

Diagnostic Assessment of Kenya's Family Planning Market

Support to the ESHE Programme

Prepared for
Palladium Group (formerly GRM/ Futures Group)
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Acronyms

ACT	- Artemisinin-based Combination Therapy
BCC	- Behaviour Change Communications
CBO	- Community Based Organisation
CBS	- Central Bureau of Statistics
CHAI	- Clinton Health Access Initiative
CHAK	- Christian Health Association of Kenya
CHW	- Community Health Worker
COC	- Combined Oral Contraceptive
CPR	- Contraceptive Prevalence Rate
CSO	- Civil Society Organisation
CYP	- Couple Years of Protection
DFID	- Department for International Development
DHIS2	- District Health Information System
DRH	- Division of Reproductive Health
EC	- Emergency Contraceptive
ESHE	- Enabling Sustained Health Equity
FBO	- Faith Based Organisations
FP	- Family Planning
HIV/ AIDS	- Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IUD	- Intrauterine Device
KAPH	- Kenya Association of Private Hospitals
KCCB	- Kenya Conference of Catholic Bishops
KDHS	- Kenya Demographic and Health Survey
KEC	- Kenya Episcopal Conference
KEMSA	- Kenya Medical Supplies Authority
KES	- Kenyan Shilling
KfW	- Kreditanstalt für Wiederaufbau, German Development Bank
KHF	- Kenya Healthcare Federation
KMET	- Kisumu Medical Trust
KPA	- Kenya Pharmaceutical Association

KSPA	- Kenya Service Provision Assessment
LAM	- Lactational Amenorrhea Method
M4P	- Making Markets Work for the Poor
mCPR	- Modern Contraceptive Prevalence Rate
MEDS	- Mission for Essential Drugs and Supplies
MFN	- Master Facility Number
mFPM	- Modern Family Planning Methods
MoH	- Ministry of Health
MSI/ Kenya	- Marie Stopes International/ Kenya
NCPD	- National Council for Population and Development
NGO	- Non-Governmental Organisation
NQCL	- National Quality Control Lab
OC	- Oral Contraceptive
POP	- Progestin Only Pill
PPB	- Pharmacy and Poisons Board
PSI/ Kenya	- Population Services International/ Kenya
PSP4H	- Private Sector Innovation Programme for Health
RH	- Reproductive Health
SES	- Socio-Economic Status
SUPKEM	- Supreme Council of Kenya Muslims
TOT	- Training of Trainers
TRaC	- Tracking Results Continuously
UNFPA	- United Nations Population Fund
USAID	- United States Agency for International Development
USD	- United States Dollar
WB	- The World Bank
WRA	- Women of Reproductive Age (women aged 15 to 49)

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Executive Summary

Background

The purpose of this diagnostic study of Kenya's family planning (FP) market is to inform the Enhancing Sustained Health Equity (ESHE) programme's understanding of FP market dynamics, as well as determine the options available for greater involvement of the commercial sector in serving unmet FP needs.

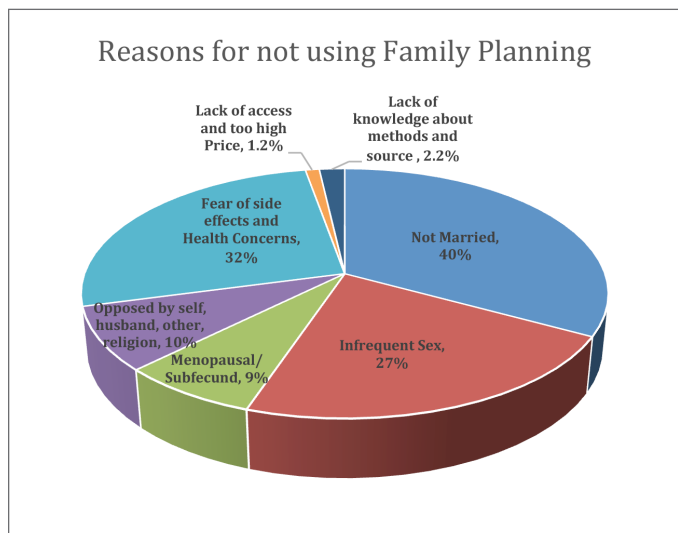
The analysis follows the Making Markets Work for the Poor (M4P) market systems development approach to diagnose why Kenya's family planning market has not met the needs of 34% of Kenyan women. This study assesses demand and supply sides of Kenya's FP market and the norms, rules and supporting functions which shape its performance. This study serves as a baseline assessment to help determine if M4P interventions can be used to make Kenya's family planning market work better through greater private sector participation. Based on the analysis, recommendations are given and research into several potential solutions that would involve commercial sector players is suggested. Finally, the study provides an updated body of evidence and analysis that could inform better coordination within the market, for instance through the development of a Total Market Approach (TMA) to family planning. Kenya's FP market includes public, private not-for-profit (e.g. faith-based organisations, non-governmental organisations, social franchises), and commercial for-profit players, all of whom would be involved in a TMA.

Key Findings

Demand Side

Thirty-four percent of Kenyan women aged 15 to 49 have an unmet need for family planning (FP), including 14% of married women¹. The unmet need is highest amongst unmarried, young, 15 to 19-year-old, rural, uneducated and poor women. Data from available literature shows that the main reasons why women are not using or have discontinued using a modern contraceptive method are because they fear FP side effects, are not married, have infrequent sex, or have health concerns.

Fear of side effects and misconceptions that there is no need for contraception when having sex infrequently and when unmarried are by far



the most common reasons for not using contraceptives^{2 3 4}. Findings show that of women with an unmet need for FP, just 1.2% of them cite access, and price as a key reason why they are not using a family planning method^{5 6}. In supply terms – which would be of immediate interest to the commercial sector – only a very small proportion of the market is currently unserved.

Supply Side

Stakeholder interviews revealed that the main reason why commercial market players show little interest in developing the FP market is that private health facilities and pharmacies are able to access almost all their contraceptives from subsidised government and NGO sources. Commercial distributors, unable to compete with the free and subsidised products, hardly sell any contraceptives through private sector retail channels. This leaves them with little or no incentive to invest in market development given such marginal contribution to their bottom line.

Meanwhile, commercial manufacturers of contraceptives are mainly selling to government and NGOs that in turn supply practically the entire market. Commercial manufacturers of contraceptives prefer to sell in large quantities to public sector clients rather than deal with a proliferation of commercial distributors who order in smaller quantities. From the manufacturers' point of view, they end up selling much higher volumes of products at the end of the day, through bulk orders from government more than they would through small orders channelled through distributors to retail customers. Manufacturers also tend to view behaviour change communications and demand creation as best left to government and NGOs. This is because few commercial players can see a direct financial benefit in 'educating the market' as their marketing investment would expand the market for competitors as well as themselves. Further, even if they were to invest in demand creation, it is unlikely that their commercial sector sales would increase significantly given the wide availability of subsidised and free FP services and products.

The public sector currently supplies 86% of the FP market, with social marketing and commercial sectors controlling only 13% and 1% respectively. Research shows that women of all income levels, from the poorest to the wealthiest, access free FP commodities. Although current GoK policies promote free FP to all Kenyans, the public sector is highly dependent on donor funding and is struggling to meet the funding requirements for FP commodities. A Total Market Approach (TMA) may be able to correct the kind of market distortion witnessed in Kenya's FP market with the public sector supplying the entire market and the private commercial sector playing a very small role. Such a TMA strategy would help in determining which segments of the FP market cannot pay, which can pay less and which can pay full commercial prices. This market segmentation would inform national quantification and forecasting so that the GOK only procures for women who cannot afford to pay, social marketing caters for those who can pay subsidised prices, while the rest of the market is served by the commercial sector. The main challenges that stakeholders would need to tackle with a TMA approach are first, determining willingness to pay for FP (what proportion of the FP users is willing to pay for FP and how much can they actually pay?), then enforcing a policy that ensures that free commodities are only accessed by those unable to pay. This would require that the GOK/MOH and stakeholders set up administrative mechanisms that make it possible to determine who is able to pay for their FP and who should get it for free. The administrative mechanisms to accomplish this are not currently in place and it is likely that the costs of determination and enforcement would exceed the potential benefits. For this reason, a cost-benefit analysis would need to be conducted prior to pursuing a TMA.

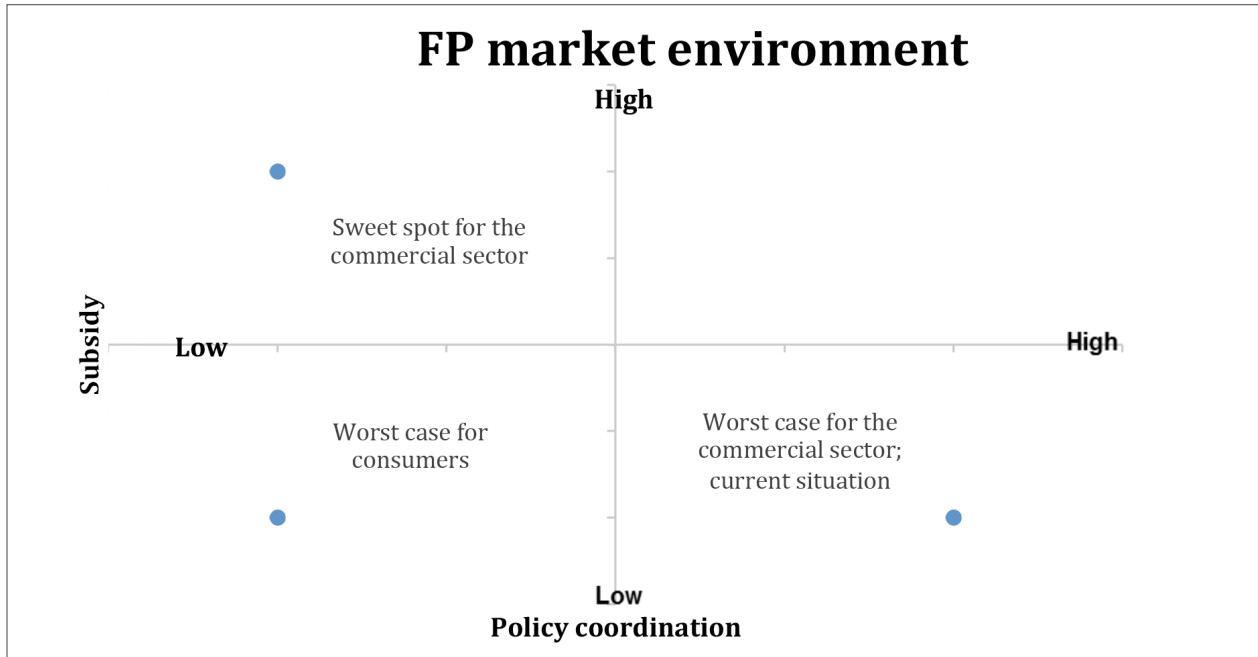
There are a number of new FP products that are either in the process of being launched or have recently entered the market indicating that manufacturers are investing in innovations to increase FP uptake. However, not all commercial manufacturers are necessarily looking to meet the needs of the unserved or underserved segments of the market. Pfizer has introduced the Sayana Press 3-month injectable that is an improvement from their current Depo Provera. Another product is Implanon NXT from Merck. Merck is also planning to introduce Marvelon pills through social marketing and is in discussions with some NGOs about marketing

them. Also relatively new in the market are Famy Care’s phasic pills that are meant to reduce side effects associated with daily pills.

Implication

So long as the current scenario remains, where free or subsidised FP commodities dominate the market, private sector actors will continue to play a passive role in FP provision through commercial channels, letting donor-funded government and NGO commodities supply end users of all income levels.

Possible future scenarios if policy coordination and/or subsidies were to change are presented in this analysis of FP market environment:



Scenario I: High Subsidy, Low Policy Coordination

This depicts the current situation in Kenya’s FP market where over 90% of users are accessing free or highly subsidised commodities due to GoK policy and donor funding. International donors fund FP commodity procurement through GoK whose policy is to provide free FP to everyone, regardless of their economic status. FP subsidies are not targeted through GoK and are partially targeted by social franchises. That results in market being saturated by free and subsidised FP commodities, crowding out the commercial sector as the latter has less than 5% of the market to cater for.

Scenario II: Low Subsidy, Low Policy Coordination

If donor and GoK funding were to decrease significantly, but no changes in FP procurement and provision policy are made, fewer people would be able to access free or subsidised FP commodities. But as it would not be coordinated who are entitled to free or subsidised commodities, those who cannot pay and those who can pay less (95% of the market) would suffer disproportionately. This scenario where there are few subsidies and low policy coordination/ dysfunctional TMA would be the worst case for the majority of FP consumers.

Scenario III: Low Subsidy, High Policy Coordination

This hypothetical scenario represents the sweet spot for the commercial FP providers. For this scenario to work, a high level of coordination and effective implementation is needed: a policy that agrees to provide free FP exclusively to those who cannot pay and regulates the NGO sector in a way that it effectively uses

limited amounts of donor funding to provide FP at a subsidised price to the market segment that can pay less. However, as mentioned earlier, such a high level of policy coordination requires a large proportion of tax payers and an administrative system that enables to determine who is able to pay for their FP. Only under such scenario it is likely for the commercial sector to crowd in and take a more active role in the FP market in Kenya.

Commentary: What Is Likely To Happen If Subsidies Were Removed?

It is unrealistic to expect that the vacuum in the market caused by the removal of subsidies will automatically be filled by the commercial private sector. The commercial sector will only move in to fill latent demand when doing so is profitable. The tendency for business is to pursue the easiest, most profitable market segments first, which are high-income consumers with clear ability to pay. This would leave lower-income consumers with lesser ability to pay (can pay less and cannot pay segments) unserved or underserved. Unfortunately, this is where the unmet need in the market currently lies. The solution of targeted subsidies benefitting only lower-income consumers would appear to address this market gap; however the administrative costs of implementing and enforcing such a solution would need to be carefully considered as they may well outweigh the benefits. A very possible outcome of removing subsidies would be less market coverage, lower CPR and higher costs.

Key Recommendations:

- Develop and implement behaviour change communications to raise awareness about contraceptive side effects and prepare women for what to expect when they take up specific methods. This should be supplemented with provider education on FP counselling and greater coordination among the different FP actors so that the public, social marketing and commercial sectors can co-exist within a more balanced FP market in Kenya. **Issue addressed:** Women do not use FP because of fear of side effects and health concerns.
- Stakeholders need to review the policy on free commodities going to commercial outlets where they are sold at uncontrolled prices. This policy shift should be aimed at ensuring that free commodities are only distributed through public sector facilities and do not find their way into the private sector outlets. This would encourage the commercial sector to be more involved in making contraceptives available through private facilities for those who can afford to pay, while also forcing private facilities to make an effort to source for FP commodities from commercial sources rather than wait for free GOK commodities. **Issue addressed:** GOK supplies free FP commodities to private providers.
- Better market segmentation and targeting of subsidies to those who cannot afford to pay commercial prices of contraceptives. This market segmentation would help in determining what proportions of the population cannot pay or can pay less for FP, as well as what the size of the commercial market is. This information would help commercial actors in making key decisions on whether this market is worth investing in or not. **Issue addressed:** Users across all wealth segments expect free and subsidised FP.

Suggestions for Further Research

There may be opportunities to address some of the systemic constraints. Further research could confirm whether some of the manufacturers would have strong enough incentives to play a more proactive role in market development if this free distribution policy were to change. The analysis points to further research on four the following specific opportunities:

- Whether manufacturers of pills and injectables would find it worthwhile to invest in educating pharmacy staff, teachers and women in general on contraceptives side effects and providing important information on contraceptive products. Further investigations include the potential return on investment for pill and injectable manufacturers from provider, teacher and consumer education and training as well as pharmaceutical and clinical professional associations offering training to their members on FP side-

effects so that they are better equipped to promote contraceptives and counsel their clients on what to expect once they take up a method. This could potentially reduce discontinuation rates and increase the sales of contraceptives.

- Whether promotion of post-partum FP presents an opportunity for commercial providers to increase access to FP among women who have recently given birth. There might be an opportunity for the commercial sector healthcare providers to fill such a gap; as studies have shown that there is high demand for FP amongst women who have recently given birth, but 1 in 3 women did not receive any information or counselling on FP after giving birth⁷.
- Additional research into the effects of the current rules and regulations preventing pharmacy staff from administering family planning injections. These rules may impede women's access to the injectable contraceptive method – which is the most popular method according to the recent KDHS 2014. Further research would focus on whether pharmacies in practice administer injections; and whether pharmacies being prevented from administering injectables makes much difference to the uptake of reliable contraception.
- Further investigation into willingness to pay for FP and whether subsidies increase access to family planning (i.e. if current usage rates are distorted due to the availability of free and subsidised goods and services) and whether their withdrawal or reduction would have negative impact on access.

Lastly, there is need for continued engagement with commercial players as well as research into the sustainability and effectiveness of existing private sector interventions aimed at enhancing FP access, such as low cost kiosks in rural areas and demand side strategies such as vouchers targeting low income women.

Introduction

1

1 Introduction

1.1 Background of the Survey

This survey was commissioned by the DFID-funded Enhancing Sustained Health Equity (ESHE) programme and the results are expected to inform the development of a Total Market Approach (TMA) strategy for family planning (FP) in Kenya. ESHE is a five-year project (2013 – 2018) that seeks to enhance access to FP through the private sector. Through ESHE's technical assistance within the TMA, it is envisioned that more space can be strategically created so that the public, social marketing and commercial sectors will co-exist within a more balanced FP market in Kenya. The involvement of more private providers is hypothesised as a key way to increase access, choice and quality; commercial players are currently crowded out of Kenya's FP market, especially for products aimed at lower – middle population segments. The commercial sector has repeatedly reported to ESHE that they are crowded out of the market due to extensive donor subsidies for oral contraceptives and injectables, which are not targeted specifically for the poorer client segments, and there is spill over into the middle segment that the commercial sector is geared to reach and which is frequently an underserved gap in the market. This crowding out effect has partly caused Kenya's total FP market to be unbalanced and has been dominated by free products and social marketing brands only. This makes the market increasingly vulnerable to shocks caused by over-reliance on just a few providers, dependence on donor subsidies and support, and a lack of a national strategy to ensure a more vibrant, complementary and sustainable market.

Cardno Emerging Markets (East Africa) is one of the ESHE consortium partners, and was selected to support the research, analysis, documentation and dissemination of this diagnostic assessment using the Making Markets Work for the Poor (M4P) framework..

1.2 Objectives of the Diagnostic Assessment

The main goal of the diagnostic study of Kenya's FP market is to enhance ESHE's understanding of FP market dynamics, including need, demand and FP usage, as well as determining the options available for greater involvement of the commercial sector.

1.3 Report Overview

- Section 1 of the report provides the background of the study and the executive summary highlighting key findings;
- Section 2 summarises the methodology used to conduct the diagnostic assessment, followed by an overview of the ESHE programme and its linkage to the diagnostic assessment;

- Sections 3 and 4 look at Kenya's family planning market from a demand and supply side perspectives respectively, including the players, structure and performance;
- Section 5 provides an overview of the supporting functions and rules;
- Section 6 focuses on a sustainability analysis of Kenya's FP market;
- Section 7 outlines the systemic constraints in Kenya's FP market; and
- Section 8 presents suggestions for further research into opportunities for commercial sector engagement.

Methodology

2

2 Methodology

This section presents a brief overview of the process used to conduct the diagnostic assessment.

2.1 Assessment Process

The first step in the FP diagnostic assessment process was the development of an M4P framework. This was followed by discovery of existing documents and information including work already done by ESHE. Interviews were also held with senior ESHE project staff to get their perspective of the main issues they wanted the assessment to address. Relevant secondary data was obtained from a variety of key sources including the commercial sector, social marketing agencies and the public sector, and the preliminary findings of the 2014 Kenyan Demographic and Health Survey data, other national policies, strategies and action plans currently in place - that affect contraceptive procurement, financing, distribution, promotion and the general business environment. After a review of all the available secondary data, consultants carried out a data gap analysis through comparison of the available data against the assessment framework. They then identified the sources of the missing data and collected it mostly through key informant interviews with key FP stakeholders. The study provides the evidence base on Kenya's FP market, including opportunities and constraints, from which the TMA can be positioned with the GoK and all other key FP stakeholders and players in the market. The study findings will ultimately provide important data for any future policy engagement and help donors and policymakers understand the broader market and the comparative importance of different players in the market.

Several secondary data sources were used for this study for various reasons. Firstly, only preliminary findings of the KDHS 2014 have been published to date. Secondly, the KDHS tends to focus mainly on married women, and leaves out sexually active unmarried women when addressing the issue of FP and unmet need. Thirdly, different studies have covered different very specific aspects of the FP market. It would have been impossible to cover all the questions necessary to analyse the market from an M4P point of view based on one source only.

2.2 Overview of the M4P Approach

M4P (Making Markets Work for the Poor or market systems development) is an approach to developing markets so that they function more effectively, sustainably and beneficially for poor people. M4P involves guidance on how to analyse markets as well as how to intervene in them. By addressing underlying causes (rather than symptoms) of weak performance, M4P interventions are:

Facilitative: by requiring that agencies play a facilitative role, not a permanent role. The role of agencies is catalytic and inherently temporary by not becoming part of the market system.

Scalable: by striving to leverage the actions of key market players to bring about extensive and deep-seated systemic change.

Systemic by fostering change market-wide, taking into account all players, supporting functions and rules within the market system.

Sustainable: by considering how key market functions and players can work more effectively in the future, so that poor women and men can continue to benefit, beyond the period of intervention^{8 9}.

In the context of ESHE, the assessment uses an M4P framework to diagnose system constraints that have hindered private sector FP engagement through sustainable solutions.

Kenya's Family Planning Market Demand Side

3

3 Kenya's Family Planning Market Demand Side

3.1 Consumers' Health Seeking Behaviour, Need and Demand

This section provides an overview of the need and demand for family planning according to different socio-economic characteristics that currently distinguish those with unmet need for family planning. Further, it describes the health seeking behaviour of contraceptive users in Kenya and reveals the main reasons for not using any contraceptive methods.

Key section highlights:

- The unmet need for FP is higher amongst unmarried, young, rural, poor and uneducated women.
- The most common reasons why these women are not using FP are because of fear of side-effects and misconceptions that there is no need for contraception when having sex infrequently and when unmarried.
- Overall the most popular methods are injectables (48%), implants (18%) and daily pills (14%).
- Free and subsidised FP products are almost equally accessed by the poorest as by the wealthiest.

Benefits

Some family planning methods, such as condoms, help prevent the transmission of HIV and other sexually transmitted infections, reduces the need for abortion and reinforces people's rights to determine the number and spacing of their children. By preventing unintended pregnancy, family planning /contraception prevents deaths of mothers and children. In 2012 there were 1,534,900 births in Kenya¹⁰ of which 881,000 or 57.4% were unintended¹¹. In the same year there were 11,670 maternal deaths that could have been avoided by the use of contraceptives. With the use of contraceptives up to 51.5% of maternal deaths could have been averted¹².

Total demand

The total demand for family planning services comprises those who fall in the met need and the unmet need categories¹³. Preliminary findings of the Kenya Demographic and Health Survey (KDHS) 2014 estimate that the total demand for family planning has increased and that 76 per cent of *married* women demand family planning. The same survey shows that among currently married women, 32 percent would like to delay their next birth for two years or more, and 47 percent do not want to have any more children. Population Services Kenya's (PS Kenya) Reproductive Health Survey 2014 estimates the total demand to be nearly 82% among all women of reproductive age (WRA)¹⁴. In 2015 there were 11,136,137 sexually active women of reproductive

age¹⁵, which means that 9,131,632 (82%) WRA need family planning. In Kenya the total demand for family planning is expected to grow over the years as both the total population and the absolute number of young people who are in or are soon to reach their reproductive age are growing¹⁶.

Unmet need

All sexually active women who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using any contraceptive method, are defined to have unmet need for family planning¹⁷. Women may pass into and out of unmet need, rather than experiencing it as a one-time event¹⁸. According to Kenya’s national surveys, the need for family planning is mainly considered as the need for spacing and limiting, but fails to take into account the need for delaying the birth of the first child. This bias is also reflected in KDHS that tends to focus mainly on married women and their need for spacing or limiting births. The unmet need, especially for delaying the birth of the first child among unmarried youth between the age of 15 and 24 is often overlooked and may indicate general cultural attitudes towards premarital sex.

The average unmet need for family planning amongst all WRA is 34%¹⁹ and 14% among married women in Kenya²⁰. However, the unmet need is not spread evenly and there are huge variations across different groups. The following sections describe in more detail the factors that influence which groups have greater unmet need for family planning.

- **Marital status and age**

The key predictor for use of modern family planning methods is marital status. None of the other factors examined in relation to this behaviour had the strength of association that this single factor had²¹. According to PS Kenya’s 2014 Reproductive Health TRaC (Tracking Results Continuously) Study, unmet need amongst unmarried women is 40.3% versus 26% amongst married women²².

Unmet need for family planning among sexually active unmarried youth who report a need for contraceptives is extremely high. Fifty-five (55%) of unmarried sexually active women between 15 and 19 have an unmet family planning need, whereas in the same age group only 26% of married women have unmet need for family planning²³. This difference may be an indicator that unmarried women have problems accessing family planning due to the stigma associated with being sexually active while yet unmarried.

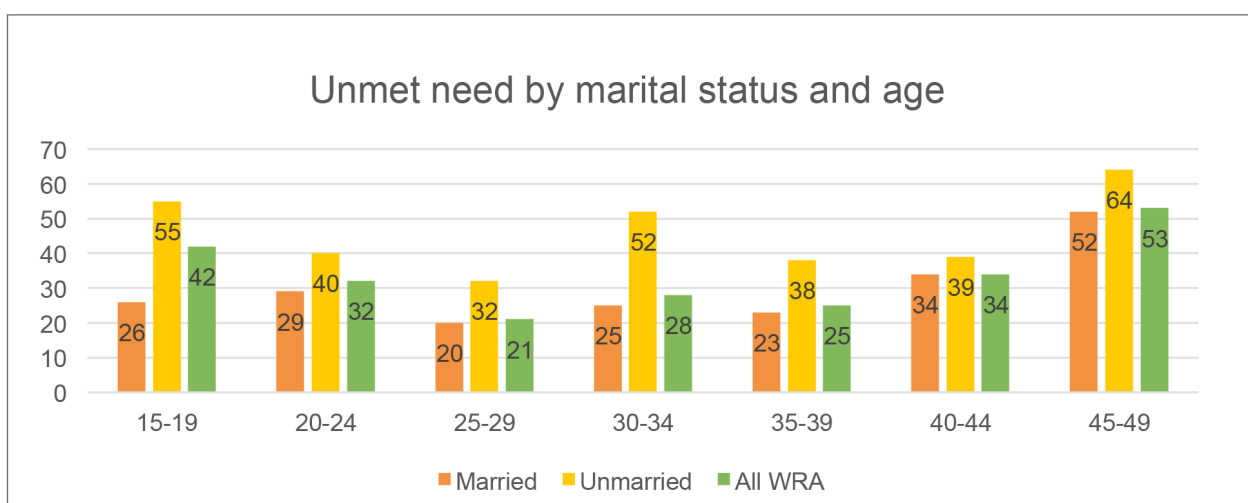


Figure 3-1 Unmet need for family planning by marital status and age, percentage.

Source: PS Kenya 2014 RH TRaC Survey

Premarital sex in Kenya is common — the average age at first sex among Kenyan women is nearly two years younger than the average age at first marriage. The median age at first marriage is 20.0 years, while the median age at first sex is 18.1 years²⁴. PS Kenya’s TRaC survey 2014 showed that 65% of unmarried adolescents aged

15-24 years are sexually active and that unmet need for FP among them is 48%²⁵. As a result, those who are not using a contraceptive method or are using a traditional method but do not want to have a child are at high risk of unintended pregnancy²⁶. The preliminary results of the KDHS 2014 also show that 18% of women aged 15-19 have begun child bearing (have had a live birth or are pregnant with their first child)²⁷ but the majority of pregnancies amongst unmarried youth are reported as unintended²⁸.

- **Urban / rural residence**

Overall, there is a slightly greater unmet need for family planning in rural areas than in urban areas. According to one study the unmet need amongst all WRA is 31% in rural areas and 27% in urban areas²⁹. According to KDHS 2014 the unmet need in rural areas is 24% versus 20% in urban areas³⁰.

When combining age and residence, it is clear that the most disadvantaged group is young, 15 to 24-year-old rural women. The average unmet need for family planning among 15 to 24 year-old women is 32.5%, but for the same age group living in rural settings it is 12.4 percentage points higher than for their urban counterparts (38.7 and 26.3 respectively)³¹. For older women between 25 and 49, the difference in unmet need for family planning in rural settings and urban settings was only 2.4 percentage points (29.2 and 26.8 respectively)³².

- **County/ geographical region**

Unmet need is highest amongst married WRA in the North Eastern region, where almost 1 in 3 women have an unmet need for family planning, followed by Nyanza province with 23%. The lowest unmet need amongst married WRA is in Central province with 9%, followed by Nairobi with 11%³³.

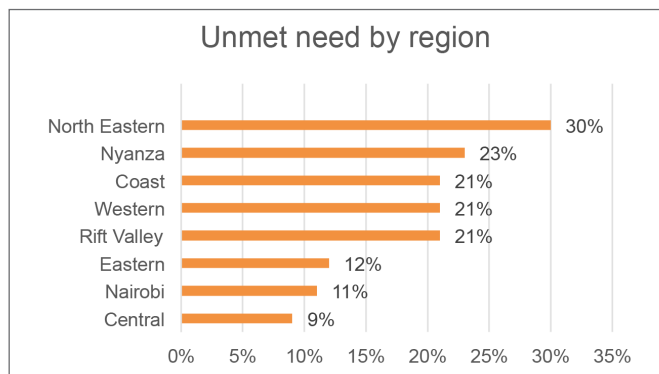


Figure 3-2 Unmet need for any method of contraception amongst married women aged 15-49 by region.

Source: KDHS 2014 Key Indicators

- **Socio-Economic Status (SES)/income**

Women with the lowest socio-economic status have the greatest unmet need for family planning. In the lowest income group nearly 1 in 3 married women are not using a contraceptive method, despite having expressed their desire to space or limit births. Only 7.6% of all users of modern contraception are from the poorest wealth quintile³⁴. The unmet need amongst women in the lowest income group is almost twice as high as it is amongst women in middle income group³⁵. Unmet need declines steadily as wealth increases^{36 37}.

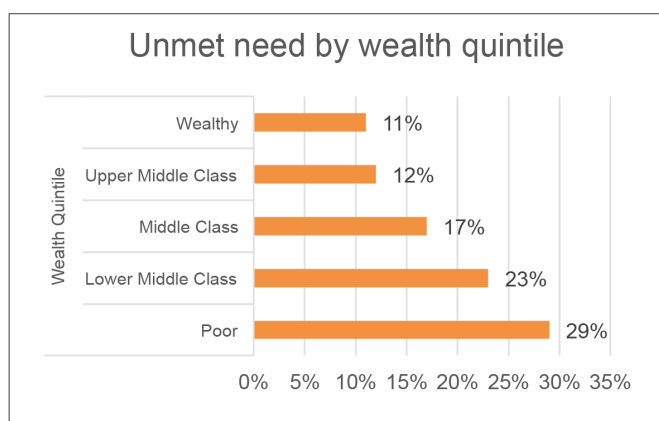
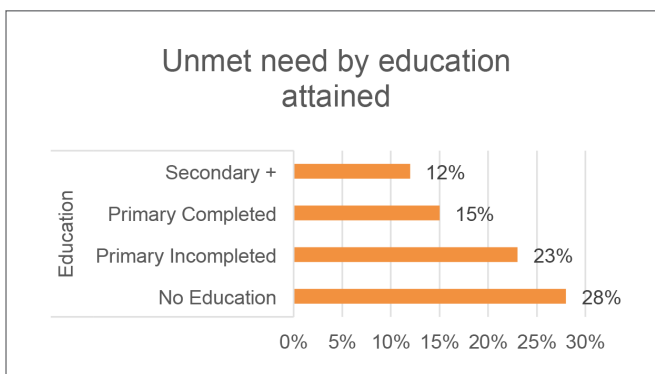


Figure 3-3 Unmet need for family planning by wealth quintile. Source: KDHS 2014 Key Indicators

- **Education**

Women who have had no formal education have the greatest unmet need for family planning compared with women who have had some education. Twenty-eight percent of married women³⁸ and 50 per cent³⁹ of all WRA with no formal education have an unmet need for family planning.



Unmet need declines steadily as the level of education increases: Unmet need among married women with secondary education or higher is 12%⁴⁰.

Figure 3-4 Unmet need by Education.
Source: KDHS 2014 Key Indicators

• **Contraceptive prevalence rate**

Contraceptive prevalence rate (CPR) is one of the measures that can indicate which groups of people have sought family planning in order to delay, space or limit their births, enhance maternal and child health and/ or for other social and economic reasons. CPR is the percent of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time⁴¹. Modern contraceptive methods include female and male sterilisation, intrauterine devices (IUD), implants, injectables, pills, male and female condoms and lactational amenorrhoea method (LAM)⁴². Sometimes emergency contraception (EC) is included in the list of modern contraceptive methods⁴³, although never regarded as a long-term method or for regular use. Traditional methods include the rhythm method (periodic abstinence), withdrawal and other folk methods⁴⁴.

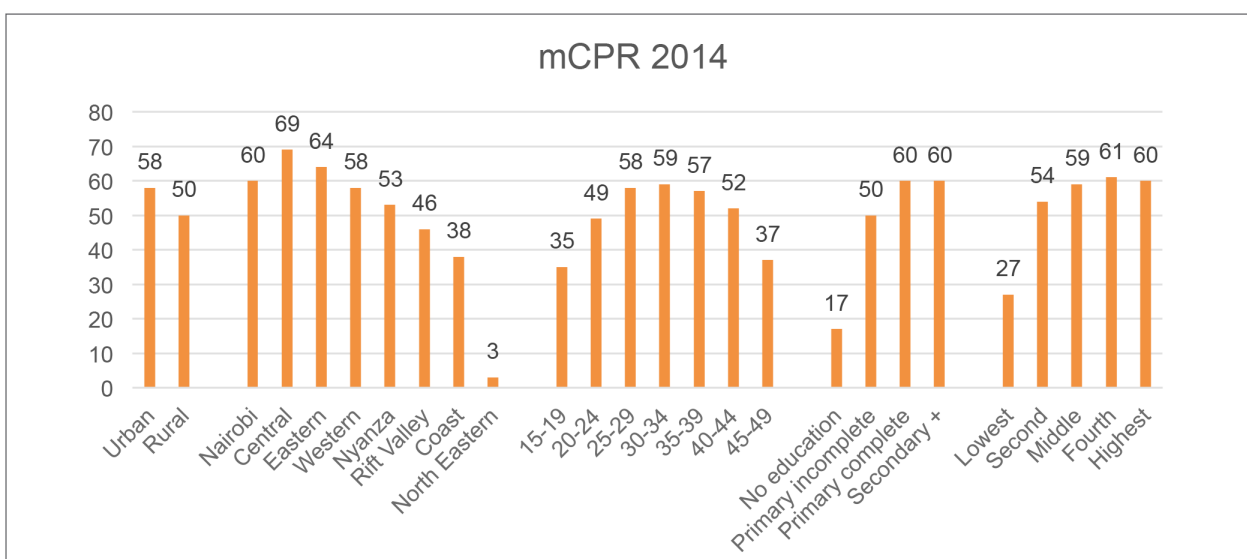


Figure 3-5 Modern Contraceptive Prevalence Rate (mCPR) amongst currently married WRA by residence, region, age, education, and wealth quintile. Source: KDHS 2014 Key Indicators

CPR very much reflects the unmet need for family planning described earlier: the CPR is higher amongst groups with lower unmet need for family planning⁴⁵. A higher percentage of urban women (58%) use a modern method of contraception, compared with their rural counterparts (50%)⁴⁶. Combining residence and age, CPR was lowest (50%) among sexually active rural WRA aged 15-24 years⁴⁷. Contraceptive prevalence increases dramatically with education. Only 18% of currently married women with no education use a method, while more than half of women with at least some primary school level of education use contraception⁴⁸.

The table below summaries the counties with the lowest CPR by region:

Region	Counties	CPR (KDHS 2014)
Coast	Tana River	20.5%
N. Eastern	Garissa	5.5%
	Wajir	2.3%
	Mandera	1.9%
Eastern	Marsabit	10.9%
	Isiolo	26.3
Rift Valley	Turkana	10.1%
	West Pokot	13.3%
	Samburu	20%

Table 3-1 CPR by counties. Source: KDHS 2014 Key Indicators

• **Method mix**

The method mix provides a profile of the relative level of use of different contraceptive methods. A broad method mix suggests that the population has access to a range of different contraceptive methods. Conversely, method mix in terms of most demanded methods can signal: (1) provider bias in the system, if one method is strongly favoured to the exclusion of others; (2) user preferences; or (3) both⁴⁹. There is no fixed formula for the right method mix, but in unreliable markets, if the majority of women rely on one method, more women are likelier to suffer from stock-outs or other changes in the market.

According to the PS Kenya 2014 TRaC survey, which presents very similar findings to the Ministry of Health (MoH) District Health Information System (DHIS-2) and also mirrors the preliminary KDHS 2014, the injectable contraceptive is by far the most popular FP method amongst women irrespective of age, followed by implants and pills respectively. The PS Kenya TRaC 2014 further shows that WRA 20-24 years mostly prefer to use the injection while the WRA 15-19 year old's second preferred method after injection is the male condom. This survey also shows that EC usage declines with age and women opt for long-term and permanent methods such as the IUD and female sterilisation.

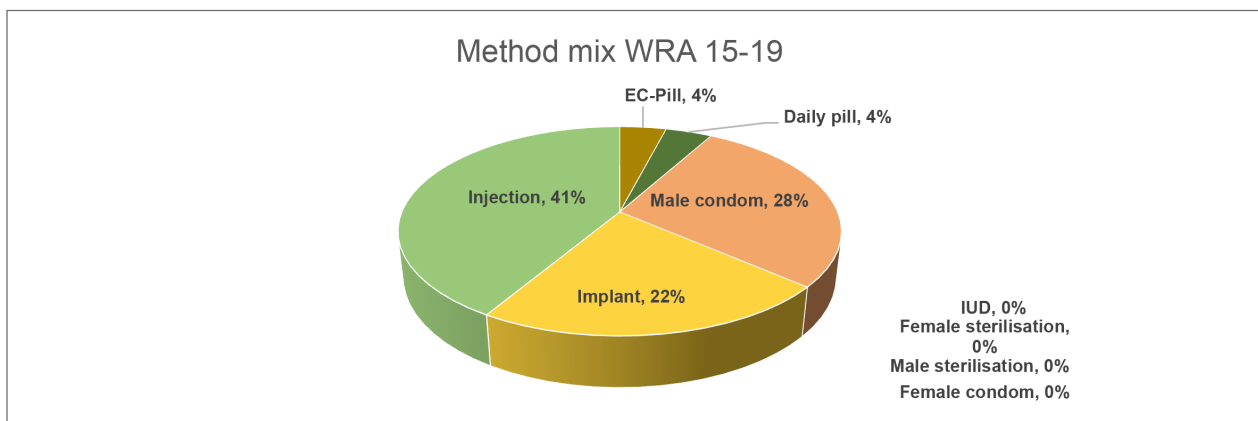


Figure 3-6 Method mix amongst sexually active women aged 15-19. Source: PS Kenya RH TRaC 2014

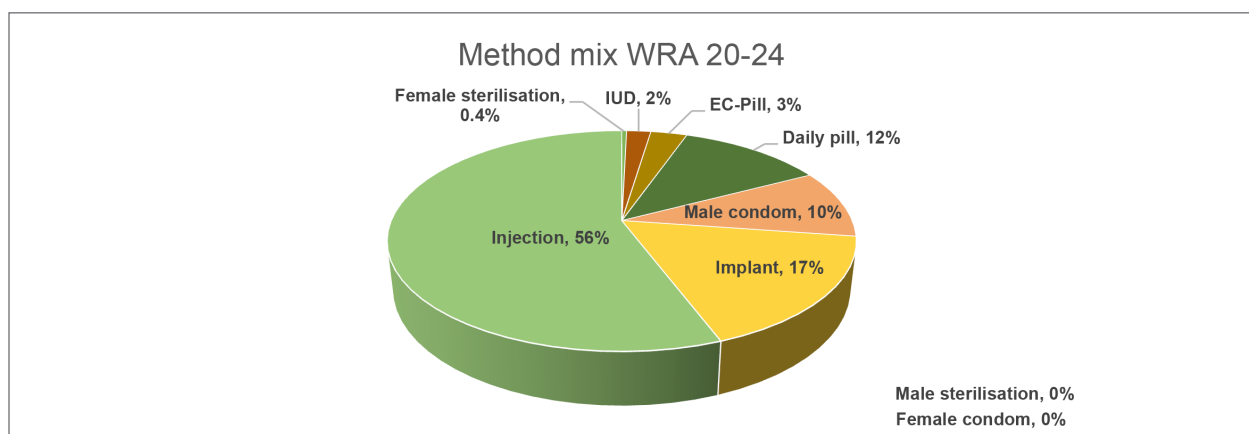


Figure 3-7 Method mix amongst sexually active women aged 20-24. Source: PS Kenya RH TRaC 2014

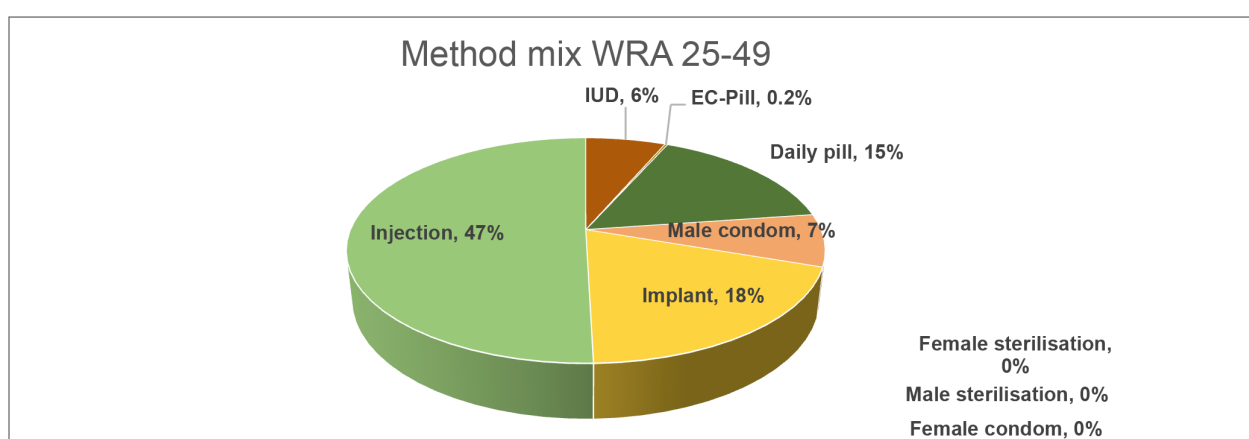


Figure 3-8 Method mix amongst sexually active women aged 25-49. Source: PS Kenya RH TRaC 2014

Modern contraceptive method		Percentage of all contraceptive users
1	Injectables	48%
2	Implants	18%
3	Daily Pill	14%
4	Condom	8%
5	Female sterilisation	7%
6	IUD	4%
7	EC	1%
	Total	100%

Table 3-2 Method mix among all WRA. Source: PS Kenya TRaC 2014 and MoH DRH presentation

By combining marital status and residence, a slightly different method mix trend occurs: condoms (30%) and injectables (18%) are the most preferred methods among urban unmarried sexually active women while their rural counterparts prefer injectables (28%), followed by male condoms (11%). There is high usage of emergency contraception (EC) across all counties among high school and college-attending students⁵⁰. Rural married women prefer injectables (28%) and implants (9%). Most urban married women also use the same methods – injectables (25%) and implants (12%).

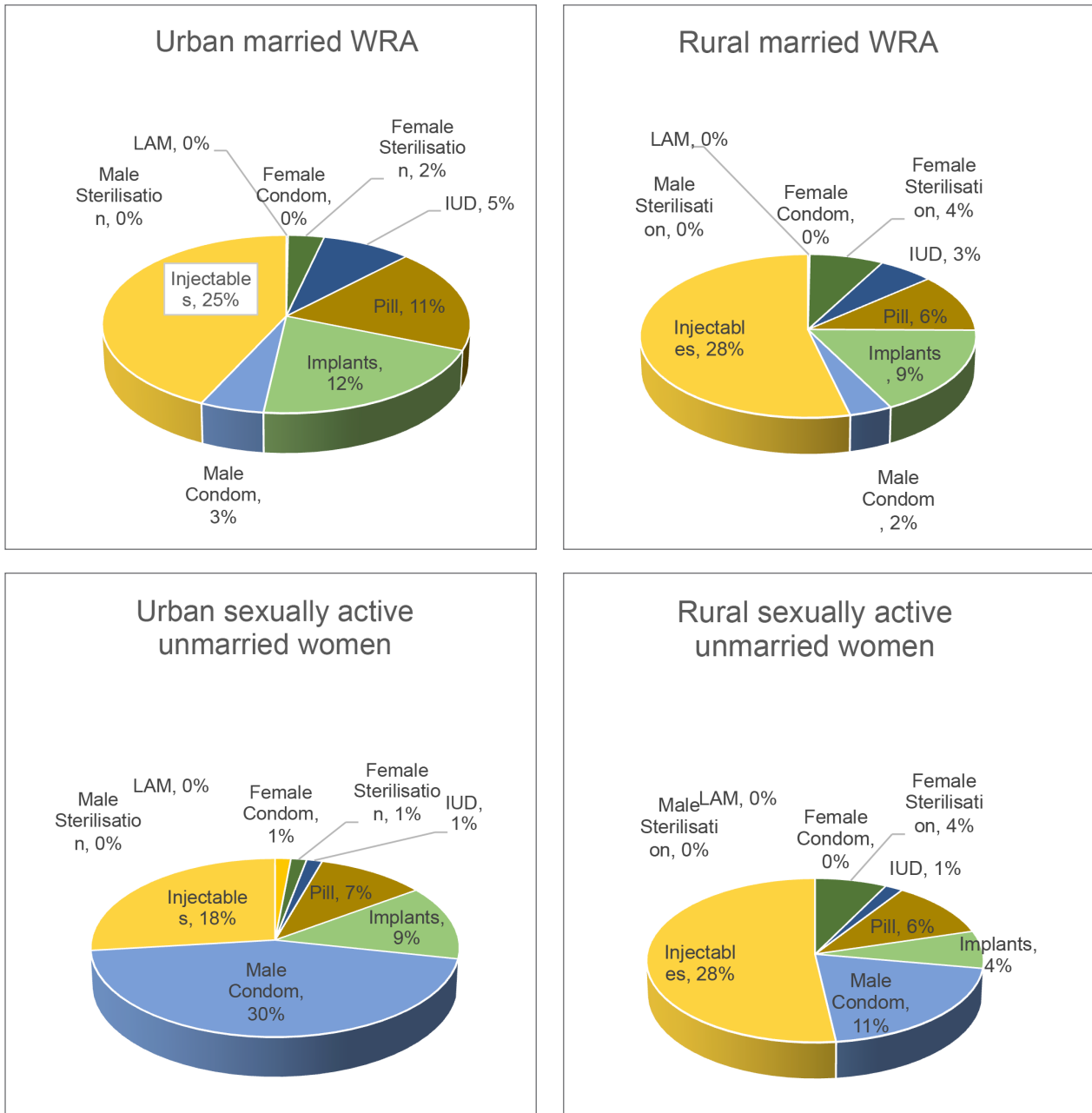


Figure 3-9 Modern method mix by residence for married and unmarried women.

Source: KDHS 2014 Key Indicators

Changes in method mix

According to PS Kenya RH study, there have been significant shifts in the use of daily pill (-2.4%), injectable (-5.6%), implants (+7.9%) and condom (-3.7%) between 2012 and 2014 among all sexually active women aged 15-49 years. The decrease in injectable was however not seen among the rural female youth aged 15-24 years where a 7.8% increase was seen. The growth in implants was seen in all the residence and age categories, as well as the marital status categories. The main reason for the changes in method mix is women switching methods because of side effects. Urban women aged 25-49 were the likeliest to change methods because of side effects. Other common reasons for switching method amongst all WRA were method efficacy and safety, followed by health related problems. Lack of access and availability and high price, were not significant reasons for switching method (2.1% and 1.1% respectively)⁵¹.

- **Brand awareness**

In general end-users distinguish and recognise different family planning methods by how they are used, rather than by brand names⁵². The proportion of currently married women and men who have heard of at least one contraceptive method exceeds 90% in all categories by age, residence, education and wealth. Exceptions are found among women with no education, women in the lowest wealth quintile and women in North Eastern province, where less than half of married women have heard of any method⁵³. These population segments would benefit from information on available FP methods and their benefits.

Focus group discussions with private pharmacy owners revealed that over the past ten years education and knowledge about contraceptives has increased resulting in younger and wealthier clientele asking for specific brands of contraceptives. Pharmacy owners reported that younger women tend to ask for Microgynon (by Bayer), while older and less wealthy women ask for Femiplan injections and pills and other generics. These are mostly brands they have heard of being advertised through various media channels especially the socially marketed brands or in the case of Microgynon, perhaps because of its wide availability even through public channels. Private pharmacy owners, however, stated that due to frequent stock-outs, the preferred method is not always available. The retail pharmacy owners indicated that whenever the preferred brand is not available, a majority of their FP clients are willing to change to another brand and/or method in order to continue avoiding unwanted pregnancies⁵⁴.

- **Reasons for not using family planning methods**

Despite many women recognising a modern method of contraception and wanting to delay their next birth or stop giving birth altogether, there are wide-spread misconceptions, fears and concerns about contraceptives side-effects, which deter women from using them. KDHS 2008-09 as well as more recent PMA2020 study from 2014 show that over 30% of women aged 15-49, irrespective of their marital status, were not using any method of modern contraception because of fear of side-effects and health concerns^{55 56}. Forty percent of respondents said that they are not using contraception because they are not married⁵⁷ (which does not mean that they are not sexually active⁵⁸). Women across all age groups frequently mentioned that they do not use contraception because they are having infrequent sex (27%). It is therefore clear that many WRA in Kenya wrongly believe that if they only have sex occasionally, they are not at risk of pregnancy, and therefore do not need to use contraception. All other reasons were less frequently mentioned, including lack of access and high price (1.2%^{59 60}). Lack of knowledge about methods and source was only mentioned by 2.2% of women⁶¹. From this data, it is clear that it is not the lack of access or affordability that most affects non-use (primarily due to availability of free and subsidised contraception), but rather fear of side-effects and a lack of basic understanding of conception.

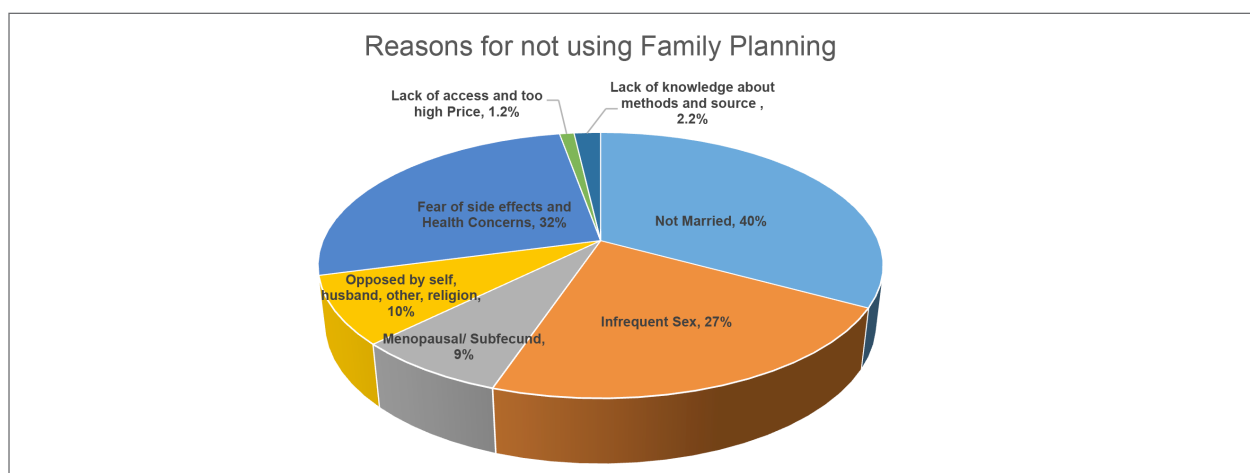


Figure 3-10 Reasons for not using family planning amongst all WRA who reported seeking to delay their next birth and not using contraception. Source: PMA2020 Project, 2014

The reasons for not using family planning are different for different age groups and vary by residence as well. For example, the most common reason for not using any contraception among young women aged 15 to 24 is because they are not married. Fear of side effects and health concerns peak among 35 to 39-year-olds. The number of women believing that they have no need for family planning because of infrequent sex remains worryingly high for all age groups⁶². The great importance that Kenyan women place on side effects compared with access and availability, and price, is also supported by PS Kenya's TraC 2014 study. The study asked women why they switched methods and surprisingly, less than 2% of women stated access, availability and price as the reasons for switching. Findings were fairly consistent across rural and urban populations and different age groups⁶³.

Reasons for not using any family planning reflect user perceptions as much as provider perceptions. A Futures Group qualitative study on family planning perceptions, attitudes and practices in rural Kenya revealed that many young people aged 15 to 19 are not using any method of family planning because of provider perceptions and attitudes towards young, single and childless youth seeking contraception. Family planning providers, especially in the public health facilities, frequently embarrass, humiliate or scold young people, sometimes even asking them to come with a partner, show a marriage certificate or asking about the number of children they already have⁶⁴. This in turn puts off youth seeking family planning and feeds false perceptions that young people do not need to use family planning while they are single or before they have had a child. Alternatively, some young people started using more easily accessible methods (i.e. condoms) or seeking family planning from private providers who are perceived as more professional and impartial⁶⁵. In 2014, 96% of health facilities reported offering adolescents family planning counselling or methods, but only 35% of pharmacies, where young people prefer seeking family planning, provided such services to adolescents⁶⁶.

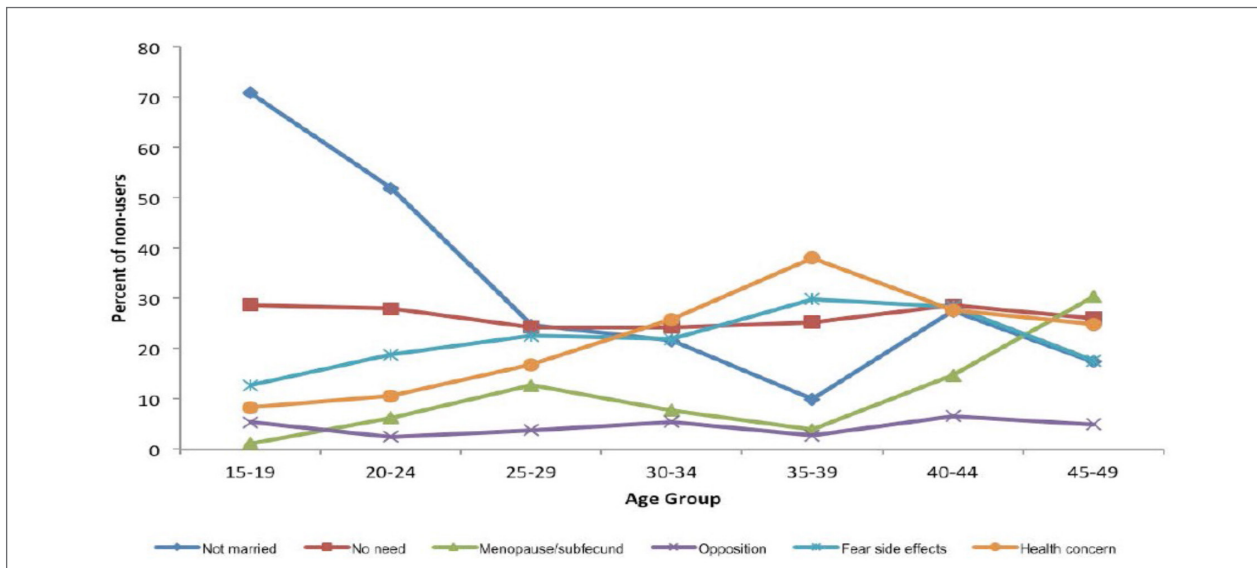


Figure 3-11 Percentage of all women aged 15 to 49 who reported seeking to delay their next birth and not using contraception, by reason for non-use and age. Source: PMA2020 Project, 2014

• Contraceptives discontinuation

The highest loyalty to a modern contraceptive method is among users of implants (60%), followed by users of injectables (53%). The lowest loyalty to a modern method is among daily pills users (22%)⁶⁷ and male condom users (41.1%)⁶⁸. The most common reason stated for switching a method or discontinuing among all categories of women was side-effects (59%), followed by health concerns (17%). Only 2.1% of women switched the method or stopped using it because the method was not available/accessible. High price was the reason for switching or stopping using contraception for only 1.1% of women aged 25 to 49 (0% among women aged 15 to 24, both urban and rural)⁶⁹.

• **Points of sale where people get contraceptives/ Source of supply**

The 2008-09 KDHS indicates that public (government) facilities provide contraceptives to 57% of users, while 36% of users are supplied through private medical sources, 6% through other private sources (e.g., shops), and less than 1% through the community-based distribution system⁷⁰. A more recent study confirms similar trends: One-third of couples obtain their family planning methods from the private commercial sector and another 10% go to facilities run by non-governmental organisations (NGOs) and faith-based organisations (FBOs)⁷¹.

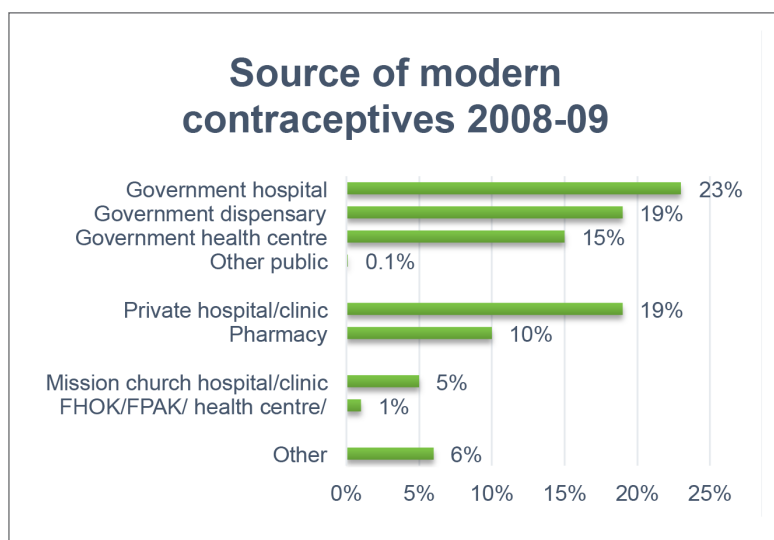
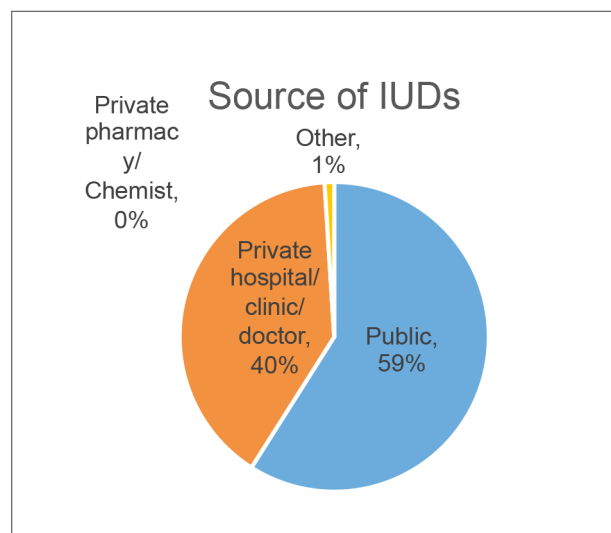
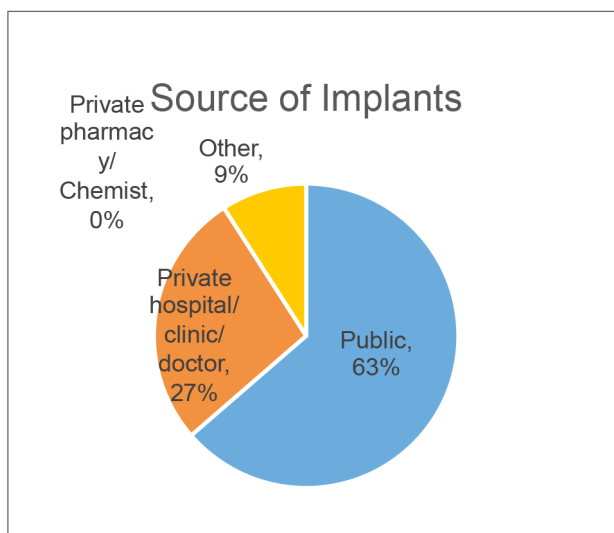


Figure 3-12 Source of modern contraceptives by supply. Source: KDHS 2008-09.

The most common source of contraceptives in Kenya is government hospitals, which supply about one quarter of all users of modern methods. Government dispensaries and private hospitals and clinics supply about one-fifth of users, followed by government health centres (15%). In total, over half of all users get their FP services from public sector sources, which generally do not charge for contraceptives. This indicates that the majority of family planning users in Kenya do not access FP from private, commercial or social franchising sources where they would pay full commercial or subsidised prices. What many users may not consider are the opportunity costs of using public sector facilities, where they may have to queue for long hours or travel long distances to access the free services.



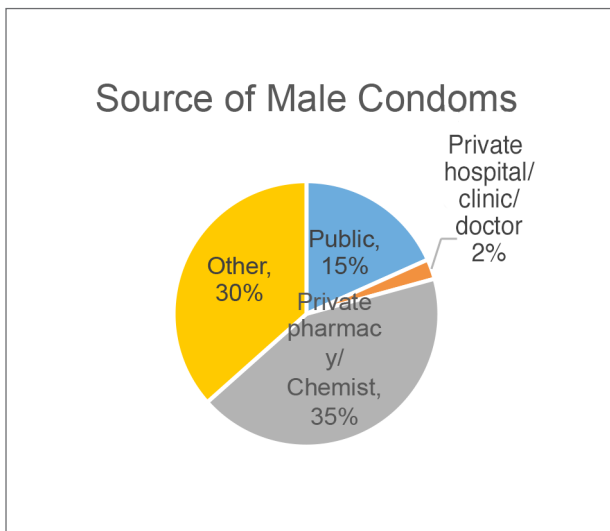
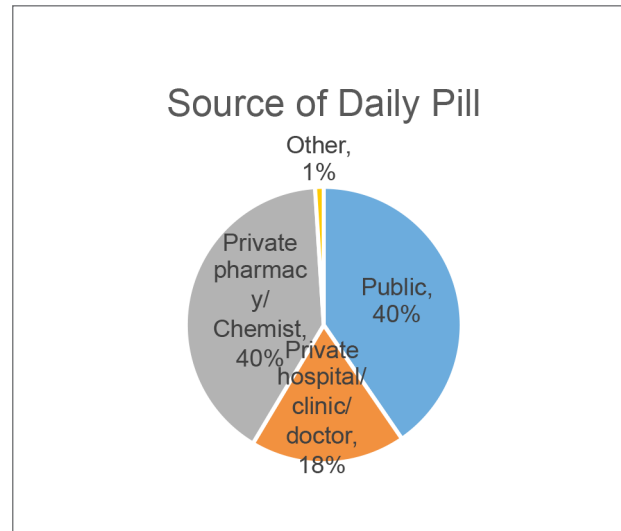
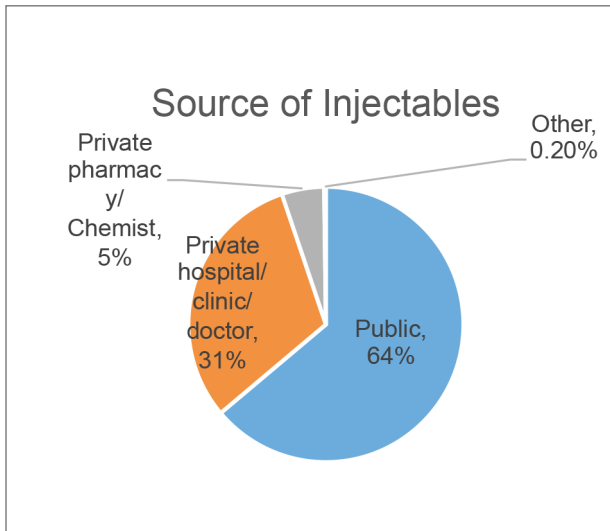


Figure 3-13 Source of Modern Contraceptives by method. Source: Kenya Endline Household Survey (Tupange), 2015

Most users of implants, IUDs, and injectables get their FP methods from public facilities perhaps because of the lower cost of the long acting methods compared to prices charged in private sector facilities. Private hospitals and clinics are also important sources of IUDs, injectables and implants. Users of daily pills and male condoms get their FP methods from private pharmacies. Shops and other private retail facilities are the second most important source for male condoms^{72 73}. Although the public sector provides all methods for free or at a lower cost than the private sector, there is a trend in which some methods are accessed more through the private sector than through the public sector. These methods (condoms and pills) are also more popular amongst 15-24-year-olds than amongst other age groups, as they might prefer private sector providers to public sector providers because of the youth-friendly, confidential and professional service they receive at private facilities, without having to justify why they are having premarital sex.

It must be pointed out that in the aforementioned studies private sector means “not public sector” and includes not-for-profit faith based organisations (FBOs) and non-governmental organisations (NGOs) as well as for-profit commercial enterprises.

Both urban and rural consumers depend highly on public facilities for FP, although this is more among the rural population than among their urban counterparts. This is partly because there are fewer private providers in rural areas than there are in urban areas. In Nairobi and Mombasa, private hospitals and clinics play a greater or equal role with public facilities in supplying contraceptives^{74 75}.

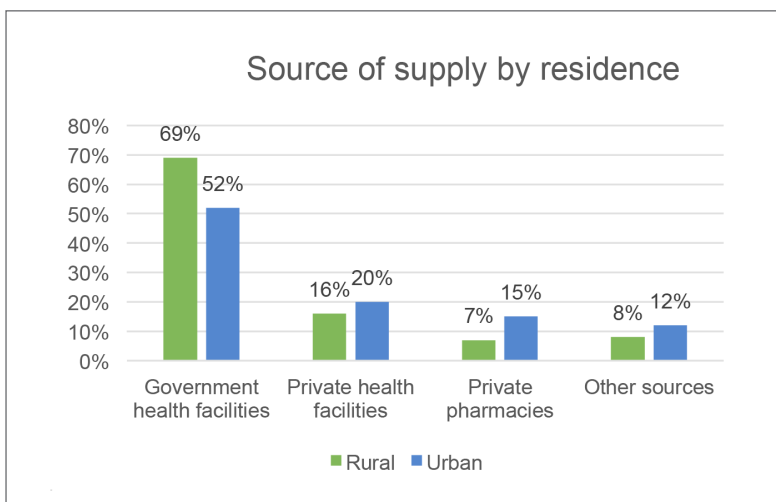


Figure 3-14 Source of Modern FP Method by Residence. Source: PS RH TRaC 2014

Further analysis based on age and residence segmentation shows the different dependencies among the age and residence categories.

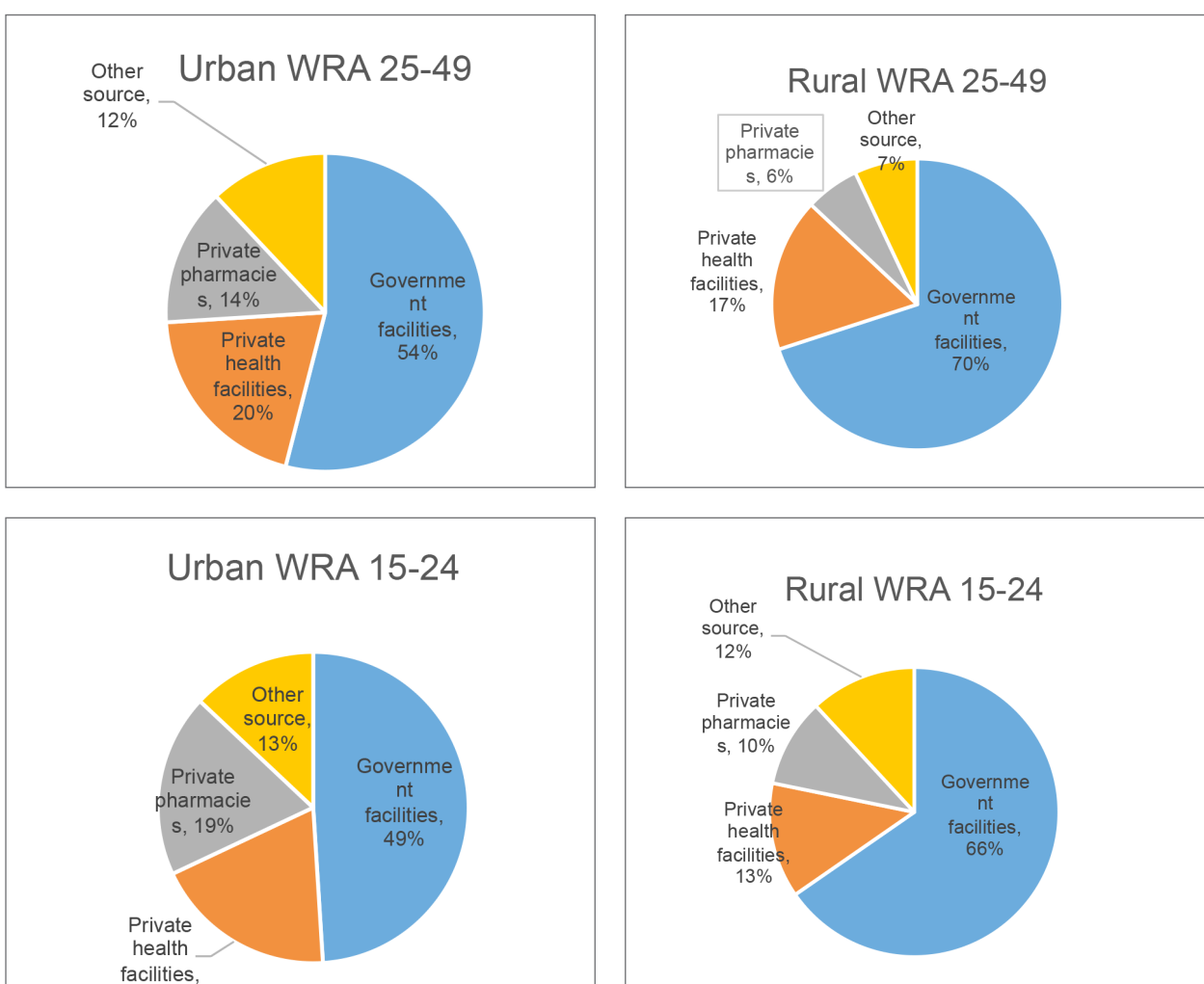


Figure 3-15 Source of Modern FP Method by Age and Residence. Note that private health facilities and pharmacies include both not-for profit and commercial sector and other sources include shops and kiosks. Source: PS RH TRaC 2014

PS Kenya's 2014 TRaC survey shows that 65% of respondents access FP from GOK sources, 18% from private sources and 8.9% from private pharmacies. Most respondents preferred public facilities, but where such facilities were not nearby or if there was a stock-out of a desired method, they would use a private facility. Younger users of family planning are likelier to access methods from private sector sources (pharmacies and shops) or from HIV counselling and testing sites^{76 77}.

Prices of modern contraceptives

In 2008-09 about 20% of women using a modern contraceptive method received the method free of charge⁷⁸. By 2014, the proportion of women receiving free modern contraceptives had increased to 46%. Free family planning commodities are commonly available in the public sector, but private providers with a Master Facility Number (MFN) are also able to access free commodities from time to time though supply is inconsistent and based on methods available in GOK stores. Apart from the free GOK commodities, private providers that are members of donor supported social franchise networks are also able to access subsidised commodities.

PS Kenya’s RH survey 2014 found that free and heavily subsidised family planning services and methods were more or less equally accessed by the poorest and the richest quintiles (55.2 % and 43% respectively). Similar proportions of people from the poorest and the richest segments were buying family planning methods that cost more than KES 300⁷⁹ (the unit of measure here is for the current method, so, if someone says they used the pill, they would indicate what they paid for the pill every time they purchased it, or if one uses the 3 month injection, they would indicate the amount they pay for the injection every time they get get). This means that the richest and the poorest are accessing FP from similar sources and pay the same prices for FP (free or highly subsidised FP from public and not-for profit sectors). As a result of the predominance of free and subsidised FP commodities in the market, the private commercial sector currently provides less than 10% of contraceptives to end users^{80 81 82}. This shows that the market is not fully segmented, and that subsidies are currently not targeted successfully at the poor and lower middle class.

As the figure below shows, free and subsidised products are almost equally accessed by the poorest as by the wealthiest (based on KNBS quintiles). This leads to market distortion, and unless it is addressed, FP actors will continue to work inefficiently. One way to address this market distortion would be through better market segmentation so that both free and subsidised products go only to those who cannot pay the full price. This can possibly be achieved through a Total Market Approach (TMA) where the roles of the different sectors are clearly articulated as part of a national government strategy. However, the challenge with a TMA is how to ensure that after market segmentation, those who can pay commercial prices would not access subsidised or free FP commodities. Enforcing such a policy could prove to be a huge administrative and logistical burden with high financial costs, as has been the case with similar approaches that have tried to target subsidies through FP vouchers for the poor⁸³.

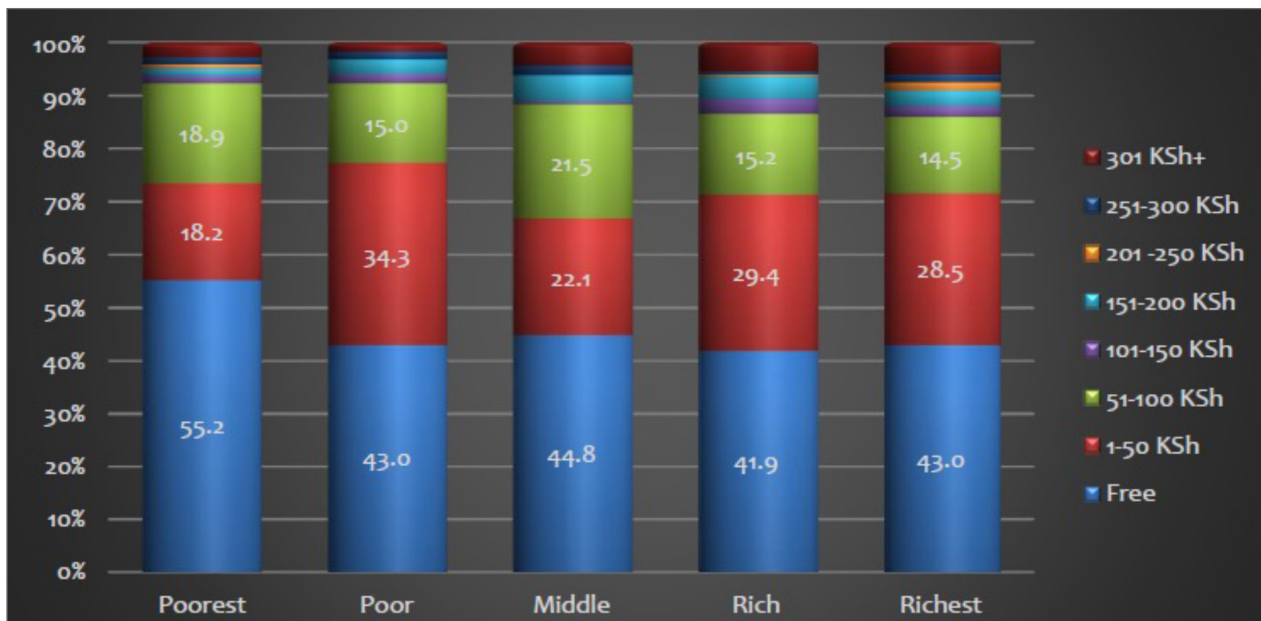


Figure 3-16 Cost of modern FP by the Different Socio-Economic Status as a proxy of source (free- government sources; 1-300 Ksh -subsidised sources; 301+ Ksh- commercial sources. Unit of measure: current method per purchase.) Source: PS Kenya RH TRaC 2014

Kenya's Family Planning Market Supply Side: Players, Structure and Performance

4

Kenya's Family Planning Market Supply Side: Players, Structure and Performance

This section is a succinct, fact-based description of the family planning market as it currently is and operates. It describes in brief how the market is structured with respect to different sectors and players within these sectors and how they perform their core function (supply). Supporting functions and rules regarding the commercial sector are presented in the next chapter. After the description of players and their core function, Kenya's family planning market dynamics, including changes in donor funding, market share, franchises and new technologies that shape the FP market are described. Key section highlights:

- Kenya's family planning market includes public, private not-for-profit (e.g. NGOs, FBOs and social franchises), and private for-profit (commercial) players.
- 48% of health facilities are public, 38% commercial, 11% FBO and 3% NGO owned.
- In 2014 public sector market share in terms of FP provision was 87%, not-for-profit sector 13% and commercial sector market share was less than 1%.
- All FP manufacturers are commercial entities whose biggest client is GoK/MoH.
- Kenya's public sector depends heavily on donor funding. International donors have committed to contribute 83% of the MoH FP budget in 2015-16.
- KEMSA is the biggest distributor of FP and supplies public, not-for-profit and commercial facilities.
- Commercial manufacturers sell mainly to MoH which through KEMSA supplies all sectors with free FP. Because commercial providers are able to access free FP commodities through KEMSA, there is little demand for unsubsidised FP from commercial distributors. Commercial manufacturers are incentivised to keep selling through MoH.

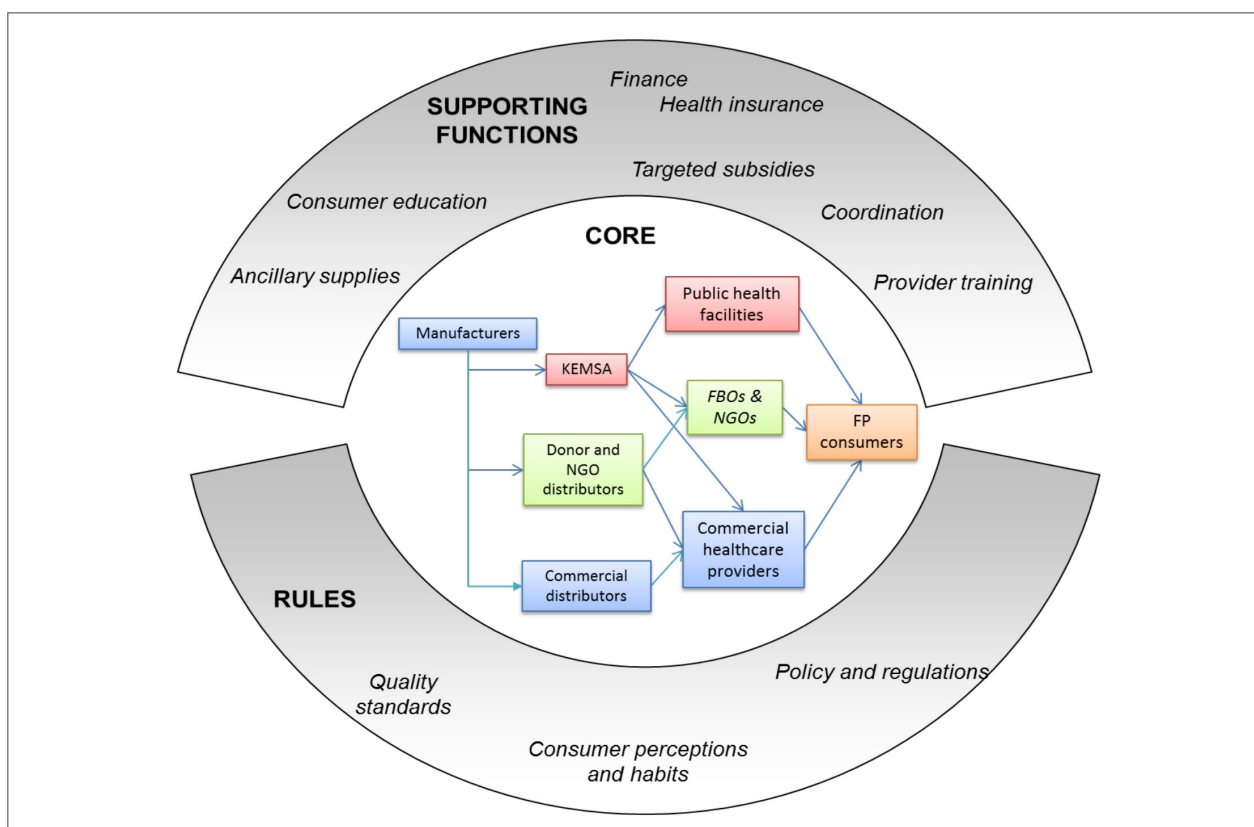


Figure 4-1 Kenya’s FP market map. Source: Cardno analysis. Colour key: blue: commercial; red: governmental; green: private, not-for-profit; orange: consumers

Kenya’s family planning market includes public, private not-for-profit (e.g. NGOs, FBOs and social franchises), and private for-profit (commercial) players. There are also three types of supply chains that operate in parallel to each other: the public supply chain, the private not-for-profit supply chain and the commercial for-profit supply chain⁸⁴. The public and private not-for profit supply chains supply all types of health facilities with contraceptives, and currently do not restrict their free and subsidised commodities from reaching commercial for-profit providers. Commercial for-profit providers rarely acquire FP commodities from commercial pharmaceutical distributors and wholesalers since they can access the same products for free from the public sector or at subsidised prices from NGOs.

The table below gives a high level overview of the main actors in Kenya’s pharmaceutical sector and their respective roles:

Actor	Roles and responsibilities
PUBLIC SECTOR	
Ministry of Health (MoH)	Policy leadership on pharmaceutical matters, and initiation and supporting of pharmaceutical legislative processes (rules & regulations on quality as well as FP guidelines and policies for providers)
Pharmacy and Poisons Board (PPB)	Oversight and implementation of regulation of pharmaceutical manufacturing, importing, distributing and retailing establishments, as well as registration of all cadres of pharmaceutical personnel
Kenya Medical Supplies Authority (KEMSA)	Semi-autonomous government body responsible for procurement, distribution and warehousing of medicine and medical commodities
PRIVATE NOT-FOR-PROFIT SECTOR	
Mission for Essential Drugs and Supplies (MEDS)	Procurement, distribution and warehousing of medicine/medical commodities, (except contraceptives) to non-profit organisations (mainly FBOs), but also public facilities and selected commercial facilities
NGO distributors	Such as PSI & Marie Stopes: Procurement, distribution, warehousing, social marketing, social franchising and selling of medical commodities such as malaria bed nets, water purifiers and contraceptives to commercial providers and other NGO programmes and social franchise networks.
COMMERCIAL FOR-PROFIT SECTOR	
Manufacturers	Such as Pfizer, Merck, Bayer, Famy Care and others: Production and marketing of pharmaceutical commodities. Production in Kenya typically entails buying the active pharmaceutical ingredients and formulating and packaging these into the final dosage forms for consumers
Distributors/wholesalers	Link between manufacturers and retailers. 'Distributors' refers to larger firms that supply wholesalers directly. Wholesalers supply retailers directly.
Retailers	Suppliers directly responsible for selling medicines to end users. In Kenya, these include pharmacies (all types of medicines) and general shops (specific pre-packaged medicines classified by law as over-the-counter)
INTERNATIONAL DONORS	
DFID, KfW, USAID, UNFPA	International donor agencies funding and supporting family planning commodity procurement, behaviour change communications, research and systems strengthening including HMIS for the public and NGO sectors
PROFESSIONAL AND ADVOCACY ORGANISATIONS	
Pharmaceutical Society of Kenya	Representing interests of member pharmacists in Kenya. Pharmacists include all personnel with a minimum of a degree qualification in pharmacy from a recognised institution
Kenya Pharmaceutical Association	Representing interests of pharmaceutical technologists in Kenya. Pharmaceutical technologists include all personnel with a minimum of a diploma qualification in pharmaceutical technology from a recognised institution. It has 6,500 members across Kenya who manage approximately 90% of all retail pharmacy business in the country.
Kenya Healthcare Federation	Private sector healthcare advocacy organisation engaging the government and all relevant stakeholders towards achieving quality healthcare through enabling policies that maximising the contribution of the private sector
Kenya Medical Association; Nursing Council; Clinical Officers Association	Representation, registration & licensing institutions for the various professional cadres

Actor	Roles and responsibilities
The Kenya Association of Private Hospitals (KAPH)	National body whose purpose is to advocate for the of small and medium sized private hospitals
TRAINING INSTITUTIONS	
Universities	Training of pharmacists, and supply of interns to manufacturers, wholesalers and retailers
Kenya Medical Training College (KMTC)	Training of nurses, pharmaceutical technologists, clinical officers and lab technologists

Table 4-1 Summary of actors in the pharmaceutical sector and their respective roles.

Source: PSP4H 2014

4.2 Overview of Public Family Planning Providers

Manufacturers of Public Sector Commodities

All manufacturers of contraceptives whose products are distributed in Kenya are commercial, for-profit enterprises with global presence. There are no Kenyan contraceptive manufacturers, although major global pharmaceuticals manufacturers have representative offices in Kenya. The manufacturers of hormonal contraceptives whose branded products are distributed in the Kenyan public sector are: Pfizer, Bayer, Merck/MSD, Wyeth, Gedeon Richter, and Icon⁸⁵. Additionally, there are manufacturers of male and female condoms, such as Innolates (Thailand) Ltd and Hartwood Enterprises.

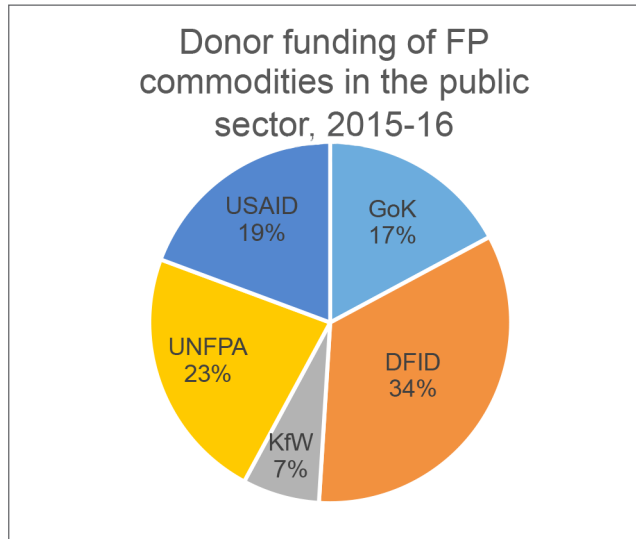
Manufacturer	Products
Pfizer, Inc.	Depo-Provera (injectable), Sayana Press (injectable)
Bayer HealthCare	Diane (COC), Eugynon (EC), Jadelle (implant), Logynon (COC), Microgynon (COC), Microgynon-30 (COC), Microlut (POP), Mirena (IUD), Neogynon (EC), Norigynon (injectable), Noristerat (injectable), Norplant (implant), Yasmin (COC)
Merck Co., Inc.	Implanon (implant), Implanon NXT (implant), Marvelon (COC), Megestron (injectable), Mercilon (COC)
Wyeth Pharmaceuticals	Microval (POP), Nordette (COC), Tridinol (COC)
Gedeon Richter, Ltd.	Postinor-2 (EC)
Icon, Ltd.	Optinor (EC)
Famy Care	Femiplan (COC), Femiplan (injectable), Smart Lady (EC)
Pregna	Copper T 380A (IUD)
Multilan AG	Multiload copper IUD
Innolates (Thailand) Ltd	Male condoms
Hartwood Enterprises	Female condoms

Table 4-2 Summary of contraceptive manufacturers and their products distributed in Kenya.

Donors

Kenya's public sector depends heavily on international donor funding for FP. The main international donors funding family planning are United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), the British Government's Department for International Development (DFID), and the German Development Bank (KfW). Donors procure whichever FP commodity GoK has not allocated funds for. This process is handled internally between donors through their own agents. Only KfW procures through

MoH and KEMSA⁸⁶. For example, in 2015, UNFPA procured contraceptive pills and emergency contraception for the government while in 2014 they procured Depo injections and implants⁸⁷. To procure the needed commodities, the donors work with all the main manufacturers of contraceptives that are approved by the World Health Organization (WHO). The main manufacturers of contraceptives are Pfizer, Bayer and Merck.



More details about contraceptive manufacturers and their products are presented under Manufacturers for the Public Sector above.

In 2015-16 donors have committed to contribute 83% to the MoH's 7.6 million USD FP budget, while GoK will contribute 17% to the FP budget. The gap in funding for 2015-16 is USD 1,270,422⁸⁸. Further analysis of the donor support over the past years and with projections for future are presented in the section describing Market Dynamics below.

Figure 4-2 Source and percentage of funding of FP commodities in the public sector in Fiscal year 2015-16. Source: MoH DRH presentation

Distributors

Government health facilities are supplied with contraceptives by the Kenya Medical Supplies Authority (KEMSA). KEMSA receives its funding by charging county governments for the medical supplies they acquire through them. However, contraceptives are provided to the counties free of charge as all FP commodity procurement costs are covered mainly by international donors and a small percentage by GoK.

KEMSA is trying to replace its old supply-driven distribution model with a new, demand-driven model. In KEMSA's new distribution model, county health facilities have to submit quarterly orders and the appropriate payment to KEMSA. Upon submission of orders and payment, KEMSA will process the order and dispatch commodities to specific facilities within the county. Under this model, KEMSA strives to ensure that its medical commodities stocks are in line with market demand⁸⁹.

The new demand-driven model is set up with one central warehouse in Nairobi, from which supplies are procured and distributed to sub-county district stores. Distribution is outsourced to third-party logistics, transport and courier providers that deliver commodities to the sub-county district stores^{90 91}.

In practice however, smaller health facilities continue to rely heavily on regional (level 5) hospitals for buffer stock as the "norm" for replenishing stock, rather than executing and monitoring effective inventory management controls within their own facilities. In many places, a mix of old and new distribution models or 'push and pull' systems are in existence. In these cases KEMSA pushes FP commodities out to facilities based on data on consumption/issues from previous quarters⁹².

KEMSA has integrated contraceptives supply to counties into the ordering system for the paid-for products. This means that at the bottom of the order form, county health facilities can order free FP commodities along with other paid medical supplies⁹³. This might make the order processing and distribution easier for KEMSA⁹⁴, but it makes county health facilities unable to order free FP commodities if they lack funds for other paid medicines.



Figure 4-3 KEMSA’s “priority” distribution chain of contraceptives

Key informant interviews give evidence to a widespread flow of free family planning commodities to the private sector⁹⁵. In fact, this is an official route from public sector to private for-profit and not-for-profit health facilities where those who have a master facility number can order FP commodities from KEMSA stores free of charge. Also, if facilities are out of stock of FP commodities before the quarterly order, they can go and collect these from the sub-county district stores⁹⁶. It is also confirmed by MoH that it has approved supplying of the private sector with FP commodities, as the GoK’s policy aims to provide free FP to all Kenyans. At the same time, the GoK wants to promote and animate private sector engagement⁹⁷. How it is envisioned to happen is less clear, as MoH and GoK expect the commercial sector to make the first move in buying FP commodities at full price from alternative sources despite the availability of free goods. Apart from the official supply of commodities from GOK through KEMSA to private facilities with a MFL number, and how much this creates a dependency on the public sector, anecdotal feedback from implementers suggest that there is unofficial leakage of supplies from GOK to private providers, e.g. pharmacies buying Depo for as low as Kes 5 per vial even though it bears the GOK “not for sale” mark.

Currently, most commercial health facilities that provide family planning rely solely on FP commodities provided by the public sector free of charge⁹⁸. It is unlikely that commercial FP providers are incentivised to find more expensive commercial supply chains as long as a) all Kenyans regardless of their economic status are entitled to free FP (a policy change would be required), b) they can access free FP commodities through public sources (both a policy change and better enforcement would be required) and c) there is not a large enough market to be worthwhile for the commercial sector to find alternative supply chains. For other medical commodities, several parallel systems of supply have emerged to supply public and commercial sector, but not for FP⁹⁹. This results in frequent stock-outs of contraceptives in both the public and commercial sectors.

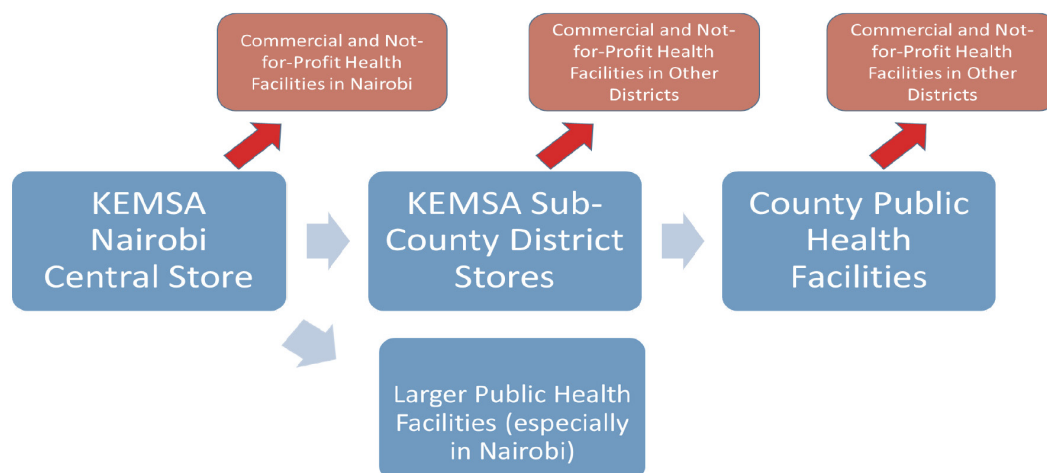


Figure 4-4 KEMSA’s actual distribution of contraceptives to the commercial and public sector

Public providers

Data compiled by the MoH shows that in 2013, the public sector owned 48% of health facilities (Figure 4-5), most of which are concentrated in Nairobi and Western part of the country (Figure 4-6). The majority of public facilities are health centres and dispensaries, while the majority of private facilities are clinics and dispensaries. The public sector also has the largest number of hospitals (56%)¹⁰⁰.

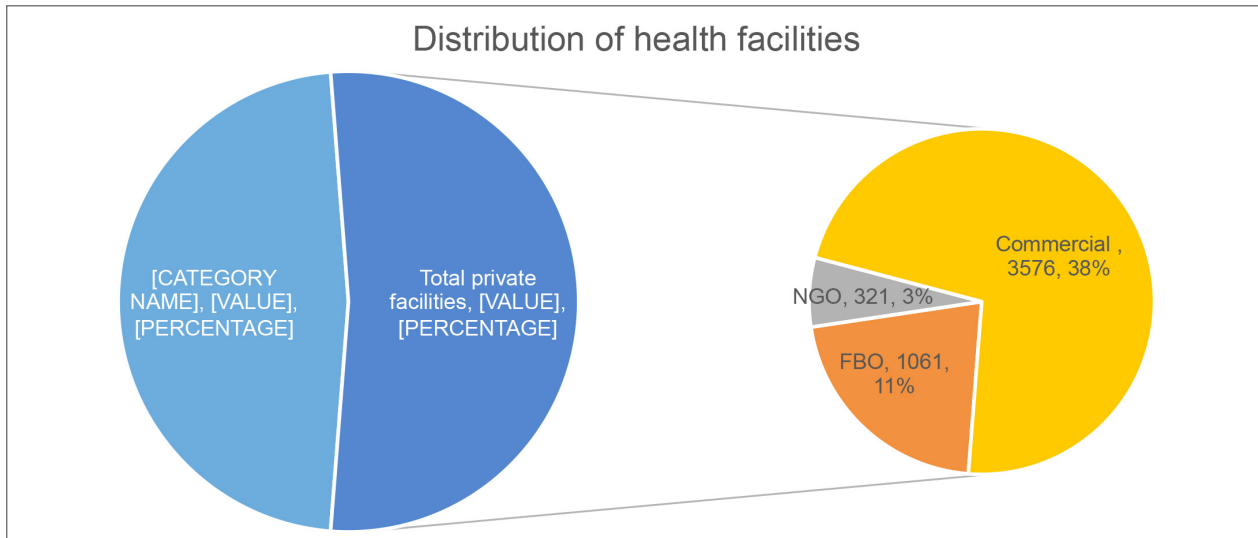
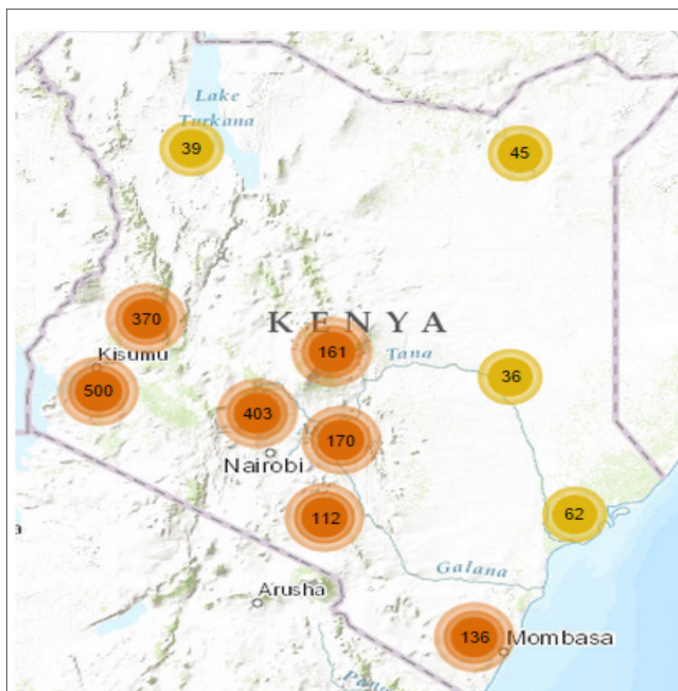


Figure 4-5 Distribution of health facilities in Kenya in 2013. Source: PSP4H2014



In 2013, the majority of Kenyan healthcare professionals worked in the private sector. Almost three quarters of doctors and almost two-thirds of nurses and clinical officers worked in the private sector¹⁰¹.

Studies have found that in Kenya, almost one third (29%) of staff were absent in a public health facility. Staff at public health centres were three times more likely to be absent than those at private, non-profit health centres. The 2010 Kenya Service Provision Assessment survey found that the prospect of being attended to quickly was an important reason for seeking care in private facilities rather than in public facilities where patients often faced longer queues and waiting times¹⁰².

Figure 4-6 Map of Kenyan public health facilities. Source: Kenya Open Data

Despite the fact that the private sector owns the majority of health facilities in Kenya, in 2014, 87% of the FP market share was under the public sector, distributing the biggest quantities of nearly all of the FP methods. The market share and quantities distributed in Kenya have remained fairly constant over the past ten years. A more detailed description of changes in the market share will be presented in the section covering Market Dynamics: Supply Side below.

Sector	Quantities distributed 2014		Market share 2014
Public sector	Pills	1,406,118	87%
	Injectables	5,841,200	
	Implants	784,273	
	IUDs	101,946	
	Total	8,133,537	
Not-for-profit sector	Pills	2,639,880	13%
	Injectables	258,336	
	Implants	18,964	
	IUDs	12,356	
	Total	2,929,536	
Commercial sector	Pills	67,689	< 1%
	Injectables	48,841	
	Implants	0	
	IUDs	0	
	Total	116,530	

Table 4-3 Quantities of FP distributed in 2014 and market share by sector.

Source: PS Kenya TMA RH 2014.

Users

Rural women tend to use public health facilities more than their urban counterparts. In Mombasa more women get their contraceptives from the private sector and in Nairobi almost as many women get theirs from the private sector as from the public sector. The greatest reliance on public facilities for family planning is amongst rural women aged 25 to 49, followed by rural women aged 15 to 24. This is partly due to the limited number of private facilities in rural setting. For more detailed information see section 3 on consumers' health seeking behaviour above.

4.3 Overview of Private Not-for-Profit (NGO and FBO) Family Planning Channels

Kenyan Faith-Based Organisations (FBOs) have a long history (over 100 years in some cases) and long-standing relationships with the MoH. Nearly one-fourth of all health facilities in Kenya are affiliated to FBOs. There are three main faith-based umbrella associations that offer health services to rural Kenyans. These are *Christian Health Association of Kenya (CHAK)*, *Kenya Episcopal Conference (KEC)*, and *Supreme Council of Kenya Muslims (SUPKEM)*.

Kenya has a thriving and active NGO health sector, in large part due to donor support in response to pressing health priorities such as HIV/AIDS, malaria, tuberculosis and family planning. The *Health NGOs Network Best Practices Technical Working Group* estimated the number Civil Society Organisations (CSOs) working in health-related activities to be greater than 6,000¹⁰³.

Manufacturers for the NGO and FBO sector

There are no not-for-profit manufacturers; all manufacturers of contraceptives are commercial, for-profit entities. These commercial manufacturers, in addition to selling branded products to government health facilities, provide the same branded contraceptives to the private, not-for-profit market through NGO and FBO family planning providers in much smaller quantities (see Table 4-2 List of contraceptive manufacturers and their

products). The not-for-profit sector is dominated by generic contraceptives such as Femiplan combined oral contraceptive, Femiplan 3-month injections (manufactured by Famy Care India and marketed by PS Kenya), and Trust condoms. The private market is also infiltrated by illegal cross border imports such as Salama condoms (manufactured by Cupid Ltd.), from Tanzania. A number of original and generic emergency contraceptives such as Postinor 2 and Smart Lady (manufactured by Famy Care Ltd. and marketed by MSK) are also available in the market. In addition to the socially marketed pills and injectables, PS Kenya also distributes IUDs (Copper T 380A manufactured by Pregna) and implants (Jadelle manufactured by Bayer and Impanon NXT by Merck) through its Tunza social franchise.

Donors

The non-for-profit family planning sector is highly subsidised and dependent on donor funding. The same donors who support FP commodity procurement for the public sector also support it in the NGO sector. For example, UNFPA subsidises the FP commodity procurement for MSK, Family Health Options Kenya, PS Kenya, and Millennium Village Project¹⁰⁴. DFID has historically funded FP commodity procurement through PS Kenya¹⁰⁵ while USAID has over the years supported demand creation and communications as well as social franchising and social marketing programme implementation¹⁰⁶. KfW has funded the AMUA network of clinics implemented by Marie Stopes Kenya¹⁰⁷.

Distributors

After KEMSA, the Mission for Essential Drugs and Supplies (MEDS) is the second largest distributor of drugs and medical products. MEDS is a Christian not-for-profit organisation registered as a Trust of the Ecumenical Partnership of the Kenya Conference of Catholic Bishops (KCCB) and the Christian Health Association of Kenya (CHAK)¹⁰⁸. MEDS supplies hundreds of health facilities in the FBO and NGO sector. It was established primarily because FBO and NGO member facilities could not count on KEMSA for obtaining supplies of drugs¹⁰⁹. However, MEDS does not procure or distribute any contraceptives because of its religious mandate. This is unlikely to change, leaving KEMSA and NGO distributors to cater for the entire FP market. Some FBOs receive FP commodities from the MoH as donations¹¹⁰.

PS Kenya mainly relies on Crown Agents, PSI's Washington office and an internal supply chain department to facilitate procurement of the health products. The products are procured using international procurement and quality standards from various manufacturers, both internationally and locally depending on availability, quality and cost of the product. PS Kenya has one central warehouse located in Nairobi where all goods from the manufacturers are received, in addition to three regional warehouses in Nyanza, Western and Coast regions. The central warehouse and three regional warehouses store and distribute products to distributors and other outlets such as clinics. The products are then moved from the distributors to wholesalers and finally to the retail level where consumers can access them¹¹¹.

PS Kenya partners with commercial sector distributors, wholesalers, retail outlets, its franchised Tunza clinics and community based organisations in the distribution of Trust and Femiplan condoms, Femiplan pills and injectables, IUDs and hormonal implants under the Reproductive Health Programme. As of September 2015, the Tunza franchise which was established in 2008 had 310 facilities. The Tunza franchise offers both long term and short term methods of FP. Tunza providers can procure IUDs and implants from PS Kenya at Kes 30 and 100 respectively. However, 75% of the commodities used in the franchise come from government sources, with only 25% being procured from PS Kenya. In 2009, PSI/Kenya started partnering with the GoK in the distribution of free condoms with an objective to improve accessibility to free GoK condoms among the poor and rural populations. PS Kenya is distributing the condoms through 278 CBOs and 186 health facilities, which further distribute them to end users¹¹².

PS Kenya condoms (Trust and Femiplan female condoms) make up 96% of sales volume of all commercially distributed condoms in Kenya, and PS Kenya's sales value share of condoms in Kenya is around 90%. All the

other male condom brands, such as Durex, Rough Rider Studded, LifeStyle and Skyn, Delux, Leo and Playboy make up less than 1% of sales volume each.

PS Kenya's socially marketed injectable called Femiplan accounts for 93% of the sales volume of injections in the private market. The rest is divided between Pharmacia N.V and Pfizer. Pfizer currently sells more to the rural segment than to the urban segment.

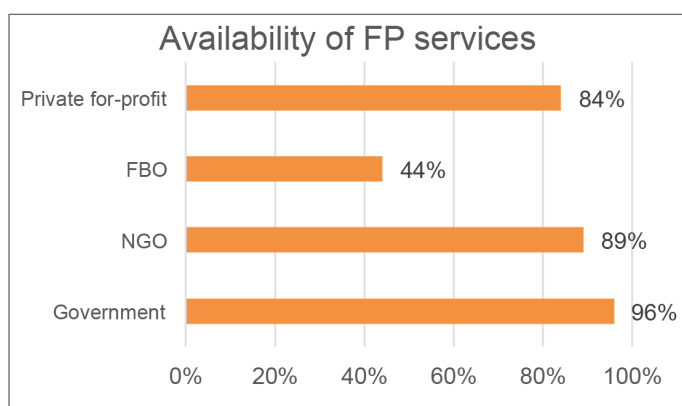
PS Kenya's socially marketed pills accounted for 99.4% of the pills volumes in May 2015. Illifamy and Schering Pharma pills account for less than 1% of the pills sales volume. About 0.3% of pills in the commercial sector are Microgynon¹¹³.

Marie Stopes Kenya has also operated the Amua franchise on behalf of the MoH and with KfW support since 2004, and currently has 406 facilities with an average annual couple years of protection (CYP) of 256,000. The primary source of FP commodities for Amua franchisees is the government via county health structures. MSK supports the franchisees in acquisition of MFL (Master Facility List) numbers, through which they are able to access the county health supply chains. However, Amua maintains FP commodity buffer stock that is distributed to franchisees at no cost during Amua Leo Events (facility based promotional events) and when there are national wide public sector stock outs. MSK procures and distributes selected facility improvement equipment which is distributed to franchisees at 80% subsidy.

The Kisumu Medical Trust (KMET) runs the Huduma Poa network, which is mainly in the Western part of the country. The Huduma Poa network was launched in 2012 and had 79 facilities by the end of 2014 and had achieved 36,274 CYPs for all methods from 2012-2014. Generally, providers get FP commodities (both long term and short term) from the government. In instances of public sector stock out, KMET bridges the gap by supplying these providers with FP commodities at subsidised cost.

Providers

In 2013 FBOs owned 11% and NGOs 3% of all the health facilities in Kenya (Figure 4-5)¹¹⁴.



Kenya Service Provision Assessment Survey 2010 found that 96% of government health facilities, 89% of NGO and 44% of FBO, and 84% of private for-profit health facilities offered modern contraceptives¹¹⁵.

Figure 4-7 Percentage of all facilities offering FP by type of facility (managing authority), in 2010.

Source: KSPA 2010

Christian Health Association of Kenya (CHAK) facilities mainly comprise medium- to large-sized facilities. They are mostly nursing and maternity homes. These facilities currently offer short-term methods, mainly due to low skills and equipment levels. They appear to have a stretched capacity, generating concern that they would be unable to manage any increase in client flow. Most of the facilities are located in rural settings serving rural populations¹¹⁶. Catholic affiliated health facilities do not offer family planning services.

FP prices of socially marketed products were found to be very constant and predictable, especially in pharmacies. The prices are approximately 30 KES for a one-month supply of FP pills and 65 KES for the injectable method (for three months). Emergency contraception prices range from 80 to 120 KES per dose for generic and original products, respectively¹¹⁷.

Users

About 10% of users go to facilities run by NGOs and FBOs¹¹⁸. For more detailed information see section 3 on Consumers' Health Seeking Behaviour, Need and Demand above.

4.4 Overview of Private For-Profit (Commercial) Family Planning Providers

Manufacturers supplying the commercial FP sector

The list of commercial manufacturers that supply the public sector, not-for-profit sector as well as commercial sector and their FP products are listed under Manufacturers for the Public Sector above. There is very little demand directly from commercial distributors and providers for contraceptives. This can be attributed to the fact that commercial distributors and providers can access the same products for free from the GoK. For instance, only about ten boxes per month of one of the most popular FP products - Depo Provera contraceptive injections - are ordered from its manufacturer, Pfizer, by commercial providers¹¹⁹. All large contraceptives manufacturers prefer selling in bulk to GoK directly or through donors, and not directly to commercial or not-for-profit sector distributors. This is because¹²⁰:

- Currently only GoK has high enough volumes
- Donors guarantee volumes (for GoK) and pay manufacturers any losses, if agreed volumes are not ordered
- Some manufacturers do not trust private distributors to distribute only in the region and fear that they might start selling cheaper contraceptives from Africa to Europe, making more profit and putting European distributors out of business

Distributors

As mentioned earlier, for-profit clinics, hospitals, dispensaries and pharmacies get most of their supplies from public sector sources¹²¹. It is an official route from public stores to private for-profit and not-for-profit health facilities who have a master facility number and can order FP commodities from KEMSA free of charge. If facilities are out of stock of FP commodities before their quarterly order, they can go and collect these from the sub-county district stores¹²². For other medical commodities, several parallel systems of supply have emerged to supply public and commercial sector, but not for FP¹²³. It is unlikely that alternative supply chains for FP will be explored while commercial providers have access to free FP commodities from the public sector.

Additionally, donor-funded socially marketed products make up over 90% of the market. Currently economies of scale for contraceptives in the commercial sector are absent. The effect of subsidies on the commercial sector is further explored under Market Dynamics and Constraints Analysis sections below.

Providers

Data compiled by the MoH shows that in 2013, the private sector owned a higher percentage of health facilities than the public sector (52% compared to 48%, respectively). Within the private sector, the commercial sector owns almost three quarters of health facilities (72%), followed by FBOs (22%) and NGOs (7%). The majority of public facilities are health centres and dispensaries, while the majority of private, facilities are clinics and dispensaries. The public sector has the largest number of hospitals (56%), followed by the for-profit sector (25%) and the not-for-profit sector (18%). The private for-profit sector dominates the nursing home segment (mainly small-to-medium-size private hospitals) and health clinics. The public sector and not-for-profit sectors own most of the health centres and dispensaries.

In 2007/08, the majority of Kenyan healthcare professionals worked in the private sector, at either a for-profit or a not-for-profit organisation. During the same period, almost three quarters of doctors and almost two-thirds of nurses and clinical officers worked in the private sector. This trend held true in 2013¹²⁴.

Despite the high number of health facilities owned by the commercial sector, in 2014 the public and not-for-profit sectors provided 99% of the FP commodities and services in Kenya. PS Kenya Total Market Approach study shows that since 2003, the commercial sector's contribution to providing FP in Kenya has stayed the same, i.e. approximately 1% of the total market share¹²⁵.

Kenya Association of Private Hospitals (KAPH facilities) are typically large health facilities and have lower volumes of FP clients compared to smaller health facilities. This is likely due to the owners' perceptions about the low profitability of FP services¹²⁶. Many of the KAPH facilities are already partnering with branded networks, the most prominent brand in these facilities being the Huduma Poa network operated by KMET¹²⁷.

Individual private sector facilities are high in number across all counties¹²⁸. They currently lack capacity in FP skills, method mix, counselling, and equipment. These facilities are easy to access with minimal bureaucracy involved. They also generally are perceived to be more affordable than KAPH facilities¹²⁹.

- **Price and profitability**

According to a study conducted in 2014, 26% of all health facilities in Kenya charged fees to clients for family planning services. Seventy-one percent (71%) of all health clinics and 63% of pharmacies charged a fee for FP services. Ten percent (10%) of health centres and 9% of dispensaries charged a fee for FP¹³⁰. The nurse midwives in private health facilities charge a minimal fee for the services they offer. The majority charge 20 Kes for pills, 50 Kes for an injection and 200 Kes for an implant¹³¹.

There is considerable downward pressure on prices and hence little potential profitability for the commercial sector. Consumers are aware of free supplies from public facilities and highly subsidised prices in the NGO sector¹³², which can make commercial providers even more inclined to rely on free contraceptives rather than finding a private distributor with non-competitive prices.

Inclusive business models have been implemented in the health sector to increase access to life saving products. These models typically bring together a wide range of public and private sector partners including commercial sector actors. They are typically low-margin, high-volume businesses where the commercial sector has to have incentives to invest in building a commercial FP market, usually in form of high volumes guaranteed by donors. An example is the AMFm partnership that brought together manufacturers of first line medicines for malaria, governments, donors and commercial distributors to expand access to affordable artemisinin-based combination therapies (ACTs), through the private sector. Through this partnership, the retail price of first line malaria medicine was reduced from approx.. Kes 200 to approx.. Kes 40 per dose. An independent evaluation of the AMFm partnership which showed that: i) a combination of price negotiations; ii) a subsidy provided directly to manufacturers; and iii) large-scale mass communications; led to rapid and major changes in price, availability, and market share of quality-assured ACTs. One of the key lessons from the ACTs partnership is that for this type of approach to work there is need for dedicated resources (financial and human resources). AMFm had a dedicated team overseeing implementation and a dedicated research and monitoring arm (the ACT Watch) to assess its impact and give feedback to stakeholders.

Another inclusive business model in health is the one promoting the uptake of oral rehydration salts (ORS) co-packaged with zinc in Kenya and Nigeria. In Kenya the strategy involves increasing awareness at each source of treatment – among caregivers, public health providers and private clinics and pharmacies. For providers in both the public and private sectors, the aim is to ensure that healthcare workers are properly trained to assess children suffering from diarrhea, and to use ORS and zinc as the first-line treatment. According to the distributor of the co-pack (PHSL), initial results showed that higher volumes are required to achieve sustainability. Only 20,000/mth were sold in the first half of 2014 whileas for the business model to be profitable at the current price, the sales volume would need to scale to 100,000 co-packs per month. Furthermore, following the adoption of a devolved structure, counties are now mandated to procure drugs directly from the Central Medical Stores (CMS). As a result of challenges with planning and financial processing, several counties had shortages of

essential medicines, including ORS and zinc. The results of initiatives that bring together all actors in the health sector to increase access to life saving products should be reviewed and the lessons from such initiatives considered when coming up with similar approaches in family planning. Results show there is need for demand creation, donor investments and high levels of coordination between public and private sectors¹³³. The primary interests of the commercial FP sector (profit) and public sector (higher CPR) differ and more often than not donors are necessary to guarantee high enough volumes and/or marketing costs, especially when governments cannot afford to do it alone.

- **Stock-outs**

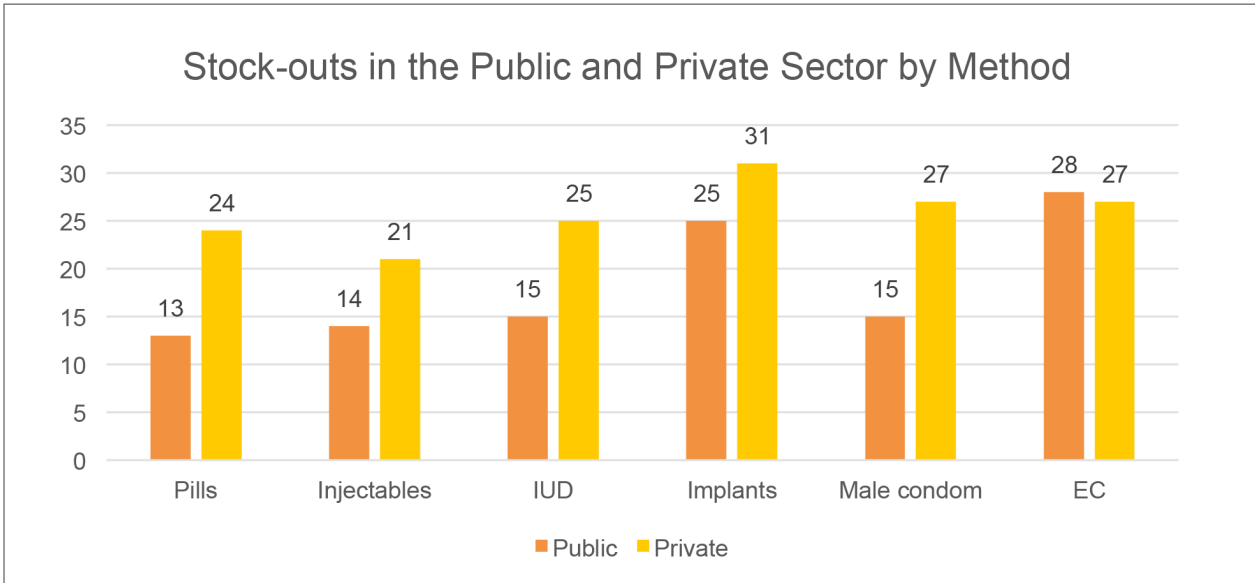


Figure 4-8 Percentage of health facilities that reported stock-outs in the past 12 months. Source: PMA 2020

Despite 16% of public and 22% of private facilities reporting stock-outs in the past 12 months¹³⁴, only 2.1% of women switched the method or stopped using it because the method was not available/ accessible¹³⁵. Commercial pharmacy owners pointed out during a focus group discussion that it is easy to convince a woman to use another method in case of stock-outs. Usually the switching is between short-term methods such as injectables to pills or vice versa¹³⁶. In some places consumers can switch providers in the event of a stock-out.

Despite problems in supply chain both in private and public sector, it is believed that women’s fear of side-effects, lack of partner communication, and provider biases are more significant barriers to increased contraceptive use than supply interruptions¹³⁷.

Users

Many Kenyans believe that healthcare should be a public good, not a profit-making business. This perception may influence consumers’ willingness to pay for consultations that they do not consider treatment for an illness. This is especially applicable to family planning: the majority of Kenyans have come to expect free contraceptives regardless of their economic status. This expectation is fuelled by widely available free and subsidised commodities as well as by GoK’s policy to provide free FP to all Kenyans.

According to PSP4H research, private sector providers are preferred over public sector providers because of their perceived quality of services, confidentiality, convenience (longer working hours), easy access to the facility, positive provider attitude and behaviours, availability of specialised services, shorter waiting times, availability of staff (particularly doctors), and availability of equipment and supplies¹³⁸. The majority of Kenyans access FP through public facilities, especially in rural areas, but there is a need for greater provider friendliness

and more positive attitude, especially for younger, unmarried FP users. This is a gap that the commercial sector could possibly fill. Under current conditions, the commercial sector will not be able to compete on price, but could attract users with unbiased, confidential and professional service. For more detailed information on users accessing FP through private and commercial providers see section 3 above.

4.5 Family Planning Market Dynamics: Supply Side

This section describes the dynamics of Kenya's family planning market, including changes in donor funding, devolution, market share, franchises and new entrants that shape the FP market. More interpretative analysis of the constraints is presented in the constraints analysis, after having established root causes and areas of impact to the FP market in the "problem tree".

Key section highlights:

- It is unlikely that the overall funding for FP commodities in the public and NGO sectors will decrease in the next few years.
- Commercial manufacturers see little demand for unsubsidised FP products from the commercial sector, preferring instead to focus on public sector tenders.
- Approximately 5% of Kenyan population can pay full commercial price for healthcare, 50% can pay less than full price and 45% can only afford free healthcare. It is likely that similar trends hold true for FP. TMA for FP would at best shift the current market by 5% towards commercial providers.
- Market share of different sectors has remained practically the same since 2003, where public sector has the greatest share. Fluctuations in the market share of public sector are compensated by the NGO sector, while the commercial sector has remained dormant.
- Even with devolution, the private sector continues to access free commodities from County health stores and hence they have little or no incentive to purchase FP commodities from commercial sources
- Vouchers have successfully been used to increase FP access through the private sector, especially for long acting methods like Implants and IUDs. However, ensuring that the subsidy is targeted at women who deserve it is labour intensive and logistically very challenging. There is need to identify more innovative and objective ways to ensure the subsidy only reaches deserving women.

• How the market is changing

Funding and provision of FP services:

The main international donors funding family planning are UNFPA, USAID, DFID, and KfW. GoK's funding of family planning commodities has decreased significantly over the years as shown in the figure below.

In 2008 the GoK started funding the procurement of family planning commodities. By 2012-13, GoK funded about 40% of the family planning commodities procured through KEMSA. However, with devolution, the national government did not fund FP commodities in 2013-14 as health was a devolved function and funds for commodities were transferred to counties. During that period counties were responsible for procuring the commodities directly for themselves through KEMSA. This did not work very well and therefore in 2015, GoK allocated 1.3 million USD for FP commodities, which is only about 17% of the need for FP procured through KEMSA, with the balance of 83% being donor funded (see Figure 4-2)^{139 140}.

How Funding of Kenya's FP Market is Changing

- GoK's funding of FP has decreased significantly over the years
- Simultaneously, international donors have increased their funding to fill the gap
- It is unlikely that the overall funding for FP commodities in the public and NGO sectors will decrease in the next few years

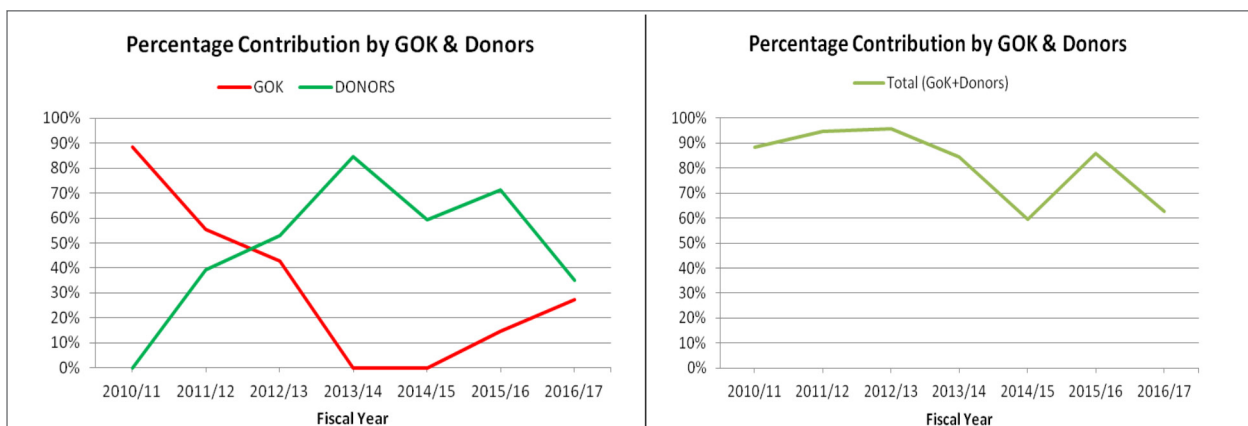


Figure 4-9 Percentage contribution towards FP commodities through the public sector by GoK and donors.
Source: MoH DRH presentation

Despite an extensive donor contribution towards GoK's FP budget, gaps for funding remain. The expected cost of supply plan (excluding condoms) for the FY2015/16 is USD 8,946,016 and for the FY2016/17 is USD 13,786,747. This cost factored in the quantities required to maintain optimal min-max levels (i.e. 16 and 22 month-of-stock respectively) and ensure uninterrupted supply. The commodities already committed against the supply plan are worth USD 7,703,900 in FY2015/16 and USD 8,629,857 in FY2016/17. Therefore the funding gaps are USD 1,242,116 for 2015/16 and USD 5,156,890 for 2016/17.

Commodity	Quantity Required	Estimated Cost (USD)	Quantity	Estimate Date of Arrival	Agency
DMPA (injectable)	5,950,000	6,188,000	2,450,000	Aug 2014	KFW
			2,000,000	Nov 2014	UNFPA
			1,500,000	Dec 2014	USAID
Jadelle (implant)	418,057	3,699,804	4,000,000	March 2015	UNFPA
			60,000	Sept 2014	USAID
			50,000	Aug 2014	KFW
Implanon (implant)	240,000	2,158,080	100,000	May 2015	USAID
			95,000	Feb-15	UNFPA
			190,000	Jun-14	USAID
COCs	1,248,792	280,978	50,000	Aug-14	KFW
			1,248,792	Jun-14	USAID
POPs	1,919,649	620,047	660,000	Jan-15	USAID
			652,419	Nov-14	UNFPA
EC Pills	24,991	22,842	24,991	Jan-14	UNFPA
IUCD	159,402	81,614	70,067	Jun-14	USAID
			89,335	Dec-14	USAID
			30,000	Sep-14	UNFPA

Table 4-4 Donor procurements by method in 2014/2015

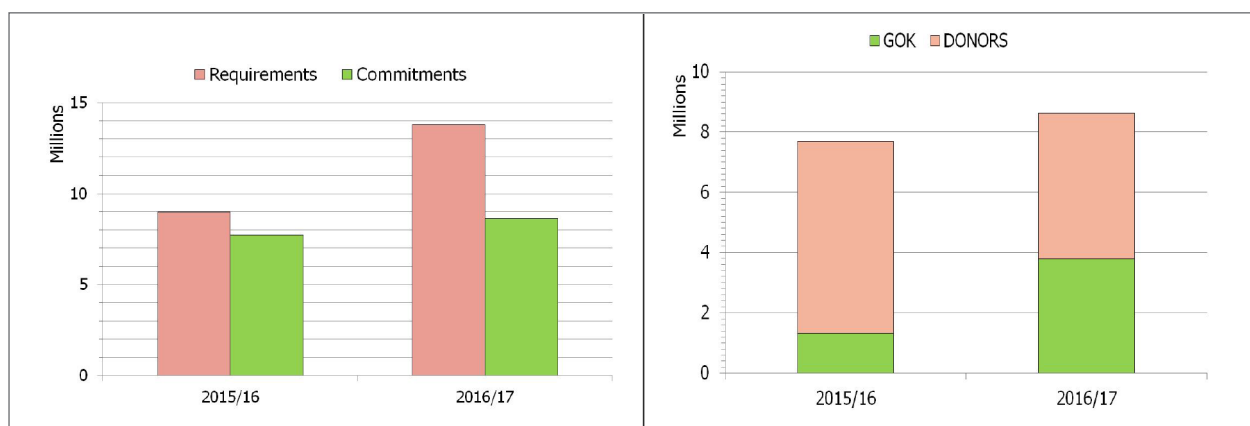


Figure 4-10 Requirements and commitments in USD for fiscal year 2015-16 and 2016-17 (left) and GoK and donor contribution towards FP budget.

Source: MoH DRH presentation

The gap in the need for FP commodities provided by GoK is covered by donor funds. With the overall increasing support from the GoK and international donors, the public sector has remained the largest provider of family planning services in Kenya. Based on funding trends in the past five years, it is highly likely that funding for FP through MoH will remain at least on the same level, as major donors have not indicated otherwise. There might be slight changes in funding direct commodity procurement through the public sector towards funding behaviour change communication and voucher schemes through the not-for-profit sector¹⁴¹.

Possible future projection in case of decreasing donor funding and subsidies are presented in the Constraints Analysis.

Subsidies:

Information on levels of subsidies is presented in the table below. Influenced by the high level of subsidies, in 2014 the public sector market share was 87% and the not-for-profit sector share 13%, leaving less than 1% to the commercial sector¹⁴². The effect of subsidies is clear: manufacturers see little demand for unsubsidised FP products from the commercial sector, preferring instead to focus on public sector tenders.

Product	PROCUREMENT PRICE 2010 (USD)	PRICE TO TRADE 2010 (USD)	PRODUCT SUBSIDY 2010 (USD)	Subsidy %
PSI Femiplan Pill	0.39	0.24	0.15	40
GoK Pills	0.31	0.00	0.31	100
PSI Femiplan injectables	1.04	0.59	0.45	43
GoK injectables	1.12	0.00	1.12	100
PSI IUDs	0.62	9.41	(8.79)	-1418
GoK IUDs	0.62	0.00	0.62	100
PSI Implants	24.95	11.76	13.19	53
GoK Implants	25.66	0.00	25.66	100

Table 4-5 Level of subsidies in the not-for profit and public sector, by method. PS Kenya that has the majority of the not-for-profit sector market share is used as a proxy for the level of subsidies in that sector. 1 USD= 85Ksh.

Source: PS Kenya TMA RH 2014

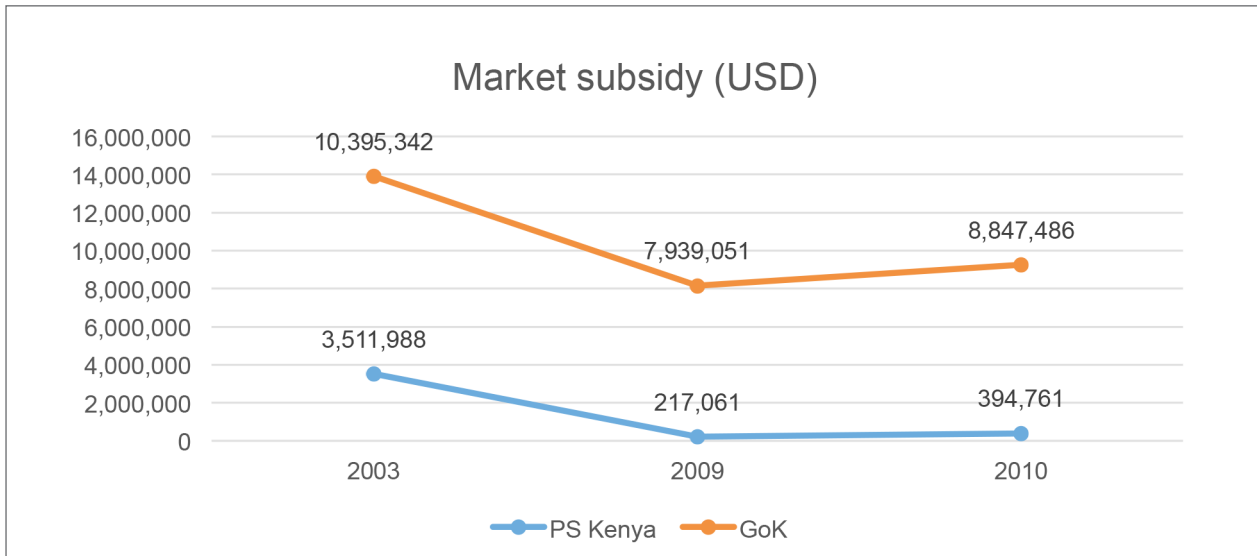
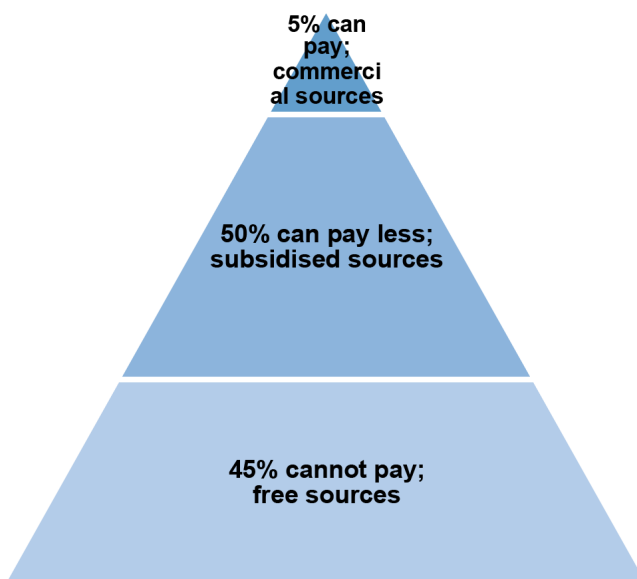


Figure 4-11 Level of market subsidy in USD. Source: PS Kenya TMA RH 2014.

Thanks to subsidies, the majority of users (99%) find contraceptives affordable¹⁴³. However, subsidies are not that well targeted as nearly 90% of the wealthiest users are getting free or highly subsidised contraceptives¹⁴⁴.

The Total Market Approach (TMA) combines free, subsidised and commercial product delivery methods for a more sustainable delivery approach that targets all segments of a population. TMA and its strategy is particularly useful when poor coordination amongst donors have led some populations to be oversupplied with health goods, while others do not have access to them. In Kenya, FP is accessed more or less equally by the poorest and the wealthiest, with only 2.1% of all WRA not being able to access FP due to price or availability. This means that consumers who cannot pay and those who can pay less for FP are currently being served by the public and NGO sectors. Due to inefficient targeting of subsidies, the segment of Kenyan population that can pay full commercial prices are able to access free or subsidised commodities as well.



PSP4H research indicates that approximately 5% of Kenyan population can pay full commercial price for healthcare, 50% can pay less than full price and 45% can only afford free healthcare¹⁴⁵. It is likely that similar trends hold true for FP as well. Although currently nearly 90% of the wealthiest consumers access free or highly subsidised commodities, implementing a TMA to determine to whom free or subsidised products go, would shift the current market by 5% towards commercial providers. It would mean cutting the subsidies from the wealthiest segment, who only constitute a marginal part of the population in Kenya. However, there may be an opportunity to investigate what proportion of the 50% who can pay less might be willing/able to buy mid-tier brands – new entrants priced between the current socially marketed brands and the high end commercial brands in the

market. The Kenyan working poor or mid-tier market already pays for healthcare out of pocket, and often in the private sector. The problem the 50% of the market is facing is cash flow and being able to plan their health expenditure. The poor pay for the service they need at the time they need it¹⁴⁶. The lack of acuteness and need

to plan spending might be a contributor to why many Kenyans have come to expect free FP. If, hypothetically, donor funding and untargeted subsidised were to decrease, FP consumers would have to reassess how much they are willing to pay for FP. There is need for further research into willingness to pay for FP among different income groups in Kenya and assessing the potential size of the commercial FP market. Otherwise it would appear that the majority of Kenyan population, i.e. segments that cannot pay or can pay less than commercial prices for healthcare are already catered for.

Figure 4-12 The Kenyan Population Pyramid as Seen by Healthcare Businesses. *Source: PSP4H analysis.*

The challenge to implementing a TMA in Kenya is creating sufficient incentives for the commercial sector to increase its share of the market for FP. The commercial sector tends to respond to increased demand for their goods but implementing a TMA is likely to increase the demand for FP through commercial providers only by 5%.

Another challenge to implementing a TMA in Kenya is policy change and monitoring. In a TMA, government should only provide free FP commodities to the poor who cannot afford subsidised or commercially priced products. Implementing this would entail a policy change to ensure private facilities do not qualify for the free commodities. This would require strict monitoring by the government to ensure that the free commodities do not filter back to the private sector where they are then charged at commercial rates. For instance, it is not uncommon to find GoK's procured free Chaguo Langu pills sold in private pharmacies.

More on subsidies and possible future scenarios if subsidies were withdrawn are presented under constraints analysis.

Changes in Market Share

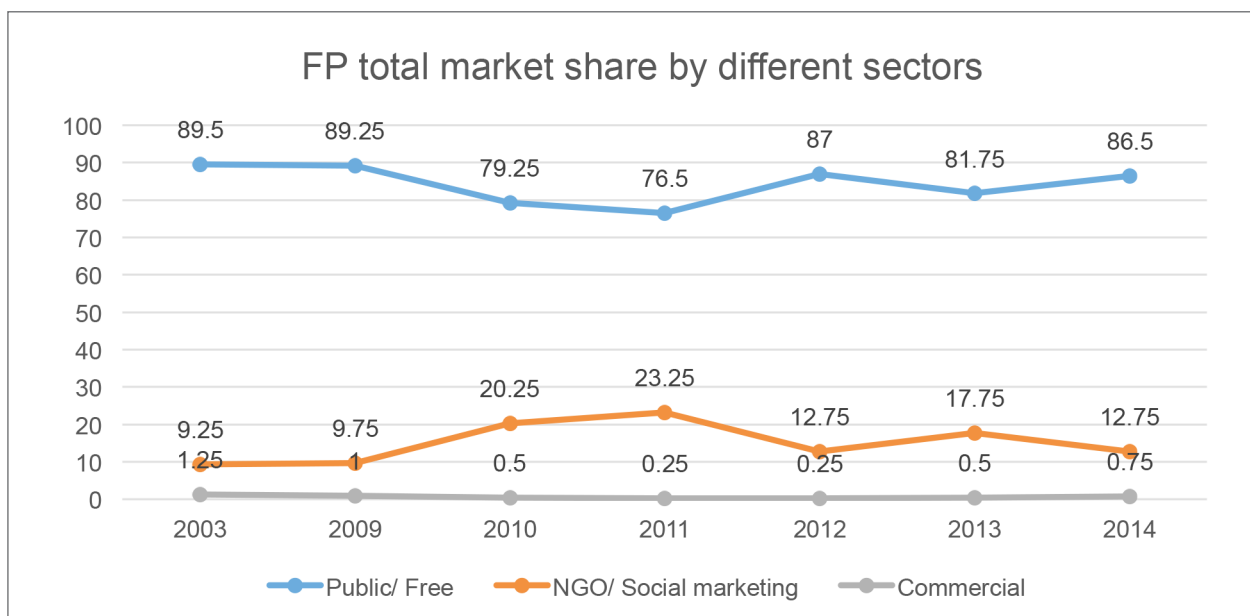


Figure 4-13 FP total market share, percentage, by different sectors 2003-2014. *Source: PS Kenya TMA RH 2014*

Devolution:

Devolution from national to county government level following the Constitution of 2010 includes the decentralisation of healthcare delivery. Devolution of healthcare in Kenya started in 2013 and is currently in a transition phase. Family planning is particularly prone to negative effects of devolution, since family planning can be controversial and susceptible to local cultural and political pressures. Experience from other parts of

the world suggests that these negative unintended consequences do arise in RH. Local governments tend to prioritise other services before FP since family planning is neither a sickness nor an emergency. Also population growth can serve political interests to have bigger electorate and grants that are allocated per capita basis.

With devolution, Counties are expected to request for free FP commodities in the same order form that they use to order for medicines and other supplies from KEMSA. At the bottom of that order form, they are required to indicate types and quantities of FP they need. When the order is being processed the FP commodities are priced at zero since they are free and delivered with the paid for commodities to requesting Counties. The problem with this system is that if a County does not have funds to order /procure other commodities, they may not request for FP until such a time that they have funds to procure other commodities. In addition, if Counties have not paid for other drugs and supplies then this means that they will not be supplied with FP either. This is a weakness in the system that needs to be addressed.

Devolution can exacerbate the delivery of services by fragmenting referral care¹⁴⁷. It has been noted that county health management teams do not plan separately for the FP needs for rural adolescents, but plan for all WRA, which does not help to decrease the unmet need for contraceptives amongst the most underserved group – rural sexually active unmarried women aged 15 to 19¹⁴⁸.

The proportion of the county budgets allocated to health is also a concern. On average only 6% of the general county budget is allocated to health, which is half of what is needed to keep health services at previous levels. FP budgets within counties' health budget are marginal.

The government medical supplier, KEMSA, despite stock-outs of FP commodities in the public sector, also supplies FP commodities to private providers with a MFL number, free of charge. Private providers are expected not to charge for contraceptives supplied by KEMSA, but there are no rules on how much private providers can charge for service provision, and many indeed sell these commodities at a price. Because of the free FP commodities coming from the public sector to the private sector, the latter is making huge profits on free, donated commodities. Private providers therefore have little or no incentives to start buying FP commodities through alternative, commercial distributors or wholesalers as long as they have access to free commodities from the government. By supplying free commodities to the private sector, not only is the private sector profiteering from free commodities it also means the supplies are stretched as they have to cater for the whole population – whether through public, not-for-profit, or commercial channels. The FP market right now is distorted because of the free and subsidised commodities making it difficult for the private commercial sector to operate. With devolution, access to free FP commodities by private providers may eventually come to an end as counties have to procure their health commodities and they may not include private sector requirements in their estimates. Alternatively this practice may recur as in the past albeit at county level.

It is difficult to establish who among the private commercial facilities gets what commodities from where. Even with devolution, commercial providers with a master facility list number can still access free FP commodities from county stores provided they submit usage reports for previously collected commodities with each subsequent request. In addition, commercial providers that are members of social franchises have the option of getting subsidised commodities. This means that buying commodities from commercial channels is the last option for many commercial providers. The effects of this on the commercial sector are unclear but it is evident that they are very real.

FP Vouchers:

Donor investment in voucher schemes has provided mixed and inconclusive results. The experience of a KfW-supported FP voucher scheme showed that providing a demand-side subsidy made little difference to use of long-acting methods. The transaction costs involved with the procedure were probably higher than the price of the method¹⁴⁹.

PS Kenya implemented a DFID-supported FP voucher programme for some years until March 2015. During the implementation of the voucher programme, there was significant increase in FP services uptake in the Tunza network, especially for long acting methods (IUDs and Implants). Analysis of FP services uptake between quarter 1 of this year (Jan –Mar 2015) when the voucher programme was in place, and quarter 2 (April –June 2015) after the programme ended shows a decline in IUD uptake of 34% and of implants by 25%. Overall, long acting methods have been the most affected by the withdrawal of the vouchers. No decline has been noted in the uptake of the short term methods which clients can get from sources other than clinics.

Challenges with FP vouchers

The process of selecting clients for the FP vouchers is subjective because the person distributing the vouchers has to make a judgement call on who gets it and who does not. Without a complete audit, including physically going to the homes of the women who have received the method, it is impossible to verify their inability to pay for the method themselves. On the one hand this would be very cost prohibitive and on the other hand would infringe on the rights of the clients to confidentiality. The system may also be prone to abuse and collusion between voucher distributors and providers where the vouchers are redeemed for FP provision because the vouchers are an extra revenue stream for these providers.

Conclusion:

From PS Kenya's experience, FP vouchers had a positive impact on the uptake of long term methods but no effect on short term methods. However, implementation is labour intensive requiring a team to distribute the vouchers to individual women, a different team to carry out back checks and possibly an external auditor to verify who actually received the vouchers. Even with all these systems, it would be practically impossible to know if the women who receive the vouchers are poor or not.

A more in-depth analysis on the real impact vs cost of implementing an FP voucher programme is needed to be able to state conclusively if it increases access among poor women.

In addition, there is need to strengthen the voucher distribution system to formalise it e.g. through automation to minimise subjectivity in selecting poor clients and to make it easier to do back checks to confirm who the actual recipients are without infringing on their rights to confidentiality. The system of selecting clients requires some form of documentation that is retrievable for ease of monitoring to ensure vouchers go to clients who need them.

Franchises:

There are at least four subsidised social franchising models that provide family planning services: Tunza (PSI), Amua (MSI), CFW Shops (Sustainable Health Foundation), and Huduma Poa (KMET). Such social franchises are promising in terms of enhancing the quality of care and provider training, but struggle with sustainability without donor funding.

Name of franchise	Years in operation	Number of franchised clinics	Total CYPs 2012-2014
Tunza family health network	Since 2008	310	872,185
Amua network	Since 2004	406	256,000
Huduma Poa	Since 2012	79	36,274

Table 4-6 Social franchises and CYP contribution 2012-2014

New products:

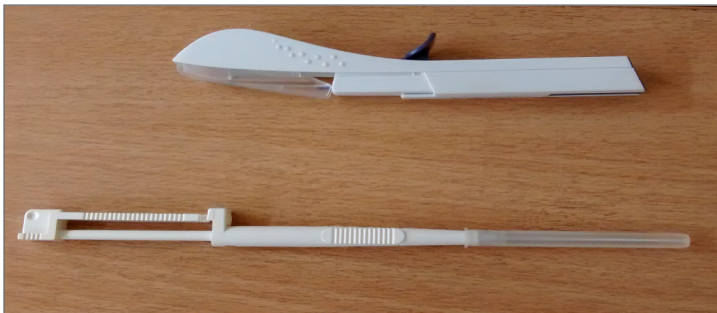
Nearly all the major manufacturers have either introduced or are in the process of introducing a new improved product. Pfizer will be introducing a lower dose Sayana Press injectable contraception which is an easier to administer 3-month injection, which is an improvement from Depo Provera. This product was originally meant for the American market but it is now in Kenya. It is a much more expensive product than Depo Provera



(expected to cost \$1.50 -2.00 to the end user) but there are efforts by Gates Foundation and others to bring down its price. The target group for Sayana Press is middle to higher income segments of the market but if efforts to bring down its price succeed, it will be affordable to wider segments of the market.

Figure 4-14 Sayana Press injectable contraception and a pen. Source: Cardno

Merck has introduced Implanon NXT implant. Merck would like to introduce Marvelon pills through social marketing and is in discussions with various NGOs about this. They would prefer to sell the product at 100% cost recovery to social marketing organisations. The product might be available at \$1 to the consumer.



They would prefer to sell the product at 100% cost recovery to social marketing organisations. The product might be available at \$1 to the consumer.

Figure 4-15 New contraceptive implant and inserting mechanism Implanon NXT (above) and older Implanon (below). Source: Cardno

Also relatively new on the market are phasic pills by Wyeth Pharmaceuticals, Bayer, Teva, Watson Pharma, Ortho-McNeil, Merck and Warner Chilcott. Phasic pills have an altered dose of oestrogen or progesterone or both during the month. This has proved to reduce the incidences of side effects and complications related to oral contraception¹⁵⁰.

Overview of Supporting Functions and Rules

5

5 Overview of Supporting Functions and Rules

In the M4P analytical framework, core supply and demand functions are surrounded by supporting functions and rules (see Figure 4-1). The table below highlights in red functions and rules that are underperforming, in orange those that are partially underperforming and in green those that are performing reasonably well. Functions and rules highlighted in red are among the underlying causes that inhibit the *private, for-profit* market from working better and require systemic change. Some functions and rules that currently seem to underperform are not highlighted in red because they are expected to improve as soon as the underlying, systemic problems are solved. Interventions might be needed in areas highlighted in red to sustainably improve how the FP market works. Key section highlights:

- Rules around consumer education, provider training and consumer perceptions and habits are underperforming while standards and financing rules are performing fairly well.

A more detailed description of supporting functions and rules can be found in the next chapter

	Manufacturers	Distributors	Providers	Users
Supporting Functions				
Finance	performing reasonably well	n/a	performing reasonably well	performing reasonably well
Equipment for family planning services	performing reasonably well	performing reasonably well	partially underperforming	n/a
Consumer education	underperforming	n/a	underperforming	n/a
Targeted subsidies	partially underperforming	partially underperforming	partially underperforming	partially underperforming
Coordination	performing reasonably well	performing reasonably well	performing reasonably well	n/a
Provider training	underperforming	underperforming	underperforming	n/a
Rules				
Consumer perceptions and habits	n/a	n/a	n/a	underperforming
Quality standards	performing reasonably well	performing reasonably well	performing reasonably well	performing reasonably well
Policy and regulations	partially underperforming	performing reasonably well	partially underperforming	performing reasonably well

Legend:

- performing reasonably well
- partially underperforming
- underperforming

Figure 5-1 Overview of the supporting functions and rules. Source: Cardno analysis

5.1 Description of Supporting Functions and Rules for the Private For-Profit Family Planning Market

Supporting Functions

Finance:

Family planning was declared free in all public health facilities in Kenya in 2013¹⁵¹. In the not-for-profit health sector family planning methods are affordable, with highly subsidised prices, funded by international donors.

Manufacturers: Commercial manufacturers are for-profit multinationals, able to raise money on capital markets and from commercial banks. Access to finance is not a major constraint.

Distributors: Commercial distributors rarely stock and supply FP because they cannot compete with the FP products given to commercial providers free-of-charge by KEMSA. Therefore they do not need finance for FP.

Providers: Commercial FP providers get their commodities through public distributor KEMSA or from distributors who are linked to PSI/Kenya. The former supplies commercial providers with free and the latter with highly subsidised FP commodities. Therefore they have very little requirement for FP finance.

Users: Only 0.4% of married WRA said that the price of contraceptives prevents them from using FP¹⁵². Too high price and access was cited as a problem by 1.2% of married and unmarried WRA¹⁵³. Of all FP methods included in this analysis, only female sterilisation has a comparatively high upfront cost. Although it is one of the most cost-effective methods in the long run, only 7% of all WRA opt for female sterilisation. However, making finance more available may not increase the uptake of sterilisation, perhaps because of its irreversible nature.

62% of what Kenya spends on health is spent in the private sector, of which private health insurance expenditure makes up about 10% and out-of-pocket health expenditure 77%¹⁵⁴. FP is often excluded from private insurers' policies, which can limit the role of the private sector providing FP to their insured clients and push them to seek FP from the public sector¹⁵⁵. But this only affects the access to contraceptives of less than 1% of Kenyan women.

Equipment for FP services:

Manufacturers: Contraceptive methods that need additional equipment for insertion or removal of the method are implants and injectables. The most popular injectable, Depo Provera manufactured by Pfizer, comes with a syringe and needle included in its pack. Also, implants come with an insertion system. Recently Pfizer developed a new injectable product called Sayana Press for easier (self-) injection. Most IUDs are manufactured with uterine sound for insertion, but do not include other necessary instruments.

Distributors: Commercial distributors stock and supply commercial providers with medical equipment necessary for insertion and / or removal of long-acting contraceptive methods as not everything is included by manufacturers. We are not aware of any major issues in sourcing ancillary equipment.

Providers: Commercial providers are not entitled to free ancillary items for family planning from the public sector. Because commercial providers prefer getting their FP supplies for free from the public sector, they might also have a skewed preference towards injectables, pills, condoms and EC as these do not require ancillary items at extra cost. A recent study revealed that nearly 90% of private clinics did not have adequate FP equipment, particularly that for implants and IUD insertion and removal^{156 157}. However, this does not significantly undermine FP sales. In a 2014 study, only 2.1% of women switched the method or stopped using it because the method was not available/ accessible¹⁵⁸.

Users: n/a

Consumer education:

Manufacturers: Most manufacturers of hormonal contraceptives do not invest and are not incentivised to invest in consumer education. The exceptions are Bayer and Merck. Merck has two consumer educational programmes: *Merck for Mothers and Brighter Future*. Neither of the programmes focuses on Merck's contraceptives specifically. They educate consumers on family planning in general. Partly this is because medicines are not allowed to be advertised in Kenya¹⁵⁹. Nevertheless, manufacturers with high market share in one of the contraceptive methods (e.g. Depo Provera) are likely to boost their sales by educating consumers on methods in general.

Currently most of the consumer education on FP is done by PSI/Kenya and their BCC, which positively reflects in their sales numbers and market share.

Distributors: n/a

Providers: Many providers fail to educate consumers resulting in fewer women using contraceptives. The most needed area of consumer education is on possible side-effects of contraceptives. 32% of all Kenyan women do not use FP because of fear side-effects and health concerns^{160 161}. Yet, 61% of recent contraceptive users were not informed about side-effects by providers¹⁶². There is also high need for consumer education among unmarried women and women who have infrequent sex: 27% of WRA do not use contraception because they are having infrequent sex and 40% of WRA because they are not married¹⁶³.

Users: n/as

Targeted subsidies:

The public sector subsidises 100% of the price of contraceptives, which are offered free to all Kenyans regardless of their economic status. The not-for-profit sector is assumed to subsidise 40% to 50% of the price of the contraceptive methods they promote (based on PS Kenya level of subsidies). Again, these subsidies are usually untargeted, reaching users across all segments of wealth. Attempts to target subsidies through voucher schemes have been expensive with a high administrative burden. The effect of the combination of subsidies and Kenya's market composition (only approximately 5% of FP users can afford to pay the full price for their healthcare) is that manufacturers see little demand for unsubsidised FP; neither do distributors who stock little other than subsidised contraceptives. Thanks to subsidies the majority of users (99%) find contraceptives affordable. However, subsidies are not that well targeted as nearly 90% of the richest users are getting free or highly subsidised contraceptives¹⁶⁴.

Coordination:

KEMSA supplies free FP to public, not-for-profit and commercial providers. Private providers are expected not to charge for contraceptives supplied by KEMSA, but there are no rules on how much private providers can charge for the "service" of administering them. Many private providers thus charge a fee for the service. There is no system in place to track how many FP commodities end up in each sector. At the end of the day, commercial players are selling the same volume of subsidised products, regardless of the distribution channel. Under current GoK's policy of "free FP to all", this lack of coordination is not negatively affecting the performance of commercial players.

Provider training:

Manufacturers: Some commercial manufacturers in collaboration with donors have contributed to provider training (Bayer), but all provider training has been targeted at public sector FP providers¹⁶⁵.

Others: Clinton Health Access Initiative (CHAI) is supporting monitoring at national and county levels on who is trained on what. Training of trainers (TOTs) on FP methods provision is led by MoH with CHAI. TOT is also biased towards the public sector but tries to capture the private sector if resources permit¹⁶⁶. Christian Health Association of Kenya (CHAK) provides teaching and assessment skills, and some infrastructure support for FBO institutions¹⁶⁷.

Distributors: Currently commercial distributors do not offer any provider training.

Providers: In general, the majority of the private providers have not had a recent FP training and most have never been trained in client communication or counselling¹⁶⁸. In the commercial sector there is a high turnover of staff¹⁶⁹. Thus business owners are less motivated to train their personnel in the first place. Also, providing some long-acting FP methods such as implants and IUDs requires practice, which smaller commercial providers may not get due to lower numbers of users¹⁷⁰.

Users: n/a

Rules

Consumer perceptions and habits

Users: 32% of all WRA do not use FP because of fear of side-effects and health concerns, another 27% do not use FP because they are having infrequent sex and think there is no need for family planning. Over a quarter of women do not use FP because they are not married¹⁷¹. Many women cited more than one reason why they are not using FP, but they mainly fell in these three categories. These are all perceptions that could be overcome by investing in consumer and provider education. Closing this gap of unmet need could increase the sales of FP methods by 30%¹⁷².

Additionally, relaxing the rules around FP provision (such as injectables) in pharmacies would increase access to FP among younger populations who do not want to go to health facilities¹⁷³.

Quality standards

The Pharmacy and Poisons Board (PPB) oversees the National Quality Control Lab (NQCL) and is responsible for registering drugs, inspecting manufacturing facilities both in Kenya and abroad, and conducting pharmacovigilance. NQCL also conducts random sampling and testing of drugs being brought into the country. The NQCL has limited capacity to conduct batch testing on all drugs being imported and registered. 94 percent of the PPB's operating revenues come from drug registration fees. This creates a strong incentive not to refuse registration of drugs¹⁷⁴. PPB can also accept the quality of a drug without it having been approved by other regulatory bodies.

Distributors, Providers and Users: have limited means to probe the quality of a contraceptive as there is no logo such as quality assured ACTs for malaria have. Users', providers' and distributors' easiest way to get a quality FP product is to purchase from trusted suppliers. This can incentivise commercial providers to keep relying on supplies from public distributors or on subsidised products. However, method failure causes only 3% of all pregnancies. This means that method failure causes nearly 9 times fewer unwanted pregnancies than poor consumer education.

Policy and regulations

Manufacturers: Contraceptive manufacturers are not allowed to advertise any medicines in Kenya. Manufacturers can support FP messages, communication and consumer education while displaying their brand name. With few exceptions, commercial manufacturers do not invest in educating consumers on contraceptives as it is not profitable to 'educate the market' which benefits competitors as well as themselves.

Distributors: We are not aware of any major policy or regulation issues holding back market development.

Providers: There are no guidelines regulating which private providers are entitled to free FP supplies from the public sector as well as how much private providers can charge in service fees when providing FP methods acquired free-of-charge.

Injectables can be administered legally only by providers who are registered and trained by the government's Nursing Council. This restriction may restrict the pool of eligible providers and impedes women's access to the method¹⁷⁵; however it is unknown how much it is enforced in practice. Further investigation would reveal if this is a major constraint and whether changing this policy would expand access through the private sector and overall uptake. The change of policy is currently under discussion and results are expected to be revealed before the end of 2015.

In areas where there are no nearby health facilities, community health workers (CHWs) are allowed to provide injectables. This policy on providing injectables only changed after a pilot and is allowed only in 12 counties, mainly in the North East of Kenya¹⁷⁶.

Jhpiego and Gates Foundation are supporting and building the capacity of providers, including of CHWs to provide and insert implants. Again, their focus is on public providers^{177 178}. Implanon NXT also has an improved insertion mechanism that dramatically reduces chances of injuries. So if the current stringent requirements of who can administer implants are relaxed then the private sector can play a greater role¹⁷⁹.

Users: MoH policy guidelines refer to medical eligibility when deciding if the user is allowed to use this or that contraceptive method. Less relevant are age limits, but in general 15 year-olds and older are considered to be of reproductive age and can ask for contraceptives¹⁸⁰.

Kenya's Family Planning Market Sustainability Analysis

6

6 Kenya's Family Planning Market Sustainability Analysis

This section builds on previous analysis of the core of the market and its supporting functions and rules. The aim of this section is to summarise in an easy-to-read table the functions and rules which shape Kenya's family planning market, and list the market players who pay and who execute these functions. The first table describes how the market is functioning currently. The second table describes how the market could function differently, for greater commercial sector involvement and sustainability. Key section highlights:

FP market current situation:

Functions and rules	Players		Why?
	Who does?	Who pays?	
CORE			
Manufacture	Manufacturers	Manufacturers	Competitive market
Import	KEMSA; PS Kenya	GoK; PS Kenya	Unreliability of KEMSA
Distribute	KEMSA; PS Kenya	GoK; PS Kenya	Unreliability of KEMSA
Retail	Public health facilities; NGOs & FBOs; commercial providers	GoK; NGOs & FBOs	"Free FP to all" policy; untargeted subsidies and donor funding; access to free FP by commercial sector
SUPPORTING FUNCTIONS			
Finance	Donors, GoK, FP users	Donors; GoK; FP users	Policy and donor commitments
Equipment	Commercial manufacturers → retailers	GoK; donors; retailers	
Consumer education	PS Kenya	Donors	Donor commitments; Commercial players perceive it as the realm of GoK and unprofitable
Targeted subsidies	GoK; NGOs & FBOs	GoK; Donors	No cost-effective ways to target low income FP consumers
Coordination	GoK	GoK	Typically a realm of government
Provider training	GoK; KPA	GoK; providers	Commercial players perceive it as the realm of GoK

RULES			
Consumer perceptions and habits	PS Kenya	Donors	Donor commitments; Commercial players perceive it as the realm of GoK and unprofitable
Quality standards	PPB/ NQCL	GoK	Typically a realm of government
Policy and regulations	GoK	GoK	Typically a realm of government

Table 6-1 FP market current situation. Source: Cardno analysis

FP market in future:

Functions and rules	Players		Why?
	Who does?	Who pays?	
CORE			
Manufacture	Manufacturers	Manufacturers	Competitive market
Import	KEMSA; commercial importers	GoK; commercial importers	Competitive market
Distribute	KEMSA; commercial distributors	GoK; commercial distributors	Competitive market
Retail	Public health facilities; NGOs & FBOs; commercial providers	GoK; NGOs & FBOs; commercial providers	Competitive, segmented market
SUPPORTING FUNCTIONS			
Finance	Donors, GoK, FP users	FP users; GoK	Competitive market
Equipment	Commercial manufacturers → retailers	Commercial manufacturers; GoK; retailers	Competitive market
Consumer education	GoK; providers	Manufacturers; providers; GoK	Profitable, competitive market
Targeted subsidies	GoK; NGOs & FBOs	GoK	Decreasing donor funding?
Coordination	GoK	GoK	Typically a realm of government
Provider training	GoK; KPA	Manufacturers; provider associations; GoK	Profitable, competitive market
RULES			
Consumer perceptions and habits	GoK; manufacturers; providers	GoK; manufacturers; providers	Profitable, competitive market
Quality standards	PPB/ NQCL	GoK	Typically a realm of government
Policy and regulations	GoK	GoK	Typically a realm of government

Table 6-2 FP market future situation. Source: Cardno analysis

Constraints Analysis Divider



7 Constraints Analysis

This section provides an analysis of each critical area of underperformance in the family planning service market, moving from the symptoms of that underperformance to the root cause(s). Both demand sided and supply side constraints are outlined. Legend: (Green) most likely actionable; (Amber) possibly actionable; (Red) likely not actionable.

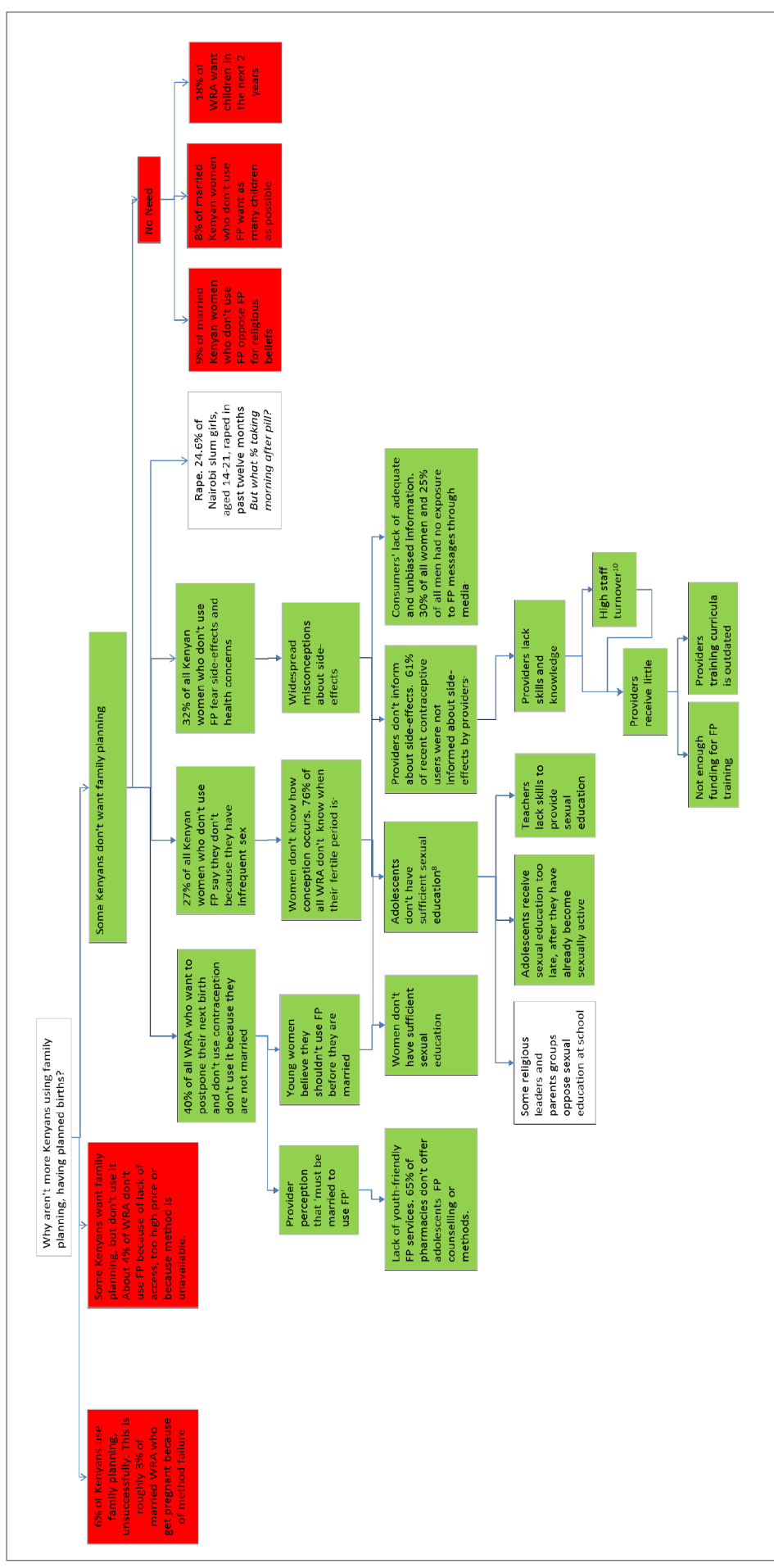


Figure 7-1 Constraints analysis from the demand side. Source: Cardno analysis

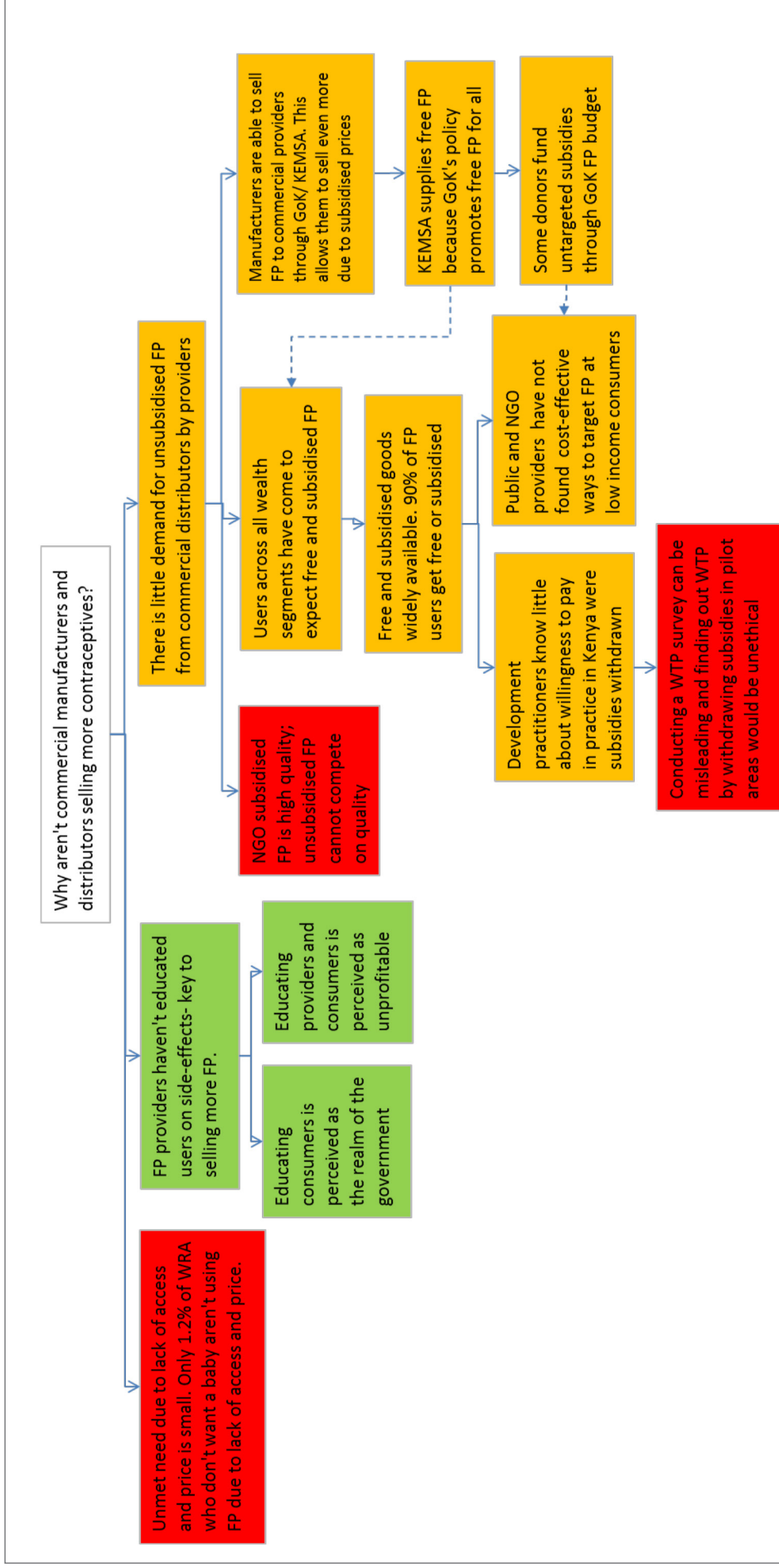


Figure 7-2 Constraints analysis supply side. Source: Cardno analysis

7.2 Overview of Constraints: Demand Side

From demand side, Kenyan women who currently do not use family planning can be grouped into three categories:

1. Do not need family planning.
2. Cannot access family planning.
3. Do not want family planning.

Firstly, women who do not use family planning because they do not need it. This includes 18% of married WRA who want to have children in the next two years. This also includes 8% of married WRA who want to have as many children as possible. 9% of married WRA¹⁸¹ and 10% of all WRA¹⁸² say that they do not need family planning because of religious beliefs. Women in this category are having wanted/ planned births and therefore currently do not need family planning.

Secondly, women who cannot access family planning. These women do not want to have children in the next two years or want to stop childbearing altogether, but are not using any method of contraception. Different studies confirm the same trend across rural and urban segments and different age groups. Only 0.4% of married WRA said that the price of contraceptives prevents them from using FP¹⁸³. Too high price and access was cited as a problem by 1.2% of married and unmarried WRA¹⁸⁴. Only 2.1% of all women switched the method or stopped using it because the method was not available/ accessible (stock-outs)¹⁸⁵. All in all, under current conditions it is less than 4% of all WRA who do not use FP because lack of access, too high price or availability.

Thirdly, women who do not want family planning despite having expressed their desire not to have children in the next two years or stop childbearing altogether. This group constitutes the majority¹⁸⁶ of women who have unmet need for FP. That is 97% of the 34% of all WRA with an unmet need for FP do not use FP for the following reasons: 1) they are not married, 2) they have infrequent sex and because 3) they fear side-effects and have health concerns.

The following sections trace back from these reasons to possible root causes why there is no demand for FP from women who do not want to have children.

7.3 Women Do Not Use FP because of Fear of Side-Effects and Health Concerns

32% of Kenyan women who want to postpone their next birth or stop giving birth altogether and do not use any contraception do so because they fear side-effects and health concerns. Fear of side effects and health concerns increase with age and peak among 35 to 39-year-olds¹⁸⁷. As the unmet need amongst all WRA is 34%¹⁸⁸, this means that 11% of all WRA do not use contraception because of fear of side-effects and health concerns. This is supported by findings from a focus group discussion, where women said that they fear that using contraceptives can make them infertile, affect their productivity, lower/ increase their libido or that the device, such as an IUD or implant can get lost in their body¹⁸⁹. Such misconceptions are widespread and are caused by inadequate and biased information.

There are several reasons why these misconceptions are common amongst WRA.

Firstly, providers do not inform contraceptive users about side-effects. Lack of unbiased information about side-effects can lead to concerns about their health if women were to use/ are using contraception. It is important to note that risks of side-effects of any contraceptive method are lower than risks associated with any normal pregnancy¹⁹⁰. This is a message that needs spreading. A recent survey showed that 61% of recent contraceptive users were not informed about side-effects by providers¹⁹¹. Non-users may be even less

informed about side-effects than recent users of contraceptives. Providers might not inform users about side-effects because they lack skills and knowledge about certain contraceptives, especially long-acting methods. This is partly caused by a high turnover of shop assistants in private pharmacies; assuming that pharmacy owners are less inclined to invest in training staff whom they fear may soon leave¹⁹². For the same reason most donors invest in capacity building of the public sector and not of the private sector.

Secondly, potential users of contraceptives lack adequate and unbiased information from the media. In 2008-09, 30% of all women and 25% of all men had had no exposure to FP messages through media¹⁹³. A more recent survey shows that between 2010 and 2014 exposure to family planning messages in media slightly increased, however, fear of side-effects and health concerns had remained on the same level¹⁹⁴.

Thirdly, sex education is inadequate. NCPD and its partners stress the importance of on-time sex education for all school children aged between 10 and 17¹⁹⁵. A clause on the necessity of sex education has been added to The Reproductive Health Care Bill of 2014. Sex education in schools has been opposed by some religious leaders and parents groups. Some fear that teachers lack skills to deliver such classes professionally. Despite ongoing opposition, studies confirm that school-based sex education programmes are effective in preventing HIV as well as unintended pregnancies in a cost-effective way¹⁹⁶.

Manufacturers of those contraceptives perceived to have harmful side-effects could sell more if they invested in dispelling these misconceptions. However, they have done little or nothing to date, probably because manufacturers are used to donors paying NGOs to do behaviour change communication (BCC). If donors invest heavily in dispelling misconceptions around side-effects, manufacturers will free-ride on these efforts rather than paying towards them¹⁹⁷.

7.4 Women Do Not Use FP because They Have Infrequent Sex

Twenty-seven percent of all Kenyan women of reproductive age, who want to postpone their next birth or stop having births, do not use family planning because they have infrequent sex¹⁹⁸. Infrequent sex nevertheless imposes these women to the risk of unwanted pregnancies even more so because majority of women lack knowledge about conception. KDHS 2008-09 shows that 76% of all WRA do not know when their fertile period is. Lack of understanding of conception and need for contraception may be due to the absence of sufficient sex education in schools. Reasons for insufficient sex education in schools are explained under the previous constraint.

7.5 Women Do Not Use Contraception Because They Are Not Married

Another 40% of all WRA who want to postpone their next birth do not use contraception because they are not married¹⁹⁹. This is a strong belief proved by a study on Kenyan adolescents' attitudes toward sex and abortion. The study found that 72% of female students believed that a sexually active schoolgirl should not be allowed to use contraceptives²⁰⁰.

Again, the root causes are insufficient sex education for adolescents as well as for women, and biased and inadequate family planning messages from media as described under the first constraint.

Lack of youth-friendly family planning services due to providers' cultural beliefs or lack of training might also add to the low uptake of contraceptives amongst unmarried young women. In fact, 65% of pharmacies do not offer adolescents FP counselling or methods²⁰¹. The overarching perception behind this is among both providers and user that family planning is for families, i.e. married couples who have already started having children and use 'family' planning to space or limit the number of births. 'Family' planning does not resonate with adolescents who do not have a steady partner, are not married and who do not want a family yet²⁰². There is a need for a different approach to contraception by manufacturers, providers and for BCC to get adolescents

to use contraceptives and avoid unwanted pregnancies. Some efforts have been already made by Merck in collaboration with Jhpiego creating a tool for university students to plan their future based on their goals for the next ten years²⁰³. Also PS Kenya is launching a distinctive BCC for adolescents which is about future planning and includes contraception²⁰⁴.

7.6 Overview of Constraints: Supply Side

From the supply side, the reasons why commercial distributors are not selling more unsubsidised FP can be grouped under three themes:

1. Lack of investment in consumer and provider education.
2. GoK policy on free FP for the entire market irrespective of ability to pay.
3. Subsidies that are not targeted.

The following sections use these themes to explain in more detail why commercial distributors are not selling more unsubsidised contraceptives.

7.7 Lack of Investment in Consumer and Provider Education

Commercial manufacturers and distributors of FP currently do not invest in consumer or provider education on side-effects, health concerns and dispelling misconceptions. The majority of WRA who do not use contraception, despite not wanting to give birth in the next two years or wanting to stop giving birth altogether, do not use FP because of fear of side-effects, health concerns and misconceptions. If these women had better access to information about FP methods, probability of side-effects through media and FP providers, and sex education in school that would dispel misconceptions about premarital sex and the right to use contraception, the demand for FP could potentially increase for 34%²⁰⁵.

Educating consumers is traditionally seen as the responsibility of the government. However, if the government and NGO consumer education programmes have not so far closed the unmet need gap, commercial manufacturers might want to consider the profitability of investing in consumer education through private-public partnerships. Currently Kenyan law prohibits advertising medicines. Yet, manufacturers are allowed to support FP messages that promote the uptake of contraceptive methods, while displaying manufacturer's logo²⁰⁶. Demand creation and moving towards commodity promotion by using existing manufacturers has been already recommended in previous PSP4H research papers²⁰⁷.

Other big commercial manufacturers providing commercially marketed socially beneficial goods, such as hand washing soap have invested in consumer education. With a sizable share of the soap market, Unilever in India and PZ Cussons in Nigeria are attracting new customers to increase their sales. These commercial businesses have understood that in order to grow the sales of their commodities they have to increase the number of customers. And the results: just a year after Unilever started its educational programmes, their sales increased by 20% all over the country, but particularly in programme areas²⁰⁸.

In Kenya, 48% of the contraceptive methods used are covered by injectables²⁰⁹. And it is highly likely that one manufacturer is providing the majority of these injectables. This needs confirmation and further investigation whether this manufacturer would find investing in consumer and provider education profitable.

7.8 GoK through KEMSA Supplies Free FP to Private and Public Providers

Commercial manufacturers of contraceptives are mainly selling to government and NGOs through KEMSA that in turn supplies practically the entire market. The government medical supplier KEMSA supplies free FP to private and public providers, because GoK's policy promotes free FP for all contraceptive users regardless of

their economic status. From the manufacturers' point of view, they end up selling the same volume of products at the end of the day, whether through bulk orders from government or through small orders channelled through distributors to retail customers. Manufacturers might even sell more when selling through government because of subsidies.

Because commercial retailers and providers can source free FP commodities from KEMSA, they have little or no incentive to buy the same commodities for a full price. Commercial distributors therefore have little or no incentives to start supplying unsubsidised FP commodities, as long as they have to compete with free commodities from the government.

There is nothing inherently wrong with a policy promoting free FP for all, especially when governments have sufficient funds. However, if commercial wholesalers and distributors are to sell larger volumes of unsubsidised contraceptives, the Kenyan government would need to change its policy of making FP free to all Kenyans, and stop providing free FP to commercial pharmacies and clinics in particular.

Commercial manufacturers indicate that they have chosen to focus on public sector tenders since there is no commercial market. The truth is that public sector tenders are bigger and more profitable as they cover both public and commercial sector needs, and any gaps in GoK's funding are covered by international donors.

If donors were to stop funding untargeted subsidies through GoK FP budget, and GoK were not to increase their funding, prior studies show that it is common for service delivery to collapse when aid is withdrawn²¹⁰. Possible future scenarios of FP market if policy and/ or subsidies were to change are examined under the next constraint on subsidies.

7.9 Users across All Wealth Segments Expect Free and Subsidised FP

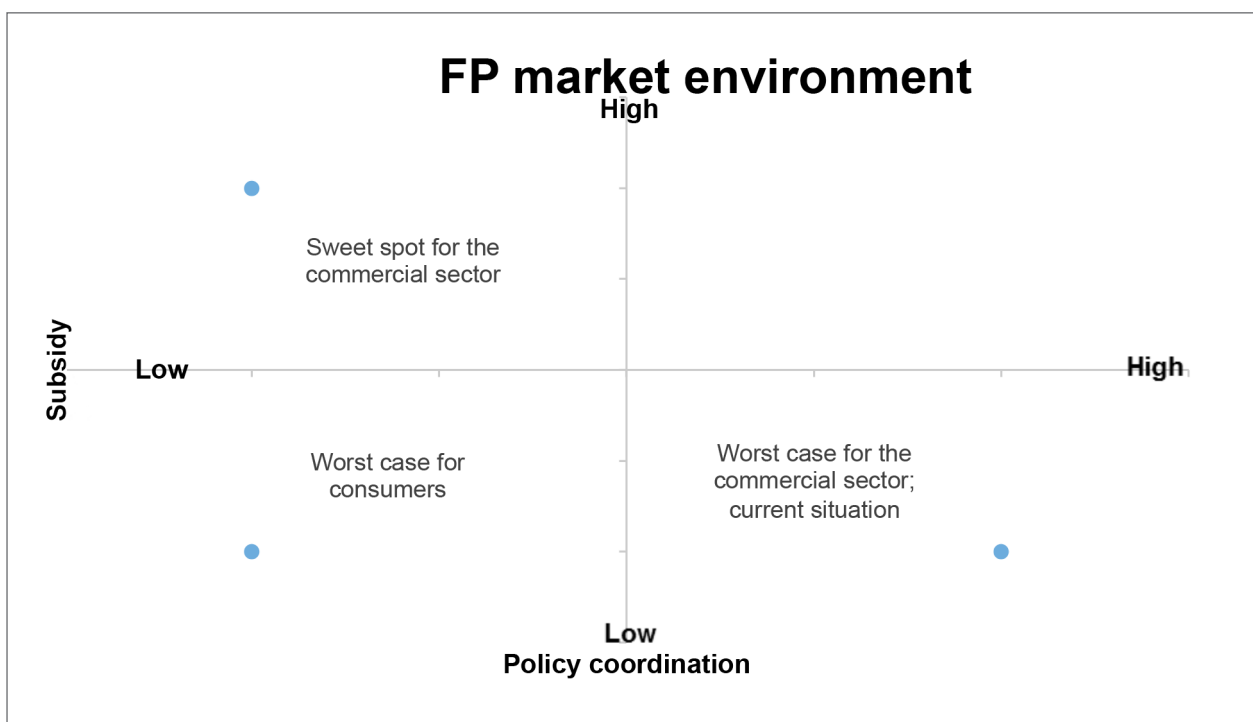
Users across all wealth segments have come to expect free and subsidised FP because of the aforementioned GoK policy which has made free and subsidised goods widely available in public and not-for-profit health facilities. PS Kenya's RH TRaC study shows that at 90% of FP users regardless of their economic status get free or subsidised goods²¹¹.

Public and NGO providers have not found cost-effective ways to target FP at low income consumers. PS Kenya piloted a voucher scheme aimed at providing contraceptives at a subsidised price to low income women. The findings as described earlier show how difficult and cost-inefficient it is to target poor women.

Development practitioners know little about willingness to pay for FP in practice in Kenya if subsidies were withdrawn. Health interventions, including FP, tend to be judged by how well they achieve their intended health goals²¹², e.g. number of averted unwanted pregnancies and lives saved, rather than by their economic sustainability. Therefore it is unlikely that major international donors such as USAID and UNFPA will stop subsidising FP, based on their growing contribution in recent years, filling gaps in GoK funding for its free FP for all policy.

Since commercial businesses look to their customers for their revenue stream, it is important that these customers are willing to pay for FP. With subsidised and free commodities widely available in Kenya, the commercial FP sector is unable to cater to the mass market. Instead, they focus on a small market segment: wealthy urban consumers.

Possible future scenarios if policy coordination and/or subsidies were to change are presented in this analysis of FP market environment:



Scenario I: High Subsidy, Low Policy Coordination

This depicts the current situation in Kenya’s FP market where over 90% of users are accessing free or highly subsidised commodities due to GoK policy and donor funding. International donors fund FP commodity procurement through GoK whose policy is to provide free FP to everyone, regardless of their economic status. FP subsidies are not targeted through GoK and are partially targeted by social franchises. That results in market being saturated by free and subsidised FP commodities, crowding out the commercial sector as the latter has less than 5% of the market to cater for.

Scenario II: Low Subsidy, Low Policy Coordination

If donor and GoK funding were to decrease significantly, but no changes in FP procurement and provision policy are made, fewer people would be able to access free or subsidised FP commodities. But as it would not be coordinated who are entitled to free or subsidised commodities, those who cannot pay and those who can pay less (95% of the market) would suffer disproportionately. This scenario where there are few subsidies and low policy coordination/ dysfunctional TMA would be the worst case for the majority of FP consumers.

Scenario III: Low Subsidy, High Policy Coordination

This hypothetical scenario represents the sweet spot for the commercial FP providers. For this scenario to work, a high level of coordination and effective implementation is needed: a policy that agrees to provide free FP exclusively to those who cannot pay and regulates the NGO sector in a way that it effectively uses limited amounts of donor funding to provide FP at a subsidised price to the market segment that can pay less. However, as mentioned earlier, such a high level of policy coordination requires a large proportion of tax payers and an administrative system that enables to determine who is able to pay for their FP. Only under such scenario it is likely for the commercial sector to crowd in and take a more active role in the FP market in Kenya.

Commentary: What Is Likely To Happen If Subsidies Were Removed?

It is unrealistic to expect that the vacuum in the market caused by the removal of subsidies will automatically be filled by the commercial private sector. The commercial sector will only move in to fill latent demand when doing so is profitable. The tendency for business is to pursue the easiest, most profitable market segments first, which are high-income consumers with clear ability to pay. This would leave lower-income consumers with lesser

ability to pay (can pay less and cannot pay segments) unserved or underserved. Unfortunately, this is where the unmet need in the market currently lies. The solution of targeted subsidies benefitting only lower-income consumers would appear to address this market gap; however the administrative costs of implementing and enforcing such a solution would need to be carefully considered as they may well outweigh the benefits. A very possible outcome of removing subsidies would be less market coverage and higher costs.

Family Planning Market Strategy and Potential Opportunities for Commercial Sector Engagement



8 Family Planning Market Strategy and Potential Opportunities for Commercial Sector Engagement

According to constraints analysis in the previous section, areas of systemic underperformance with high enough impact (significant number of beneficiaries) have been highlighted green. Areas of underperformance which have lower impact have been highlighted with red and therefore not considered to be an area worth intervening.

One of such areas of underperformance that does not have significant number of beneficiaries is method failure. According to the analysis of underperformance in the family planning market, only 6% of Kenyan women use family planning unsuccessfully and have unintended pregnancies. However, this is only about 3% of married WRA (users and nonusers of contraceptives) who get pregnant because of method failure. Because of the small proportion of contraceptive users affected by the constraint, there is probably nothing that can be done about this.

Similarly, another area of systemic constraints to which family planning programmes usually place emphasis on is affordability, access and availability of contraceptives. These programmes try to fix it by providing vouchers, highly subsidised methods, improving supply chains, a broader method mix, and mobile and nearby clinics.

Yet, currently only about 4% of WRA do not use FP because of lack of access, price being too high or because the method is unavailable. Under current conditions, assuming that free and highly subsidised FP methods will keep being provided by the public and not-for-profit sector, there is practically no space for the commercial sector to fill any gaps or provide a better alternative, particularly for lower income groups who have less purchasing power.

The greatest opportunities for increasing the usage of contraception in Kenya lie in consumer and provider education and creating demand that could potentially close a 30% gap in unmet need for FP.

Based on the preceding constraints analysis that explains the root causes of why the majority of WRA do not use FP despite not wanting to conceive, four initial opportunities for deeper commercial private sector involvement in Kenya's FP market have been identified. Further opportunities may be discovered through ongoing direct engagement with private sector players.

8.1 Investigate the Potential Return on Investing in Education and Training

Because fear of side-effects and health concerns is one of the main reasons why women who do not want to conceive are not using contraception, there is a need for educating FP providers, sex education teachers and women on side-effects of contraceptives. Currently, FP providers do not inform users adequately on side-effects, youth has no access to sex education and potential consumers lack information about FP. Injectables and daily pills are the most popular contraceptive methods in Kenya, but many do not use them because their concerns about side-effects and health concerns outweigh their benefits. An opportunity for enhancing the usage of contraceptives could be in pill and injectable manufacturers educating:

- a) Pharmacy staff on side-effects of their products;
- b) Teachers on contraception and their products;
- c) Women on side-effects.

Other big commercial manufacturers with a sizable share of the market, providing commercially marketed socially beneficial goods, have invested in consumer education, as described earlier²¹³. There is a need to investigate the size of the market share of injectables and pills manufacturers in Kenya and the potential returns on investment from provider and consumer education and training.

Such training on contraceptives side-effects and health concerns could be part of pharmacists' continuous professional development through the Kenyan Pharmaceutical Association (KPA). Community pharmacy staff in Kenya are primarily from the pharmaceutical technologist cadre who are organised professionally through the KPA. The KPA's functions include continuing professional/ clinical education. KPA could also offer training to pharmacists on side-effects and health concerns given that this would increase the sales of contraceptives.

8.2 Investigate Restrictions on Who Can Administer FP Methods

Currently injectables can be administered legally only by providers who are registered and trained by the government's Nursing Council²¹⁴. This rule may restrict the pool of eligible providers and impedes women's access to the method. Further investigation is needed to understand if this is a major constraint and whether changing this policy would expand access through the private sector and overall uptake. If this is the case, then there is a need for relaxing the policy around administering injectables, so that new products such as Sayana Press can provide an opportunity for private pharmacies' involvement and sales. This might also increase access to younger populations who do not want to go to health facilities.

8.3 Explore Promoting Post-Partum Uptake of FP through Private Providers

The 32% of WRA in Kenya who do not use FP because of fear of side-effects and health concerns are in danger of unintended pregnancy. In fact, 85% of women who use no contraceptive methods experience an unintended pregnancy within the first year²¹⁵. Possibly influenced by the circumstances of pregnancy, case studies show that FP uptake is extremely high immediately after childbirth²¹⁶. Yet, studies show that in 2010 44% of women did not receive any information or counselling on FP after giving birth (when at the facility for delivery). In 2014 this number had fallen to 32%²¹⁷. Information and counselling on FP and its lower side-effects compared with any normal pregnancy are likely to encourage the uptake of FP after giving birth.

It is worth exploring in depth how using private sector maternal new-born health providers such as private clinics and/ or community midwives could promote the uptake of family planning methods amongst post-partum women.

8.4 Further Investigate the Possible Impact if Donor Subsidies are Reduced and are Better Targeted

Greater involvement and sustainability of the commercial sector is likely to happen only there is better market segmentation to determine the potential sizes of the free, subsidised and fully commercial sectors. The commercial providers would be incentivised to start procuring FP through the commercial distributors if these three preconditions have been reached. These are:

- a) GoK stops providing free FP to commercial providers through KEMSA
- b) GoK stops providing free FP to all regardless of their ability to pay
- c) Donors stop funding untargeted, subsidised and free FP through all channels

It is worth noting however that given the constitutional right to health of all Kenyans, it would not be possible to turn away the wealthy from accessing free commodities on the basis of their SES. Furthermore, there is currently no system to determine the SES of the people accessing free services from public sector. Like with the free maternity services, anyone who goes to a public facility is able to get the service and constitutionally no one can be turned away on the basis that they are wealthy.

Prior to promoting such changes in the current FP market investigation into three areas is needed:

- a) Willingness to pay for FP among different income groups in Kenya
- b) Assessing the size of the potential commercial FP market
- d) Effective ways to target FP at these consumers who cannot pay or can pay less for FP

Such research has to be based on other countries that have successfully implemented TMA for FP or based on other products that have successfully implemented targeting mechanisms such as vouchers. We recommend research into willingness to pay for FP and cost-effective ways to target FP at low income consumers to establish if there is a viable alternative to how the FP market is currently operating in Kenya.

Lastly, there is need for continued engagement with commercial players as well as research into the sustainability and effectiveness of existing private sector interventions aimed at enhancing FP access, such as low cost kiosks in rural areas and demand side strategies such as vouchers targeting low income women.

Endnotes

9

9 Endnotes

- ¹ Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
- ² Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
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- ⁴ Kenya Demographic and Health Survey 2014 Key Indicators
- ⁵ Kenya Demographic and Health Survey 2008-09.
- ⁶ Performance Monitoring and Accountability 2020 (PMA2020) Project, International Centre for Reproductive Health Kenya (ICRHK). 2014. Detailed Indicator Report: Kenya 2014. Baltimore, MD: PMA2020. Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health.
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- ¹⁷ Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
- ¹⁸ Population Reference Bureau. 2014. Kenya Reproductive Transitions: Unmet Need for Family Planning.

- 19 Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
- 20 Kenya Demographic and Health Survey 2014 Key Indicators
- 21 Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
- 23 Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
- 24 Kenya Demographic and Health Survey 2008-09. According to PMA /Kenya 2014 median age at first sex was 18.0 years and median age at first marriage 20.5 years. Performance Monitoring and Accountability 2020 (PMA2020) Project, International Centre for Reproductive Health Kenya (ICRHK). 2014. Detailed Indicator Report: Kenya 2014. Baltimore, MD: PMA2020. Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health.
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- 32 Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
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- 36 Kenya Demographic and Health Survey 2014 Key Indicators
- 37 KDHS 2014 estimates the unmet need for married women of reproductive age in the lowest wealth quintile to be 29 per cent and 11 per cent in the highest quintile.
- 38 Kenya Demographic and Health Survey 2014 Key Indicators
- 39 Population Services International Kenya 2014 Reproductive Health TRaC (Tracking Results Continuously). Study on Uptake of Modern Family Planning among Sexually Active Women aged 15-49 Years in Kenya.
- 40 Kenya Demographic and Health Survey 2014 Key Indicators
- 41 http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cpr
- 42 Kenya Demographic and Health Survey 2014 Key Indicators
- 43 Kenya Demographic and Health Survey 2008-09.
- 44 Kenya Demographic and Health Survey 2014 Key Indicators
- 45 Contraceptive prevalence rate in many cases reflects the unmet need for family planning, but not always. If the CPR is low and also the unmet need for family planning is low, it is likely that there is a widely spread preference for large families. Fertility preferences are closely related to the number of living children a woman has. Interest in controlling the number of births grows rapidly as the number of children increases; for instance, more than half of currently married women with three or more children want no more children or are sterilised, but only 3 percent of women with no children want no more (KDHS 2014). Yet, in some parts of

Kenya, such as in the North Eastern region women and men often want to have as many children as possible (KDHS 2008-09). However, there is still a gap between actual and desired family size. A Kenyan woman, on average, gives birth to one child more than she wants (4.6 vs. 3.4). The difference between the total and the wanted fertility rates highlights just how difficult it is for a woman to meet her fertility desires. This disparity is particularly striking among rural and poor women, who have 1.5–2.0 children more than they intend to. Much of the gap between actual and desired fertility in Kenya can be attributed to the high level of unmet need for contraception (Guttmacher Institute. 2012. Abortion and Unintended Pregnancy in Kenya. In Brief).

- 46 Kenya Demographic and Health Survey 2014 Key Indicators
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- For** implants insertion and removal equipment if not included in the kit and expendable medical supplies (e.g. local anaesthesia, bandaging, and infection prevention) are needed.
- For** injectables disposable instruments if not included in the kit, and expendable medical supplies (e.g. local anaesthesia, bandaging, and infection prevention) might be needed.
- For** female and male sterilisation extensive list of medical instruments and expendable medical supplies are required. Infection prevention supplies for autoclave sterilisation of reusable instruments are required for mini-laparotomy. Emergency resuscitation equipment might be needed.
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- 173** Key informant interview with CHAI

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