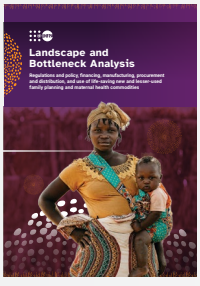
Landscape and Bottleneck Analysis

Regulations and policy, financing, manufacturing, procurement and distribution, and use of life-saving new and lesser-used family planning and maternal health commodities

EXECUTIVE SUMMARY

Table of Contents

Bibliography
(To view, kindly scan the QR below)



The full Landscape and Bottleneck Analysis - Regulations and policy, financing, manufacturing, procurement and distribution, and use of life-saving new and lesser-used family planning and maternal health commodities Report is available on the UNFPA's Website: https://esaro.unfpa.org/en/publications/landscape-bottleneck-analysis-regulations-and-policy-financing-manufacturing

Acronyms

Acronym	Full term, title, organization name, or initiative
AfCFTA	African Continental Free Trade Agreement
AMA	African Medicines Agency
AMRH	African Medicines Regulatory Harmonization
API	Active pharmaceutical ingredient
AUDA-NEPAD	African Union Development Agency-New Partnership for Africa's Development
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CHW	Community health worker
DMPA-SC	Subcutaneous depot medroxyprogesterone acetate
eLMIS	Electronic Logistics Management Information System
EML	Essential Medicines List
FCDO	Foreign, Commonwealth & Development Office
GMP	Good Manufacturing Practices
HSC	Heat-stable carbetocin
LNG-IUS	Levonorgestrel-releasing intrauterine system
MMR	Maternal mortality rate
MISO	Misoprostol
MSD	Merck Sharp & Dohme
NLUM	New and lesser-used medicines
NMRA	National Medicines Regulatory Authority
PPH	Postpartum hemorrhage
RHSC	Reproductive Health Supplies Coalition
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SRHR	Sexual and reproductive health and rights
TXA	Tranexamic acid
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

BACKGROUND

Sub-Saharan Africa faces a staggering and persistent burden of maternal mortality, accounting for 70 per cent of all maternal deaths worldwide in 2023. With an MMR of 454 deaths per 100,000 live births—more than seven times the global average—women in the region continue to face preventable risks during childbirth. Postpartum hemorrhage (PPH) remains the leading cause, responsible for over a quarter of maternal deaths in Africa.

Globally, approximately 260,000 women died from pregnancy-related causes in 2023, the vast majority in low-resource settings where access to timely, quality care is limited. Although maternal deaths have decreased by 40 per cent since 2000, this progress has stalled and reaching the SDG 3.1 target of fewer than 70 maternal deaths per 100,000 live births by 2030 is increasingly out of reach without renewed commitment and innovation. Encouragingly, sub-Saharan Africa has made important strides: between 2016 and 2023, the proportion of deaths among women of reproductive age due to maternal causes declined from 19.8 per cent to 16.9 per cent, and the region's overall MMR dropped by 22.2 per cent. Yet the scale of the challenge remains immense—and the cost of inaction is measured in lives lost.[1]

Early and unintended pregnancies significantly increase the risk of maternal and child complications, including unsafe abortions; this can be avoided with modern contraceptives. In 2022, 77.5 per cent of women of reproductive age (15 to 49 years) globally had their need for family planning met with modern methods (SDG indicator 3.7.1), marking a 10-percentage-point increase from 67 per cent in 1990. That still leaves 164 million women with unmet need (meaning they wish to avoid pregnancy for the time being but are not using any method of contraception).

Family planning and maternal health commodities are critical for improving access to sexual and reproductive health services and rights. These commodities directly address maternal mortality and reproductive health and equitable access to health care. The following six new and lesser-used life-saving commodities will be the focus of this report, **levonorgestrel-releasing intrauterine systems (LNG-IUS), Subcutaneous depot medroxyprogesterone acetate (DMPA-SC), tranexamic acid (TXA), heat-stable carbetocin (HSC), Misoprostol (MISO),** and the **combi-pack of Misoprostol plus Mifepristone (Combi-Pack)** (see Table 1). Despite their transformative promise, systemic challenges in regulation, financing, manufacturing, procurement and service delivery prevent widespread adoption and scale-up.

Table 1. Six Key New and Lesser-Used Family Planning and Maternal Health Life-Saving Commodities in Postpartum Haemorrhage Prevention and Management.

Product	Overview
REPRODUCTIVE HEALTH COMMODITIES:	
Levonorgestrel-releasing intrauterine systems (LNG-IUS) (implant)	Long-acting reversible contraceptive that releases levonorgestrel in the uterus.
Subcutaneous depot medroxyprogesterone acetate (DMPA-SC)	Long-acting, injectable contraceptive releasing medroxyprogesterone acetate.
MATERNAL HEALTH COMMODITIES:	
Tranexamic acid (TXA)	Medication that reduces bleeding by stabilizing blood clots.
Heat-stable carbetocin (HSC)	Uterotonic similar to oxytocin but is heat stable; induces uterine contractions.
Misoprostol (MISO)	Prostaglandin analog used for PPH prevention/treatment, labour induction (uterotonic), and abortion.
Combi-pack of Misoprostol plus Mifepristone (Combi-Pack)	Combination for medical abortion, with Mifepristone blocking progesterone and Misoprostol inducing contractions.

Overview of six family planning and maternal health life-saving commodities relevant to postpartum haemorrhage prevention and management.[59, 60, 61]

Study scope and methodology

This Executive Summary is based on a Landscape and Bottleneck Analysis, which examined the barriers and opportunities for scaling the six family planning and maternal health new and lesser-used life-saving commodities across sub-Saharan Africa. A comprehensive literature review (peer-reviewed publications, grey literature and documents provided by stakeholders) and extensive stakeholder consultations informed the findings, synthesizing insights from global organizations, regional bodies and local experts. The analysis focused on regulatory frameworks, financing models, manufacturing capabilities, procurement processes and service delivery systems to identify bottlenecks and actionable ways of addressing them to improve maternal health outcomes.

Regulations and Policy

A robust regulatory framework is crucial for ensuring access to quality family planning and maternal health commodities. The African Medicines Regulatory Harmonization (AMRH) Platform and the African Medicines Agency (AMA) streamline regulatory processes. Despite progress, challenges include outdated Essential Medicines Lists (EMLs) and limited capacity of National Medicines Regulatory Authorities (NMRAs). Misalignment with World Health Organization (WHO) guidelines delays the adoption of innovations, like HSC and TXA. Strengthening NMRA capacity and harmonizing regulations across regions remain priorities.

Fragmented national regulatory systems contribute to delays and inefficiencies. Inconsistent registration processes and limited inter-agency coordination hinder the timely introduction of new commodities. Regional harmonization efforts, such as ZaZiBoNa within the Southern African Development Community (SADC) have reduced approval timelines but require broader adoption to achieve widespread impact.

Quality assurance remains a significant barrier. Adherence to WHO Prequalification and Good Manufacturing Practices (GMP) is limited among regional manufacturers. Capacity-building initiatives and technical assistance are essential to address these gaps and ensure the safety and efficacy of family planning and maternal health commodities.

Though TXA, HSC, MISO and Combi-Pack are all on the WHO EML, LNG-IUS and DMPA-SC are not, and the regulatory status and availability of the six new and lesser-used commodities by country is less clear. WHO added HSC and Combi-Pack to the EML in 2019, but its regulatory approval at the country level varies greatly. HSC is currently approved in 22 countries in sub-Saharan Africa and is at various stages of approval in other countries. A 2022 review of nine countries (Burkina Faso, Democratic Republic of the Congo, Ethiopia, Ghana, Liberia, Rwanda, Sierra Leone, South Sudan, Uganda) found that HSC and TXA was included in most country's EMLs (6/9 HSC and 7/9 TXA), though HSC was registered for PPH prevention in only 5 countries and TXA was registered for treatment of PPH in only two countries.[2]

As for other commodities, it seems that either both MISO and Combi-Pack or one of them is available in most countries, but other countries lack official data (such as Kenya and Eritrea).[3, 4]

A good example of why it is challenging to precisely determine the regulatory approval and availability status of each commodity can be seen clearly in DMPA-SC. This commodity has been approved and introduced in several sub-Saharan African countries, but by different regulatory agencies. In Ethiopia, the Ethiopian Food and Drug Administration approved DMPA-SC, with implementation research in 2021 demonstrating its high acceptability, leading to plans for phased nationwide introduction.[5] Malawi introduced DMPA-SC self-injection into its family planning programme in 2018, with a national rollout approved by 2020, making it a pioneer in sub-Saharan Africa.[6] Nigeria integrated DMPA-SC into its national family planning programme, focusing on policy, distribution and training to facilitate self-injection and private sector engagement.[7] Senegal and Uganda piloted DMPA-SC, showing high client and provider satisfaction, which supported scaling up availability.[8] These efforts highlight growing regulatory approval and adoption of DMPA-SC to improve reproductive health services across the region.

Key takeaways and next steps

Adopt updated WHO guidelines at the country level (ensure provision of technical support to do so, according to context) for maternal health commodities to accelerate regulatory alignment.

Enhance NMRA capacity through targeted training and resource allocation.

Promote regional regulatory harmonization via platforms like AMRH and AMA.

Financing

Sustainable financing is pivotal for the availability of family planning and maternal health commodities. Innovative mechanisms, such as the United Nations Population Fund (UNFPA) Match Fund, can reduce donor dependency by incentivizing domestic investment. However, fragmented procurement systems and high operational costs undermine efforts. Programmes like the Implant Access Program and pooled procurement initiatives under the African Continental Free Trade Agreement (AfCFTA) demonstrate cost-saving potential but require expansion.

Donor reliance creates vulnerabilities in commodity availability. While international funding supports procurement, it often lacks sustainability. Encouraging domestic investments and public-private partnerships can address funding gaps and ensure consistent supply.

Value-based procurement can optimize resource allocation. Procurers must balance cost efficiency with quality assurance to minimize the prevalence of substandard commodities. Training programmes for procurement officials can enhance decision-making processes.

Many countries in sub-Saharan Africa rely heavily on donor funding for maternal health and family planning services and commodities and UNFPA's Match Fund are starting to include maternal health drugs, leading to vulnerabilities when donor priorities shift. That said, the UNFPA Supplies Partnership is working to strengthen government commitments through a mechanism called Compacts. Compacts are agreements signed by ministries of health and finance to promote sustainable financing for family planning and maternal health. These agreements commit governments to gradually increase their domestic budget allocations for contraceptives and maternal health medicines. As of 2023, all 44 eligible countries have signed Compacts, marking a historic milestone as the first time so many governments have formally pledged domestic financing for reproductive health commodities.[9]

High transportation costs, import tariffs and logistical expenses make it challenging to maintain an affordable and steady supply of maternal health and family planning products, especially in remote or landlocked countries. Countries without robust domestic manufacturing capabilities depend on imported products, which suffer from fluctuating prices and inconsistent availability due to logistical constraints.

Fragmented procurement in decentralized systems present some challenges; in countries with decentralized procurement practices, such as Nigeria and Kenya, regional variations in pricing and supply often arise, causing disparities in access to essential health commodities. States independently procure products, sometimes resulting in quality inconsistencies and stockouts. This decentralized model complicates efforts to achieve consistent national-level access to quality maternal health and family planning services.

Promising finance-focused initiatives – public-private partnerships and task shifting:

- **Amref Health Africa's Big Bet Initiative:** In Kenya, Amref Health Africa collaborates with private partners like Safaricom's M-PSSA Foundation to finance the 'Big Bet' initiative, aimed at reducing maternal mortality by addressing funding gaps in high-priority regions. This partnership demonstrates the value of private-sector engagement in expanding maternal health programmes and provides a model for similar initiatives in other African nations.[10]

Policies and programmes supporting sustainable financing:

- **The UNFPA Match Fund:** The fund incentivizes governments to invest in their maternal health and family planning commodities by matching government contributions with donor funds. This approach aims to reduce donor dependency and promote domestic resource allocation for family planning and maternal health commodities by aligning donor support with domestic resources.

- **AMA, the Africa Centres for Disease Control and Prevention (Africa CDC) and Regional Procurement Initiatives:** AMA and Africa CDC play complementary roles in advancing sustainable financing for health in Africa. AMA, a specialized African Union agency supported by WHO and UNFPA, focuses on regulatory harmonization to ensure access to quality-assured health products. It builds on initiatives like AMRH to streamline regional systems under frameworks, such as AfCFTA, creating a foundation for pooled procurement. Meanwhile, Africa CDC actively develops and manages these regional procurement systems, leveraging pooled purchasing power to reduce costs and improve access to health commodities, particularly in East Africa. By addressing logistical inefficiencies and enhancing self-sufficiency, these initiatives mitigate the impact of international supply chain disruptions while strengthening the continent's health financing sustainability.[11, 12, 13, 14]

- **Market shaping collaborations:** The Clinton Health Access Initiative (CHAI) has partnered with the Gates Foundation to negotiate price reductions for maternal health and family planning commodities, notably implants, in African countries like Nigeria, Kenya, Uganda and the Democratic Republic of Congo.

This market-shaping strategy includes introducing new suppliers, reducing costs through price guarantees and facilitating domestic manufacturing. By lowering costs and diversifying suppliers, this initiative ensures long-term affordability and accessibility for family planning and maternal health commodities across multiple countries.[15] Ferring Pharmaceuticals also signed an access pricing agreement to manufacture HSC for the public and not-for-profit markets.[16]

- **Catalytic Opportunity Fund for Introduction and Scale-Up of New and Lesser-Used Postpartum Hemorrhage Medicines (NLUM-PPH):** The Reproductive Health Supplies Coalition (RHSC) Maternal Health Caucus launched a small-grants initiative in 2023 to improve access to NLUM-PPH, including HSC for prevention and TXA for treatment. This initiative is supported by the Catalytic Opportunity Fund, which finances government-supported preparatory activities aimed at enhancing the introduction and expansion of these medicines in low- and lower-middle-income countries.[17]

Key takeaways and next steps

Expand pooled procurement initiatives to leverage economies of scale and reduce costs.

Develop innovative financing models to promote domestic investment in family planning and maternal health commodities.

Strengthen capacity for value-based procurement to prioritize high-quality commodities.

Manufacturing

Efforts to manufacture family planning and maternal health commodities in Africa are limited in scale, with most of the continent's pharmaceutical products still imported. Over 70 per cent of all medicines are sourced from outside Africa, particularly Asia, making local manufacturing a strategic focus for organizations like Africa CDC, the African Union Development Agency-New Partnership for Africa's Development (AUDA-NEPAD) and Unitaid.[18, 19] On the African continent, Emzor (Nigeria) is the only manufacturer of MISO. TXA is only produced by Tasa Pharma in Kenya (it was also produced by another manufacturer in South Africa but was discontinued due to loss of a tender). There are no producers of HSC in Africa,[20] and there are also no local producers of LNG-IUS or DMPA-SC.

Adhering to WHO Prequalification and GMP remain major barriers, particularly for smaller manufacturers who face high costs, stringent requirements and high demands on administrative staff capacity/availability. GMP emphasizes personnel capacity, quality of active pharmaceutical ingredients and other aspects of hygiene and environmental conditions to produce quality medicines.[21] WHO Prequalification, initially launched in the late 1980s, assesses the safety, quality and efficacy of health products, particularly for lower to middle-income countries, to guide procurement decisions by international, regional and national agencies.

This programme is part of a broader regulatory network involving developers, manufacturers, regulatory agencies and WHO entities that issue guidelines to support global health product access. The steps for the prequalification process outline the coordinated actions taken by these actors to facilitate access to essential health products in low-resource settings.[22]

Achieving GMP certification is a critical milestone. Many African manufacturers struggle with the high costs and technical requirements associated with GMP compliance. Strengthening regulatory support and providing financial incentives can facilitate this process. **Collaborative efforts within** the Reproductive Health Supplies Coalition (RHSC), including WHO, UNFPA, PATH, Johns Hopkins Center for Communication Programs, Marie Stopes International, the Concept Foundation and global stakeholders have played a pivotal role in advancing the development, procurement and quality assurance of family planning and maternal health life-saving commodities through the establishment of essential guidelines and targeted initiatives for GMP. RHSC and its partners played a key role in developing the Interagency List of Essential Medicines for Reproductive Health (2006),[23] the WHO Model List of Essential Medicines and the Essential Medicines for Reproductive Health: Guiding Principles for Their Inclusion on National Medicines Lists.[24] These efforts and collaborative partners are key to setting quality standards relevant to life-saving commodities.[25]

Key takeaways and next steps

Support local production by addressing scalability challenges and facilitating GMP certification.

Invest in technology transfer programmes to build regional manufacturing capacity.

Enhance regional collaboration through initiatives like AMRH to improve resource sharing.

Procurement and Distribution

Medicine procurement in Africa is centralized and driven by public-sector systems. National procurement agencies or central medical stores oversee purchasing and distribution for public health systems, including family planning and maternal health life-saving commodities. Demand forecasts based on historical data determine procurement quantities, underscoring the importance of accurate data for supply-demand alignment.

Procurement processes are slow and constrained by technical and systemic inefficiencies. Lengthy tendering processes and limited technical capacity often delay procurement. In South Africa, for instance, a centralized system guided by the national EML faces challenges, such as supplier delays and outdated inventory systems, which undermine efficiency.

Weak infrastructure and fragmented logistics hinder equitable distribution of medicines. After procurement, medicines move from central warehouses to regional and district stores before reaching health facilities. However, poor infrastructure, inadequate forecasting and fragmented systems frequently lead to stockouts, particularly in rural areas. Private-sector supply chains, operating under different standards, may secure distinct commodities.

These systemic barriers complicate the adoption of innovative products like TXA and HSC, which require additional regulatory and logistical steps.

Efficient systems are crucial for consistent access to commodities. Centralized procurement faces inefficiencies, such as delayed tenders and fragmented logistics. Innovative models like the Informed Push Supply Chain in Senegal and pooled procurement frameworks under AfCFTA reduce stockouts and improve access.

Logistical challenges undermine supply chain efficiency. Poor infrastructure, inadequate inventory management and fragmented distribution networks create barriers to timely delivery of commodities. Electronic Logistics Management Information Systems (eLMIS) offer solutions, but require broader implementation.

Key challenges:

- **Procurement delays are common due to inefficiencies in tendering systems and complex multi-tiered supply chains.** Delayed tenders and reliance on the buy-out process often result in significant stockouts, with buy-outs requiring time-intensive paperwork and approvals.[26]

Similarly, long lead times for international orders and poor logistics contribute to delays across Africa, exacerbating medicine shortages and driving up costs.[27, 28]

- **Non-performance by suppliers, including late deliveries and incomplete orders, is a major challenge in ensuring consistent supply of family planning and maternal health life-saving commodities.** South African hospitals report frequent instances of suppliers failing to meet contract obligations.[29] Additionally, Africa's reliance on imports for over 70 per cent of its pharmaceutical needs makes it vulnerable to global supply chain disruptions, including shortages of active pharmaceutical ingredients (APIs).[30]

- **Inconsistent and outdated inventory systems limit the ability to track stock levels and consumption accurately.** For example, South Africa's RxSolution system is plagued by inaccuracies, leading to poor forecasting and under-ordering.[31] Increasing data visibility through routine supply chain assessments and electronic systems can help identify bottlenecks, optimize product flow and improve overall supply chain performance.[32]

- **Finally, fragmented procurement processes and reliance on international suppliers inflate costs and limit access to commodities**. Without regional collaboration or pooled procurement mechanisms, individual countries struggle to leverage economies of scale.[33]

Key takeaways and next steps

Streamline procurement processes to reduce delays and improve commodity flow.

Invest in electronic logistics systems to enhance inventory management and forecasting.

Expand Public-Private Partnerships to strengthen supply chain resilience.

Service Delivery

Delivery models:

- **Community-based models rely heavily on CHWs who extend family planning and maternal health information and services to rural and underserved populations.** Historically, such programmes have proven to increase contraceptive prevalence, particularly due to task-shifting (so that CHWs were able to provide more services particularly in areas without higher-level facilities or providers).[34] Studies of CHW maternal care in sub-Saharan Africa have shown that CHWs delivered accurate and relevant health information and mothers reported high satisfaction, specifically valuing the CHWs' understanding of their life circumstances and the practical, accessible advice and support they offered. However, the CHWs themselves expressed a need for additional training.[35] Expanding training has also been shown to improve maternal care, and tailored training for HCWs has notably been found to improve SRHR services, especially for adolescents.[36, 37]

- **Facility-based models in health-care centre are staffed with trained personnel who can provide a full range of family planning and maternal health services.** Most pilot programmes and interventions also happen in these settings, as they are better equipped and more convenient for research projects, so their staff and patients benefit more from the trainings that accompany an implementation study, for instance. Generally, in Africa, family planning and maternal health services are stronger (with better availability of commodities) in urban, private and higher-level facilities.[38, 39]

- **Innovations like mobile health units expand service reach to remote areas that lack access to regular facilities.** These mobile clinics are successful where displacement due to ongoing conflict or living far from facilities.[40] These outreach services integrate community engagement, offering educational sessions alongside clinical services to build trust and promote acceptance of family planning methods.

Barriers to effective service delivery:

- **Family planning and maternal health services face significant challenges, particularly related to health-care workforce shortages (especially midwives), limited cultural acceptance of certain family planning methods and variability in provider training.** Health-care provider shortages remain a primary barrier, especially in rural regions.[41]

- **Cultural beliefs and social norms also influence SRHR service uptake, as do traditional attitudes and misconceptions about family planning and maternal health commodities.**[42] To address these cultural barriers, health-care workers should provide counselling that respects local beliefs, while clarifying myths around contraception.

- **Variability in health-care worker training presents additional challenges to service quality.** Inconsistent training affects providers' ability to deliver high-quality care, particularly with new and lesser-used family planning and maternal health commodities like TXA. Single trainings that are part of pilot studies, medical degrees or other one-off interventions, without practical components or follow-up, lead to the provider not feeling confident to use the new and lesser-used medications in the case of a PPH crisis (when they are needed most).[43]

Key takeaways and next steps

Expand CHW training programmes to improve service quality and reach.

Increase support for mobile health clinics to address geographic barriers.

Foster community engagement to address cultural and social barriers to service uptake.

Access and Availability

Barriers include geographic distance, financial constraints and cultural norms related to religion and gender. Poor infrastructure and transportation challenges limit distribution to remote areas. Gender dynamics and societal stigma restrict utilization, especially among adolescents.

- **Geographic:** Seasonal weather patterns, such as the rainy season, cut off certain regions, delaying the delivery of maternal health and family planning commodities,[44] or frequent stockouts in rural facilities.[45] Limited transport infrastructure also affects distribution, causing supply shortages that compromise family planning and maternal health commodities availability in underserved areas.[46]

- **Financial:** In many low-resource settings, financial constraints limit both the supply of and demand for family planning and maternal health services. The resultant inconsistent pricing model deters low-income populations from accessing family planning services, especially high-cost items like implants.[47]

- **Religious restriction:** Religious beliefs and doctrine impact family planning acceptance across various regions,[48] as well as areas where traditional beliefs are held. Conservative religious leaders often discourage contraceptive use, associating it with unapproved premarital activity or family planning practices that challenge cultural norms around large family sizes. As a result, young adults and adolescents face obstacles in accessing family planning services, which are seen as morally incompatible with religious expectations.

- **Gender dynamics:** Dependence on male partners to approve contraception use, with fear of relationship instability or domestic repercussions leading many to forgo family planning services. Male-controlled decision-making limits women's autonomy over their reproductive health, creating obstacles for those wishing to space or prevent pregnancies.

- **Age-specific barriers:** Adolescents are sexually active and have unmet need for family planning, but they face unique barriers in accessing family planning and maternal health services. This is mainly due to societal stigma around youth sexual health, and birth to girls under the age of 15 years poses especially high health risks.[49] Across many sub-Saharan Africa countries, such as Uganda,[50,51] Ethiopia,[52] Nigeria,[53] Zambia,[54] South Africa,[55] Democratic Republic of the Congo,[56] and Tanzania,[57] adolescents encounter judgment from health-care providers, family members and community leaders, making it difficult to obtain family planning services without experiencing stigma.

Collaborative initiatives improve access in underserved regions. Programmes engaging community leaders and promoting youth-friendly services show promise in overcoming barriers. In Madagascar and Kenya, community education initiatives have increased awareness and acceptance of family planning commodities.

Investment in infrastructure is essential. Enhancing transportation networks, storage facilities and digital tools can improve last-mile delivery and ensure consistent availability of life-saving commodities.

Key takeaways and next steps

Invest in infrastructure improvements to enhance last-mile delivery.

Promote youth-friendly services to address age-specific barriers.

Strengthen community engagement to overcome cultural and societal barriers.

Utilization and Awareness

Education and awareness levels:

- **Providers:** Provider awareness of TXA and HSC is limited due to delayed guideline updates and inadequate training. Despite WHO recommendations, these commodities remain inaccessible in many lower-level facilities. A 2024 Nigeria study revealed poor TXA knowledge and usage, with barriers including cost and guideline unfamiliarity. Efforts to improve access focus on education, pilot projects and scaling beyond urban areas.

- **Users:** Raising awareness of PPH risks can encourage facility-based delivery. Campaigns, like Kenya's 2024 PPH Awareness Marathon, address this need. While awareness of long-acting family planning methods like implants has risen significantly in sub-Saharan Africa, knowledge of maternal health commodities like TXA and HSC remains limited.

- **Policymakers:** Delays in adopting updated guidelines have slowed the integration of TXA and HSC into health-care systems. Advocacy must target sustainable financing and policy support to ensure availability in rural and lower-level facilities.

- **Community leaders:** Engaging community and religious leaders fosters acceptance of family planning and maternal health. Programmes involving men in family planning education enhance support and utilization, reducing stigma and misinformation.

Awareness campaigns are vital for improving utilization. Provider knowledge of innovative maternal health commodities, like HSC and TXA remains low.

Policymaker and donor advocacy drives systemic change. Sensitization initiatives targeting policymakers emphasize the long-term benefits of integrating family planning and maternal health commodities into national health-care systems. Donor support ensures sustained investment and capacity-building.

User-centered education enhances service uptake. Addressing misconceptions and promoting accurate information through community-based programmes increases trust and utilization of family planning and maternal health services.

Key takeaways and next steps

Implement provider training programmes to improve awareness of innovative commodities.

Enhance community education initiatives to address misconceptions and promote uptake.

Advocate for policy integration of family planning and maternal health commodities to ensure sustainable access.

CONCLUSION

Policy: Integrating TXA and HSC into national policies and regulatory frameworks will institutionalize their use. Including these commodities in EMLs and harmonizing regional frameworks can streamline their adoption and ensure availability across all levels of health care.

Financing: Financial barriers must be addressed through sustainable strategies. Integrating family planning and maternal health commodities into national health insurance schemes and leveraging price negotiation models can reduce costs and make these commodities more accessible.

Supply chain: Improving supply chain systems is critical for ensuring consistent availability of TXA and HSC. Systems like eLMIS and last-mile delivery innovations are essential for reducing stockouts, while partnerships with regional manufacturers can ensure a reliable supply of quality-assured products.

Service delivery: Addressing gaps in provider training is essential to improving the use of family planning and maternal health life-saving commodities. Strengthening health-care worker training through hands-on mentorship models, such as Low-Dose, High-Frequency Midwifery Training, will build provider capacity to use these commodities effectively, especially in underserved areas.

Utilization and awareness: Sociocultural resistance must be tackled through community engagement and male involvement. Collaboration with religious and community leaders, alongside male engagement initiatives, can foster acceptance of family planning and maternal health services and improve utilization rates.

Next steps

Short-term (next two years)

Enhance PPH management with WHO's bundled approach. Countries should adopt comprehensive PPH guidelines, train health-care workers, and ensure TXA and HSC are integrated into protocols and clinical guidelines for prevention and management of PPH.

Strengthen supply chain systems. Implement data-driven inventory management like eLMIS and push-based distribution models to ensure consistent availability of family planning and maternal health commodities, particularly in underserved areas.

Expand community outreach and engagement. Localized education campaigns should reduce stigma and increase awareness of family planning and maternal health services, while scaling male engagement initiatives to foster supportive environments for women's health-care decisions.

Bolster local manufacturing and quality assurance. Support partnerships to produce quality-assured family planning and maternal health commodities regionally, integrating verification technologies like QR codes to enhance trust in distributed products.

Long-term (now to 2030)

Institutionalize sustainable financing mechanisms. Governments must develop innovative funding models, such as health bonds and cost-sharing schemes, to reduce donor dependency and ensure long-term programme sustainability.

Build resilient supply chains and infrastructure. Invest in decentralized storage, advanced logistics systems and partnerships with local transport networks to improve last-mile delivery. Regional collaboration through pooled procurement mechanisms will further stabilize supply chains.

Leverage technology for health-care delivery. Expand AI-driven forecasting, mobile health platforms and drone technology to enhance access to family planning and maternal health commodities in remote and underserved areas.

Normalize reproductive health education. Integrate family planning and maternal health topics into national curricula and scale peer-led programmes to empower youth with accurate, stigma-free information.

United Nations Population Fund
East and Southern Africa
9 Simba Road / PO Box 2980, Sunninghill, Johannesburg, 2191 / 2157, South Africa
Tel: +27 11 603 5300

Website: esaro.unfpa.org
Email: comms-team-esaro@unfpa.org
Twitter: @UNFPA_ESARO

Facebook: UNFPA East and Southern Africa
LinkedIn: UNFPA East and Southern Africa
Instagram: unfpaesaro