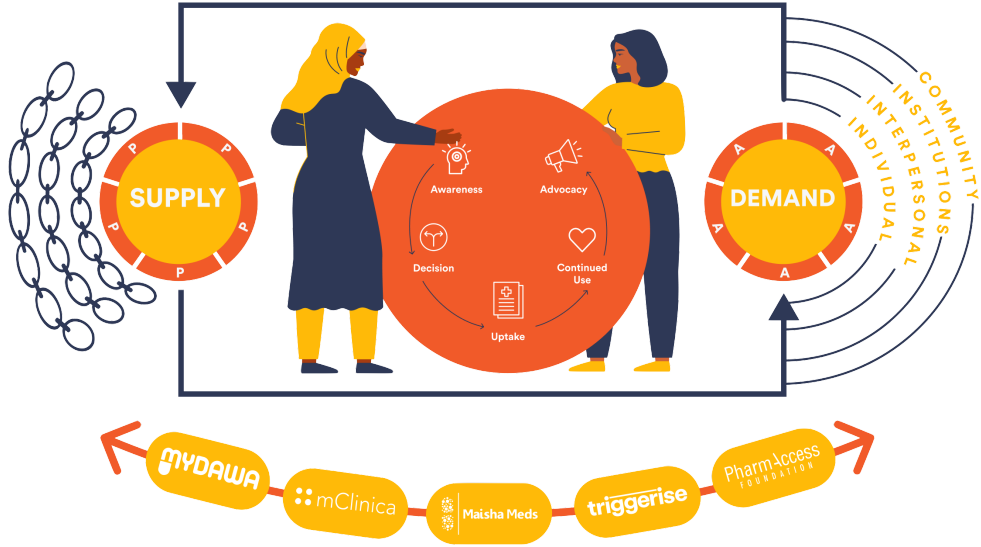
Ipas

POPULATION COUNCIL
Ideas. Evidence. Impact.

IMPACT FOR HEALTH

PMAC KENYA MSDP REPORT: KEY FRAMEWORKS & MILESTONES

November 17th, 2022



Contents of This Document

1. Keystone and Overview of MSDP
2. Vision of Success: Target Consumer Segments
3. Sustainability Analysis Framework: Who Does, Who Pays?
4. PMAC Kenya Theory of Change
5. PMAC Kenya Learning Agenda

Keystone

We've adapted the Population Services International (PSI) Keystone design framework for use within our strategy design process. Keystone was chosen for its particular approach that marries human-centered design with market systems development in one strategy design process. It is also well-resourced in terms of guidance.

In adapting Keystone we commit to sharing our learnings, both on content and process, with PSI and the wider community of practice.

KEYSTONE

Overview of the Keystone MSDP Process

SET STRATEGY → **BUILD INTERVENTION**

Diagnose

Diagnose Insights Synthesis Deck (Final, Aug 22 2022)

- Define Health Need
- Identify target consumers & segments
- Assess market performance and structure
- Identify high-impact constraints

Decide

Decide Workshop (Aug 25 2022)

- Agree on vision of success
- Build framework for sustainability
- Decide strategic priorities
- Develop intervention objectives
- Cross-walk prototypes with intervention objectives & strategic priorities

Design

Designing for Alignment Workshop (Sept 19 2022)

- Adapt existing prototypes and/or design new prototypes based on Decide workshop

Deliver

Deliver Workshop (Oct 26 2022)

- Identify implementation, learning and adaptation milestones for interventions, as well as roles and responsibilities
- Transition point from IHI (design facilitators using MSDP) to Ipas (implementation plan) and PopCouncil (Learning and Adaptation Plan)

PRIMARY OUTPUT:

DIAGNOSE INSIGHTS SYNTHESIS DECK	UPDATED THEORY OF CHANGE	NEW INTERVENTION DESCRIPTIONS	INTERVENTION MILESTONES AND R&R

LEARN & SHARE

MSDP Report

Vision of Success

Target Consumer Segments

OVERALL VISION OF SUCCESS

GOAL (from the existing Theory of Change) — *Improved health outcomes through the reduction of unintended pregnancy and the associated maternal morbidity and mortality.*

Primary Outcome (comprised of a target audience and consumer behavior) — *Informed decision-making among young unmarried women and married adult women, leading to correct and consistent use of affordable contraceptives and subsequent peer referrals.*

Primary Audience

Njeri, the Young Woman

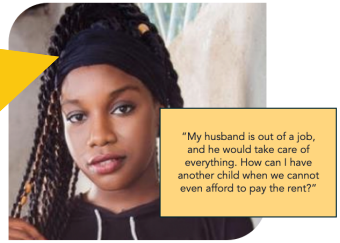
Age: 20-24 years

Size of segment: 2,334,778
(2019 Census) 20-24 years
Key Influencers: college activations, peers, boyfriend/sponsor , social media.
Opportunity to reach: social media, peers, sponsor, boyfriend, digital platforms

- **Larger population sizes**
- **More financially stable to make use of the demand generated**
- **Higher acceptance of contraceptives**

Mama Joni, the Prudent Mother

The Adult
Age: 30



Size of segment: 7,160,459
(2019 Census) 25-49 years
Key Influencers: chama, CHVs, husband, social media , mass media
Opportunity to reach: social media, digital platforms, husband, CHV, Chama

We are still reaching adolescent girls as a secondary audience: one way is adolescent girls value 'big sis' advice so effects will trickle down therefore larger influence.

Sustainability Analysis Framework

Who Does Who Pays?

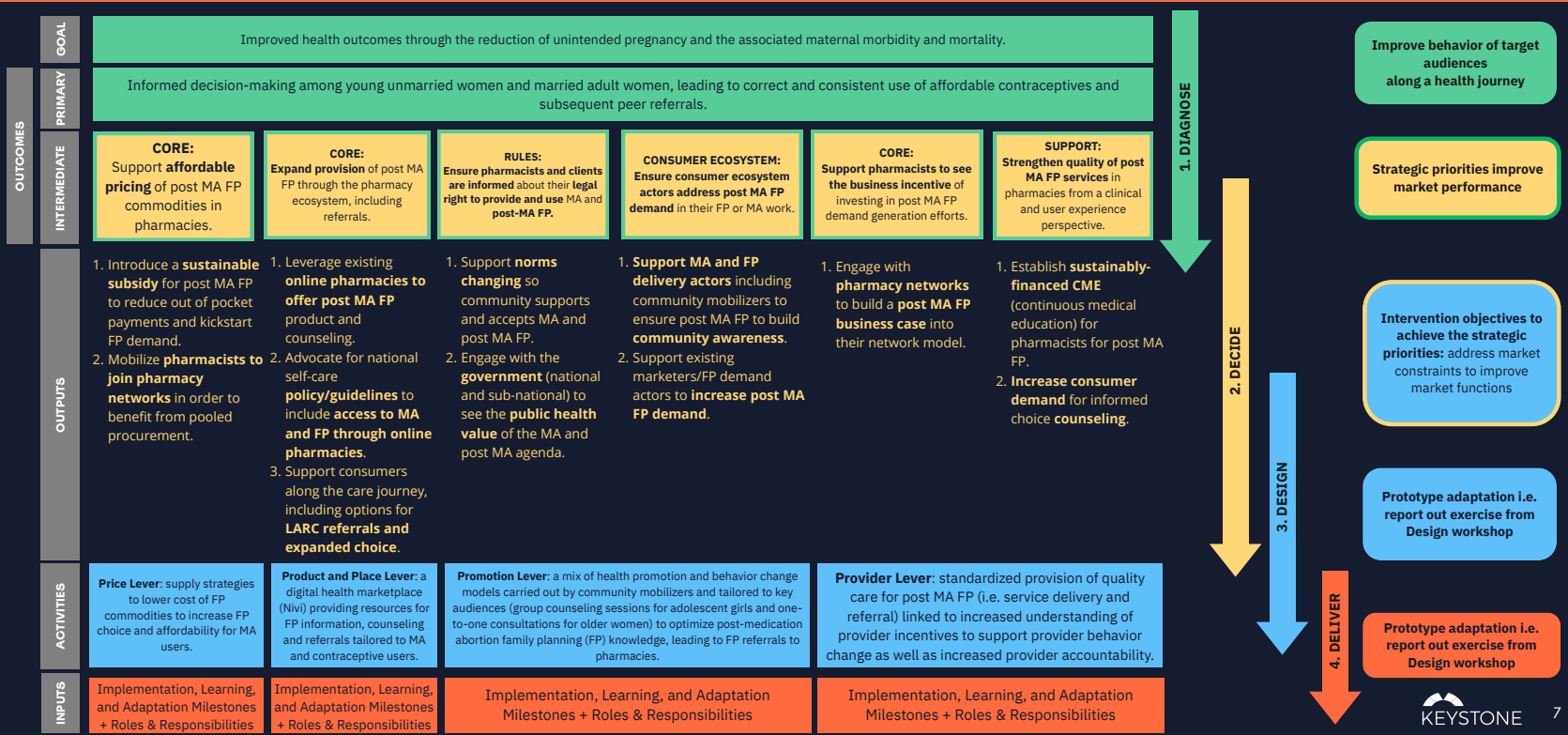
GOAL (5-10 years): Improved health outcomes through the reduction of unintended pregnancy and the associated maternal morbidity and mortality.

6 constraints initially prioritized by PMAC team through Stargazer Activity (18 Aug)

	Current Constraints	Who Does now?	Who Pays now?	Vision of the function in 5 years	Who Does in 5 years?	Who Pays in 5 years?
CORE	High and inconsistent cost of post MA FP in pharmacies	mPharma, Maisha Meds, triggerise, m-tiba	Out of pocket payments, donor funding, county governments	Price is affordable to all.	Current and supply chain partners, pharmacists, pharmacy networks, triggerise (incentives), m-tiba, Maisha Meds, Shelf Life.	Same payers
CORE	Limited availability of post MA FP through pharmacy channels	Online e.g. mydawa, Kasha, Jumia, Good Life	Out of pocket payments, donor funding	Multiple channels to give people the care they need.	Online platforms, pharmacists, peer educators, community mobilizers.	Same players (and payers)
CORE	Limited incentive for pharmacists to build post MA FP demand	Missing beyond PMAC project	Missing	Pharmacists understand the business incentive for post MA FP and are actively involved in generating demand.	Nivi and other consumer-facing marketplaces can serve as the marketing channel for pharmacies.	Make the franchise model self-sustaining by helping pharmacists buy into this model using existing platforms and pay at an affordable price.
SUPPORT	Poor quality of post MA FP in pharmacies	Inadequate: SMOs (DKT, MSK), CBOs	Inadequate: SMOs, CBOs	Clients leave pharmacies empowered and speak positively about the services provided (MA + FP) - equipped to address any side effects of the FP method.	OJT. Attach CPD points to training. Distributors like DKT/MSI to take responsibility for trainings. Training partners: Pharmaceutical Society of Kenya, MoH (Division of RH).	Clients pay (at an affordable rate), NHIF (unlikely!), pharmacists pay for training. Include training cost in commodity price?
RULES	Unclear legality of MA creates hesitancy to provide or use post MA FP uptake	Missing beyond PMAC project	Missing	Pharmacies, clients, and communities know their rights to provide/access MA and FP.	Government (partner on the MA + FP agenda) + pharmacists, clients and communities know their rights	CSOs? Professional associations like RHNK (membership fee includes legal representation), social franchises, pharmacy networks.
CONSUMER ECOSYSTEM	Limited community awareness around need for and availability of post MA FP	Inadequate: SMOs (DKT, MSK), CBOs	Inadequate: SMOs, CBOs	MA users are fully aware of the need for FP, the options available in the market and where to access them.	Both the public and development sectors have a role in improving awareness.	All sectors have a role, using every opportunity of contact with potential users to create awareness.

PMAC Kenya Theory of Change

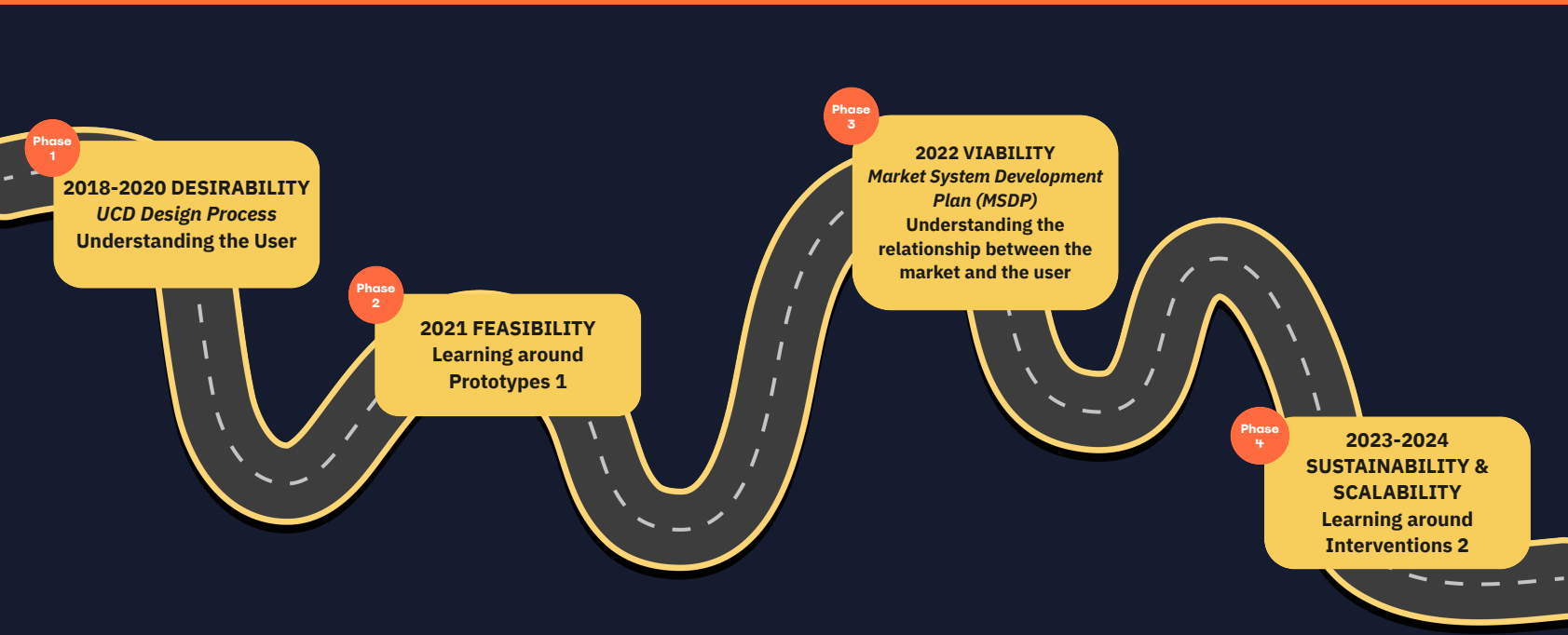
November 2022



KEYSTONE

PMAC Kenya Learning Journey: 2018-2024

Four phases of learning and adaptation around the user and the market



During each phase, best practices for learning agenda setting were followed:

Gather stakeholders & identify relevant areas

Curate existing research

Formulate & prioritize questions

Develop a plan to address questions

PMAC Kenya Learning Agenda Journey: Key Outputs

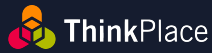
	WHAT Methods	SO WHAT Key Findings	NOW WHAT Recommendations
PHASE 1 User Centered Design Report (ThinkPlace, 2022)	**April 2018 - Nov 2020** Africa Population Health Research and ThinkPlace conducted formative and UCD research respectively. The UCD research included empathy sessions with girls and women, immersive qualitative research, five ideation sessions and three testing sprints.	**24 concepts** progressed through three testing sprints, resulting in **3 prototypes** for implementation. 1. **Peer support sessions:** Community mobilizer-led one-on-one and group counseling sessions and referrals for post-MA contraceptive. 2. **Discount Code:** mobile-based intervention accessible through both feature and smartphones for MA users to claim a discount (Ksh 50/=) upon return to pharmacy after MA. 3. **Nurse Nisa & Aunty Jane:** A combination of chat-bot and toll-free line where women and girls can receive personalized contraceptive counseling, then linked to nearest service providers for uptake and continuation.	Pilot test the **3 prototypes** in Nakuru county.
PHASE 2 PMAC Project Kenya Intervention Pilot Report (Ipas 2021)	**July - October 2021** Ipas led one co-creation workshop with providers (Jan 2021) to identify additional opportunities for iteration of the prototypes and incentive systems to maximize potential for viability and scalability. Ipas pilot tested three prototypes with 23 pharmacists and 400 women and girls across six sub-counties of Nakuru County, Kenya between July - October 2021.	Mixed methods research indicated that: 1. **Peer support sessions:** were more popular among younger women, while adult women preferred one-on-one telephone counseling due to time constraints. 2. **Discount Code:** resulted in increased post-MA contraceptive uptake, both at point of purchase and 30-day follow-up. However, some women did not feel empowered and thus did not make use of the discount. 3. **Nurse Nisa & Aunty Jane:** utilization for Nurse Nisa was relatively low, due in part to poor promotion by pharmacists, preference by some to discuss their needs in person, lack of smartphone access, and privacy concerns with an online platform. Participants felt that Aunty Jane hotline operators were not relatable as it was based in Nairobi.	**Revise prototypes** in the context of a clearer understanding of the **market system** to ensure sustainability and scalability.
PHASE 3 MSDP Final Report (IHI, 2022)	**June - Nov 2022** Impact for Health International (IHI) and Ipas co-created a Market Systems Development Plan (MSDP) to situate and adapt the prototypes in the context of a clearer understanding of the market system to ensure sustainability and scalability of the interventions. The MSDP was conducted in 4 phases: **Diagnose:** the health problem within the market system **Decide:** how best to intervene in the market **Design:** and adapt sustainable and scalable interventions **Deliver:** interventions through learning and adaptation	The MSDP resulted in three adapted interventions, and one new one: 1. **Promotion Lever:** This intervention will be **interrogated** on its efficiency and sustainability. It changed from one-on-one and group counselling to differentiated education models tailored to key audiences (group counseling sessions for adolescent girls and one-to-one consultations for older women) to optimize post-medication abortion family planning (FP) knowledge, leading to FP referrals to pharmacies. 2. **Price Lever:** The intervention **evolved** from a narrow consumer subsidy to a three-pronged supply side strategy (free seed stock from Ipas, credit access and capacity building by ShelfLife, free product provision by MOH) to broaden FP options in the market and increase FP demand through reduced prices for users and greater profit margins for pharmacists. 3. **Product & Place Lever:** The intervention **evolved** from a limited digital counsellor to a digital health marketplace (Nivi) providing high-quality resources for FP information, counseling and referrals to service providers tailored to MA users. 4. **Provider Lever:** Although pharmacists were oriented to post MA FP, these providers were not a focus of the PMAC project as a separate intervention The **new** provider intervention is standardized provision of quality care for post MA FP (i.e. service delivery and referral) linked to increased understanding of provider incentives.	**Implement adapted interventions** with learning/feedback loops to inform further adaptation
PHASE 4 PMAC Learning & Adaptation Plan (PopCouncil, 2023)	**Jan 2023- June 2024:** Population Council will define a learning and adaptation plan with periodic pause and reflect moments, co design, and iteration sessions. The plan will triangulate qualitative and quantitative data for decision making, and will include long-term learning questions (uptake and continuation) and short-term learning questions more proximal to the interventions themselves.	TBD!	TBD!

THANK YOU!


Ipas


POPULATION
COUNCIL
Ideas. Evidence. Impact.


IMPACT
FOR
HEALTH


ThinkPlace


Gf