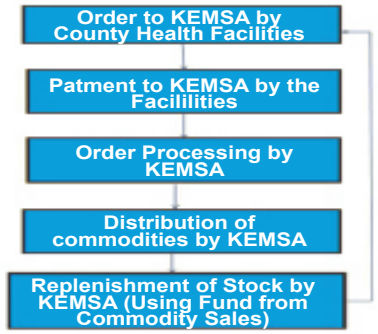
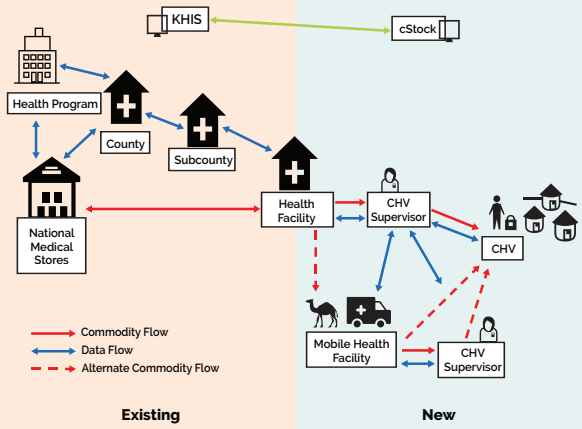
REPORT OF THE ANALYSIS OF THE KENYA FAMILY PLANNING COMMODITIES (FPC) SUPPLY CHAIN, FINANCING & PROCUREMENT

JUNE 2021



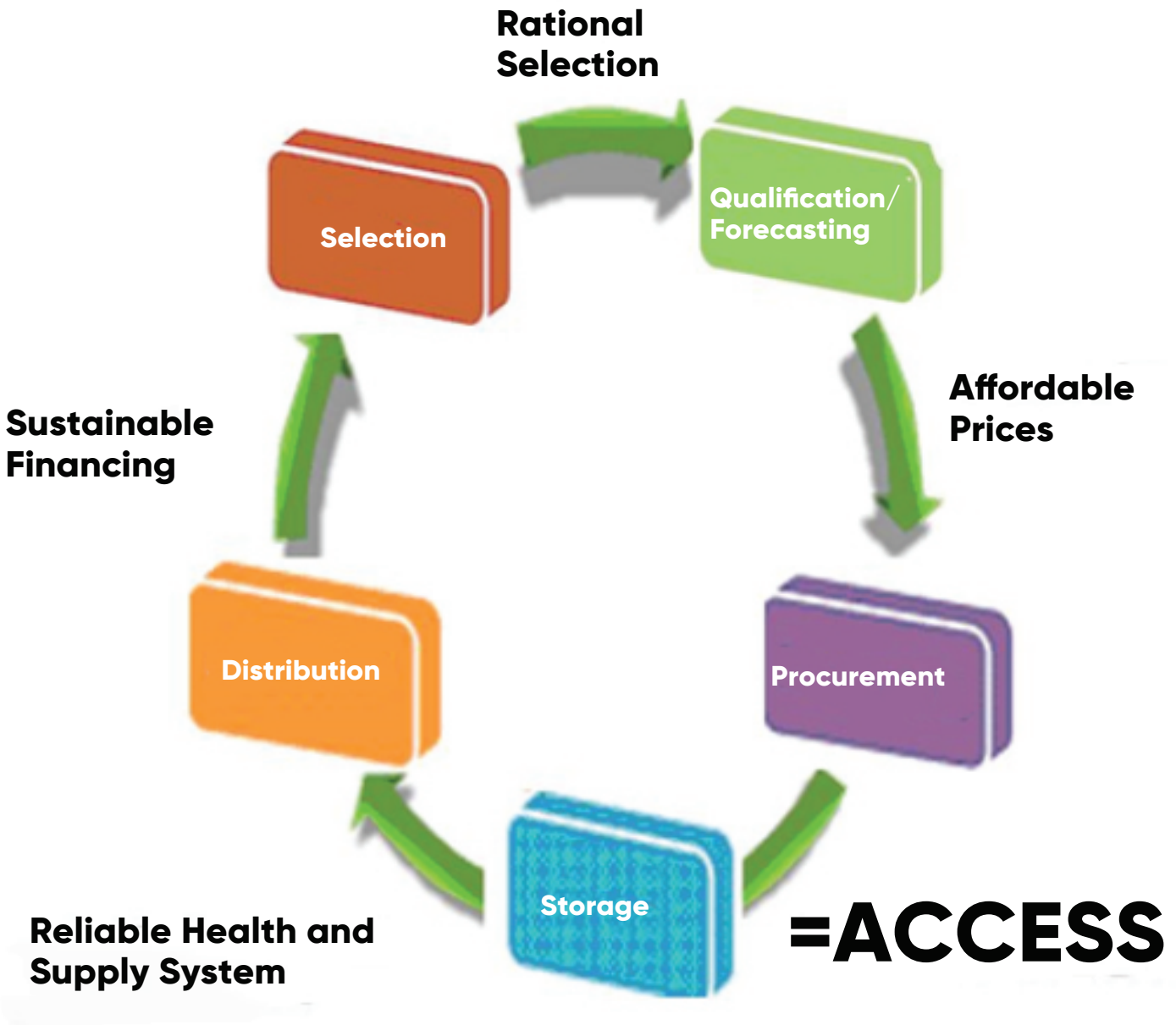


Population Action INTERNATIONAL
HEALTHY FAMILIES HEALTHY PLANET

ACCESS TO MEDICINES PLATFORM
"Health Systems Strengthening forUniversal Health Coverage"

MeTA KENYA Medicines Transparency Alliance

THE PROCESS OF ENSURING UNIVERSAL ACCESS OF COMMODITIES



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ABBREVIATIONS

AWP	Annual Work Plan
BMGF	Bill & Melinda Gates Foundation
CBD	Community Based Distribution
CHAI	Clinton Health Access Initiative
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CMS	Central Medical Stores
CRT	Commodity Requirement Tool
CSO	Civil Society Organisation
DESIP	Delivering Sustainable and Equitable Increases in Family Planning in Kenya
DHIS	District Health Information Software
DRM	Domestic Resource Mobilization
EML	Essential Medicines List
ERP	Enterprise Resource Planning.
FP	Family planning
FPET	Family Planning Estimation Tool
FY	Financial Year
GFF	Global Financing Facility
PSM	Procurement and Supply Management
IAP	Implant Access Program
IPM	Informed Push Model
IUD	Intra-Uterine Device
KII	Key Informant Interview
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Agency
LAPM	Long Acting or Permanent Methods
LARC	Long-acting reversible contraceptives
LMIS	Logistic Management Information Systems
McPR	Modern Contraceptive Prevalence Rate
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSI	Marie Stopes International
OOP	Out of Pocket
PFM	Public Financial Management
PPM	Pooled Procurement Mechanism
PPMR	Procurement Planning and Monitoring Report
RMNCH	Reproductive Maternal Newborn and Child Health
SCM	Supply Chain Management
SDG	Sustainable Development Goal
SDP	Service delivery point.
SOP	Standard Operating Procedures
SRHR	Sexual and Reproductive Health and Rights
STM	Short Term Method
TWG	Technical Working Group
THE	Total Health Expenditure
TMA	Total Market Approach
TOR	Terms of Reference
UHC	Universal Health Coverage
WB	World Bank

Acknowledgement

We acknowledge the support and cooperation of various individuals and organizations that participated in the mapping exercise and for the valuable data they provided. We are especially thankful to the 8 counties who participated in the study as part of our Key Informative Interviewees and who not only created time but provided honest feedback and documentation to support the mapping exercise.

and feedback. We thank the team at the Africa Development & Strategy Centre for diligently working with us and developing tools and a methodology that was able to provide us with accurate data that showed the current status of the Family planning supply chain in Kenya.

We also acknowledge the contribution of Robert Athewa who was our lead researcher scheduling and undertaking the key informant interviews including mobilization for the validation workshop.

The report was drafted and edited by Ms. Dorothy Okemo, Executive Officer- Access to Medicines Platform/ MeTA Kenya with support from a small team of experts conversant with the family planning landscape in Kenya. It was also reviewed by colleagues from MeTA Uganda, MeTA Zambia and Population Action International.

A special thank you to the UHC Engage project team from PAI for supporting this study from inception, we hope that the findings and recommendations will form an integral part of advocacy work in Kenya that will increase domestic financing of FP Commodities.

We hope that this study will open more opportunities for evidence based advocacy that will not only change the FPC landscape but improve access, financing and the entire supply chain of Family Planning Commodities in Kenya.

1. PROJECT BACKGROUND

Kenya's FP program surpassed the national FP2020 target of 61% modern Contraceptive Prevalence Rate (mCPR) for married women in 2018, two years in advance of the target (MOH and Track20 2019). With changes in the donor financing landscape for FP commodities and the need for the country to increase its domestic financing of FP Commodities, this momentum seems to be on a downward trend- a worrying trend for access to FPCs. Universal health coverage (UHC) is the defining health goal of the sustainable development era and requires country-specific health systems and financing changes. As governments across Asia and Africa introduce UHC financing reforms centered on nationwide health insurance schemes, policymakers have the chance to design reforms that deliver for women and girls from the beginning. Through the policy process, there are advocacy entry points for sexual and reproductive health and rights (SRHR) champions from civil society to engage alongside government counterparts. Advocates can use these opportunities to ensure decision-makers develop UHC policies that are rights-based; increase the availability, affordability, acceptability, equity and quality of sexual and reproductive health services and commodities; and bolster sustainable domestic financing for family planning (FP).

With this urgent motivation, PAI launched UHC Engage, a multiyear, evidence-based advocacy project that supports SRHR champions in countries where governments are introducing UHC-oriented reforms, including Ethiopia, Ghana, India, Kenya, Uganda and Zambia. PAI is working with civil society partners to prioritize SRHR within emerging UHC policies and share learnings from these local FP advocacy efforts to inform the global UHC conversation. As countries introduce national health insurance schemes as the crux of UHC financing reforms, and decide new benefits packages, SRHR CSOs are advancing advocacy strategies to ensure FP services and commodities are included and covered by the new programs. Looking to the future, country partners are seeking to understand how FP commodities can potentially be purchased and procured through new national health insurance funds and management authorities. Having an understanding of how FP commodities are currently procured and purchased in-country, which domestic and/or donor entities bear responsibility for purchasing and/or procuring commodities, and at which stages, and will equip advocates with a clear picture of the current status quo. Then, as UHC-centered financing and policy reforms such as national health insurance schemes give way to opportunities for new purchasing and procurement roles and responsibilities, SRHR CSO partners will be equipped to work together with decision-makers to ensure UHC financing arrangements ensure availability and accessibility of FP commodities.

1.1 Purpose of the study

Map current family planning supply chains in Kenya to support UHC Engage partners' understanding of the supplies landscape and strengthen their advocacy efforts in the near term as national and subnational UHC policy and financing reforms advance.

1.2 Objectives of this study

The Terms of Reference (TOR) identified the following objectives of this study:

1. **Building the evidence base**. Document and analyze current FP financing and supply chain issues—specifically, procurement of contraceptives—in Uganda, Zambia and Kenya. Output: produce written analyses for each country, internal use only for discussion and advocacy planning.
2. **Country partner technical assistance**. Using the evidence generated, support partners' understanding of how FP supplies are currently procured and purchased, which may change if/when FP is included in NHI benefits packages. Provide advice to partners and PAI on FP supplies-UHC advocacy asks and messaging.
3. **Draft brief /case study.** Develop a primer FP/RH supplies, UHC reforms and options/considerations for procuring contraceptives to follow through on commitments to quality and full choice of methods.

1.3 Study Questions

The table below list the main study questions under each component:

Component	Key questions	**Data Source**
FP financing	a) Does the country have laws, regulations, or policies that increase access to effective family planning commodities (CIPs)? b) How much of government funds (national & county) are allocated and spent on contraceptive procurement in the most recently completed fiscal year c) Who else finances purchase of FP Commodities (in kind/through treasury/national level/ or specific counties)? d) Are FPC covered under UHC/ NHIF/ Linda mama and other county maternal health programs?	Literature review KIIs
Procurement and purchasing of FP commodities	Who are the main players in FPCs procurement? Who offers technical assistance in public and private sector in Kenya? According to the MoH how many wholesalers are registered in the country (for distributing FP products)? At what level does government-financed procurement of public-sector FP commodities occur? Do counties do their own FPC procurement? How are rights and quality being assured in strategic purchasing mechanisms?	Literature review KIIs
Supply chain	What is the delivery point (i.e., to what level does the supplier deliver the commodities)? Is there a national logistics management information system (LMIS) that collects data on contraceptive commodities? a. If yes, what types of health facilities report into the system? b. If there is a national LMIS, how is contraceptive commodity data collected at the county level? What is the average annual stock-out rate by product and across products at the national and county level? How is quantification and forecasting of FPC done? Who is responsible for forecasting? What is the fill rate? What strategies can be put in place to increase coverage of FP services?	Literature review complemented by KIIs KIIs
UHC	What does the proposed UHC policy say on FPC? What is the status of family planning services within major insurance and health financing schemes? Where family planning services are included, what is the actual coverage and level of access (e.g., methods and availability)? How do we make financing of FPC sustainable within UHC? Given national policies for UHC, identify some potential barriers to access to family planning commodities in Kenya?	Literature review complemented by KIIs

2.0 METHODOLOGY

Various methodologies, tools and techniques were used to capture data accurately, reliably and fast enough within the current global pandemic situation and for the time allocated. This consisted of literature review and key informant interviews from targeted organizations/governments and implemented in various phases.

2.1 Phase 1 Inception:

This involved start-up activities geared towards kick-starting the mapping processes with discussions with the Access to Medicine platform contact person to harmonize the understanding of the assignment, collect relevant documentation and other literature relevant for the assignment.

2.2 Phase 2: Literature/Document Review

We conducted literature review and documents from grey literature which involved;

- Audit of other reviews and studies and developing an inventory of reports, evaluations, research studies, other documents and carrying out gap analysis in FP programme implementation.
- Review of program efficiency in allocation and utilisation of resources.
- Review of policies, programme efficiency review and county challenges that touch on FP
- Review of the changing environment including the implications of health financing on FP.
- Review of KDHS reports, key studies on FP and Reproductive Health (RH) at National Council for Population and Development (NCPD), Ministry of Health (MOH) and partners including Clinton Health Access Initiative (CHAI) and the World Bank (WB) among others.

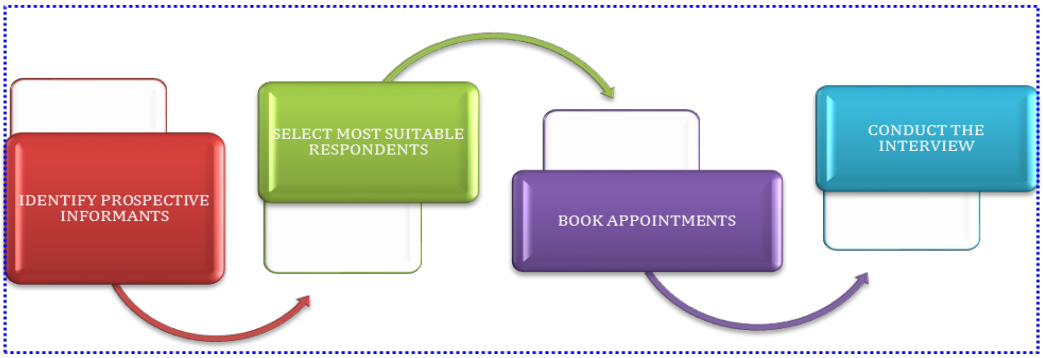
This helped us to understand the following:

- Family planning Commodity security
- Sustainable financing of FP commodities and programme, including trends in resource flows.
- Supportive policy, legislative and regulatory environments.
- Government leadership and stakeholder coordination.
- FP information management, data capture, flow and use for planning and decision making.
- Taking stock of the county progress against existing FP action plans and targets, while discussing gaps and challenges that impede achievements.
- Identify opportunities, entry and leverage points for UHC Engage, advocacy work at the county level and linkages with national level efforts to enhance coherence.

2.3 Phase 3: Implementation of Fieldwork

Key informant interviews

Key informant interviews were conducted to complete and enrich the information obtained through the literature review. The selection and list of key informants was developed in collaboration with Access to Medicine Platform/MeTA Kenya. The KII's would normally adopt the approach outlined below:



The Key Informants (KIs) were drawn from the following organizations/agencies:

Table 1: List of Key Informants Interviewed

	Organization	Designation	sex
1	DESIP	Sustainability lead	M
2	National Council for Population and Development (NCPD)	Track20 Focal person	F
3	National Council for Population and Development (NCPD)	Assistant Director Population and National Advocacy	F
4	UNFPA	SRH/FP Advisor	M
5	ICRHK	Senior Technical Advisor-PMA Project	F
6	PATH	Research and Development Officer	M
7	Independent consultant	Former Health Advisor Council of Governors (COG secretariat)	M
8	KMET	Advocacy officer	F
9	Jhpiego	Country Manager	M
10	County Government of Turkana	County Pharmacist	M
11	County Government of Taita Taveta	County Pharmacist	M
12	County Government of Kakamega	County Pharmacist	F
13	County Government of Bungoma	County Pharmacist	M
14	County Government of Isiolo	RH –Coordinator	F
15	County Government of Kajiado	County Pharmacist	M
16	County Government of Isiolo	County Pharmacist	F
17	County Government of Turkana	RH –Coordinator	M
18	County Government of Kakamega	County Pharmacist	F
19	County Government of Kwale	RH Coordinator	F
20	County Government of Kisumu	RH Coordinator	M

Two key informant interview guides for national and county stakeholders were utilized (see annex). The questionnaires were kept deliberately short to facilitate quick responses from busy senior government and partner agencies staff. A total of 25 key informants were interviewed or consulted. Out of those, 20 completed the questionnaire. Prior to completion of the questionnaires, the research team briefed the interviewees on the purpose of the survey and explained in detail the objectives of the assessment. Every effort was made to protect the confidentiality and the identity of the participants. Data was stored in a secure place by the assessment team and access to the data will be restricted to the project investigators.

2.4 Phase 4: Report Writing and Dissemination

Analysis and report writing took place between March 1st and 20th 2021. First, the notes taken during the interviews were then analyzed in MAXQDA followed by synthesize of the findings from literature review and other document review and analyzed further against the new findings for comparison. A report comprising of the methodology, results, and key policy recommendations, and annexes of tools used was then presented to Access to Medicines Platform for review and feedback.

3.0 LITERATURE REVIEW SECTION:

3.1 Recent Trends and Developments in Relation to Family Planning in Kenya.

There has been a steady progress in the family planning policy landscape in Kenya in the last two decades. Recognising family planning (FP) as an essential component of national development, Kenya has in place robust constitutional, policy and political commitments. Family planning has been prioritized as one of the central pillars of reproductive health through the Reproductive Health Programme and wider National Health priorities as outlined in the Kenya Health Sector Policy and vision 2030. In 1992 after the International Conference on Population and Development (ICPD), the government of Kenya set up the National Council for Population and Development (NCPD). As a government agency, NCPD mandate was to coordinate population matters and planning within government. Over the years, the NCPD has worked closely with the national Ministry of Health and development partners to develop favourable family planning policies.

Kenya signed the Family Planning 2020 (FP2020) commitment and has always demonstrated remarkable performance in realising their goal. Kenya's socio-economic status has also changed over the last decade and the country now is ranked as a lower-middle income economy. A status that translates to less donor dependency and more domestic investment required in delivery of key government services including health care- and by extension family planning. At the FP2020 stage, Kenyan government in 2016 renewed its commitment to improve access to family planning services.

Its commitments were as follows:

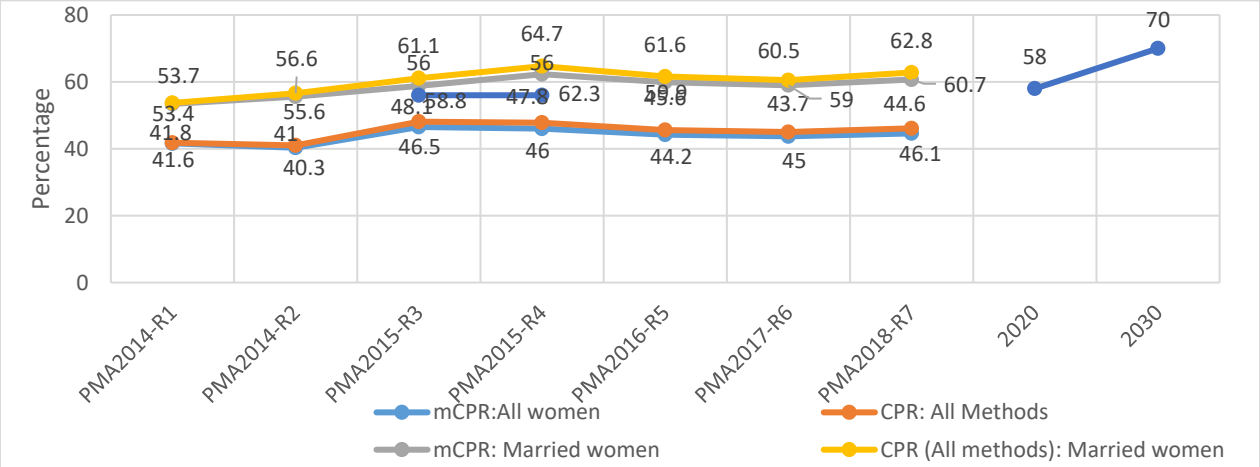
(i) Finalise and disseminate the family planning national Costed Implementation Plan (CIP) (2017-2020);

(ii) Strengthening national family planning programme by making a commitment to increase domestic financing for family planning at both levels of government and

(iii) Strengthen partnership with the private sector through a total market approach to enable an increase in private sector FP delivery contributions

The anticipated impact of Kenya's revised commitments included; increased modern contraceptive prevalence rate (mCPR) from 61% to 66% by the year 2030, increased CPR for any contraceptive method among adolescent women (15-19 years) from 40% to 50% by 2020 and to 55% by 2025 and to reduce teenage pregnancy among adolescent women 15-19 years from 18% to 12% by 2020 and 10% by 2025. The desired outcomes are faced with numerous challenges which the country clearly captured and developed an action plan through its second Family planning costed implementation plan (FP-CIP) 2017-2020.

Figure 1: Trends in FP, Kenya



Kenya's second national FP CIP 2017-2020 now takes cognizance of the two-tier system of governance.

The provision of health care services across Kenya is a function of devolved government. Significantly, this document is aligned to FP2020 goals, ensuring county governments contribute to the nation's global commitments. This national CIP provides a clear policy framework which guides county governments as they develop specific. It was estimated that the funding requirement for Kenya's FP-CIP 2017-2022 would be KSh 30.80 billion (US$ 305 million). The county governments as a policy requirement are required to finance their own FP-CIPs. *In FY 200/21 the national government allocated about Ksh. 800,000,000 towards FP commodities. The 2021 budget process is still underway.*

Family planning and skilled birth attendance are the most effective public health interventions for preventing maternal, newborn, infant and under five child deaths as well as improving the health of these cohorts. *However the Health Sector Working Group (SWG) Report 2021/22-2023/24 states that more than half of Women of Reproductive Age are not receiving FP commodities and about one third of deliveries are not conducted by skilled health workers.*

Table 2: The indicators around provision of FPCs in Kenya 2012-2019

	2012	2013	2014	2015	2016	2017	2018	2019
Number of additional users of modern methods of contraception	0	386,000	766,000	1,127,000	1,358,000	1,566,000	1,749,000	1,967,000
Contraceptive prevalence rate, modern methods (mCPR)	38.1	40.3	42.3	44	44.5	44.8	44.8	45.1
Percentage of women with an unmet need for a modern method of contraception	23.3	21.5	19.9	18.4	17.8	17.5	17.2	16.9
Percentage of women whose demand is satisfied with a modern method of contraception	75.1	76.3	77.4	78.2	78.4	78.4	78.4	78.4
Number of unintended pregnancies	909,000	907,000	905,000	903,000	903,000	906,000	910,000	917,000
Number of unintended pregnancies averted due to use of modern methods of contraception	1,604,000	1,751,000	1,897,000	2,035,000	2,123,000	2,203,000	2,273,000	2,356,000
Number of unsafe abortions averted due to use of modern methods of contraception	353,000	386,000	418,000	448,000	468,000	485,000	501,000	519,000
Number of maternal deaths averted due to use of modern methods of contraception	6,000	6,500	7,100	7,600	7,900	8,200	8,500	8,800

Through intergovernmental consultations, it has been agreed by consensus that National Government takes up ALL the funding for FP commodities and attendant distribution costs to all Counties; while Counties would take up implementation of support activities such as capacity building and awareness creation.
The County Assemblies therefore have a significant role in working through the budget making processes to ensure there is allocation for FP and RMNCAH.

Counties implement their CIDPs and make decisions in planning and resource allocation. Inadequate accurate data to inform evidence-based decision making for priorities such as family planning (FP) & RMNCAH remains a challenge. Although health is the largest expenditure item in the devolved units, with 30% of the County budget, family planning and reproductive health remain largely underfunded. Hence, the need for sensitization.

Individuals from various counties are experiencing varying inequalities in reproductive health services based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment.

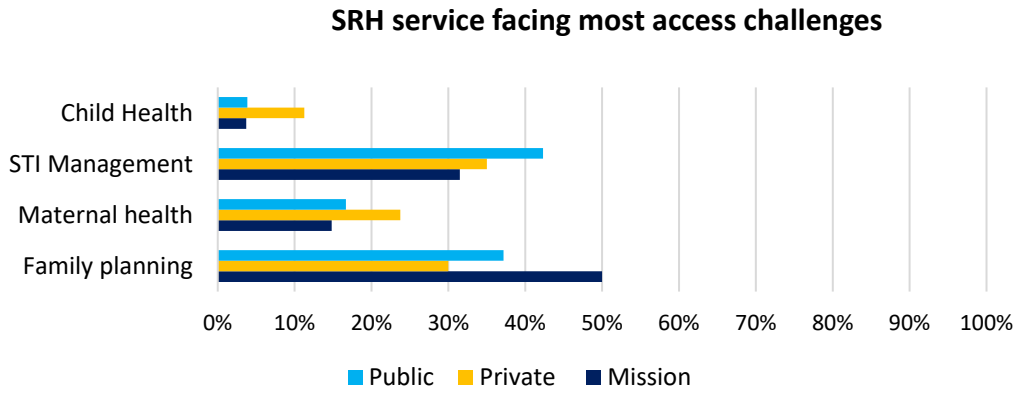
Mobilizing resources, especially at county level for family planning required strong advocacy from civil society organizations. A snippet on budgets at county level, the health sector would be seen to have been allocated the highest percentage in sharable revenue amongst sectors ranging from 10-20%. Despite these huge allocations, the health sectors have huge recurrent expenditure budgets and less for development and service provision. It is as this point in time that provision of family planning services is resource constrained.

Most of the county governments do not have a family planning budget line, despite robust advocacy efforts by civil society organizations implementing FP programmes. Evidence based advocacy has been key to influence decision makers to prioritize and plan for family planning services. Investing in family planning is cost-effective and saves money. Until 2015, every Ksh.85 (US$1) spent on FP saved Ksh 381 ($4.48) in direct healthcare costs in Kenya. County governments therefore should accelerate progress in the uptake of modern FP methods. That action would result to savings up to to Ksh 464 (US$5.46) per every Ksh 85 (US$1) spent. Evidence demonstrated that, sustained investments in family planning would have saved Kenya an additional Ksh 6.8 billion (US$80 million) in direct healthcare expenses by the end of the 2020 financial year.

The impact now model report released in 2014 on estimating the health and economic impacts of investing in family planning read: *"The government of Kenya commits to increase the portion of the national budget for family planning services, specifically through a budget line allocated to the family planning. It is noted that contraceptives are not included in the National Health Insurance Fund (NHIF) funded free maternity programme, for example. Inclusion of contraceptives in the existing health insurance schemes will increase access to FP for insured individuals, bolstering equitable access to Family Planning. The government will ensure post-partum family planning services are included as part of its Free Maternity policy (Linda Mama programme) which the Government invest 3 billion Ksh annually to ensure mothers access free care at the point of delivery."*

Financing for family planning in Kenya has had many challenges. Considering only few county governments have FP-specific budget lines within their Programme Based Budgets (PBB). However, the national government through its line ministry of health has taken up stewardship and ownership to ensure access to FP services to everyone is guaranteed. In a study conducted by Health Action International (HAI) on SRH commodities; availability, affordability and stock outs in Kenya 2019 indicates that, healthcare providers, family planning commodities faced the most challenges overall (38%) while they believed child health services faced the least challenges overall (7%).

Figure 2:



Most demand creation efforts at county level are not met with commensurate availability of commodities. The community health strategy is seen to be one of the most effective way to support family planning programmes. However, county governments are shy from the arguably high cost of engaging Community Health Volunteers (CHVs) in demand creation. CHVs are not part of the Kenyan health system human resources for health and they operate as volunteers.

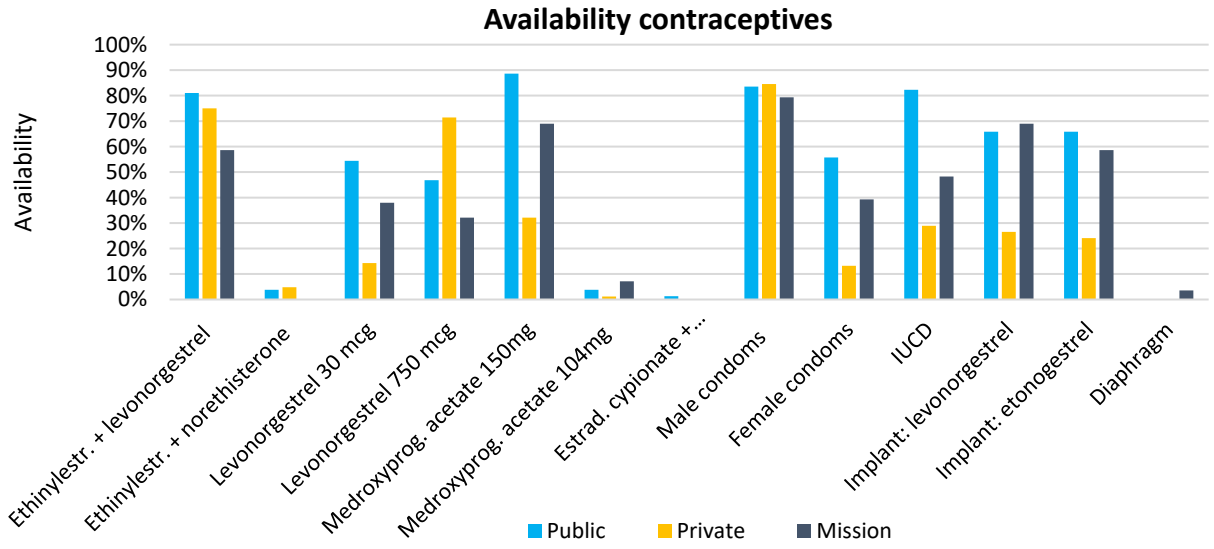
Nearly all county governments lack a budgetary allocation to include CHVs in their health structures despite recognizing the important role of community units in the health system. This situation poses a challenge to sustained engagement in demand creation activities and utilization of family planning.

Supply of family planning commodities to public health facilities has been inadequate and inconsistent. This is mainly due to systemic issues at KEMSA, the agency mandated to procure and distribute family planning commodities and the systems and capacities for county level to forecast and order on time. Few Kenyans are able to seek FP services at private facilities. Recent data on the proportion of Kenyans seeking FP services from private sector including clinics, hospitals pharmacy outlets and health facilities is scanty - only 38% of registered private facilities reporting on FP service provision data.

FP commodities and reproductive health medicines in public health facilities across Kenya have limited availability. Our supply chain includes bottle necks such as use of a decentralized supply chain design through KEMSA to serve a decentralized health system. Assessments by some of FP partners in Kenya have established that there are weak commodity management practices at county level. Additionally, there exists inadequate commodity data for decision making due to low reporting rate and poor-quality data. Private sector data is not included in the forecasting and supply planning processes. The push for long term methods as in line with most county level governments strategies is not aligned to resources availed by the same governments to procure the necessary methods.

Figure 3: Availability of contraceptives, per sector.

The private sector seemed to have a lower availability of most contraceptives



However, the Kenya national Ministry of Health has a robust strategy which aims to achieve increased allocation of resources to FP programme by national Treasury, county governments, donors, partners and private sector. This strategy will see consistent and reliable financing to procure contraceptives to ensure they are available when and where needed by health programs and clients. The strategy notes that financial sustainability will also be supported by an enabling environment created through advocacy and policy reviews opening the space for civil society engagement with governments at both levels. This clearly highlights opportunities for more evidence informed dialogues. Currently, many actors within the FP space are empowering civil society at grassroots to engage in public participation and sector working groups during budget making process at county level.

Aware that donors are exiting the Kenyan development space and whose contribution was critical to offer family planning services the government of Kenya, has boldly made commitments to mobilise domestic resources to fill the gap. The establishment of a contraceptive repository located at a central level such as KEMSA and stocked with donor and government procured contraceptives was a significant milestone. At national level, the government opened a contraceptive revolving fund. This revolving fund was established to ensure sustainability post-donor funding for procurement of contraceptives arising from the resizing of the Kenya economy to a lower middle income (LMIC) status. To address the limited financial commitment to FP commensurate to need, governments' health departments at both levels and partners-including civil society are advocating for increased funding within national and county budgets. As a step in the right direction, county governments have started including FP activities within county development plans and consequently budgets under the RMNCAH programme.

The Global Financing Facility in the past has presented an opportunity for additional funds for FP programming. Kenya's investment case was approved and it prioritizes FP. National government stewardship and implementation of a Total Market Approach (TMA) is engaging stakeholders through advisory groups and network analysis, assembling evidence for decision-making, such as determining the needs of private providers to provide FP, identifying market segments, surveying commercial product availability, and modelling different financial resource scenarios, and building the total market plan.

These efforts are key to streamline the supply chain for FP commodities in Kenya and accelerate countries progress to realize its 2030 promises under the revised FP2020 commitments and achieving Universal Health Coverage (UHC). UHC means all people resident in Kenya have access to health services that are of good enough quality to work, whenever they need them, and without encountering financial hardship. UHC comprises a set of health system goals: equity in service use, quality, and financial risk protection.

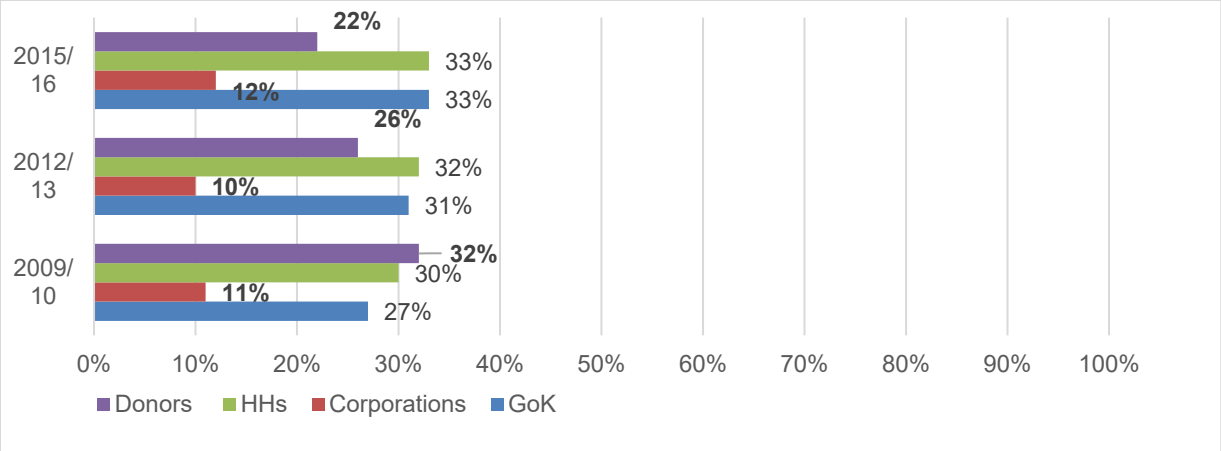
4.0 ANALYSIS AND FINDINGS

These findings highlight per each objective in the assessment. These report will be validated through a series of dissemination workshops at national and county level organized by Access to Medicines Platform. About 80% (20/25) of the respondents completed the questionnaire.

4.1 Financing for FP commodities

Government role in financing health care in Kenya has been low for some time but has recently increased and now constitutes a greater share of total available resources for health. Government contribution to total health spending increased from 27% in 2009/10 to about 33% in 2015/16, an increase of about 22% between the two periods. Counties are emerging as major financier of health judging from the growth in county budget allocation that goes to health which is the major reason for increase. Donor support has been key in financing health care in Kenya for decades, however declining, as the country is transitioning to lower middle-income status with the share of contribution declined from 32% in 2009/10 to about 22% of total health spending in 2015/16.

Figure 4: Sources of Financing Health Care in Kenya



Source: Kenya National Health Accounts, 2015/16

In Kenya, family planning commodities are currently provided by USAID, Bill and Melinda Gates Foundation, DFID, the World Bank, UNFPA and the European Union (EU). USAID commodities are procured directly through the donors' own procurement systems, but DFID and EU commodities are procured through Crown Agents. The World Bank, which supplies some Norplant®, uses GTZ as the procurement agent. A noticeable lack of supplies from UNFPA is partly due to a cut in funding, but also because the MOH did not place a request for commodities in good time.

Figure 5 below shows FP commodity funding in the country between FYs 2010/11 and 2012/13, the government contributed significantly by investing US$10 million to the MoH for the purchase of FP commodities. According to the Clinton Health Access Initiative (CHAI), with the start of devolution in FY 2013/14, no national budget was allocated to purchase of FP commodities thus a decline of funding between 2014/15 until the government picked up in 2016/17 as funds were redirected to the counties. This was due to the lack of guidance to the counties to allocate the specific budget line. Although counties assume a greater responsibility in the implementation of FP programing a lot of the financial resources are dedicated towards human resources and operations and maintenance as opposed to addressing health systems gaps like commodity supplies.

Figure 5. Kenya FP commodity funding 2010-2020 (US$ million)

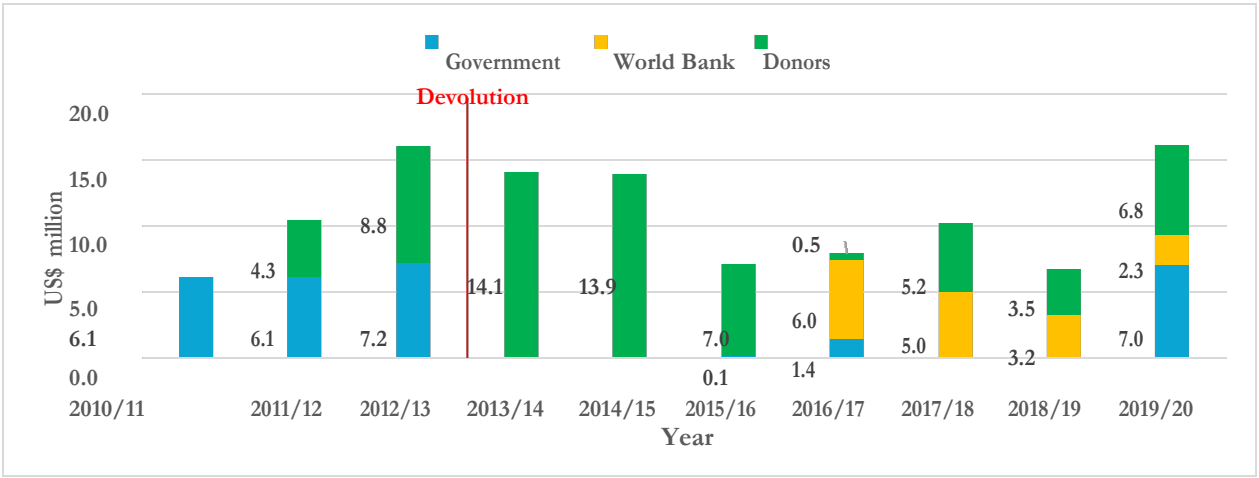
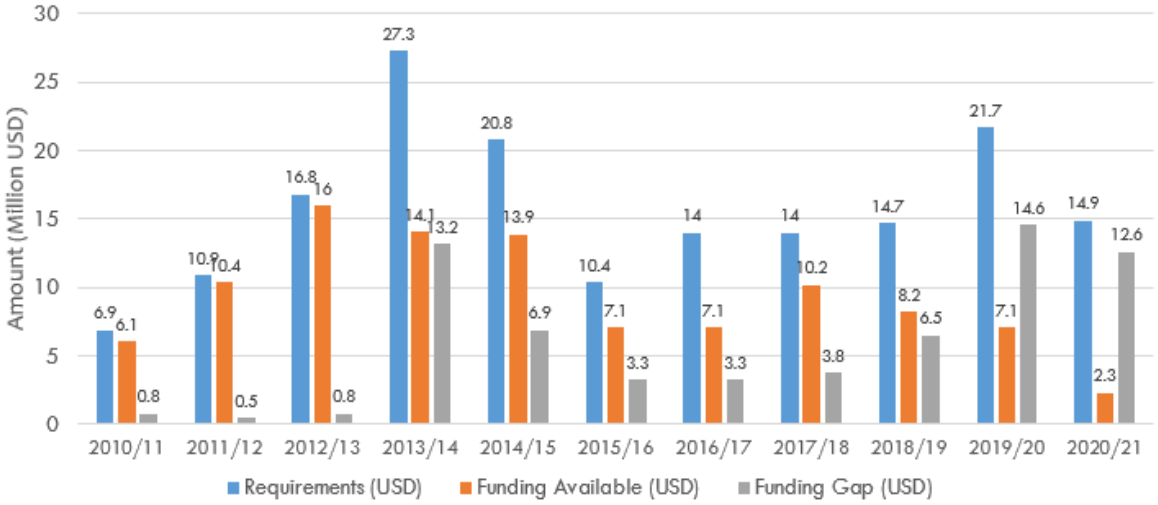


Figure 6: Funding gaps for FPCs in Kenya (in million USD)



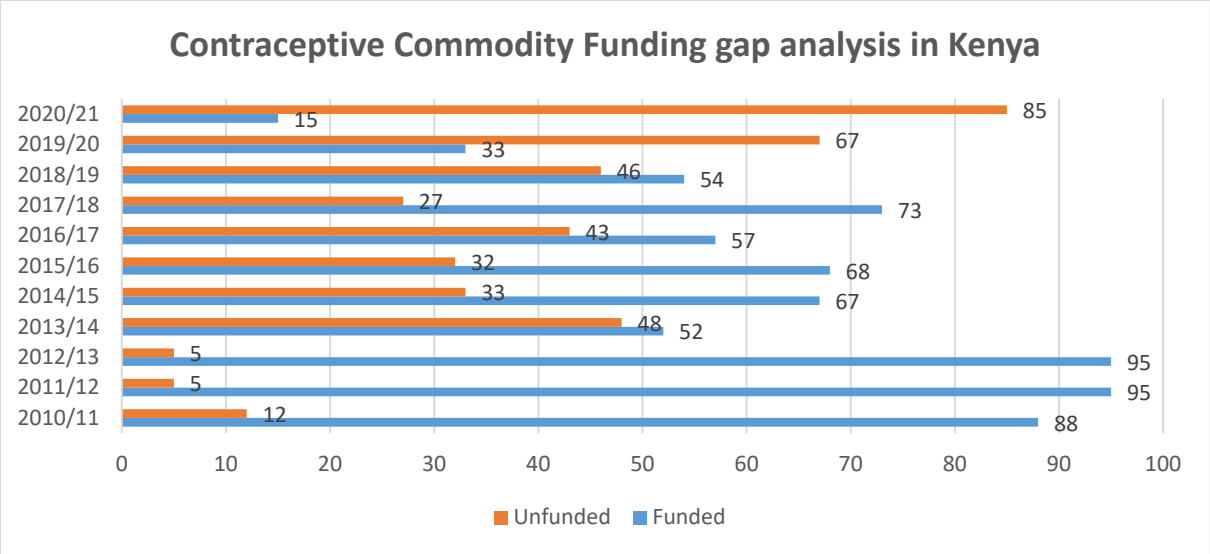
4.1.1 Family planning financial and programme commitments

Discussions with KII mostly at national level pointed out that Kenya's FP programme has been supported by commitments from international donors and the GOK. The GOK pledged an additional US$1Million per year to increase national financing for FP commodities and services specifically through a budget line allocated to the FP. The FP-CIP 2017-2020 sought to address the key FP funding issues through diversifying funding sources, increasing funds allocation by the government and strengthening advocacy for funding from multiple sources including the county treasuries; all 47 counties have CIPs by 2020 and FP budget line by 2020; review of policy on "free" FP commodity allocation to private entities; work with Kenya Medical Supplies Agency to ensure FP commodities are costed before distribution to counties; increase demand for and access to family planning among those counties with the lowest mCPR and highest unmet need and to improve contraceptive commodity security. Expansion of insurance cover for full method mix was also envisaged through strategies such as risk pooling, however it has been notes that contraceptives are not explicitly included in the NHIF-funded free maternity programme, Linda Mama programme.

It has been noted that there has been declining internal resourcing/ budgetary allocation for FP commodities which was marked by a steady drop in budget for FP. For example, in 2012/13 US$6.6 Million (40% of commodities) was allocated, then dropping to US$ 500,000 (2.9%) in 2015. In 2017/2018 Fiscal Year US$5 Million was allocated for procurement of FP commodities at the national level with funding from WB/GFF. Forecasting and quantification of FP commodities was conducted in March 2018 and the funding gap for 2018/2019 Fiscal Year was US$18 Million, WB/GFF allocation for 2018/19 Fiscal Year was US$4 million (UNFPA, 2019b). In the in Fiscal Year 2019/20 the Ministry of health committed KShs.500 Million, which was almost half of the required US$ 11 Million.

In 2020, UNFPA has secured $1,863,071, in addition to the $5,058,000 in 2019 to support the Ministry of Health to procure additional contraceptives. (KII). *UNFPA has also mediated a public-private partnership between the Kenya Medical Supplies Authority (KEMSA) and Coca-Cola Beverage Africa with an aim to enhanced delivery of family planning commodities to all parts of the country including those in hard to reach areas as part the last mile.*

Figure 7



From figure 7 above, available funds from both external and domestic sources for family planning commodities will cover just 15 percent of the estimated total need in 2020-21.

With regard to improvements in quality of data and increased visibility on the status of commodities at facility level in the counties UNFPA partnered with Health Strat in the development of a mobile-based reporting tool known as QualiPharm. Majority of the KII participants indicated that lack of prioritisation of FP at both national and county levels has led to major funding gaps and high dependency on external financing for FP commodities still continue. The FP CIP (2017-2020) presents the available resources by government (national & county), development partners and others for the period 2017 and 2020. However, only 24% of the required resources have committed by the county governments indirectly through human resources and operations and maintenance.

Table 3: Resource Projection for CIP (2017 to 2020)

	2017	**2018**	**2019**	**2020**	**Total**
	KSh Million	**KSh Million**	**KSh Million**	**KSh Million**	**KSh Million**
Government (National Level)	52	52	52	52	208
Government (County Level)	1,314	1,314	1,314	1,314	5,254
USG	1,904	1,904	1,904	1,904	7,617
UK	796	796	796	796	3,186
UNFPA	342	342	342	342	1,368
World Bank (GFF commodities)	**606**	**505**	**404**	**303**	**1,818**
World Bank (GFF to counties)	63	139	152	152	505
Bill and Melinda Gates Foundation	404	403.58	4.00	4.00	815
Others	202	202	202	202	808
Total	5,683	5,658	5,170	5,069	21,580

Source: National FP CIP 2017 – 2020

Table 4 shows answers to the question: '*what are some of the policy recommendations that need to be implemented by governments at all levels to ensure sustainable domestic financing of FP Commodities?*

The respondents outlined a number of opportunities/recommendations, namely: Increase domestic resource mobilization; Adopt a Total Market Approach and private sector inclusion; and FP policies implementation, monitoring and public accountability; were the most frequently cited opportunities.

Table 4 Existing local opportunities to strengthen Family planning financing system

Opportunities
Increase domestic resource mobilization i.e budget allocation in fiscal planning for FP commodities at the national and county level.
Complete and accurate reporting in the KHIS to provide quality data for forecasting and quantification as well monitoring of FP stockout.
Governments implement the regional commitment such as Abuja declaration and Maputo declarations ICPD as a development agenda for saving life as committed.
Adopt a Total Market Approach where all sectors are given the space to play a role in FP commodity supply.
FP policies implementation, monitoring and public accountability
Prioritize FPC as a development agenda with inclusion into UHC benefits package.

Below is a summary key findings and Bottlenecks challenges from the responses on financing of FP commodities.

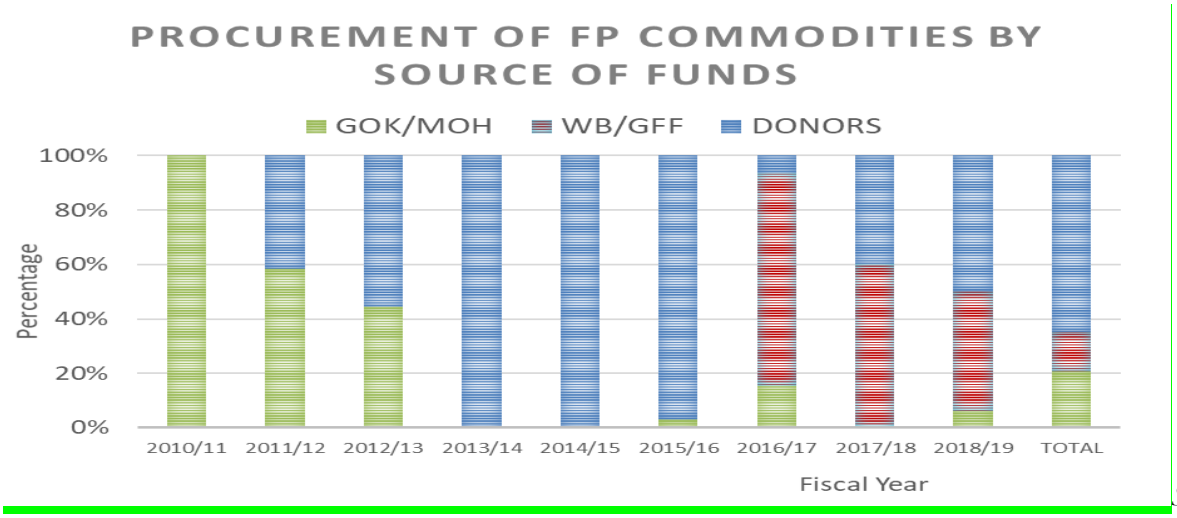
- Budget not fully aligned with Government of Kenya commitments for FP P2020.
- Low budget allocation for FPCs at both national and county levels.
- Centralized controls with strict rules & regulations; does not encourage leveraging of other health financing opportunities.
- Little evidence of private sector expenditure on FP
- Poor funding of county FP services leading to lack of access, particularly for adolescent youth and the poor
- Gaps in training and orientation of health officials on financial management and the health financing system.
- Weak monitoring and feedback to ensure efficient budget spending.

4.2 Procurement of Family Planning Commodities.

Overview of Procurement Process

The government manages the procurement of goods and services. The end-to-end procurement process can be divided into five main activity areas: supply planning, preparing the procurement request, approving the request and preparing the order, executing the order, and clearing and receiving the order. FP commodity security requires funding, yet the current financing level is in most cases inadequate or unsustainable, or both. The RHCS 2013-17 strategy takes into consideration financing for contraceptives from all sources. The government pays for RH supplies and services with budget funds. Donors provide financing or donate products. Households are the ultimate source of private finance, whether through the purchase of subsidised products, participation in the fully commercial marketplace, which allows businesses to invest in the provision of RH supplies or the payment of other fees at service sites or insurance premiums.
Table 3 reveals that FP financing was envisaged to remain heavily dependent on development partners, a situation that is confirmed by Figure 5.

Figure 8: Procurement of FP Commodities by Source of Funds



Source: DESIP & RH FP Strategy Background Situational Analysis Information, June 2019

One of the positive developments in the FP commodity financing is the signing of MOU between MoH, BMGF, DFID and USAID on an agreed matching ratio for the period between July 2019 and 30th June 2024. The development partners will match MoH financing as per the ratios shown in the table below. This ensures government commits to take on an increasing share of the overall funding for FP commodity financing each year so that in 2022 and 2023, the government will invest double the amount invested by development partners and in 2024 this will increase to four times the external investment thus increased national ownership of FP domestic financing and sustainability beyond 2024. The matching ratio is as follows: 2020 (1:1.5); 2021(1:1); 2022 (1:0.5); 2023(1:0.5) and 2024 (1:0.25).

Under the thematic area of sustainable financing of FP Commodities within the national costed strategy, the following are some of the priority outcomes and activities proposed:

"Outcome: *Increased allocation of resources to FP programme by national Treasury, counties, donors, partners and private sector.*

Strategy

Focus will be on consistent and reliable financing to procure contraceptives to ensure they are available when and where needed by health programs and clients. This will be achieved by increasing allocation and diversifying sources of funds for FP. Financial sustainability will also be supported by an enabling environment created through advocacy and policy reviews[1]. In the face of other competing demands for public sector resources, the FP program through MOH and partners will mobilize country and county resources to fill the financial gap left by donor phase-out.

[1]*For example, laws must allow cost recovery if that is the strategy chosen. Similarly, institutions must have the capability to collect and account for revenues so generated and demand should not be compromised.*

Strategic activities

FS1. Establishment of a contraceptive repository. *This will be achieved by establishing a contraceptives stock repository located at a central level such as KEMSA and stocked with donor and government procured contraceptives.*
In order to gain from economies of scale, KEMSA will be responsible for procurement, warehousing and distribution of the contraceptives to points of care based on orders received from the counties. Both the public and private sector will draw their requirements from the central repository.
FS2. Establishment of a contraceptive revolving fund. *FP revolving fund will be established to ensure sustainability post-donor funding for procurement of contraceptives arising from the resizing of the Kenya economy to a lower middle income (LMIC) status. The funds charged to the clients accessing their contraceptives through the Contraceptive Repository will be placed in "Kenya FP Fund" account and used to finance replenishment of FP stocks.*
FS3. Mobilization of resources for FP programme. *This will entail advocacy for incorporating Reproductive Health Commodity Security (RHCS) in national budget and fostering partnerships for increased consolidation of FP resources. To address the limited financial commitment to FP commensurate to need, the RHMSU, County Health Departments and partners will advocate for increased funding within national and county budgets, starting with the inclusion of FP activities within county development plans and consequently budgets. GFF presents an opportunity for additional funds for FP programming. Kenya's investment case is approved and prioritizes FP*
FS4. Stewardship and implementation of a Total Market Approach (TMA) *. The steps in the TMA process include engaging stakeholders through advisory groups and network analysis, assembling evidence for decision-making, such as determining the needs of private providers to provide FP, identifying market segments, surveying commercial product availability, and modelling different financial resource scenarios, and building the total market plan. Given that most of these studies have been done, the FP CIP 2017-2020 will focus on the implementation of the recommendations arising from various research and modelling work.*
FS5. Establishment of a risk pooling mechanisms. *This will be realized through advocacy for inclusion of the full range of FP methods and contraceptives in health insurance schemes including National Health Insurance Fund (NHIF) and private insurance schemes in Kenya. MOH in collaboration with partners and insurance service providers will develop a business case and rationale for inclusion of full contraceptive method mix in health insurance scheme packages. Currently only tubal ligation and vasectomy procedures are covered by NHIF. Private insurance companies are yet to include FP in the package of insurance cover. Thus, the need to advocate for the same."*

All the KII identified the following bottlenecks and challenges in relation to procurement of family planning commodities in Kenya:

- Public Finance Management system.
- Delayed initiation of procurement process and slow supply from KEMSA.
- Counties are not authorized to purchase commodities except from Kenya Medical Supplies Authority (KEMSA) as per the Kenya Health Law 2019.
- Gaps in forecasting of FP commodities leading to stock outs of FP commodities (mostly LAPM);
- Lack of reliable data on out-of-pocket expenditure for FP services
- Continued high unmet demand for FP services (particularly among young people, in rural areas

Furthermore, communication from KEMSA on commodity availability is triggered on a quarterly basis, when CDoH place commodity orders. In other words, a CDoH may not be aware of method mix shortages at national level only until they place an order for the same. In this context, they must "make do" with what is availed.

Data from the national family planning costed plan for year 2017-2020 notes the following as other key challenges faced by counties in procurement and provision of FP commodities in Kenya:

Table 5: Key challenges in FP service delivery

Key issue	
Unequal deployment of health service providers and sufficiency of health care worker	➢ Government focus is equality rather than equity which continues to marginalize the already underserved areas ➢ Inadequate health care workers compromise access to and quality of FP services provided by the existing personnel
Insufficient operationalization of FP guidelines on FP provision	➢ FP guides relating to provision of FP methods by different categories of service providers to ensure quality, equity in availability of investments needed for the services delivery not fully implemented ➢ Healthcare providers often lack training to provide the full range of FP methods applicable to their cadre (especially the more effective and less expensive LARC
Public health facilities Inadequate supply of equipment and supplies Insufficient strategies for provision of high quality youth friendly services (YFS)	➢ Lack of adequate and steady supply of equipment, supplies and consumables for actual FP services provision ➢ Lack of support by critical stakeholders (parents, health care workers, religious leaders) and a multisectoral approach is not consolidated ➢ Health care workers' biases exists ➢ Inadequate youth friendly service delivery points.
CHVs engagement is unsustainable	➢ CHVs are technically volunteers and thus not considered as part of the human resources for health therefore not included in the budgeting process. ➢ Consequently, they do not have a steady income to enable them sustain providing services ➢ Diminishing support from partners who initially supported CHVs activities ➢ High numbers of CHVs (over 150,000) poses a challenge in their overall supervision and financing
Private facilities holistic integration in FP	➢ Data on the proportion of Kenyans seeking FP services from private sector including clinics, hospitals pharmacy outlets and health facilities is scanty - only 38% of registered private facilities reporting on FP service provision data
Cultural factors	➢ Low male involvement in FP and RH services

4.3 Supply Chain for Family Planning Commodities and Procurement Partners

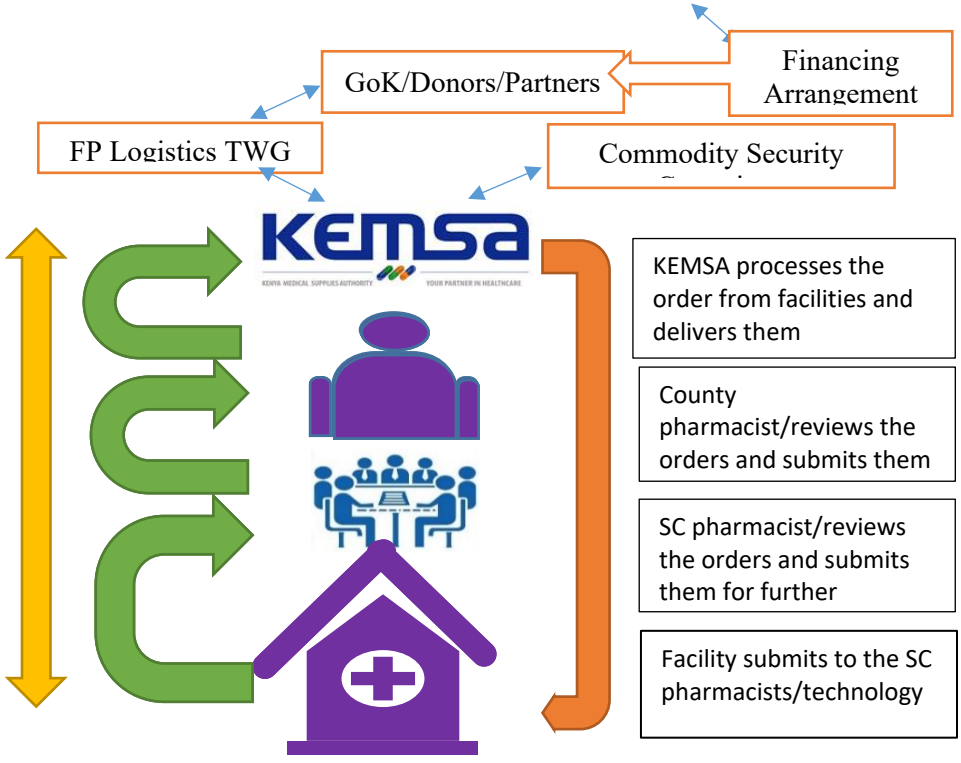
Supply chain management organizes the vast network of supply chain players; procurers, manufacturers, shippers, distributors, warehouse agents, facility managers, and service providers—in a system to ensure timely delivery of products from the central and county warehouses, and ultimately to service delivery points and communities.

MOH, Department of Family Health technical division of reproductive and maternal health programme takes the lead role in managing the supply chain for FP commodities in Kenya. Donors, non-governmental organization and other development partners collaborate to improve and sustain the national and county ownership by strengthening the public sectors mainly providing functional support for the supply chain, capacity building and advocacy at the national level as well as supply chain performance improvement through system enhancements.

The Kenya Medical Supplies Authority (KEMSA) manages the national procurement and supply centrally, maintaining a central warehouse from which it supplies the counties. KEMSA's core mandate is to procure, warehouse and distribute drugs and medical supplies for the prescribed public health programmes, the national strategic stock reserve, prescribed essential health packages and national referral hospitals both for the counties and the national government. In order to have an effective and seamless supply chain that ensures family planning commodities are available for uptake by clients at facility level, government and other stakeholders work together to finance and continuously monitor commodity status at central storage stores (KEMSA) and facility level to ensure that FP products are available.

Figure 9.

FP Commodity Supply Chain



A number of other local and international organizations participate in or lead activities, in coordination with the Public Sector.

Coordination of activities among partners take place at National and County level is facilitated through the Technical Working Groups (TWGs). At national level, there are two steered Technical Working Groups (TWGs) and technical committees, whose roles are detailed below;

FP Logistics TWG: It discusses the commodity situation in the country and come up with strategies to avert stock outs. The TWG's objective is to coordinate the national efforts of determining the stock status of FP commodities, gaps and potential procurement needs.

Interventions by this TWG helps to achieve FP commodity security in line with the health sector policies and plans, guidelines and FP program objectives. These actions support continuous improvement in access to, availability of and accountability for these medicines. One of the key outputs of this TWG has been the support to Ministry of Health to prepare the National supply plan and provide TA for the National stocktaking exercise.

Commodity Security TWG: This is a donor led committee which is instrumental in advocating for allocation of resources by both the government and donors. The team meets to review the commodity status in the country alongside the supply plan and resolves the challenging commodity situation, arising from issues in the procurement process caused by delays in the release of the government's allocation.

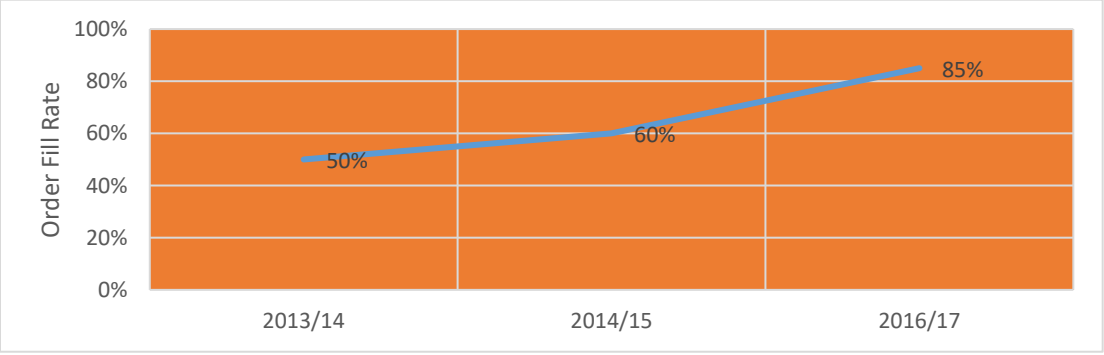
At county level, county governments provide resources required to support service delivery, though this indirect through human resources and operations and maintenance.
The county pharmacists and sub-county pharmacists do develop correct forecasting and quantification plan and conduct timely ordering of FP commodities and follow up with KEMSA to ensure that orders are received and processed for timely delivery to facilities.

4.3.1 Logistics Management Information System (LMIS).

A strong supply chain requires good data visibility, based on routinely and accurately updated records and timely reporting, so that managers and supervisors throughout the system can make informed decisions. Using data to make wise resupply decisions and for monitoring the performance of the supply chain is essential to maintaining an efficient and effective supply chain. In the counties included in this assessment, reporting rates were very good. Majority of the KIIs noted that that Kenya has a strong electronic logistics management information system (LMIS), but long-standing data quality concerns have hampered its use for key supply chain decisions such as quantification and resupply.

The figure below shows improvement of KEMSAs order fill rate between 2013 and 2017 through the use of the Enterprise Resource Planning (ERP) and Logistic Management Information System (LMIS).

Figure 10: KEMSA Order Fill Rate



Source: KEMSA 2017

It was noted from the respondents that KEMSA has signed MOUs with all 47 county governments for the supply of medicines and medical supplies to improve targets to 98% by 2018/19 through the improved efficiency in automation of all operation activities. Health facility workers have been trained on the LMIS that has boosted medical commodities order turnaround and has helped KEMSA address the challenges experienced in inaccuracy of quantity ordered, forecasting, reduced paper work and building a data bank where facilities quantify volumes of drugs they consume. As a result, the order turnaround time has reduced from 12 days in 2013/14, 10 days in 2014/15 to 9 days in 2015/16 with a target of 7days in 2018/19.

KII with respondents in the counties still indicate absence of or incorrect use of stock records in facilities in most of the counties was identified as a major cause of poorly reported data and a lack of training in stock cards was evident which creates need for quality assurance. It was also noted that no documentation for Private Sector because they are not linked.

Private health facilities have largely not been proactive in reporting to the national information system. There is an opportunity to capture data from private sector. This is not being done. (KII)

Table summarizes the strategies can be put in place to increase coverage of FP services.

Strategies
Build and support a competent, professional supply chain workforce
Support counties on quantification; Training on quantification and forecasting
Capacity building on strategic health purchasing (Health Technologies Assessment, HTA)
Implementation of task sharing policies, strategies to eliminate stockouts, debunking myths, improving the skills of providers including counselling and strengthening political commitment and financing.
Strengthening community distribution system
Capitalize on private sector supply chain capacity, where appropriate

Majority of the respondents from the counties revealed that in terms of staffing, consistently reported that there were insufficient staff to manage supply chain activities, both in data management and storekeeping. Regarding training, staff indicated that, while most of them had received some training in supply chain, either in stores management or LMIS, it was either several years ago or insufficient to ensure they or their supervisees were competent to do their jobs.

4.3.2. Forecasting of family planning commodities.

The department of Family Health technical division of reproductive and maternal health is responsible for ensuring contraceptive commodity security in the county. This involves quantification and forecasting of contraceptive commodity needs, monitoring and coordinating procurement, and monitoring the storage and distribution of these FP commodities. As per the RHCS strategy 2013-17 the FP programme hosts a quantification workshop every six months to validate the FP commodity requirements and quantities to be procured at national level. Based on the generated requirements, current in-country stocks and planned/pending shipments from the government and development partners, a national supply plan is prepared to guide procurement process. The quantification exercise takes into consideration the stock on hand at both the central and peripheral level and shipments of supplies and medicines ordered, but not yet received. Quantification is a critical supply chain activity that links information on services and commodities from the facility level with the program policies and plans at the national level; it is then used to inform higher-level decision-making on the financing and procurement of commodities. KII revealed that more needed to be done on these aspects as regards to using available data.

Reality Check® tool is often used to produce a population-based (demographic) forecast for all FP commodities. Data from KDHS 2014, the PS Kenya TRaC 2016 and PMA surveys, KNBS 2019 Census as well as commodity and service statistics from KHIS are used to validate the forecast. The supply plan is generated using the PipeLine® tool. National supply plan parameters are held at a minimum of 16 months and maximum of 22 months. (National stakeholders KII)

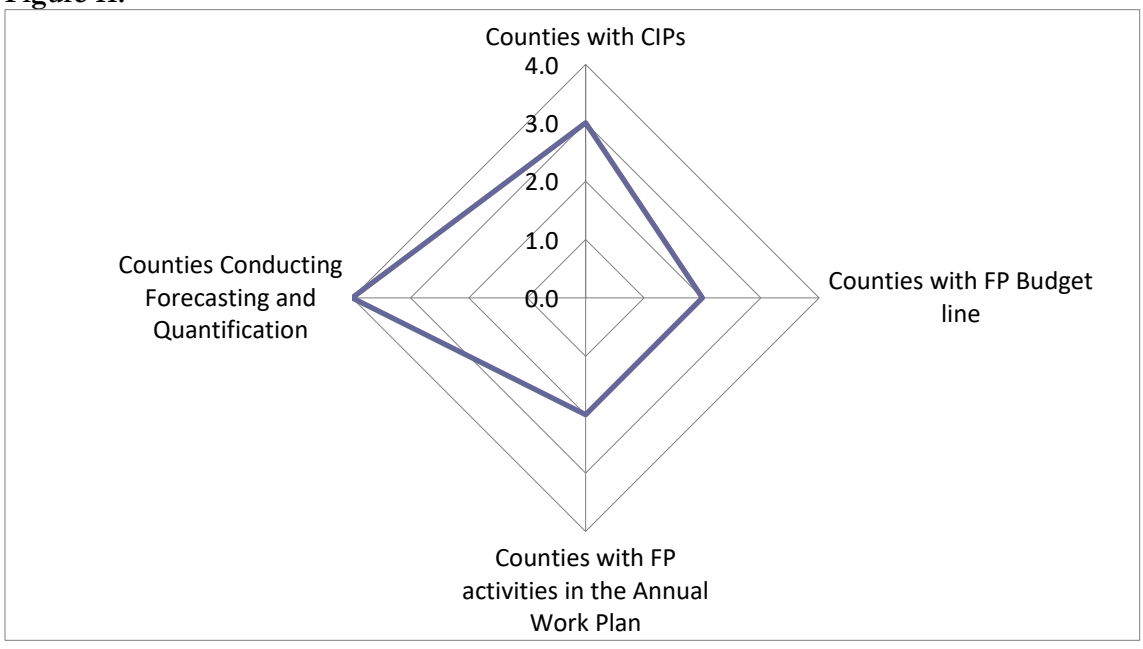
The FP dashboard indicates existence of commodities in the counties though for some reasons they do not get to the service delivery points, a problem that can easily be addressed through improvements in quality of data being used for forecasting & quantification, information flow and logistics & distribution among others. Providers cannot do their jobs without the support of a logistics system that reliably distributes to them all the products they require: contraceptives and other essential medicines, consumable supplies, and equipment. KEMSA has put in place a distribution system that delivers drugs and contraceptives directly to the health facilities. KII revealed that the system is effective, reliable and efficient.

The shift from the push system to pull systems has led to a significant reduction in overstocking and expiry of drugs and contraceptives in the health facility.
There are still cases reported of overstocking but this has been attributed to either use of inaccurate data or poor estimation of needs due to lack of skills. (KII).

4.3.3. Forecasting & Quantification at county level.

The counties are also encouraged to conduct one annually with a mid-year review. All the KII participants indicated that forecasting and quantification at the counties is mostly done by the county pharmacists and RH coordinators. Quantification is primarily based on service targets rather than demand, leading to stock imbalances at the counties level with delays in the procurement process at the central level have had a significant impact on product availability at the lower levels.

Figure 11.



Kakamega, Kisumu and Kajiado counties have also developed FP costed implementation plans (CIP).

Allocations for FP from county funds varies considerably across the 10 counties, two are using UHC funds for supporting FP programming. For those that had annual work-plan it was noted that investments on some equipment, staff trainings and mentorship, outreaches, and a range of demand generation activities including

community awareness/dialogues etc. Only three counties have plans for "strategic purchasing" opportunities, specifically through the NHIF national scheme Linda Mama which includes FP to some extent.

Almost half of all the counties KII participants reported that they have always been supported by partners in forecasting and quantification though some for example, Turkana and Taita Taveta counties reported that Some of the challenges reported in the counties include;

- There are serious knowledge gaps in forecasting and quantification as a result staff turnover
- Lack of support from the county leadership as FP is not a priority
- Inaccurate estimates citing capacity gaps. They cited that in most cases the estimates lead to overstocking hence leading to expiries.

Respondents indicated that going forward, the ministry of health should consider updating the demand-based forecast annually and using it as the main input to the supply plan. Regular, periodic collection and analysis of demand data, like this, can highlight trends in consumption and signal *in advance* when action is needed. Moreover, doing so can create a consistent base of information for procurement planning, as well as other management decisions related to commodity needs.

4.3.4 Overview of selected counties and family planning financial, procurement and supply chain related issues

	Financial		**Procurement**	**Supply chain**	
County	**Estimated cost of National CIP (2020)**	**Allocation**	**Supply chain partners supporting forecasting**	**Source of commodity**	**Who supplies Private sector**
Isiolo	14,852,809		Quarterly forecasting	KEMSA	
Kisumu	194,334,618	Kshs 60M (lumped within RMNCAH)	Quartely forecasting	KEMSA	
Bungoma	262,888,881		THS, IPAS, Marie Stopes, Afya Ugavi	KEMSA	
Kajiado	115,251,711		Quarterly forecasting supported by Afya Ugavi	KEMSA	
Kakamega	190,846,732.74	Kshs. 2M for year 2020		KEMSA	Afya Halisi hormonal implants MSI Sayana Press
Kwale	89,109,141		Quarterly forecasting supported by FHI, Plan, Action Aid	KEMSA	
Taita Taveta	59,955,251	63m		KEMSA	MSI
Turkana	42,023,620		Afya Ugavi, John Snow and Afya Timiza (Amref)	KEMSA	

Source: Key Informants, February 2021

4.4 General challenges identified by KIIs in FPC provision

- Uptake is high in the urban and low in the rural
- Method mix lacking
- Low uptake of some of the commodities i.e. IUCDs, Pills
- Stock outs
- Lack of specific budgets for FPC
- Delays in distribution particularly in hard to reach areas
- Logistics management
- Low demand in some rural areas
- Knowledge gap on quantification and management of supply chain
- No documentation for Private Sector because they are not linked
- observed increased stock-out levels in last 3 years especially for implants, IUD, injectable and pills
- The lumping together of FP products with other medical supplies has affected smooth flow of the products since they can be withheld by KEMSA if other payment for other medical has not been done.
- Inaccurate reporting for both the consumption and service statistics data

4.5. Universal Health Coverage

Piloting UHC in Kenya.

In late 2018, the Government of Kenya launched the Afya Care Universal Health Coverage (UHC) pilot program in four counties in Kenya. Under the initiative, county governments discontinued all user fees at secondary public hospitals and, in return, received commodities and additional funds from the National Government. The four pilot counties – Isiolo, Kisumu, Machakos, and Nyeri – were selected because they are characterized by high incidence of both communicable and non-communicable diseases, maternal mortality, and road traffic injuries (Nzwili 2018). The pilot was intended to run for one year starting December 13, 2018 (MOH 2020). The National Government stated the intent to scale up the program to the rest of the country following the review of the pilot, with the final goal of reaching 100% population coverage by 2022 (Nzwili 2018).

The objectives of the UHC program were:

- Ensure that Kenyans have access to an explicit unified progressive health benefit package
- Expansion of the population under universal health insurance coverage
- Increasing the availability and coverage of quality essential interventions
- Ensure financial risk protection for Kenyans with a special focus on the poor and the vulnerable groups; and
- Ensure adequacy of health resources for the delivery of health services.

The design of the scheme involved households in Isiolo, Kisumu, Machakos and Nyeri registering for Afya Care. Following registration, households would receive a card that would entitle them to access free services in public facilities. The card would also prevent residents from other counties in Kenya from accessing services in the four pilot counties. As per the agreement between the National Government and the counties, Isiolo, Kisumu, Machakos, and Nyeri county governments would discontinue user fees at level 4 and 5 facilities. The National Government would use conditional grants to reimburse the four counties for the lost revenue from the user fees foregone, with support from development partners (Mbuthia et al. 2019). The four pilot counties – Isiolo, Kisumu, Machakos, and Nyeri – would receive KSh. 3.1 billion in total, divided across four areas. Most funds were allocated for the delivery of basic and specialized care services (72%), followed by activities for health system strengthening (15%), community health services (12%), and public health services (1%).

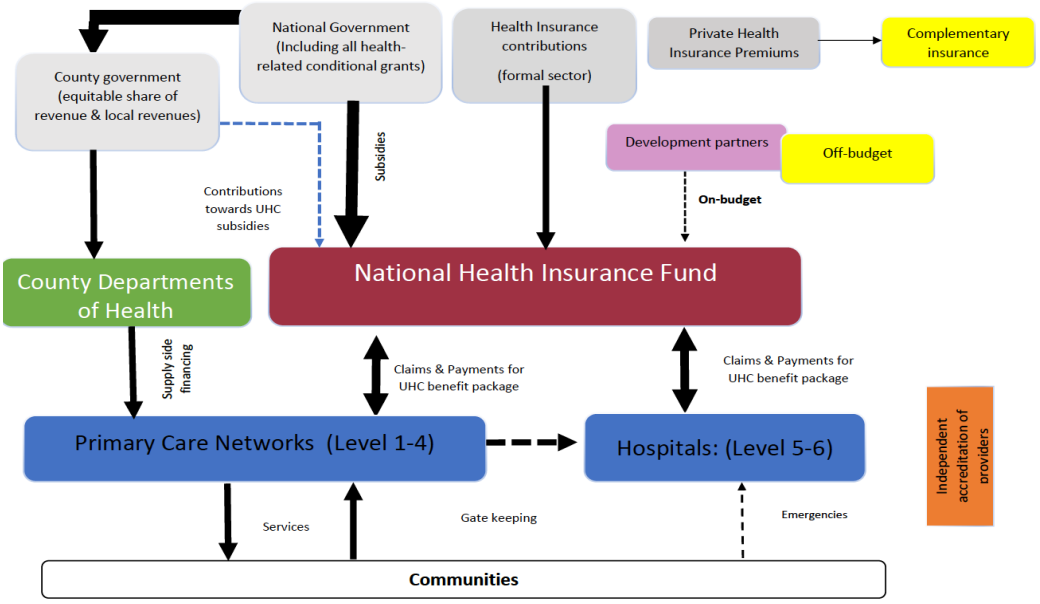
Leveraging on UHC mandate to improve access to FPCs

Under the UHC policy, the Ministry of Health provided additional guidelines on the use of funds, under the category of public health services.

These were exclusively allocated to County Health Management Teams (CHMTs) for service quality control, data collection, and surveillance. The funds for community health services were intended to support training of and supplies for community health workers (CHWs). Most of the funds under the category of health system strengthening were allocated to support recruitment of health workers, preferably on a contract basis. The remainder of funds were for the provision of basic medical equipment in health facilities through the Kenya Medical Supplies Authority (KEMSA). The guidelines stated that a minimum of 5% of the resources for health system strengthening must be used for performance-based financing (PBF) at the facility level (60% allocated to health workers and 40% allocated to improve the working conditions in health facilities). While 70% of funds for basic and specialized care services were to flow to KEMSA for medicines and other supplies, the remaining 30% went to counties to cover operations and maintenance at level 4 and 5 facilities (MOH 2018a).

Kenya has a well-articulated vision for how it wants to organize health financing to achieve Universal Health Coverage (UHC). One of the strategies outlined in the draft UHC policy 2020-2030 identifies strengthen strategic purchasing to enhance the linkage between available financial resources and the health services to which Kenyans are entitled. The figure 9 illustrates the financial flows during the policy period and beyond:

Figure 12: UHC Health Financing Model



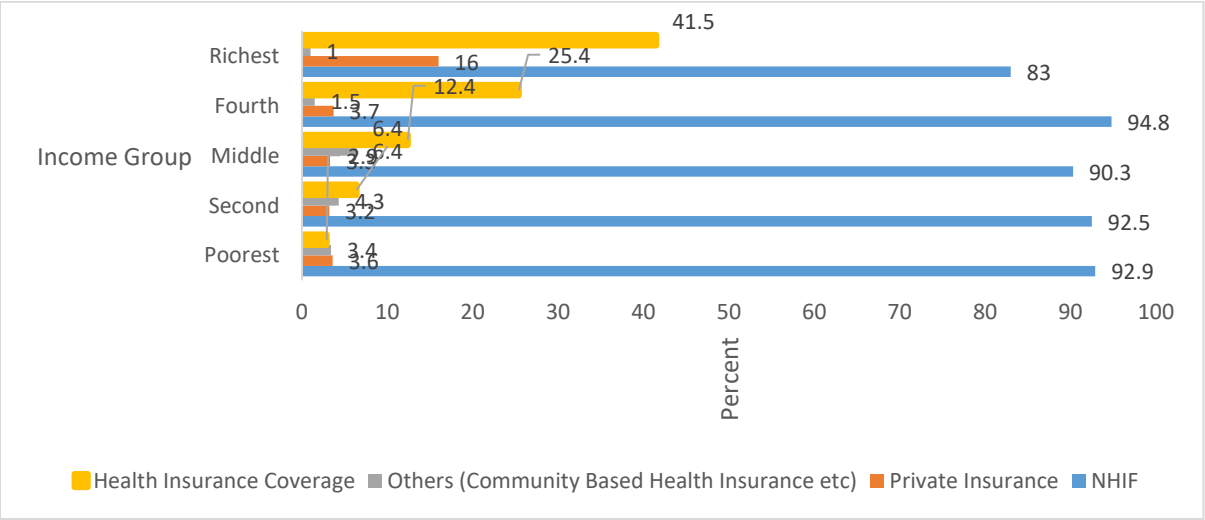
***Source**: Ministry of Health Kenya 2019*

The Government's approach includes UHC in an ecosystem that includes investment in legislative reforms; restructuring of key agencies like the KEMSA and NHIF among others. Central to the achievement of UHC is increasing health insurance penetration. Health insurance coverage in Kenya remains low, although it has increased from 10 to 18 percent between 2007 and 2018 (KHHEUS, 2018) i.e no of individuals are covered by some form of health insurance with the poor bearing the highest burden of non-coverage (KDHS 2014). Only 2.9 of the poorest 20% Kenyans have any form of health insurance coverage, although, the nationwide survey found that a majority of Kenyans, regardless of their household wealth were covered by the NHIF.

It is evident from the below from figure 10 that the bulk of the market is served by NHIF (83% to 94.8%), which also covers the bulk of the poorest (though they have the lowest coverage 2.9 %). Private insurance serves the richest, with NHIF dropping to 83 percent within this group (with a coverage of 41.5%). However, special initiatives being implemented have contribute to the rise namely Health Insurance Subsidy Programme and Linda Mama Programme.

The Scaling up of health insurance to all Kenyans and building of partnership and collaboration between levels of government as well as working closely with the health service providers in the private sectors is key in the realisation of UHC. And this provides a great opportunity for increasing the domestic financing of FP Commodities in Kenya both by national government and the county governments

Figure 13: Health Insurance Market and Coverage



Source: KDHS 2014 and UNFPA 2017a

The lack of resources at the facility level were a recurring theme in discussions with facility staff and the County Departments of Health (CDoH). In addition to shortages and stock outs of FP commodities, facilities grapple with a lack of financial resources to perform basic functions and provide essential services. Preceding to devolution, health facilities in Kenya were able to retain any revenue they collected from user fees and the National Hospital Insurance Fund (NHIF) and use it to pay for basic facility costs, including commodities in the case of stocks-outs. With devolution, many counties have insisted that these funds be remitted to their own revenue fund. Most of the respondent's notes that there are frequent delays of one to three months especially with Linda mama schemes operated by NHIF, this affects health facilities costs payment.

It is evident that the thinking behind UHC guided by the strategies and policies if well implemented could be a game changer in terms of improving access of FP services and Commodities. With the focus on more financing for Commodities, integration of existing financing mechanisms for healthcare, health worker retention and training, training of CHWs and strengthening reporting and the CHMTs are all important opportunities that can and will improve FPC supply and financing in Kenya in the long run.

Inclusion and provision of contraception as part of health benefits packages (HBPs) can help assure a more sustainable approach (KII).

There is need for robust advocacy to ensure that UHC conversations take cognizance of the significant role and important it can play in improving financing, supply and procurement of FPCs parallel to other funding mechanisms at all levels of government inclusive of private sector involvement.

6. Recommendations

6.1 Quantification & Procurement

The assessment highlighted that current methodologies and procedures used for quantification and procurement were not meeting current demand for certain methods. This was partially due to forecasting of requirement based on targets rather than consumption, and some delays in procurement.

Respondents from the KII at both national and county level recommended that capacity building of staff in quantification was required, that funds be allocated for conducting quantification, that family planning commodities supply should meet demand, and procurement should be conducted in a timely manner.

The overall recommendations based on the findings for quantification and procurement are to increase advocacy interventions for the following priority areas:

- Capacity build staff especially county pharmacist and RH coordinators to be able to properly undertake forecasting and quantification.
- Support the digitalization of documentation and quantification particularly in the lower level facilities that still use a manual system.
- Counties to be supported in managing FP commodities and distribution. This will ensure that they have adequate stocks of commodities since they will not over or under quantify the FP need
- Forecasting of family planning commodities requirements should be developed using consumption data as a primary source of data, validated with demographic and service data and with consideration to program targets.
- A fixed procurement schedule should be established so that regional warehouses know when to expect products and can properly plan to prevent stock imbalances.
- Supply planning should be based on consumption-based forecasts and updated more frequently based on current consumption and stock levels.
- Adequate buffer stock should be developed at the central-level warehouse to service emergency needs.
- A feedback mechanism should be developed for product quality and product specifications should be modified based on user and provider needs and concerns.
- Supplementary consumables should be available at all times to ensure services are provided in a timely manner.

6.2. Supply Chain:

Overall reporting rate of logistics data is generally good, however, the quality of data was reported as a concern by qualitative respondents and was confirmed through the interviews. A major reason for poor data quality as identified in the quantitative results was poor use of stock records which are the primary source of data for logistics reports. Other explanations for poor data quality include calculation errors and transcribing errors. Although the FP program has a supervision structure in place, the supply chain component of the supervision is not sufficient.

From the findings, participants recommended that all counties have staff trained in accurately completing stock records and logistics reports, that routine mechanisms be established for monitoring and data validation.

Based on the assessment findings the recommendations for the supply chain include:

- Improve IT infrastructure and build human capacity to implement on logistics reporting system to create efficiencies and improve data visibility throughout the supply chain.

- Develop job aids and conduct training on correct use of stock cards and continue to support facility staff in their use through routine monitoring and on-the-job training.
- Build a culture of data use for decision making, through designing user-friendly supply chain dashboards that can facilitate rapid analysis for decision making.
- Develop tools to monitor key LMIS indicators such as data accuracy, reporting rates, and report timeliness, which are critical inputs to implement an appropriate inventory control system.
- Develop a dedicated mechanism for supply chain that facilitates routine monitoring and on-the-job training that can complement classroom trainings, SOPs, and job aids. Where possible, combine with product distribution.
- Improve communication and coordination within and across levels in the supply chain by forming teams with a common vision of improving product availability.
- Design and track key supply chain performance indicators and create structures for joint problem solving and action planning to address challenges and improve performance.
- Develop a plan to regularly recognize good performers within the supply chain so as to increase accountability and improve staff motivation
- Strengthen primary health and community led approached to improve access to FPC and increase demand
- Improve supply chain visibility by digitalizing documentation at level 2 & 3 facilities for consolidated reporting in KHIS.

6.3 Financing

There has been a steady decline in financing of FP commodities over the past 8 years, in 2012/13 US$6.6 Million (40% of commodities) was allocated, the funding gap for 2018/2019 Fiscal Year was US$18 Million, while in the Fiscal Year 2019/20 the Ministry of health committed KShs.500 Million, which was almost half of the required US$ 11 Million!

The disconnect between the FP2020 financing estimates and commitments versus actual allocations are even worse and unless more deliberate effort is put in, the country is looking at a catastrophe and a complete reversal of gains made within the Family Planning sphere.

Based on the analysis within this report some of recommendations made to improve financing of FPCs include:

- Increase domestic resource mobilization i.e budget allocation in fiscal planning for FP commodities at the national and county level.
- Prioritize FPC as a development agenda with inclusion into UHC benefits package
- Adopt a Total Market Approach where all sectors are given the space to play a role in FP commodity supply
- Align Government of Kenya budget commitments for FP P2020 (now FP2030), estimates and actual allocation- advocacy and CSO engagement required to ensure accountability.
- Improve training and capacity building of health officials on financial management and the health financing system with alignment to robust quantification based on county FPC requirements.
- Leveraging on existing programs e.g. UHC, Linda Mama, Beyond Zero and other county specific programs (e.g. Oparanya care, marwa, Makueni care) to increase resources for FPCs
- Counties should be encouraged to domestic the national FP-CIP rather than draft from scratch. This will ensure support is provided from national level to streamline and make realistic prioritization and commitments that ensure the CIPs are well funded within the county budgets. Furthermore, counties should provide a legal framework for budgeting and ring fencing funds for FPCs

- Inclusion of contraceptives in the existing health insurance schemes will increase access to FP for insured individuals, bolstering equitable access to Family Planning.
- The government should ensure post-partum family planning services are included as part of its Free Maternity policy as a financing mechanism to increase access
- Delink supply of FPCs from other essential medicines to ensure uninterrupted supply, reduced delays and stock outs

7. Opportunities for Advocacy

Some interviewees were sceptical about the effectiveness of advocacy to increase investment in FPCs by governments, as they believe many other factors play a (more important) role in decision making on budget allocation by governments. Before embarking on county and national advocacy for FP UHC engage partners should consider the following;

- ✓ Firstly, Policy analysis, review and developing advocacy evidence of existing advocacy initiatives as part of monitoring and public accountability. This will include review of commitments to FP budgeting and financing that the national and county governments have made before which is not limited to critical review of published FP data and reports for evidence based decision making. Studies have shown that Insurance coverage is associated with higher rates of healthcare utilization and if FP provision is included it presents a great opportunity.
- ✓ Secondly, creating spaces for UHC engage partners to participate in policy dialogue with policy makers at the county level departments of health, Treasury bureaucrats and politicians including Members of the County Assemblies. This will strengthen the political will for family planning and the fact that it is not considered a development issue and not included in the County Integrated Development Plans, hence the omission from the AWP and budget.
- ✓ Thirdly, use forecast as an advocacy tool with Commodity Security Group and FP Logistics TWGs forums to share regular updates on the status of supply. LMIS system captures the data and usually aggregated to inform the quantification exercise.
  There has been a significant improvement in health facility reporting from about 45% in 2013 to 80% in 2018. DHIS2 also indicates service data or facility-level data and the type of contraceptive provided.
- ✓ Fourthly, embrace stewardship, coordination and oversight to stakeholders in SRH/FP through effective mechanisms including establishment of the FP inter-agency coordinating council, structured regular multi-stakeholder engagements at both national and county level and an effective monitoring & evaluation system to capture what each actor is doing among others. Exploring existing accountability structures used by other partners.
- ✓ Lastly, Embracing and Supporting Total Market Approaches (TMA) which increases opportunities for private sector to play an increased role as private health facilities have largely not been proactive in reporting to at both county the national information system. This will bring on board innovation on information i.e. cost-effective channels through technology for delivery of services, young people prefer access of FP services through private sector etc. Private insurance companies can also develop health insurance products. Lack of adequate regulation of the private sector continues to be a challenge in many LMIC
- ✓ Participate in county level domestication and development of UHC policies and benefits package to influence inclusion of FP Commodities as priority medicines covered under this package
- ✓ Advocate for counties to develop CIPs and ensure annual incremental allocations for FPCs within the county annual budget and workplan mechanisms. Push the counties to ensure that family planning is included as part of sector-wide planning, budgeting and prioritization at county level.

- ✓ Strengthen forecasting and quantification and advocate for county ownership and resourcing of the process as part of strengthening of the supply chain gaps and ensuring consistent supply of commodities based on county specific needs and utilization.
- ✓ The COVID-19 pandemic is causing tremendous disorder to health systems around the world, disrupting global supply chain of essential reproductive health commodities and supplies, hindering access to family planning services and information for many women and girls of reproductive age.

8.0 Conclusion and Next Steps

The rapid key informant survey succeeded in gathering the preliminary views of stakeholders selected at both National and county level. The literature identified through the review provided the necessary information to draft an overall picture of the situation regarding FP commodities in the focus areas identified by TOR. KIIs provided additional information and allowed for further building of the evidence base as well as inform country partner technical assistance.

Family Planning in Kenya faces a number of challenges including inadequate financing, commodity insecurity, lack of effective governance & stewardship and weak data management systems. The current financing level is in most cases inadequate or unsustainable, or both. There has been declining internal resourcing for FP Commodities which was marked by a steady drop in budget for FP, which is not limited to commodities only.

Achieving the FP2020 and now FP2030 goals is a critical milestone to ensuring universal access to sexual and reproductive health services and rights by 2030, as laid out in Sustainable Development Goals 3 and 5. A strong and dynamic family planning supply chain system that achieves universal availability of a full range of contraceptive methods is critical to achieving this goal. A holistic customer focused approach that addresses all components of the supply chain system is essential to ensuring that the six rights of supply chain management are achieved.

Health service delivery including family planning services in Kenya is devolved with FP constituting to 47% of health services delivery. However, several policies and components of the supply chain, such as quantification and procurement of contraceptives and LMIS, are centrally managed.

A comprehensive supply chain strategy and implementation plan by the central level with well aligned policies can provide the much needed direction to the county levels to achieve improved supply chain performance.

A data-centric approach built on a robust LMIS that incudes quality and timely data is needed to inculcate a culture of data use for supply chain decision making. Strengthening human capacity and accountability will also ensure policies are implemented efficiently and a high quality of FP service is maintained. The political momentum for strategic health purchasing activities of the health system offers an extraordinary opportunity to systematically improve availability, quality, and affordability of FP services.

As Kenya embarks on achieving universal health coverage for all, inclusion of family planning commodities as part of the health benefits package will be crucial. A responsive supply chain system that can adapt to the changing method mix and support the needs of an increasing number of new users will be critical to meeting this mandate. This can only be achieved through a concerted partnership between the public and private sectors. GFF presents an opportunity for additional funds for FP programming. Kenya's investment case is approved and prioritizes FP. Coherent purchasing mechanisms are one essential component to achieving UHC and can facilitate change in other health sector areas as well. In working towards solidified and coherent purchasing structures, engagement with related efforts will be critical to ensure a coordinated approach.

Implementation of a robust advocacy strategy around the key opportunities identified is critical for the realization of increased domestic resource mobilization for Family planning commodities.

Policy formulation particularly costed implementation plans by all 47 counties is one such step that will ensure more domestic resources are directed towards not only purchasing of FPCs but improving the infrastructure and supply chain that will ensure universal access to FPCs. Engaging in UHC conversation and scaling advocacy for inclusion of FPCs in the essential benefits package list will ensure additional financing and focus towards Family Planning Commodities. All these can be realized and achieved by implementing the advocacy opportunities identified and recommended within this study.

ANNEXES/TOOLS

LIST OF INTERVIEW GUIDES AND DATA COLLECTION INSTRUMENTS

- Key Informant Interview Guide for National Stakeholders.
- Key Informant Interview Guide for RH Coordinators/Pharmacists
- Literature review guide
- Report of challenges and process of data collection
- Report of validation meeting of the report

Annex 1: KEY INFORMANT INTERVIEW GUIDE FOR KEY NATIONAL STAKEHOLDERS

INTRODUCTION

Access to Medicines Platform in partnership with Population Action International (PAI) is implementing *UHC Engage*, an evidence-based advocacy project that seeks to prioritize SRHR within emerging UHC policies by equipping civil society organizations to work together with decision-makers to ensure UHC financing reforms and arrangements ensure availability and accessibility of Family Planning commodities.

To this end, we plan to undertake an analysis of the Kenya family planning supply chain focusing on financing and procurement of Family Planning Commodities. We believe, this will be useful to both the Ministry of Health and other stakeholders in the FP space in using evidence-based approaches to strengthen access to FP Commodities and increase domestic resource mobilization for provision of FP commodities and services.

We are therefore inviting you to participate in this study where we will ask you a few questions. Please note that your participation will be voluntary and all information provided will be treated with utmost confidentiality.

DATE OF THE INTERVIEW	
TIME AND DURATION OF THE INTERVIEW	
NAME OF THE INTERVIEWEE	
ORGANIZATION AND ROLE OF THE INTERVIEWEE	
LENGTH OF TIME IN CURRENT POSITION: YEARS/MONTHS	
CONTACT DETAILS	
INTERVIEWER 1	

1	Is your organization currently working or has been involved in the past in the area of Family planning? Did you work at national or subnational level? What was your family planning intervention about? Probe specifically for domestic financing or commodity security in Kenya?
2	What are /has been the developments over the past 2 years on FP commodities within in Kenya? Probe for availability of commodities, delivery and uptake.
3	Is your organization sponsoring any efforts currently or in the near future that might affect consumption trends of family planning commodities?
FINANCING	
4	Do you understand how the government-finances the procurement of public-sector contraceptives? Probe for knowledge on how much is invested?
5	Do you know the key players at national and subnational level involved in the financing, procurement & distribution of family planning commodities? **Probe for** a. Who procures what (government/ donors/ county)? b. What are the sources of commodities for the private sector c. Comment on the private sector method mix d. How much do they procure (quantity)?
6	Are you responsible for the provision of any family planning commodities (either bilaterally or through basket funding) in the health system? If so, which, and to what extent? (This may include provision to NGOs, social marketing, private concerns, as well as the MOH.)

7	What are some of the policy recommendations that need to be implemented by governments at all levels to ensure sustainable domestic financing of FP Commodities?
8	Are there other players/actors who finance/or make accessible FP Commodities (in kind/through treasury/national level/ or to specific counties directly?
PROCUREMENT	
9	Is there a national logistics management information system (LMIS) that collects data on contraceptive commodities? a. If yes, what types of health facilities report into the system? b. If there is a national LMIS, how is contraceptive commodity data collected at the county level?
10	What do you consider as opportunities and the roles of the private sector in the provision of FPC commodities in Kenya?
11	What do you consider as important barriers, risks and vulnerabilities of the private sector in provision of FPCs
SUPPLY CHAIN	
12	How are the FP Commodities supplied? What is the delivery point (i.e., to what level does the supplier deliver the commodities)? What is the extent of donor collaboration in the field of FP commodities and logistics?
13	If you are involved in providing family planning commodities, have you ever thought of, or do you, provide extra funds for the logistics management? Why or why not?
14	What is your impression of the supply situation at the service delivery points during the past three years? Do you think the service providers know the donor of each type of commodities?
15	What is the average annual stock-out rate by product and across products at the national and county level? Probe for what has been some of the bottlenecks or challenges in the supply chain and procurement of FP commodities at national or subnational level.
16	How is quantification and forecasting of FPC done? Who is responsible for forecasting? What is the fill rate?
17	Are you involved with any training initiatives that may have an effect on the supply chain of FP commodities? If so, what are they? If not, is there a role for any training?
18	What strategies can be put in place to increase coverage of FP services?
UHC	
19	How do you see the evolution of family planning financing in the context of UHC in Kenya? Probe for: (FP) included in the benefits packages within these UHC-oriented mechanisms? status of family planning services within major insurance and health financing schemes etc.

20	Universal Health Coverage aims to provide basic health care for all without incurring financial hardship. Given national policies for UHC, identify some potential barriers & opportunities to access to family planning commodities in Kenya?
21	What factors need to be considered in the National UHC policy to ensure adequate coverage of FPC at all levels of the public health system?
	Wrap-up
22	Do you have any additional comments or insights about the topics that we have discussed? Is there anyone else you know that I should speak with about these topics, who may have some additional ideas? Do you have any relevant documents on the topic that you could share with us? Do you have any questions for us?

Thank you very much for your time and for sharing your experiences with us.

Annex 2: KEY INFORMANT INTERVIEW GUIDE FOR RH COORDINATORS/PHARMACISTS

INTRODUCTION

Access to Medicines Platform in partnership with Population Action International (PAI) is implementing *UHC Engage*, an evidence-based advocacy project that seeks to prioritize SRHR within emerging UHC policies by equipping civil society organizations to work together with decision-makers to ensure UHC financing reforms and arrangements ensure availability and accessibility of Family Planning commodities.

To this end, we plan to undertake an analysis of the Kenya family planning supply chain focusing on financing and procurement of Family Planning Commodities. We believe, this will be useful to both the Ministry of Health and other stakeholders in the FP space in using evidence-based approaches to strengthen access to FP Commodities and increase domestic resource mobilization for provision of FP commodities and services.

We are therefore inviting you to participate in this study where we will ask you a few questions. Please note that your participation will be voluntary and all information provided will be treated with utmost confidentiality.

DATE OF THE INTERVIEW	
TIME AND DURATION OF THE INTERVIEW	
NAME OF THE INTERVIEWEE	
ORGANIZATION AND ROLE OF THE INTERVIEWEE	
LENGTH OF TIME IN CURRENT POSITION: YEARS/MONTHS	
CONTACT DETAILS	
INTERVIEWER 1	
1	What is your role in the county health department? And how is access of FP Commodities handled by the county health department (which programs provide this)?
2	What are /has been the developments over the past 2 years on FP commodities within in Kenya? Probe for availability of commodities, delivery and uptake.
FINANCING	
3	Do you have a budget for FP in your county? Do you have an FP-CIP? Which years does it cover? 1=Yes 2=No **If Yes in Q4, provide the detailed budget lines for every year (3 years)**

4	Where do you source your commodities from? 1=KEMSA 2=Private Suppliers 3=Mix of the above 4=Other (Specify) _____ a. Follow up question on percentages
5	Who else finances/ donates FP Commodities in your county? Which donors do you have the most dealings with, and what do each of them contribute to your county?
6	What are the challenges you experience with commodities financing?
PROCUREMENT	
7	Is there a logistics management information system (LMIS) that collects data on contraceptive commodities? a. how is contraceptive commodity data collected at the county level? b. If yes, what types of health facilities report into the system?
8	How is procurement of FP Commodities done in the county? Who carries out the procurement planning? How often?
9	What commitment do you have from the GoK/county government to procure commodities?
10	What are the challenges you experience with commodities procurement?
11	How do you see the future in terms of family planning commodity procurement in the county?
SUPPLY CHAIN	
10	How are the FP Commodities supplied? What is the delivery point (i.e., to what level does the supplier deliver the commodities)?
11	What is your impression of how well the commodities are moving down the system?
12	Who supports you in the forecasting and quantification (TA)? Is there a dedicated officer for managing supplies in your program/ in the county?
13	How is quantification and forecasting of FPC done? What is the fill rate? Who is involved in the quantification exercise?
14	What strategies can be put in place to increase coverage of FP services across the county?
15	What are the challenges you experience with commodities supply chain?
UHC	
16	How do you see UHC contributing to increased access to FP Commodities in your county?

17	Universal Health Coverage aims to provide basic health care for all without incurring financial hardship. Given national policies for UHC, identify some potential barriers to access to family planning commodities in the county?
18	What are some of the policy recommendations that can be addressed through government intervention to increase access to FPC? What strategies can be put in place to increase coverage of FP services?
	Wrap-up
19	Do you have any additional comments or insights about the topics that we have discussed? Is there anyone else you know that I should speak with about these topics, who may have some additional ideas? Do you have any relevant documents on the topic that you could share with us? Do you have any questions for us?

Thank you very much for your time and for sharing your experiences with us.

Annex 3: LITERATURE REVIEW MATRIX TEMPLATE FOR ATMP

- A Literature Review is an objective, survey and critical summary of scholarly sources that provides an overview of a particular topic under consideration. The main purpose is to create familiarity with current thinking/situation and research on a particular topic. In this case our topics are summarized in this table below.
- You will therefore conduct literature review, articles and documents from grey literature (KDHS reports, CIDPS/key studies on FP and Reproductive Health (RH) at National Council for Population and Development (NCPD), Ministry of Health (MOH) and partners among others. websites searches etc.
- The following key **SEARCH TERMS** can be used in various combinations: reproductive health/family planning/ health/financing/supply chain/strategic purchasing, methodological challenges/cost estimation/ resource flows/health accounts/aid. Additional hand searching was conducted by reviewing the references of all retrieved studies.

Literature Review Matrix Template

Concept/Topic	**Guiding Research Question (s)**	**Key findings/ Conclusions** *To be written in prose /paragraphs. Include tables and chats where appropriate.*	**Implications for the analysis/mapping objectives /or advocacy work**	**Reference /Source Accurate in-text citations complete and correct citations**

Family Planning Context Policy	Kenya's FP Snapshot? Trends in FP, Kenya? What is the supportive policy, legislative and regulatory environment? Government stewardship and stakeholder coordination			
Demand & Supply	Review of program efficiency in allocation and utilisation of resources and key service delivery program areas. Availability of health products (KEMSA Fill rates)			
Financing for health & FP	Review of the changing environment including the implications of health financing on FP. FP Health Expenditures?			
Health financing strategy	source of financing, budget, agents, and pathways of funding flows to service providers, identifying gaps Kenya's Commitment to UHC Operationalizing? Is (FP) included in the benefits packages within these UHC oriented mechanisms? Identify opportunities, entry and leverage points for UHC			

Strategic Purchasing mechanisms for FP –	How is the Purchasing Structure? health insurance schemes similarities and differences Why support strategic purchasing for FP Procurement Process and Timelines?			
Family Planning Commodities Supply Chain	How are FP Commodities supplied FP Forecast and Supply Plans, supply chain players— procurers, and service providers, service delivery points, challenges can a well-functioning supply chain etc,			

N/B: Refer to the literature the methodology section Literature Review Phase II and Tools for additional information that may be relevant.

Annex 4: REPORT ON DATA COLLECTION OF ANALYSIS OF THE KENYA FP SUPPLY CHAIN

Abbreviations

ATMP	Access to Medicines Platform
CEO	Chief Executive Officer
CoG	Council of Governors
FP	Family Planning
FP-CIPs	Family Planning Costed Implementation Plans
KIIs	Key Informant Interviews
RH	Reproductive Health
SRHR	Sexual Reproductive Health and Rights
TWGs	Technical Working Groups
UHC	Universal Health Coverage

Project Scope:

Purpose:

Map current family planning supply chains in Kenya to support UHC Engage partners' understanding of the supplies landscape and strengthen their advocacy efforts in the near term as national and subnational UHC policy and financing reforms advance.

The following were specific tasks:

- To understand the project scope and background
- Participate in planning and review meetings as and when necessary

- To develop a plan of work for collection of data on FP commodities financing and purchasing in Kenya (include any missing persons/institutions/counties to be interviewed).
- To review the inception report
- To administer the data collection tool and get as accurate information as possible including any support documents that may be available
- To enter data (transcription) as directed by the lead consultant ADSC
- To provide a summary report of the data collection process including the bottlenecks and observations
- Respond to any data queries and provide evidence as required

Data Collection Exercise

The exercise targeted 10 counties. The following are the ones that were interviewed: Kajiado, Narok, Taita Taveta, Kwale, Isiolo, Kakamega, Kisumu, Bungoma and Turkana focusing on Key Informant Interviews (KIIs) mainly County Pharmacists and County Reproductive Health (RH) Coordinators. Six County Pharmacists and three RH Coordinators were interviewed. Most of those interviewed had served in the same position for over 2 years. There were also 10 National Stakeholders in the field of FP that were targeted. However, there were 10 that were: PATH, ICRHK, JHPIEGO, NCPD, UNFPA, DESIP, KMET and a Consultant in the health sector (formerly with CoG). KEMSA, Council of Governors and Marie Stopes declined. There was prior introduction of the exercise to the respondents through mail and phone calls for appointment purposes. This helped a great deal to remove bottlenecks (if any) during the entire process.

The questionnaire was administered to a total of 17 respondents with 3 of them declining. Three others were done by a Research Assistant based in Isiolo and Kisumu counties. Majority of the interviews were through phone interview except two that were via zoom involving Meshack Ndolo (former Health Advisor, CoG) and Dr. Dan Okoro, UNFPA. Most of the respondents exhibited high level of cooperation during the process with some voluntarily offering to be interviewed late as 7pm and over the weekend due to competing tasks. Turkana County health team was one of the most cooperative teams during the exercise. After communication with the County Pharmacist and County CHS Coordinator, they both went ahead and fixed an appointment for the County Reproductive Health Coordinator. They further followed up to reschedule as was convenient. Equally cooperative was the Kajiado County Pharmacist who insisted on face-to-face interview at Kitengela.

However, respondents from KEMSA, Council of Governors (CoG) and Marie Stopes were not interviewed. The KEMSA one declined at the last minute after postponing for several times. At one point he indicated he would fill online. He later referred to the CEO as a matter of protocol of which he still declined to share contacts. One from Marie Stopes did not respond to email, calls and texts despite having worked together before. As for the CoG, she declined at the last minute saying the questionnaire was too long. Efforts to have her fill less some questions proved futile. We also reached out to the Ministry of Health Division of Family Health but all our email and phone calls went answered with promises to get back to us not bearing any fruit. We however wrote a letter to the office of the Director General of Health indicating our intention to carry out the analysis and this letter was stamped and acknowledged as received.

The prior interaction with the respondents in the health sector and during previous research work made it convenient to effectively fix appointments. There was willingness to be part of the process with some requesting a face-to-face interview even with the pandemic in place. However, due to the Covid-19 pandemic, phone interview and zoom were the preferred mode of interview except for Kajiado and PATH respondents where face-to-face interview was done at Kitengela and Nairobi respectively.

We also undertook a comprehensive literature and data review process and intergrated these findings with those of the key informant interviews to provide a 360 degree overview of the family planning supply chain in Kenya.

Observations

One general observation during the entire process was that all the participants were ready and willing to share relevant data to the benefit of their specific counties and to a large extent, the nation. They were inquisitive in wanting to know how relevant this was going to benefit their work especially in strengthening the supply chain.
At county level, there were issues raised regarding inadequate capacity in forecasting and quantification, stock-out management, coordination of FP services coupled with redistribution due to logistics challenges. For instance, Turkana county is vast and during rainy season, roads become impassable. Both county and national stakeholders urged for need for advocacy efforts for more budgetary allocations itemized under FP.

UHC is seen as a window of opportunity to further increase FP services in the country. However, there is lack of linkage between UHC programme in relation to FP services. Taita Taveta County stood out as one of the counties with no concerns on FP coverage.
Further, all the people interviewed were well versed with the topics at hand. Hence, vital data was collected.

Challenges Encountered
The exercise went on well almost as per the schedule. However, there were a number of challenges encountered.

- Postponement of appointments due to other competing tasks by the interviewee leading to delays as new appointments had to be rescheduled.
- There were protocol issues: Government agencies i.e. KEMSA officers could not offer themselves for interview even after committing and scheduling a date for the same due to government protocols. Declined at the last minute and requested the formal communication to be channeled through the Chief Executive Officer (CEO). Refused to share any details/contacts for CEO. However, other stakeholders including county officers were cooperative all through. This could be attributed to the long working relations with them.
- Some of the respondents complained of the questionnaire being too long to administer. Hence did not respond even after clarifications on some questions to omit. A case in point was the Council of Governors (CoG) respondent.

Requests from Counties

- All those interviewed requested for the findings to be shared
- They further requested for support in areas of capacity building, support on quantification and forecasting activities. A lot of capacity building is needed.
- Continued engagement especially on development/implementation of FP-CIPs (Family Planning Costed Implementation Plans). A lot of advocacy and training required
- Benchmarking with other counties that are performing well in provision and management of FP services.

Recommendations
Based on findings and conclusions in this study, the following recommendations were made:

- It is important that the findings be shared with all those stakeholders involved in the exercise. This will enhance future collaboration and partnership. Where possible hold dissemination meetings on the findings.
- Explore possible opportunities for advocacy work on FP commodities in the country; both at national and county level. Policy review and implementation i.e. FP-CIPs will be key as well as push for more budgetary allocations and prioritization of FP services as a life-saving intervention i.e. on maternal deaths by county governments. Most insurance companies do not cover FP services. Their inclusion under NHIF and into the UHC essential package would be key in increasing FP coverage in the country especially among the low income clients.
- Hold meetings for experience sharing between stakeholders at national and county level.
- Need to strengthen Technical Working Groups (TWGs) for effective coordination of services.

Conclusion

In view of the requests by County respondents (County Pharmacists and Reproductive Health Coordinators) and responses from other stakeholders, there is need to strengthen the FP services at the county especially capacity building on forecasting and quantification. This will help in streamlining the FP services for better planning i.e. procurement.

Interview in progress (Left: Robert Athewa, Right: Dr. Diane Sibi, Kajiado County Pharmacist)

Annex 5: Report of validation meeting for the FPC supply chain analysis

REPORT OF THE VALIDATION MEETING
Family Planning Commodities supply chain analysis
Validation & dissemination Hybrid meeting
3rd June, 2021, Four points hotel, Nairobi Hurlingham

TIME	AGENDA ITEM	RESPONSIBLE
10.00-10.15	Arrival/ registration/ morning tea	Secretariat
10.15-10.30	Introductions in person & online participants	Moderator
10.30.11.00	Presentation of findings of the FPC analysis	Dorothy
11.00-11.45	Q & A -Comments to the findings - Emerging issues - knowledge sharing on the FPC situation in Kenya	Dorothy/ Moderator
11.45- 12.15	Perspectives from the counties	Kakamega/ Kajiado/ Bungoma/ Kwale/ Isiolo/ Kisumu/ Turkana/ Taita Taveta/COG rep
12.15-12.40	Perspectives from national level players	MOH/UNFPA/NCPD/ Embassy of Netherlands/Plan/ JHPIEGO
12.40-12.50	Review , input and adaptation of recommendations	Dorothy/ Moderator
12.50-13.10	Identification of priority advocacy interventions and way forward	Moderator
13.10.13.20	Closing Remarks	MoH representative/ CDH-county representative
13.20	LUNCH & DEPARTURE	ALL

Participants present

1. Dr Ezekiel Kapkoni- County Director of Health- Kajiado
2. Beatrice Okundi- Deputy Director- NCPD
3. Johnstone Kuya- Partnerships, Embassy of Netherlands

4. Jessicah Koli- Kakamega county reproductive health services coordinator
5. Grace Otieno- Kisumu sub-country RH Coordinator
6. Sifuna Haron- Department of Health- Turkana county
7. Jane Owour- Kisumu county RH Coordinator
8. Dr Camilitta Wandera- Kisumu County Pharmacist
9. Dr.Lukorito Mathias - Bungoma county pharmacist
10. Oliver jacktone Okeyo- County department of health Kisumu
11. Timone Ayieko- DESIP
12. Hezron Ochieng-VSO-DESIP
13. Dr Elly Obonyo- Kajiado County department of health
14. Robert Athewa- FAWE/ Breakfree Alliance
15. Teresa Otieno- FAWE
16. Daniel Momposhi – Plan International
17. Patricia Nudi- KMET
18. Victone Onyango- Inuka Success- Kisumu
19. Dorothy Okemo (AtMP/ MeTA Kenya)
20. Mwanaisha Aura (AtMP/MeTA Kenya)
21. Sophie Nyongesa (AtMP/ MeTA Kenya)

Absent with Apologies

1. Amina- Isiolo County
2. Johnpaul Omollo- PATH
3. Sam Mulyungu – JHPIEGO
4. Peter Ofware
5. Meshak Ndolo -formerly COG
6. Dan Okoro- UNFPA

A PowerPoint presentation summarizing the methodology, findings and recommendations of the analysis done of the family planning supply chain in Kenya was made. The meeting was a hybrid of in-person and online participation. The findings and recommendations were divided thematically into financing, procurement and supply chain. A recording of the validation is also available.

After the presentation the following were some of the reactions/ additions and comments to the presentation:

- Can PAI consider supporting the digitalization of documentation that supports forecasting and quantification
- Finding community-based approaches to improve access and demand creation by use of CHVs
- Community engagement critical in improvement of FP indicators, increase uptake and demand and demand for these services.
- Family planning is part of family health hence need to strengthen primary health care in order to meet UHC
- There is need to fast track release of funds to counties
- Counties do not have a mandate to procure FPCs but rely on national government to distribute- FPCs are purchased by partners and GOK and usually distributed alongside other EMM
- In the last financial year GOK allocated 863M kshs and later reduced to 563M Kshs, the reduced amount went into covid response interventions.
- Integrate FPC into RMNCAH for greater acceptability and allocations especially in patriarchal counties
- Private sector reporting in KHIS needed
- Rural communities still have unmet need for FP
- There is a policy no reporting no commodities; however, in some instances reporting is done monthly and it takes up to 5 months for commodities to be supplied leading to stockouts
- VSO- DESIP: leave no one behind, include persons with disability in SRH/FP mainstreaming
- The notion of lump sum procurement is still with the counties although the procurement of FP and essential medicines is separate.
- The FPC reporting tool was updated however this version has not been uploaded on KHIS contributing
- Turkana: Using community health volunteers would help assist to demystify the myths at community level thus improving service provision. Training of CHVs is needed.

- National level should come up with a way forward for the counties on how long it should take for health facilities to receive FP commodities.
- Family Planning is related to numbers which relate closely with resources. There is need for demand creation for Family Planning commodities.
- There is need for advocacy to leaders on family planning (More resource allocation for advocacy and training)
- Supply chain visibility starts with documentation, very poor at level 2 & 3, develop online tool that can be used at these levels who are still using the manual format.
- Findings narrow to community based approach to access to and demand for FPCs
- Statistics on teen pregnancies, inclusivity of MoE in FP approaches
- Kakamega is in the process of validating their FP-CIP 2022-2025 this is likely to reduce some of the challenges identified
- Kajiado CIP in place however there is need for demand creation, improve supply chain visibility, forecasting, quantification and documentation at service delivery point
- 'No reporting no commodities' policy indicates the need for proper forecasting and timely asking for the needed commodities by the Sub-County and County pharmacists.
- Focus on political leadership for Family Planning
- Bridge the gap at KEMSA procurement and manufacturers
- Netherlands Embassy: The findings are a true reflection of the FP situation on the ground, SRH-FP are critical focus areas for the embassy who have invested over 400million Euros reaching 120 million with FPs. UK budget cuts likely to affect UNFPA, IPPF, MSI, the embassy is engaging to see where it is possible to bridge the gap. He further added that the findings were rich and encouraged partnership and engagement to implement the recommendations
- Domestic Resource mobilization is key in addition to political support and goodwill
- NCPD-It is government's responsibility to help people understand what FP is and why it is important. This would contribute to demand creation.
- A total market approach should be adopted in the to improve the FP commodities supply chain and access.
- Need to engage KEMSA to reduce stockouts, delays, late and inadequate distribution
- Understanding the concept of Family planning is key in addressing the challenges of access and FP supply chain.
- There is a missing link on FP data in the counties thus weak reporting systems on the national Health System Platform.
- Documentation of FP at the service delivery points especially level 2 and 3 facilities is important
- There is need to address the idea that FP is equal to population control.
- VSO undertook to look at the challenges an implement the recommendations made in the report
- KMET lauded the study as it looked at the entire FP supply chain and were now working on the operationalization of the CIP in Kisumu county
- DESIP- updating the KHIS commodity reporting tool and the new tool will be uploaded and updated by 1st of July
- MoH had sent a communication of KEMSA to delink FPCs and EMM supply to reduce the delays, DESIP had already tested this by procuring FPCs for some counties without the supply being pegged to supply of other medicines. They were also part of the Commodities Logistics working group and would share the full report findings and recommendations of this report for consideration and implementation.
- NCPD- counties need to embrace concept of redistribution to ensure commodities do not expire an are actually redistributed to where demand is high
- The partners currently supporting the purchase of FPCs are UNFPA/ BMGF/ World Bank/ USAID, the German cooperation KfW stopped supporting purchase of FPCs a while back
- Counties should domesticate the national CIP (that was currently undergoing review) rather than coming up with their own CIPs

In closing:

- ✓ The additional recommendation made during the validation will be included in the final report
- ✓ Good will from partners present to engage and support implementation of the recommendations was noted
- ✓ Participation in the validation was a reflection of the health being devolved as we had any counties present

- ✓ Scale up advocacy, improving data quality and reporting as well as demand creation based on the recommendations and findings
- ✓ Disseminate widely the final report and policy briefs with partners for wider distribution and implementation of the recommendations
- ✓ Appreciation of AtMP and PAI for supporting the study, the County Director reiterated the quality of the data and validity of the findings and endorsement of proposed recommendations

Kajiado County Director of Health, Dr. Ezekiel Kapkoni giving his closing remarks

Executive Officer-Access to Medicines Platform, Ms. Dorothy Okemo making a presentation on the FP supply chain analysis

Group photo

ACCESS TO MEDICINES PLATFORM

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