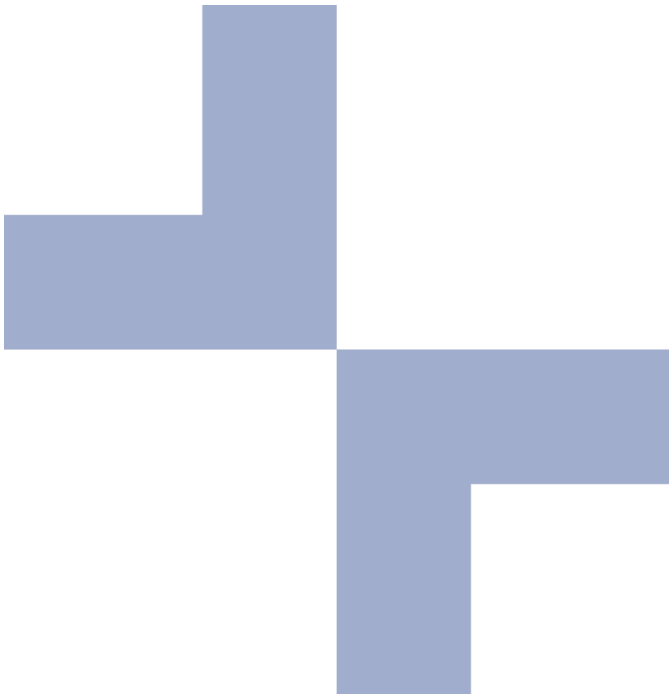
SHOPS PLUS

Côte d'Ivoire Private Health Sector Assessment: Family Planning



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About SHOPS Plus: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government priorities, including ending preventable child and maternal deaths, an AIDS-free generation, and FP2020. The project improves the equity and quality of the total health system, accelerating progress toward universal health coverage.

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Côte d'Ivoire Private Health Sector Assessment: Family Planning

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Acronyms

ACPCI	Association des Cliniques Privées de Côte d'Ivoire
AFD	Agence Française de Développement
AIBEF	Association Ivoirienne pour le Bien-Etre Familial
APPCI	Association des Producteurs Pharmaceutiques de Côte d'Ivoire
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
DC-PNSR/PF	Direction de la Coordination de la Sante de la Reproduction et de la Planification Familiale
DEPS	Direction des Etablissements et des Professions Sanitaires
DPML	Direction de la pharmacie du médicament et des laboratoires
EC	Emergency Contraceptives
FP	Family Planning
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
LARC	Long-acting Reversible Contraceptives
mCPR	Modern Contraceptive Prevalence Rate
MSHP	Ministère de la Sante et de l'Hygiène Publique
OCP	Oral Contraceptive Pills
PAN	Plan d'Action National Budgétisé de Planification Familiale
PNSME	Direction de Coordination du Programme National de Santé de la Mère et de l'Enfant
PSA	Private Sector Assessment
PSHP	Private Sector Health Project
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SHOPS Plus	Sustaining Health Outcomes through the Private Sector Plus
UNFPA	United Nations Family Planning Association
USAID	United States Agency for International Development

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Executive Summary

Côte d'Ivoire has experienced an impressive period of economic grow in the last few years, reaching the World Bank's definition of a middle-income country. Since an armed rebellion divided the nation in 2002, Côte d'Ivoire has made progress towards a political resolution of the conflict, though it still experiences sporadic periods of instability.

Despite economic and political improvements, a significant number of health challenges persist in Côte d'Ivoire and access to care remains difficult for many. The country is experiencing a generalized HIV epidemic with an adult prevalence rate of 3.2, a fertility rate of 4.9 children per woman, and persistently high neonatal and maternal mortality rates. The health system in Côte d'Ivoire is characterized by a well-developed legal and administrative framework, but lacks the resources needed to implement health programs that can meet the health needs of its 22 .7 million citizens. The private health sector can play a larger role in meeting these needs, particularly in the area of family planning (FP), but data and information about this sector are scarce. The Sustaining Health Outcomes through the Private Sector (SHOPS) Plus, in collaboration with USAID/Abidjan, conducted this assessment of the FP market with the goal of sustainably leveraging this sector to help achieve Côte d'Ivoire's modern contraceptive prevalence rate (mCPR) target.

The private healthcare sector in Côte d'Ivoire

In Côte d'Ivoire, healthcare is dominated by the public sector, but the private sector, which was formally recognized in the late 1990s, is an important source of care and a growing contributor to public health initiatives. This sector includes a well-developed pharmaceutical distribution network, for-profit facilities, and nonprofit health organizations. The private sector accounted for 80-90 percent of the supply of pharmaceutical products in 2014.

Private providers in Côte d'Ivoire tend to struggle with low access to financing for equipment and infrastructure, limited opportunities for training, and a lack of representation in discussions of health policy and law. Private facilities also face difficulties attracting highly skilled providers and must hire public sector specialists under the widespread practice of "double vacation," in which health professionals employed in the public sector also work part-time in the private sector.

The *Ministère de la Sante et de l'Hygiène Publique* or *Ministry of Health and Public Hygiene* (MSHP) nevertheless is keenly aware of the need to better understand and engage the private sector, especially private providers and clinic owners. The *Direction des Etablissements et des Professions Sanitaires or Directorate of Establishments and Health Professions* (DEPS) is responsible for the governance of the private sector and recently completed a census of private providers in the south and west of the country (MSHP 2017). However, more research is needed to understand this sector and develop effective public-private collaboration.

Support for family planning

At the Ouagadougou (2011) and London (2012) conferences, the government of Côte d'Ivoire committed to increasing the availability of FP in health facilities from 60 percent in 2010 to 100 percent in 2015. To support these ambitious goals, the MSHP developed the Family Planning Strategic Plan 2013-2016 and key policy documents to operationalize it. Among the most successful initiatives of the MSHP has been the reintroduction of contraceptive distribution

through community health agents, which is credited with a general increase in the demand for and usage of FP services where it has been introduced. The country's performance in the area of FP, however, has fallen short of the targets included in the national action plan for family planning. Côte d'Ivoire did not reach the 25 percent targeted mCPR in 2016 and may have difficulties achieving the 2020 target of 36 percent.

Côte d'Ivoire receives assistance from a number of donors and multilateral agencies. Historically, government funding for FP has focused on staff salaries, program management and supervision, while development partners contributed to the purchase of contraceptive products and specific FP programs. In particular, there is heavy reliance on the United Nations Family Planning Association (UNFPA) commodity donations for FP programs in both the public and private sectors.

Demand for FP methods

In the period between the most recent Demographic Health Surveys (1998/99 and 2011/12), overall contraceptive prevalence has remained relatively steady at 19-20 percent of women of reproductive age. Since 1998, Côte d'Ivoire has experienced a significant shift away from traditional methods toward modern, almost exclusively short acting methods. Although the overall contraceptive prevalence rate (CPR) has remained the same, the mCPR increased from 10 to 14 percent.

The greatest number of modern users obtain their methods from private sources but the majority do so through pharmacies or shops. Users of methods involving a service provider are more likely to obtain them from the public sector.

A significant number of women still have unmet need, which could potentially be met by private providers: approximately 940,000 for spacing and 266,000 for limiting. In addition, many of the women without an estimated unmet need intend to use contraception in the future. Many of these women could be potentially served through the private sector which plays a large role in providing short-acting methods.

FP product supply in the private sector

The private sector in Côte d'Ivoire plays a large role in providing contraceptive products through pharmacies, depots, private clinics, and social-marketing distribution channels. The supply chain infrastructure for these products is fairly robust, with four major wholesalers, over 800 private pharmacies, two active social marketing organizations (AIMAS and DKT), and the presence of commercial manufacturers of hormonal contraceptives. As most other pharmaceutical products, contraceptives are imported and subject to a fairly strict pricing and marketing environment.

With the exception of condoms, inexpensive socially-marketed products dominate the contraceptive market, with shares as high as 90-100 percent. In the oral contraceptive pill (OCP), emergency contraception (EC), and condom markets, there is a wide range of product formulations, brands, and price points available. The EC and condom markets show relatively high levels of use of more expensive commercial brands, indicating that some clients are willing to pay for higher-priced products. There is limited supply of injectable contraceptives and IUDs, and no supply of implants in commercial pharmacies, therefore the products used in facilities are mostly donated or subsidized. While contraceptive security is the weakest for

implants, four newly launched DKT IUD brands are likely to bolster the offer of long-acting methods through the private sector.

FP Service delivery in the private sector

The main service providers in the private sector are the *Association Ivoirienne pour le Bien-Etre Familial or Ivorian Association for Family Welfare* (AIBEF) clinics, and facilities affiliated with AIBEF or donor supported networks. AIBEF has been instrumental in expanding the number of private facilities providing FP services by providing training and technical support to clinics by supporting them with training and technical assistance and helping them keep a stock of contraceptive products on the premises. AIBEF is also piloting a provider franchise project, consistent with the national strategy to increase the number of franchised facilities.

The larger clinics in Abidjan do not consider FP a specialty area but a service provided by gynecologists. Unless they are affiliated with a network, private clinics follow a business model that favors specialists as FP providers that are less likely to use task-shifting or a stand-alone model for FP. Clinicians in private for-profit clinics often prescribe oral contraception and are less likely to provide long-acting reversible contraceptives (LARC) methods because of the additional training required.

Midwives and gynecologists do not work as collaboratively in the private sector as they might in the public sector. Some clinics visited for this assessment appeared to have no problem task sharing with midwives, while in others midwives merely provided counseling, referring the client back to the gynecologist for an implant or IUD insertion.

Challenges in the private sector

Key challenges with respect to FP product supply include a high degree of market subsidization, strict regulations that prevent social marketing organizations from increasing their prices and commercial suppliers form advertising their products; and a lack of data or information about the users of EC products.

Key challenges with respect to FP service delivery include a relatively high dependency on donor support for NGO-provided services, and difficulties in making FP service delivery fit the private sector model. Unaffiliated facilities are hampered in their ability to offer a full method mix or the one-stop-shop found in public and NGO facilities. These facilities may also have difficulty hiring trained specialists and securing a source of implants for their clients. The lack of insurance coverage for FP services is especially problematic for methods than fetch high prices, such as the IUD, resulting in the unnecessary referral of patients to a public or NGO facility.

Recommendations

Foster improved contraceptive security

Contraceptive supply in Côte d'Ivoire is currently not threatened but the dominance of donated and subsidized brands in the private sector is concerning. Should UNFPA donations be considerably reduced in the future, the burden of supporting subsidized programs would likely fall on the Government. SHOPS Plus recommends advocating with the *Direction de la pharmacie du médicament et des laboratoires* or *Department of Pharmacy and Medicine* (DPML) to allow social marketing brands to increase prices or segment their portfolio, which may also stimulate commercial competition. Private clinics need better access to implants but

should purchase them at a price above the replacement cost for this commodity, to avoid further increasing the burden of the public sector.

Expand the availability of Sayana Press in the private sector

The roll-out of *Sayana Press*, a sub-cutaneous injectable contraceptive, presents a unique opportunity to increase mCPR by leveraging the private sector. The practice of providing clients with a supply of Sayana Press for future use at AIBEF clinics is helping increase the acceptability of self-injection. SHOPS Plus recommends expanding the distribution of *Sayana Press* commercially through private providers in the short term, and through commercial pharmacies with a doctor's prescription in the long term.

Secure and sustain access to implants

Implants are becoming the preferred contraceptive method in private clinics offering that method. At the moment, however, the only way to make this commodity available to private clients is to allow clinics to buy it from public and NGO channels. Allowing private providers to access implants is necessary for this method to be more accessible to private sector clients, but it should be done at replacement cost or higher to avoid further increasing the burden of the public sector.

Advocate for a more balanced approach to the contraceptive market

Greater flexibility in product pricing and the loosening of regulations prohibiting direct to consumer advertising of contraceptive products can help create a more sustainable and competitive market. SHOPS Plus recommends advocating with the DPML to allow social marketing brands to be sold at a higher prices, and allowing commercial manufacturers to advertise for their own brands.

Enable more for-profit facilities to provide FP services

In the long term, it is critical to insure that for-profit facilities have an incentive to provide FP services. Failure to do this implies that people who are privately insured or have the ability to pay out of pocket will continue to use publicly funded services and products. A flexible approach is needed to address the specific needs of providers because the private sector is not homogenous. The one-stop-shop model used in public and NGO facilities is not easily replicable in the for-profit sector, but some clinics simply need a source of implants and better access to training and technical support.

Support public/private collaboration

Some private facilities play a critical role in meeting the needs of underserved and low-income populations. Their ability to generate a profit, however, is weak because most of their clients are not insured and many cannot afford to pay anything. These facilities have a service delivery model based on high volume, low fees, task sharing, and a reduced reliance on specialists that makes them natural partners of the public sector. Creating better linkages and contracting mechanisms between Ministry of Health (MOH) facilities (reference hospitals or health centers) and providers serving vulnerable populations should be a key priority.

Support insurance coverage for FP

Because for-profit facilities are more likely to serve insured clients, it makes more sense to advocate for expanded coverage for FP than to subsidize products and services, or refer private clients to the public sector. A sust v
ainable approach to include in the *Direction de Coordination du Programme National de Santé de la Mère et de l'Enfant or Coordinating Department for Maternal and Child Health* (PNSME) strategy to leverage financing from employers is to encourage them to purchase insurance coverage for FP services, particularly post-partum IUD insertions. At the other end of the spectrum, facilities located in vulnerable areas where clients need commodity and financial support should eventually be contracted under the National Health Insurance indigent fund.

Conduct market research

SHOPS Plus recommends conducting market research to better understand the demographics and reproductive intentions of users of EC, who are not reflected in the DHS. A second market area that warrants exploration is the capacity and willingness to pay among users of short-acting methods so that public resources are effectively targeted to low income users.

Another opportunity for research lies in the phasing out of the FP component of the Private Sector Health Project (PSHP) provider network. A short survey of these providers after the program ends can shed light on their motivations, and help develop tailored approaches to working with the for-profit sector.

Introduction

Antecedents

Despite its promising economic growth rate, Côte d'Ivoire struggles to improve its performance in health and other areas of development. In particular, the modern contraceptive prevalence rate (mCPR) among women aged 15-49 has remained one of the lowest in sub-Saharan Africa, at 16.2 percent, and the percentage of women with an unmet need for contraception has remained one of the highest, at 27 percent (Track20 2015, World Bank 2012).

To respond to the population's growing need for family planning (FP), the government and international donors must improve the country's ability to meet the demand for information, commodities, and services. Achieving this goal requires leveraging the capabilities and resources of the public and private sectors, but doing so implies a good understanding of the market for FP products and services in Côte d'Ivoire. This report analyzes the demand for FP methods and the role of the private sector in meeting this demand, and identifies opportunities to expand financing, access, and method choice through this sector.

Private sector assessment

To inform future FP programming and better understand the dynamics of the FP market in Côte d'Ivoire, USAID/Côte d'Ivoire requested the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project to carry out a FP-focused private sector assessment (PSA). The main purpose of the assessment is to identify opportunities and provide recommendations for USAID/Côte d'Ivoire to support increased access to and use of modern FP methods through the private sector. To this end, SHOPS Plus proposed that the PSA focus on the following objectives:

- **Policy and health sector overview –** Provide an overview of the private healthcare sector including relevant stakeholders, focusing on their size, scope, and role in the provision of FP. Review existing and draft legislation, policies, financing, and human resources issues to identify opportunities and potential barriers to greater public-private engagement in health.
- **Demand for FP in the private sector –** Assess current and potential future demand for FP in the private health sector, including identifying user demographic characteristics, motivations, and any barriers in accessing private sector products and services.
- **Supply of FP services and products in the private sector –** Analyze contextual issues that affect the delivery of FP methods through the private sector, such as government policies, regulations, access to finance, human resources, and training. Identify opportunities and constraints, focusing on regulations, access to finance, health financing, human resources for health, and access to commodities. This analysis addressed both for and nonprofit providers and organizations.

Methodology

SHOPS Plus and its predecessor project, Sustaining Health Outcomes through the Private Sector (SHOPS), have conducted more than 25 PSAs, including several in sub-Saharan Africa. Many of these assessments have led to field-based programs designed to engage private sector actors in helping countries address priority health needs. The PSA in Côte d'Ivoire followed SHOPS Plus methodology and consisted of five phases:

Figure 1. Steps in a private sector assessment

1. **PLAN:** The PSA process began with a comprehensive review of the peer-reviewed and grey literature. This step included an analysis of existing Demographic and Health Surveys (DHS) datasets and Track20 models to identify potential market segments that currently access—or potentially could access—FP services through the private sector. This provided the assessment team with a clear overview of the landscape and context, as well as key challenges and gaps in information. The results of this review informed the development of a list of key stakeholders to interview during the second phase.
2. **LEARN**: SHOPS Plus convened a multidisciplinary team to conduct the private health sector assessment, focusing on the policy and enabling environment, the demand for FP methods, and the supply of FP products and services in the private sector. The team consisted of two private sector and FP experts and was supported by the Abt Private Sector Health Project in Abidjan. Between May 22nd and June 2nd, 2017, the SHOPS Plus team travelled to Abidjan and Yamoussoukro to conduct interviews with key stakeholders. The SHOPS Plus team met with over 30 stakeholders in the public and private health sectors.
3. **ANALYZE**: The analysis began in country, as part of nightly debriefings where the PSA team shared findings, determined whether additional key informants should be added, and began to form actionable recommendations. This process continued past the fieldwork, as the team integrated findings and developed recommendations.
4. **SHARE**: This step consisted of debriefing with USAID/Côte d'Ivoire during the trip to Abidjan as well as disseminating the final report both locally and globally.
5. **ACT:** The final step is to support action and programming based on findings and recommendations from the PSA.

Health context

Key health indicators

Located in West Africa, Côte d'Ivoire is home to approximately 22.7 million people (World Bank 2017). Following a period of civil war in the 2000s, the political and security situations have stabilized and the country has experienced an impressive period of economic growth of over eight percent per year in both 2015 and 2016 (projected) (World Bank 2017). As a result of this increase, per capita GDP increased to approximately $1,410 in 2015 and the poverty rate fell to 46 percent of the population; furthermore, Côte d'Ivoire has achieved lower middle-income status according to the World Bank's definition (Ibid).

Despite these economic and political improvements, a significant number of health challenges persist in Côte d'Ivoire. The country is experiencing a generalized HIV epidemic with an adult prevalence rate of 3.2 percent (UNAIDS 2016). Fertility rates (4.9 children per women) and neonatal (37.9 deaths per 1,000 live births) and maternal (645 deaths per 100,000 live births) mortality rates remain persistently high (WHO 2016). FP use, while growing slightly in recent years, remains low. Only 977,000 women—or 17 percent all women and 15.3 percent of married women—used a modern contraceptive method as of 2016 (Track20 2017). Only an estimated 34.4 percent of demand for modern methods is successfully satisfied (Ibid). As a result of these gaps in FP use, nearly one-third of all adolescent girls have given birth or are currently pregnant (Direction Générale de l´Office National de la Population 2016).

Health system characteristics

Côte d'Ivoire's health system is largely governed by policies and regulations inherited from the French colonial administration. Unlike France, however, Côte d'Ivoire has traditionally considered the provision of health care as the sole purview of the public sector and it wasn't until 1996 that decrees No. 96-877 and No. 96-878 established a framework for licensing and registering private health care providers.

The health system in Côte d'Ivoire has an administrative and a medical component. Each component has three levels. The medical component of the health system is delivered through both the public and private sectors, but the most recent publicly available data on the size and distribution of medical facilities across sectors and across the country dates back to 2010-2011.

Despite decreasing poverty rates, access to care remains difficult for many. In Côte d'Ivoire, household payments as a percentage of total health spending have long been among the highest in the West African Economic and Monetary Union region (HFG 2014). A small percentage of the population is employed in the private sector and has access to private insurance. The government of Côte d'Ivoire has begun the process of designing a strategy to achieve UHC and aims to gradually expand protection against the financial risks associated with disease to the entire population. UHC initiatives will be steered by a central structure known as the National Health Insurance Fund, which will delegate responsibility for parts of its mission to various existing public and private insurance institutions. The proposed National Health Insurance Fund is expected to include a compulsory contributory program for workers and retirees and a noncontributory medical assistance program for indigents, pregnant women, and children under five years of age. Unfortunately, Côte d'Ivoire's efforts to develop UHC have been hampered and delayed by its political problems. The package of services covered has not yet been defined, but it will likely focus on primary health care.

Public sector

In Côte d'Ivoire, the provision of care is dominated by the public sector. There are three levels of service delivery facilities in the public sector: public primary health care institutions, general, regional, and specialized hospitals at the secondary level, and at the tertiary level, university teaching hospitals and specialized health institutes (MSHP 2014).

Table 1. Number and types of public facilities in Côte d'Ivoire, 2010

Public Health Facilities		2010
Level III	University hospital centers	4
	National specialized institutes	5
	National Center for Blood Transfusions (CNTS)	1
	National Public Health Laboratory (LNSP)	1
	New Public Health Pharmacy (NPSP)	1
	Emergency Medical Aid Service (SAMU)	1
Level II	General hospitals	68
	Regional hospital centers	17
	Specialized hospital centers	2
Level I	Primary health care facilities	1,870
Total		2,067

Source: Répertoire des Structures Publiques et Privées de Côte d'Ivoire , DIPE (2011)

The majority of health facilities in the public sector are categorized as Level 1, followed by Levels 2 and 3.

In addition, some of the ministries participate in service delivery, including the Ministries of Defense, Economy and Finances, Public Service and Administrative Reform, National Education (MSHP 2014).

Private sector

The private health sector is an important growing source of care in Côte d'Ivoire. It includes both commercial for-profit and nonprofit (both faith-based and association-based) providers as well as workplace-based clinics. The sector provides insurance to a very small percentage of the population primarily composed of formal sector workers. However, the private sector accounted for 80-90 percent of the supply of pharmaceutical products in 2014 (MSHP 2014).

Services in the private sector are organized as follows:

- **Medical facilities**, such as polyclinics, clinics, imaging centers, and provider practice
- **Pharmaceutical facilities**, including retail pharmacies, "dépôts" authorized to sell a restricted range of pharmaceutical products, wholesalers, and manufacturers
- **Private diagnostic laboratories**
- **Paramedical facilities** including nursing centers, village health huts, and other providers of health and dental needs

- **Socio-sanitary facilities** such as centers for consultation and ambulatory care
- **Facilities for alternative medicine**

As in the public sector, there are three levels of service delivery facilities in the private sector. Level 1 facilities staffed by lower level health workers and focus on primary care and consultation. They must refer clients to higher-level facilities for more complex conditions. Level II facilities include specialty clinics and larger medical centers that have specialists on staff. Level III facilities include polyclinics that provide consultation and hospitalization for general medicine, general surgery, pediatrics, obstetrics and gynecology, and other specialties.

The majority of health facilities in the private sector were categorized as Level 1, followed by Levels 2 and 3 in the MSHP's 2010 survey:

Table 2. Number and types of private facilities in Côte d'Ivoire, 2010

Private Health Facilities		2010
Level III	Polyclinics	13
Level II	Clinics	136
Level I	Nursing centers	964
	General medicine and OB/GYN offices	114
	Dental offices	101
	Laboratories	20
	Radiology centers	4
	Chinese clinics	67
	Ambulatory care centers	4
	Hemodialysis centers	1
	Osteopathy centers	2
	Miscellaneous care units (counseling center, homeopathic office, etc.)	147
	Workplace health centers	463
Total		2,036

Source: Répertoire des Structures Publiques et Privées de Côte d'Ivoire , DIPE (2011)

Private facilities tend to be concentrated in urban areas, especially in and around Abidjan, although both for-profit and nonprofit facilities are found throughout the country. Many of these operate outside of the formal health system. A 2015 SHOPS analysis of private facilities estimated that almost three-fourths of private facilities were not authorized by the *Ministère de la Sante et de l'Hygiène Publique* or *Ministry of Health and Public Hygiene* MSHP (SHOPS 2015).

Representative organizations

There are multiple representative organizations in Côte d'Ivoire's health sector that fall into three large categories: professional *Ordres* (councils), professional associations, and industry or business associations.

Table 3. Types of representative organizations

Key Organizations	Role
Ordres Ordre des Médecins Ordre des Sages-Femmes et des Maieuticiens Ordre des Pharmaciens	Regulate and monitor practices in the profession, ensuring that members follow the rules laid down by their respective professional code (*Code de déontologie*).
Professional Associations Société de Gynécologie et d'Obstétrique Association des Sages-Femmes Ivoiriennes Association des Infirmiers de Côte d'Ivoire	Support improvements of the quality of service delivery and represent the interests of members of the profession.
Industry and Business Associations Association des Cliniques Privées de Côte d'Ivoire Union Nationale des Pharmaciens Privés Fédération des Mutuelles Maladies	Represent the interests of a specific industry or business group in the private healthcare sector.

Challenges faced by private providers

Private providers in the West Africa region tend to struggle with low access to financing for equipment and infrastructure, limited opportunities for training, a lack of representation in discussions of health policy and law. They also have been experiencing difficulties dealing with insurance providers and protecting their ability to charge prices that enable them to make a profit. The *Association des Cliniques Privées de Côte d'Ivoire* or *Association of Private Clinics of Côte d'Ivoire* (ACPCI) understandably has been focusing on strengthening their ability to defend their interests with respect to these issues. Because these facilities are primarily concerned with profitability, they typically favor providing services that have high profitability.

Private facilities also face difficulties attracting highly skilled providers. The so-called "double pratique" (dual practice), is widespread in Côte d'Ivoire. This practice of allowing public sector providers to also practice in the private sector is the combined result of laissez-faire and the need for part-time providers in private facilities. A previous assessment estimated that up to 70 percent of physicians and 50 percent of other cadres engage in dual practice (SHOPS 2012).

Private sector contribution to public health goals

Several reports and studies have identified weaknesses in the private health sector that impede its ability to contribute to public health outcomes. A 2014 assessment of the legal regulatory framework for the private health sector in Côte d'Ivoire (SHOPS, 2014) determined that regulatory texts would need to be adapted to enable the private sector to contribute more actively to health outcomes. It also found that regulatory bodies lack the resources required to fulfill their role and enforce regulations.

The MSHP nevertheless is keenly aware of the need to better understand and engage the private sector, especially private providers and clinic owners. The creation of the *Direction des Etablissements et des Professions Sanitaires or Directorate of Establishments and Health Professions* (DEPS), responsible for the governance of the private sector, was created in part to increase the recognition and contribution of the private sector in public health initiatives. The DEPS recently completed a census of private providers in the south and west of the country (MSHP 2017).

Family Planning in Côte d'Ivoire

Government support for FP

At the Ouagadougou (2011) and London (2012) conferences, the government of Côte d'Ivoire committed to increasing the availability of FP in health facilities from 60 percent in 2010 to 100 percent in 2015. Côte d'Ivoire has also sought to strengthen community-based services, provide a wider range of modern methods, and improve services to key target groups (i.e. women living with HIV and youth).

To support these ambitious goals, the MSHP developed the *Plan Stratégique de la Planification Familiale* or *Family Planning Strategic Plan* 2013-2016 and developed key policy documents to operationalize it (see Table 4). The country's key objective is to increase the modern contraceptive prevalence rate to 36 percent by 2016. The entity responsible for the implementation of the strategic plan is the *Direction de la Coordination de la Sante de la Reproduction et de la Planification Familiale* or *Directorate of Reproductive Health Coordination and Family Planning (DC-PNSR/PF).*

Public health facilities are an important source of family planning services in Côte d'Ivoire accounting for 61 percent of the supply of modern family planning methods nationally (MSHP, 2014). Family planning methods are provided at local, regional, and national facilities. The MSHP has begun reintroducing community-level distribution of contraceptives as well through community health agents. The implementation of this approach is credited with a general increase in the demand for and usage of FP services in the two districts where it has been introduced (Health Policy Project 2015).

In addition, the MOH has acknowledged the importance of working with the private sector to improve FP performance, as indicated in Table 4 below:

Table 4: Key policy documents relating to family planning

Policy Document	Purpose
Plan d'Action National Budgétisé de Planification Familiale 2015-2020 (PAN).	National budgeted action Plan aligned with the strategies and commitments that resulted from the Ouagadougou Conference. The PAN stipulates targeted mCPR of 36 percent by 2020, key strategies to achieve it, and a monitoring and evaluation plan.
Projet de Loi sur la Sante Sexuelle et Reproductive SSR	Draft Sexual and Reproductive Health Law law that is still pending. The MSHP also proposed a roadmap and technical work group to enable the implementation of the law.
Arrêté N°309 MSHP/CAB – October 2 2007	Outlines the roles and responsibilities of the DC-PNSR/PF, responsible for coordinating and managing national FP/RH programs.
Note de service du 28 avril 2017 relative à la contraception en post-partum immédiat	Internal memorandum by the *Direction Générale de la Santé* of the MSHP inviting all qualified providers to offer FP counseling and a full method choice in the post-partum period.

Despite support from the MSHP, the country's performance in the area of FP has fallen short of the targets included in the above policy documents as shown in Table 5. The country did not

reach the 25 percent targeted mCPR in 2016 and may have difficulties achieving the 2020 target of 36 percent.

Table 5: Côte d'Ivoire 's FP targets and Actual Performance

Year	Projected number of WRAs	Targeted mCPR (%)	Actual mCPR (%)	Targeted number of additional users per year	Actual number of additional users per year
2013	5,943,400	16.7	14.79	164,186	48,000
2016	6,443,408	25.0	17.01	177,999	155,000
2020	7,168,415	36		265,538	

Source: MSHP, 2014; Track20 Project, 2017

Côte d'Ivoire received disappointing scores throughout the 2014 Track20 Survey (Avenir Health 2014). All four components of family planning effort (FPE) which include policy, services, monitoring and evaluation, and accessibility, registered lower scores in 2014, and the overall country score was 45 percent compared to 54 percent in 2009. The highest access scores went to condoms (79 percent), pills (62 percent), and injectable contraceptives (57 percent) and the lowest to male (5 percent) and female (10 percent) sterilization. Côte d'Ivoire only received a 49.8 score out of a possible 100 on the 2015 DELIVER contraceptive security index (USAID/DELIVER 2015). Furthermore, the monitoring and evaluation of FP programming remains weak at the national, regional, and local level. The piloting and technical committees mentioned in the Plan National de Développement or National Development Plan 2012-2015 have yet to be created (MSHP 2014).

Public/private collaboration

One of the strategies included in the *Plan d'Action National Budgétisé de Planification Familiale (PAN) 2015-2020* specifically refers to reinforcing FP services by engaging the private sector in FP service delivery, notably through social franchising. More recently, the memorandum designed to institutionalize post-partum contraception was intended to include private providers.

The Direction de Coordination du Programme National de Santé de la Mère et de l'Enfant or *Coordinating Department for Maternal and Child Health* (PNSME), which coordinates maternal and child health programming at the MSHP has developed an advocacy document outlining a strategy to leverage private financing for the PAN, primarily through companies operating in Côte d'Ivoire. The document notes the lack of integration of FP services in workplace clinics, and aims to encourage employers to fund both the promotion and delivery of FP services, including commodities. The PNSME is planning a program of visits to large companies to obtain their commitment to supporting the financing of the PAN. The visits will be followed by a roundtable focusing on resource mobilization.

The healthcare industry, however, is rarely consulted on health policy initiatives and there is limited dialogue between this sector and the government. For example, the pending health law includes the creation of technical working groups that includes professional associations and national NGOs, but no representatives of the healthcare industry. Moreover, a pervasive lack of data makes it difficult for the MSHP to effectively engage private providers in FP initiatives because a majority of private facilities do not report the services they provide, according to the PAN monitoring and evaluation plan (MSHP 2014).

Poor understanding of the private sector and weak coordination of its activities with the public sector results in missed opportunities to meet the growing need for FP services. According to a 2015 study, the *DC-PNSR/PF* lacks the resources needed to manage the coordination of RH/FP initiatives across the public and private sectors (Health Policy Project 2015).

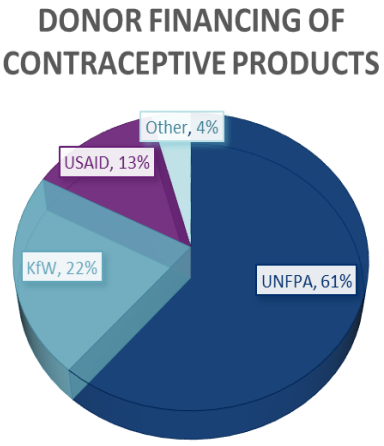
Donor assistance to the FP program

USAID, the *United Nations Family Planning Association (UNFPA)* and the *Agence Française de Développement or French Development Agency (AFD)* are the main donors operating in Côte d'Ivoire, with varying degrees of focus on FP. While USAID/Côte d'Ivoire's health portfolio is quite large (estimated at $138 million for FY2017), it is almost exclusively PEPFAR-funded. Some bilateral programs, namely the Private Health Sector Program, include activities to promote FP-HIV integration. The most significant source of USAID funding for FP comes from the USAID/West Africa mission, which launched the regional *Agir pour la Planification Familiale* project, operated by EngenderHealth in five west african countries in 2014. In Côte d'Ivoire, the project works to increase both supply and demand for FP by training providers and educating target populations and underserved communities on the benefits of FP. USAID also supported the development of the aforementioned *PAN 2015-2020*.

UNFPA's current investments in Côte d'Ivoire are guided by the 6th Cooperation Program (2009-2013), which has been extended on an annual basis beyond the original implementation period. This program has three main objectives: increasing the use of integrated reproductive health services (family planning, maternal health, and HIV), strengthening capacity of the national government to operationalize and implement its policies and strategies, and reducing gender inequality. The program also has a strong focus on increasing the use of FP methods by adolescents and youths.

AFD implements a broad range of development activities designed at strengthening the health, agricultural, and business sectors in Côte d'Ivoire. For health specifically, AFD funds programs that improve public sector delivery of priority health services (including maternal and child health services), strengthen HIV services for stigmatized populations, and promote mutual health insurance schemes to support universal health coverage reforms.

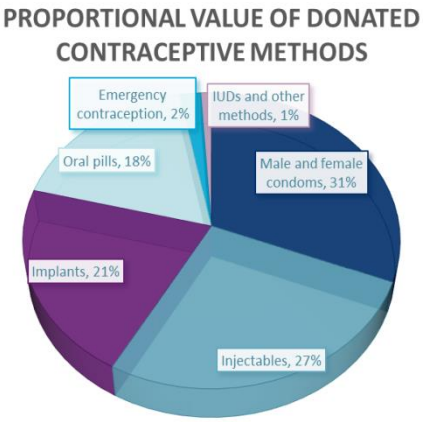
Public financing of contraceptive commodities



Historically, government funding for FP has focused on staff salaries, program management and supervision, while development partners contributed to the purchase of contraceptive products and specific FP programs (Health Policy Project 2015). Of the $11.4M financing for contraceptive products by foreign donors between 2012-2016 in Côte d'Ivoire, 61 percent came from UNFPA, 22 percent from Germany's development bank, KfW, 13 percent from USAID, and 4 percent from other donors including the International Planned Parenthood Federation (UNFPA 2016). In addition to the donation of contraceptive products, UNFPA supports FP in Côte d'Ivoire through their integrated sexual and reproductive health services program, through which they support national capacity to strengthen enabling environments, increased demand for modern contraceptives, and improvements in the quality family planning services. UNFPA's FP budget for Côte d'Ivoire in 2016 ($1.7M) was about half

the size of their maternal health budget ($3.3M), which also falls under their integrated sexual and reproductive health services program (UNFPA 2017).

The proportional value of donated contraceptive methods over five years was 32 percent ($3.6M) for male and female condoms, 27 percent ($3.1M) for injectables, 21 percent ($2.4M) for implants, 18 percent ($2.0M) for oral pills, 2 percent ($0.2M) for EC, and less than 1 percent for IUDs and other methods. Most of these products are channeled through the public sector but some are also distributed through NGOs such as the *Association Ivoirienne pour le Bien-Etre Familial or Ivorian Association for Family Welfare* (AIBEF).



A review of contraceptive shipments to Côte d'Ivoire over the past five years (2012-2016) reveals little discernable pattern in the annual dollar value of different methods imported which rise and fall dramatically, sometimes by a factor of ten, from year to year (see Table 6). Similarly, the total value of imported contraceptives over time does not indicate a sustained trend in donor financing of contraceptive commodities. The one apparent trend is that the proportional value of implants, compared to the value of all imported contraceptives in a given year, increases each year, indicating increasing donor prioritization of this product, compared with other products.

Table 6. Dollar and proportional value of contraceptive imports, by year

	2012 Value (%)	2014 Value (%)	2016 Value (%)
Condoms (m)	$1,213,554 (34%)	$744,268 (17%)	$310,676 (15%)
Condoms (f)	$230,604 (6%)	$327,438 (8%)	$179,634 (9%)
Implants	$304,507 (8%)	$784,905 (18%)	$1,005,258 (48%)
IUDs	$4,661 (<1%)	$2,029 (<1%)	$8,947 (<1%)
Injectables	$1,044,772 (29%)	$1,249,611 (29%)	$570,386 (27%)
Oral pills	$576,892 (16%)	$1,197,218 (28%)	$0 (0%)
EC	$213,600 (6%)	$8,894 (<1%)	$0 (0%)
Other	$589 (<1%)	$5,046 (<1%)	$0 (0%)
Total value of donations:	**$3,589,179**	**$4,319,409**	**$2,074,901**

Source: UNFPA 2017

Table 6 demonstrates that donor financing and donations of specific methods can vary significantly from year to year. Not included in Table 6 but worth noting is that total product donation values of contraceptives were substantially lower in 2013 and 2015 ($1.0M and 0.4M, respectively). In both years, donation values of injectables and oral contraceptives were much lower than in 2012 and 2014. Further, in 2015 no male or female condoms were donated.

In Côte d'Ivoire, there is heavy reliance on UNFPA for public sector products. At the same time, there has been some high-level discussion of developing a sustainable ownership plan so that the MSHP can become less reliant on UNFPA for products. To this end, the MSHP budgeted XOF 400M ($700,000) to finance contraceptive products in 2016. One important factor to consider in this transition strategy is the relative price of contraceptive methods and the potential resulting shift in method mix as the MOH seeks to purchase products with limited

resources. In particular, at $8.50 the contraceptive implant is the most expensive method by far when looking at the unit cost (see Table 7). The long-acting nature of the IUD and the implant means that the cost per couple years of protection (CYP) for these two methods is the lowest of all the methods, but here too, the implant is much more expensive than the IUD. From a purely financial perspective, unless donors continue to fund contraceptive implants, there may be a shift away from this relatively expensive product.

Table 7. UNFPA Negotiated Costs for Contraceptive Products

Product	Unit Cost (Min)	Unit Cost (Max)	Unit Cost (Avg)	Average Cost per CYP
IUD (Copper T)	$0.25	$0.35	$0.30	$0.06
Implant	$8.50	$8.50	$8.50	$2.94
Condom (male)	$0.03	$0.05	$0.04	$3.03
Combined Oral Pill	$0.23	$1.20	$0.26	$3.94
Progestogen-only Pill	$0.30	$0.73	$0.33	$4.92
Injectable	$0.72	$1.15	$0.82	$5.55
Emergency Contraception (EC)	$0.10	$0.66	$0.35	$7.03
Condom (female)	$0.33	$0.55	$0.49	$59.34

Source: UNFPA 2016

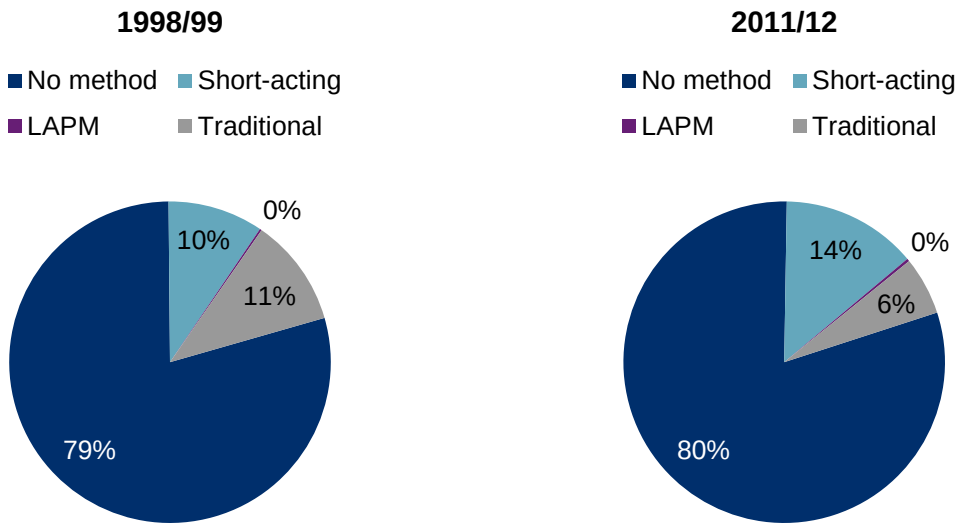
Demand for family planning methods

The FP market has experienced little growth over the past decade and a half. In the period between the most recent Demographic Health Surveys (1998/99 and 2011/12), overall contraceptive prevalence has remained relatively steady at 19-20 percent of women of reproductive age (see Figure 2).

Usage patterns

Since 1998, there has been significant shift away from traditional methods (which fell to 6 percent in 2011/12) toward modern, almost exclusively short acting methods (e.g. pills, condoms, etc.). Although the overall contraceptive prevalence rate (CPR) has remained the same, the mCPR increased from 10 to 14 percent.

Figure 2. Changes in FP use

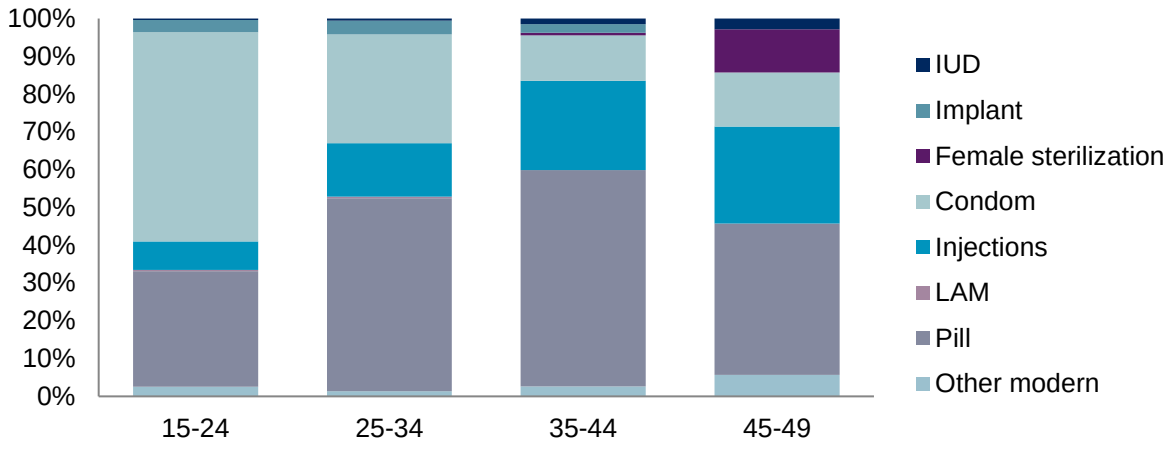


Source: Côte d'Ivoire DHS 1998/99 and DHS 2011/12

The 2013 KfW-funded TRac study (Research International 2013) provided additional insight into FP use in the Abidjan and Yamassoukro districts. Among women in union aged 25-35, contraceptive prevalence was found to be 37.7 percent (42.5 percent in urban areas vs. 28.8 percent in rural areas). The proportion of modern verus traditional method use was found to be 26.2 percent and 11.5 percent.

The use of modern methods varies significantly across age groups. Short acting methods dominate the market overall. Younger populations tend to use condoms much more than other methods, while older groups use pills and injectables at higher rates (see Figure 3).

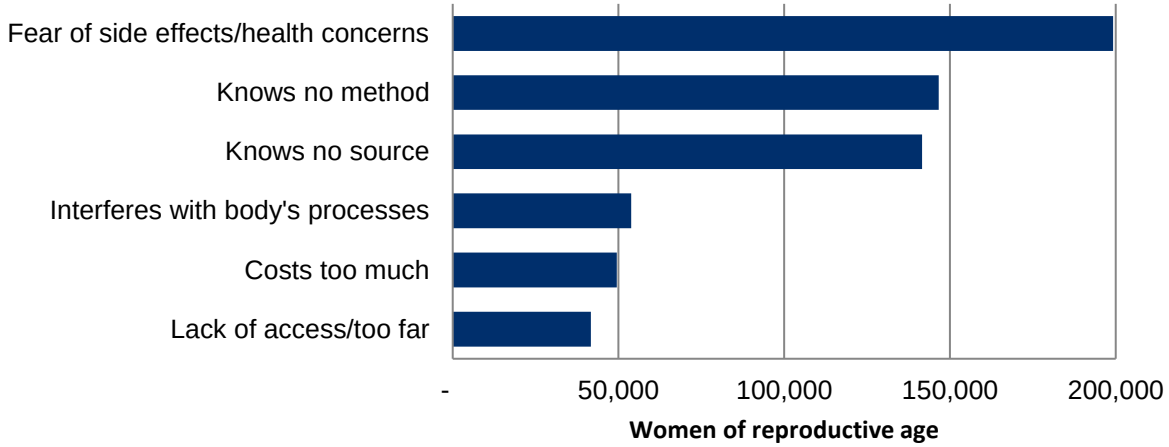
Figure 3. Use of modern FP methods by age



Source: Côte d'Ivoire DHS 2011/12

Reasons for non-use of FP methods are multiple, and include breast feeding, not having sex, and postpartum amenorrhea. However, among women who intend to use in the future, fear of side effects and health concerns, together with knowledge of methods and sources, are likely to influence their choice of method.

Figure 4. Women not using FP who intend to use in the future



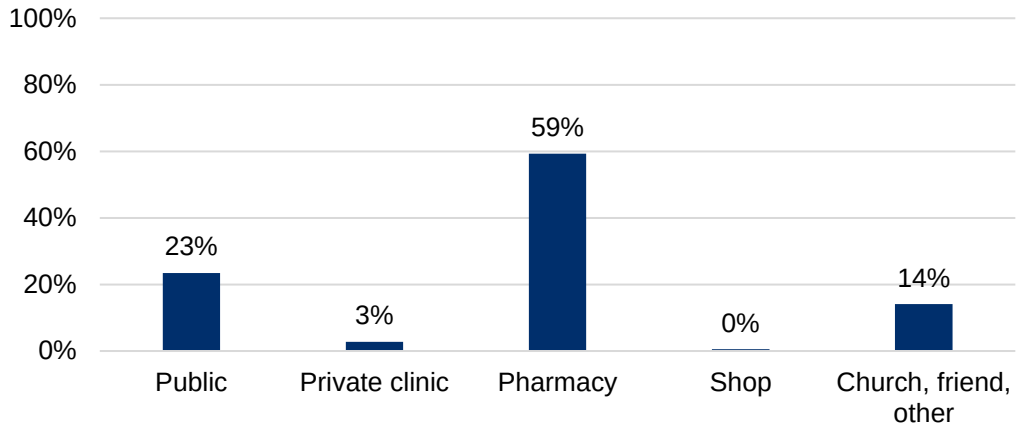
Source: Côte d'Ivoire DHS 2011/12

Note: The 2013 TRac study reported high unmet need among 25-35 year old women in union: 21.6 percent of pregnant women in this group wanted to be pregnant later while 2.7 percent did not want any more children. The study also estimated the use of emergency contraception (EC), which is not reported in the DHS, to be about 0.3 percent among women in this group, while intention to use this method in the future stood at 0.7 percent. Unfortunately, there is no source of data for the use of EC by young women or those currently not in union.

Sourcing patterns

The greatest number of modern users obtain their methods from private sources but the majority do so through pharmacies or shops. This is consistent with a high reliance on short-term methods (pills, condoms) but may also suggest limited availability of FP services through private clinics. Over half of oral contraceptive users obtain this method from a pharmacy (see Figure 5) while 45% and 27% of condoms users purchase the method from pharmacies and shops, respectively.

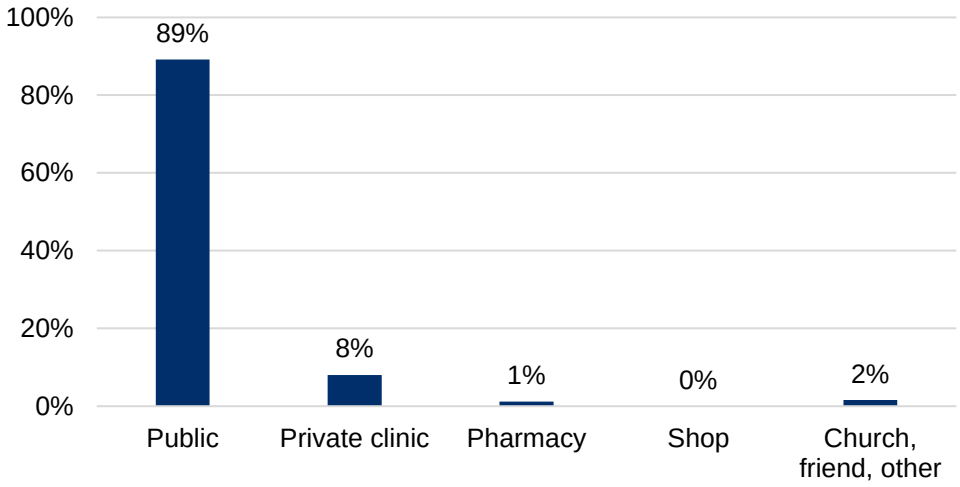
Figure 5. Source of supply for pill users



Source: Côte d'Ivoire DHS 2011/12

Predictably, users of methods involving a service provider are more likely to obtain them from the public sector. For example, 89 percent of women using injectable contraceptives (see Figure 6), obtain them from a public facility. For users of implants and IUDs, this number is 87 percent and 96 percent, respectively.

Figure 6. Source of supply for injection users

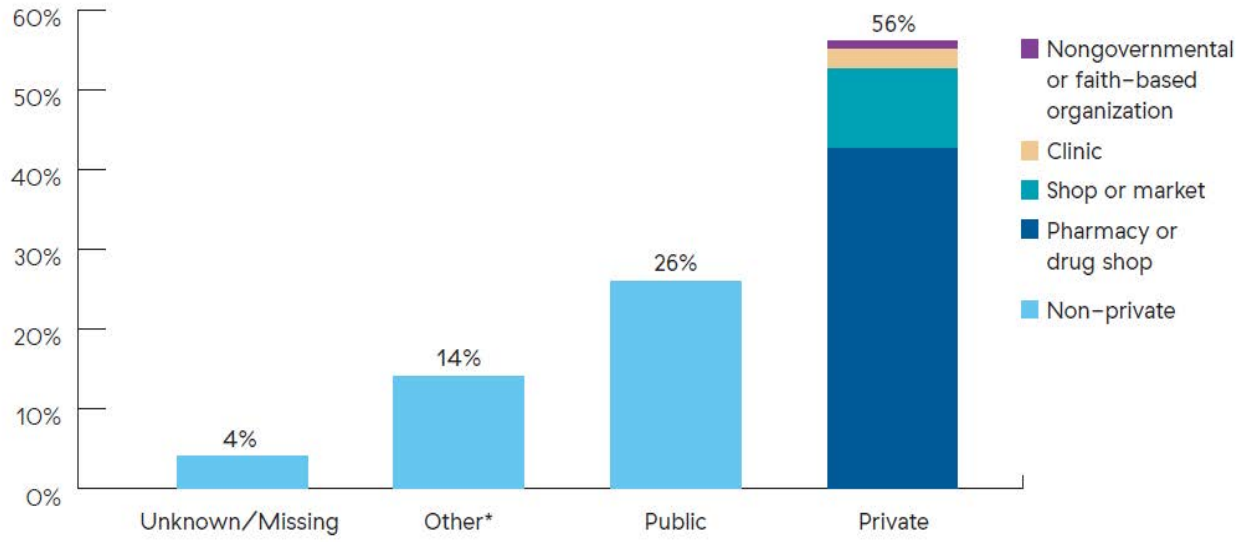


Source: Côte d'Ivoire DHS 2011/12

Potential market (demand side)

Using population estimates from UN Population Division, World Population Prospects 2015, there are approximately 760,000 women using a modern FP method and 318,000 using a traditional method. Additionally, there are approximately 1.9 million more women who were not currently using a method but intended to do so later (see Figure 7). This figure is more than double the number of current modern method users and presents a significant opportunity for the private health sector in Côte d'Ivoire. Looking at current sourcing patterns, the greatest number of modern users obtains their method from a private sector source, mainly pharmacies and shops. This finding is in line with the types of modern methods that are most popular (i.e. those that do not include a clinical service delivery component).

Figure 7. Sources of FP methods



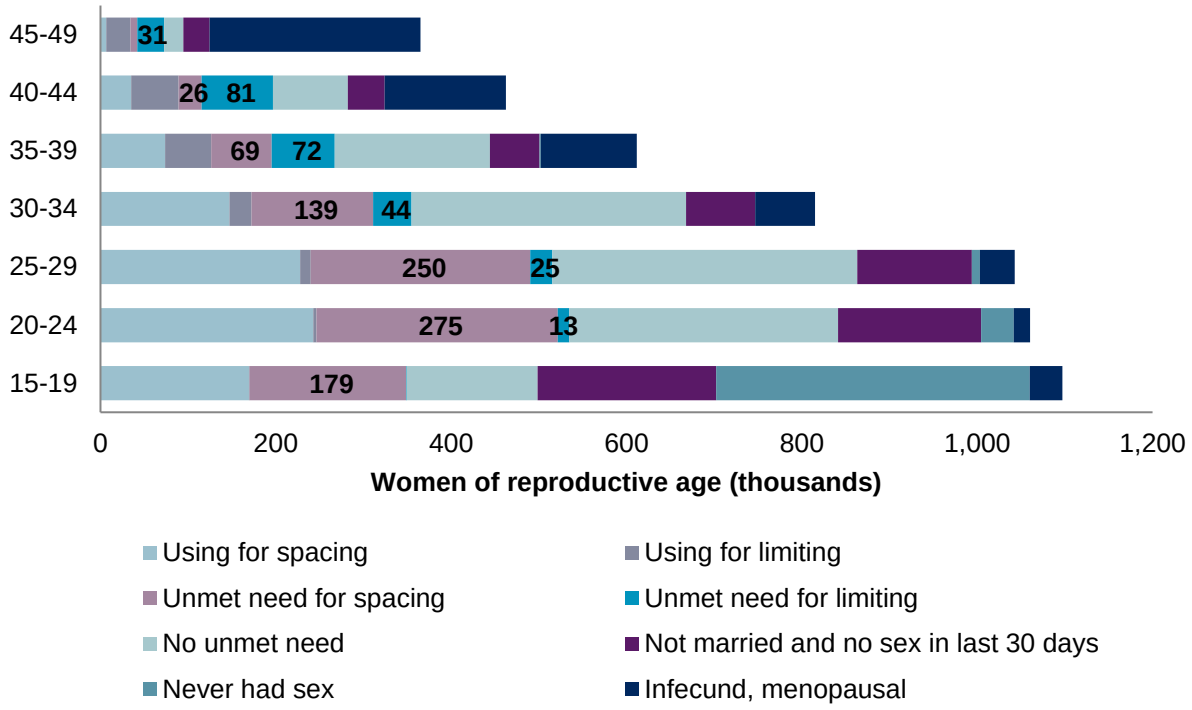
Source: Côte d'Ivoire DHS 2011—12

*Other sources include friends and relatives.

Examining the potential market reveals that a significant number of non-users, especially youth populations, have no unmet need (see Figure 8). Half of women aged 15-19 (about 10 percent of all women of reproductive age) have either never had sex or have not in the past 30 days. Additionally, 33 percent of women aged 20-24 have no unmet need because they either are or want to become pregnant in the next two years.

This relatively low unmet need is partially caused by lack of knowledge. According to the Enquête Démographique et de Santé et à Indicateurs Multiples or EDSCI III, in 2012, 73 percent of women and 67 percent of men have not heard a FP message on the radio, television or in journals. Ninety percent of women who do not use contraceptives did not talk to a health agent or someone working in a health facility about FP in the 12 months before the survey (Côte d'Ivoire DHS 2011/12).

Figure 8. Potential users by age category



Source: Côte d'Ivoire DHS 2011/12

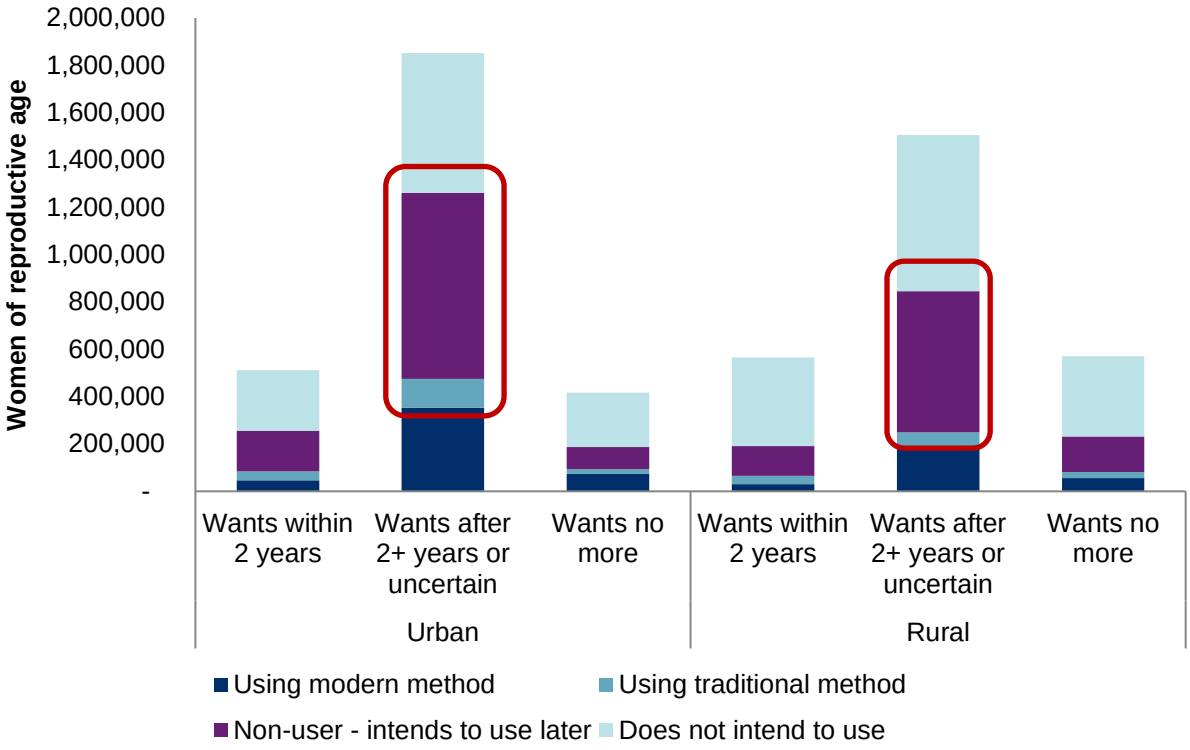
Demand is also impacted by perception. Patients doubt the confidentiality of services and exams provided by health providers. Use of contraception by unmarried women and youth in particular, is very negatively perceived, which encourages them to use the private sector, essentially pharmacies or street vendors. Women remain uncomfortable discussing their FP needs with male community health agents, affecting demand, as the majority of providers are men, especially in smaller health centers and rural centers. Lack of engagement of community leaders and men in FP increases the impact of these aforementioned social barriers (MSHP 2014).

Because of these challenges, significant numbers of women still have unmet need, which could potentially be met by private providers: approximately 940,000 for spacing and 266,000 for limiting. In addition, many of the women without an estimated unmet need intend to use contraception in the future but currently are not due to breastfeeding (11 percent of non-users who intend to use later), health concerns or lack of knowledge (10 percent), not having sex (8 percent of non-users who intend to use later), or postpartum amenorrhea (7 percent) (Côte d'Ivoire DHS 2011/12).

Many of these women could be potentially served through the private sector which plays a large role in providing short acting methods. About 1.6 million women want to delay their next pregnancy by at least years and are either using a traditional method, or not using any method but intend to use later (see Figure 9). Just over 907,000 of these women are located in urban areas where private providers are concentrated, presenting potentially low hanging fruit. An additional 665,800 of these women are in rural areas (Côte d'Ivoire DHS 2011/12). While the

private commercial sector is less present in these settings, there still could be avenues to reach them through NGOs, social marketing organizations, and other non-governmental avenues.

Figure 9. Potential market for private sector FP



Source: Côte d'Ivoire DHS 2011/12

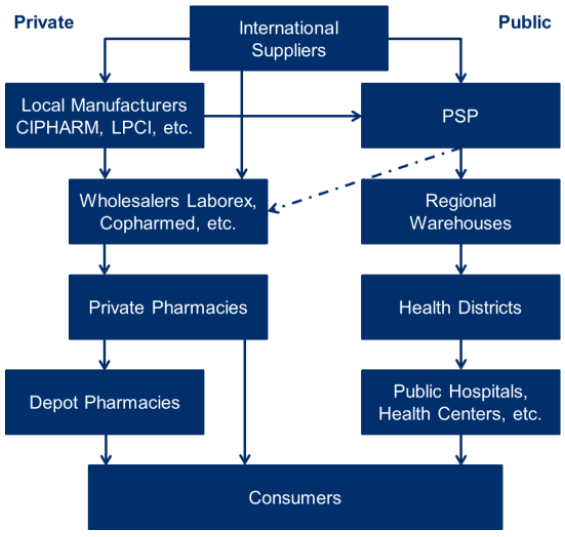
Private sector supply of FP products

Distribution of FP products in the private sector

The private sector serves the largest number of modern method users in Côte d'Ivoire and within the private sector, pharmacies are the largest private source of contraceptive methods (Côte d'Ivoire DHS 2011/12). Pills and condoms dominate the product mix in pharmacies and shops, but other products, such as injectables, EC, and occasional long-term methods flow through these outlets as well. Supply chains stocking these outlets are therefore a critical component of ensuring contraceptive security, a state in which people are able to reliably choose, obtain, and use affordable, high-quality contraceptives for FP and prevent sexually transmitted infections. Contraceptive security is measured through an index of five components: supply chain, finance, health and social environment, access, and utilization (DELIVER 2015). These components are further broken down into indicators of which supply chain has five: storage and distribution, logistics management and information system (LMIS), forecasting, procurement, and contraceptive policy. In 2015, Côte d'Ivoire was assessed for all indicators and scored an overall weighted score of 14.6 out of a possible 20 points (73 percent) for supply chain, which is slightly higher than the regional average for sub-Saharan Africa (14.1). Côte d'Ivoire received an overall contraceptive security score of 49.8 out of 100, slightly lower than the regional average for sub-Saharan Africa (56.6).

The pharmaceutical supply chain in Côte d'Ivoire can be delineated into public and private sectors, each with its own set of actors, opportunities, and challenges (see Figure 10). International suppliers including pharmaceutical manufacturers, donors, and NGOs import almost all contraceptive products in Côte d'Ivoire; imports make up approximately 90 percent of the pharmaceutical market (SHOPS 2014). Donated contraceptives are managed by the *Pharmacie de la Santé Publique,* which also manages imports of other medicines. While most of these donated products then flow down through regional warehouses, public health districts, and public facilities, some of them are distributed through wholesalers and private non-profit clinics.

Figure 10. Supply chain in Côte d'Ivoire



In the private sector, the *Association des Producteurs Pharmaceutiques de Côte d'Ivoire* or *Association of pharmaceutical producers of Côte d'Ivoire* (APPCI) promotes Ivoirian pharmaceutical manufacturing and hopes to increase their share from 10 percent to 30 percent in the next five years. To this end, APPCI seeks to ensure high-quality practices, and fights against low-quality or counterfeit drugs that appear in the market. Members of APPCI include CIPHARM (oldest/largest manufacturer), OLEA, LPCI, LICPHARMA, ROUGET, PHARMIVOIRE, DERMOPHARM, and GALEFORM. Four of these manufacturers (CIPHARM, OLEA, LPCI, and LICPHARMA) have Good Manufacturing Practice certification but none of the Ivoirian manufacturers has WHO manufacturing accreditation.

Four large pharmaceutical wholesalers (Laborex/UbiPharm, Copharmed, TEDIS Pharma, and Distribution Pharmaceutique de Côte d'Ivoire) manage most of the distribution of products in Côte d'Ivoire. These companies have established supplier relationships with international manufacturers, but they also procure and sell generic products in addition to higher margin, branded drugs. Prominent international pharmaceutical companies that import family planning products to Côte d'Ivoire and distribute through these four wholesalers include Bayer, Pfizer, HRA Pharma, and Merck (MSD).

Wholesalers all have a coefficient markup of 20 percent on top of the negotiated pharmaceutical price of a drug, which is mandated by law. Wholesalers obtain and track consumption data from the more than 800 pharmacies they serve, enabling them to maintain minimal stocks and ensure just-in-time delivery to the pharmacies. In theory, resupply to any pharmacy in the country takes place within 24 hours of a pharmacy placing an order, and within the major towns, resupply reportedly occurs within 4–6 hours. However, there is limited data on private pharmacy stock to support these assertions.

Regulation of contraceptive products in the private sector

The *Direction de la Pharmacie, Medicament, et Laboratoire* (DPML) is the ministerial body that approves, registers, and regulates pharmacies, drugs, and labs in Côte d'Ivoire. In order to limit competition, the DPML requires that private providers can only offer pharmaceutical products to clients and patients under their care in certain treatment cases as defined by the MSHP. Private clinics are not legally authorized to sell products but must either offer them as part of a service or write a prescription and send the clients to pharmacies to purchase the product and return for administration. This rule is not always adhered to in practice, however, as it adds a layer of logistical difficulty in accessing contraceptive products. International and national NGOs, such as AIBEF, must also seek this permission from DPML.

Among its responsibilities, the DPML sets drug prices in the private sector and prohibits commercial marketing of drugs and products. Medicine prices in both the private and public sector are regulated by the *Décret n°94-667* from December 21, 1994. The DPML also authorizes the establishment of private pharmacies and has policies regulating the distance between pharmacies to ensure that there is not an overconcentration of pharmacies in urban areas. However, regulations mandating minimum distances between pharmacies are not always followed and rural areas remain underserved. To address this issue, the health system has established a lower tier pharmaceutical retail outlet called *dépôts*, which are designed to serve more rural areas and do not require the full-time presence of a pharmacist. The creation of *dépôts* is subject to regulatory approval and *dépôts* require pharmacists to initiate the investment and take responsibility for supervision and resupply.

The DPML is also charged with investigating sales of counterfeit or expired drugs, though post-marketing surveillance is weak. The DPML and the National Public Health Laboratory have limited resources to test samples or conduct effective monitoring. Certified private pharmacists are allowed to sell pharmaceutical products to the public, which they purchase through import

wholesalers. These wholesalers are regulated by the *Arrêté n°049/MSHP/CAB* from February 10, 2010. Due to the purchase of products through dispensaries and the presence of parallel and illegal markets it is difficult to offer precise estimates of the supply of FP products through the private sector, but some data is available through manufacturers, wholesalers, IMS, and social marketers (SHOPS 2014). The DPML does not maintain data on contraceptives.

Contraceptive products sold in Côte d'Ivoire

Contraceptive products in Côte d'Ivoire can be categorized into social and commercial brands. Socially marketed brands are typically subsidized by donors and developed and distributed by NGOs through wholesalers to pharmacies and through direct offering to clinics. Socially marketed products are typically less expensive than commercial brands but perceptions of quality vary between socially marketed and commercial brands. In Côte d'Ivoire, there are three social marketers: AIMAS, DKT, and PSI, and numerous commercial pharmaceutical companies and brands. Table 8 gives an overview of the range of products, brands, and prices contraceptive products on the market in private pharmacies and clinics. Oral contraceptive pills, EC, and injectables are sold under prescription at pharmacies. Implants and IUDS are not included in this table as they were minimally available through private pharmacies or social marketers in 2016.

Table 8. Overview of contraceptive market in Côte d'Ivoire

Private Sector	Product type	No. of Brands	Units sold between 5/2016-4/2017	Observed price range in pharmacy (USD)[+]
Commercial	Oral pills	19+	94,320[a]	$1.08-$12.24
Social	Oral pills	1	851,547[a]	$0.82-$0.87
Commercial	EC	9+	169,708[a]	$3.67-$9.17
Social	EC	1	139,165[a]	$1.84
Commercial	Injectable	1	2,397[a]	$6.77
Social	Injectable	1	97,280[b]	$1.75-$1.98
Commercial	Condoms (pack of 3)	17+	Unavailable	$0.72-$2.62
Social	Condoms (pack of 3)	3	Unavailable	$0.51-$0.90

Oral Contraceptive Pills

Sources: [+]Observations from six pharmacies in Abidjan and Yamoussoukro, [a]IMS data, [b]Estimates from data shared by wholesalers (IMS data unavailable)

Oral contraceptive pills (OCPs) are the most popular birth control method in Côte d'Ivoire and dominate the market, particularly when considering methods available through pharmacies. An estimated 945,867 units of oral contraceptive pills were sold by wholesalers between May of 2016 and April of 2017 (IMS 2017). This is slightly less than sales in the two years prior. In 2016 there were 972,413 units sold and in 2015, there were 1,029,759 units sold. These decreases come from lower sales for both the social brand (*Confiance*) and key commercial brands (*Adepal*, *Stediril*), indicating a mild contraction of the market.

Overall, the OCP market offers fairly robust choice for users (see Table 9). There are four formulations of OCPs on the market: monophasic, triphasic, multiphasic, and progestin-only. Across these formulations, there are a wide range of brands and pricing. The largest market share (90 percent) belongs to *Confiance*, a brand that is socially marketed (donor-subsidized)

through AIMAS. This near-monopoly stems from the extremely low cost and high availability of the product. Adding to its appeal, *Confiance* also comes in packs of three cycles while many other OCPs come in packs of one cycle (prices shown below are for smallest unit of sales). Pfizer and Bayer are the other two key players in the OCP market, with Pfizer having 7 percent of the OCP market and Bayer having 1 percent of the OCP market. It is difficult for commercial products to compete with a highly-subsidized product like *Confiance*, but both companies do produce multiple brands and target population segments that can be more discerning about branding despite higher price points. The use of *Confiance* has increased by over 800 percent since 2011 when only 11 percent of women currently using pills used a socially marketed brand of pill (DHS 2012). Only products whose primary classification was listed as a contraceptive were included in this analysis, excluding anti-acne products like Bayer's *Diane 35* and Effik's *Holgyeme*.

Table 9. Oral contraceptive pill brands sold in Côte d'Ivoire (IMS 2017)

Brand	Laboratory	Formulation	Units Sold[+]	Market Share (volume)	Est. Retail Price[++]
Monophasic					
CONFIANCE*	AIMAS	Levonorgestrel .15 mg; EE .03mg	851,547	90%	$0.86
STEDIRIL	Pfizer	Norgestrel .5mg; EE .05mg	43,454	5%	$1.93
ADEPAL	Pfizer	Levonorgestrel .15mg; EE .03mg	15,425	2%	$2.08
MINIDRIL	Pfizer	Levonorgestrel .15 mg; EE .03mg	13,957	1%	$1.91
MICROGYNON/FE	Bayer	Levonorgestrel .15 mg; EE .03mg	12,424	1%	$1.03
JASMINE	Bayer	Drospirenone 3mg; EE .03mg	535	0%	$19.26
MELIANE	Bayer	Gestodene .075mg; EE .02mg	305	0%	$16.56
VARNOLINE	MSD	Desogestrel .15mg; EE .03mg	22	0%	$6.56
JASMINELLE	Bayer	Drospirenone 3mg; EE .02mg	5	0%	$17.22
MERCILON	MSD	Desogestrel .15mg; EE .03mg	1	0%	$14.35
HARMONET	Pfizer	Gestodene .075mg; EE .02mg	1	0%	$16.74
MINESSE	Pfizer	Gestodene .06mg; EE .015mg	0	0%	$0.00
Triphasic					
TRINORDIOL	Pfizer	Levonorgestrel .05-.125 mg; EE .03-.4 mg	2,784	0%	$2.83

Brand	Laboratory	Formulation	Units Sold[+]	Market Share (volume)	Est. Retail Price[++]
TRIELLA	Janssen/ CodePharma	Norethindrone 0.5-1mg; EE .035	2,382	0%	$2.43
PHAEVA	Bayer	Gestodene .05-.1mg; EE .03-.04mg	0	0%	$0.00
Multiphasic					
QLAIRA*	Bayer	Dienogest 2-3 mg; Eestradiol valerate 1-3mg	0	0%	$0.00
Progestin-Only					
MICROVAL	Pfizer	Levonorgestrel .03mg	3,010	0%	$2.57
CERAZETTE	MSD	Desogestrel .075mg	15	0%	$10.52

While most commercial OCP prices are two to five times as expensive as the socially-marketed *Confiance* brand, the prices of Bayer's commercial *Microgynon* brands of oral contraception (approx. $1.03) are fairly competitive with the socially marketed *Confiance* brand (approx.

**Sold in 3 cycle packs only*
[+]Units sold between 5/2016-4/2017
[++]Estimated based on a 2.2 multiplier of wholesaler unit cost to pharmacies

$0.86). However, all commercial OCPs are relatively expensive when considering that three cycles are included in the price of *Confiance*. The price of *Microgynon* is the result of a public-private partnership between USAID and Bayer Healthcare. Despite a relative price-point similarity, *Microgynon* has not seen the same kind of uptake as *Confiance* or even other commercial brands and this discrepancy warrants further exploration.

Emergency Contraception

An estimated 308,079 units of EC were sold by wholesalers between May of 2016 and April of 2017 (see Table 10). This is a significant decrease from prior years; 755,787 units of EC were sold in 2016 and 569,329 units of EC were sold in 2015. While sales of commercial brands increased by an average of 62 percent between 2016 and 2017, sales of the socially marketed product, *Pregnon* (AIMAS), decreased by 78%. Overall, *Pregnon* still has the 45% of the market, followed by *Norlevo* (HRA Pharma). It is clear that AIMAS and HRA Pharma target different market segments with their brands; *Pregnon* is a donor-subsidized social product and one of the least expensive products on the market, and HRA Pharma products *Norlevo*, *ellaOne*, and *Vikela* are the most expensive brands on the market, likely targeting the middle and upper wealth quintiles with the ability to pay more.

Table 10. Emergency contraception brands sold in Côte d'Ivoire

Brand	Laboratory	Formulation	Units Sold[+]	Market Share (volume)	Est. Retail Price[++]
PREGNON	AIMAS	Levonorgestrel; 2 tablets .75mg	139,165	45%	$1.83
NORLEVO	HRA Pharma	Levonorgestrel; 1 tablet 1.5mg	65,909	21%	$9.18
LEVO-BD	BDA Pharma	Levonorgestrel; 1 tablet 1.5mg	45,979	15%	$5.24
SECUFEM	Urufarma	Levonorgestrel; 1 tablet 1.5mg	16,632	5%	$5.86
LEVOPREG	Médicale Pharmaceutique	Levonorgestrel; 1 tablet 1.5mg	18,811	6%	$4.73
NORVEL-72	MedNext Pharma	Levonorgestrel; 1 tablet 1.5mg	13,896	4%	$5.74
ELLAONE	HRA Pharma	Ulipristal acetate; 1 tablet 30mg	4,591	1%	$11.77
PROTECT-PILL	MSR Lab	Levonorgestrel; 1 tablet 1.5mg	2,772	1%	$4.72
VIKELA	HRA Pharma	Levonorgestrel; 1 tablet 1.5mg	315	0%	$8.92
VIKELA	HRA Pharma	Levonorgestrel; 2 tablets .75mg	122	0%	$8.17
PRESTO	OdyPharm	Levonorgestrel; 1 tablet 1.5mg	681	0%	$4.18

[+]Units sold between 5/2016-4/2017

[++]Estimated based on a 2.9 multiplier of wholesaler unit cost to pharmacies

Looking at the overall EC market picture, one key takeaway from this data is that clients have many brands of EC from which to choose at a wide variety of prices. In addition to the one socially-marketed EC brand (*Pregnon*) currently available through AIMAS, two new socially-marketed brands of EC are also expected to launch in the next year through DKT and PSI. A second key takeaway is that because 22 percent of the market pays for one of the most expensive brands of EC indicates that there may be ability and willingness to pay for EC products, particularly for recognized brands. All formulations, except for *ellaOne*, are progestin-only (Levonorgestrel) and most come in a 1-pill dose. *ellaOne* has a progesterone receptor modulator and is more effective than progestin-only pills in the fifth day after unprotected sex.

While comprehensive, IMS data does not capture data on products that are not sold through wholesalers (i.e. that are sold directly from laboratories to pharmacies). One such product worth noting is *Nornet*, made by PAR Laboratories, which was available in pharmacies for XOF 1000 ($1.78). This is an Indian product with a price comparable to that of *Pregnon*, making it the least expensive commercial EC on the market. Further research is needed to determine the sustainability of this product's pricing and its channels of distribution.

A final point worth making is that the DHS has not collected data on current or previous use of EC in Côte d'Ivoire, and going forward, new standard survey questions do not ask about

previous of EC. It is therefore difficult to know much about the population segment that uses EC. Because of the high levels of EC use in Côte d'Ivoire, it is important to better understand the demographics and reproductive intentions of populations who use this method.

Injectable Contraceptives

As with the OCP and EC markets, the socially-marketed injectable *Harmonia* (AIMAS) is heavily preferred over Pfizer's commercially available *Depo-Provera*, likely because of the wide price differential. *Harmonia* and *Depo-Provera* are both progestin-only intramuscular injectables that protect women for three months. While still slower to sell in pharmacies than other short-acting methods, injectables are reportedly becoming more and more popular at clinics, after the contraceptive implant. This could also raise their profile in pharmacies. One reason for their popularity may be their cost: starting at $1.77 per 3-month period, injectables are much cheaper over time than *Pregnon.* They are, however, still twice the price of the three-cycle pack of *Confiance*. One benefit injectables have over OCPs is that they are more discreet and do not require daily routines. One potential barrier to use of injectables in Côte d'Ivoire is that women often get their prescription at the clinic but then must go to the pharmacy to pick up the drug, and then return to the facility to get it injected. This creates a potential barrier to uptake of this method.

Table 11. Injectable contraceptive brands sold in Côte d'Ivoire

Brand	Laboratory	Formulation	Units Sold	Market Share (volume)	Observed Retail Price[+]
HARMONIA	AIMAS	medroxyprogesterone acetate 150mg	72,640a	99%	$1.77
DEPO-PROVERA	Pfizer	medroxyprogesterone acetate 150mg	890b	1%	$6.88
SAYANA PRESS	Pfizer	medroxyprogesterone acetate 104mg	Unavailable	0	Unavailable

[a] *Calculated based on direct wholesaler reported data (interviews; May 2017)*
[b] *IMS data*
[+] *Prices observed in pharmacies in Yamoussoukro and Abidjan in May 2017*

Pfizer's *Sayana Press* is also available in some private clinics, such as AIBEF clinics. A key advantage of *Sayana Press* is its ability to be administered through a sub-cutaneous Uniject injection system which makes self-injection possible. There is currently a pilot exploring the feasibility and acceptability of self-injection in three districts in Côte d'Ivoire, though AIBEF reportedly already offers this method of administration. *Sayana Press* has been registered for use in Côte d'Ivoire since 2013 but is not yet permitted to be sold commercially, according to the DPML. Because the administration of *Sayana Press* requires minimal training, it is especially suitable for use in rural areas, which are often underserved in Côte d'Ivoire. Further, as of May, 2017, Pfizer has agreed to reduce the price of *Sayana Press* from $1 per dose to $0.85 per dose for qualified purchasers (Pfizer 2017). While this price is not immediately accessible to private sector actors, it may mean that there will be supply increases in Côte d'Ivoire more broadly, and this will likely increase availability in the private non-profit sector, and possibly also the private for-profit sector.

Condoms

Condoms are mostly sold through pharmacies and depots in Côte d'Ivoire. The condom market is one that is filled with colors, tastes, brands, and competitors. There are three socially-marketed brands of condoms including *Prudence* (AIMAS), *Complice* (AIMAS), and the newly launched *Kiss* (DKT) in strawberry, banana, mint, and original flavors. Beyond social brands, there are a large number of commercial products such as *Manix* (JK Ansell), *Gtm* (Afrasia Trading), and *Label Vie* (Indus Medicare). *Prudence*, *Complice*, and *Kiss* offer the least expensive prices in the market, at approximately USD 0.20 per unit (usually sold in boxes of three for ~$0.60). Commercial brands range from approximately $0.25 to $1.50 per unit and are often sold in packs of 3 to 15 (between $1-$10 per box). Despite the higher cost, commercial brands are preferred to cheaper social brands, a fact confirmed by wholesalers and by pharmacists whose popular *Manix* products were outselling the social brands by factor of seven. This is a change from 2011 when 86 percent of women (and presumably their male partners) currently using condoms used a social marketing brand of condom (DHS 2012).

Manix condoms were two to three times more expensive than the social brands. This gives a strong indication that buyers are willing to pay more for luxury products in the condom market. This raises the question of how much of this willingness to pay is due to buyers simply having more discretion at lower price points and how much of it is due to perceived quality and brand image. Condom prices are comparable to those of OCPs and so it appears that there is potential capacity and willingness to pay among purchasers of short-acting contraceptive products which may be an important nuance of the contraceptive market to explore.

IUDs

As in many other settings, IUDs are not typically sold through pharmacies because they are used primarily by health providers who acquire the product through other supply sources. However, Bayer's *Mirena* IUD is available commercially, though the sales are minimal. The *Mirena* is a levonorgestrel-releasing intrauterine system that protects against pregnancy for up to five years.

However there is a lot of momentum around IUDs in the private sector. Four new IUDs have come onto the commercial market in 2017 through DKT which will tremendously increase access to, and affordability of, this product type. The four new IUDs will improve choice for both providers and users of LARC methods, as limited options currently exist. These IUD choices will include the *Lydia Copper T*, *Lydia Copper Y*, *Lydia Safeload*, and the *Lydia Sleek*. The *T, Y,* and *Safeload* products all last for 7-10 years while the *Sleek* lasts for 5 years. Though the four IUDs have many similarities, they will be marketed in different ways; *Lydia Sleek* will be marketed for younger, nulliparous women, the *Lydia Copper Y* will be marketed as a more comfortable fit, and the *Safeload* will be marketed as a faster, easier insertion process. The price to consumers for the IUD products is targeted to be between XOF 1,000-15,000 (USD 1.76-26.34). AIMAS has also reportedly brought an IUD to the commercial market, though it has not yet been reflected in their online communications.

Because of its long duration, the IUD is the cheapest product over time. With five new diverse products on the market, the IUD may see an increase in uptake as long as adequate provider training and client sensitization are also offered. One potential focus area for IUDs is for post-partum insertion, and this can potentially start with the private sector. Insurance companies already cover basic maternal health and delivery packages and the inclusion of the option for a postpartum IUD is a natural fit that would not add significant cost to that package because it would not require additional visits. Political advocacy and sensitization would be needed to make this opportunity a reality.

Implants

As with IUDs, there is limited current offering of contraceptive implants in the private sector. Subdermal contraceptive implants are not sold through wholesalers or pharmacies and there are not currently any socially-marketed implants available in Côte d'Ivoire. *Jadelle* (Bayer) and *Implanon NXT* (MSD) are both available through UNFPA donations in donor-associated clinic networks. The active ingredient in *Jadelle* is levonorgestrel and it protects women for up to five years. The active ingredient in *Implanon NXT* is Etonogestrel and it protects women for up to three years. Contraceptive implants are a relatively expensive product to procure and require training to administer, making them a less feasible option for profitable sales in the private sector in low-resource settings. In the small number of private clinics where implants are available and health workers are trained on insertion (typically AIBEF or other donor-related networks) implants are reportedly the most popular method. This commodity however is typically provided to private clinics at a price below its replacement cost. Donors and governments purchase implants at a preferential cost of $8.50, yet private clinics affiliated with AIBEF or a donor-supported network pay a fraction of this cost—for example $5.00 in one of the Private Sector Health Project (PSHP) network clinics. As a result, the provision of implants through the private sector further increases the level of subsidization of this method.

Key suppliers

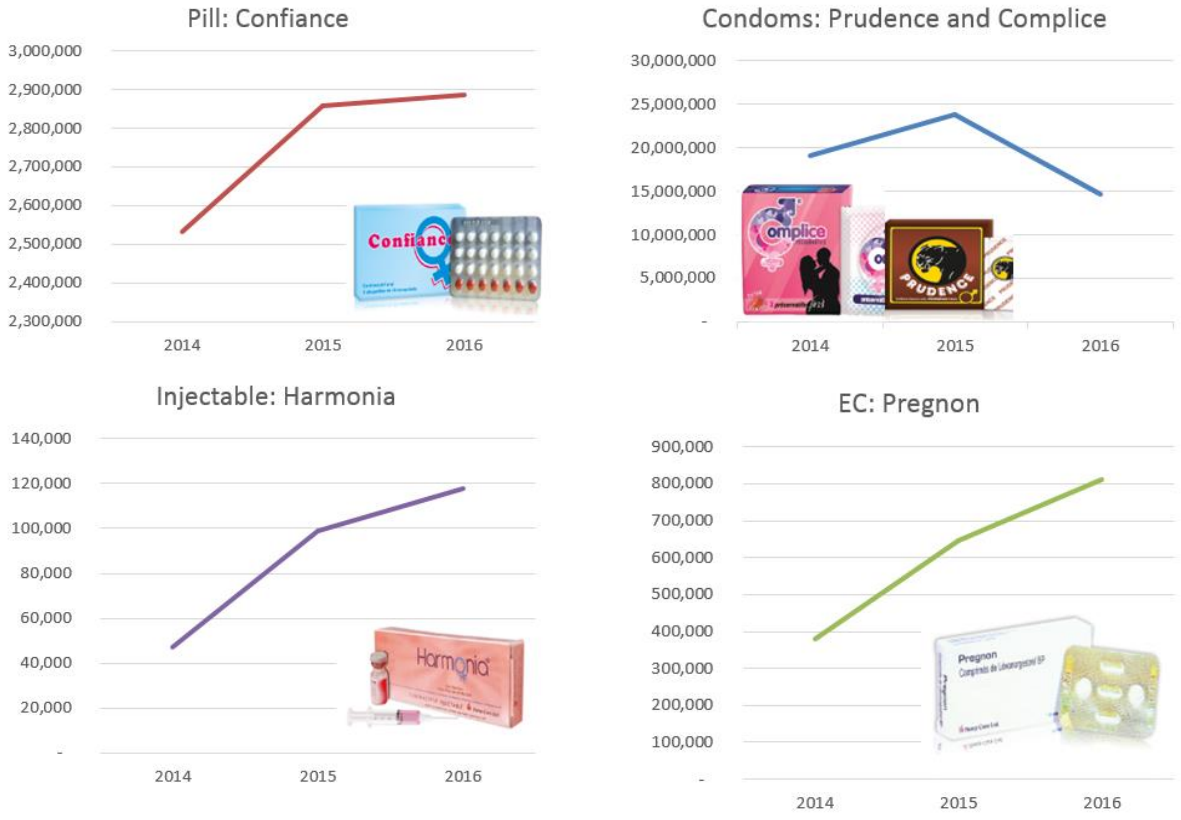
Social Marketing Organizations

Social marketing organizations use commercial marketing techniques, mass media and telecommunications, and existing commercial infrastructure to promote and sell products. Globally, there are more than 93 contraceptive social marketing programs in 66 countries. These programs are subsidized in part or entirely by international donors and NGOs and their objectives are to reduce unmet need for family planning. In Côte d'Ivoire, there are three social marketing organizations: AIMAS, DKT, and PSI, though currently only AIMAS and DKT are actively marketing products.

Agence Ivoirienne de Marketing Social (AIMAS)

AIMAS is the principal social marketing organization in Côte d'Ivoire with five products currently on the market: *Prudence* (male condom), *Complice* (male condom, marketed to youth 15-24), *Confiance* (combined OCP), *Pregnon* (EC), and *Harmonia* (3-month injectable). In 2017, AIMAS also reportedly added an IUD to the list of products that they offer. Product sales through wholesalers make up only a fraction of their product distribution, which include private facilities and other distribution channels. In the last three years, distribution (sales) of most of their products have increased, with the exception of Prudence (see Figure 11).

Figure 11. AIMAS products distributed in Côte d'Ivoire, by year



Source: AIMAS 2017

All AIMAS products are funded by KfW except for *Pregnon* which is financed exclusively with AIMAS funds. The current DPML-negotiated prices for these products only cover the product costs and do not allow for the recuperation of overhead costs. AIMAS is currently advocating with the DPML to increase the price so that they can have a more sustainable business model. Thirty clinics are part of the AIMAS network, including 11 public clinics and 19 private clinics. AIMAS estimates that with their six products, they respond to approximately 45 percent of demand for contraceptive products in Côte d'Ivoire. To support sales of their products, AIMAS works with nearly twenty SBCC partners including NGOs and Ministries of Health, Education, and Youth to promote family planning through multiple mass communication channels.

DKT

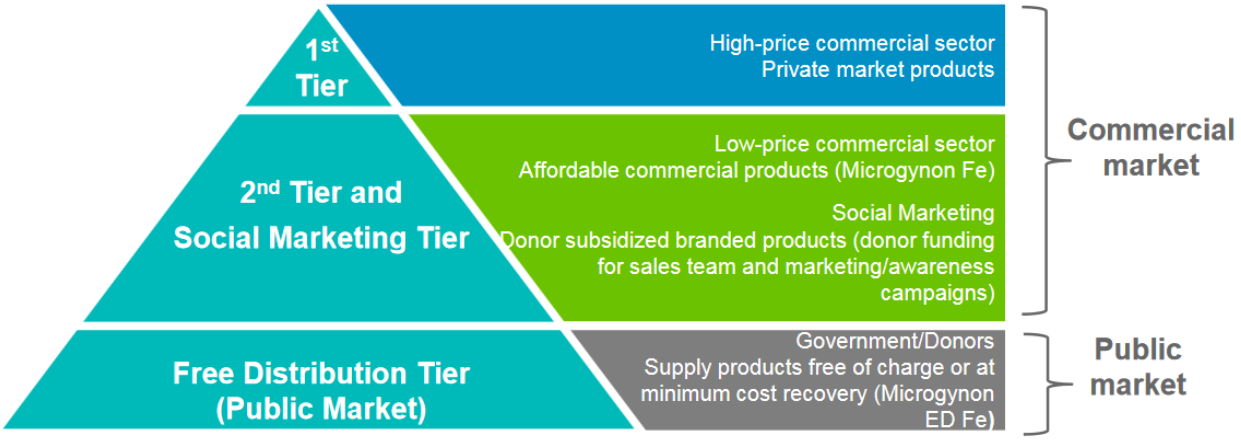
DKT manages some of the largest and most successful contraceptive social marketing programs globally. As part of its growing West African regional portfolio, DKT opened a social marketing office in Côte d'Ivoire in 2017. DKT recently launched its *Kiss* brand of condoms and is rolling out four brands of IUDs. It also in exploring offering brands of EC, OCP, and an injectable (potentially an off-brand *Sayana Press* (DMPA-SC)). DKT has also expressed interest in offering an implant, but has not yet identified a supplier.

Unlike AIMAS, which is an NGO, DKT is incorporated as a company in Côte d'Ivoire. As a starting point, DKT hopes to recuperate the product cost but expects to spend funds on overhead and marketing, especially during startup. DKT is in the process of developing relationships with wholesalers and private clinics to whom they can sell the products in the future. DKT funders include the Bill and Melinda Gates Foundation and an anonymous donor.

Commercial manufacturers

Prominent commercial manufacturers that have offices in Côte d'Ivoire include Bayer and Pfizer. In the OCP market, Bayer uses a "second tier marketing approach" which targets a lower-income population segment in the commercial sector (similar to social-marketing brands) (see Figure 12). The public-private partnership that Bayer has with USAID for *Microgynon FE* attempts to address the growing gap between the growing demand for contraceptive products and the ability of donors to pay for these contraceptives. It is an important opportunity for Bayer to increase its visibility in this space and potentially introduce additional brands and products in the future to a clientele already familiar with the Bayer reputation in family planning. Bayer has other contraceptive products in the commercial Ivoirian market including other OCPs and *Mirena*, a hormonal IUD. Bayer's contraceptive implant *Jadelle*, is available through UNFPA donations.

Figure 12. Bayer 2nd tier marketing approach for Microgynon FE



Source: Heerde, M 2017

Pfizer is another key commercial pharmaceutical company in Côte d'Ivoire. Pfizer offers five brands of oral contraceptives (*Adepal*, *Microval*, *Minidril*, *Stediril*, and *Trinorodial*) as well as *Depo Provera* and *Sayana Press* injectable contraceptives. Pfizer sells products to wholesalers (commercial) and to UNFPA (public sector). The target market for Pfizer in the commercial sector is the middle class (1st Tier in Bayer's model) and they promote their products to this

segment. Pfizer asserts that more sensitization is needed to increase awareness and visibility of family planning in Côte d'Ivoire.

Challenges in the supply of FP products

The private contraceptive market in Côte d'Ivoire presents several challenges to sustained supply of affordable products.

High level of market subsidization

Social products dominate the OCP, EC, injectable, and IUD markets, and donated products are the only available options for contraceptive implants. While both Bayer and Merck both have a presence in Côte d'Ivoire, there is limited availability of *Jadelle* or *Implanon NXT* in private clinics, reducing contraceptive choice for most of the population. There is a small but active commercial market for most contraceptive products, however the level of commercial investment may be deterred by the current market balance.

In contrast to the short-acting product markets, there are currently no commercial or social contraceptive implants in Côte d'Ivoire. Despite the presence of Bayer and Merck in country, all implants in Côte d'Ivoire are donations through UNFPA. In the last three years donations of implants have increased, but as UNFPA looks to transition the sustainable financing of contraceptives to public and private sources in Côte d'Ivoire there may be some issues around contraceptive security for the implant. Markets for injectable contraceptives and IUDs are minimal but growing as additional brands and products (DKT's *Lydia* and Pfizer's *Sayana Press*) are developed and brought to market.

Regulatory constraints

Further limiting sustainable market competition in the private sector is the strict regulatory environment, which limits where pharmacies can be established, who can sell products, and how much products can be sold for, and restricts commercial advertising of all pharmaceutical products, including contraceptives. Both commercial companies and social marketers must petition the government if they want to change the price of a product. This is the case for AIMAS, which would like to increase the sustainability of some of its products by increasing their price points. These regulations prevent organizations and companies from reacting in a timely manner to market forces and leave them unable to generate demand for their specific products through marketing. Commercial marketing of contraceptive products in particular can have the effect of increasing sensitization around family planning in general.

Lack of market visibility for EC

A final product issue is that there is limited understanding of demand for products like EC, and the demographics of users who make up that demand segment. Understanding who uses EC may provide an opportunity to move users along a contraceptive continuum to more proactive or longer acting methods that may provide a better match for their reproductive intentions and contraceptive needs. In terms of improving market segmentation for products, it would also be very important to better understand capacity and willingness to pay among short-term contraceptive users and potential users.

FP services in the private sector

Private sector contribution to FP services

Private health facilities play a very minor role in delivering contraceptive methods in Côte d'Ivoire. DHS data suggest that the majority of FP users who obtain their method in the private sector are condoms and OC users who purchase these products from a retail outlet (pharmacy or shop) (DHS 2011/12). Although little is known about users of EC pills, it is safe to assume that they also obtain this method directly from retail outlets.

The MSHP estimates that private health structures account for 13 percent of the overall supply of modern family planning methods nationally. This number probably does not reflect their full contribution because many do not report service statistics to the MSHP. According to 2014 data from the regional departments, only 65 percent of public and private facilities offered basic FP products (pills, injectables, condoms), 7 percent offered IUDs, and 11.9 percent offered implants (MSHP 2014).

A small number of studies to date have assessed the availability of FP services in the private health sector. A 2014 survey conducted by the *Ecole Nationale Supérieure de Statistique et d'Economie Appliquée*, found that 66.7 percent of faith-based facilities, and 75 percent of NGO facilities could offer at least 5 methods. In contrast, only 27.5 percent of private for-profit clinics offered as many methods, though this was a significant increase from the 3.3 percent that reported doing so in 2013 (ENSEA 2014).

In 2015, the SHOPS Plus project conducted a survey of 32 private clinics in Abidjan and Yamassoukro, with the goal of integrating FP and HIV care and treatment at those facilities. Two-thirds of these facilities reported having received requests for FP services from their patients but only half of the clinics offered these services (SHOPS Plus 2015).

Providers of FP services

Association Ivoirienne pour le Bien-Etre Familial (AIBEF)

AIBEF is the main provider of FP services in the private sector. This affiliate of the International Planned Parenthood Federation has been a key stakeholder and partner in efforts to increase the use of FP n Côte d'Ivoire. The NGO has received support from the AFD, the European Union, the Global Fund Against TB and Malaria, Alliance International and the World Bank, and it is currently a partner of the USAID-funded *Agir pour la Planification Familiale* regional project. This has enabled AIBEF to become a key provider of LARC methods, and reach previously underserved groups through community-based activities.

AIBEF owns 10 facilities and maintains a presence in 8 regions by providing supportive services to about 300 facilities. Of those facilities, 30 are "traditional centers" located in public facilities that offer counseling and a full choice of contraceptive methods. AIBEF also supports workplace clinics, and about 10 for-profit facilities with training services and helps them keep a stock of FP commodities on the premises. These products are not actually purchased from AIBEF but delivered and stored at the clinics until they are sold to patients. The clinics then pay AIBEF for the cost of the products, plus a 10 percent commission. Private clinics are not franchised and do not use the AIBEF logo or comply with a common set of rules and standards. AIBEF however is receiving support from the USAID-funded SIFPO project to pilot a franchise project.

Provider networks

PSHP Private Sector Network

From September 2014 to January 2016, The USAID-funded SHOPS project developed a network of private providers of HIV care and treatment services, now supported through the PSHP. Of the current 44 clinics in the network, 33 have also received FP assistance in the form of training and technical support, and are able to obtain commodities from the MSHP or AIBEF. The FP component of the project however is scheduled to end in October 2017.

BELFAM franchise

The social marketing organization AIMAS is managing a franchise of public and private providers with funding from DfID. The Belfam franchise currently includes 30 facilities (20 in Abidjan, 5 in Korhogo et 5 in San-Pédro). Of these facilities, 11 are private, 10 public, and 9 community health centers. Each facility has received an initial donation of contraceptive commodities and receives additional supplies when it participates in promotional “fairs” where community members receive free consultations and services. The rest of the time, private facilities can purchase commodities from the health district or from AIMAS.

The Blata Medical Center

This private community clinic affiliated to the Belfam network is the main source of primary, obstetric, pediatric and family planning services in Gonzague ville, a densely populated suburb of Abidjan. Between 50 and 100 people come to the clinic seeking FP services every month. The clinic also participates in “free day fairs” that attract large numbers of new and existing clients. FP services are provided by one midwife who is trained to administer implants (50 percent of clients chose this method) and IUDs. Because it serves a very low income clientele, the clinic suffers from a lack of resources to purchase equipment and supplies, and struggles to break even while keeping its fees very low. The cost of an IUD insertion at this clinic is 4000 CFA.

Independent facilities

The larger clinics in Abidjan offer multiple services, especially radiology, pediatric services, gynecology, and ophthalmology. In these clinics, FP is not a stand-alone specialty area but a service provided by the gynecologists employed by the clinic as *vacataires*. More than half of the patients in those clinics are covered by a private insurance such as Ivoire Santé, NSIA, LaLoyale Assurances, ASCOMA, or MCI-SOGEM. These plans do not generally cover FP services except for the gynecological consultation during which contraceptive methods might be discussed. Clinicians in private for-profit clinics often prescribe oral contraception but are less likely to provide LARC methods unless the clinic is affiliated with a donor network that can provide subsidized supplies and training. Of the 32 clinics surveyed by SHOPS Plus in 2014,

only one was receiving regular supply of commodities because it was affiliated with the AIBEF network. In effect, this affiliation appears to provide an exemption from the law. However, it does not solve the problem of unaffiliated clinics that are in the majority and see the most patients.

Midwives and gynecologists do not work as collaboratively in the private sector as they might in the public sector (SHOPS Plus 2014). It is unclear whether the expansion of the SHOPS Plus network has succeeding in changing this mindset. Some clinics visited for this assessment appeared to have no problem task shifting to midwives, while in others, midwives merely provided counseling, referring the client back to the gynecologist for an implant or IUD insertion.

Challenges to private provision of FP services

The low availability of FP counseling and methods in the private sector is primarily due to the following factors:

Obstacles to expansion

The main sources of FP services in the private sector are AIBEF-affiliated clinics (about 300) and facilities that have been organized into networks with support from USAID and the UK Department for International Development (DfID). As is the case for contraceptive products, the supply of FP services is very donor-dependent. Expanding the number of facilities offering FP services through networking or franchising, would certainly increase access to services but also require additional donor support. Because this support does not necessarily correlate with the demand for FP services, but tends to be budget-dependent, further expansion of FP services delivery capacity is likely to be constrained.

Financial sustainability of AIBEF

AIBEF recognizes that it is highly dependent on donors to continue operating as a key service provider, and as a supplier of commodities and technical assistance to public and private clinics. The NGO is primarily supported by donors (such as UNFPA, IPPF, AFD and KFW) in the form of product donations and subsidies, and through partnerships with donor-funded projects. AIBEF expects the MSHP to continue supporting it should UNFPA eventually phase out its donation program. However, this would make the NGO dependent on budget funding for commodity procurement. The organizations is actively considering strategies to improve its financial sustainability, possibly by increasing its prices, launching new products, and providing income generating services to private companies and facilities.

Pharmaceutical sales regulations

Private facilities are not legally authorized to dispense pharmaceutical products to patients. This restriction is often blamed for the low availability of FP services in private for-profit clinics. Although some clinics are thought to be selling medicines illegally, they are unlikely to take this risk for contraceptive products if the method can easily be purchased in a pharmacy. Some private clinics however reportedly offer implants imported from France because the product is not available in pharmacies (see below).

Ability to provide implants

The clinics surveyed by the SHOPS project in 2015 that reported patient requests for FP services also reported that a third of those patients specifically requested implants. Interviews conducted by the assessment team in Abidjan and Yamassoukro revealed high demand for implants. This is consistent with reports of increasing demand for the method in FP centers and AIBEF clinics. Unfortunately, it is almost impossible for private facilities unaffiliated with a franchise or network to offer this method because it is not available through commercial pharmaceutical distributors, wholesalers or pharmacies. When an independent private provider (most likely a gynecologist) is asked about implants, he or she must refer the client to the public sector or an AIBEF clinic.

Organization of services in the for-profit sector

The dominant model for health service delivery in the private for-profit sector is very different from that of public or NGO facilities. As in other francophone countries in West Africa, private clinics lack access to financing for expansion and equipment, and are unable to hire many full-time providers, especially for specialty services. A large private clinic may employ nurse's aides, laboratory technicians, and radiologists, but hires most of its clinical staff on a part time basis and at a negotiated rate for services provided. The vast majority of gynecologists, pediatricians and many general practitioners are trained and employed in the public sector but work in private clinics after their regular hours of service as *vacataires*.

The remuneration of the *vacataires* is based on each consultation and treatment provided, and the independence of these health professionals in making clinical decisions is guaranteed by law. It is therefore nearly impossible to try and replicate the service delivery model found in the public sector or NGOs where health providers are employees and subject to policies determined by the health institution.

This does not imply that services provided in the private sector are substandard, but simply that they are difficult to standardize. Attempts to create a public sector or NGO-like service delivery setting in a private clinic are likely to require some level of subsidy or incentive that may not be sustainable over the long term. For example, task sharing, an approach that saves costs and enables the public sector to serve more patients is not as helpful in the for-profit sector where consultations by specialists are both lucrative and more easily expandable as demand increases.

When it comes to FP services, private facilities can earn more money from having highly paid specialists perform certain tasks (i.e. implant or IUD insertions) Doing so also provides a higher perceived value to patients who choose private facilities in order to see a specialist.

Provider competency

Specialists who are hired by private clinics as *vacataires* are not necessarily well-trained in FP technology or the administration of certain methods. Most gynecologists work in the public sector where they may or may not be providing FP services. At the hospital level, FP services tend to be a vertical program managed by one gynecologist and are not necessarily integrated in the overall Ob/Gyn practice. Furthermore, the public sector tends to use midwives for the provision of FP services but when these providers work as *vacataires*, they are asked to assist with deliveries, not provide FP services. The consequence of these different patterns of service delivery leads to a lack of trained FP providers in the private sector. Finally, the only opportunities for training in contraceptive technology and practice are those offered to

gynecologists in the context of their MSHP employment, or through affiliation with a donor-funded FP project. Therefore a private clinic wishing to offer FP services is dependent on the availability of a trained *vacataire* with an interest in providing these services to clients.

Clinique Notre Dame de l'Incarnation

This clinic, located in Abidjan's Cocody neighborhhod, is known for its active obstetrics/gynecology practice, run by a gynecologist who also practices and teaches at a public hospital. This provider, who strongly believes that the practice of gynecology must include FP services, has trained five other gynecologists employed by the clinic as *contractors*. The practice provides FP services to about 15 to 20 clients per week, mostly after a delivery during the 6-week post-partum visit. The clinic's patients are usually covered by private insurance, which pays for the cost of delivery and gynecology consultations. FP services, however, are not covered. As a result, many patients hesitate to pay the 30,000CFA fee for an IUD insertion and are referred to a public hospital. Some women request the less expensive implant insertion, but the clinic must obtain implants from a public source because they are not available for purchase in pharmacies.

Insurance coverage for FP services

According to the ACPCI, about 90 percent of private clinic patients carry some form of private insurance. Services covered through insurance vary depending on the scheme and the level of co-payment, but most employer-sponsored insurance programs offer employees plans that include comprehensive maternal/delivery care packages. Yet almost none of these employer-sponsored plans offer any FP benefits, including the placement of a post-partum IUD. Despite the cost-savings that could be gained from FP coverage, employers and insurers likely consider FP to be the purview of government and donors, and do not feel the need to cover these services. As a result, insured patients who do not want to pay the out of pocket payment for an IUD insertion are routinely referred to a public or NGO facility. This is both a loss to the provider, and an added burden for the public sector. This lack of experience also exacerbates the provider competency issue in private facilities.

Conclusions and Recommendations

Based on the findings presented in the previous section, the SHOPS Plus team identified several opportunities for strengthening access to and use of modern FP methods through the private sector. These opportunities are discussed in further detail in this section.

Summary of Findings

Contraceptive commodity supply

The private sector in Côte d'Ivoire plays a large role in providing contraceptive products through pharmacies, depots, private clinics, and social-marketing distribution channels. The supply chain infrastructure for these products is fairly robust, with four major wholesalers, over 800 private pharmacies, two active social marketing organizations (AIMAS and DKT), and the presence of commercial manufacturers of hormonal contraceptives. As with most other pharmaceutical products, contraceptives are imported and subject to a fairly strict pricing and marketing environment.

With the exception of condoms, inexpensive socially-marketed products dominate the contraceptive market, with shares as high as 90-100 percent. In the OCP, EC, and condom markets, however, there is a wide range of product formulations, brands, and price points available. The EC and condom markets show relatively high levels of use of more expensive commercial brands, indicating that some clients are willing to pay for higher-priced products. There is limited supply of injectable contraceptives and IUDs, and no supply of implants in commercial pharmacies, therefore the products used in facilities are mostly donated or subsidized. While contraceptive security is the weakest for implants, four newly launched DKT IUD brands are likely to bolster the offer of long-acting methods through the private sector.

Key challenges with respect to FP product supply include a high degree of market subsidization, strict regulations that prevent social marketing organizations from increasing their prices and commercial suppliers form advertising their products; and a lack of data or information about the users of EC products.

Service delivery

The main service providers in the private sector are the AIBEF clinics, and facilities affiliated with AIBEF or donor supported networks. Independent facilities not affiliated to a network or FP program follow a different service delivery model than public and NGO facilities and are more likely to hire specialists that can increase their profitability than have lower-level providers delivery FP counseling and methods.

Key challenges with respect to FP service delivery include a relatively high dependency on donor support for NGO-provided services, and difficulties in making FP service delivery fit the private sector model of service delivery. Unaffiliated facilities are hampered in their ability to offer a full method mix or the one-stop-shop found in public and NGO facilities. These facilities may also have difficulty hiring trained specialists and securing a source of implants for their clients. The lack of insurance coverage for FP services is especially problematic for methods than fetch high prices, such as the IUD, resulting in the unnecessary referral of patients to a public or NGO facility.

Recommendations

Foster improved contraceptive security

Contraceptive supply in Côte d'Ivoire does not appear threatened at the present time. The dominance of donated and subsidized brands in the private sector however is concerning. Should UNFPA donations be considerably reduced in the future, the burden of supporting subsidized programs would likely fall on the government. Social marketing programs will have no choice but to improve their cost recovery by increasing prices or segmenting their portfolio, which is only be possible if price controls are loosened. SHOPS Plus recommends advocating with the DPML to allow social marketing brands to be sold at a higher prices, and commercial manufacturers to advertise their own brands.

The private sector can also help increase and sustain access to implants through private clinics. Implant manufacturers, however, have been reluctant to change their policy of restricting implant distribution to government and NGO channels in developing countries. Therefore, at the moment, the only way to make these products more widely available in the private sector is to allow clinics to buy them from public and NGO channels. Private clinics, however, should purchase implants at a cost recovery price (above $8.50, the current replacement cost for donors and governments) to avoid further increasing the burden of the public sector.

Expand the availability of *Sayana Press* in the private sector

The roll-out of *Sayana Press*, a sub-cutaneous injectable contraceptive, presents a unique opportunity to increase mCPR by leveraging the private sector. AIBEF clinics already offer *Sayana Press* through self-injection. UNFPA and the MSHP are conducting a two-year pilot in three districts to assess, among other things, whether self-injection may be feasible and acceptable, at scale. In Senegal, studies have shown that self-injection is both feasible and acceptable to clients and that clinic-based providers and community agents preferred it over intramuscular administration of DMPA (Burke 2014, Cover 2017). The practice of supplying clients with a supply of Sayana Press at AIBEF clinics for future use is helping increase the acceptability of self-injection. SHOPS Plus recommends expanding the distribution of *Sayana Press* commercially through private providers in the short term, and through commercial pharmacies with a doctor's prescription in the long term.

Enable more for-profit facilities to provide FP services

For-profit facilities constitute an important and growing sector that can and should play a much bigger role in delivering FP services. Private policlinics in particular, serve people with insurance in urban areas and are likely to be contracted under UHC when and if this mechanism is in place and fully funded. Thus in the long term, it is critical to insure that for-profit facilities have an incentive to provide these much needed services. Failure to do this implies that people who are privately insured or have the ability to pay out of pocket will continue to use publicly funded services and products. It may also be contributing to low contraceptive prevalence because private sector users lack quality counseling and/or access to certain methods through their preferred provider.

The one-stop-shop model used in public and NGO facilities that enables women to obtain counseling and a method in a single visit is not easily replicable in the for-profit sector. DHS data show that a large proportion of users obtain their method from a pharmacy, suggesting that writing prescriptions for FP methods should not be a significant deterrent, at least where

pharmacies are easily accessible. Private sector clients are accustomed to this practice for all other health services and every effort should be made to work within existing private sector systems when adding new services. On the other hand, some methods are currently unavailable in private facilities because of the lack of trained providers and/or difficulties in obtaining implants. A flexible approach would address the specific needs of providers rather than impose a one-size fits-all model.

Support public/private dialogue and collaboration

The DPML officially regulates much of the contraceptive market but does not have the resources to monitor or enforce its policies. Facilitating a channel for dialogue between supply chain actors and the DPML may help both parties achieve key successes. In the area of services, private facilities that serve low-income populations have trouble remaining profitable because their clients are not insured and have low ability to pay. These facilities have a service delivery model based on high volume, low fees, task sharing and a reduced reliance on specialists that makes them natural partners of the public sector. Creating better linkages and contracting mechanisms between MOH facilities (reference hospitals or health centers) and providers serving vulnerable populations should be a key priority.

Support insurance coverage for family planning

Consultations with a specialist (such as a gynecologist) and the provision of certain FP methods (injectables, implants, IUDs) are potentially attractive services, especially if demand increases in the near future. As a result, there is an opportunity for private facilities to offer services that will help increase their income. Because for-profit facilities are more likely to serve clients covered by private health insurance, it makes more sense to advocate for expanded coverage for FP than to subsidize products and services, or refer private clients to the public sector. This is especially true for implants and IUDs, two methods that can substantially contribute to increasing the mCPR, yet are in short supply in Côte d'Ivoire.

The PNSME is currently working on a strategy to leverage private financing from employers. A highly sustainable approach to include in this strategy is for these companies to purchase insurance coverage for FP services. For example, incorporating post-partum IUD insertions into the maternal/delivery care packages, coupled with counseling, is an effective and sustainable way to increase FP service-provision. At the other end of the spectrum, facilities located in areas where clients are less likely to be insured or even employed. These facilities should be contracted under the National Health Insurance Fund, and their clients eligible for coverage under the indigent fund.

Conduct market research

SHOPS Plus recommends conducting market research in two areas to better understand and shape the offer of and demand for contraceptive products in the private sector. The first market area that should be explored is the demographics and reproductive intentions of users of EC. EC use is increasing and it is important to understand who is using it, why, and in what context. DHS does not collect this information and EC users may be better served if the market has a better understanding of this population segment. A second market area that warrants exploration is the capacity and willingness to pay among users of short-acting methods. There is some indication that users can and will pay for more expensive brands. It is therefore important to better understand how to target programs and products to populations in different income

segments so that the limited resources available are effectively targeting populations that would otherwise be unable to afford contraception.

Another opportunity for research lies in the phasing out of the FP component of the PSHP provider network. When providers no longer receive technical support and commodities through their network affiliation, will they continue to provide FP services? Will they permanently adopt the practice of employing midwives as FP providers? A short survey of these providers after the program ends can shed light on their motivations, and help develop tailored approaches to working with the for-profit sector.

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