

# Urban Supply Chain Management

Kenya

**Kenya Final Compendium**

**November, 2011**

BILL & MELINDA  
GATES *foundation*

## Executive summary – Family planning context (1/5)

### Overall Family Planning context

- With 4 years to 2015, Kenya is **far from reaching its MDG target to decrease maternal mortality rates** (MMR) from 488 (2009) to 147 in 2015 per 100,000 live births and currently ranks at 36 worst worldwide
- At 46%, contraceptive prevalence rates (CPR) are among the highest in Sub-Saharan Africa. However, there is still a long way to go. Out of the ~9.3 million women of reproductive age an estimated **26% of married women age 15-49 have an unmet need for family planning**. And over the next 4 years an **estimated 1 million young women will enter reproductive age**, presenting additional challenges to maternal health as well as meeting the need for contraception
- Implementation of **Family Planning programs is an important agenda item for the Kenyan government** and ranks as a high priority in the country's national strategic plan, Vision 2030. The national goal is to **increase CPR for all contraceptive methods from 46% in 2009 to 56% by 2015** through targeting the poor, youth, and lower educated quintiles
- The **Bill and Melinda Gates Foundation (BMGF)** offers support to the Kenyan government's and other donor's goals through the Kenyan Urban Reproductive Health Initiative (KURHI/Tupange), a **5 year program to increase CPR by 20 percentage points in 5 selected cities** as part of an integrated effort with partners
- **Stock-outs have undermined access to contraceptives in Kenya** and threaten Tupange's ability to achieve its goals
- In this context, BMGF, in collaboration with local and global stakeholders, has **launched a supply chain assessment to understand the root causes of contraceptive stock-outs and to identify potential solutions**. As Kenya transitions in 2012 to a devolved county government structure, stakeholders have a rare opportunity to implement these solutions and ensure that the root causes of contraceptive stock-outs are adequately addressed as the supply chain is redesigned

## Executive summary – Contraceptive landscape (2/5)

### Kenyan contraceptive landscape

- As part of its strategy to increase CPR the government offers free reproductive health commodities to public, not-for-profit and private facilities, and are therefore responsible for most of the reproductive health (RH) commodities bought into and distributed across the country.
- Kenya has two supply chains:
  - **The public** sector supply chain is the predominant one in Kenya. It is responsible for 98% of the central supply (wholesale) of long acting contraceptive methods (IUCDs and implants), and 79% of short acting contraceptive methods (injectables, pills and condoms). Commodities are procured by a parastatal organisation (KEMSA) and funded by government and donors. KEMSA distributes through 2 distribution channels. ~23-40% of commodities are sent directly to facilities (predominantly Ministry of Health (MoH) facilities) from KEMSA, the remaining ~60-77% of commodities are sent to District Stores which then supply municipality, private not-for profit and for-profit facilities. KEMSA is not responsible for the distribution from District Stores to facilities rather each facility must arrange their own transport
  - **The private** sector supply chain manages only ~2% of long acting contraceptive methods and ~21% of short acting contraceptive methods. Long acting methods are mainly imported by Social Marketing organisations (PSI and MSK) to fill gaps at facilities they support during periods of public sector stock-outs or during in-reach<sup>2</sup> at public facilities. Short acting methods are mostly imported by private for-profit wholesalers and sold to private retailers (pharmacies, facilities and grocery retail stores). Quantities remain small as government's provision of free RH commodities limits the financial attractive of the business.
- In spite of public dominance at the wholesale level, private retailers (pharmacies and facilities) play a vital role in RH service provision supplying commodities to 39 percent of women aged 15-49. For short acting contraceptive methods, the private retailers provide 41% of the commodities vs. 33% for long acting contraceptive methods.

## Executive summary - Findings on stock-outs (3/5)

### Findings on stock-outs in Nairobi and Mombasa

The diagnostic assessment in Nairobi and Mombasa confirmed that stock-outs have been a severe problem over the last 12 months for the two products that were traced (implants and injectables):

- There are two distribution channels in the public sector supply chain with those direct served having much higher stock availability:
  - **District Store distribution:** 60-77% of women access commodities through facilities (municipality, private, FBOs and NGOs) that are predominantly served by the District Stores. These facilities suffer severe stockouts with stock availability of ~34% for public facilities (mainly municipality) and ~32% for private facilities. NGOs are much higher at ~84% as they receive top-up commodities from sponsors
  - **Direct to facility distribution:** 23-40% of women access commodities through facilities that are served directly from KEMSA. These are predominantly MoH facilities, and have stock availability of ~82%
- In addition to more stock outs in District Store distribution vs. direct to facility distribution we also found significant differences in the flexibility of the channels:
  - **Deliveries:** the direct channel receives an average of 2-3 deliveries a year vs. 0-1 deliveries for District Stores
  - **Fulfillment rates:** facilities under District Stores receive only 4-45% of what they order vs. 62-82% for facilities on direct distribution

## Executive summary – Supply chain diagnostic findings (4/5)

### Supply chain diagnostic findings

Many initiatives have already been launched and are starting to have impact, particularly in forecasting, funding and procurement. The majority of issues are now caused by distribution challenges

- **Forecasting, procurement and funding:** There appears to be sufficient RH commodities brought into the country and money committed to cover the funding: Yet, forecasting remains a top-down exercise as true demand signals from facility level cannot be gathered due to stock-outs and poor reporting rates
  
- **Distribution:** Several financial, operational and planning issues hamper commodity distribution
  - Lack of sufficient funding for commodity distribution: Budgeting processes do not adequately account for the cost of distribution of RH commodities (neither from KEMSA's central warehouse to government district stores and direct served facilities nor from district stores to facilities)
  - Inadequate information flow: There is an inadequate system for information to flow between facilities, districts and central level to provide demand and consumption estimates, feedback on orders and inventory, and to ensure transparency and accountability. Reporting rates from SDPs and district stores are <60% and often orders are rationalised<sup>1</sup> at central level without feedback to concerned facilities
  - Lack of operational procedures and systems in place: No fixed schedule for distribution from KEMSA to district stores. And at the district stores there is no established operational procedure in place for allocation of commodities between different non-government facilities, nor efficient tracking and monitoring of consumption, patient loads and orders
  - The responsibility for quantifying facility needs and placing orders sits with the nurses and RH coordinators who lack core skills in commodity and inventory management: Not only have many nurses and RH coordinator not been trained, but they also have limited capacity to fulfill orders for multiple programs. This places even more demand on already strained resources since nurses are typically the ones responsible for care-delivery.

# Executive summary (5/5)

## Short term solution

- **Informed push model:** Tupange should ensure stock availability in the facilities they support by an informed push model in which stock-on-hand at facilities and at district stores is tracked through mobile-based technology and commodities are re-distributed amongst facilities on an ongoing basis to ensure that there is always stock available at facilities

## Medium term solutions

- **Funding:** DRH has committed to allocate 10% of commodity cost to KEMSA for operating costs for the next 1-2 years. Nonetheless distribution from District Stores to facilities still remains an unaddressed issue, as it is beyond the scope of KEMSA. Funding from Government or donors is needed to close this funding gap. Several logistical options exist (1) outsource the responsibility to private distributors (2) arrange direct distribution to facilities (3) allocate a budget to either District Store or each facility
- **Information flow:** KEMSA has taken on the responsibility to develop a new LMIS system. The RH community should ensure that the RH tools are standardized, so facilities do not have to fill in both CDRR and SORF, and that the system allows for greater transparency on delivery dates and modified orders
- **Resolving the district store issue:** The two remaining issues (operational procedures and commodity management) manifest themselves more severely in the District Store distribution channel. How these issues are addressed will depend on what stakeholders elect to do with District Stores:
  - Bypass district stores and move selected or all facilities to direct distribution from KEMSA. This can be achieved fairly quickly with the support of KEMSA as working operational procedures are already in place.
  - Fix distribution to district stores. This will take more time as it requires developing SOPs and up-skilling the district stores and their staff. The model should be evaluated via a district- or city-level pilot before implementing nationwide

## Long term solutions

- From interviews with stakeholders it became clear that there is not a clearly defined strategic role for the private sector in RH. Further investigation is needed to understand how the private sector could help reach CPR targets and ensure long-term financial sustainability. We recommend establishing a working group or commissioning an RFP to examine this

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- National contraceptives landscape

- Findings on stock-outs

- Supply chain diagnostic findings

- Potential initiatives to improve the contraceptives supply chain

- Potential roles for BMGF

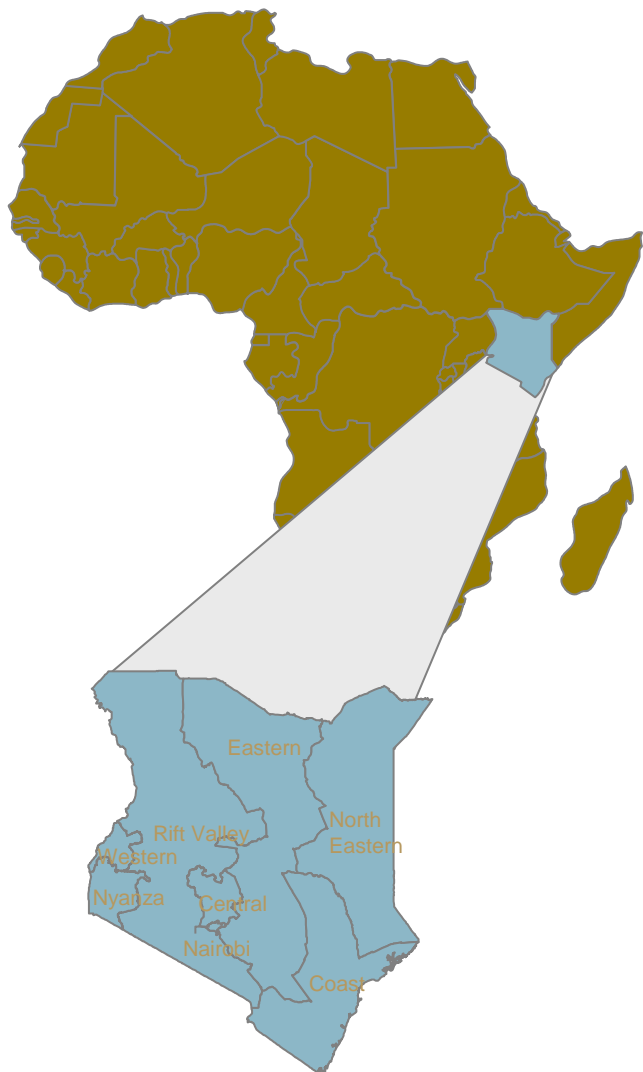
- Back up

# Executive summary – Family planning context

## Overall Family Planning context

- With 4 years to 2015, Kenya is **far from reaching its MDG target to decrease maternal mortality rates** (MMR) from 488 (2009) to 147 in 2015 per 100,000 live births and currently ranks at 36 worst worldwide
- At 46%, contraceptive prevalence rates (CPR) are among the highest in Sub-Saharan Africa. However, there is still a long way to go. Out of the ~9.3 million women of reproductive age an estimated **26% of married women age 15-49 have an unmet need for family planning**. And over the next 4 years an **estimated 1 million young women will enter reproductive age**, presenting additional challenges to maternal health as well as meeting the need for contraception
- Implementation of **Family Planning programs is an important agenda item for the Kenyan government** and ranks as a high priority in the country's national strategic plan, Vision 2030. The national goal is to **increase CPR for all contraceptive methods from 46% in 2009 to 56% by 2015** through targeting the poor, youth, and lower educated quintiles
- The **Bill and Melinda Gates Foundation (BMGF)** offers support to the Kenyan government's and other donor's goals through the Kenyan Urban Reproductive Health Initiative (KURHI/Tupange), a **5 year program to increase CPR by 20 percentage points in 5 selected cities** as part of an integrated effort with partners
- **Stock-outs have undermined access to contraceptives in Kenya** and threaten Tupange's ability to achieve its goals
- In this context, BMGF, in collaboration with local and global stakeholders, has **launched a supply chain assessment to understand the root causes of contraceptive stock-outs and to identify potential solutions**. As Kenya transitions in 2012 to a devolved county government structure, stakeholders have a rare opportunity to implement these solutions and ensure that the root causes of contraceptive stock-outs are adequately addressed as the supply chain is redesigned

# Kenya at a glance



## Population metrics

	Units	Kenya
<b>Total population</b>	Millions (2011)	41.8
<b>Population growth</b>	CAGR (2001-11)	2.9
<b>Total fertility rate</b>	Births per woman (2008/09)	4.6
<b>Contraceptive prevalence rate, all methods</b>	Percent (2008/09)	46
<b>Contraceptive prevalence rate, modern methods</b>	Percent (2008/09)	39
<b>Maternal mortality rate</b>	Maternal deaths per 100,000 live births (2008-09)	488
<b>Population under 24 years</b>	Percent (2010)	63.5

## Geographic facts

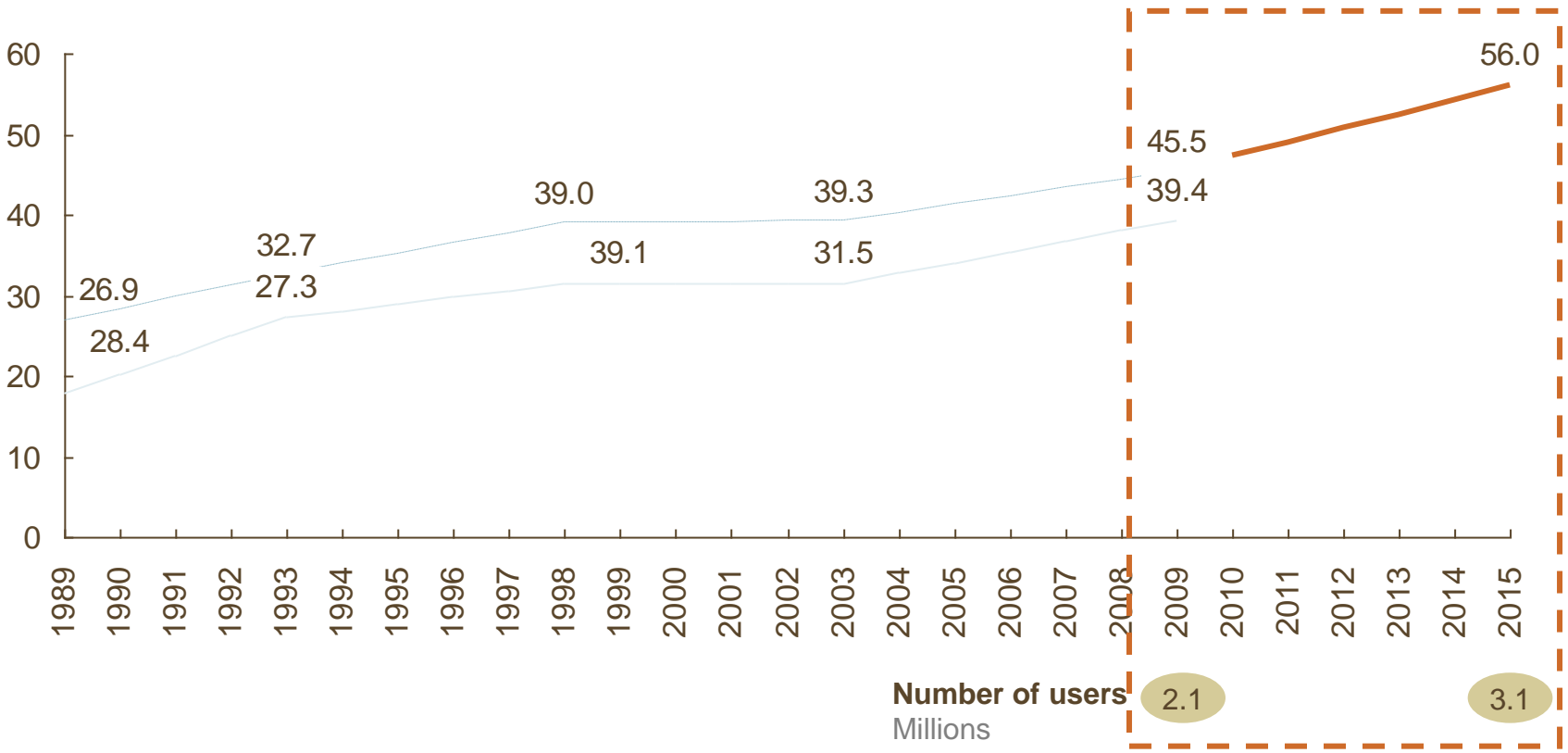
- Divided into 8 provinces
- City of Mombasa located in Coast region
- City of Nairobi located in Nairobi region

# The Kenyan Government has an ambitious goal of increasing overall CPR from 46% in 2009 to 56% by 2015

## Historical and target contraceptive prevalence rate (CPR)

Percent, All methods (modern and traditional) amongst married women age 15-49

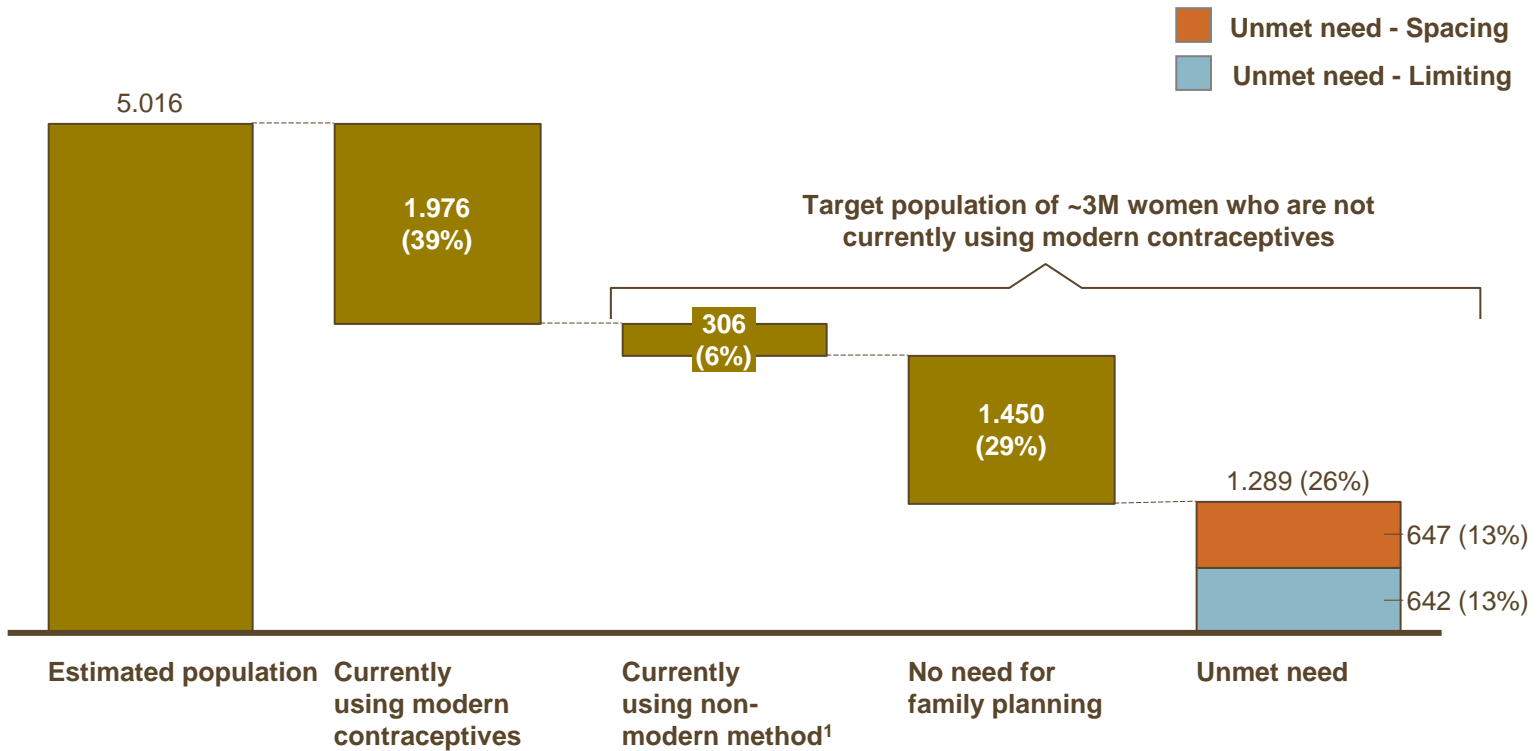
- All methods
- Target CPR
- Modern methods



**The goal of increasing CPR by 10p.p implies serving an additional 1 million women, or roughly 1.4 times today's volumes**

# However, 26% of women still have an unmet FP need in Kenya

Estimation of target population in Kenya for 2011  
 Number of currently married women aged 15-49 (in thousands)



<sup>1</sup> Non-Modern methods Includes: Periodic abstinence, withdrawal and other traditional methods

# To address this unmet need, the RH strategy calls for enhanced multi-sectoral participation at all levels to enhance reproductive health status

National Reproductive Health Strategy 2009 - 2015

## Goal:

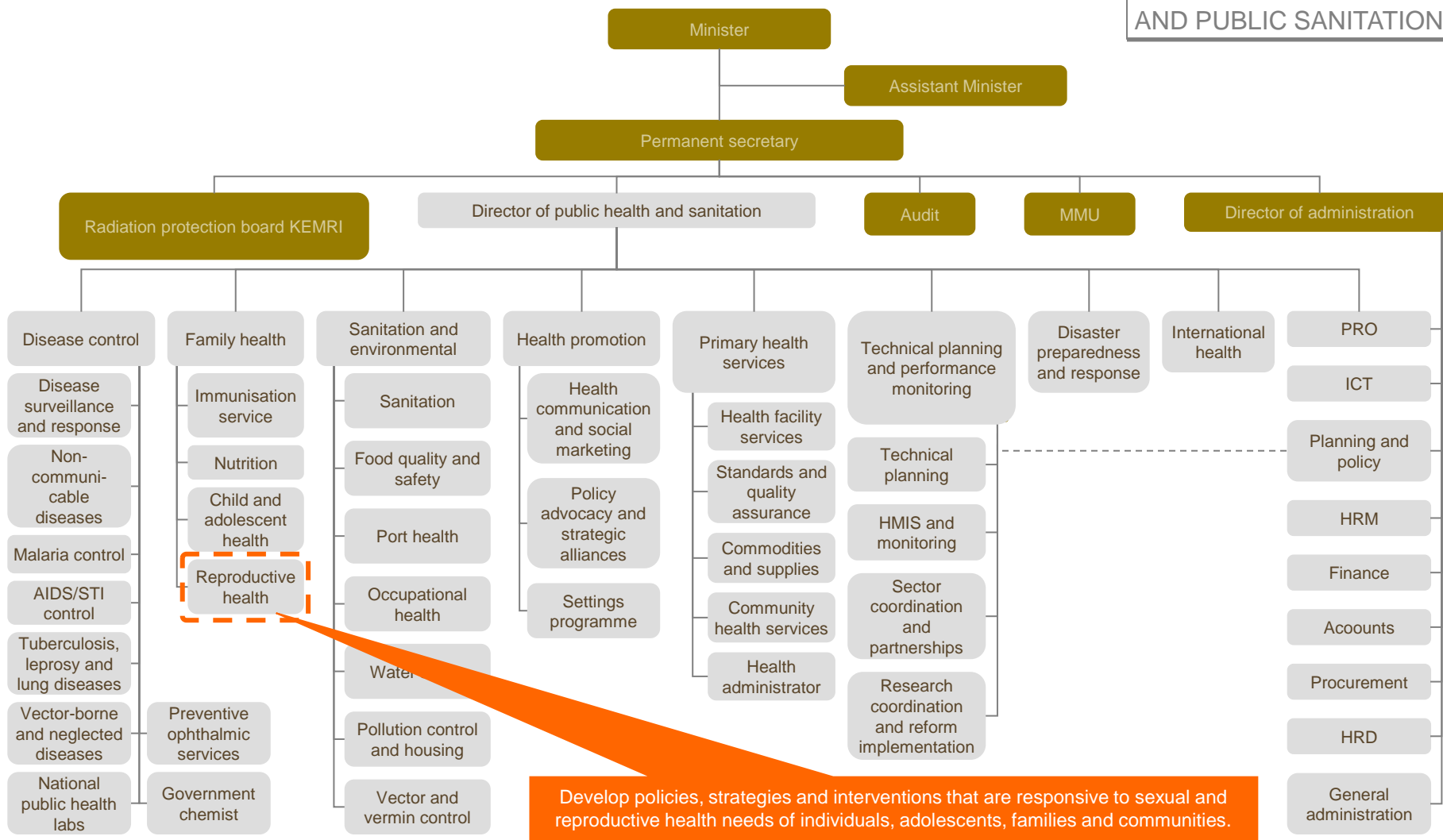
- **Facilitate the operationalisation of the National Reproductive Health Policy (2007) through a national multi-sectoral approach:**

*“To enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs”*

## Broad policy objectives:

- Formulate strategies that will enable the achievement of the goal and objectives of the national reproductive health policy.
- Identify priority activities and major implementers of the national RH program
- Identify resource mobilization strategies
- Facilitate/enhance effective management of a sustainable national reproductive health program

# The overall responsibility for RH policies sits with the Division for RH within the Ministry of Public Health & Sanitation...

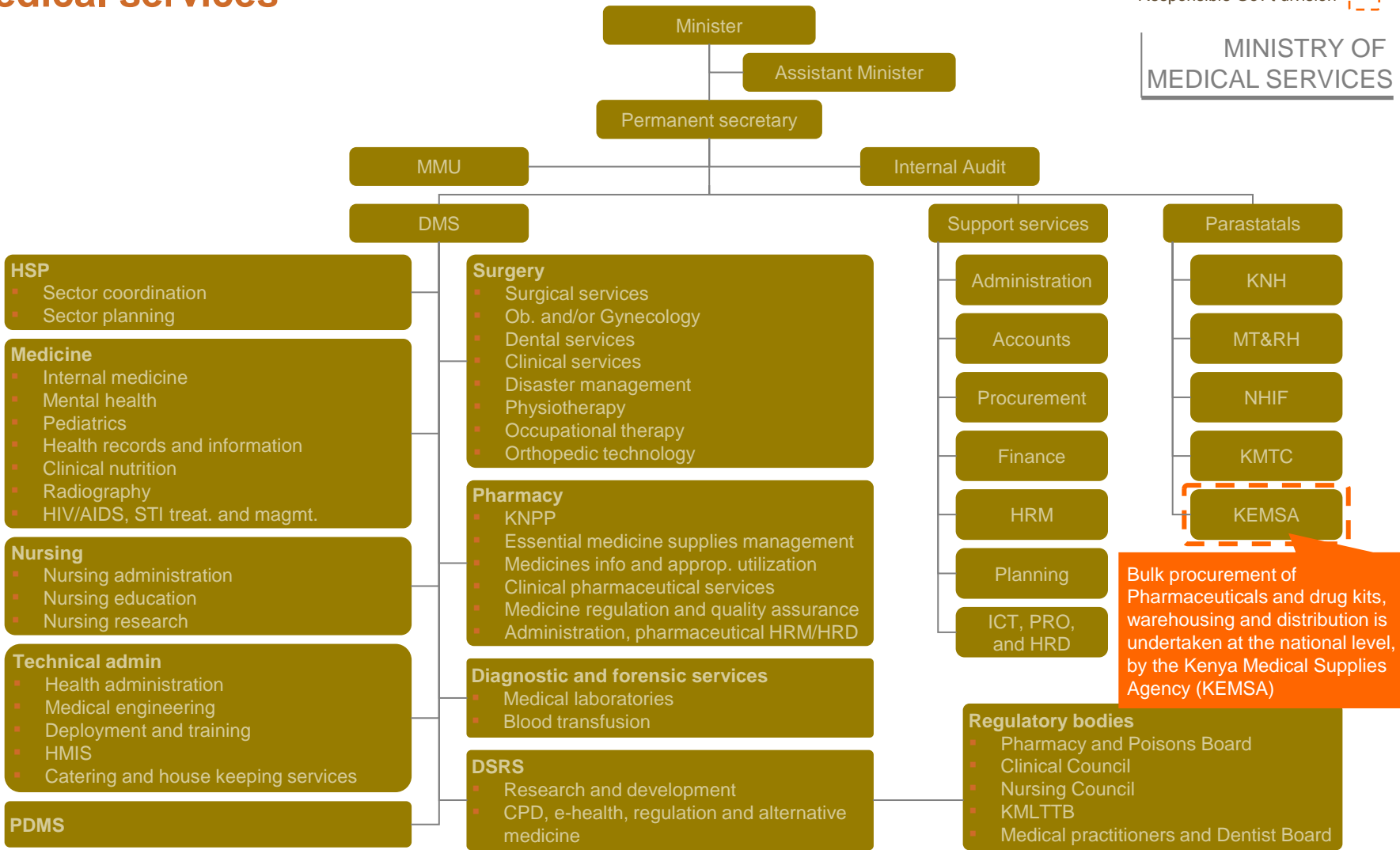


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Key: HMIS – Health management information system; HRD = Human resources development; HRM – Human resource management; ICT – Information and communications technology; KEMRI = Kenya medical institute; MMU = Ministerial management unit; PRO = Public relations office

# ... while the responsibility for actual procurement and logistics of RH commodities in the public sector sits with KEMSA under the Ministry of Medical services

Responsible Gov't division   
**MINISTRY OF MEDICAL SERVICES**



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# Several donors and implementing partners support the government in reaching these goals

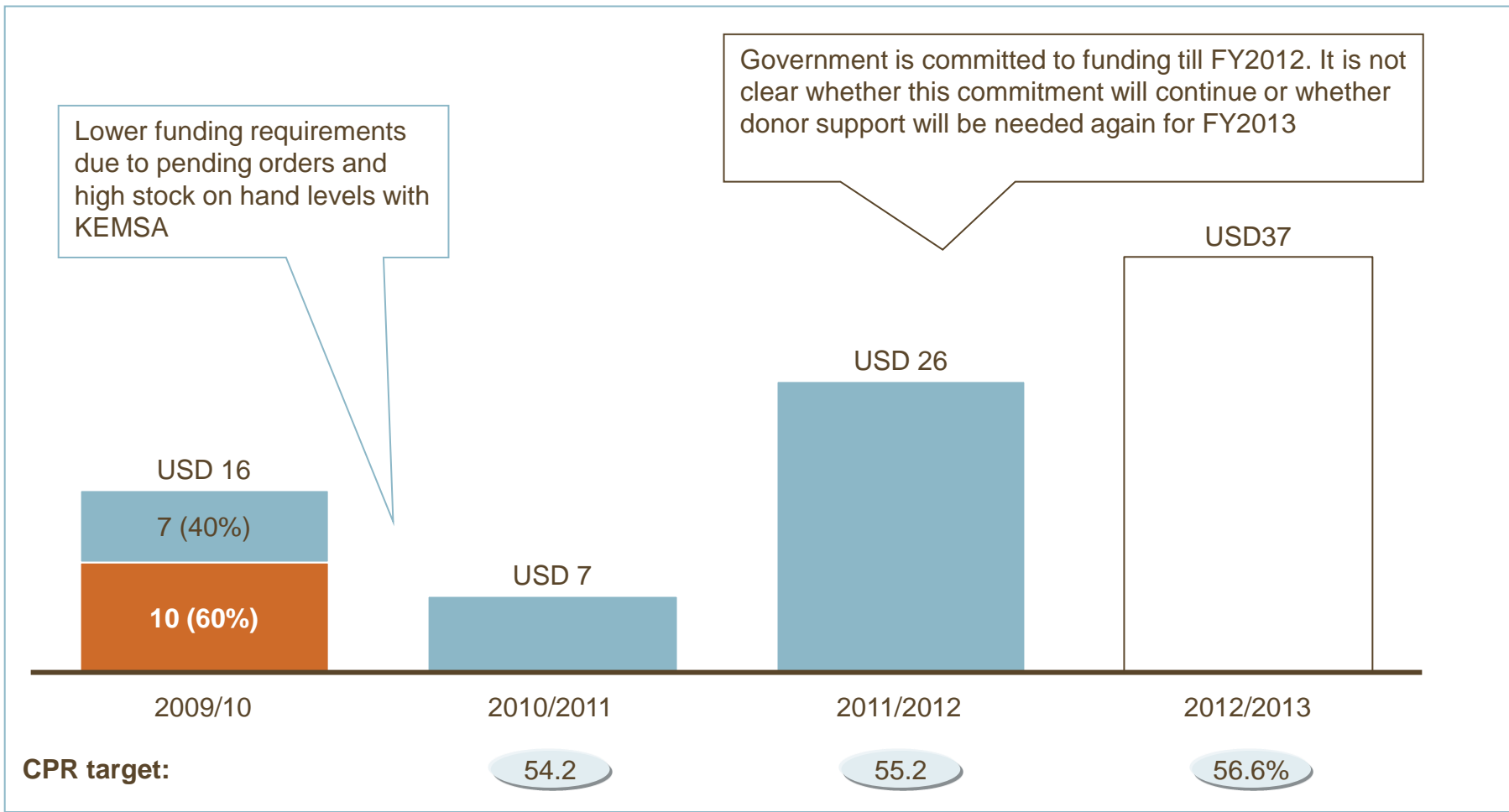
	Primary roles related to FP (none exhaustive)	Areas of activities	
		FP commodities	FP technical assistance (TA)
	<ul style="list-style-type: none"> <li>UNFPA is contracted by the World Bank to procure condoms on their behalf. Previously, they used to procure contraceptives</li> </ul>		✓
	<ul style="list-style-type: none"> <li>In the process of defining and seeking approval for a new health program</li> <li>Has financed commodities for both public and social marketing for several years</li> </ul>	✓	✓
	<ul style="list-style-type: none"> <li>Single largest donor for RH in Kenya through commodity funding and TA</li> <li>Provides TA to KEMSA and the DRH</li> </ul>	✓	✓
	<ul style="list-style-type: none"> <li>Provides funding for RH condoms</li> </ul>	✓	
	<ul style="list-style-type: none"> <li>Focuses on demand generation and commodity security activities in 5 priority cities through the Kenya Urban RH Initiative (Tupange) grant</li> </ul>		✓
	<ul style="list-style-type: none"> <li>Focuses on primary health care through funding for essential medicines, improving staffing at health facilities and implementation of pull system in several regions</li> </ul>	✓	✓
	<ul style="list-style-type: none"> <li>Provides funding for procurement of commodities, mainly FP</li> <li>Supports social franchising of RH services in non-state AMUA clinics</li> <li>Considering commissioning a supply chain study for the whole of Kenya</li> </ul>	✓	
	<ul style="list-style-type: none"> <li>Supports the DRH with special emphasis on development of youth friendly services as well as RH communication</li> </ul>	✓	✓

- Stakeholders meet in a Reproductive Health Commodity Security Committee chaired by the DRH; meetings are scheduled for once per quarter
- In addition, there is a technical working group who support the committee's work, and meet more frequently. This group is also responsible for forecasting planning

# The Government has funded all commodity cost for the last 1.5 years

- Government
- Donors
- xx CPR target assumption

Estimated cost<sup>1</sup>, USD m



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<sup>1</sup> Taking increased CPR target and change in product mix into account

# BMGF supports Tupange with a focus on increasing modern CPR by 20% percentage points with a focus on the urban poor

## The presence of URHI in Kenya

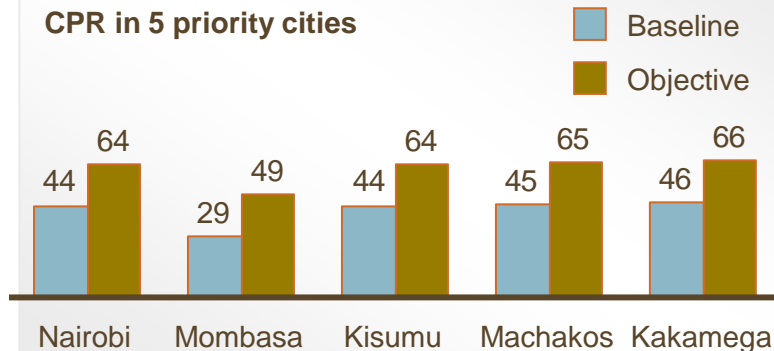
- The Family Planning team's country action supports the Urban RH Initiative (URHI) in 4 geographies: Kenya, Nigeria, Senegal, UP (India), focused on harnessing the private sector and demand channels in urban areas with a focus on the urban poor
- The objective of the initiative is to determine whether a series of focused initiatives can achieve a 20 % points target increase in improving modern contraceptive use in focus cities of Sub-Saharan Africa and South Asia
- URHI initiatives include implementing a range of strategies including social marketing, awareness building, community outreach, strengthening services, and establishing the proof-of-concept for integrating FP into MNCH, HIV, postpartum and post-abortion services
- In Kenya, URHI goes under the name Tupange, and is a consortium of lead partners Jhpiego, Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (CCP), Pharm Access Africa Limited, National Council for Population & Development (NCPD), Marie Stopes - Kenya(MSK)

# BMGF has launched Tupange, focusing on advocacy, service delivery, public-private partnerships and demand creation in 5 cities

## Overall objectives

- A** Increase CPR among the urban poor by 20 points in 5 selected cities, to initiate change in a larger environment

CPR in 5 priority cities



- B** Increase to **private sector** share of contraceptive market: harnessing the private sector to find sustainable solutions for improving / increasing in contraceptive flows

- C** Focus interventions to increase CPR within the **poorest portion of the population**, with an increase of **long-acting contraceptive** methods

## 5 Key components of Tupange

- i** **Integration of FP with other services**
  - Developing cost-effective interventions for integrating quality FP services into existing maternal and child health and HIV services
- ii** **Service delivery**
  - Improving the quality of FP services for the urban poor with emphasis on high volume clinical settings
- iii** **Public Private Partnerships (PPP)**
  - Testing innovative private-sector approaches to increase access to and use of FP by the urban poor
- iiii** **Funding**
  - Increasing funding and financial mechanisms and a supportive policy environment for ensuring success to FP supplies and services for the urban poor
- v** **Demand creation**
  - Developing interventions that create demand for and sustain the use of contraceptives

# Stock-outs are hindering URHI's progress; we have therefore launched the Urban Reproductive Health supply chain assessment

## Context

- **Stock-outs and shortages of contraceptive products** are impacting women's ability to choose and use their method of choice, thus limiting URHI's ability to increase CPR. NURHI and BMGF even had to advocate for USAID to help donate products to some cities
- Preliminary diagnostics on supply chain security have been conducted, but **gaps remain in understanding the root causes and potential solutions**, which are **particularly critical given the window of opportunity presented by the recent policy change to provide free contraceptives**

## Objectives of supply chain assessment

Against this backdrop, BMGF launched the Urban Kenya RH supply chain assessment, aiming to:

- Understand issues in the end-to-end contraceptive supply chain (public and private<sup>1</sup>) and **root causes** for the stock outs in target geographies
- Draw **learnings** from other sectors on innovative and effective models
- Develop and disseminate **solutions** that can be tested - either within the context of URHI or separately - and **convene** relevant stakeholders
- Develop **global and local advisory committees** to provide guidance and input, and to join in coordinated advocacy and solution implementation
- Define an **advocacy agenda** toward Federal and States' governments, and toward other stakeholders

<sup>1</sup> Commercial and non-commercial, i.e. NGOs, non-profits, faith-based organizations, for-profit

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- Context
- **Approach**
- National contraceptives landscape
- Findings on stock-outs
- Supply chain diagnostic findings
- Potential initiatives to improve the contraceptives supply chain
- Potential roles for BMGF
- Back up

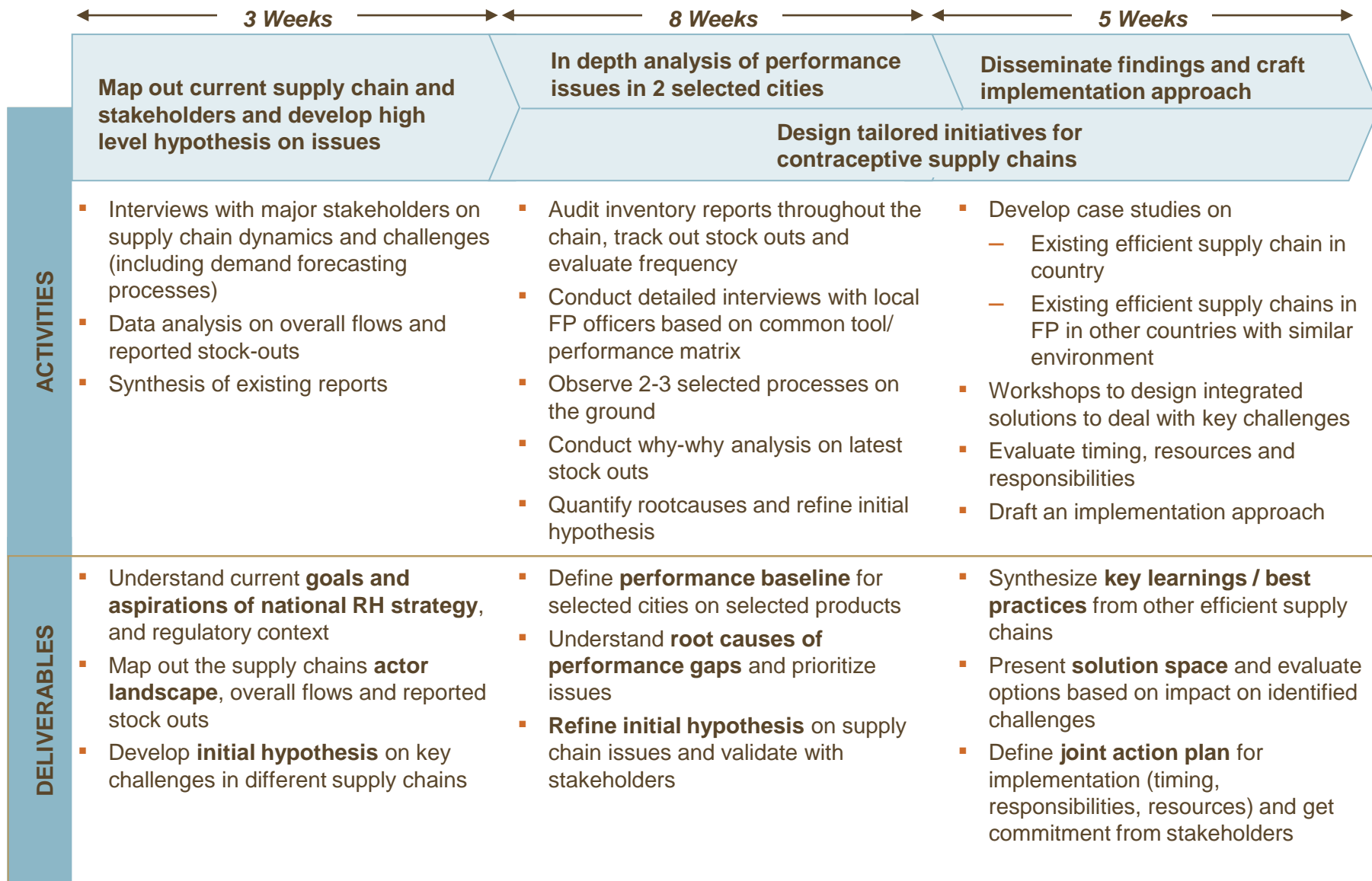
# Approach: Guiding principles for supply chain assessment

## Principles

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- Conduct an in-depth diagnostic with focus on **fieldwork**
  - Collect historical data
  - Perform detailed interviews with major stakeholders
  - Conduct field observations to assess real behaviors
- Apply a **standardized framework** and methodology to show supply chain performances and failures' root causes
- Focus efforts on **two products, two cities**:
  - Cities representative of two **geographical and socio-political** contexts
  - Products that would allow a holistic understanding of supply chain in both **private and public** sectors
- Design potential solutions that are **replicable and scalable**
- Investigate potential to **integrate** RH into other supply chains



# We undertook a three-phase approach to diagnose the supply chains



# A Local Advisory Committee (LAC) was formed leveraging on an existing national committee (RH Commodity Security Committee) and inviting additional private sector stakeholders

## Roles and responsibility

- Will leverage existing RH Commodity Security Committee chaired by the Division of Reproductive Health (DRH)
- Role of McKinsey and Tupange is to share fact base on identified issues in the RH supply chain and facilitate a discussion on the findings and emerging solutions
- Role of the LAC members is to provide input into emerging solutions – and ensure local ownership on implementation

Market actors	Representative organizations
<b>Government agencies</b>	<ul style="list-style-type: none"> <li>Division of Reproductive Health</li> <li>KEMSA</li> <li>Department of Pharmacy</li> </ul>
<b>Donors</b>	
<b>NGOs/ Private</b>	

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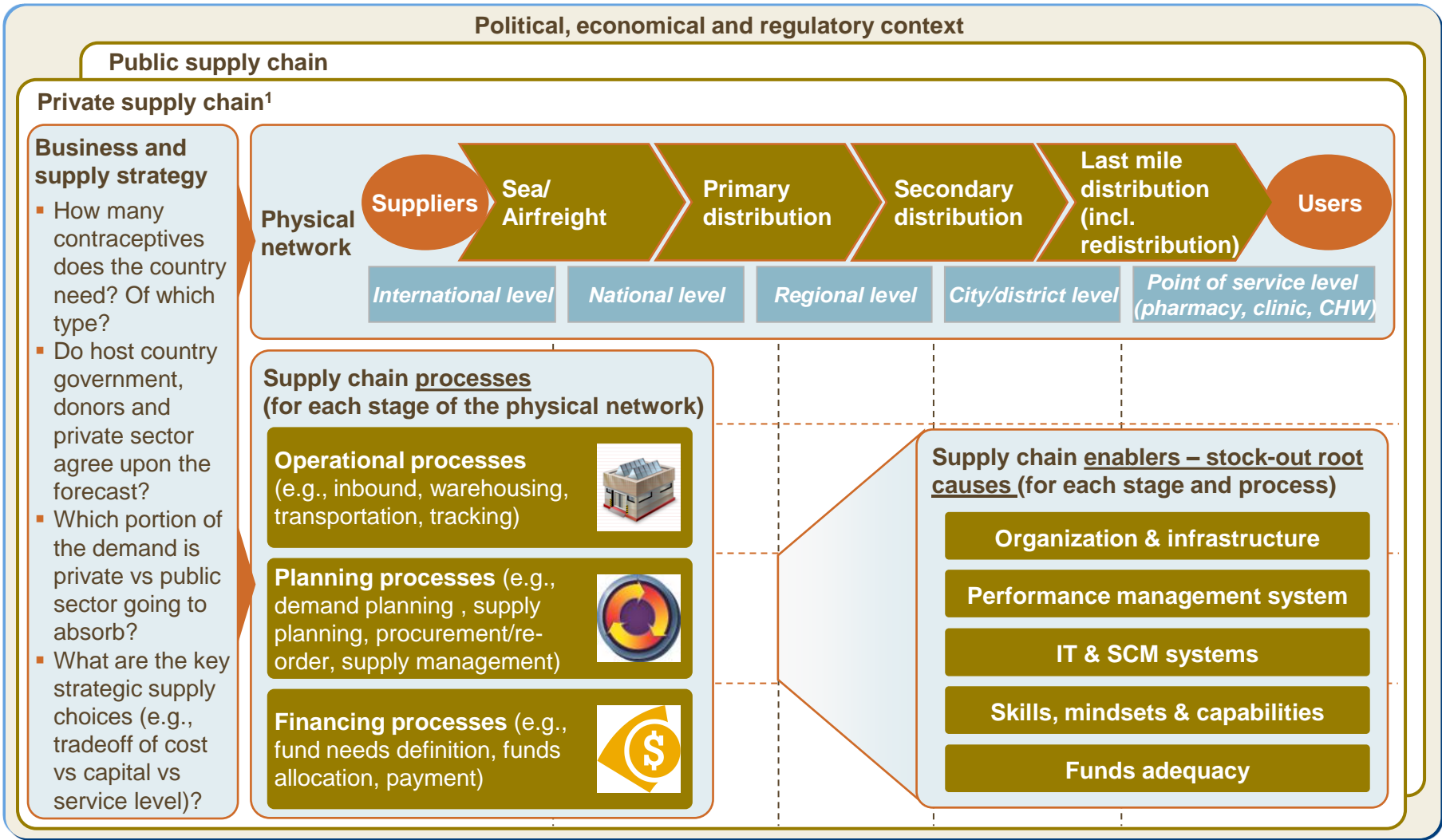
# Interviews were conducted with several public and private stakeholders (1/2)

		Deep dive interview notes <span style="background-color: #cccccc; border: 1px solid #000; display: inline-block; width: 15px; height: 15px;"></span>
<b>Conducted</b>		
	<b>Interviewee</b>	<b>Organisation</b>
<b>Government &amp; service providers</b>	1. Dr. Bashir Issak (Head – Division of Reproductive Health)	<ul style="list-style-type: none"> <li>▪ MoPHS</li> <li>▪ MoPHS</li> </ul>
	2. Dr. Jonah Maina (Program Pharmacist, Division of Reproductive Health)	<ul style="list-style-type: none"> <li>▪ MoPHS</li> </ul>
	3. Provincial RH coordinators	<ul style="list-style-type: none"> <li>▪ Nairobi &amp; Mombasa</li> </ul>
	4. District RH coordinators	<ul style="list-style-type: none"> <li>▪ Nairobi &amp; Mombasa</li> </ul>
	5. District store managers	<ul style="list-style-type: none"> <li>▪ Nairobi &amp; Mombasa</li> </ul>
	6. RH nurses	<ul style="list-style-type: none"> <li>▪ Nairobi city council</li> </ul>
	7. Dr. Ayisi (city council medical officer)	<ul style="list-style-type: none"> <li>▪ Nairobi City Council</li> </ul>
<b>KEMSA</b>	1. Kiumbura Githinji (business development advisor)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	2. Joshua Obell (operations director)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	3. Charles Ezekiel (procurement director)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	4. Samuel Wataku (ICT manager)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	5. Carolyne Gichinga (snr. procurement officer)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	6. John Kabuchi (procurement manager)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	7. Ignatius M'arithi (distribution manager)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	8. John Mwangi (finance manager)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>
	9. John Munyiri (assistant warehouse manager)	<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>

## Interviews were conducted with several public and private stakeholders (2/2)

Conducted		Deep dive interview notes
Interviewee		Organisation
<b>Donors &amp; NGOs</b>	1. Piet Kelfmann (Country director), Cynthia Macharia (Health Program Officer)	▪ KFW
	2. Rhoda Njuguna (Health Programme Officer)	▪ Danida
	3. Stephen Waynee (Assistant Country Representative)	▪ UNFPA
	4. Jean-Marion Aitken (Health Programme Officer)	▪ DFID
	5. Lawrence Mbae, Veronica Musembi, Joyce Wanderi Maina	▪ PSI Kenya
	6. Edwin Mbugua	▪ Marie Stopes Kenya
	7. Joseph Mukoko, Joseph Mwangi, James Riungu	▪ MSH
	8. Boniface Njenga, Jyoti Dhiman, Feddis Mumba	▪ Tupange
<b>Private</b>	1. Jennifer Chavez (Operations Director)	▪ KenyaPharma
	2. Dr. Musana (head of gynaecology/FP)	▪ Aga Khan
	3. Adrian Imbuga (Distribution Manager)	▪ Coca Cola
	4. Gladys Mburu (Customer Service Officer)	▪ MEDS
	5. Joyce Mbithi (Sales and Commercial Manager)	▪ Laborex
	6. Ibrahim Otiso (deputy distribution & purchasing manager)	▪ Omaera

# We used a supply chain framework to assess key components of the existing contraceptive supply chains and trace root causes of stockouts



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<sup>1</sup> Includes social marketing

# Nairobi and Mombasa were chosen based on representativeness and potential for impact Focus city

## Selection principles

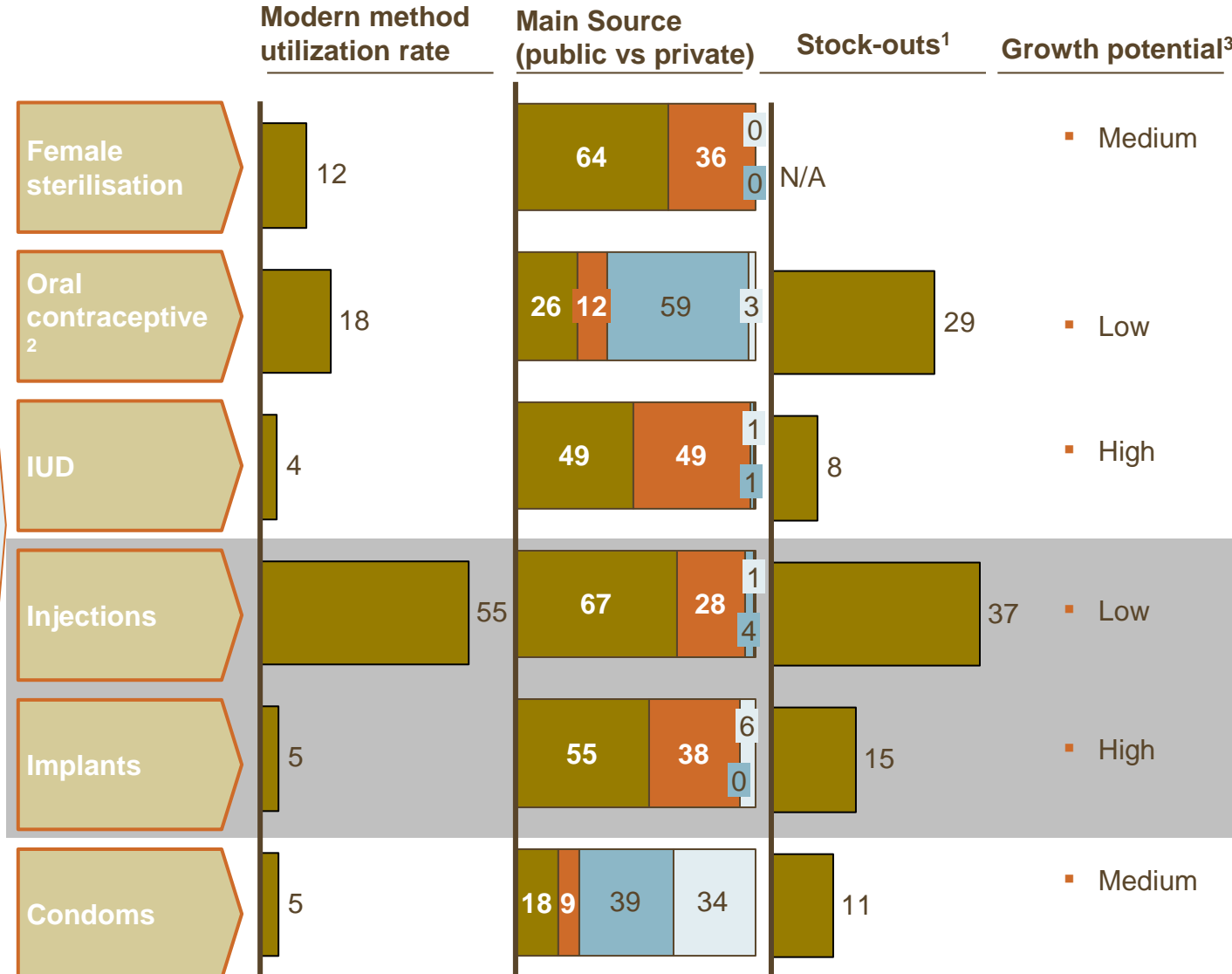
- Significant differences with regards to:
  - **Location**
  - **Socio - Cultural characteristics**
  - **Religious zones**
  
- Size of potential impact:
  - **Population size**
  
- Relevant FP landscape:
  - **High CPR**
  - **High unmet demand for FP**

	Location & representativeness	Population	FP indicators
<b>Nairobi</b>	<ul style="list-style-type: none"> <li>▪ Capital</li> <li>▪ Location for central warehouse</li> </ul>	<ul style="list-style-type: none"> <li>▪ 3 138 369</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modern CPR: 43.7</li> <li>▪ FP unmet need: 22.0</li> </ul>
<b>Mombasa</b>	<ul style="list-style-type: none"> <li>▪ Coastal city</li> <li>▪ Swahili dominated culture</li> </ul>	<ul style="list-style-type: none"> <li>▪ 939 370</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modern CPR: 29.4</li> <li>▪ FP unmet need: 26.9</li> </ul>
<b>Kisumu</b>	<ul style="list-style-type: none"> <li>▪ Lake city</li> </ul>	<ul style="list-style-type: none"> <li>▪ 968 909</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modern CPR: 44.4</li> <li>▪ FP unmet need: 24.3</li> </ul>
<b>Kakamega</b>	<ul style="list-style-type: none"> <li>▪ Town</li> </ul>	<ul style="list-style-type: none"> <li>▪ 1 660 651</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modern CPR: 46.0</li> <li>▪ FP unmet need: 23.9</li> </ul>
<b>Machakos</b>	<ul style="list-style-type: none"> <li>▪ Town</li> </ul>	<ul style="list-style-type: none"> <li>▪ 1 098 584</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modern CPR: 45.3</li> <li>▪ FP unmet need: 16.7</li> </ul>

# Injectable and implants were chosen due to high utilisation and potential for growth

Public Pharmacy<sup>1</sup> Focus products  
 Private Other<sup>3</sup>

- Selection principles**
- FP products must be **well used by urban poor women**
  - Mix between public and private sector availability of products **to understand both supply chain**
  - The **stock out levels** for products must be relatively high and/or frequent where applicable
  - The **potential for increased** utilization (future demand)



# Contents

- Context
- Approach
- **National contraceptives landscape**
- Findings on stock-outs
- Supply chain diagnostic findings
- Potential initiatives to improve the contraceptives supply chain
- Potential roles for BMGF
- Back up



# Executive summary – Contraceptive landscape

## Kenyan contraceptive landscape

- As part of its strategy to increase CPR the government offers free reproductive health commodities to public, not-for-profit and private facilities, and are therefore responsible for most of the reproductive health (RH) commodities bought into and distributed across the country.
- Kenya has two supply chains:
  - **The public** sector supply chain is the predominant one in Kenya. It is responsible for 98% of the central supply (wholesale) of long acting contraceptive methods (IUCDs and implants), and 79% of short acting contraceptive methods (injectables, pills and condoms). Commodities are procured by a parastatal organisation (KEMSA) and funded by government and donors. KEMSA distributes through 2 distribution channels. ~23-40% of commodities are sent directly to facilities (predominantly Ministry of Health (MoH) facilities) from KEMSA, the remaining ~60-77% of commodities are sent to District Stores which then supply municipality, private not-for profit and for-profit facilities. KEMSA is not responsible for the distribution from District Stores to facilities rather each facility must arrange their own transport
  - **The private** sector supply chain manages only ~2% of long acting contraceptive methods and ~21% of short acting contraceptive methods. Long acting methods are mainly imported by Social Marketing organisations (PSI and MSK) to fill gaps at facilities they support during periods of public sector stock-outs or during in-reach<sup>1</sup> at public facilities. Short acting methods are mostly imported by private for-profit wholesalers and sold to private retailers (pharmacies, facilities and grocery retail stores). Quantities remain small as government's provision of free RH commodities limits the financial attractive of the business.
- In spite of public dominance at the wholesale level, private retailers (pharmacies and facilities) play a vital role in RH service provision supplying commodities to 39 percent of women aged 15-49. For short acting contraceptive methods, the private retailers provide 41% of the commodities vs. 33% for long acting contraceptive methods.

1 When PSI or MSK spend a full day at public facilities offering FP services

# The public sector is the main supply chain for Long Acting Methods, while the private sector plays a larger role for Short Acting Methods

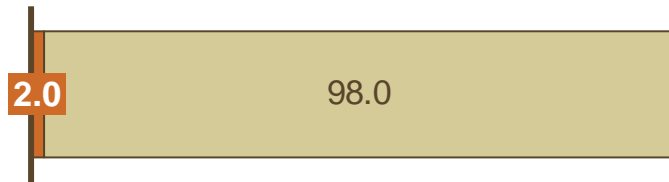
Private  
Public

## Share of supply chain for RH commodities

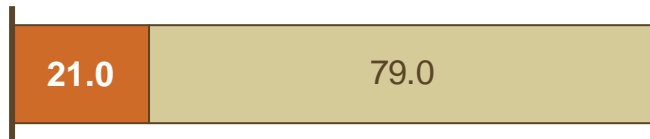
Percent, Value

ESTIMATES

Long Acting  
Contraceptive  
Methods<sup>1</sup>



Short Acting  
Contraceptive  
Methods<sup>4</sup>



- For Long Acting Methods, the public sector (KEMSA) supplies 98%<sup>2</sup> of stock
- Social marketing solely imports Long Acting Methods to fill gaps at their supported facilities, while private-for-profit imports very small quantities due to poor financial incentives (high product cost + free commodity policy)
- For Short Acting Methods private-for-profit and social marketing sectors play a larger role (21%<sup>3</sup>), but KEMSA still dominates

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1 Implants, IUCD

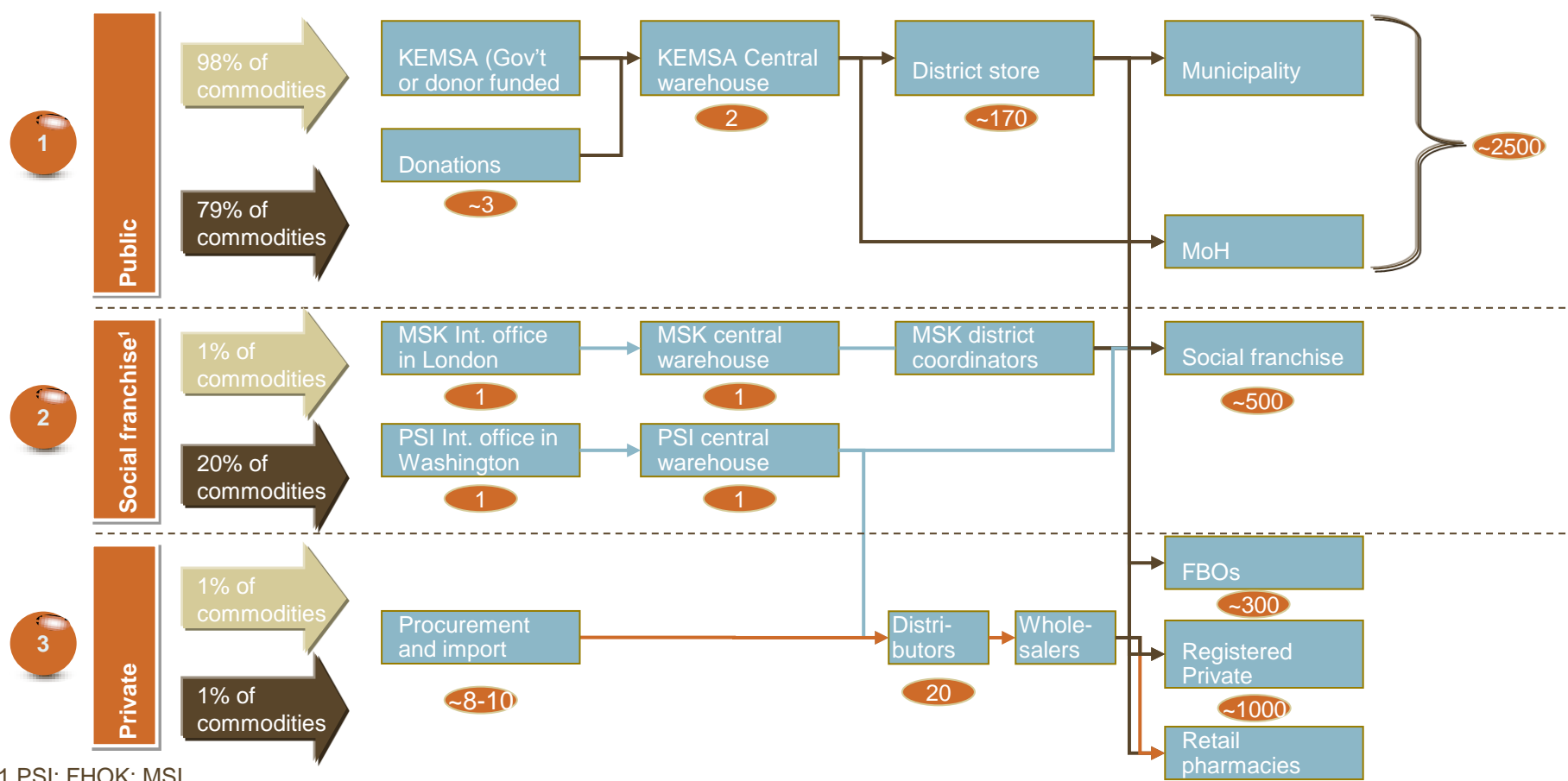
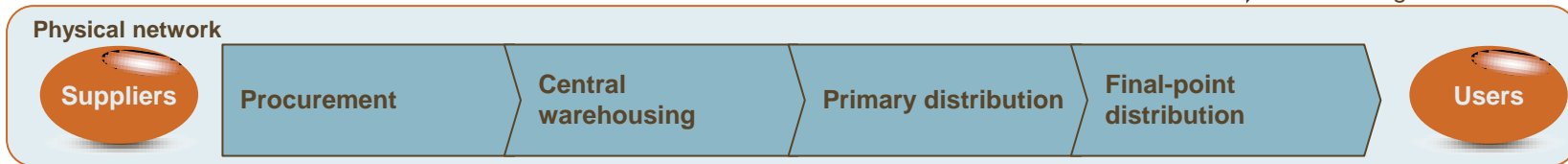
2 Split based on RHInterchange on recipient data for all RH shipments

3 Based on F&Q May 2010 and PSI

4 Condoms, pills; injectables

# The majority of RH commodities are handled through the public supply chain, with bridging to private retail at district stores

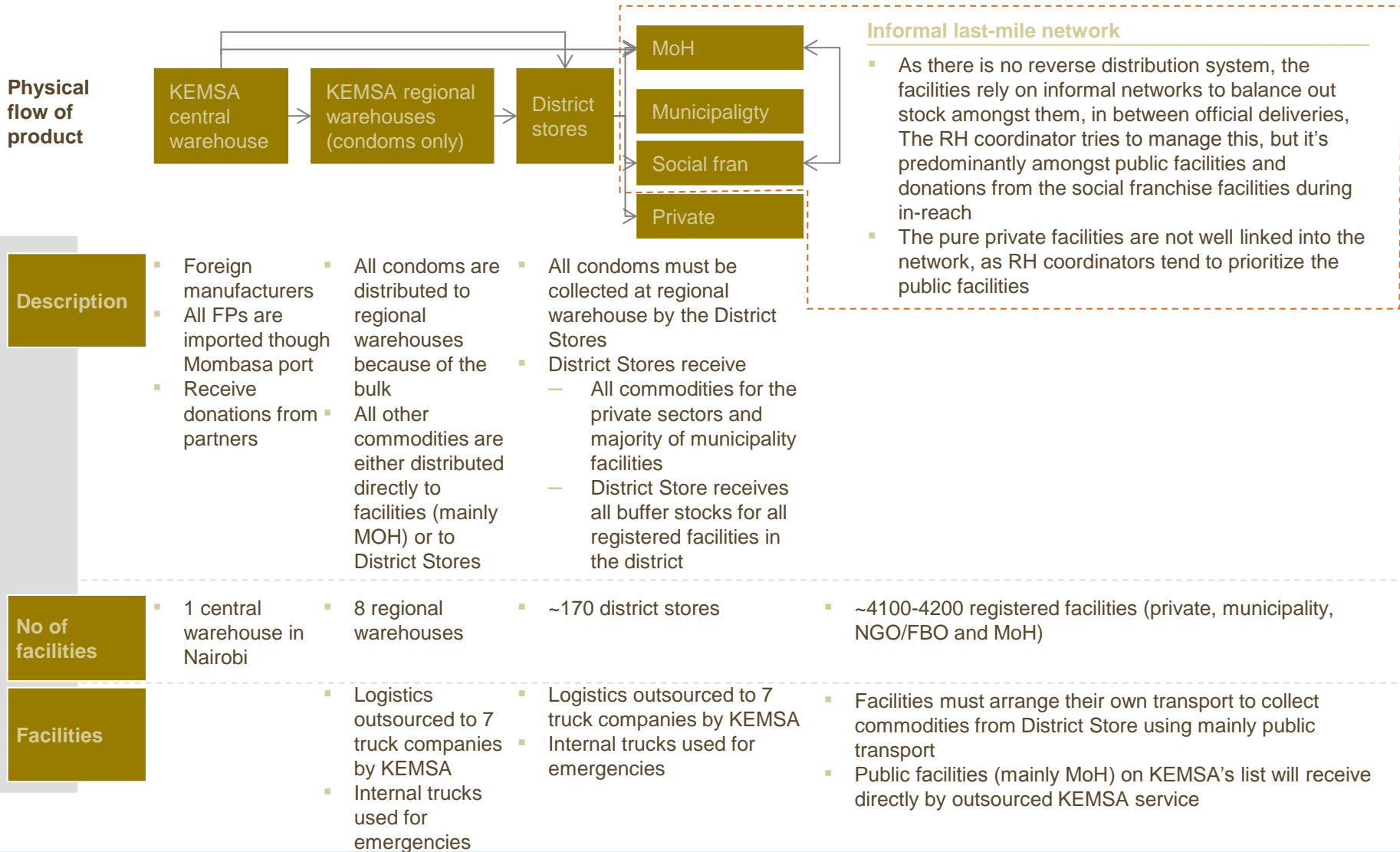
 # of stakeholders  
 Long acting methods  
 Short acting methods



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1 PSI; FHOK; MSI

# 1 The public SC is the main sources of RH commodities in Kenya



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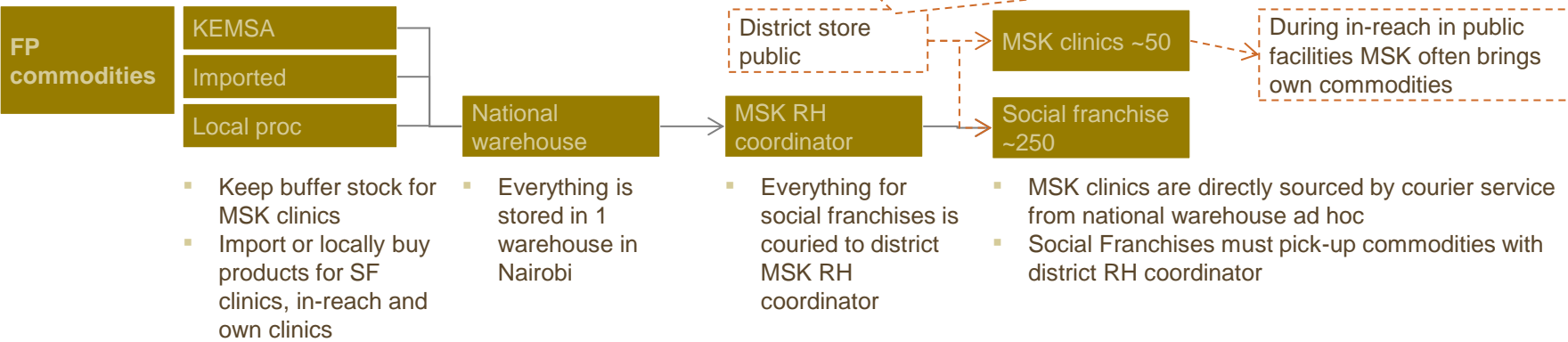
2

# The social marketing organisations supply chain's are fragmented and play the role of a gap filler for the public supply chain

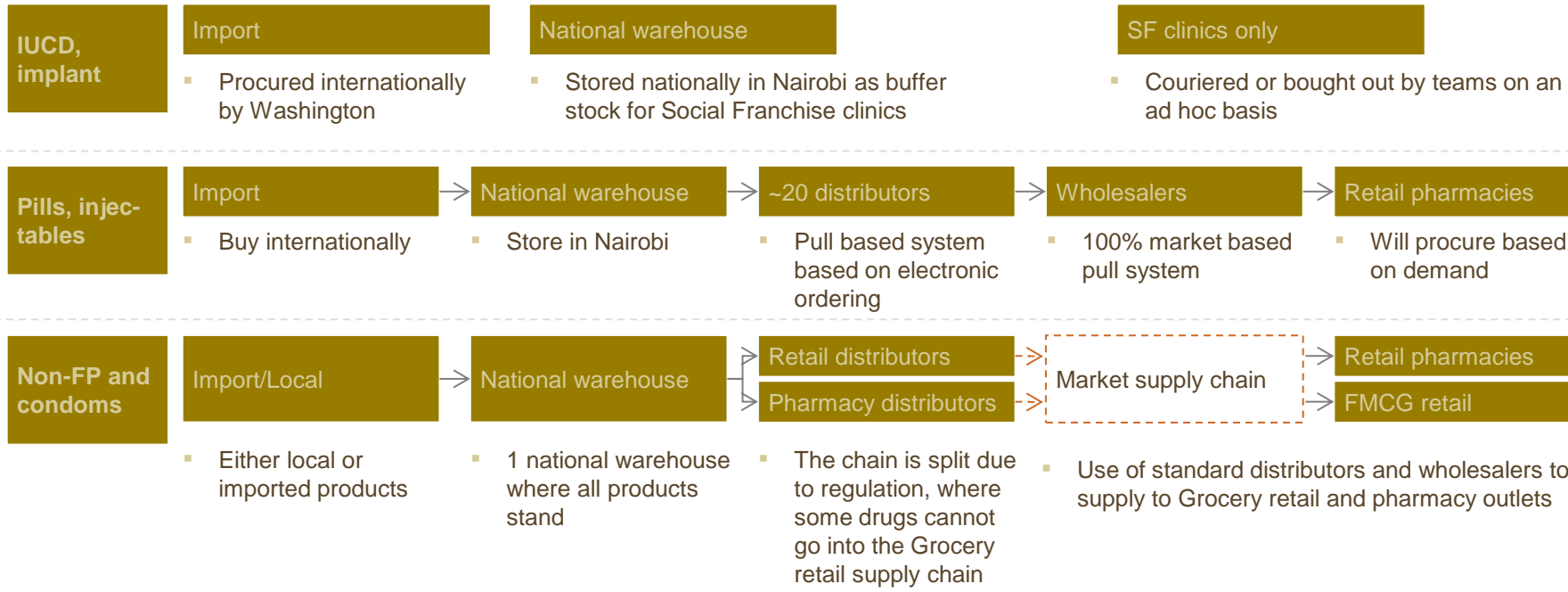
The public district store is the primary source for RH commodities. Only use the MSK products in case of stock out at District Store

During in-reach in public facilities MSK often brings own commodities

MSK



PSI Kenya



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### 3 The private for profit wholesalers already have supply chains in place that allows them to reach most private facilities...



Example of private sector players	Laborex		
	Omaera	<ul style="list-style-type: none"> <li>Already procure RH commodities from 5 international manufacturers (Schering Plough, Pfizer, Bayer, Janssen Cilag, Karuri)</li> <li>Scale-up of procurement for additional commodities is estimated to take 3 months</li> </ul>	<ul style="list-style-type: none"> <li>1 headquarter with central warehouse in Nairobi</li> <li>5 provincial offices, which works as regional warehouses</li> <li>Central telesales team (7 people) who take daily orders from up to 1800 clients</li> </ul>
	<ul style="list-style-type: none"> <li>Already procure some RH commodities                             <ul style="list-style-type: none"> <li>~90% are short acting methods</li> <li>~10% are long acting methods</li> </ul> </li> <li>Scale-up of procurement for additional commodities is estimated to take 3-5 months</li> </ul>	<ul style="list-style-type: none"> <li>1 headquarter with central warehouse in Nairobi</li> <li>8 provincial offices, which works as regional warehouses</li> <li>Central telesales team (8 people) who take daily orders from up to 2000 clients</li> </ul>	<ul style="list-style-type: none"> <li><u>Within Nairobi:</u> Direct daily distribution using either motorbikes/cars with 1-2 hours lead time for small orders and half day lead time for bulk orders</li> <li><u>Outside Nairobi:</u> Distribution outsourced to G4S with less than 24 hour lead time</li> </ul>

**The private sector already has a well developed supply chain in place – as they are already supplying essential medicines to private facilities in large quantities. They are however only moving very small quantities of RH commodities**

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3

## ... but for RH commodities they have a very low market share due to insufficient financial incentives

### Insufficient financial incentives

“ The main reason we do not carry many RH commodities is that the government gives them out for free – We cannot make any money

We cannot compete with free commodities

”

### Highly variable demand

“ It is very difficult to forecast demand. Whenever there is a massive persistent stock out at KEMSA we see a peak in demand. But obviously we cannot predict such situations or carry excess-stock and risk expiry

We order conservatively as we only sell small quantities for the majority of the year – we cannot plan for the peaks

”

### Supply chain is already in place

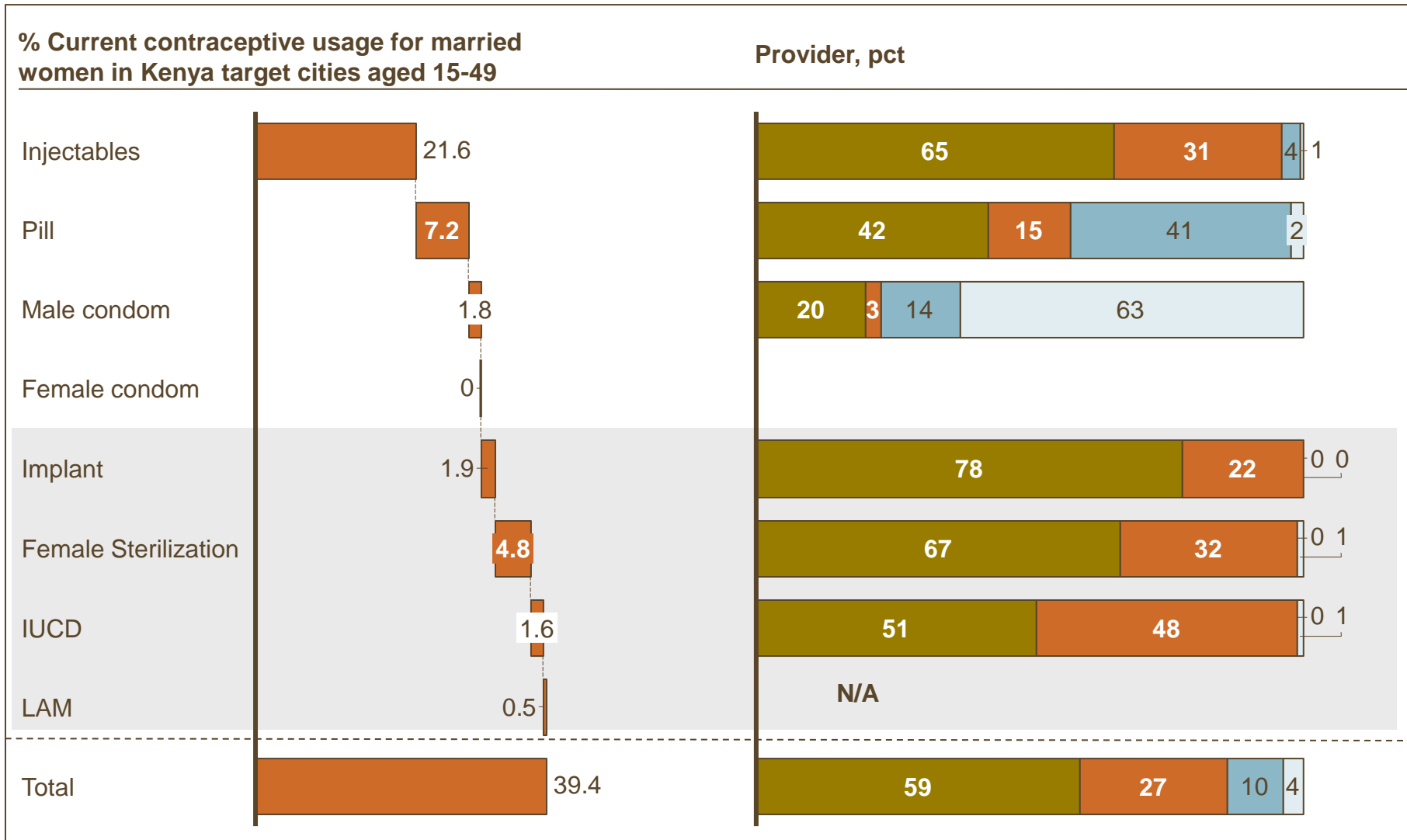
“ We already know who and where the clients are! We distribute essential medicines to them. We could begin tomorrow if the market became truly competitive

All our operations are ready – we are just waiting for the policy change (government to stop giving free commodities)

”

# At the retail level there is an almost 60-40 split between the public and private sectors

- Public
- Private
- Pharmacy
- Other<sup>1</sup>



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<sup>1</sup> Others include mobile clinics, shops etc. that be both public and private

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- **Findings on stock-outs**
- Supply chain diagnostic findings
- Potential initiatives to improve the contraceptives supply chain
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# Executive summary - Findings on stock-outs

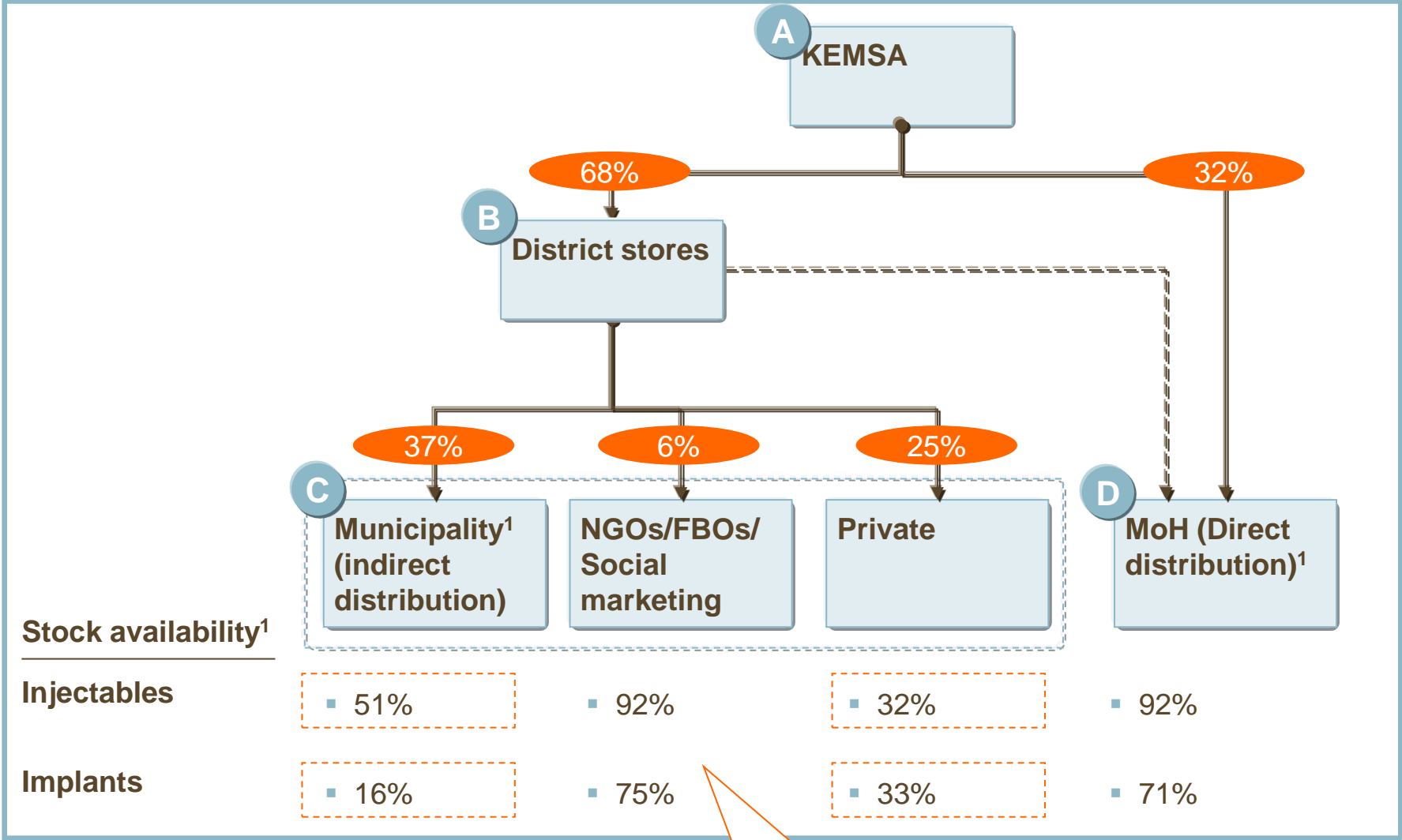
## Findings on stock-outs in Nairobi and Mombasa

The diagnostic assessment in Nairobi and Mombasa confirmed that stock-outs have been a severe problem over the last 12 months for the two products that were traced (implants and injectables):

- There are two distribution channels in the public sector supply chain with those served directly by KEMSA having much higher stock availability:
  - **District Store distribution:** 60-77% of women access commodities through facilities (municipality, private, FBOs and NGOs) that are predominantly served by the District Stores. These facilities suffer severe stockouts with stock availability of ~34% for public facilities (mainly municipality) and ~32% for private facilities. Stock levels of NGOs are much higher at ~84% as they receive top-up commodities from sponsors
  - **Direct to facility distribution:** 23-40% of women access commodities through facilities that are served directly from KEMSA. These are predominantly MoH facilities, and have stock availability of ~82%
- In addition to more stock outs in District Store distribution vs. direct to facility distribution we also found significant differences in the flexibility of the channels:
  - **Deliveries:** the direct channel receives an average of 2-3 deliveries a year vs. 0-1 deliveries for District Stores
  - **Fulfillment rates:** facilities under District Stores receive only 4-45% of what they order vs. 62-82% for facilities on direct distribution

# Stock-outs were traced through the public supply chain to facility level to determine if performance varied by distribution channel

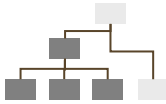
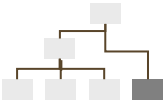
Pct. of commodities



<sup>1</sup> For the past 12-15 months

Receive top-up from sponsors

# There are two distribution channels: Direct to facilities and distribution through the District Store

	<b>District Store distribution</b> 	<b>Direct to facility distribution</b> 
Facilities served	<ul style="list-style-type: none"> <li>All private (NGOs, FBOs and for-profit) facilities</li> <li>Most <u>municipality</u> facilities (public)</li> </ul>	<ul style="list-style-type: none"> <li>Most <u>MoH</u> facilities (public)</li> </ul>
Distribution	<ul style="list-style-type: none"> <li>District stores receive deliveries 0-1 times a year</li> <li>Facilities must pick up their own commodities from District Store</li> </ul>	<ul style="list-style-type: none"> <li>Facilities receive deliveries 2-3 times a year</li> <li>Facilities receive commodities directly from KEMSA</li> </ul>
Information flow	<ul style="list-style-type: none"> <li>Facilities fill in the RH specific CDRR form monthly to record patients, inventory and orders</li> <li>District RH coordinators consolidate the reports monthly</li> <li>RH coordinators pass on orders to DRH who must then authorize KEMSA to distribute to District Stores every quarter</li> </ul>	<ul style="list-style-type: none"> <li>Facilities fill in a Standard Order &amp; Requisition Form (SORF) quarterly. Covers all commodities</li> <li>SORF reviewed by District Pharmacist and sent directly to KEMSA who then process orders</li> <li>Facilities must also fill in CDRR and submit to RH coordinators for recording consumption data, but no orders processed based on this form</li> </ul>

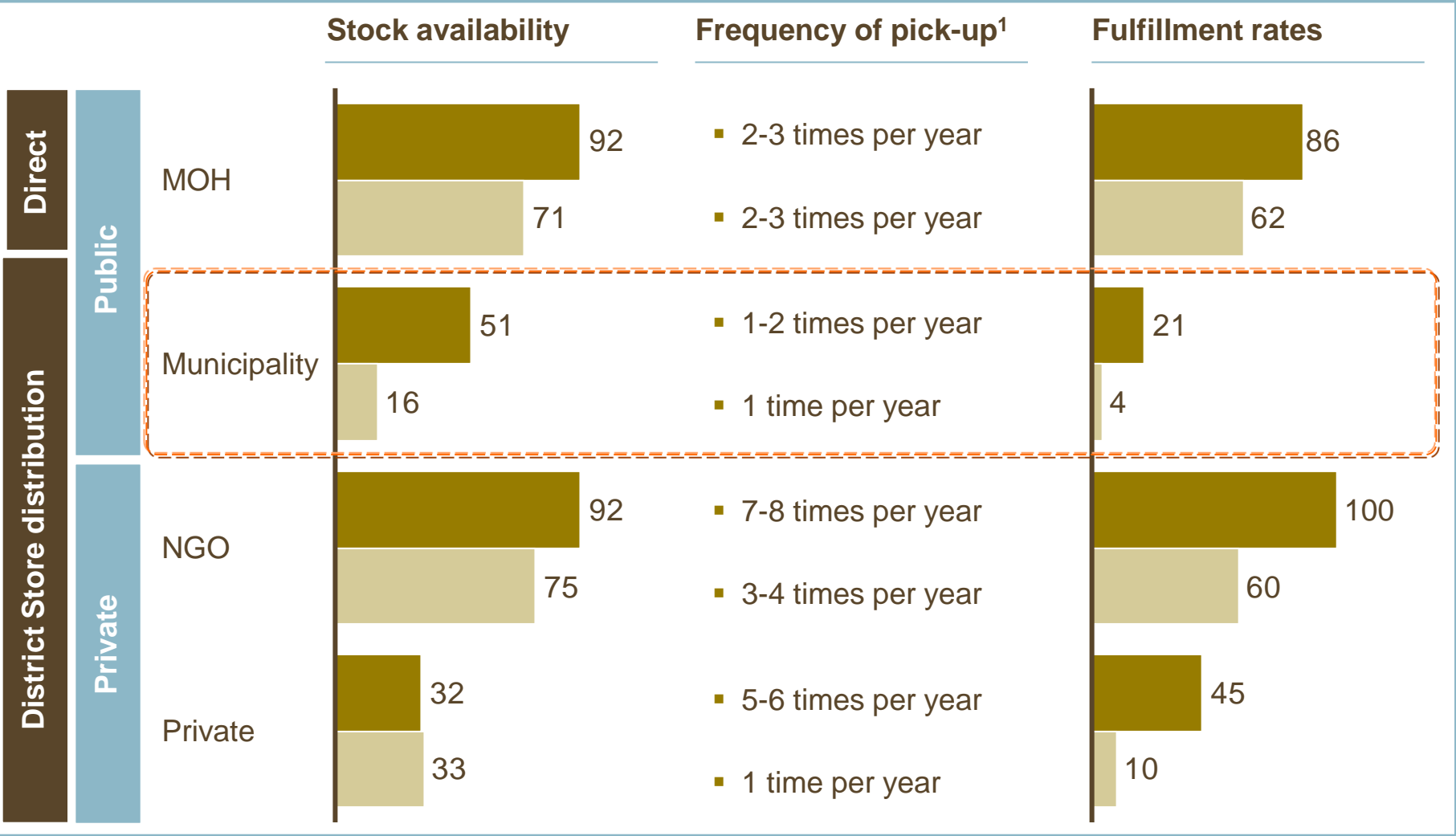
**Distribution and information flow characterized by involvement of several institutions and several levels in the chain**



**Simple and direct distribution and information flow between facility and central level**

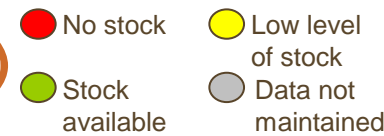
# Public facilities served via the district stores suffer the most

■ Injectable  
■ Implants



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<sup>1</sup> For MoH facilities it is defined as "Frequency of delivery"  
SOURCE: FP Workbook from MSH; CDRR and BIN reports from visited facilities; Team



# MOMBASA – INJECTABLE: The facilities served by the district store experience the most significant stock-outs (1/2)

Stock on Hand



**Injectables in stock at central level**  
 ▪ KEMSA had sufficient stock in the entire period

**Inefficient distribution**  
 ▪ No deliveries from KEMSA due to lack of distribution plan

**Efficient distribution**  
 ▪ Scheduled distribution ensures that all facilities served directly by KEMSA have stock on hand

**No commodities at district stores**  
 ▪ District store is stock out

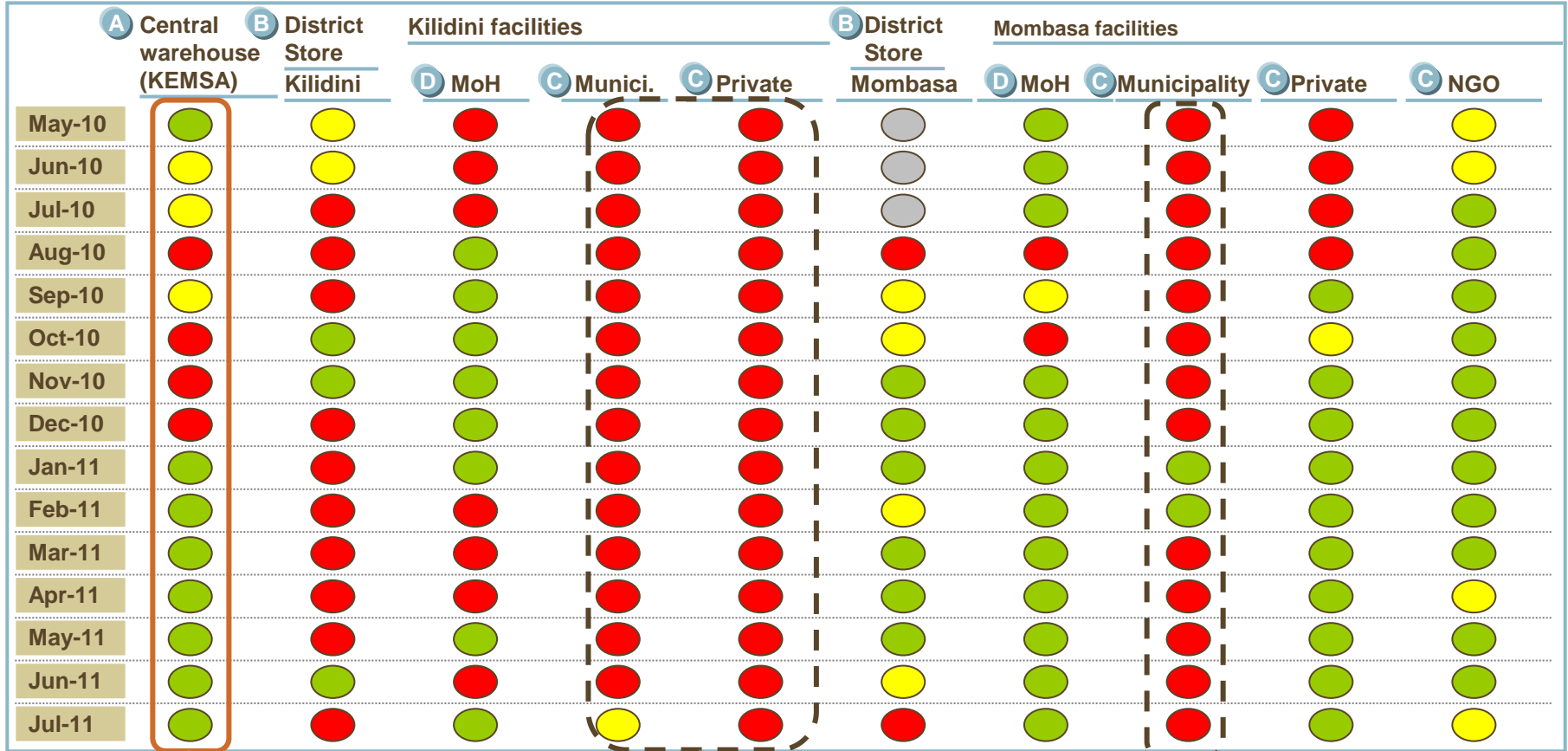
**Own commodities**  
 ▪ Facility receive commodities from social franchise as gap filler

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- No stock
- Low level of stock
- Stock available
- Data not maintained

# MOMBASA – IMPLANTS: The facilities served by the district store experience the most significant stock-outs (2/2)

## Stock on Hand



**National shortage**

- KEMSA had insufficient stock in the part of the period

**Lack of commodities**

- The municipality facilities are not prioritised in situations of low stock on hand in district store

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- ✓ Injectable
- ✓ Implant

# MOMBASA: The frequency of delivery is associated with stock availability

DELIVERIES FROM MAIN SOURCE (KEMSA, DISTRICT STORE OR PRIVATE SUPPLIER)

Month	Kilidini facilities				Mombasa facilities				
	B District Store Kilidini	D MoH	C Munici.	C Private	B District Store Mombasa	D MoH	C Munici.	C Private	C NGO
May-10				✓		✓			
Jun-10				✓		✓			✓
Jul-10	✓	✓	✓	✓		✓			✓
Aug-10	✓	✓	✓	✓		✓		✓	✓
Sep-10		✓		✓	✓	✓		✓	✓
Oct-10		✓		✓	✓	✓		✓	✓
Nov-10		✓		✓		✓		✓	✓
Dec-10							✓	✓	✓
Jan-11		✓					✓	✓	✓
Feb-11		✓					✓	✓	✓
Mar-11		✓				✓		✓	✓
Apr-11		✓					✓	✓	✓
May-11		✓				✓		✓	✓
Jun-11	✓	✓	✓	✓			✓	✓	✓
Jul-11	✓	✓	✓	✓			✓	✓	✓

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**In frequent distribution**  
 Only 1-2 deliveries over a 15 month period

**Frequent distribution**  
 MoH are frequently receiving commodities from KEMSA

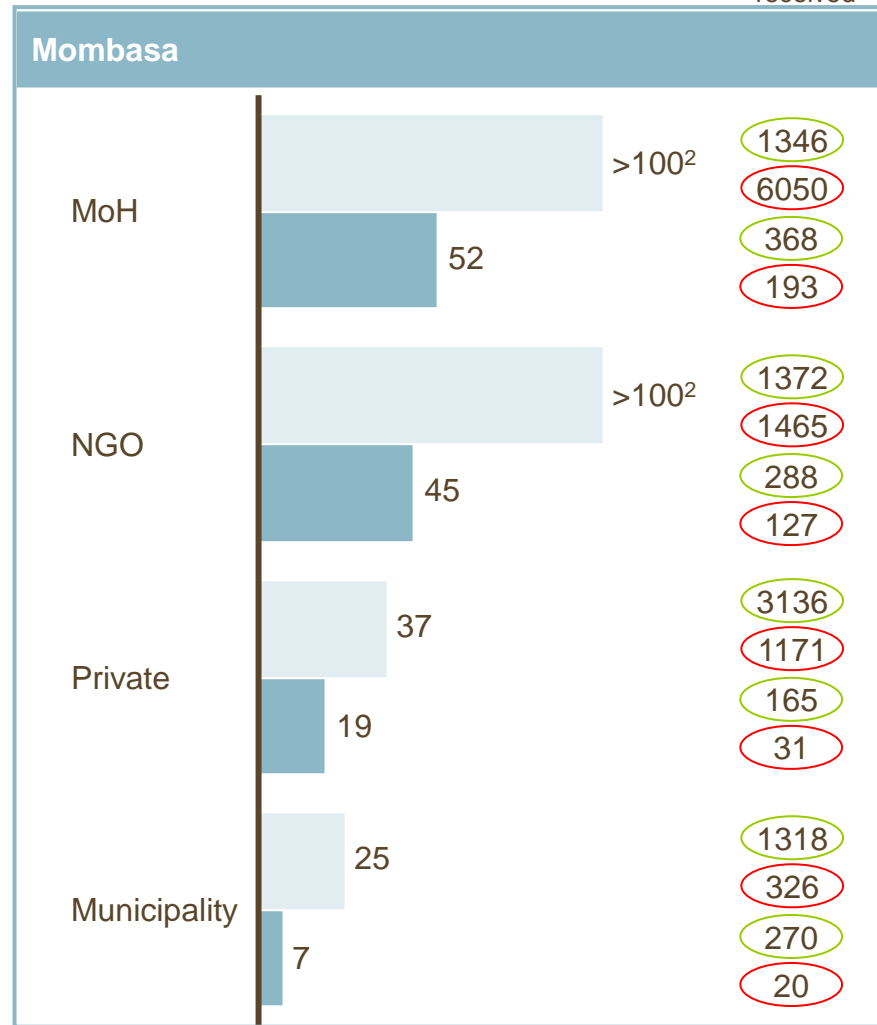
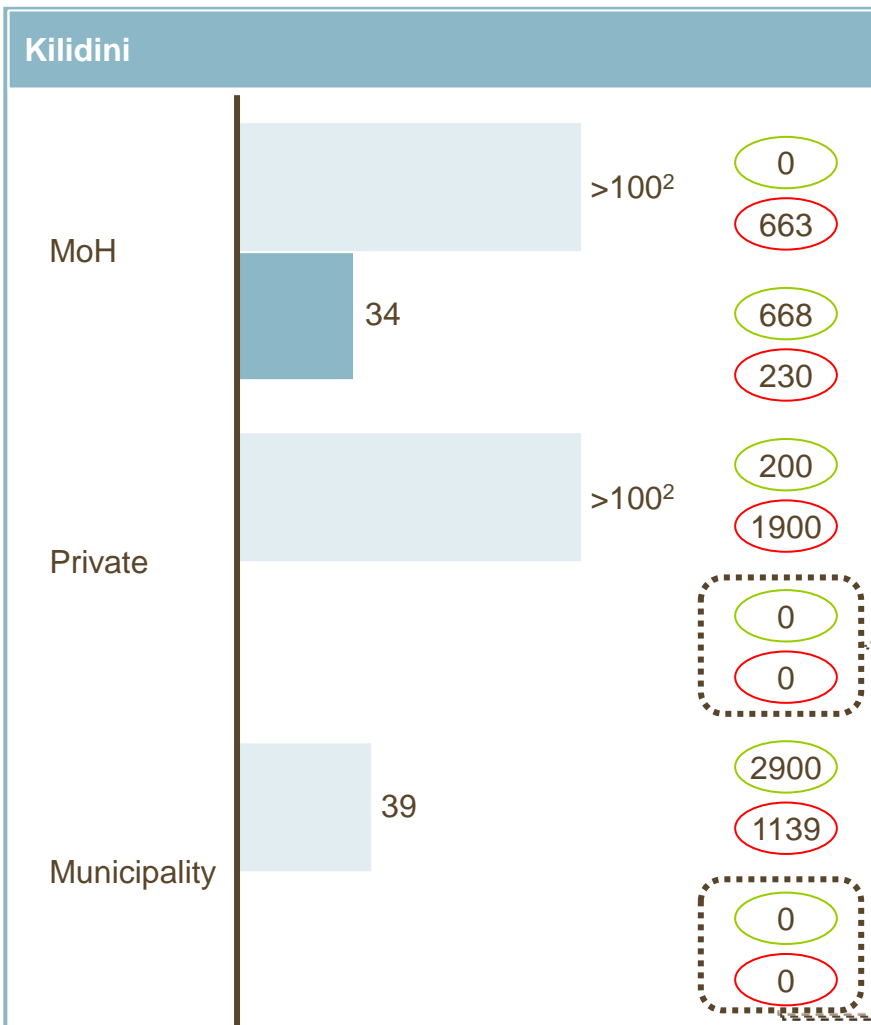
**Additional source of commodities**  
 The private facilities get commodities more frequently than the municipality as they will top up with commodities from the private sector

**Constant influx of commodities**  
 Facility is receiving commodities from both public and Social franchise

# MOMBASA: The fulfillment rates also associated with stock availability

FULFILLMENT RATES<sup>1</sup>, May 2010 – Jul 2011, Percent

Injectable (x) Commodities requested  
 Implant (x) Commodities received

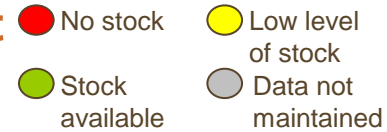


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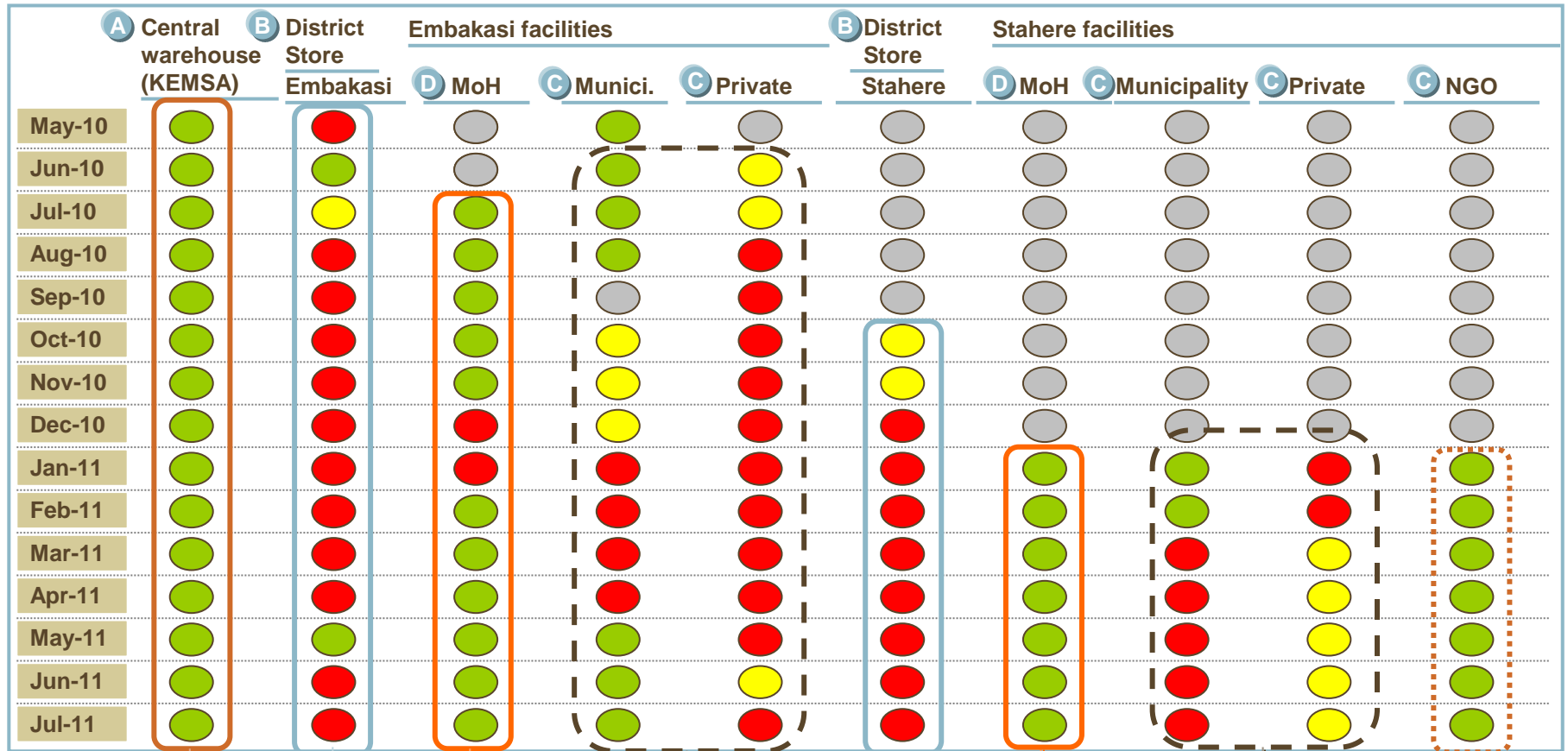
**No quantities requested**

Often facilities will not order implants when they know that there is shortage at district store

1 # commodities received /# requested  
 2 If a facility received more commodities than they requested



# NAIROBI – INJECTABLE: The facilities served by the district store experience the most significant stock-outs (1/2)



**Injectables in stock at central level**  
 ▪ KEMSA had sufficient stock in the entire period

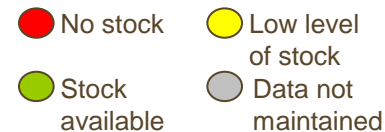
**Inefficient distribution**  
 ▪ No deliveries from KEMSA due to lack of distribution plan

**Lack of commodities**  
 ▪ No commodities as district store is out of stock

**Efficient distribution**  
 ▪ Scheduled distribution ensures that facilities served directly by KEMSA have stock on hand

**Own commodities**  
 ▪ Facility receive commodities from social franchise as gap filler

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# NAIROBI – IMPLANTS: The facilities served by the district store experience the most significant stock-outs (2/2)

	A Central warehouse (KEMSA)	B District Store Embakasi	Embakasi facilities			B District Store Stahere	Stahere facilities			
			D MoH	C Munici.	C Private		D MoH	C Municipality	C Private	C NGO
May-10	Green	Yellow	Grey	Green	Grey	Grey	Grey	Grey	Grey	Grey
Jun-10	Yellow	Red	Grey	Green	Yellow	Grey	Grey	Grey	Grey	Grey
Jul-10	Yellow	Green	Green	Yellow	Yellow	Grey	Grey	Grey	Grey	Grey
Aug-10	Red	Green	Green	Yellow	Yellow	Grey	Grey	Grey	Grey	Grey
Sep-10	Yellow	Yellow	Green	Grey	Yellow	Grey	Grey	Grey	Grey	Grey
Oct-10	Red	Red	Green	Yellow	Red	Grey	Grey	Grey	Grey	Grey
Nov-10	Red	Red	Green	Yellow	Red	Green	Grey	Grey	Grey	Grey
Dec-10	Red	Red	Green	Yellow	Yellow	Green	Grey	Grey	Grey	Grey
Jan-11	Green	Green	Red	Red	Green	Green	Green	Red	Red	Yellow
Feb-11	Green	Red	Red	Red	Red	Yellow	Green	Red	Red	Yellow
Mar-11	Green	Red	Green	Red	Green	Red	Green	Red	Red	Green
Apr-11	Green	Red	Green	Red	Green	Red	Green	Red	Red	Green
May-11	Green	Red	Green	Red	Green	Red	Red	Red	Red	Green
Jun-11	Green	Green	Green	Green	Green	Red	Yellow	Red	Red	Red
Jul-11	Green	Yellow	Green	Green	Green	Red	Red	Red	Red	Green

**National shortage**  
 KEMSA had insufficient stock in the part of the period

**Lack of commodities**  
 The national shortage affect the district store and the facilities under it

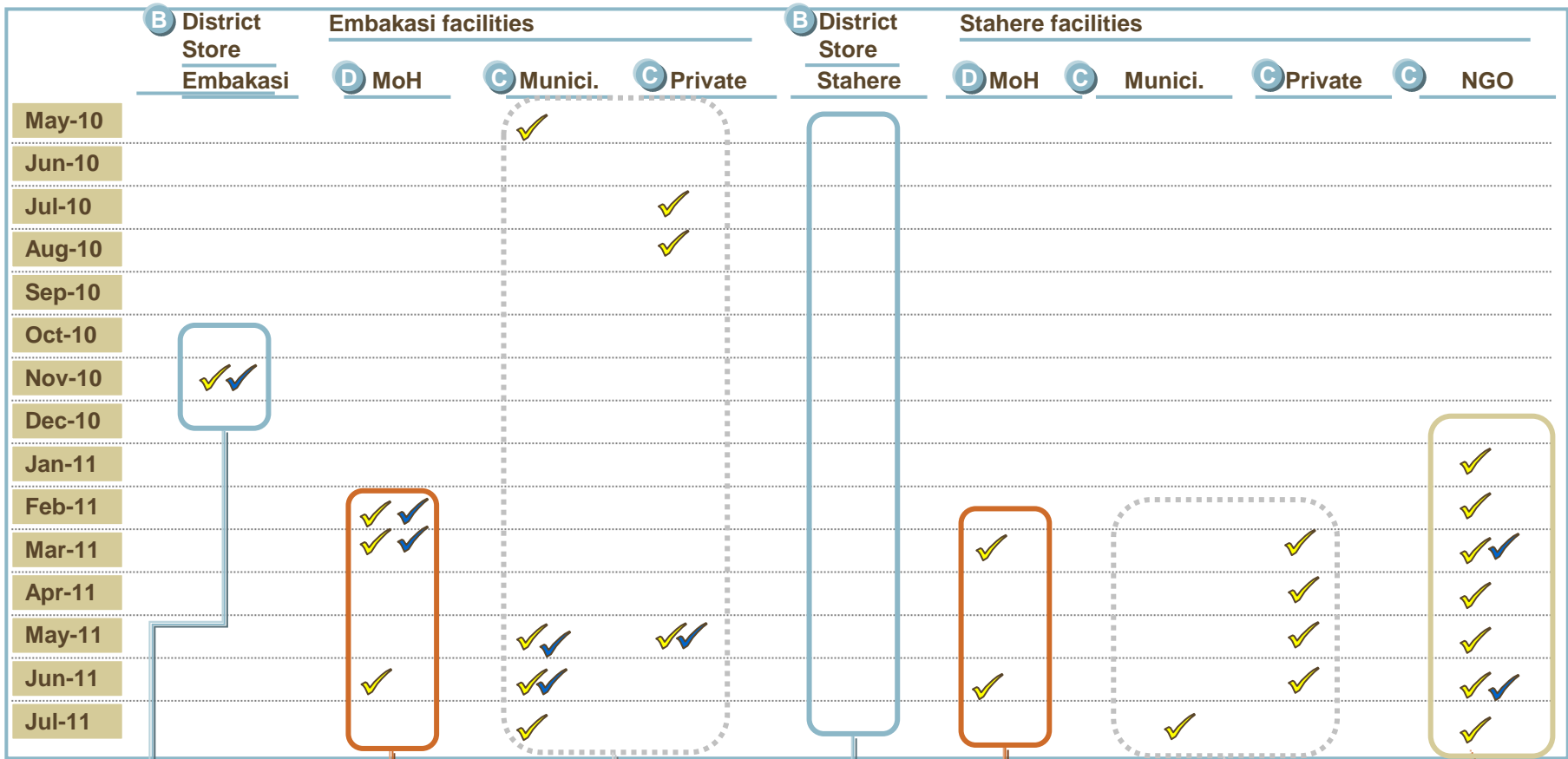
**Own commodities**  
 Facility receive commodities from social franchise as gap filler

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- ✓ Injectable
- ✓ Implant

# NAIROBI: The frequency of delivery is associated with stock availability

DELIVERIES FROM MAIN SOURCE (KEMSA, DISTRICT STORE OR PRIVATE SUPPLIER)



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**In frequent distribution**  
 Only 1 or none deliveries over a the period

**Frequent distribution**  
 MoH are frequently receiving commodities from KEMSA

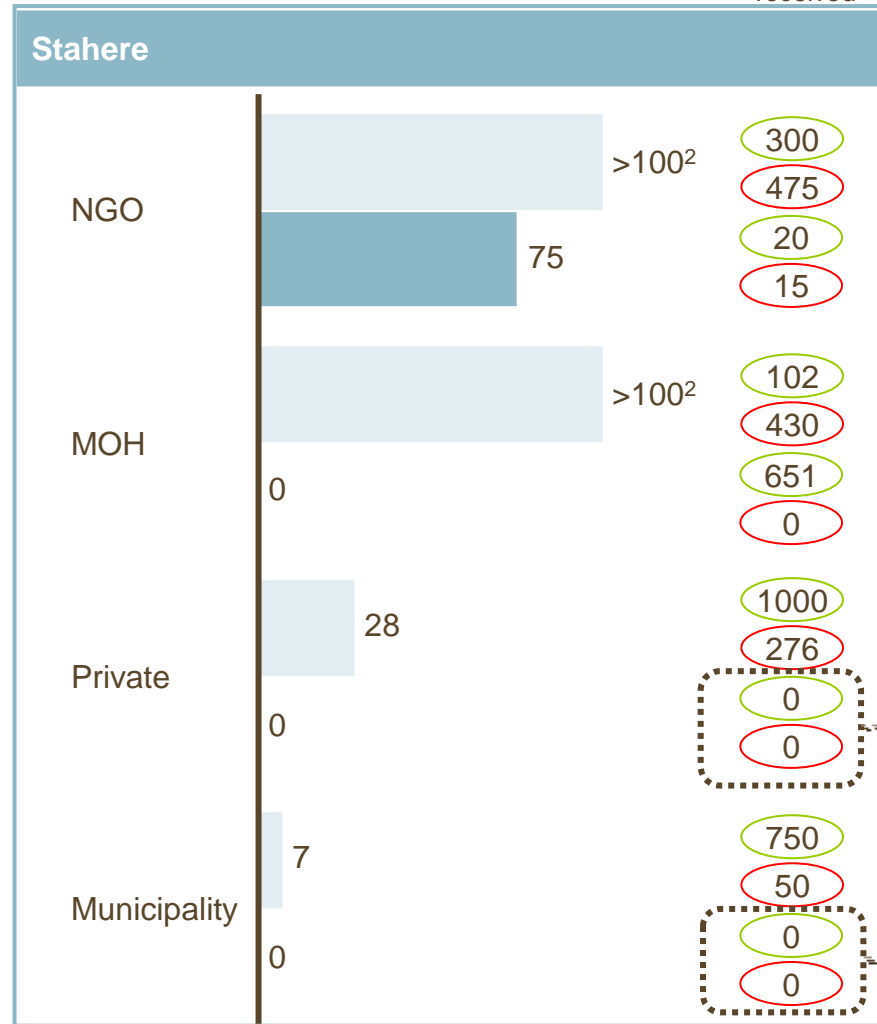
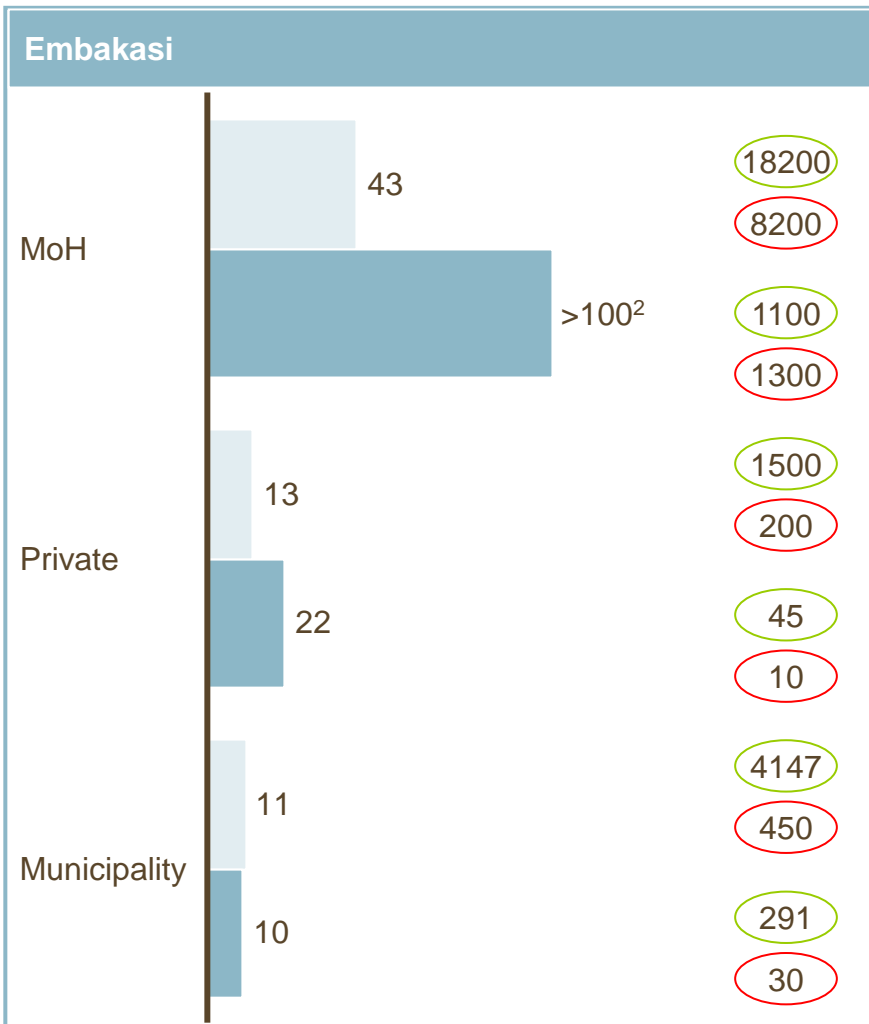
**Additional source of commodities**  
 The facilities have received commodities from other facilities or buying in private sector as the District store was out of stock

**Constant influx of commodities**  
 Facility is receiving commodities from both public and Social franchise

# NAIROBI: The fulfillment rates are also associated with stock availability

FULFILLMENT RATES<sup>1</sup>, May 2010 – Jul 2011, Percent

■ Injectable x Commodities requested  
■ Implant x Commodities received



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0  
0

1 # commodities received /# requested  
 2 If a facility received more commodities than they requested

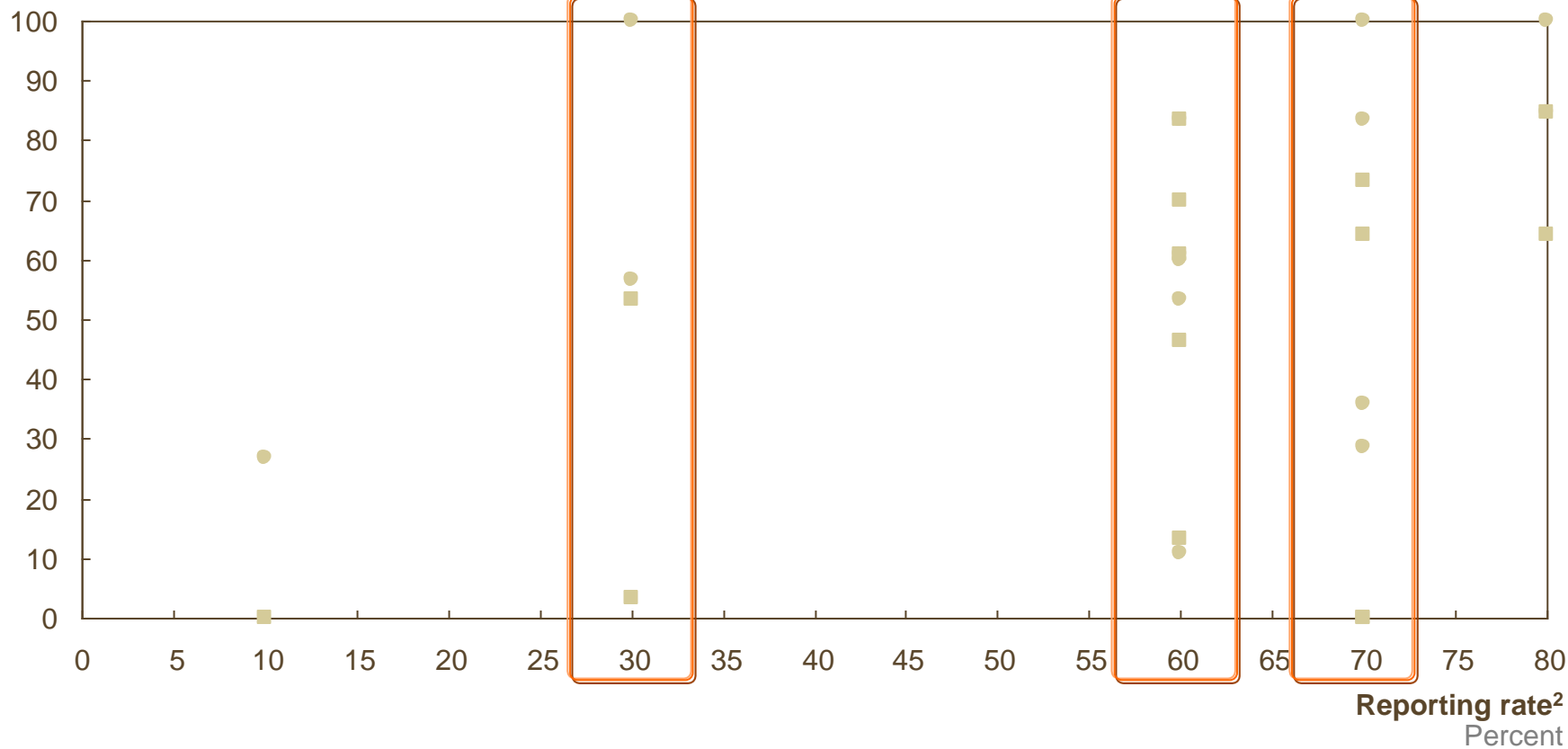
**No quantities requested**

Often facilities will not order implants when they know that there is shortage at district store

# Mombasa & Nairobi: However, there doesn't appear to be a strong correlation between reporting/ordering rates and stock availability

## Correlation between SoH<sup>1</sup> and reporting rates

**Stock on Hand<sup>1</sup>**  
Percent



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<sup>1</sup> Calculated as: ( # months green x 1 + # months yellow x 0.5 + # months red x 0 ) / total # of months with data available

<sup>2</sup> Measured as no. of reports submitted in time period: April '10 – Jan '11, percent

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- Findings on stock-outs
- **Supply chain diagnostic findings**
- Potential initiatives to improve the contraceptives supply chain
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# Executive summary – Supply chain diagnostic findings

## Supply chain diagnostic findings

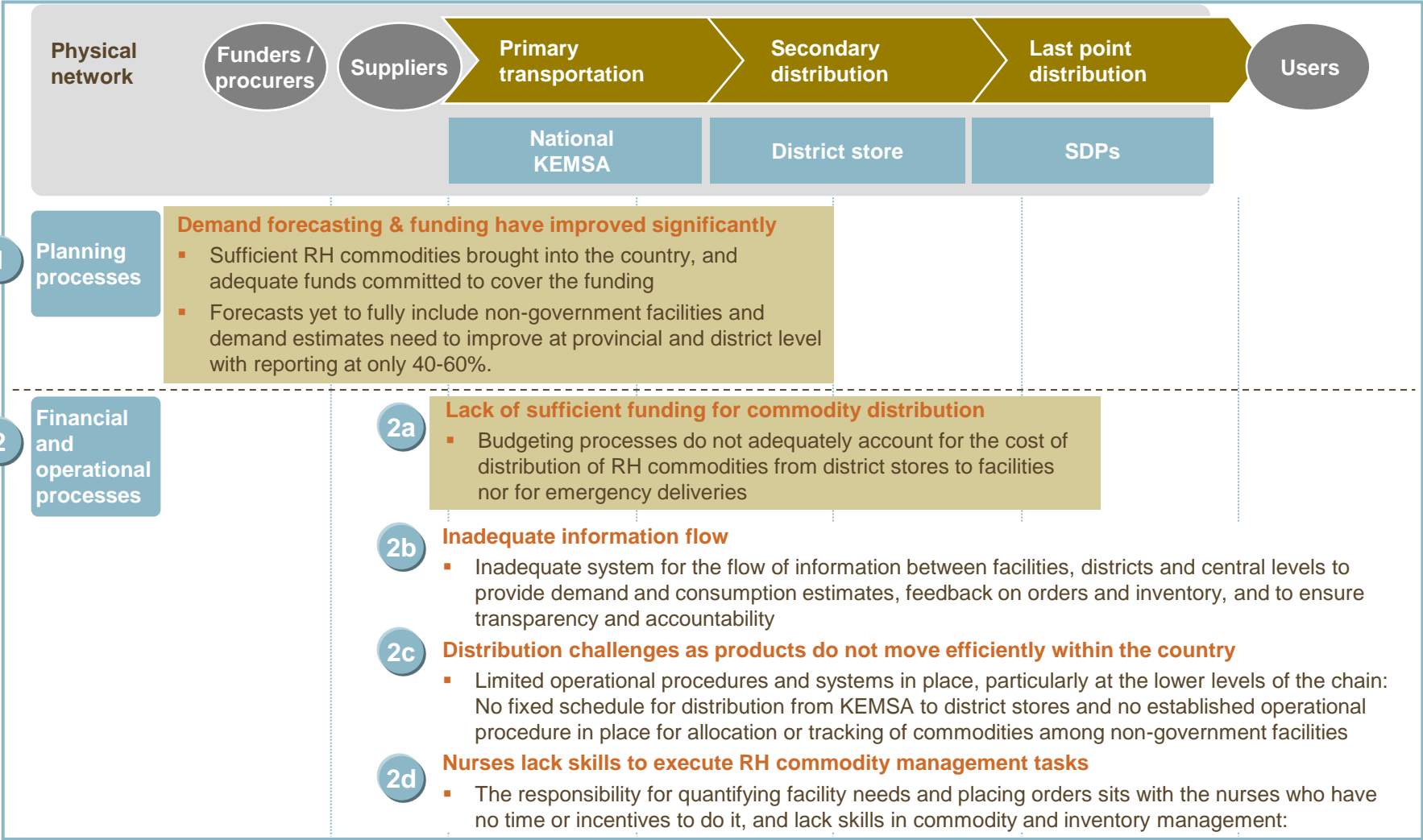
Many initiatives have already been launched and are starting to have impact, particularly in forecasting, funding and procurement. The majority of issues are now caused by distribution challenges

- **Forecasting, procurement and funding:** There appears to be sufficient RH commodities brought into the country and money committed to cover the funding: Yet, forecasting remains a top-down exercise as true demand signals from facility level cannot be gathered due to stock-outs and poor reporting rates
  
- **Distribution:** Several financial, operational and planning issues hamper commodity distribution
  - Lack of sufficient funding for commodity distribution: Budgeting processes do not adequately account for the cost of distribution of RH commodities (neither from KEMSA's central warehouse to government district stores and direct served facilities nor from district stores to facilities)
  - Inadequate information flow: There is an inadequate system for information to flow between facilities, districts and central level to provide demand and consumption estimates, feedback on orders and inventory, and to ensure transparency and accountability. Reporting rates from SDPs and district stores are <60% and often orders are rationalised<sup>1</sup> at central level without feedback to concerned facilities
  - Lack of operational procedures and systems in place: No fixed schedule for distribution from KEMSA to district stores. And at the district stores there is no established operational procedure in place for allocation of commodities between different non-government facilities, nor efficient tracking and monitoring of consumption, patient loads and orders
  - The responsibility for quantifying facility needs and placing orders sits with the nurses and RH coordinators who lack core skills in commodity and inventory management: Not only have many nurses and RH coordinator not been trained, but they also have limited capacity to fulfill orders for multiple programs. This places even more demand on already strained resources since nurses are typically the ones responsible for care-delivery.

# Public sector stock-outs are predominantly due to deficiencies in distribution and information management

Currently being addressed by key family planning stakeholders

Public sector family planning supply chain

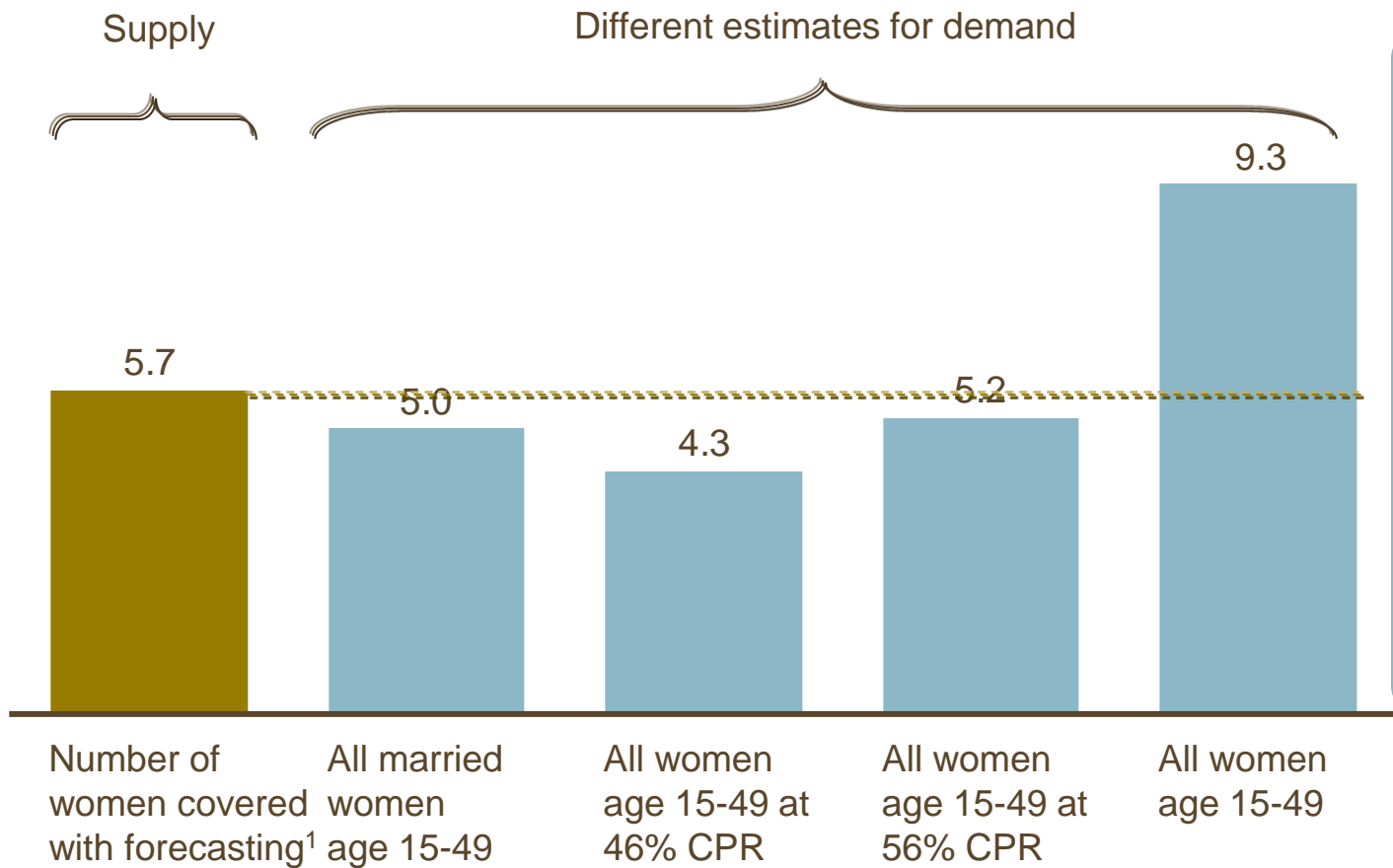


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1

# The forecasting appears to sufficiently cover the women with FP needs in Kenya, and with strong funding commitments

Forecasting, 2011/12, million women



**Funding**

- The RH technical and working committees have created a collaborative setting, where government and donors strategically agree on funding commitments
- For FY2011/12, government will cover the funding 100%

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<sup>1</sup> Number of women covered by the quantification, assuming 1 woman uses 120 condoms/year, 15 pills/year, 0.5 IUCD/year, 2 Cyclebeads/year, 0.2 implants/year, 4 injections/year and including 8% wastage

# 1 The quantification methodology is already advanced compared to peer countries, but could be strengthened further

## Best practice forecasting takes into account:



Demographic data	✓
Consumption data	✓
Impact on method mix from:	
– Urbanisation trends	✗
– Wealth trends	✗
– Demographics trends	✓
– Strategic plans	✓
Changes in public-private mix	✓
Ambitions to drive family planning	✓

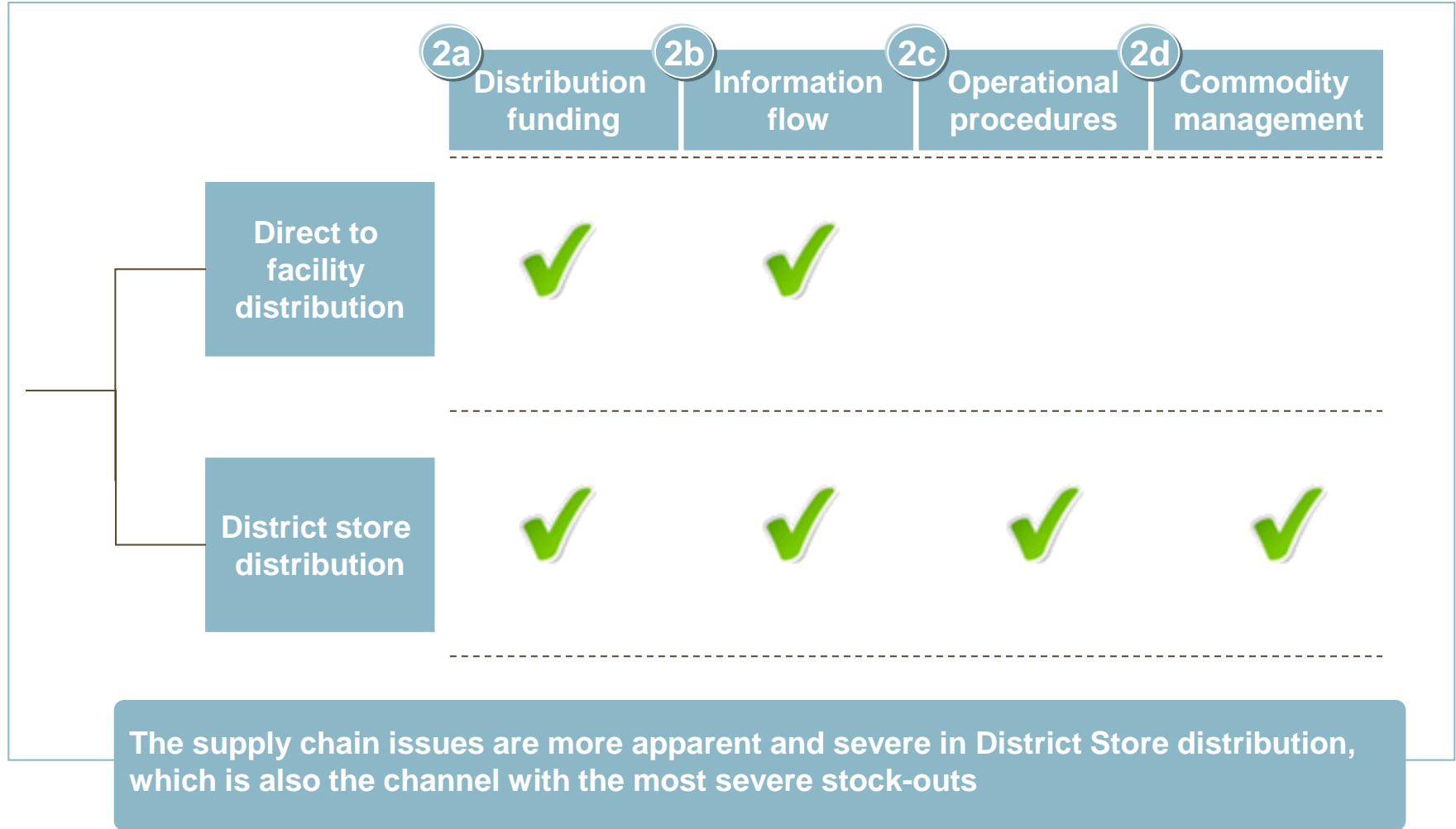
## Potential improvements

- Put more weight on capturing changes in key socio economic determinants for contraceptive usage
  - Urbanisation
  - Wealth
- Improve the quality (reporting rates, completeness and accuracy) of consumption data

## 2 The distribution issues identified manifest themselves differently by distribution channel

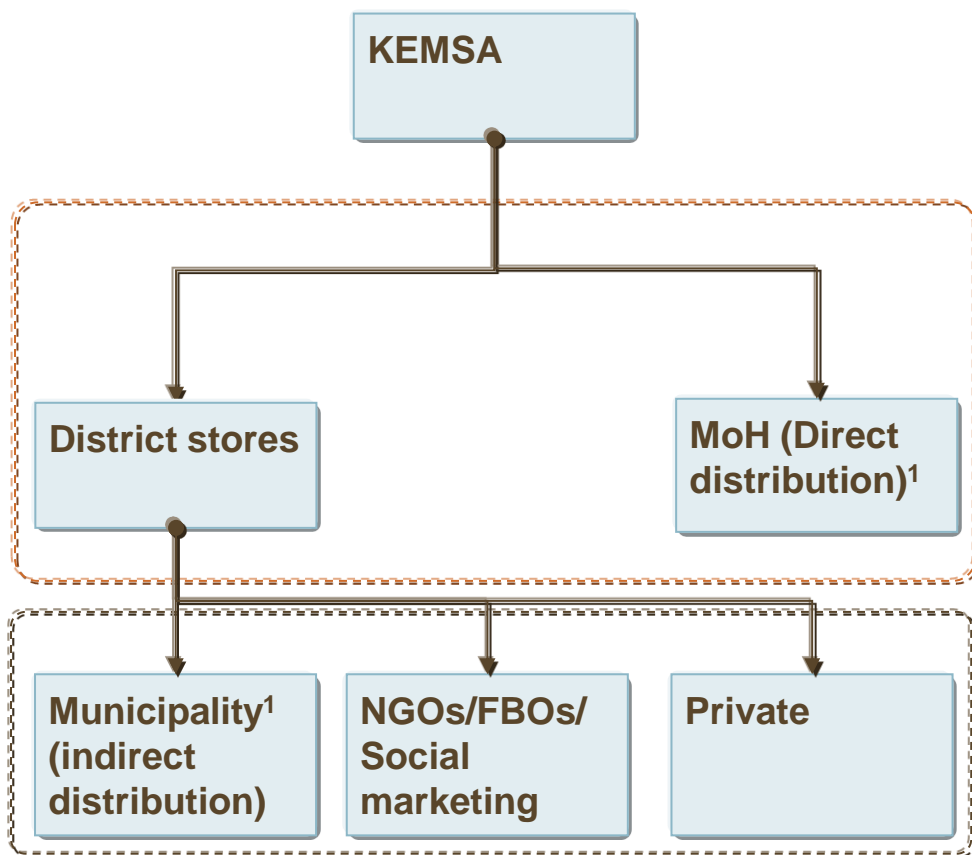
Issue ✓

Issues identified in the distribution chain by channel



## 2a Lack of funding for commodity distribution is hindering an effective distribution

“... funding for KEMSA’s operating cost budget is \$1.857 Million. This compares with \$1.365 Million of MEDS annual operating costs, which has a narrower scope of operations in terms of number of clients and volume of commodity throughout. KEMSA can never function well as a supply system if the agency is starved for operating funds...<sup>1</sup>”



DRH is however committed to raise their contribution to distribution costs. As part of taking over full commodity funding responsibility for RH commodities, DRH has also committed to ensuring 10% of commodity value is earmarked for distribution

There is no funding in place to ensure efficient distribution to facilities served under the District Stores

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<sup>1</sup> Evaluation of KEMSA in 2006 sponsored by USAID and DFID by Maggie Huff Rouselle

## 2b An unnecessarily complicated and disintegrated information system hinders two-way communication and feedback ...

### How current information system works

- **Direct to facility distribution:** Fill in the Standard order and Requisition form (SORF) quarterly, which is then reviewed by the District Pharmacist and sent directly to KEMSA, who can process the order. These facilities must also fill in the CDRR report and submit to the District RH coordinators, although no orders should be processed based on this form. Orders are only processed based on SORF
- **Direct Store distribution:** The SDPs under the District Stores must fill in the CDRR monthly, and it is the responsibility of the RH coordinators to consolidate the reports quarterly, and pass on the orders to DRH (exl. Direct distribution facilities). DRH must then authorise KEMSA to conduct a distribution to the District Stores

### Key issues

- **Delays or absence of reporting:** Many SDPs do not submit reports on time while others do not submit any reports at all
- **Significant inaccuracies in stocks and consumption level:** Many SDPs observed do not keep accurate inventory of stock or consumption levels
- **Data is not reviewed for completeness nor accuracy:** Data is not used centrally to improve performance
- **Districts often base their reports on SDPs that have reported:** Some districts will make an order for only those SDPs that have submitted a report, thus ensuring stock-outs at non-compliant clinics
- **There are no operational procedures for feedback cycles** with facilities when orders are modified at central level

KEMSA is in the process of defining a new LMIS system to address this information flow challenge

## ... especially for the facilities served under the District Store

### Orders and stock levels collected from each SDP ...

- Each SDP completes a monthly CDRR report which includes:
  - Order quantity
  - Stock levels
  - Consumption
  - Patients seen
- Order quantity based on 3 months consumption + buffer

### ... Orders are consolidated at district ...

- Each district collects the reports and consolidates them into a district level report
- This report is submitted to both KEMSA and DRH

### ... District orders consolidated into national data

- A team of 30 data clerks type up the orders to create a consolidated national report
- Data is however not reviewed for completeness nor accuracy

### ...DRH bases shipments on received orders ...

- A unit within DRH will decide on how big quantities to send to each facility served under the District Store
- DRH doesn't consult with the facilities when changing orders

### ... KEMSA will distribute commodities ...

- Once KEMSA has received a distribution list and funding from DRH, they will deliver the commodities to the facilities

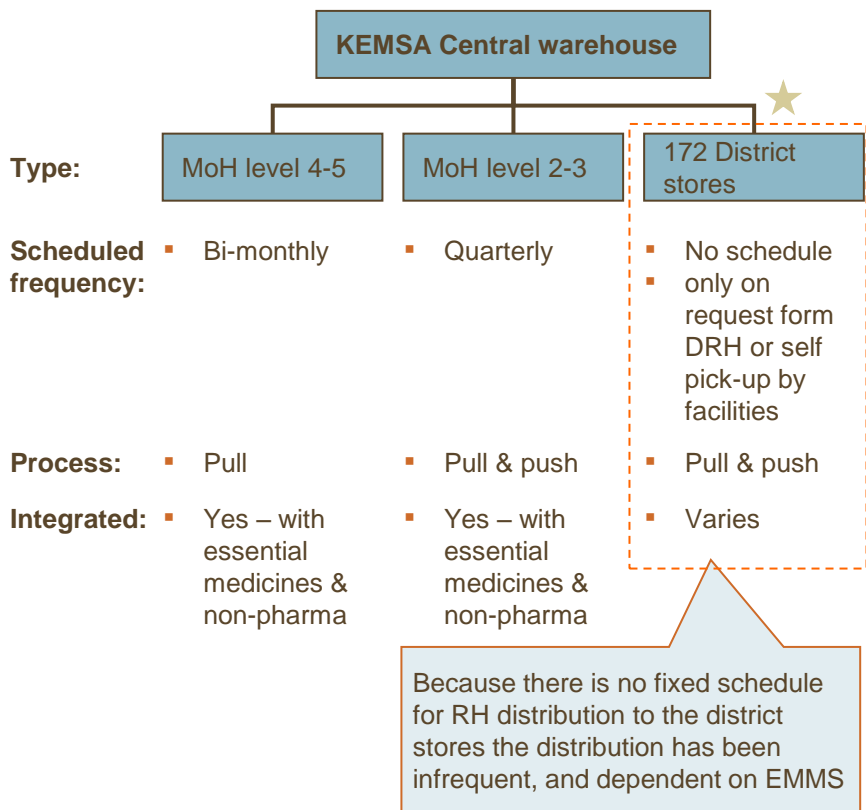
### Issues

- There are no operational procedures for feedback cycles with facilities when orders are modified at central level
- Further, all facilities visited during the course of this project, stated that they never knew the expected date and time for next delivery
- Very lengthy process before data is captured at national level

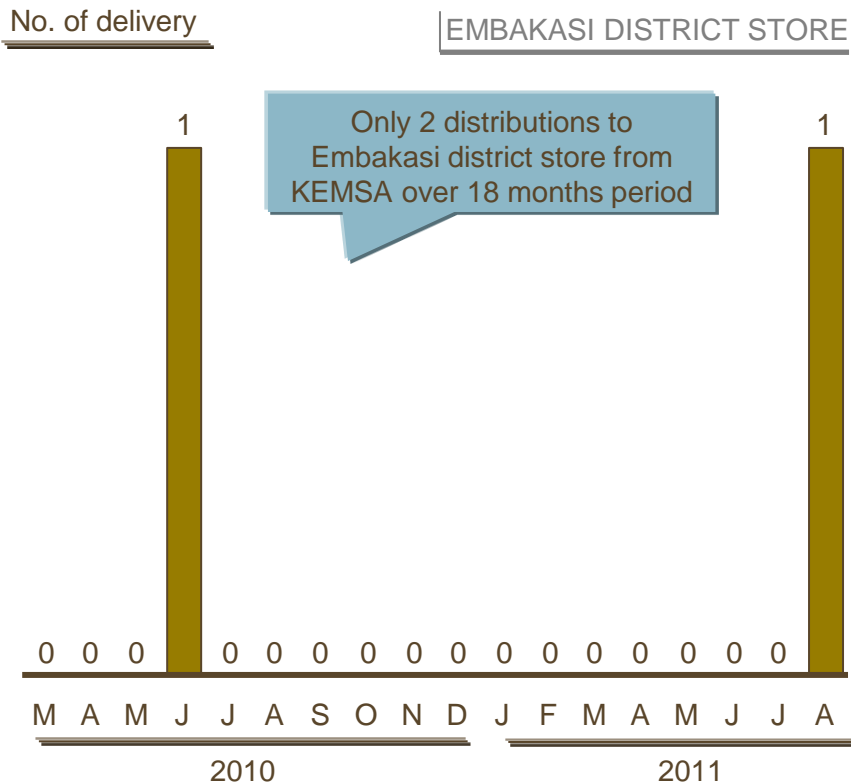
## 2c Primary distribution to district stores is a key stock-out driver as it's not planned on a fixed schedule like distributions to MoH's level 2-5 facilities

★ Issues

There are 3 types of service points



Examples of distributions from KEMSA to district stores



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2c

## There is a perceived lack of coordination between the two main actors (DRH & KEMSA) involved in distribution of commodities

PRELIMINARY

### Delivery of RH commodities is often late

“ We send the orders on time but we don't get the products on time. DRH and KEMSA need to better coordinate amongst themselves”

When we do not receive the commodities on time we do not know who to call. KEMSA? or DRH? Nobody contacts us to inform about the delay

”

### Lack of clarity on the roles and responsibility amongst DRH and KEMSA

“ There is a lot of confusion about what DRH is supposed to do and what KEMSA is responsible for – especially for the District Stores. For a long time, KEMSA did not receive a distribution list from DRH, and hence there were no deliveries to District Stores for almost a year

There appears to be a breakdown or lack of communication between DRH and KEMSA because there is not a central person with ties to both organisations to bind it all together like for other programs

”

### Greater need for KEMSA and DRH to take more of a leadership role

“ We don't do logistics. That's not our job. We pay KEMSA to manage the logistics.

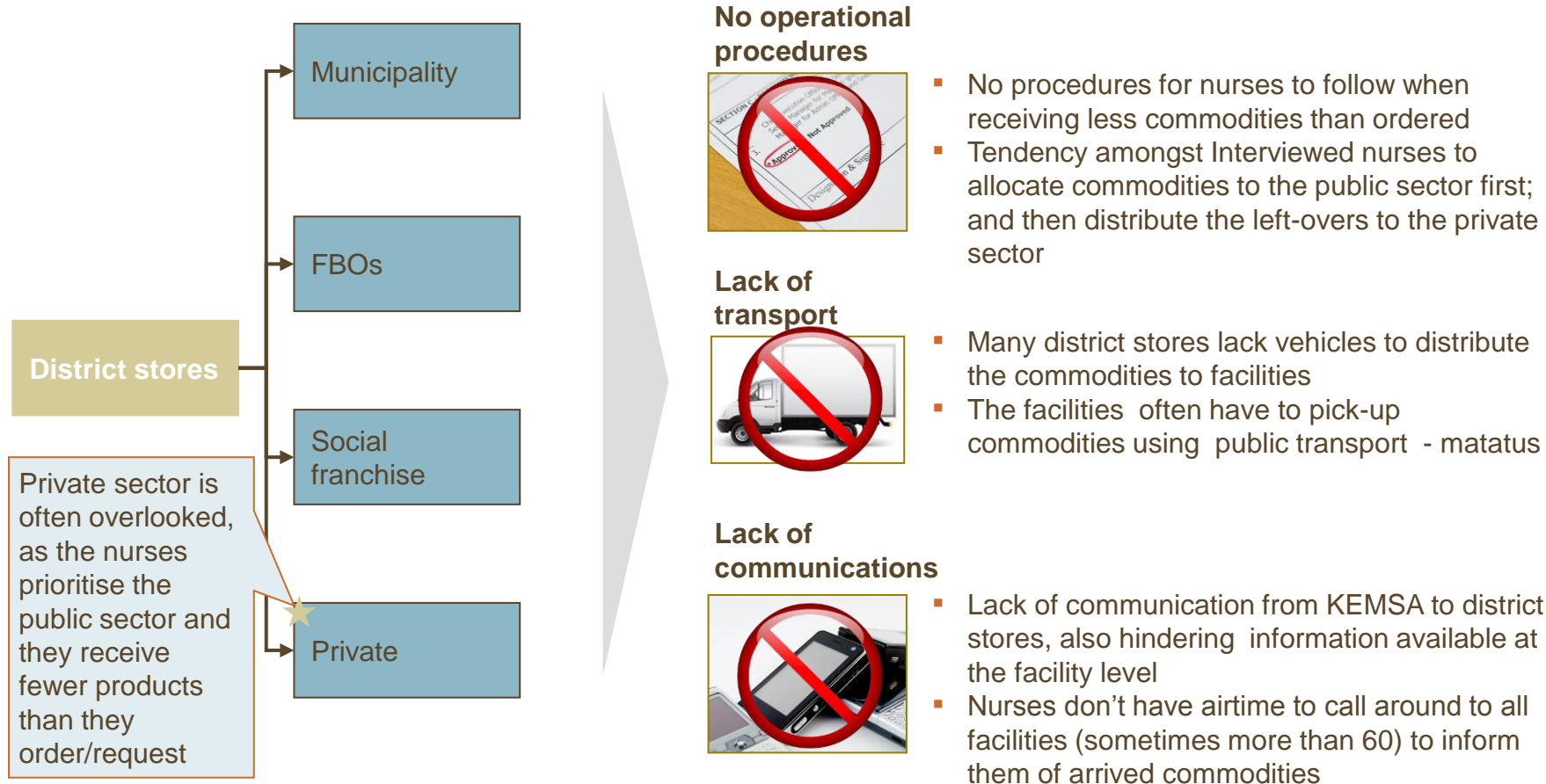
We can only do a delivery to the District Stores when DRH give us a distribution list. If we do not receive a list, we will not make a distribution. If, they miss the distribution for essential medicines, they must find more money to pay for a separate RH distribution

”

## 2c Lack of operational procedures for distribution from district stores to private and municipality facilities

★ Issues

Currently no system in place to manage distribution of FP commodities at final point

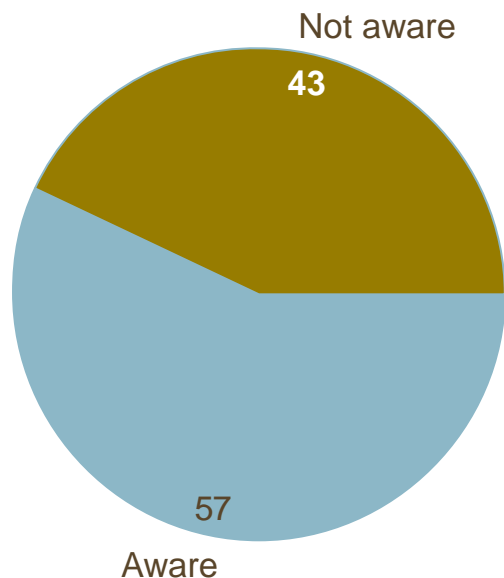


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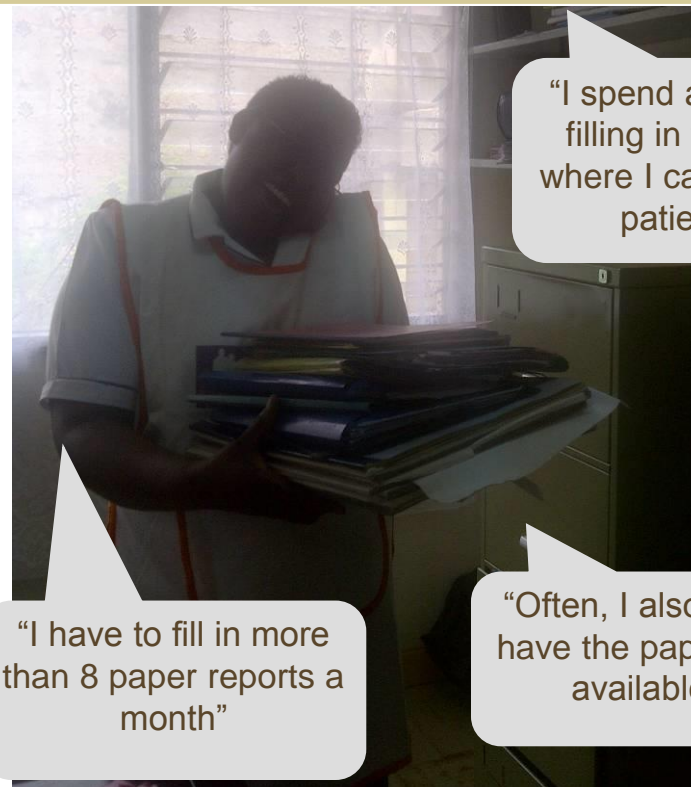
## 2d The responsibility for quantifying facility needs and placing orders sits with the nurses and District RH coordinators for whom commodity management is not part of their core skills

Few nurses are aware of the national supply chain system for FP ...

Share of nurses who aware of national supply chain system for FP  
Percent



... and there is high no. of paper forms to fill in which takes time away from service delivery



“I spend a full day filling in forms – where I cannot see patients”

“I have to fill in more than 8 paper reports a month”

“Often, I also don’t have the paper tool available”

# Contents

- Context
- Approach
- National contraceptives landscape
- Findings on stock-outs
- Supply chain diagnostic findings
- **Potential initiatives to improve the contraceptives supply chain**
- Potential roles for BMGF
- Back up



## Executive summary (5/6)

### Short term solution

- **Informed push model:** Tupange should ensure stock availability in the facilities they support by piloting an informed push model in which stock-on-hand at facilities and at district stores is tracked through mobile-based technology and commodities are re-distributed amongst facilities on an ongoing basis to ensure that there is always stock available at facilities

### Medium term solutions

- **Funding:** DRH has committed to allocate 10% of commodity cost to KEMSA for operating costs for the next 1-2 years. Nonetheless distribution from District Stores to facilities still remains an unaddressed issue, as it is beyond the scope of KEMSA. Funding from Government or donors is needed to close this funding gap. Several logistical options exist (1) outsource the responsibility to private distributors (2) arrange direct distribution to facilities (3) allocate a budget to either District Store or each facility
- **Information flow:** KEMSA has taken on the responsibility to develop a new LMIS system. The RH community should ensure that the RH tools are standardized, so facilities do not have to fill in both CDRR and SORF, and that the system allows for greater transparency on delivery dates and modified orders
- **Resolving the district store issue:** The two remaining issues (operational procedures and commodity management) manifest themselves more severely in the District Store distribution channel. How these issues are addressed will depend on what stakeholders elect to do with District Stores:
  - Bypass district stores and move selected or all facilities to direct distribution from KEMSA. This can be achieved fairly quickly with the support of KEMSA as working operational procedures are already in place.
  - Fix distribution to district stores. This will take more time as it requires developing SOPs and upskilling the district stores and their staff. The model should be evaluated via a district- or city-level pilot before implementing nationwide

## Executive summary (6/6)

Bypassing District Stores appears to be the fastest way to impact. This solution is further supported by the fact that KEMSA is looking to pilot a regional distribution model (with 3 regional warehouses) with more direct distribution to facilities in preparation for the county devolvement. This provides an opportunity to integrate the two pilots.

However, if the “*fix the District Store*” is the preferred solution, two initiatives must be undertaken:

- **Creating operational procedures:** the technical working committee and KEMSA should co-create Standard Operational Procedures (SOPs) for distribution from KEMSA to the District Stores, and onwards to the facilities. Such procedures could be piloted in select facilities (Tupange are willing to help with their supported facilities)
- **Strengthen commodity management:** the unclear split of responsibilities for commodity management between (1) the RH coordinators and the district pharmacists and (2) KEMSA and DRH must be addressed. Stakeholders should support a clear definition of roles and responsibilities and aim to establish the district pharmacist as the critical role in commodity management (as per DRH intentions) and to eliminate DRH involvement in regular ordering as is the case on direct served facilities today.

### Long term solutions

From interviews with stakeholders it became clear that there is not a clearly defined strategic role for the private sector in RH. Further investigation is needed to understand how the private sector could help reach CPR targets and ensure long-term financial sustainability. We recommend establishing a working group or commissioning an RFP to examine this

# Overall implementation roadmap

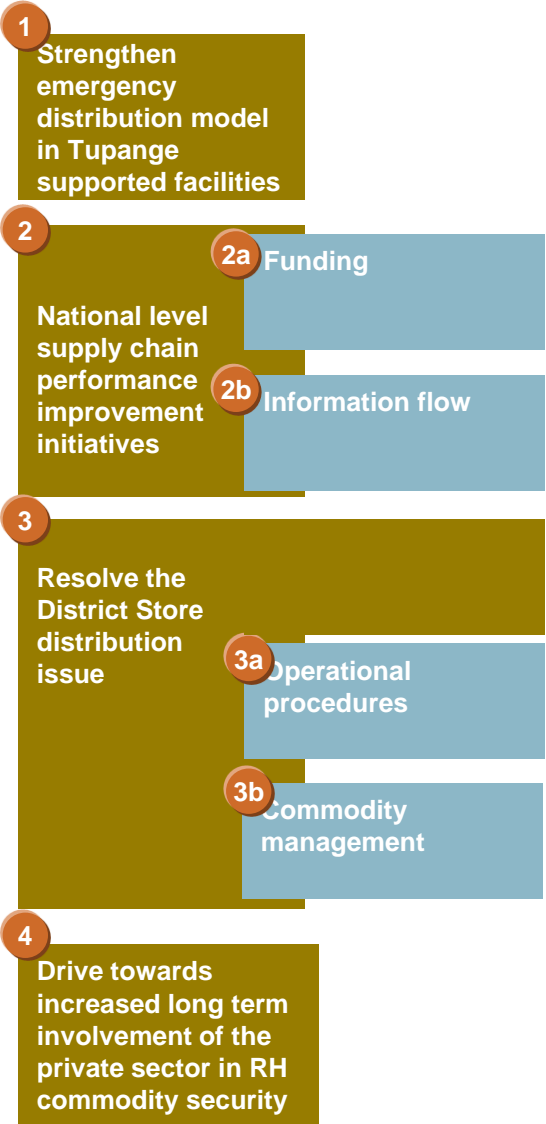
	Next 6 months	6-18 months	>18 months	Leader
<b>1</b> <b>Strengthen emergency distribution model in Tupange supported facilities</b>	<ul style="list-style-type: none"> <li>Continue implementation of emergency model in Nairobi, Mombasa, Kisumu</li> <li>Extend use of TSCT<sup>1</sup> System</li> <li>Track improvements</li> </ul>	<ul style="list-style-type: none"> <li>Roll out to more facilities in 3 target cities</li> </ul>	<ul style="list-style-type: none"> <li>Roll out to 2 additional cities</li> <li>Share model and learnings with other stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>DRH &amp; Tupange</li> </ul>
<b>2</b> <b>National level supply chain performance improvement initiatives</b>	<b>2a Funding</b> <ul style="list-style-type: none"> <li>DRH to allocate 10% of commodity cost to KEMSA for distribution. Track number of deliveries by channel</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate performance of distribution</li> <li>Reassess whether 10% is correct funding requirements</li> </ul>		<ul style="list-style-type: none"> <li>DRH &amp; KEMSA</li> </ul>
	<b>2b Information flow</b> <ul style="list-style-type: none"> <li>The RH commodity security committee to ensure representation in the KEMSA LMIS working group</li> </ul>			<ul style="list-style-type: none"> <li>KEMSA</li> </ul>
<b>3</b> <b>Resolve the District Store distribution issue</b>	<ul style="list-style-type: none"> <li>LAC: decide on distribution model to pilot (bypass vs. fix the District Store)</li> <li>Develop SOPs and pilot in Tupange supported cities</li> </ul>	<ul style="list-style-type: none"> <li>Track &amp; monitor performance</li> <li>Collect &amp; disseminate findings</li> <li>Prepare and start roll out nation wide (if successful)</li> </ul>	<ul style="list-style-type: none"> <li>Continue nation wide roll out</li> </ul>	<ul style="list-style-type: none"> <li>KEMSA &amp; Tupange</li> </ul>
	<b>3a Operational procedures</b> <ul style="list-style-type: none"> <li>Develop SOPs to improve distribution</li> <li>Implement new SOPs</li> </ul>	<ul style="list-style-type: none"> <li>Track &amp; monitor performance</li> <li>Collect &amp; modify SOPs based on findings</li> </ul>		<ul style="list-style-type: none"> <li>Technical working committee</li> </ul>
	<b>3b Commodity management</b> <ul style="list-style-type: none"> <li>Develop new job descriptions and training materials</li> <li>Roll out pilots in Tupange supported facilities</li> </ul>	<ul style="list-style-type: none"> <li>Track &amp; monitor performance</li> <li>Collect &amp; disseminate findings</li> <li>Prepare and start roll out nation wide (if successful)</li> </ul>		<ul style="list-style-type: none"> <li>Technical working committee</li> </ul>
<b>4</b> <b>Drive towards increased long term involvement of the private sector in RH commodity security</b>	<ul style="list-style-type: none"> <li>Establish a working group of DRH, KEMSA and private stakeholders to propose a detailed strategy</li> </ul>	<ul style="list-style-type: none"> <li>Design a pilot study to test feasibility of proposed strategy</li> <li>Evaluate performance and prepare roll out</li> </ul>	<ul style="list-style-type: none"> <li>Start roll out</li> </ul>	<ul style="list-style-type: none"> <li>TBD</li> </ul>

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<sup>1</sup> TSCT: Tupange SMS Commodity Tracking System

# Status of ownership of initiatives

- ✓✓ High degree of commitment and capability
- ✓ Commitment and capabilities in place but significant roadblock to be removed
- ✗ Low degree of commitment and capability



Leader	Status	Description
<ul style="list-style-type: none"> <li>▪ Tupange</li> </ul>	✓ ✓	<ul style="list-style-type: none"> <li>▪ Tupange is already in the process of implementing the emergency distribution model</li> <li>▪ They appear to have the commitment and capability to coordinate the emergency model to ensure a significant decrease in stock outs in their facilities</li> <li>▪ Still need for strengthening of their performance management system to inform initiatives and track impact</li> </ul>
<ul style="list-style-type: none"> <li>▪ DRH</li> </ul>	✓ ✓	<ul style="list-style-type: none"> <li>▪ DRH has publicly stated that they are committed to allocated 10% of commodity costs</li> </ul>
<ul style="list-style-type: none"> <li>▪ KEMSA</li> </ul>	✗	<ul style="list-style-type: none"> <li>▪ Still in the early phases, and the pace and ambition for the changes are not yet clear</li> </ul>
<ul style="list-style-type: none"> <li>▪ KEMSA &amp; Tupange</li> </ul>	✓	<ul style="list-style-type: none"> <li>▪ Request from DRH to present suggested solutions at LAC meeting for decision making on which solution to pilot</li> <li>▪ KEMSA is interested in discussing a pilot with Tupange</li> </ul>
<ul style="list-style-type: none"> <li>▪ Technical working committee</li> </ul>	✓	<ul style="list-style-type: none"> <li>▪ MSH already started work on SOPs, which can serve as a starting point</li> <li>▪ Tupange will be able to contribute with perspective on managing the process and content</li> <li>▪ Commitment from KEMSA is still TBD</li> </ul>
<ul style="list-style-type: none"> <li>▪ Technical working committee</li> </ul>	✓	<ul style="list-style-type: none"> <li>▪ DRH is committed to see the transfer happen in reality, as the memorandum has been circulated for months now with no clear results, as it has not been followed up with an implementation plan</li> </ul>
<ul style="list-style-type: none"> <li>▪ TBD</li> </ul>	✗	<ul style="list-style-type: none"> <li>▪ Leadership is needed from the government. It is not yet clear which role they wish to take</li> <li>▪ Higher level of commitment from the private sector and social marketing, but they have not yet been able to get the government on board</li> </ul>

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# 1 To address immediate needs, Tupange is launching an emergency model, which they should continue to strengthen

Already implemented ✓  
Not in place yet ✗

<b>Product</b>	<ul style="list-style-type: none"> <li>▪ Ensure RH commodity availability for Tupange supported facilities through:             <ul style="list-style-type: none"> <li>– Access to MSK/PSI/FHOK/IFPP own imported commodities ✓</li> <li>– Re-distribution within facilities and District Stores ✓</li> <li>– Agreement with KEMSA/DRH, where Tupange can pick up commodities directly at Central Warehouse ✓</li> </ul> </li> </ul>
<b>Distribution</b>	<ul style="list-style-type: none"> <li>▪ Ensure commodities reach facilities:             <ul style="list-style-type: none"> <li>– Tupange has 1 commodity security officer in each city with responsibility for physical distribution of commodities to facilities in case of stock-out/low stock ✓</li> <li>– Dedicated vehicle ✗</li> </ul> </li> </ul>
<b>Training of facility staff</b>	<ul style="list-style-type: none"> <li>▪ Train facility staff on commodity management and use of SMS reporting system (TSCT System) ✓</li> </ul>
<b>Performance management</b>	<ul style="list-style-type: none"> <li>▪ Reports from facilities on <u>end of month stock levels</u> through TSCT System ✓</li> <li>▪ Reports from facilities on <u>low stock or out of stock as they occur</u> through TSCT System ✗</li> <li>▪ Establish scorecard on supply levels and demand that is circulated every 2 weeks ✗</li> </ul>

**High impact:**  
Potential to drive stock-outs to <10% in Tupange supported facilities

**Low cost:** 1 person + car investment required for each city

**Easy to run:** Three cities are ~150 SDPs (increasing to ~200 in 2012), requiring 3 small vans / 4x4's

**In addition to addressing immediate Tupange needs, this pilot will:**

- Provide a reliable basis to understand demand (CPR, method mix, public-private mix) using the TSCT System

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# 1 Tupange should strengthen the performance management aspect of their model to track impact

Additional steps needed to strengthen informed push model

## Example of facility level dashboards

### Proposed dashboard

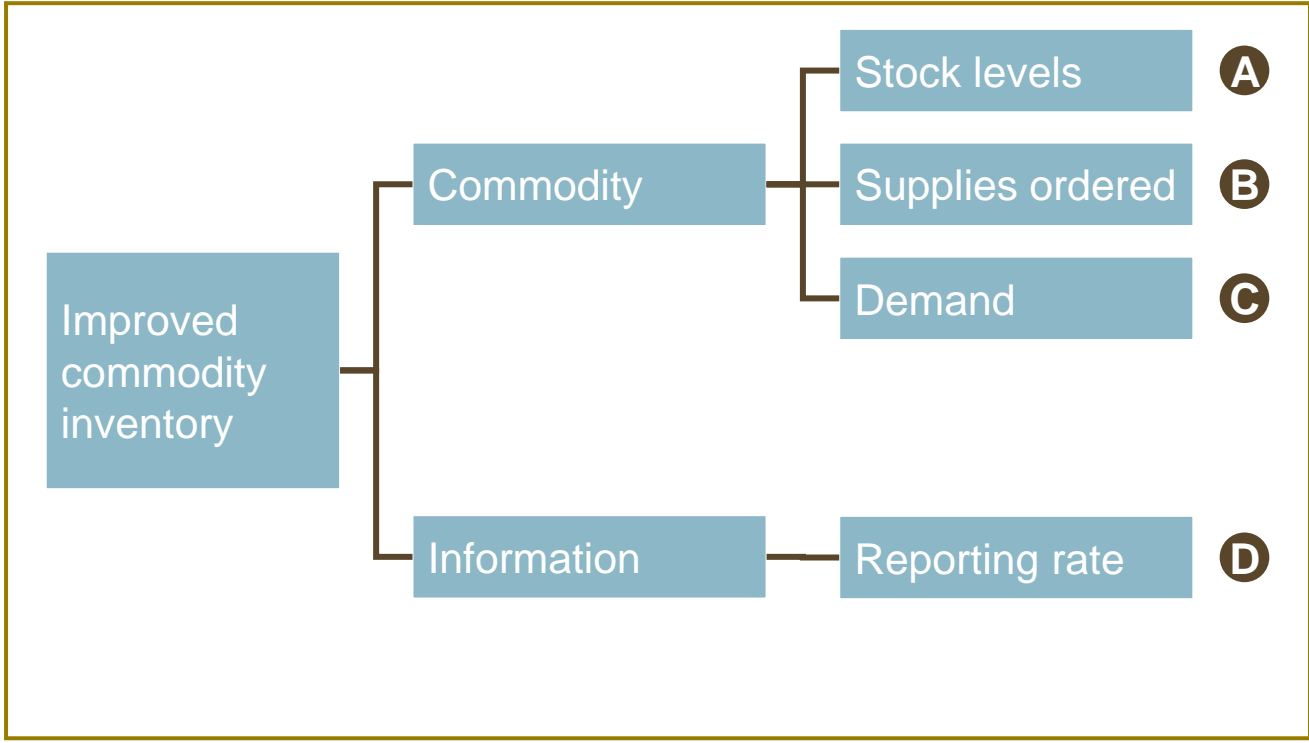
- On track
- Potential issues
- Urgent issues

Area	Description of KPI	Measurement		
<b>A</b> Stock levels	▪ # of units in stock <sup>1</sup>	<span style="color: green;">●</span> 3-4 months of stock	<span style="color: yellow;">●</span> 1-2 months of stock	<span style="color: red;">●</span> <1 month stock
	▪ Forecasted stock	▪ TBD	▪ Re-distribution: >4 months of stock ▪ TBD	▪ TBD
<b>B</b> Supplies ordered	▪ Fulfillment rate	<span style="color: green;">●</span> 0% deviation	<span style="color: yellow;">●</span> 20% deviation	<span style="color: red;">●</span> >20% deviation
	▪ Lead time from KEMSA – by type of facility, and distribution of lead time	<span style="color: green;">●</span> 0-3 months	<span style="color: yellow;">●</span> 3-4 months	<span style="color: red;">●</span> > 4 months
<b>C</b> Demand	▪ # of patients seen by method	<span style="color: green;">●</span> More than average of previous 3 months	<span style="color: yellow;">●</span> Same or 20% less than average of previous 3 months	<span style="color: red;">●</span> More than 20% less than average of previous 3 months
<b>D</b> Reporting rate	▪ # of reports submitted	<span style="color: green;">●</span> 90-100%	<span style="color: yellow;">●</span> 70-89%	<span style="color: red;">●</span> <70%
	▪ Completeness of report	<span style="color: green;">●</span> 100%	<span style="color: yellow;">●</span> 80-99%	<span style="color: red;">●</span> <80%
	▪ Accuracy of report	<span style="color: green;">●</span> 0% deviation	<span style="color: yellow;">●</span> 1-20% deviation	<span style="color: red;">●</span> >20% deviation
	▪ Timely submission of report	<span style="color: green;">●</span> On time	<span style="color: yellow;">●</span> 1-2 days late	<span style="color: red;">●</span> >2 days late

Establish dashboard on supply levels and demand that is circulated every 2 weeks to track performance of the system and document impact for later dissemination

1

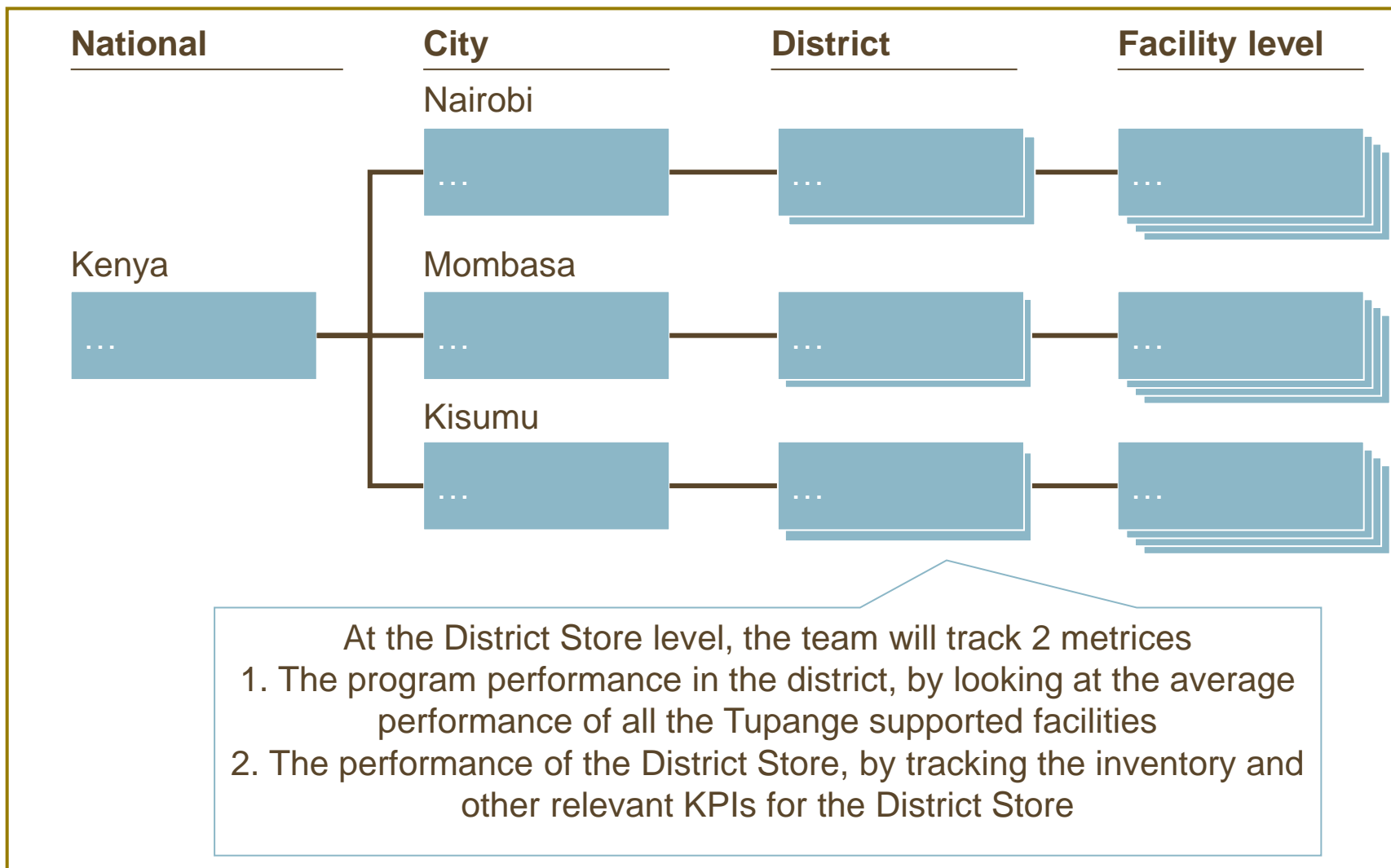
# The commodity security team will track performance of the Key Performance Indicators (KPIs)






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1

## The KPIs have been designed to be informative at all relevant levels of the supply chain



# 1 Example of proposed KPIs

-  On track
-  Potential issues
-  Urgent issues

Area	Description of KPI	Measurement		
<b>A</b> Stock levels	▪ # of units in stock <sup>1</sup>	 3-4 months of stock	 1-2 months of stock	 <1 month stock
	▪ Forecasted stock	▪ TBD	▪ Re-distribution: >4 months of stock ▪ TBD	▪ TBD
<b>B</b> Supplies ordered	▪ Fulfillment rate	 0% deviation	 20% deviation	 >20% deviation
	▪ Lead time from KEMSA – by type of facility, and distribution of lead time	 0-3 months	 3-4 months	 > 4 months
<b>C</b> Demand	▪ # of patients seen by method	 More than average of previous 3 months	 Same or 20% less than average of previous 3 months	 More than 20% less than average of previous 3 months
<b>D</b> Reporting rate	▪ # of reports submitted	 90-100%	 70-89%	 <70%
	▪ Completeness of report	 100%	 80-99%	 <80%
	▪ Accuracy of report	 0% deviation	 1-20% deviation	 >20% deviation
	▪ Timely submission of report	 On time	 1-2 days late	 >2 days late


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<sup>1</sup> To be calculated based on previous months # of patients seen

## 2 Regardless of the distribution channel, two issues must be addressed: *'Funding'* and *'information flow'*

Deep dive 

Issues identified in the distribution chain by channel

		Funding	Information flow	Commodity management	Operational procedures
	Direct to facility distribution	✓	✓		
	District store distribution	✓	✓	✓	✓

**Across both distribution channels, 'funding' and 'information flow' are challenges that needs to be addressed to improve the overall functionality of the supply chain**

## 2a The DRH has promised to allocate sufficient funding for distribution

### Current funding situation

- **KEMSA receives ~ 5% of commodity value for logistics across all commodities**
  - Not sufficient funding to make all scheduled deliveries to facilities and districts
  - Often have to combine deliveries across programs to fund the distribution. This means that one of the programs will not follow own or integrated schedule, but will have to postpone delivery dates and sometimes quantities due to space restrictions

### New funding situation

- **KEMSA will receive 10% of commodity cost from DRH, as requested:**
  - Ensure that stock will be delivered to the district and facility level according to integrated schedule with essential medicines
  - Ensure that emergency orders can be delivered in case of stock-outs or if integrated delivery with essential medicines was missed
  - Use the provincial customer service team to ensure facilities and District Stores are aware of upcoming deliveries and can plan accordingly

**Likely result is a more deliveries to facilities and District Stores**

**2a) Several logistical options exist to distribute the commodities from District Store, yet funding from either the Government or donors is needed**

**Options for distribution from District Stores to facilities**

<b>I</b>	<b>Outsource the responsibility of last mile distribution to private distributors</b>	<ul style="list-style-type: none"><li>▪ The private distributors already have a distribution network in place and could easily handle the last mile distribution, as they already distribute essential medicines to all the private facilities</li></ul>
<b>II</b>	<b>Arrange budget for direct KEMSA distribution to facilities</b>	<ul style="list-style-type: none"><li>▪ Extend the number of facilities that receive direct distribution from KEMSA to include facilities under the District Store</li></ul>
<b>III</b>	<b>Allocate a budget to either the District Store or to each facility to arrange for their own distribution</b>	<ul style="list-style-type: none"><li>▪ Allocate a budget either centrally to the District Store or de-centrally to the facilities so they can arrange efficient distribution in a timely manner to avoid unnecessary lead time from the time commodities arrive at the District till they are available at the facilities</li></ul>

**Common for all three options is that funding is needed to address the issue**

Working Draft - Last Modified 2011/11/20/08:08:33:47 AM Printed 2011/11/20/08:08:41:46 PM

## 2b The RH community must work closely with KEMSA to ensure that changes to the LMIS system offer a platform for better information flow

### Opportunities to improve information flow

### Next steps

1 Ease the reporting burden at the facility level, and integrate the SORF and CDRR

- Align between DRH and KEMSA on:
  - Data points to collect
  - The time period for reporting (monthly, quarterly, bi-annually?)
- Pilot new reporting tool
- Accelerate implementation if successful

2 Decrease the time-lag from submission till registration at central level by:

- Define number of required data clerks and cost the solution
- Assess the possibilities for electronic reporting for facilities with IT equipment (esp. for private sector) to speed up data capturing

- Hiring more data clerks
- Allow for electronic reporting of data

3 Use data to actively manage performance by identifying KPIs that will allow timely reaction to stock-outs and establish group to manage them and provide/receive feedback from the facility and district levels

- Assess possibility to create a dedicated central team to manage KPIs and initiate actions based on data – ideally team is integrated across various programs

### 3 The two remaining issues manifest themselves more severely in District store distribution which present an opportunity to re-consider the distribution design

Issues identified in the distribution chain by channel



	Funding	Information flow	Commodity management	Operational procedures
Direct to facility distribution	✓	✓		
District store distribution	✓	✓	✓	✓

There are two design options to address the remaining issues:

- I **By-pass the District Stores** and move selected or all facilities to direct distribution from KEMSA. This can be achieved fairly quickly with the support of KEMSA, as working operational procedures and ordering are already in place
- II **Fix the distribution to District Stores.** This will be a longer process as it requires developing SOPs and up-skilling the District Stores and their staff to improve commodity management.

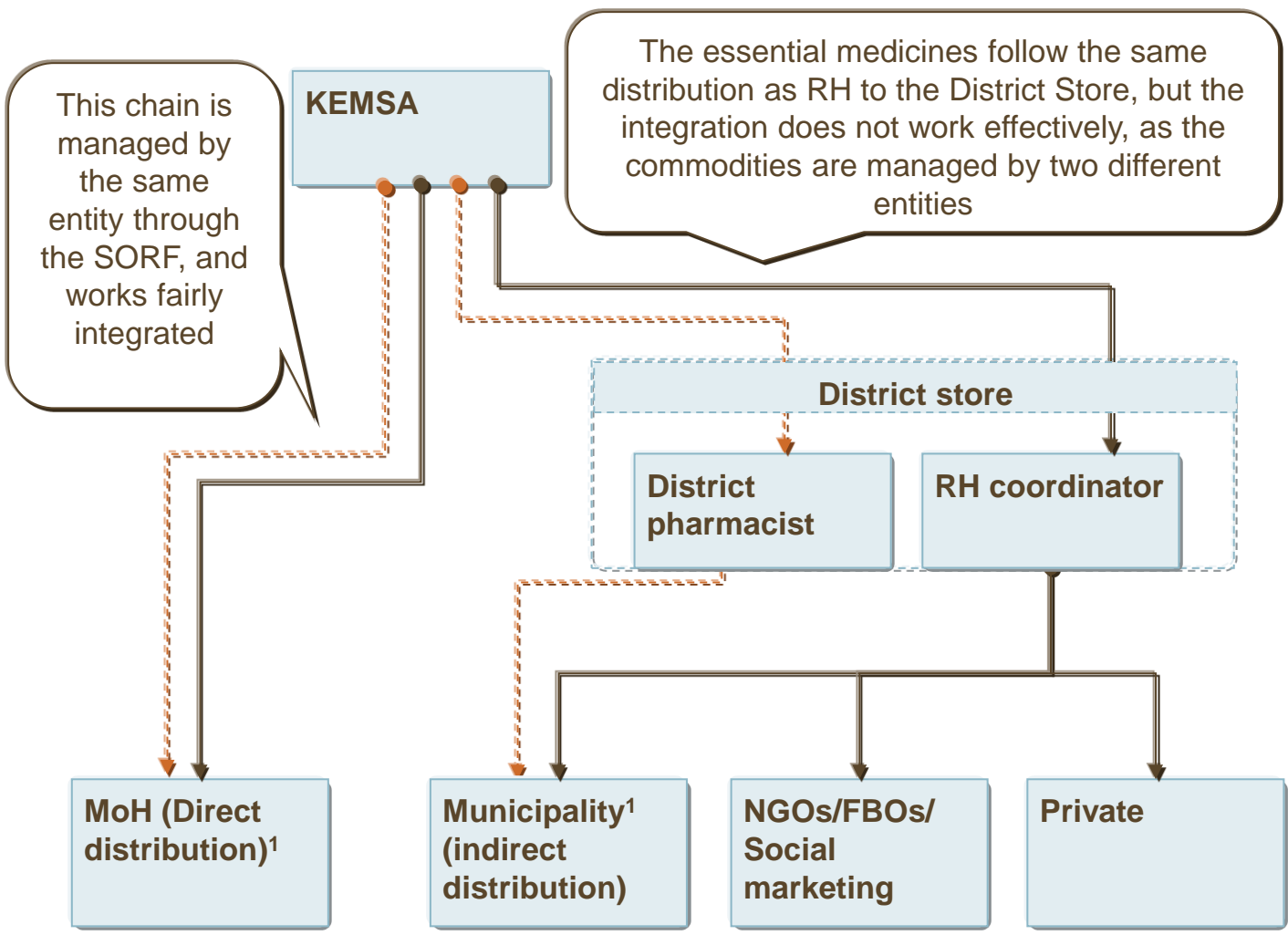
Working Draft - Last Modified 2011/11/20/08:08:33:47 AM Printed 2011/11/20/08:41:46 PM

### 3 Any suggested changes to the RH supply chain must consider the impact on the essential medicines supply chain

RH   
 Essential medicines 

#### Integration

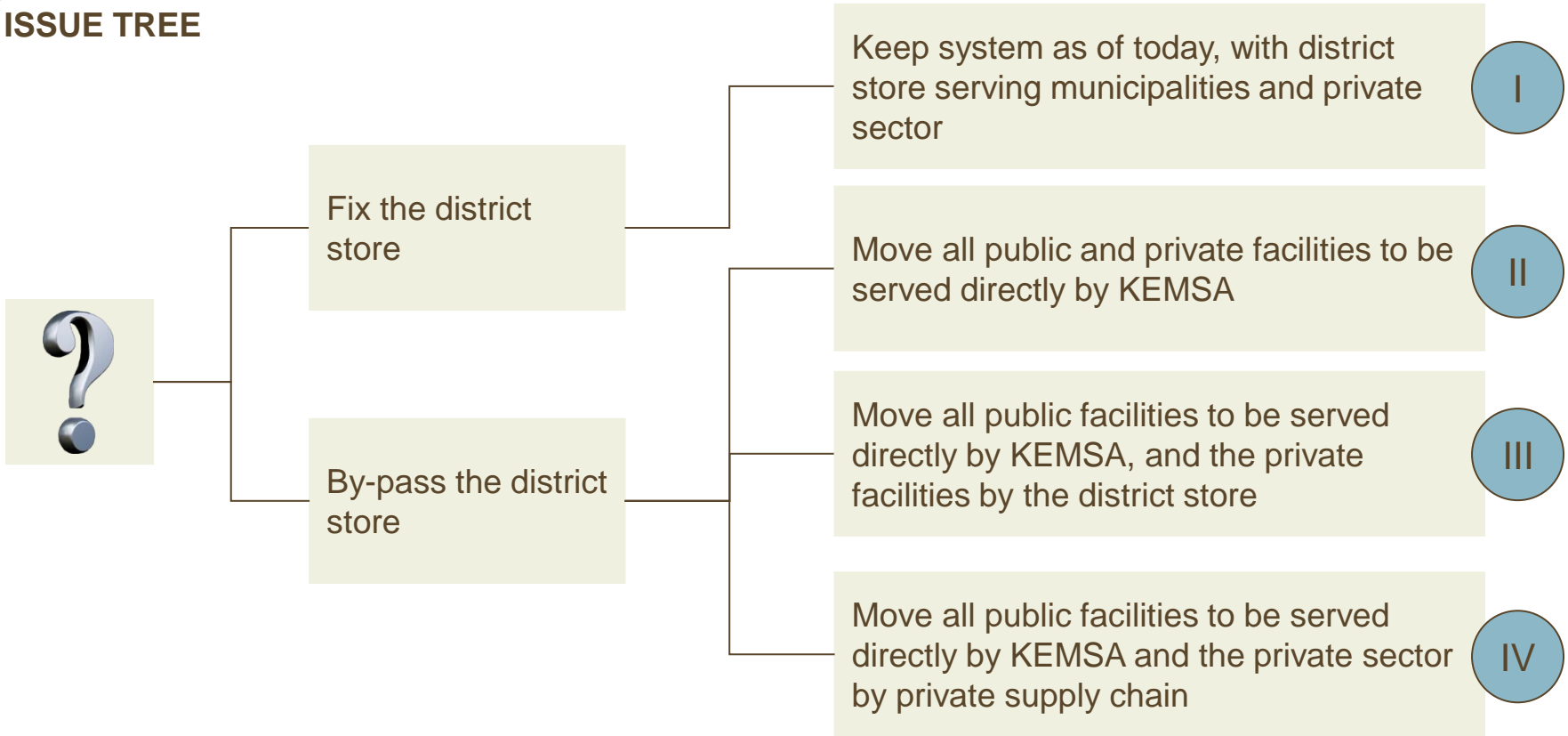
- RH commodities and essential medicines are supposed to be integrated in the distribution
- However the integration does not work optimally at all levels of distribution, as there are several examples of essential medicines being distributed without RH commodities and vice versa (especially in distribution to district store)
- The changes made in the distribution model for the RH supply chain must consider the impact on the essential medicines supply chain to minimise disruptions



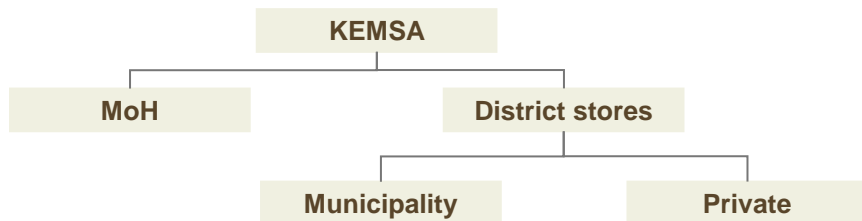
### 3 Options for possible solutions for integrated RH/essential medicines distribution

**Objective:** To ensure that the public facilities currently served under the district store improve their RH commodity security

#### ISSUE TREE



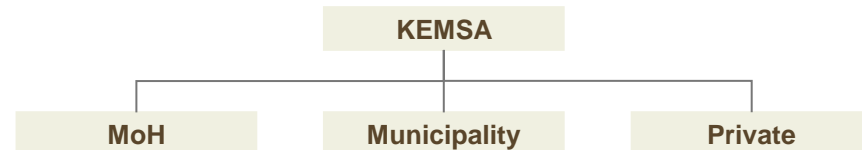
### I A hybrid - 'Fix the district store'



#### Description

- Keep design as today
- Fix the distribution to district stores

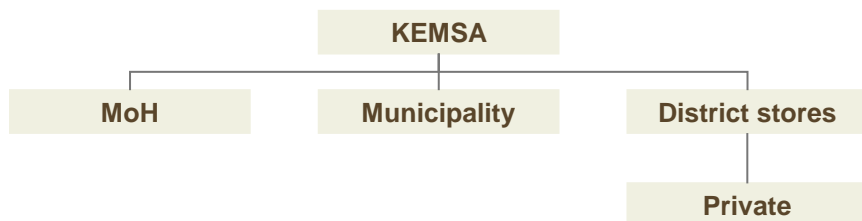
### II Fully integrated - 'By-pass the district store'



#### Description

- By-pass the district store
- Ensure all facilities are served directly by KEMSA

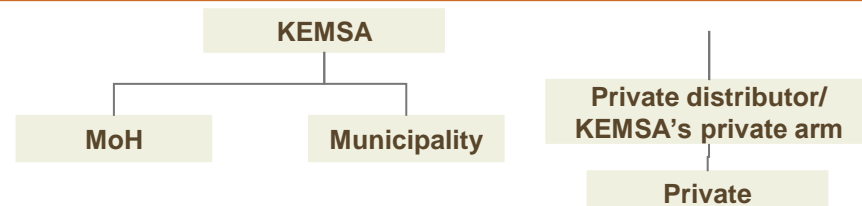
### III Separated and public - 'Direct distribution to all public facilities and keep district store for private facilities'



#### Description

- Ensure all public facilities are served directly by KEMSA
- Keep district store to manage flow of commodities to the private sector

### IV Separated and private - 'Direct distribution to all public facilities and privatize the distribution to private facilities'



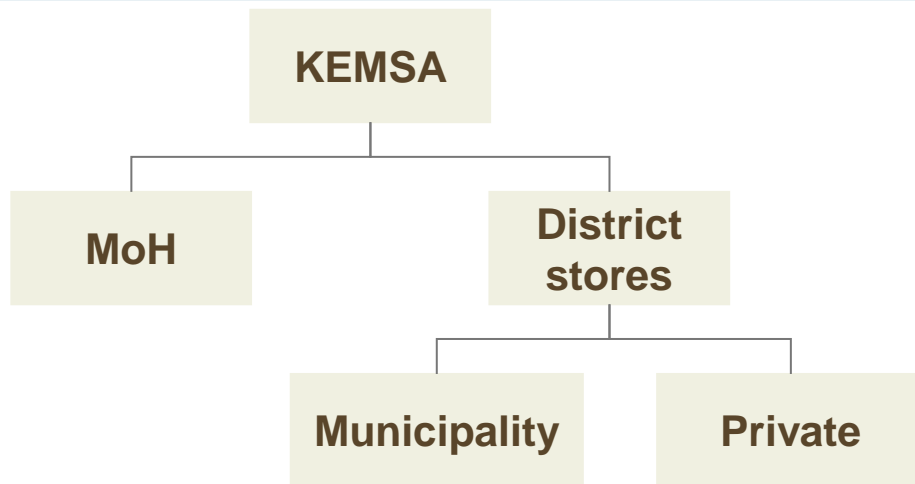
#### Description

- Ensure all public facilities are served directly by KEMSA
- By-pass district store
- Contract 3<sup>rd</sup> party to manage the distribution to the private sector or let KEMSA's commercial arm handle this distribution<sup>1</sup>

<sup>1</sup> Still unknown when the commercial arm is operational

## I A hybrid - 'Fix the district store'

### Description



- Keep structure as today
- Focus on fixing the distribution to the District stores to ensure a healthy influx of RH commodities and inventory levels

### Pro

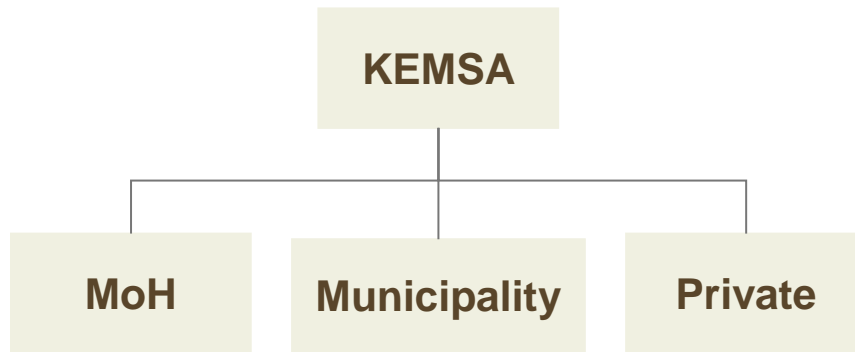
- No need for policy changes, as design is unchanged

### Con

- The system has not worked until now
- Requires fundamental changes in the SOPs for KEMSA to District store distribution
- Would still require creation of SOPs for distribution between Municipality and private facilities

## II Fully integrated - *‘Eliminate the district store’*

### Description



- Eliminate the district store
- Include all private and public facilities to be served directly by KEMSA on either bi-monthly or quarterly basis – depending on size of facility

### Pro

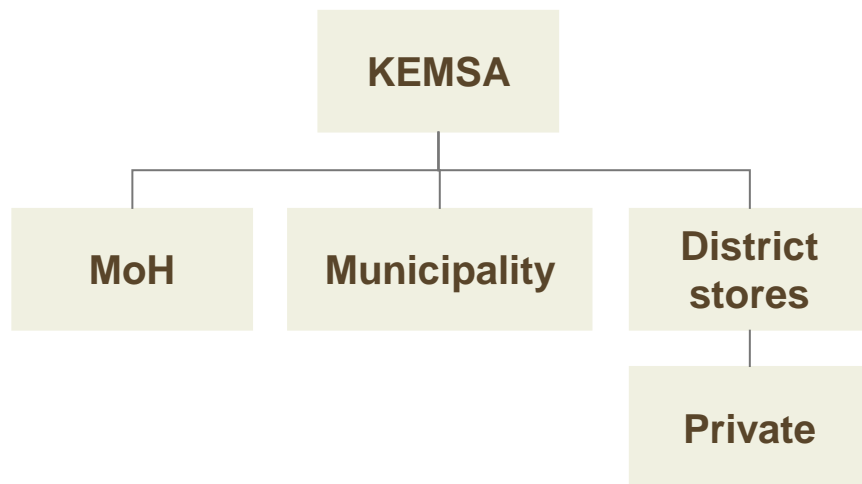
- Simplifies the system, as there are no “middle-men”

### Con

- Policy change needed to close the district store
- Transition period expected for full implementation
- Significant no. of service points for KEMSA (>4100 registered SPDs today)
- Increased distribution costs

### III Separated and public - *'Direct distribution to all public facilities and keep district store for private facilities'*

#### Description



- Include all public facilities to be served directly by KEMSA on either bi-monthly or quarterly basis – depending on size of facility
- Keep district store to manage flow of commodities to the private sector

#### Pro

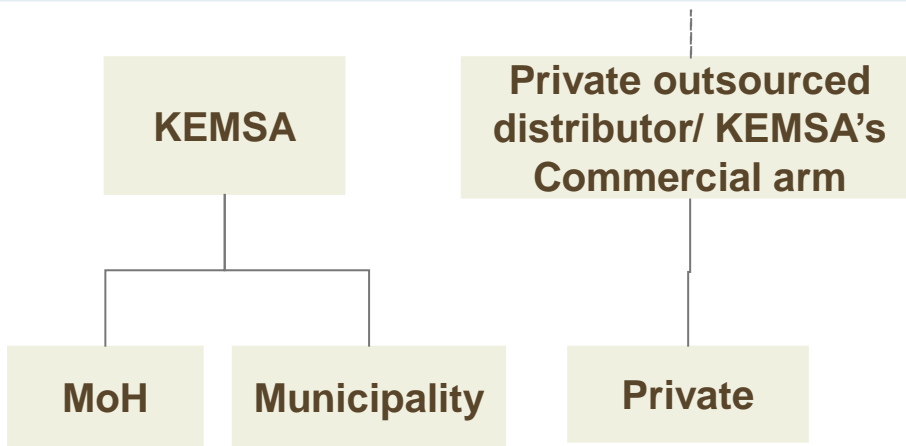
- Simplifies the system for the public facilities, as there are no “middle-men”
- Keep a single point of contact for private sector
- There will be a natural place to keep buffer stock close to facilities by keeping the District store
- Limits the distribution costs as no. of delivery points are kept at manageable level

#### Con

- Still need to fix the distribution from KEMSA to the District stores to ensure product availability in the private sector
- Would still require SOPs for distribution from District store to private facilities

## IV Separated and private - ‘Direct distribution to all public facilities and privatise the distribution to private facilities’

### Description



- Include all public facilities to be served directly by KEMSA on either bi-monthly or quarterly basis – depending on size of facility
- Eliminate district store
- Contract 3rd party to manage the distribution to the private sector or let KEMSA's commercial arm handle this distribution

### Pro

- Simplifies the system for the public facilities, as there are no “middle-men”
- Limits the distribution costs as no. of delivery points are kept at manageable level
- Create a total market based approach with a financially viable private sector

### Con

- Can limit the control with “*what happens*” in the private sector (cost to patients, no. of patients seen, quality of services offered etc.)
- No single point of contact in the districts for buffer stock etc.

# 3 A number of key factors should be considered before deciding on a solution

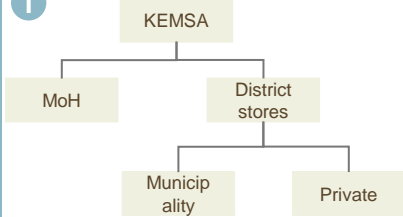
## What would you need to believe?

### Solution

### Impact on stock-outs

### Resourcing

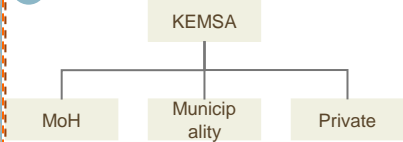
I



- DRH/KEMSA can improve the operational procedures for the distribution to District Stores and last-point distribution

- Cost neutral distribution costs

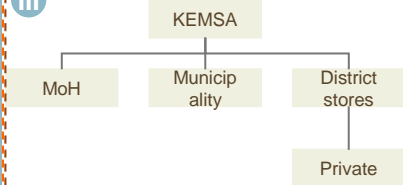
II



- KEMSA can deliver same quality to all the facilities, as they are providing the MoH facilities today

- DRH/KEMSA are able and can afford to reach >4100 SDPs 4-6 times a year

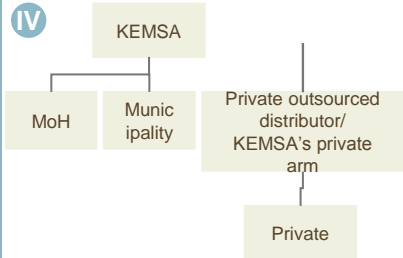
III



- KEMSA can deliver same quality to all the public facilities with direct distribution
- DRH/KEMSA can improve the operational procedures for District Store distribution

- DRH/KEMSA are able and can afford to reach 1-2 times more SDPs directly compared with today

IV



- KEMSA can deliver same quality to all the public facilities with direct distribution
- The private sector can scale up their supply chain and has incentives to carry the products

- DRH/KEMSA are able and can afford to reach 1-2 times more SDPs directly compared with today

### 3 If the preferred solution is 'fixing the District Stores', the 2 remaining issues must be addressed

Issues identified in the distribution chain by channel

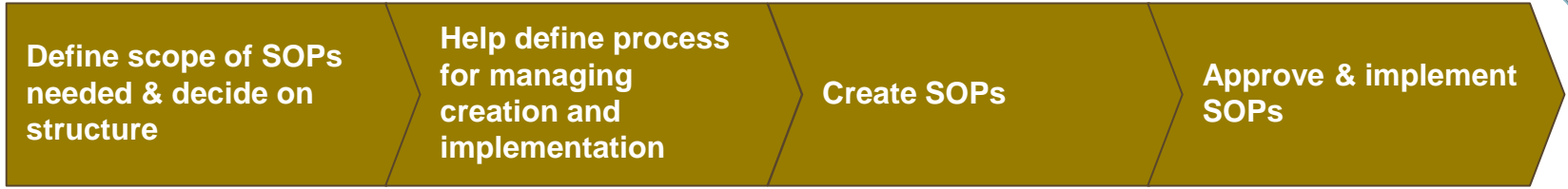
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There are two design options to address the remaining issues:

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**II Fix the distribution to District Stores.** This will be a longer process as it requires developing SOPs and up-skilling the District Stores and their staff to improve the commodity management.

# The technical working committee will be in charge of developing SOPs for the selected model (Tupange willing to support the process)

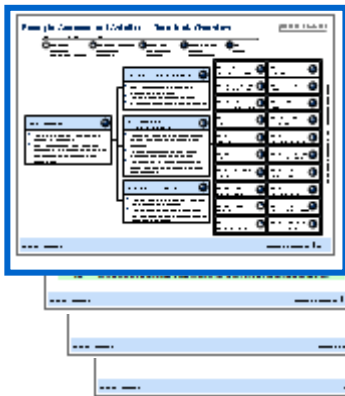


**Task**

- Actions**
- Collect all existing SOPs that might exist in the system
  - Review best-practice for developing SOPs
  - Define areas where SOPs are needed for efficient distribution with KEMSA and DRH
  - Decide on high level structure of SOPs
  - Identify working team and decision making team
  - Identify options to managing the creation and implementation process
  - Creation of SOPs over max. 3 months periods
    - The technical working committee could lead this work
    - Incomplete drafts already exists for some
  - DRH to review draft SOPs
  - KEMSA to approve the SOPs
  - Prepare implementation of new model with partners

**End product**

High level structure of SOPs



Overview of process



Final draft version of SOPs



Implementation plan



3B

**A memorandum from DRH on the transfer of responsibility for RH commodities has been issued, and the technical working committee will create an action plan for implementation (Tupange willing to support this process)**

	<b>Actions</b>	<b>Lead</b>
<b>Q1 2012</b>	<ul style="list-style-type: none"> <li>Define new roles and responsibility for all affected HRH positions</li> <li>Develop training/ orientation manuals</li> <li>Plan training process</li> </ul>	<ul style="list-style-type: none"> <li>Technical working committee</li> </ul>
<b>Q2 2012</b>	<ul style="list-style-type: none"> <li>Pilot training modules in Tupange supported facilities</li> <li>Oversee change in facilities</li> </ul>	<ul style="list-style-type: none"> <li>Tupange</li> </ul>
<b>Q3 2012</b>	<ul style="list-style-type: none"> <li>Monitor and track impact from change using pre-defined KPIs</li> </ul>	<ul style="list-style-type: none"> <li>Tupange</li> </ul>
<b>Q4 2012</b>	<ul style="list-style-type: none"> <li>Collect and disseminate results from pilots with the broader RH community</li> </ul>	<ul style="list-style-type: none"> <li>DRH, Tupange, Technical working committee,</li> </ul>

4

## A short private sector paper is being developed with input from private and public stakeholder, which can serve as the starting point for the working group

### Content of short private sector paper

- **Overview of CPR and the role of the private sector in Kenya**
  - Both the public and private sector are necessary for growth in CPR
  - As incomes increase, women are more likely to use the private sector for contraceptive needs
- **Defining the critical areas for investigation**
  - Understanding demand (market trends and patient segmentation)
  - Deciding on a retail strategy for ensuring sufficient access points
  - Enabling financial sustainability of the private sector levels
  - Ensuring higher stock availability in the private sector by assessing whole sale options
- **Suggested next steps**



## A working group consisting of public and private stakeholders should be established to lead the work

### Suggested working committee members and roles

#### Public sector

- **DRH:** Responsible government entity steering overall RH strategies in Kenya
- **KEMSA:** The main supply chain channel today
- **NCPD:** The overarching body in charge of population growth in Kenya

#### Private sector

- **Social marketing organisations**
  - **PSI and MSK:** The largest private sector supplier in the market, who can offer insights from Kenya and other markets
- **Private for profit** such as PharmAccess, Laborex and Omaera, who can offer a perspective on current barriers to entry
- **Private facilities and pharmacies** to leverage on-the-ground experience from a retail perspective

Alternatively, the work can be outsourced via a RFP, and the working committee can work as a steering committee together with donors

# Contents

- Context
- Approach
- National contraceptives landscape
- Findings on stock-outs
- Supply chain diagnostic findings
- Potential initiatives to improve the contraceptives supply chain
- **Potential roles for BMGF**
- Back up



## 2 Overall, there are 3 areas in which the Gates Foundation can help accelerate progress on the broader supply chain issues

1. **Attend LAC meeting**, which is the forum for decision making of piloting a new distribution model
2. **Support establishment of private sector working group or create a RFP for external support to conduct the work.** Advocate for DRH and relevant private stakeholders to lead the effort
3. **Ensure that findings from Tupange pilots are disseminated** with RH key stakeholders. **Advocate at national level** (CEO of KEMSA, Director of Public Health) **for appropriate actions for nation wide roll out** (if pilots are successful)

# Contents

- Context
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- Potential roles for BMGF
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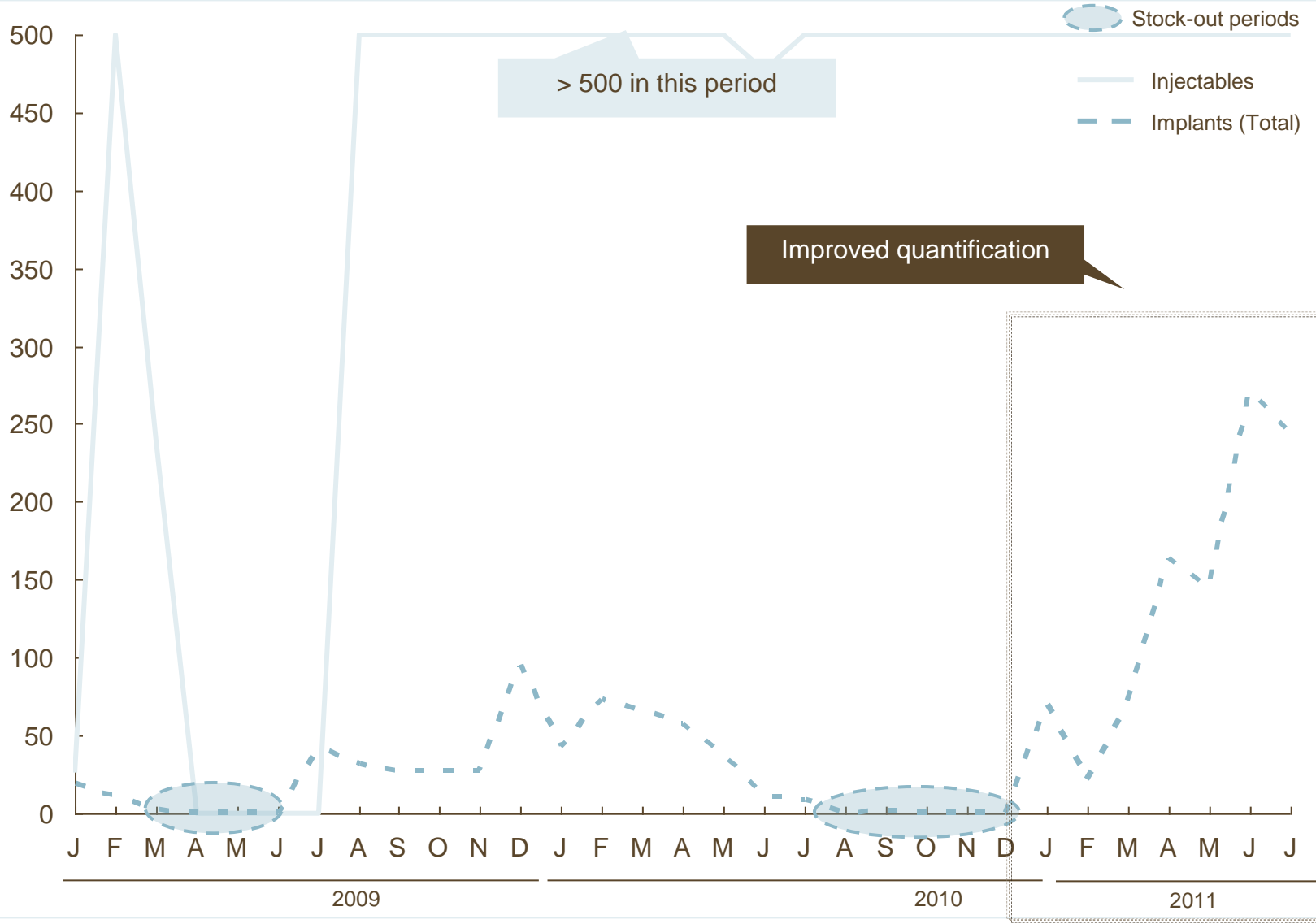


# A National stock level – Injectable & implants

NATIONAL LEVEL

SOH, Thousands units, at KEMSA central warehouse

Long Acting Methods

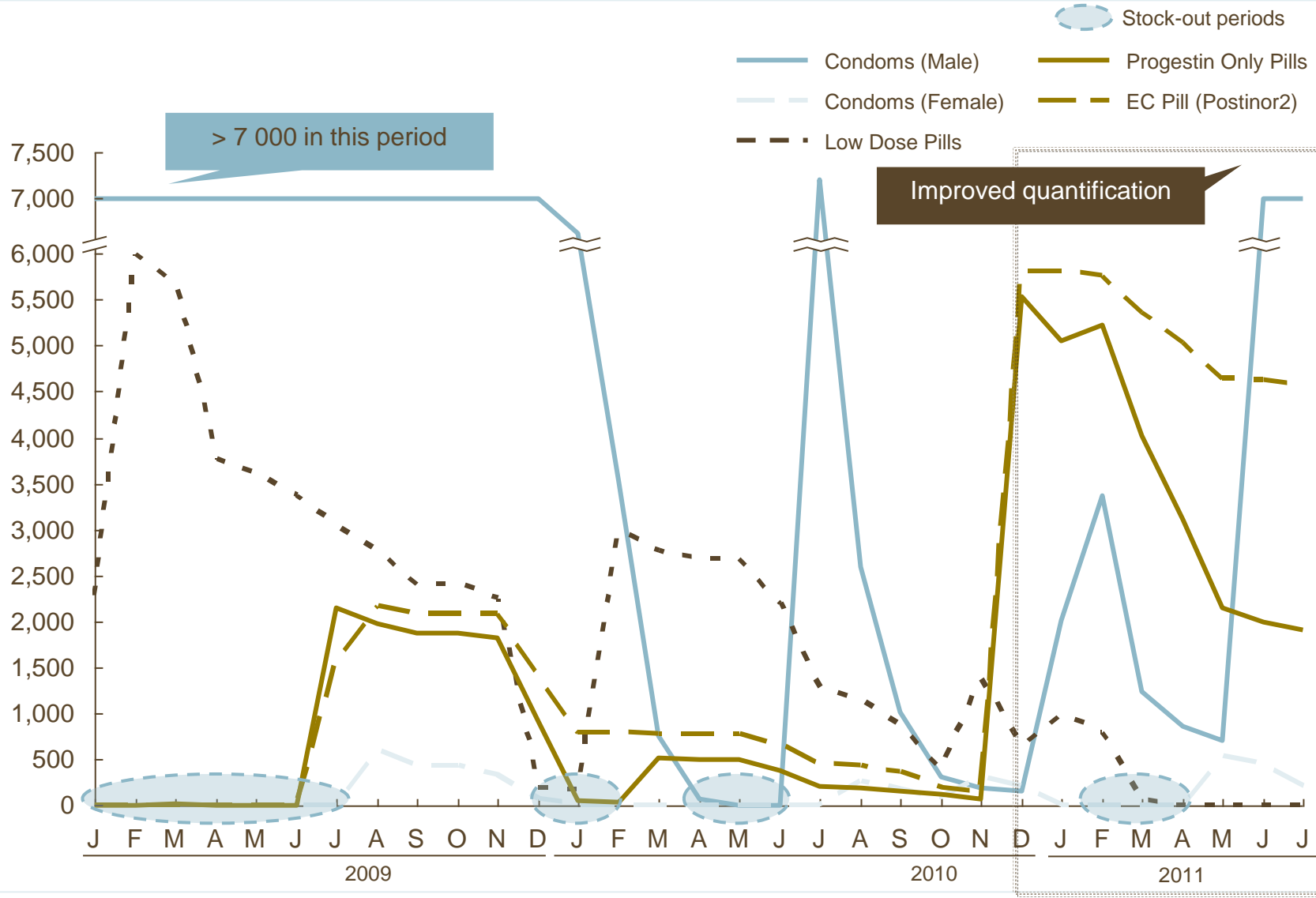


# A National stock level – short acting methods

NATIONAL LEVEL

SOH, Thousands units, at KEMSA central warehouse

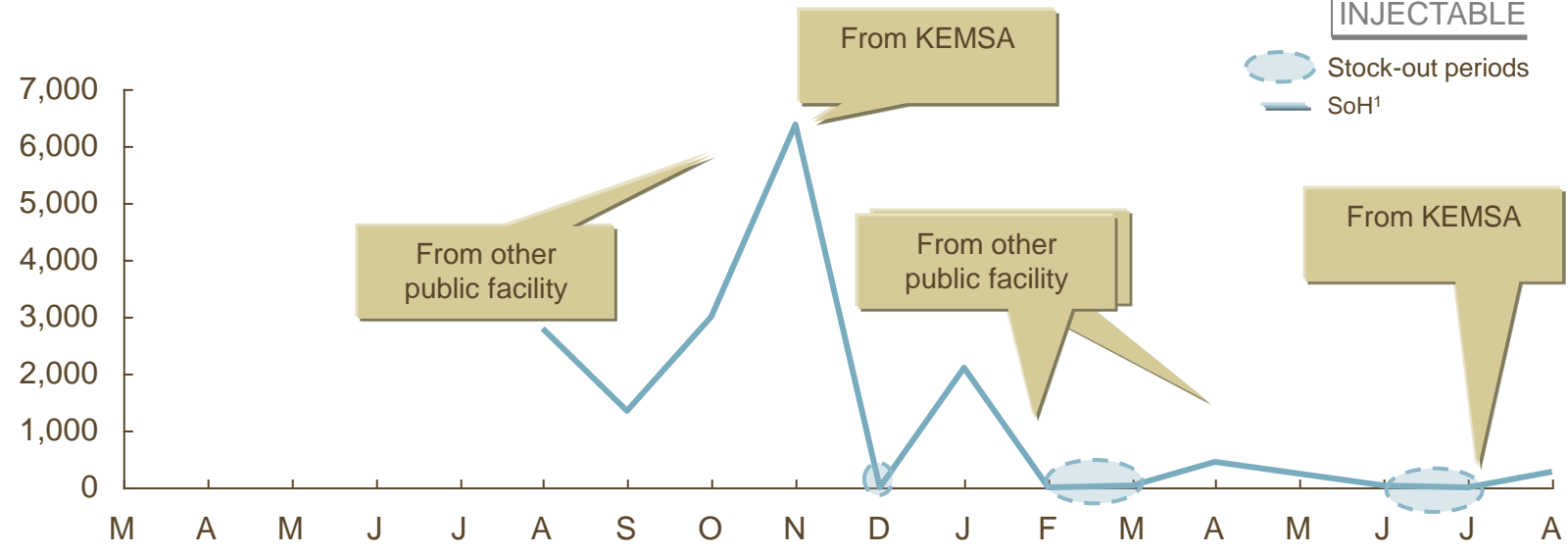
Short acting methods



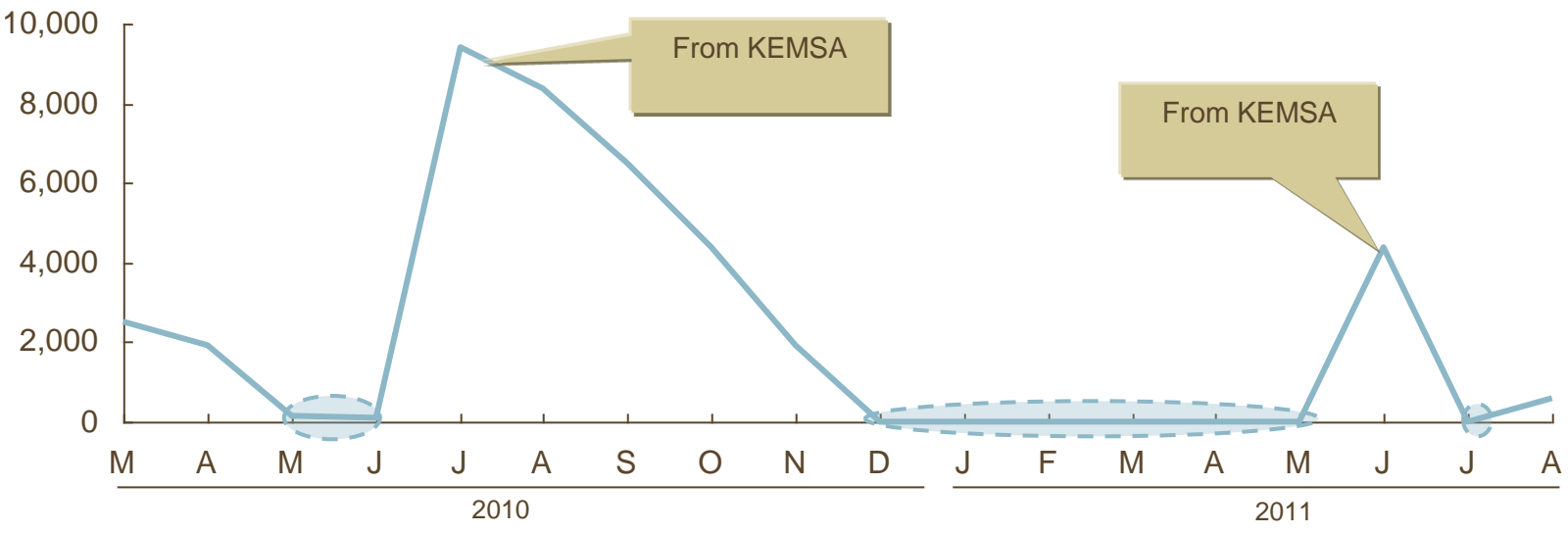
# B District stores – Mombasa - Injectable

MOMBASA  
DISTRICT STORES  
INJECTABLE  
Stock-out periods  
SoH<sup>1</sup>

Mombasa District store



Kilidini district store

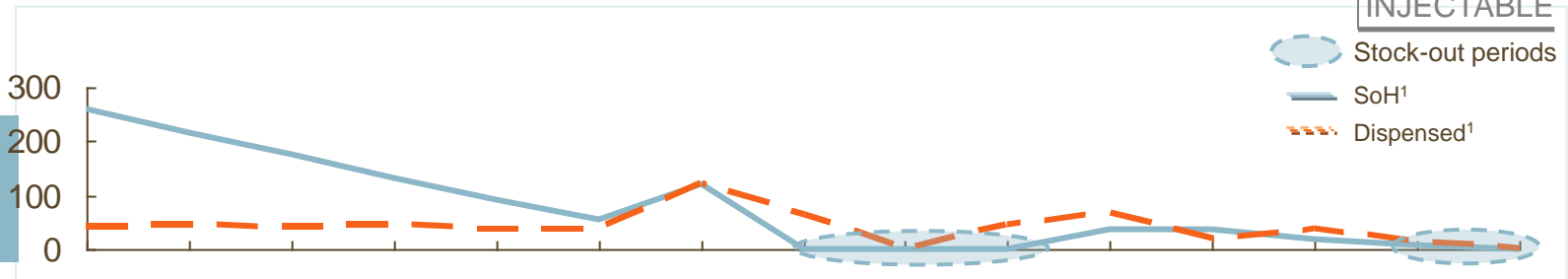


1 Stock on Hand the 1<sup>st</sup> in the month  
SOURCE: Stock register at district stores; CDRR stock reports

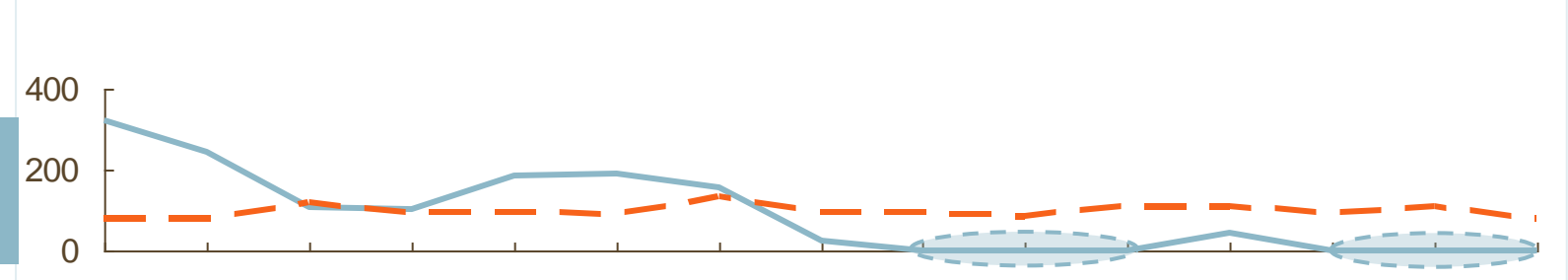
# C D Facilities – Mombasa - Injectable

MOMBASA FACILITIES  
INJECTABLE

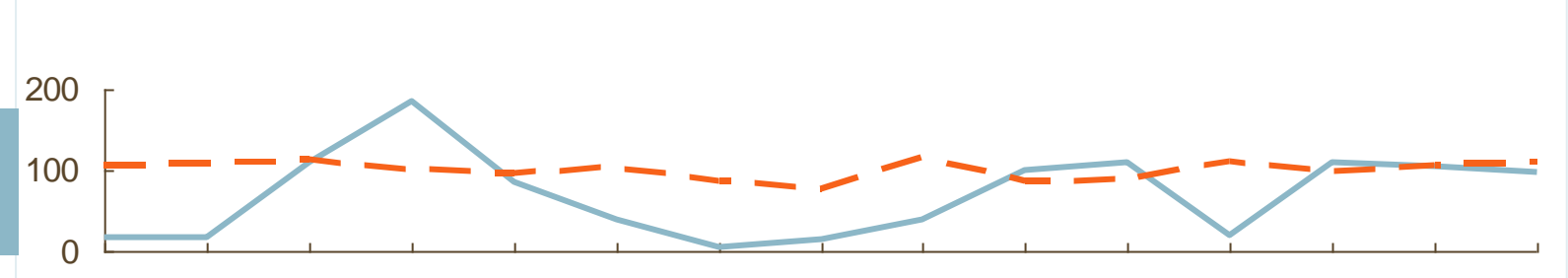
C Mvati municipality facility



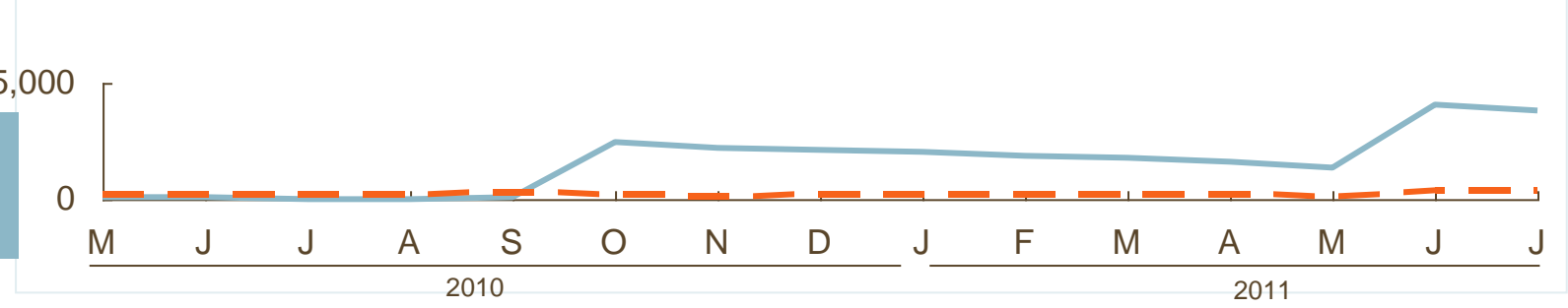
C Jambo private facility



C FHOK NGO facility



D Tudor District Hospital



# C D Facilities – Kilidini - Injectable

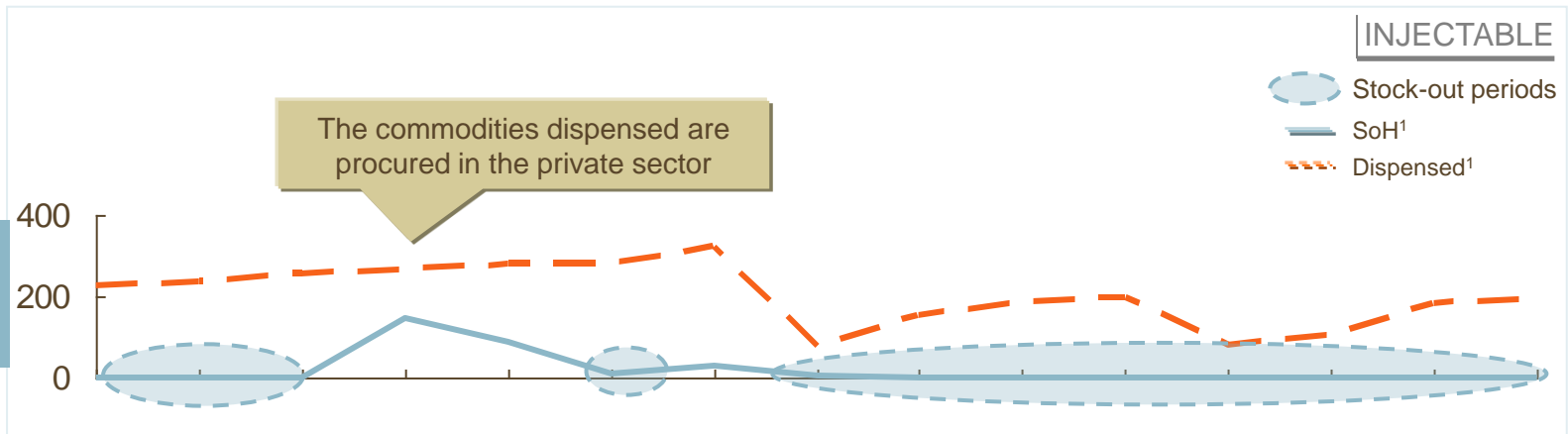
KILIDINI  
FACILITIES

INJECTABLE

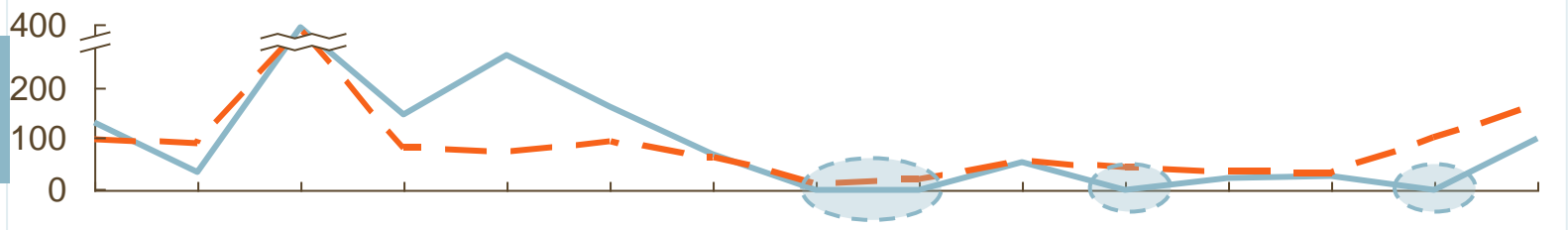
- Stock-out periods
- SoH<sup>1</sup>
- Dispensed<sup>2</sup>

The commodities dispensed are procured in the private sector

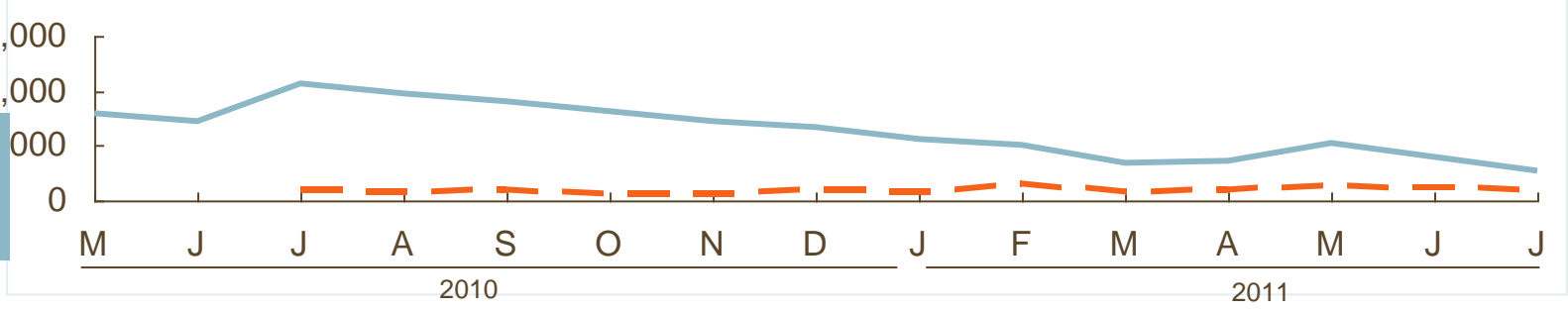
C  
Miranga private facility



C  
Chaani municipality



D  
Port Reitz District Hospital

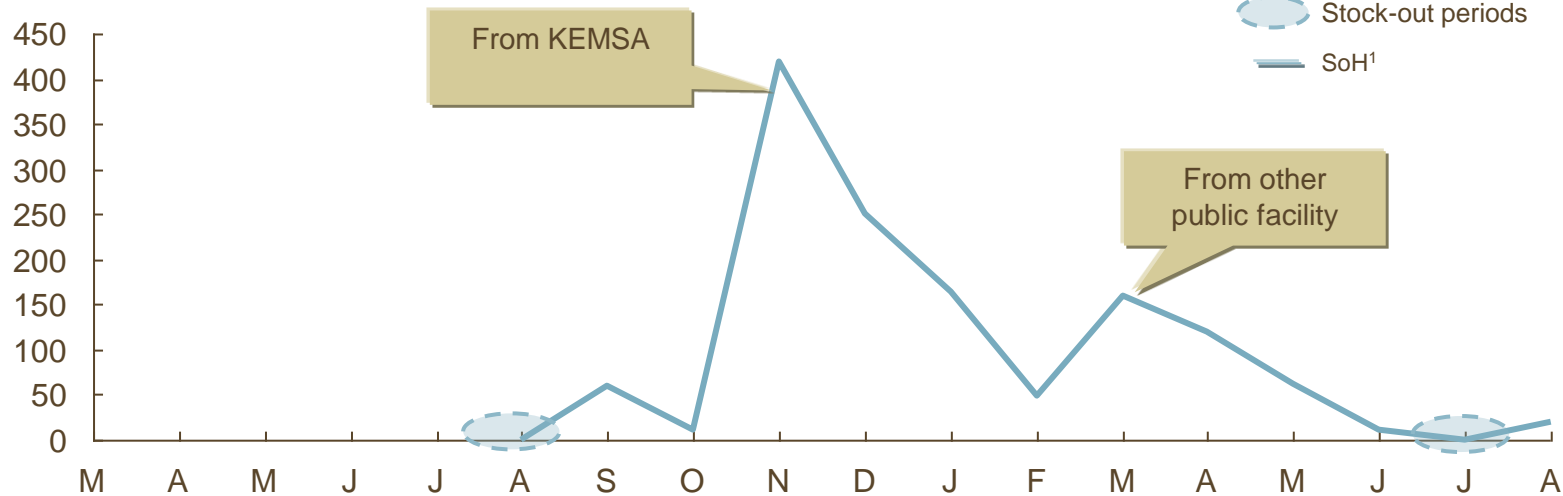


1 Stock on Hand the 1<sup>st</sup> in the month  
2 What is dispensed to patients. If this is higher than SoH, the facility has either borrowed from another facility, received donations or bought from the private sector  
SOURCE: Team; CDDR order and stock books for selected facilities in Embakasi district  
© 2011 Bill & Melinda Gates Foundation | 99

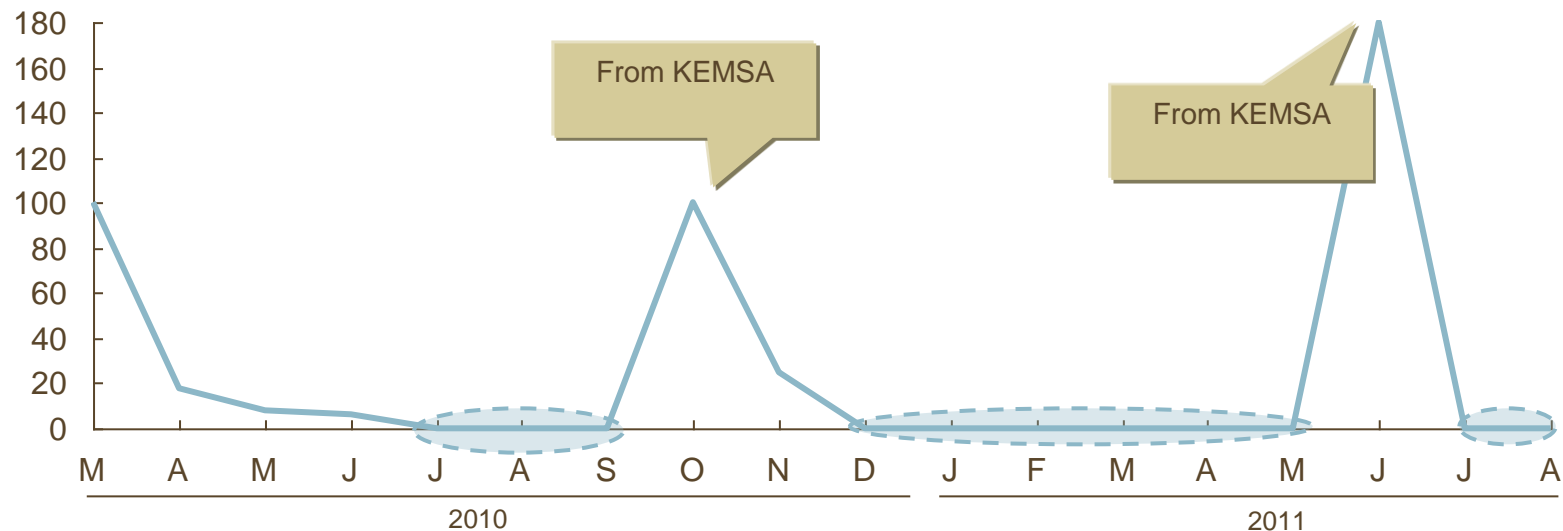
# B District stores – Mombasa - Implants

MOMBASA  
DISTRICT STORES  
IMPLANTS

Mombasa District store



Kilidini district store



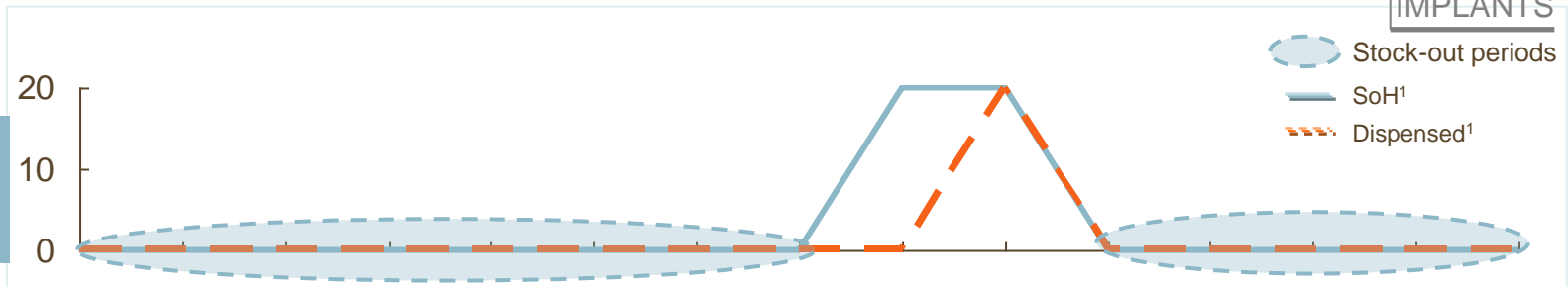
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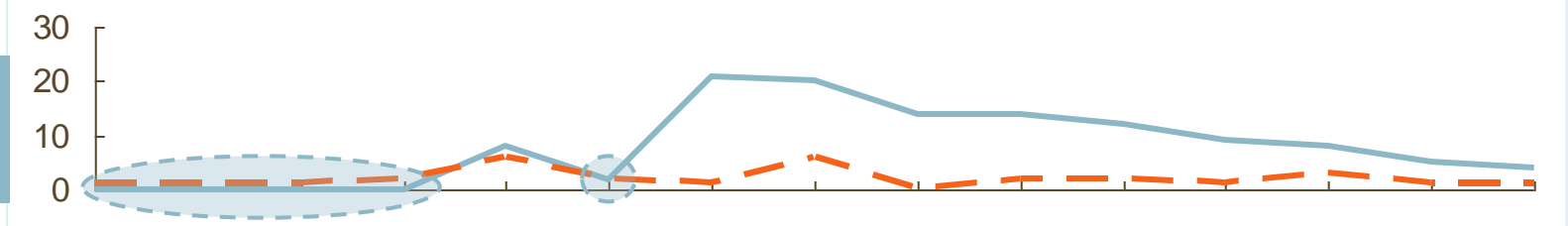
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MOMBASA  
FACILITIES  
IMPLANTS

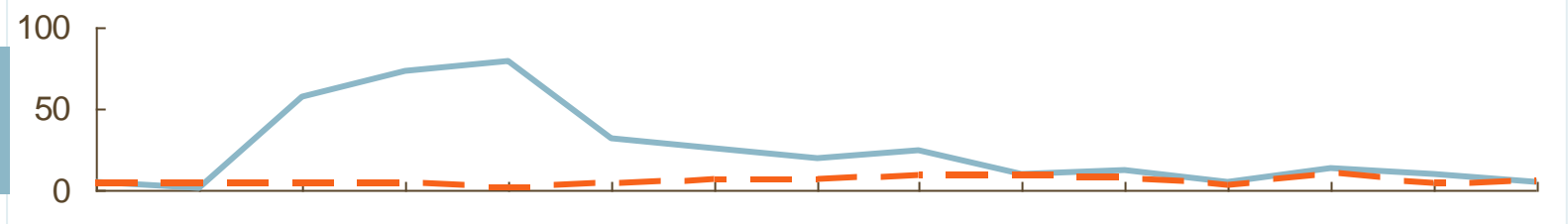
C Mvati municipality facility



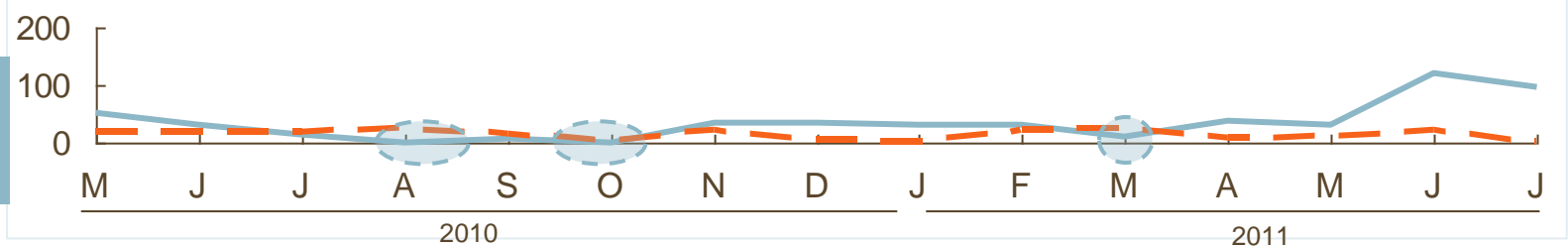
C Jambo private facility



C FHOK NGO facility



D Tudor District Hospital



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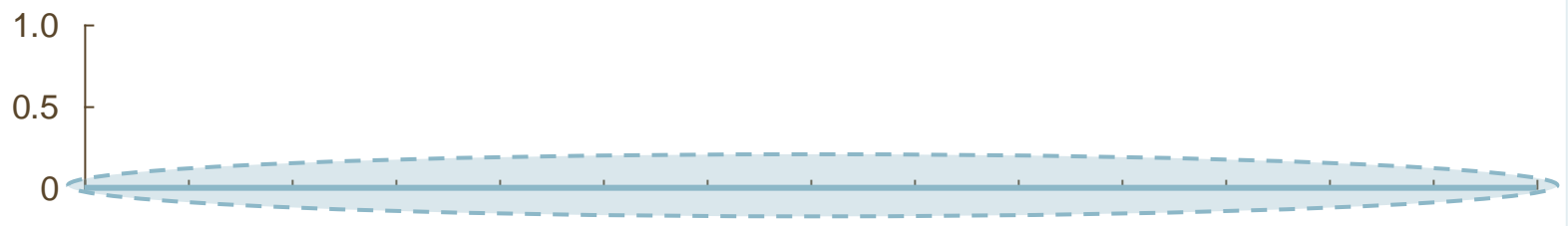
# C D Facilities – Kilidini - Implants

KILIDINI  
FACILITIES

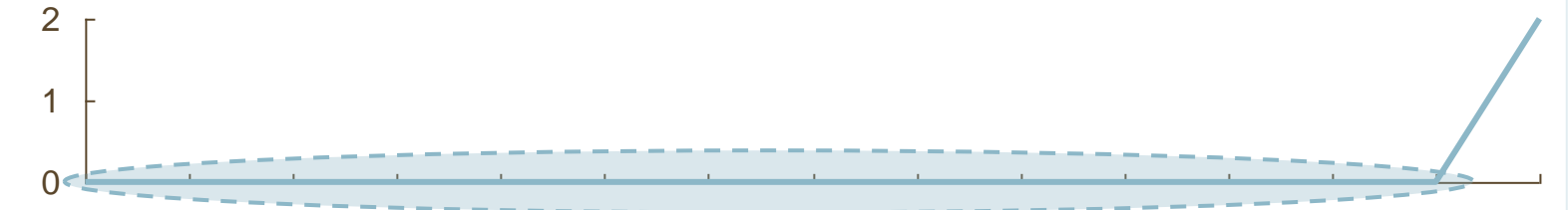
IMPLANTS

- Stock-out periods
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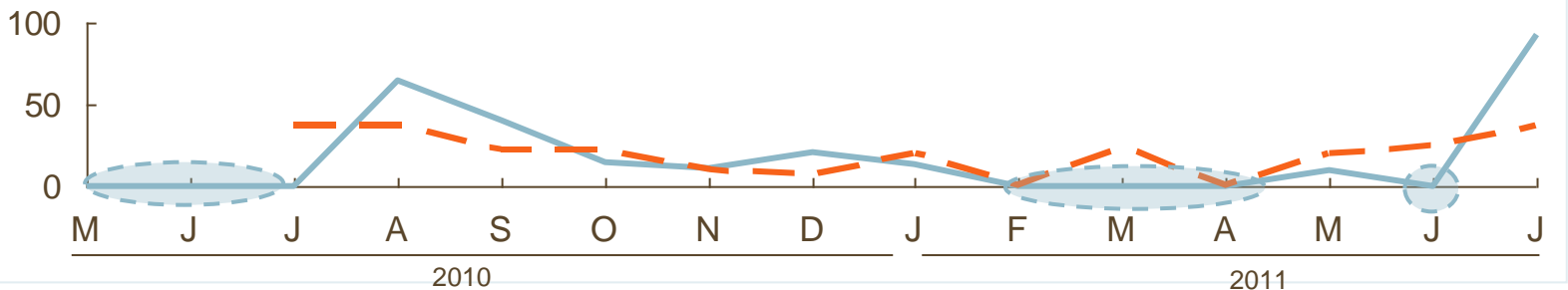
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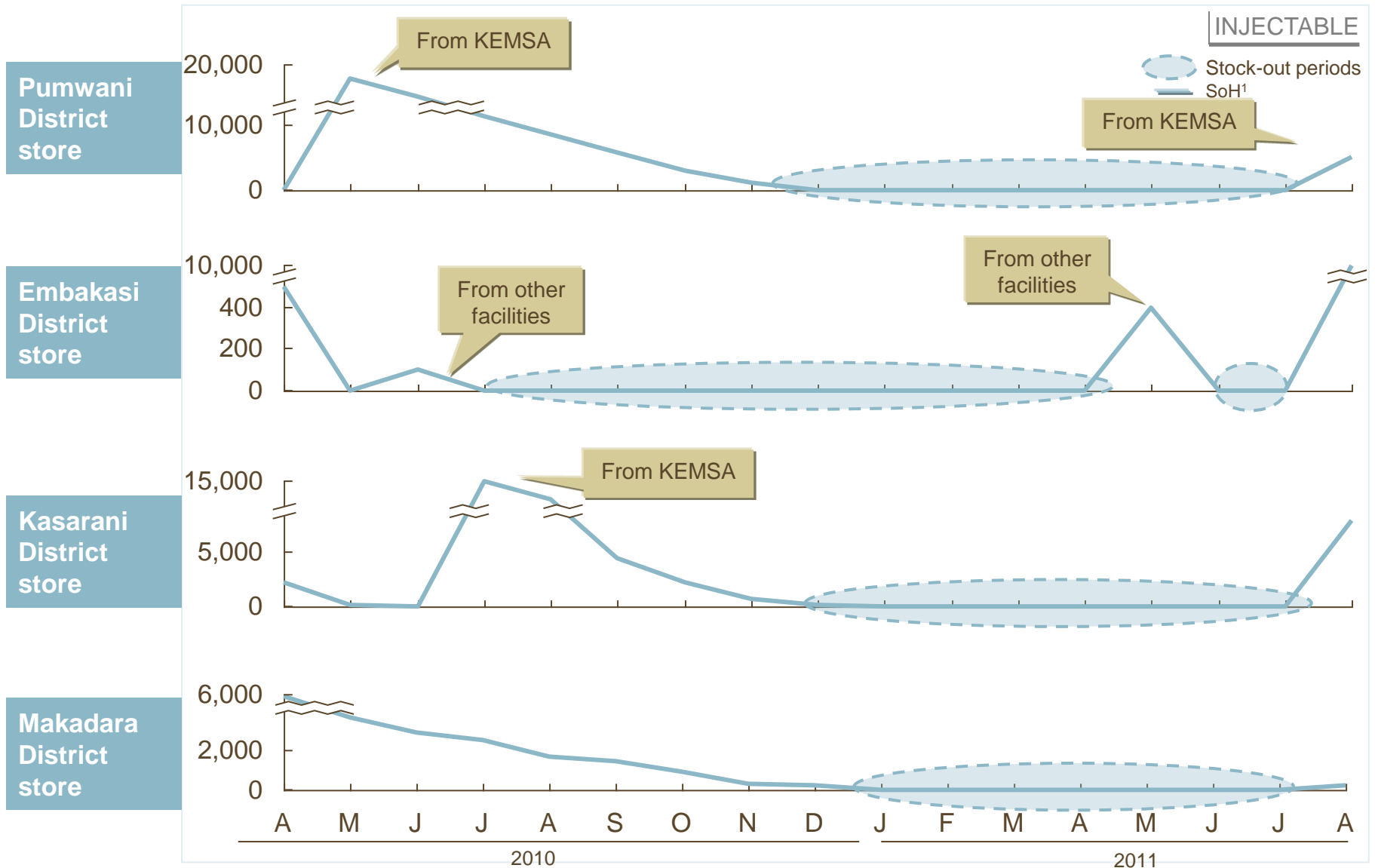
<sup>1</sup> Stock on Hand the 1<sup>st</sup> in the month      <sup>2</sup> What is dispensed to patients. If this is higher than SoH, the facility has either borrowed from another facility, received donations or bought from the private sector

# B District stores - Nairobi - Injectable

NAIROBI

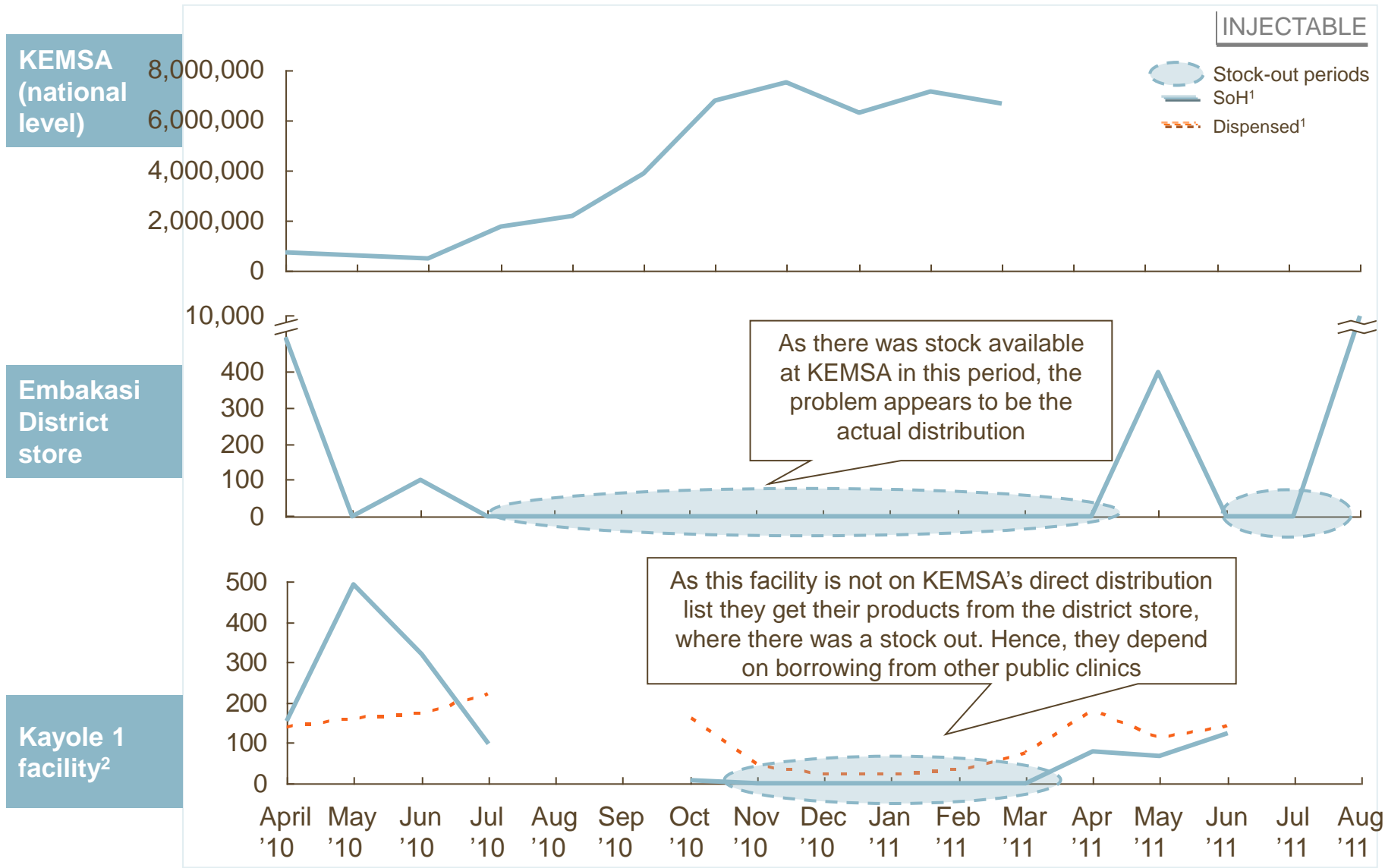
DISTRICT STORES

INJECTABLE



1 Stock on Hand the 1<sup>st</sup> in the month

SOURCE: Team; CDDR order and stock books for selected facilities in Embakasi district



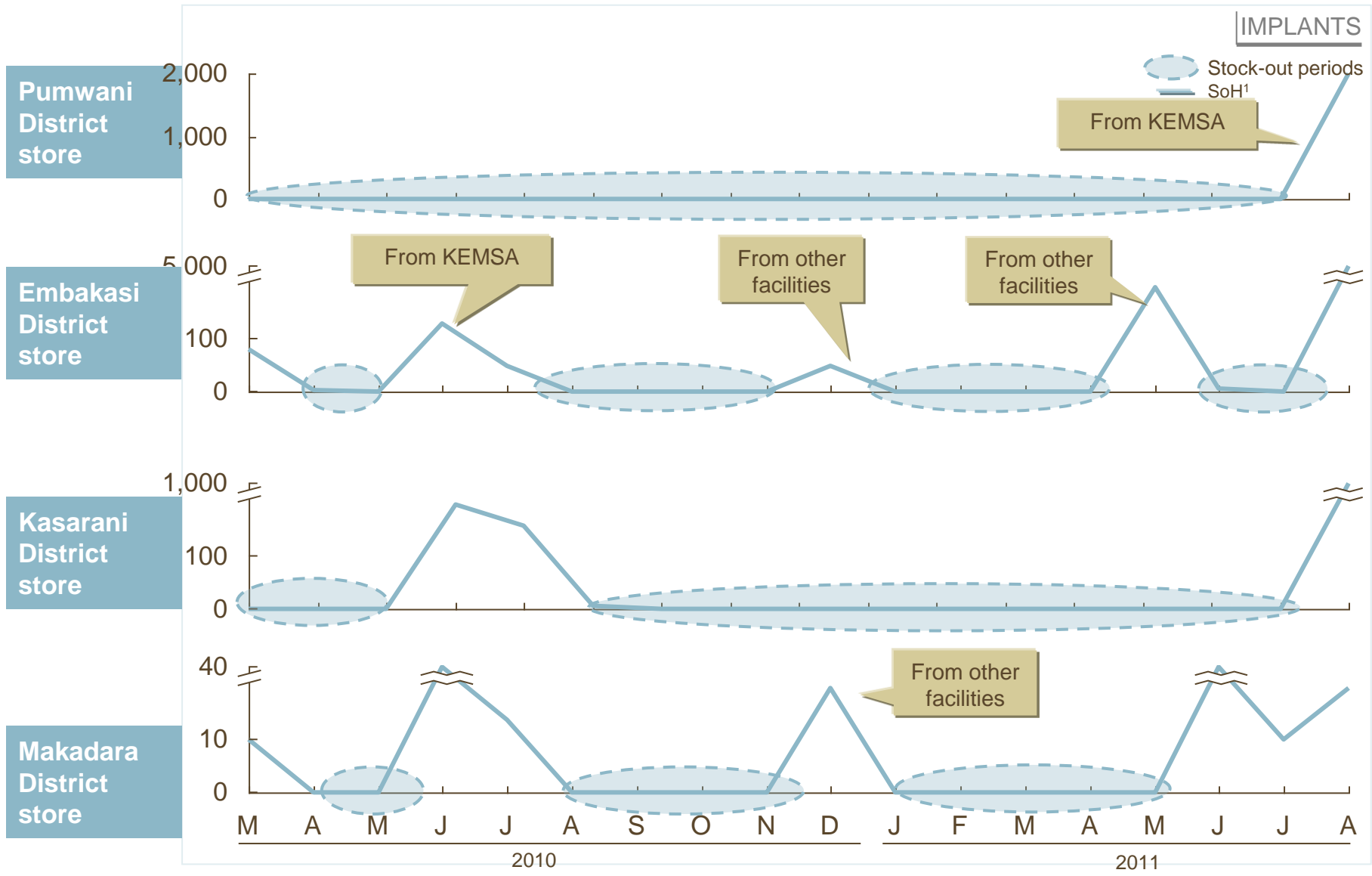
1 What is dispensed to patients. If there is not any stock, this is based on borrowing stocks from peer clinics under Embakasi district      2 Kayole 1 is just 1 out of 4 public facilities under Embakasi district

# B District stores - Nairobi - Implants

NAIROBI

DISTRICT STORES

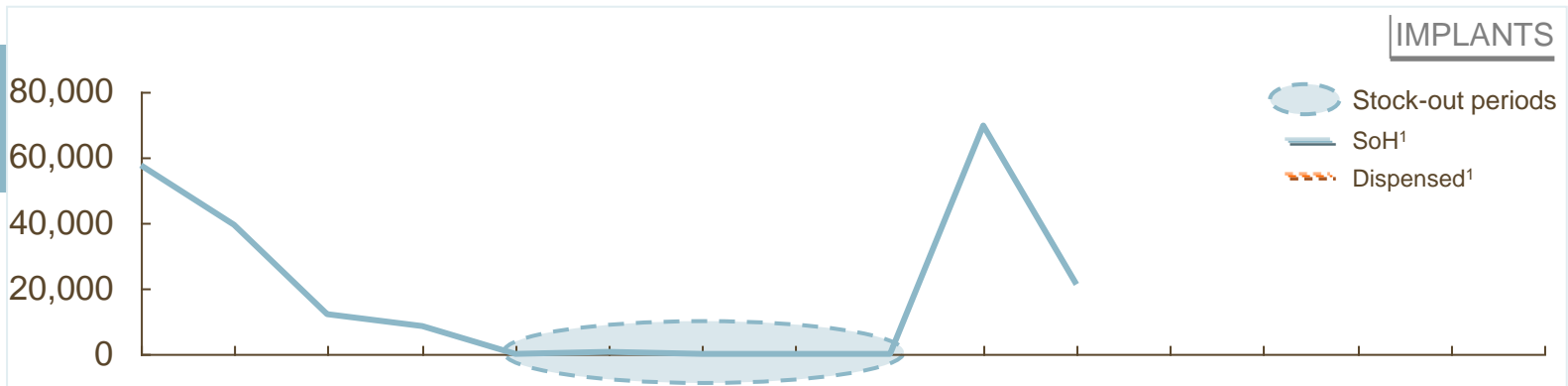
IMPLANTS



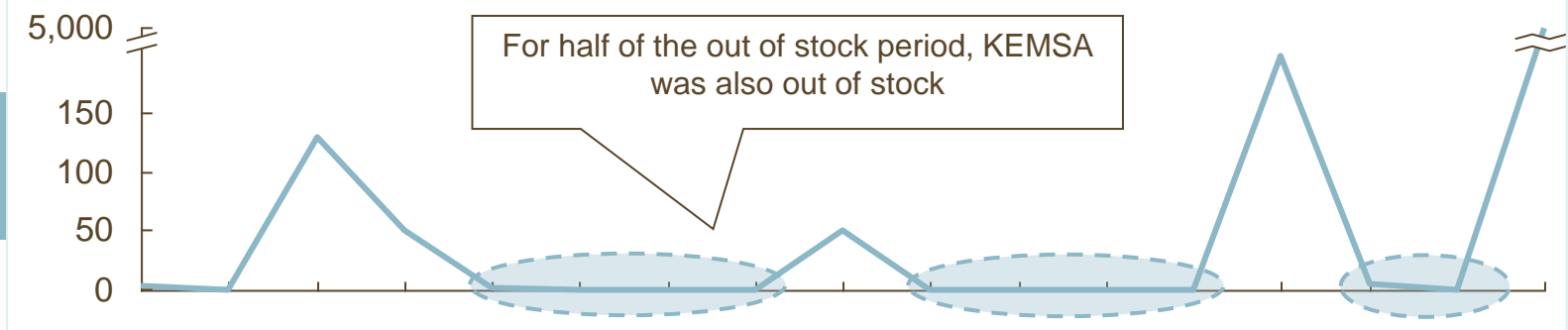
1 Stock on Hand the 1<sup>st</sup> in the month

SOURCE: Team; CDDR order and stock books for selected facilities in Embakasi district

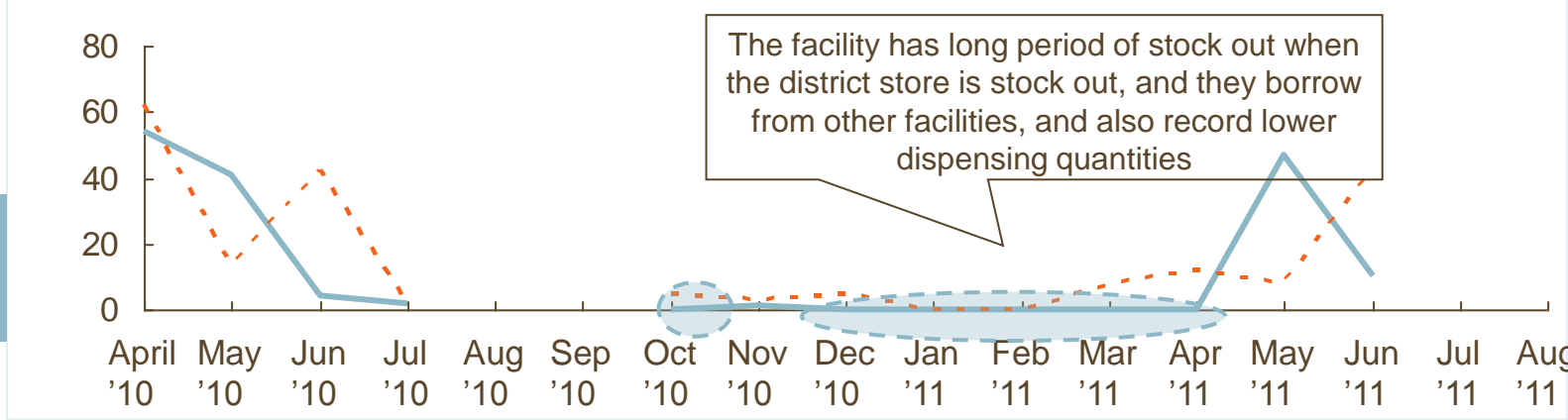
KEMSA  
(national  
level)



Embakasi  
district  
store



Kayole 1  
facility²



1 What is dispensed to patients, if there is not stock, this is based on borrowing stocks from peer clinics under Embakasi district

2 Kayole 1 is just 1 out of 4 public facilities  
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# Lack of reliable reporting data from facilities is a significant problem

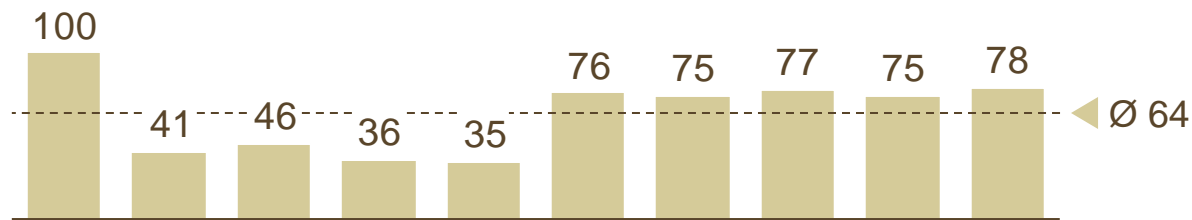
FACILITIES

No. of type<sup>1</sup>

Reporting rates, percent

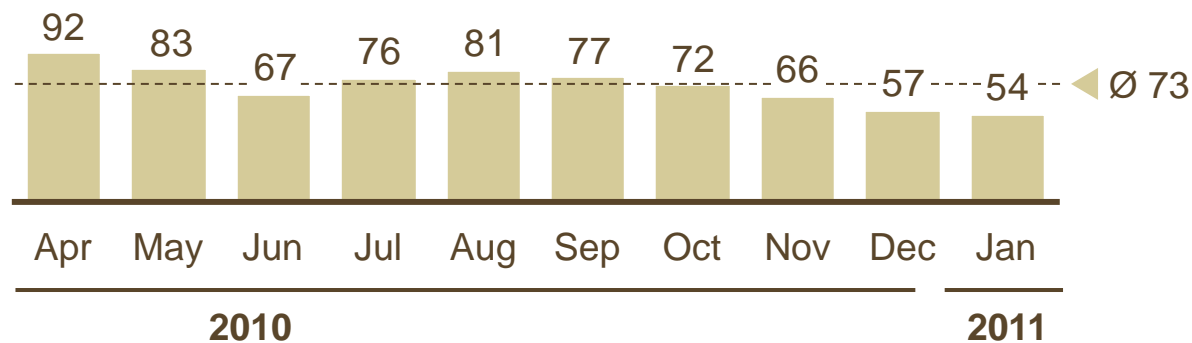
Mombasa

83



Nairobi

302



<sup>1</sup> For last reporting monthly (Jan 2011)