lower median price)
- DRC also relatively consistent for urban versus rural, but notably, 4-5x more expensive than in Ethiopia
- Nigeria consistent across the public clinics sampled, more notable difference for private providers

Conclusions from Market Shaping Analysis

India: Root causes of shortcomings are provider related

Predominant drop-off risk

- Non-menstruating clients asked to return during menses

Market observations

- Public procurement of PTs in place & ongoing
- PTs widely available in both sectors at various prices

Shortcomings	Root Causes
<ul style="list-style-type: none"> • Providers do not use the checklist to initiate FP • Provider behavior is a clear barrier • Providers use PTs only for clients with delayed menses • High home use results in lost opportunity to reach potential FP users 	<ul style="list-style-type: none"> ➤ Cultural norms, provider training, risk aversion ➤ Possibly provider behavioral economics ➤ Disconnect between PT use & access to FP services

Kenya: Multiple root causes including policy, demand fragmentation, procurement behavior

Predominant drop-off risk

- Public clinic clients drop-off if cannot afford the PT cost

Market observations

- MOH policy supports PT use after checklist/history
- PT procurement conducted at county level
- Private sector has large array of PTs; wide availability
- Franchise clinics often get lower cost or free PTs
- Medical product supply disorganized; poorly regulated
- Retail and clinic level margins are relatively high

Shortcomings

- Possible lack of affordability as PTs are administered at a cost to public sector clients
- Variability in performance in county level procurement
- Clinics purchasing from local retail outlets
- Mixed familiarity with checklist, variation in practice

Root Causes

- Policy does not fund free provision of PTs
- Fragmented demand
- Inefficient ordering
- Clinics purchasing at retail prices
- Mixed awareness; adherence to use of FP checklist
- Lack of incentives to standardize treatment protocols

Madagascar: Root causes are in policy and provider training, norms

Predominant drop-off risks

- FP clients whose pregnancy status cannot be ruled out are given OCs and asked to return after 10 days
- Clients may self-delay FP visit outside menses

Market observations

- Wide availability of PTs in the private sector
- MOH added PTs to EML and supported introduction of community-based distribution of free PTs for FP through MIKOLO project

Shortcomings	Root Causes
<ul style="list-style-type: none"> • Inconsistent use of WHO checklist in public clinics • PTs not available in public sector • MOH does not procure PTs to be used in the context of FP services • Commercial PTs may not be affordable to some clients 	<ul style="list-style-type: none"> ➤ Poor provider training, cultural norms ➤ MOH policy emphasizes checklist; not supportive of PT use for FP in public clinics ➤ Commercial built-in margins drive up PT prices

Malawi: Root causes are around policy, awareness and adherence to protocols

Predominant drop-off risk

- PTs are rarely available at public clinics, so clients sent to buy PT and/or return during menses

Market observations

- Malawian RH policies support use of PTs after checklist
- Public sector not sourcing & providing PTs
 - PTs are theoretically free (if available)
 - Limited evidence of PT donations
- Private sector has wide availability of PTs
 - Dipstick is most common (and most affordable)

Shortcomings	Root Causes
<ul style="list-style-type: none"> • PTs are not being funded or procured by CMST for public clinics for FP services • Public clinics not fully utilizing WHO checklist and practice guidelines • Commercial PTs may not be affordable for some clients 	<ul style="list-style-type: none"> ➤ Procurement policy and/or funding absent ➤ Limited PT supply prioritized for ANC ➤ High cost & complexity of guideline provision and training ➤ Mixed awareness; adherence to use of FP checklist in public clinics

Zambia: Root causes are in capacity and execution

Predominant drop-off risk

- FP clients must buy a PT in the private sector when they are not available at the public clinic, incurring delays and added costs

Market observations

- MOH policy supports PT use for FP
- National PT procurement system
- PTs widely available in private sector

Shortcomings

- PT stockouts at public clinics
- Demand for PTs in public clinics exceeds supply
- Commercial PTs may not be affordable to some clients

Root Causes

- Ineffective or deprioritized ordering
- Insufficient supply chain visibility, weak ordering process, logistics issues
- Insufficient funding
- Commercial margins drive up PT prices

Summary: Availability and Affordability



- **Availability: No issues related to global or local supply of PTs**

- No observed or reported issues with manufacturer capacity or participation
- Inadequate supply of and use of PTs in public clinics appear to stem from policy and procurement practices



- **Affordability: Likely not a barrier for private sector clients**

- Low global procurement prices make use of PTs affordable to NGOs
- Mark-ups applied at both retail and clinic outlets are not unusual

Caveat: Affordability may be low for public sector users and those living in underserved areas not covered in this assessment, but would need to be further researched at the population level

Summary: PT Quality and Design



- **Assured quality: No reported concerns or negative outcomes**

- Caveat: PTs were not evaluated against quality standards



- A possible shortcoming related to quality is the lack of information about minimum quality standards

- **Appropriate design: Not identified as a potential market shortcoming**

- Across the five regions, PT product design was not identified as a reason for non-use

- Several designs available in each country; dipstick and cassette tests were the most common

Summary: Awareness & Programmatic issues



- **Awareness: Low knowledge of appropriate use of PTs in FP context**
 - Knowledge of WHO guidelines was found to be low or mixed in both sectors in all countries
- **Programmatic issues**
 - National policy and healthcare provider behavior are key factors influencing the appropriate and consistent use of PTs according to WHO guidelines
 - Inappropriate or confusing protocols lower demand for PTs in the public sector, prevent accurate procurement of PTs, and result in stockouts
 - Non-inclusion of PTs in FP service protocols is a missed opportunity to support integration in RH/FP and MNCH programs

Market shaping analysis (5As)

	India	Kenya	Madagascar	Malawi	Zambia
 Affordability*	+ public + private	- public + private	+ public + private	+ public + private	+ public + private
 Availability	++ public	- / + public	- public	- public	- /+ public
	PTs are widely available across private sector, including pharmacies and clinics				
 Awareness**	Practice in both sectors is to initiate FP during menses.	Mixed awareness of checklist; variations in practice.	No policy support for use of PTs for FP. Variable practices.	Supportive policy; Variable clinical practice	MOH support for using both checklist and PTs as needed
 Assured Quality	No provider-reported quality issues for PTs (not evaluated)				
 Appropriate Design	Wide variety of PT types and brands generally available. Ease of use is reported for providers and clients.				

(*) Based on pricing observations. Actual affordability could not be assessed.

(**) Includes both awareness of PT use and best practices (e.g. use of checklist).

Evaluation of Possible Interventions to Reduce Risk of FP Client Loss; and Recommended Intervention Set



Originally generated list of possible PT interventions spanned the Market Shaping/Programmatic Continuum

RESEARCH & DEVELOPMENT



MANUFACTURING



PROCUREMENT



DISTRIBUTION



SERVICE DELIVERY/USER ADOPTION

Market shaping interventions

Global health programmatic interventions

19 Insert FP information in PT packaging

11 Change contraceptive product labeling

6 Aggregate orders across countries

3 Joint forecasting of PTs and contraceptives

5 Aggregate demand in the public sector

15 Pool NGO procurement of PTs

2 Incentivize data reporting

14 Retailers to provide low-cost PTs

13 Channel subsidy to reduce markups on PTs

16 PT vouchers for low-income clients

7 Sliding-scale payments for PTs

4 Co-locate PTs at public clinics

18 Vouchers for PT buyers to access FP

1 Include on-site use of PTs in MOH FP protocols

10 Train MOH providers in pregnancy Checklist

9 Advocate for use of Checklist in MOH guidelines

8 Provide quick-access pass to returning clients

17 Lower PT fees in franchised clinics

12 Social marketing of PTS

20 Pharmacy customer referrals to FP clinics

21 Change clinical practice in private clinics

22 Train private healthcare providers

'Sticker voting' exercise during RHSC session(s) highlighted first-pass support for select interventions: public sector*, 1 of 2

Client loss risk	#	Intervention	Type	Drawbacks/Challenges	Prerequisites for Implementation
<p>Client with inconclusive pregnancy status drops out because:</p> <ul style="list-style-type: none"> ▪ PTs are not available on premises ▪ Having to buy a PT causes delays and added costs ▪ Client cannot afford PT cost in public clinic 	1	1 - Include on-site use of PTs in FP protocols and enable regular procurement of PTs		Policy change can be slow Possible funding issues since stock outs exist for other products in FP protocols	Funding available for procurement Supply chain is functional
	2	Subsidize or incentivize data reporting on PT usage and improve re-ordering process for PTs		Likely not sustainable unless part of an overall effort to improve supply chain	MOH support
	3	Jointly forecast PTs and contraceptives to increase priority of filling PT demand		Complicated by multiple FP methods in use	Appropriate formula for forecasting commodity needs
	4	Partner with retail pharmacies to co-locate PTs at public clinics		May not be legally possible	MOH staff must handle \$ unless the government buys the PTs
	5	Aggregate demand in the public sector to lower procurement costs		May not be consistent with decentralization policies in some countries	Supportive public procurement systems
	6	Aggregate demand and orders across countries that all use the dipstick		Does not address high retail margins	Supportive public procurement systems
	7	Use sliding scale payment in clinics that charge for PTs based on client socioeconomic indicators		Loss of revenue for clinics	MOH support
	8	Provide quick-access pass to clients who have bought a PT elsewhere due to public clinic stockout	P	Loss of revenue for clinic that charge returning clients	MOH support

* Interventions highlighted in yellow received the most votes, all were intended for exploratory discussion, not being put forth as recommendations

'Sticker voting' exercise during RHSC session(s) highlighted first-pass support for select interventions: public sector*, 2 of 2

Client loss risk	#	Intervention	Type	Drawbacks/Challenges	Prerequisites for Implementation
Client is turned away because norms prevent dispensing FP services outside menses	9	Advocate for use of Pregnancy Checklist in MOH protocols	P	Policy change can be slow	MOH support and cooperation at all levels
	10	Retrain providers on Pregnancy Checklist and same-day FP initiation to increase quality of FP services.	P	Changing provider behavior may require more than training; Risk aversion not addressed	MOH support and available resources
	11	Remove from product labeling the requirement to wait until menses to initiate contraception		May require multiple manufacturers to change their labels. Slow to implement.	Support from manufacturers at the global and local level

* Interventions highlighted in yellow received the most votes, all were intended for exploratory discussion, not being put forth as recommendations

'Sticker voting' exercise during RHSC session(s) highlighted first-pass support for select interventions: private sector*, 1 of 2

Client loss risk	#	Intervention	Type	Drawbacks/Challenges	Prerequisites for Implementation
Client with inconclusive pregnancy status drops out because she cannot afford PT prices in the private sector.	12	Introduce lower-price PTs through social marketing program		May not be sustainable over the long term without subsidizing related program costs	Donor support or: cross-subsidy program within SMO
	13	Channel subsidy to reduce markups on commercially sold PTs		May discourage distributors from importing low-cost PTs	Donor support
	14	Partner with select retailers to provide low-markup PTs to referred clients, including referrals from public sector		May not have much impact if most clients are willing to pay current prices	Policy framework for facilities to partner with pharmacies
	15	Pool or centralize procurement within and/or across procurers to lower costs		Does not address high markup in commercial retail outlets	Price savings overcome loss of convenience from single supplier/centralized ordering
	16	Voucher provided by clinic to low-income clients covers the cost of PT in retail outlets		May slow down process of obtaining PT if few clinics participate	Management structure Incentive for pharmacies to participate
	17	Negotiate lower PT fees from franchised clinics		Loss of revenue from low-income clients	Must be commercially viable
	18	Voucher provided with PTs purchased by low-income clients covers the cost of FP services		Difficulty of targeting low-income clients with negative results	Voucher management structure Public resources to pay for vouchers

* Interventions highlighted in yellow received the most votes, all were intended for exploratory discussion, not being put forth as recommendations

'Sticker voting' exercise during RHSC session(s) highlighted first-pass support for select interventions: private sector*, 2 of 2

Client loss risk	#	Intervention	Type	Drawbacks/Challenges	Prerequisites for Implementation
Women who use a home PT and get a negative result may not be aware of what to do next.	19	Partnership with manufacturer or distributors to include "Q&A" printed information in PT packaging.		Logistically challenging May only be feasible through social marketing program	Motivated private sector partners Legal approvals
Women who use a home PT and get a negative result may not know how to access FP services.	20	Partnership with pharmacist association to support customer referrals to FP clinics.		Logistically challenging May only be feasible through social marketing program	Supportive pharmacist association
Non-menstruating client is turned away because norms prevent dispensing FP services outside menses	21	Partner with professional associations and private facilities to change clinical practice	P	Slow pace of changing clinical practice in the private sector	Support from medical associations and facilities Changes in medical curriculum
	22	Retrain Providers to improve the quality of FP services.	P	Difficult to implement. May not be possible with independent providers	Supportive private providers Time and money

* Interventions highlighted in yellow received the most votes, all were intended for exploratory discussion, not being put forth as recommendations



Consultation inputs emphasized the programmatic and inter-dependent theme of improving PT access and use

Clinical policy and provider behavior were the focus of multiple interventions

- Demand generation and utilization originates with inclusion of PTs in national FP and MNCH policies
- Provider clinical practice can be considerably improved in both public and private sector settings
- Provider behavior must be mandated through policy, and beyond training

Procurement solutions will consist of multiple components

- Country policy to support funding, standardized procurement and demand aggregation
- Quantification best practices including joint forecasting and utilization tracking

Interventions must be pursued in parallel and customized to country conditions

- Policy and provider behavior change will support procurement change
- Procurement alone will not result in increased access and use of PTs

Four possible public sector interventions were highly supported through the consultative process, 1 of 2

Client Loss Risk	Intervention	Highlighted Support, Key Considerations for the Selected Interventions
<p>Non-menstruating clients turned away because PTs are not available on premises</p>	<p>Mandate use of PTs in conjunction with pregnancy checklist in MOH protocols</p>	<ul style="list-style-type: none"> • Need top-down advocacy as well as service delivery training to facilitate adoption • Goal should be inclusion in country guidance, then get into pre-service and in-service training; evidence from other programs endorses investment in supportive supervision • Key role of USAID along with WHO to incorporate into bilateral FP projects with countries
	<p>Enable regular procurement of PTs for FP services in public clinics</p>	<ul style="list-style-type: none"> • Ordering PTs needs to become routine, similar to gloves, gauze pads, other supplies • National policy drives inclusion on tenders, need top level advocacy; consider prior case studies such as auto-disposable syringes and the advocacy efforts with MOHs • Champions within a program area are a key component to success
	<p>Jointly forecast PTs and contraceptives to avoid stock outs</p>	<ul style="list-style-type: none"> • MSI joint forecasting for PTs and contraceptives was highly successful, resulted in supporting this as a high potential intervention • If countries are currently relying on external vertical contraceptive programs, then need for PTs is likely not recognized, and therefore not on procurement lists • Uganda example provides support and key considerations - recent CHAI / JSI work with Uganda MOH, including PTs in 3-year contraceptives quantification exercise - revealed 1) the issue of little centrally available information, 2) the need to procure PTs for explicit purpose of FP, 3) question of 'how PTs used currently' versus 'how PTs should be used', 4) inclusion on LMIS and other SOP documentation is critical to documenting demand to then inform procurement and stocking

Four possible public sector interventions were highly supported through the consultative process, 2 of 2

Client Loss Risk	Intervention	Highlighted Support, Key Considerations for the Selected Interventions
<p>Non-menstruating clients turned away because PTs are not available on premises</p>	<p>Procure FP commodities 'bundled' with PTs (donors, governments, NGOs)</p>	<ul style="list-style-type: none"> • Pregna IUD Kit: Dip strip PT included with supplies; this program warrants exploration with manufacturer and consideration for related / additional programs • CHAI implant consumables kit has been offered as a separate kit - likely worth understanding the uptake and provider views • Potential to pursue 'bundling' will vary by country, based on strength of procurement systems; avoid 'bundling' at points such as the CMS in order to prevent unintended consequences • Need to consider product expiration management
<p>Non-menstruating client turned away because norms prevent dispensing FP services outside menses</p>	<p>Address clinical practice through policy change and retraining of providers on same-day FP initiation</p>	<ul style="list-style-type: none"> • Consensus view that a sustainable model is key, training should focus on appropriate use; to position checklist as first-line tool and PT as second-line tool • May require customized country research and pilot programs - consider controlled studies to evaluate association of increased PT availability with same-day FP method start • Requires a strong link with country level policies, procurement, national and donor funding • Provider behavior is impacted by existing country policies • Critical to understand provider behavior, including behavioral economics

Five possible private sector interventions were highly supported through the consultative process

Client Loss Risk	Intervention	Highlighted Support, Key Considerations for the Selected Interventions
Non-menstruating client turned away because norms prevent dispensing FP services outside menses	Partner with professional associations and private facilities to change clinical practice	<ul style="list-style-type: none"> Highly consistent with public sector provider behavior change - the need for normative guidance, supportive supervision, and consideration of provider behavioral economics
Women who use a home PT and get a negative result may not know how to access FP services	Link PT purchase to information about FP services (e.g. advertise FP services through pharmacies)	<ul style="list-style-type: none"> Addresses the root cause of client behavior, where pregnancy exclusion does not result in accessing FP counseling and services
Client with inconclusive pregnancy status drops out because she cannot afford PT prices in the private sector	Introduce lower cost PTs through existing social marketing program linked to community or home-based distribution in underserved areas	<ul style="list-style-type: none"> Considered most appropriate for underserved and low-income client segments Link to existing social marketing program rather than a new program, achieves economies of scale and synergies
	Voucher provided by clinic to low-income clients covers the cost of PT in retail outlets. Can be used in conjunction with quick-return pass for public sector clients	<ul style="list-style-type: none"> Recognizes the potential affordability issue for target groups Reduces the barrier of revisiting the clinic
	Negotiate lower PT fees from franchised clinics, which could increase volume of FP product sales	<ul style="list-style-type: none"> Must be commercially viable Requires support of franchising organizations and/or donor-funded social franchises

Two possible cross-cutting interventions were highly supported through the consultative process

Client Loss Risk	Intervention	Highlighted Support, Key Considerations for the Selected Interventions
<p>Non-menstruating clients turned away because PTs are not available on premises</p>	<p>Consider developing new High Impact Practices combining checklist and PT use for dissemination to USAID missions and implementing partners</p>	<ul style="list-style-type: none"> • Foundational to the barriers that are most preventing access to same-day start of contraceptive methods • Highly consistent with recently updated FHI360 guidance / job aids and 2016 updated WHO FP guidelines • Strong synergistic opportunity across multiple implementing partners • Recognizes the cross-sector challenges which are provider-based
<p>Client with inconclusive pregnancy status drops out because she cannot afford PT prices in the private sector</p>	<p>Population-based and consumer research around affordability and willingness to pay, and impact on initiation of FP services</p>	<ul style="list-style-type: none"> • Client behavior was identified as a barrier to accessing of FP services and same-day start of contraceptive initiation • Deeper understanding of client behavior and willingness to pay can directly inform intervention planning and possible inclusion in existing FP programs, both country and donor-driven

Multiple public sector interventions were not supported through the course of the consultations and analysis; should be tabled

Intervention	Summary Points on Evaluation
Subsidize or incentivize data reporting on PT usage and improve re-ordering process for PTs	Procurement best practices in general are needed for PTs, not specific to incentivizing data reporting; improving ordering processes would be subsumed within other procurement efforts
Partner with retail pharmacies to co-locate PTs at public clinics	Likely unfeasible from a legal and operational standpoint; programmatic efforts were deemed more appropriate to address root causes
Aggregate demand in the public sector to lower procurement costs	This intervention requires further analysis of individual country procurement systems
Aggregate demand and orders across countries that all use the dipstick	Product fragmentation was not a root cause behind non-availability and non-use of PTs
Use sliding scale payment in clinics that charge for PTs based on client socioeconomic indicators	Population research would be required to determine whether and where affordability is a barrier to PT access and use
Provide quick-access pass to clients who have bought a PT elsewhere due to public clinic stock out	Consultations did not demonstrate support for this intervention
Remove from OC product labeling the requirement to wait until menses to initiate contraception	Consultative views were that changing product labeling (such as for oral contraceptives) would be a resource intensive and slow process, and would not contribute to near term changes in same-day access

Multiple private sector interventions were not supported through the course of the consultations and analysis; should be tabled

Intervention	Summary Points on Evaluation
Channel subsidy to reduce markups on commercially sold PTs	Could disincentivize distributors from importing PTs
Pool or centralize procurement within and/or across procurers to lower costs	Would not address root cause of PT cost to end users, which is markup in the channel
Negotiate lower PT fees from franchised clinics	May not have sufficient impact to justify the loss of revenue
Voucher provided with PTs purchased by low-income clients covers the cost of FP services	This voucher concept address FP services rather than access to PTs. Better addressed through other private sector interventions, such as more broadly promoting FP services through private sector pharmacies
Partnership with manufacturers or distributors to include “Q&A” printed information in PT packaging	Linking PT purchase to pursuit of FP services would be better addressed through other partnerships, i.e. with pharmacies

Interventions recommended by SHOPS Plus



Selection criteria for proposed interventions

- Justified: Linked to a demonstrated barrier to access to FP
- Feasible: in terms of time, resources, and likely success
- Cost effective: high value, low investment (e.g. through integration in existing programs or systems)
- Sustainable: with the potential to be owned and supported by the government or private sector
- Backed by experts: including FP, service delivery, supply chains and private sector specialists

Public sector: Change policy and clinical practice; fund and improve the procurement of PTs

Client loss risk	Intervention	Drawbacks/Challenges	Prerequisites for Implementation
Non-menstruating clients turned away because PTs are not available on premises	Include use of PTs in conjunction with pregnancy checklist in MOH protocols	<ul style="list-style-type: none"> • Policy change can be slow and may not result in desired provider behaviors 	<ul style="list-style-type: none"> • Support for policy change from MOH and medical institutions
	Enable regular procurement of PTs for FP services in public clinics	<ul style="list-style-type: none"> • Risk of over-reliance on PTs 	<ul style="list-style-type: none"> • Funding for procurement • Use of checklist in facilities
	<p>Introduce joint forecasting of PTs and contraceptives to avoid stock outs</p> <p>Possible bundling of PTs with FP commodities (donors, governments, NGOs)</p>	<ul style="list-style-type: none"> • Logistics may be complex • Risk of overstock and waste 	<ul style="list-style-type: none"> • Ratios for forecasting commodity needs • Functional procurement and supply chain systems
Non-menstruating client turned away due to norms opposing FP method start outside menses	Address clinical practice through policy change, provider training on same-day FP initiation	<ul style="list-style-type: none"> • Slow pace of changing clinical practice • Provider resistance 	<ul style="list-style-type: none"> • Support for policy change from MOH and medical institutions • Resources for provider training • Better understanding of provider behavior (e.g. risk aversion)

Private sector: Country level, context specific interventions

Client loss risk	Intervention	Drawbacks/Challenges	Prerequisites for Implementation
Non-menstruating client turned away due to norms opposing FP method start outside menses	Partner with professional associations and private facilities to change clinical practice	<ul style="list-style-type: none"> Large number of private facilities 	<ul style="list-style-type: none"> Strong support from medical associations and facilities May require changes in the medical curriculum for FP Program mechanism
Women who use home PT and get a negative result may not know how to access FP services.	Link PT purchase to information about FP services (e.g. advertise FP services through pharmacies)	<ul style="list-style-type: none"> Likely to be inefficient through pharmacies only 	<ul style="list-style-type: none"> Funding for communication (e.g. mass media campaign) Targeting mechanism Best addressed through existing MNCH/FP, or youth-friendly programs
Client with inconclusive pregnancy status drops out because she cannot afford PT prices in the private sector.	Introduce lower cost PTs through existing social marketing/community-based distribution program in underserved areas	<ul style="list-style-type: none"> May not be sustainable over the long term without subsidies for related program costs 	<ul style="list-style-type: none"> Existing SM project with links to community-based network
	Voucher provided by clinic to low-income clients covers the cost of PT in retail outlets; can be used in conjunction with quick-return pass for public sector clients.	<ul style="list-style-type: none"> May have limited impact if few clinics participate, or if clients are willing to pay current prices Management burden 	<ul style="list-style-type: none"> Management structure Incentive for pharmacies to participate Funding for voucher program Apply lessons from SHOPS Jordan program
	Negotiate lower PT fees from franchised clinics, which could increase volume of FP product sales	<ul style="list-style-type: none"> Loss of revenue from low-income clients 	<ul style="list-style-type: none"> Must be commercially viable

Cross-cutting interventions could be applied at the country-level, although perhaps global in design

Client loss risk	Intervention	Drawbacks/Challenges	Prerequisites for Implementation
Non-menstruating clients turned away because PTs are not available on premises	Consider developing new High Impact Practices combining Checklist and PT use for dissemination to USAID missions and implementing partners	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Consensus on recommended practice
Client with inconclusive pregnancy status drops out because she cannot afford PT prices in the private sector.	Support population-based and consumer research around affordability and willingness to pay, and impact on initiation of FP services	<ul style="list-style-type: none"> • High cost of population research • May not provide definitive answer 	<ul style="list-style-type: none"> • Time and money to support research • Implementing organization or existing MNCH/FP project • Resources for interventions that can mitigate risk of client loss

Appendix

The pregnancy checklist is included in WHO family planning materials and resources

Three tools: PTs, checklist, send client home

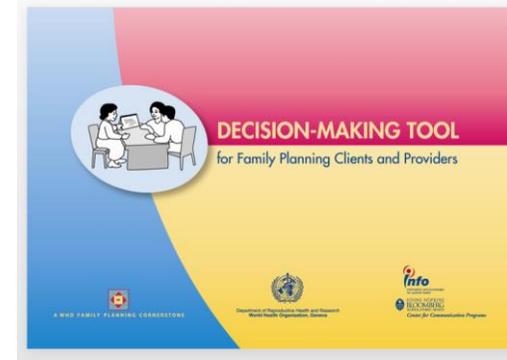
- Patient history, i.e. the checklist, can effectively rule out pregnancy, was developed in late 1990s
- Less desirable is to send the woman home to await menses and then return to clinic

Decision-Making Tool for Family Planning Clients and Providers

- Prepared by WHO and INFO Project at JH Bloomberg School of Public Health; 2005
- Flipchart tool, also adapted for CHWs

Combined simplified MEC + SPR Tool in development for countries' adoption

- Planned for 2017
- Will include pregnancy exclusion questions



1: Questions to be reasonably sure a woman is not pregnant (for family planning clients not menstruating now)

Women who are not currently menstruating may still be able to start hormonal methods (pills, injectables, implants), the IUD or to have sterilization NOW. Ask these questions to be reasonably sure she is not pregnant.

If the client answers **NO** to ALL of the questions, pregnancy cannot be ruled out. She should wait until next menstrual period (and avoid sex or use condoms until then) or else take pregnancy test.

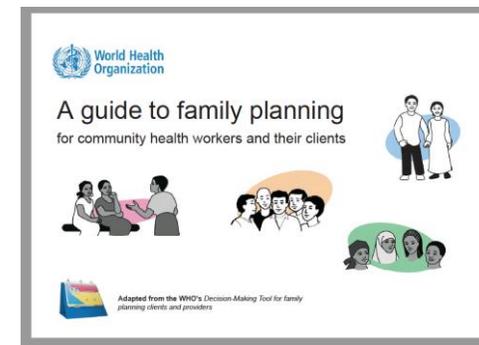
If the client answers **YES** to AT LEAST ONE of the questions and has no signs or symptoms of pregnancy, provide her with the method.

NO	YES
1. Did your last menstrual period start within the past 7 days?	YES
2. Have you given birth in the last 4 weeks?	
3. Are you fully (or nearly fully) breastfeeding AND gave birth less than 6 months ago AND had no menstrual period since then?	
4. Have you had a miscarriage or abortion in the past 7 days?	
5. Have you had NO sexual intercourse since your last menstrual period?	
6. Have you been using a reliable contraceptive method consistently and correctly?	

Signs of Pregnancy If a woman has a late menstrual period or several other signs, she may be pregnant. Try to confirm by pregnancy test or physical examination.

Early signs	Later signs
Late menstrual period	Weight change
Breast tenderness	Darkening of nipples
Nausea	Mood changes
Vomiting	More vaginal discharge than usual
Urinating more often	Enlarged abdomen
	Movements of a baby

AP 1



Questions to be reasonably sure a woman is not pregnant

Women who are not currently having their monthly bleeding may still be able to start hormonal methods (pills, injectables, or the implant) NOW. Ask these questions to be reasonably sure she is not pregnant.

If the client answers **NO** to ALL of the questions, pregnancy cannot be ruled out. She should wait until next menstrual period (and avoid sex or use condoms until then) or else take pregnancy test.

If the client answers **YES** to AT LEAST ONE of the questions and has no signs or symptoms of pregnancy, provide her with the method.

NO	YES
1. Did you have a baby less than 6 months ago, are you fully or nearly fully breastfeeding, and have you had no menstrual period since then?	
2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	
3. Have you had a baby in the last 4 weeks?	
4. Did your last menstrual period start within the past 7 days?	
5. Have you had a miscarriage or abortion in the past 7 days?	
6. Have you been using a reliable contraceptive method consistently and correctly?	

Signs of pregnancy

Early signs	Later signs
Late menstrual period	Weight change
Breast tenderness	Darkening of nipples
Nausea	Mood changes
Vomiting	More vaginal discharge than usual
Urinating more often	Enlarged abdomen
	Movements of a baby

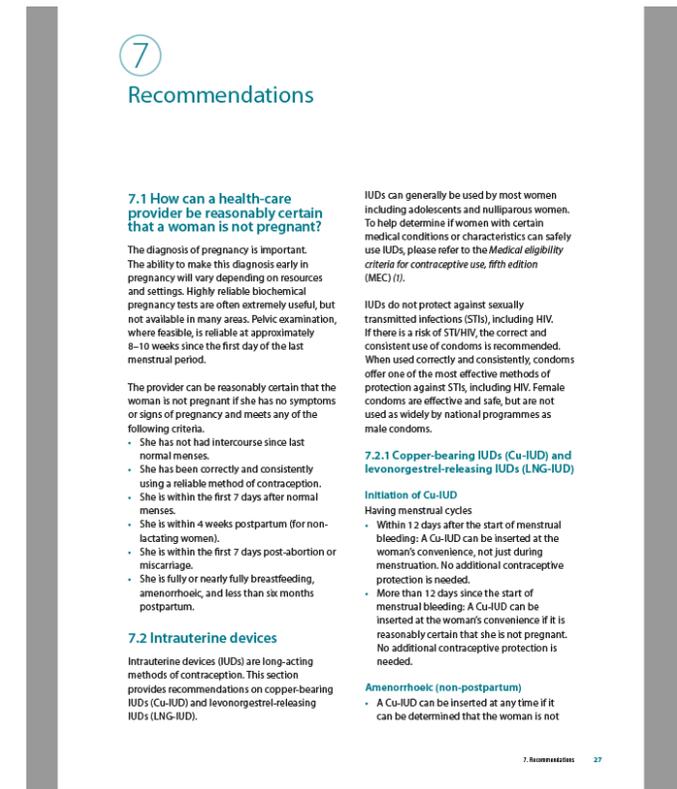
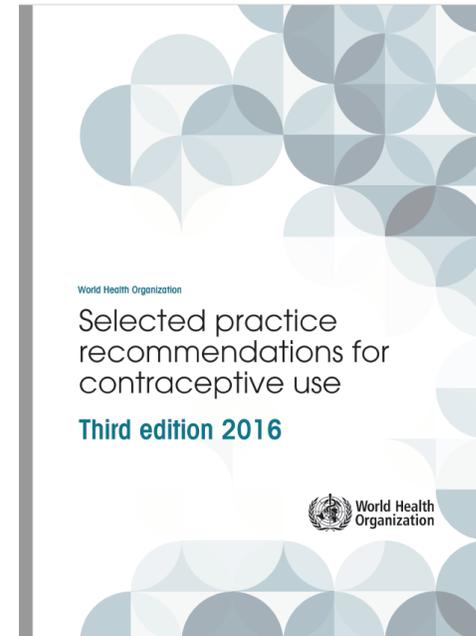
Pregnancy checklist 20

http://www.who.int/reproductivehealth/publications/family_planning/9241593229/en/

Recently updated WHO recommendations continue to recommend use of patient history / checklist to exclude pregnancy to confirm eligibility for contraception start

WHO Selected Practice Recommendations for Contraceptive Use

- Exclusion of pregnancy via ‘checklist’ questions has been included since 2001, initial edition
- Third Edition, just released December 2016
- WHO plans to promote the updated recommendations at various global and SSA meetings during 2017
 - Such as International Confederation of Midwives, 31st Triennial Congress, June 2017



http://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/

Individuals consulted via webinars and 1:1 calls

Topic Area	Organizations	Individuals	
Clinical Guidance and Policy	FHI360	Tracey Brett Elena Lebetkin Kate Rademacher	Marsden Solomon John Stanback
		Service Delivery	Abt Associates
ICEC	Elizabeth Westley		
USAID	Jasmine Baleva		
Procurement	CHAI	Raj Gangandi	Caitlin Glover
	FHI360	Tracey Brett	
	JSI	Alexis Heaton	
	PSM	Anita Deshpande	Ellen Thompsett
	PATH	Fay Venegas	
	USAID	Kevin Peine	
WHO Guidelines	WHO	Mary Lyn Gaffield	



Abt Associates

- Francoise Armand
- April Warren
- Emma Golub
- Caroline Quijada

William Davidson Institute

- Andrea Bare

USAID Center for Accelerating Innovation and Impact

- Amy Lin
- Janine Hum

USAID Office of Population and Reproductive Health

- Lois Schaefer
- Jasmine Baleva