KENYA URBAN REPRODUCTIVE HEALTH INITIATIVE

Contraceptive Security Issues Paper

April 2011

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ACRONYMS AND ABBREVIATIONS

AMC	Average Monthly Consumption
AMREF	Africa Medical Research Foundation
CDF	Constituency Development Fund
CDRR	Contraceptive Data Report and Request Form
CS	Contraceptive Security
CSIP	Contraceptive Security Issues Paper
DFID	Department for International Development
DMPA	Depot Medroxyprogestrone Acetate
DoP	Department of Pharmacy
DRH	Division of Reproductive Health
DRHC	District Reproductive Health Coordinators
EC	Emergency Contraception
FBO	Faith Based Organizations
FP	Family Planning
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
GoK	Government of Kenya
IUCD	Intra-Uterine Contraceptive Device
KEMSA	Kenya Medical Supplies Agency
KRC	Kenya Red Cross
LATF	Local Authority Transfer Fund
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
MDG	Millennium Development Goals
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NCAPD	National Coordinating Agency for Population and Development
NGO	Non-Governmental Organization
PAAL	Pharm Access Africa Limited
PPB	Pharmacy and Poisons Board
PRHC	Provincial Reproductive Health Coordinators
PSI	Population Services International
RH	Reproductive Health
RHF	Rural Health Facility
SDP	Service Delivery Point
SOP	Standard Operating Procedures

SORF	Standard Order and Requisition Form
UNFPA	United Nations Population Fund
USAID	Unites States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Contraceptive Commodity Security exists when people are able to choose, obtain, and use affordable, high quality contraceptives and condoms whenever and wherever they want them.

While the Kenya Government has committed to ensuring access to Family Planning (FP) services, one of the main challenges is ensuring the availability and continuous supply of contraceptives in the country. According to a policy brief on "Financing the Kenya Family Planning Program", the Ministry of Public Health and Sanitation anticipated huge budgetary shortfalls of approximately 6.8 billion for 2010 – 2012 fiscal years for the financing of FP commodities. In addition, challenges in the contraceptive supply chain system hamper the procurement, distribution and reporting of FP commodities, leading to inefficient planning and subsequent poor access to contraceptives for clients.

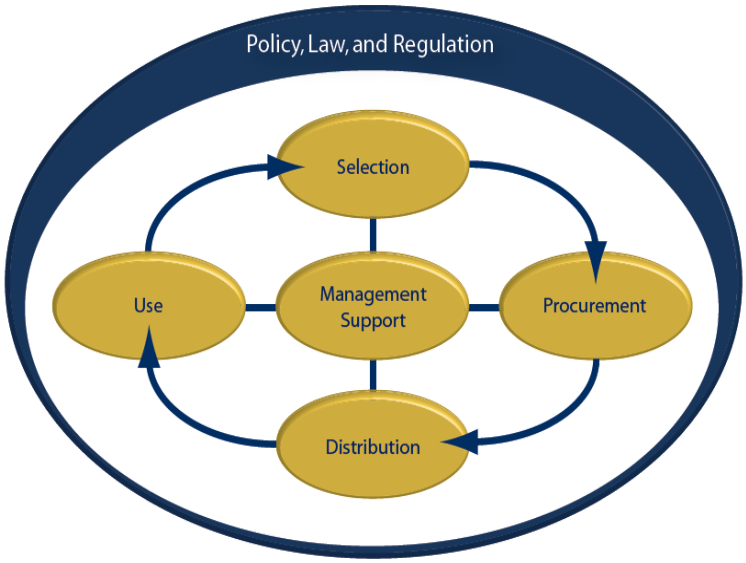
After the 2009 international FP conference in Kampala Uganda, a taskforce was formed by the Division of Reproductive Health and stakeholders (see Terms of Reference for the Task Force to Accelerate Implementation of FP Priority Actions to Achieve MDGs and Vision 2030) to support in Accelerating Implementation of Family Planning Programs to Achieve Health Related MDGs in Kenya by 2015. This taskforce noted that one of the priority areas of intervention was to improve FP Commodity security.

In Kenya commodity security is guided by the supply chain cycle which includes; Selection, Procurement, Warehousing, Distribution and use. These elements are governed by national policies and regulations under the mandate of the Ministries of Health – the Division of Reproductive Health (DRH) under the Ministry of Public Health and Sanitation is mandated to Identify and maintain up to date information on donors/potential donors for funding of contraceptives; monitor the utilization and effectiveness of commodity security operations at all levels; maintain/update comprehensive national data on utilization of contraceptives in both public and private sectors; organize and co-coordinate the training of health workers on RH commodity management, provide FP commodity distribution requirements to KEMSA regularly and monitor the integration of contraceptive services with other reproductive health services among other functions.

On the other hand, the Kenya Medical Supplies Agency (KEMSA) under the Ministry of Medical services (MOMS) is mandated to operationalize an efficient and effective commodity supply chain system including (procurement, warehousing and distribution). The Pharmacy and Poisons Board also under the MOMS is required to regulate registration and provision of all pharmaceuticals in Kenya while the Department of Pharmacy (also under the MOMS) has oversight on all pharmaceutical management activities including development of clinical guidelines, management of National Medical and therapeutics Committees, etc.

The Government of Kenya (GoK) has also appointed District RH Coordinators whose mandate is to manage all FP matters in the district. This is a great opportunity for establishing contacts, mobilizing the facility teams and disseminating strategies to facilities offering FP services.

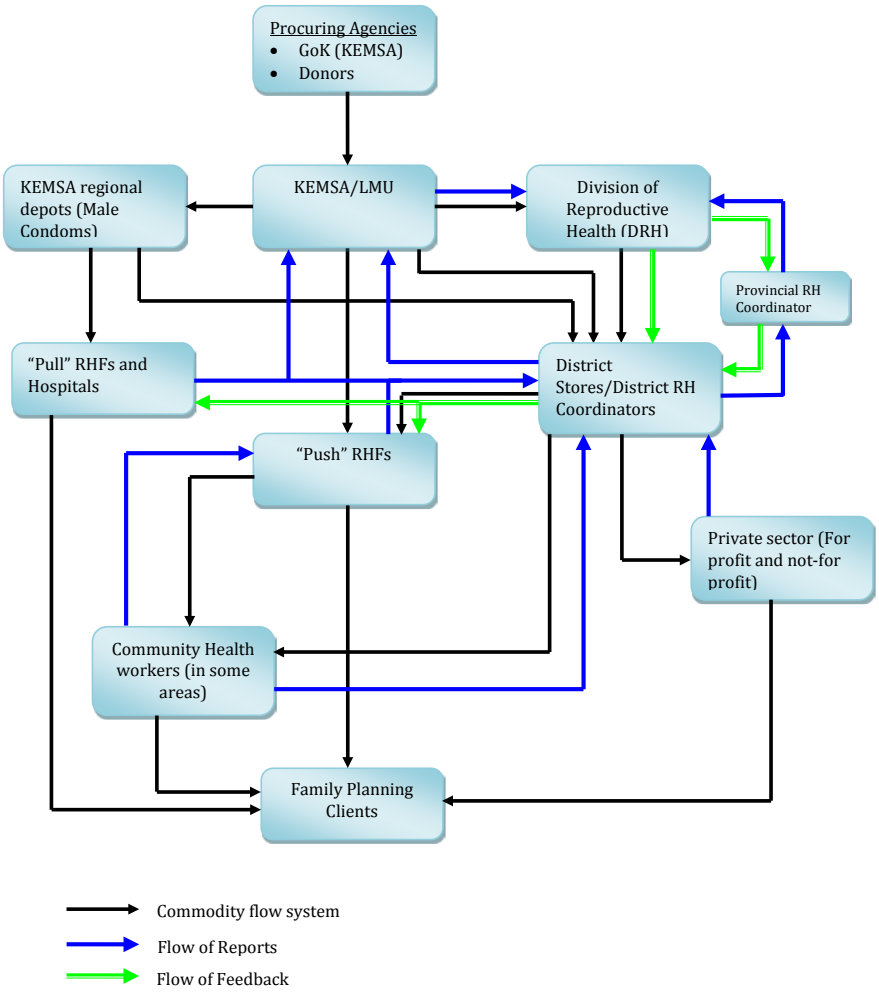
In order to ensure contraceptive commodity security, there is need to approach it from a holistic and client centred perspective. The supply chain cycle below provides this approach:



Source: Management Sciences for Health

CURRENT FAMILY PLANNING COMMODITY SECURITY SYSTEM

Below is a diagrammatic representation of the national FP commodity supply chain system with the key players;



Using the supply chain cycle components, below is the current commodity security status in Kenya:

SELECTION

The Division of Reproductive Health in Kenya has identified and registered nine modern contraceptive methods for use in both the public sector. In addition to the nine, the private sector is allowed to procure any additional method as long as it is registered by the Pharmacy and Poisons Board (PPB). The nine methods are:

1) Male condoms
2) Female condoms
3) Depot Medroxyprogesterone Acetate (DMPA) Injection
4) Combined oral Contraceptives
5) Progestin Only Pills
6) Emergency Contraceptive Pills
7) Intra-Uterine Devices
8) Implants
9) Cycle beads

FINANCING AND PROCUREMENT

The contraceptive procurement system in Kenya is based on the funding source and service provision sector. According to a rapid assessment on contraceptives Supply and Security in Kenyan Urban Areas conducted by PAAL in March this year, the cost of contraceptives in both the public and private sectors is minimal with a median cost of ksh.0 to 100 for all methods. According to the GoK, all contraceptive methods are supposed to be provided free of charge in all public health facilities but due to inconsistency in the supplies, some of the public sector health facilities are forced to procure from the private sector and thus must charge a minimal fee to recover their capital. This is an indication of the commitment of Health Facilities to improve access to FP services by charging minimal fees for the services but also an indication of challenges in the system to ensure consistent availability of contraceptives at all public health facilities.

In the public sector, contraceptives are funded by the Government and donors. Over the last few years, the GoK has included a line in its annual budget of approximately 6 million USD for procurement of contraceptives – in the 2009/2010 and 2010/2011 financial years, the GoK allocated Ksh. 530,000,000 and Ksh. 522,750,000 respectively. Currently, all GoK funded contraceptives are procured by the Kenya Medical Supplies Agency (KEMSA). In addition, many public health facilities are free to utilize funds derived from their cost sharing collections for procurement of contraceptives; usually these funds are not sufficient and are hardly used for this purpose.

Donors also provide funding for procurement of contraceptives mainly to subsidize the GoK. Donor funds are either given directly to the government, in which case procurement is conducted by KEMSA; with the exception of both male and female condoms which are procured through UNFPA. In other cases, donors procure contraceptives equivalent to the amount they committed, and donate to the GoK in-kind.

Every year the DRH conducts an annual forecasting, quantification and procurement planning (FQPP) exercise, where the quantities derived are used to inform funding commitments. From

the quantities derived, the GoK invests the full amount allocated in that financial year and donors make commitments to top up the remaining funding gaps. The last annual FQPP was done in May 2010 and reviewed in December 2010. The national gap in funding for contraceptives was identified as follows;

Year	Amount USD (millions)
2010-2011	8,934,033.83
2011-2012	14,284,966.00
2012-2013	37,039,158.54

The private sector procurement system is also relatively complex and can be separated according to organizations offering services either "for-profit" or "not-for-profit". Commercial organizations offering services for profit follow their own procurement systems but are only allowed to procure contraceptives registered by the Pharmacy and Poisons Board (PPB).

The organizations offering services without the intention of making any profits e.g. NGOs and FBOs get contraceptive supplies from the GoK. In the absence of these supplies, they use their own procurement systems.

WAREHOUSING AND DISTRIBUTION

At the central level, the warehousing and distribution of contraceptives in the public sector is the mandate of KEMSA which runs two warehouses in Nairobi – one is mainly a holding warehouse and the other is the operations warehouse. There are another seven regional warehouses, which are mainly holding warehouses located in all provinces. KEMSA plans to fully decentralize its warehousing and distribution functions as soon as the new national administrative boundaries are in place. All the 3 phase one Tupange intervention cities (Nairobi, Kisumu and Mombasa) have a KEMSA depot.

All contraceptives for the public sector, except male condoms, are stored in the central level operations warehouse and distributed directly to facilities from there. Male condoms are distributed from the central level warehouse to the regional depots and onwards to public health facilities mainly because of their bulkiness.

During the rapid assessment on contraceptive supply and security, most health facilities indicated the availability of a specific officer responsible for requesting, receiving and storage of contraceptives in majority of the facilities, thereby ensuring the existence of a certain level of accountability and focus.

The public sector distribution system(s) in Kenya are complicated, puzzling and grossly underfunded. In this sector there are three distinct distribution systems:

a) *Distribution to Rural Health Facilities (RHFs) under the "Push" system*
   Distribution to Rural Health Facilities (RHFs) is done by KEMSA along with the Essential Medicines Kit. This system is cyclic and recurs every 3 months. It's a "push" distribution system where the quantities in the kit are pre-determined based on average monthly consumption data. For the FP kit, KEMSA relies on a list of FP commodities with quantities from the DRH. Currently the quantities for FP commodities for the RHF kits are District specific.

b) *Distribution to hospitals and RHFs under the "Pull" system*
Distribution to Hospitals and Rural Health Facilities (RHFs) under the "Pull" system is done by KEMSA along with the Essential Medicines Kit. This system is cyclic and recurs every 3 months for RHFs and every 2 months for hospitals. Quantities for both the RHFs and Hospitals are ordered directly from the facility using the Standard Order and Requisition Form (SORF).

c) *Distribution to District Stores*
The distribution to district stores was previously done by the DRH with support from partners. As from early this year, distribution to district stores has been integrated into the KEMSA distribution system, albeit with challenges. It is also a "push" system and the re-supply quantities are determined using Average Monthly Consumption (AMC) data. This distribution is yet to be institutionalized and it currently rides on the Hospital Distribution cycle (every two months). In addition, KEMSA depends on a distribution list from the DRH for it to effect this distribution.

The private sector, both "for-profit" and "not-for-profit", has very efficient and elaborate distribution systems. Organizations like Population Services International (PSI), AMREF, and Kenya Red Cross (KRC) etc. have their own distribution vehicles and/or warehouses. For those private sector organizations that depend on FP commodities from the GoK, they also depend on the KEMSA district store distribution cycle.

USE

The national FP guidelines recommend a rights-based approach to the provision of contraceptives and assume a holistic view of clients. This view takes into account clients' sexual and reproductive health needs and considers all appropriate eligibility criteria and practise recommendations in helping a client make an informed choice. By ensuring contraceptive commodity security, all potential FP clients should be able to make a free and informed choice as well as understand the appropriate and rational use of their method of choice.

CROSS-CUTTING ISSUES

For effectiveness and efficiency, the commodity security functional components (Selection, Procurement, Warehousing and Distribution and use) do not operate in isolation but are interdependent. Certain key systems must be put in place to ensure that these interdependencies are addressed and that all functional components work cohesively. The common cross-cutting issues in commodity security are; Logistics Management Information Systems (LMIS), Capacity building and Advocacy.

In the recently conducted rapid assessment, availability and use of records in both public and private health facilities was found to be impressive. This indicates that facility staffs appreciate the importance and usefulness of documentation. Records for requesting, receiving, dispensing and reporting were up to date. The other positive thing was the use of similar tools for receiving, dispensing and reporting in most of the public health facilities, this harmonization ensures consistency and ease of analysis and decision making.

1. *Logistics Management Information Systems (LMIS)* – The Division of Reproductive Health (DRH) is in charge of reporting on use of contraceptives while KEMSA manages the operational aspects of the LMIS. Reporting provides useful data for informed decision making e.g. for resupply. Currently 2 distinct reporting systems exist:

- Using the DRH Contraceptive Consumption Data Report and Request (CDRR) Forms – This is a manual system that requires the filling of CDRR forms in triplicate every month. It functions at 3 levels; the Service Delivery Point (SDP), the district and the national level. The SDP CDRRs are completed by the facility in-charge by the 5th of every month and forwarded to the district RH coordinator (DRHC). The DRHC then aggregates all the information in SDP CDRRs and fills the District CDRR and forwards to the Provincial RHCs and the National Logistics Management Unit (LMU) located at KEMSA by the 15th of every month. The copy that goes to the PRHCs is mainly for information and decision making at that level. The copy that is received at the LMU is also used to derive re-supply quantities, for national level decision making as well as for information on the current status of contraceptive use nationally among other things.

- Using the KEMSA Standard Order and Requisition Forms (SORF) – these forms are mainly for use by the sites that "pull" directly from KEMSA. The SORF is completed and submitted to KEMSA every 2 months and is mainly used for derivation of re-supply quantities. It is not a substitute for the CDRRs.

Recently the DRH have started providing feedback to the facilities that report. This feedback is 2-pronged; an auto-generated monthly feedback to all facilities that are supposed to report and a quarterly comprehensive feedback to the provinces and districts. This system is still in its initial stages and the effects are yet to be felt.

2. *Capacity building* – Between 2009 and 2010, the DRH provided training of Provincial and District teams in Reproductive Health (RH) commodity management practices, they included – Some, Provincial and District Public Health Nurses and RH coordinators, Pharmacists and a few stores personnel. In addition, the DRH has developed RH Standard Operating Procedures (SOPs) and Job Aids but is yet to disseminate them to service providers. A few support supervision exercises on RH have been conducted as well as logistics assessments to various sites.

3. *Advocacy* – Various local and international organizations have been involved in advocacy activities that would address commodity security challenges in Kenya. The main issues of concern are additional or improved funding mechanisms for procurement of contraceptives and associated logistical requirements.

From the discussion above, the current FP commodity supply chain system is clearly not very structured and several inefficiencies and gaps can be seen. Regardless, it has some strong points which are well articulated during the recently conducted contraceptives supply and security mini-assessment. These include;

The cost of contraceptives is minimal with a median cost of KES 0 to 100 for all the methods. IUCD's were the most expensive with a median cost KES 100 [range 0 – 1,500], while condoms were relatively low cost with a median of KES 0 and ranging between KES 0 to 20. The main advantage of this is that health facilities are willing and committed to improve access to FP services by charging minimal fees for FP services. Conversely, even the very low costs can be a barrier to some potential FP clients as they may not be able to afford regardless of how cheap they may be.

The largest source of FP commodities is KEMSA at 75% (19% sent directly to facilities and 56% through district stores). This provides an opportunity to improve access to FP commodities because by targeting KEMSA, Tupange will be able to reach at least 75% of intervention facilities.

Majority of the facilities have designated officer(s) responsible for inventory management of FP commodities i.e. requesting, receiving, reporting and storage. This is indicative of a desire to promote accountability and to ensure FP commodities are given the attention they require.

Records for requesting, receiving, dispensing and reporting were up to date while majority of the facilities use similar tools. This indicates that facility staffs appreciate the importance and usefulness of documentation. The uniformity of data collection tools also makes it easier for analysis and targeted capacity building.

The presence of district RH coordinators is a great opportunity for establishing contacts, mobilizing the facility teams and disseminating strategies to the FP facilities.

CHALLENGES OF CONTRACEPTIVE SECURITY IN KENYA

Challenges facing contraceptive security in Kenya are very real and dynamic. In order to understand and attempt to address these challenges, the use of the supply chain functional components and understanding cross-cutting issues is imperative.

The rapid assessment, recently conducted in the Tupange intervention cities, showed the real and perceived FP commodity security challenges at the facility and district levels. It also brought out the strengths and weaknesses of the existing FP commodity supply chain system thus giving Tupange the necessary insight on required interventions.

During the rapid assessment, the national FP program manager admitted that the FP supply chain system was complicated and confusing. He also mentioned that some of the decisions regarding FP commodity supply chain systems are made at higher policy levels where the program has minimal control.

According to the survey, majority of the respondents did not clearly understand the national FP commodity supply chain system or understood only certain components. As a result, service providers are not able to comprehend the importance of correct, accurate and timely quantification and forecasting of facility contraceptive needs; need for documentation of all transactions; correct and timely reporting and specific roles and responsibilities in relation to FP commodity security.

The District RH coordinators have different understanding of how the national FP commodity supply chain and logistics system functions. This is very critical because they are the coordinators of the program at the grassroots. Therefore, their lack of understanding makes it very difficult for health facility staff whom they supervise, train and mentor to be able to know the requirements of the system.

SELECTION

Currently selection of all public health commodities is the mandate of the Department of Pharmacy (DoP) under the ministries of health in collaboration with KEMSA. The registration of health commodities is done by the Pharmacy and Poisons Board (PPB).

Both the DoP and the PPB do not have the capacity (both infrastructural and technical) to conduct research and introduce new contraceptive methods in Kenya. The GoK does not provide funds for contraceptive research and any such research is funded by donors and conducted by

NGOs. In addition, there are structured RH research protocols developed in Kenya by the NGO community which the GoK have adapted and used.

The Pharmacy and Poisons of Board have started pharmacovigilance monitoring for other medicines and it is recommended to include contraceptives in this monitoring system.

FINANCING AND PROCUREMENT

Due to regular contraceptives stocks outs, the DRH has limited data on the actual demand of the contraceptives commodities in the country. There exists a serious disconnect between demand and supply of contraceptive commodities.

Results of the rapid assessment indicated that there is inadequate financing to ensure Contraceptives commodity security. There also appears to be little joint planning, advocacy and resources mobilization between the government and its stakeholders in ensuring commodity security. Solid financial commitments by donor agencies and social marketing organizations are not always known at the DRH.

Funding of contraceptives depends on both GoK and donor funds. Although the government has been allocating some amount of money for procurement of contraceptives, this amount is still insufficient to cater for current and future needs. The national health budget on medicines which include contraceptives has dropped from 12% in 2008-2009 and 10% in 2009-2010 to 8.87% in the current fiscal year.

Diverse funding strategies for contraceptives are not well explored and there is need for the government to take lead in these activities. The public/private interaction, especially regarding contraceptive financing is very blurred. Clear, evidence driven strategies need to be put in place. Certain strategies e.g. the Out-Based-Aid[1] (OBA) voucher system, the social marketing system etc. have been attempted but suffer from inadequate government leadership and are donor or NGO driven. In addition, use of other government funds at the community and local government levels such as Constituency Development Fund (CDF), Local Authority Transfer Fund (LATF), etc. have not been explored.

Procurement systems are different and depend on different funding agencies. Thus, differences in procurement lead times may cause delays in delivery of commodities, while differences in procurement audit systems may compromise quality. Procurement Lead times range from 9 months for the most efficient up to 12 months or more.

Quantification of private sector and municipal county needs that depend on government stocks is also a challenge. Usually the government is not involved in the private sector quantification processes and there is lack of clarity on actual need. Therefore, the private sector demand is hardly clear and sometimes it may lead to consumption of contraceptives identified for the public sector.

Another issue is that forecasting and quantification skills at lower levels are wanting. The rapid assessment indicated that most service providers lack these skills and the few who have, lack good quality information to effectively quantify there actual needs.

[1] The OBA/ voucher concept represents a demand-side approach to financing health care by subsidizing health care clients directly and dispensing money only when services are actually provided. The client is free to choose a service provider which may be public, private or a non-governmental organization (NGO) from a list of approved health facilities

WAREHOUSING AND DISTRIBUTION

The rapid assessment indicated that 80% of facilities assessed had experienced stock outs of at least one FP commodity lasting 5 days or more. At the same time, the national FP manager maintains that there are sufficient stocks of most contraceptive methods to last the next 18 months. This is a situation of stocks being available at national level (KEMSA) but lack of an efficient and well-coordinated supply chain system to deliver the same to where they are needed. During a Tupange meeting in Mombasa, the DRH reported having over six million injectables, yet most of Coast province had low or no stocks of the same commodity!

In addition, KEMSA being the largest source of FP commodities and having been blamed as being unreliable, inefficient and untimely (according to respondents in the rapid assessment) it means that many facilities and by extension clients are not assured of receiving the FP methods of their choice.

Approximately 46% of the assessed facilities showed fair or poor storage conditions (both capacity-wise and equipment-wise). Some limitations to good storage that were observed included inadequate or complete lack of storage space; very tiny and crammed up stores/cupboards; poorly ventilated or no ventilation at all.

In addition, storage records were poorly kept as there were no standardized storage tools available (bin cards, ledgers, dispensing tools, etc.). Facilities improvise or use other records such as dispensing and reporting records as storage records. Therefore, there is need to strengthen record keeping at the storage area.

After integrating the FP commodity distribution to district stores with the regular hospital distribution cycle, there was hope that this would increase efficiency and lead to reduced stock-outs at the district stores. The main challenge is that the system is ad hoc and depends on provision of a distribution list to KEMSA by the DRH. In February and March this year, KEMSA in collaboration with DRH and partners, conducted the first such distribution.

There is also lack of clarity in the funding for warehousing and distribution of FP commodities. According to KEMSA all commodities procured, warehoused and distributed by them are subject to a 10% fee broken down as follows; 2% Procurement, 3% warehousing and 5% distribution. These logistical fees are not usually factored in by donors when they procure for and donate to the government. In addition, the GoK does not provide sufficient funds for these logistics including commodities it has procured itself.

Distribution or collection of contraceptives by municipal council and registered private sector facilities (those with Service Delivery Point numbers) does not occur as well as it should. Many of them may not even be aware that they are allowed to collect contraceptives from district stores. Because of perennial stock-outs at district stores, some of the municipal clinics and registered private sector organizations that can collect contraceptives from district stores end up giving up and/or forgetting and may need to be reminded and alerted once the contraceptives arrive at the district stores.

There is also inadequate capacity to distribute commodities from the district stores to other facilities including the lack of vehicles for collection and/or distribution. The same challenge is felt when it comes to redistribution and reverse logistics.

USE

The rapid assessment indicated that only 11.4% of facilities offered the full range of contraceptives. Since uptake and use of FP in Kenya is premised on informed choice, the lack of availability of all contraceptive methods denies clients full access to a preferred method thereby increasing the chances of non-compliance.

The appropriate use of contraceptives is a major challenge, especially Emergency Contraception (EC) which is used as a regular method by many clients, especially young women.

There exists a great deal of provider bias to some potential FP clients and this makes them fear to seek information on contraceptive use[2] - Some of these biases include; limited counselling on available FP options and side effects as well as condescending or unfriendly language; Providers also reported being overwhelmed by staff shortages and heavy workloads. In such cases, a provider noted, it is easier to provide the method the client asks than to initiate a full counselling session; poor provider-client interactions.

Poor counselling skills among providers also cause poor use or uptake of certain methods of contraception. In addition, there are many myths and misconceptions propagated in many communities as well as political interference leading to lack of use by many potential clients.

CROSS-CUTTING ISSUES

Logistics Management Information Systems (LMIS)

Due to inconsistency and lack of a clear number of facilities providing FP nation-wide, the actual reporting rates are not really known. As of January this year, based on the "expected" reporting rates, the SDP reporting rates were 57.2%. These reporting rates are very low for efficient planning.

When using the "push" system where commodities are supplied with or without reports, there is a tendency for the SDP personnel to disregard the importance of reporting as it does not matter whether they report or not. The general assumption is that the information contained in the report is only used to determine re-supply quantities and forget that it is very useful in national FP commodity forecasting and quantification.

The human resource capacity for quality reporting is also inadequate. Both skills and numbers are lacking when it comes to reporting. The SDP in-charge is expected to provide services, manage the institution and prepare multiple programmatic reports on time. This has led to data quality challenges such as late reporting, inaccurate reports, and incorrect reports among others.

Multiple tools exist for reporting and ordering – KEMSA Standard Order and Requisition Forms (SORF), SDP and district CDRRs. In addition, these tools are manual. To further compound the problem, there exist multiple reporting systems with the potential for duplication i.e. SORF are sent from "pull' facilities directly to KEMSA and also to the DRHC. The DRHC aggregates the report and also send to the LMU which is housed in KEMSA – in reality the quantities ordered

[2] In 2009, Health Policy Initiative, through USAID funding carried out various analyses to quantify the level of inequality in FP/RH service access, identify the barriers the poor face in seeking services.

will be the same in both the CDRR and the SORF. Currently the CDRR booklets are inadequate and most health facilities cannot report or would have to dig into their pockets to print/photocopy the CDRR in order to report.

The skills required to make decisions using the available data is also inadequate. The existing system, though designed for multi-level usage, is mainly used at central level and most personnel at the lower levels do not use this information to make decisions at that level.

There is a clear disconnect between provision of contraceptives to the private sector and the demand for private sector reporting. Most private organizations do not report regularly and some not at all, yet they are supplied with contraceptives from the government. Thus, when the national F&Q is being conducted these private sector facility requirements are not factored in. But when procurement is done, they demand to be supplied thereby resulting in insufficient stocks for the public sector facilities and the private sector facilities that have reported.

Capacity building

Although there have been several trainings on RH commodity management there is still very high staff attrition at public health facilities. This leads to insufficient commodity management skills and numbers. The private sector has not been involved in these trainings and therefore is low on commodity management skills.

Because of the poor or complete lack of dissemination of RH commodity management job aids and SOPs, inventory management reference documents for facility personnel are unavailable. This can be challenging especially for SDP personnel who have limited skills in RH commodity management. Interestingly, these SOPs and job aids are available nationally.

There is also inconsistent and irregular support supervision to both public and private health facilities thereby denying SDP personnel an opportunity to express their challenges to superiors on a regular basis. In addition, these support supervision exercises would be used to conduct informal on-the-job-training and mentorship to SDP personnel.

Advocacy

Appreciation of the need for family planning services among the political leadership is still lacking and therefore convincing them to increase the budgetary allocation for contraceptives and associated logistics becomes very difficult.

Some members of the donor community are still not convinced about funding logistics as they believe their contribution for contraceptives should be complemented by the government providing funds for logistics.

TUPANGE RESPONSE IN ENSURING COMMODITY SECURITY

The recently conducted contraceptive supply and security rapid assessment clearly articulates some of the challenges faced at the facility and district level and proposes the following recommendations:

1. Capacity building (Training, Review and Dissemination of SOPs and Job Aids, mentorship, etc.) of FP methods needs to be conducted in all facilities in order to improve access.

2. The supply chain and logistics system to be reviewed and streamlined such that, whether facilities receive their supplies directly from KEMSA or from the district store, the system

should be: regular, reliable and timely to ensure uninterrupted supply of contraceptives to facilities and avert the too common stock outs.

3. Data collection and reporting tools to be availed and users trained on them for consistent quality data. This will lead to improved quantification of reorder quantities, national forecasting and quantification, minimal stock–outs etc.

4. Adequate commodity financing to ensure security of contraceptives is an urgent need to ensure the pipelines are sufficiently filled and regularly replenished with strong supply chain management. The FP program together with its stakeholders has developed the National Contraceptive Commodities Security Strategy – 2007 to 2012 (2). This strategy should be implemented sooner than later to ensure contraceptives security in Kenya.

5. Once streamlined, the system should be disseminated to all stakeholders including; Personnel from MOPHS and MOMS, District and Municipal council RH Coordinators, Health Facility staff, community staff etc. so that all players have a clear understanding of the system, how it works and roles and responsibilities of all players.

6. Storage conditions at target health facilities to be improved either through provision of cabinets or renovations of existing stores, together with provision of specific storage records to be used at the storage area.

Based on these recommendations, discussions with various stakeholders, available documentation and other contraceptive security issues and challenges articulated above, Tupange in collaboration with the DRH and KEMSA, proposes to do the following;

1. Preparatory Activities;

This Contraceptive Security Issues Paper (CSIP) highlights the current Commodity Security status, identifies challenges and proposes recommendations and actions which will be used to review the Tupange year two and subsequent year work plans

Tupange will develop an inter-agency commodity security action plan which will highlight specific roles and responsibilities for DRH, KEMSA, District RH Coordinators, and the Tupange commodity security team **(Annex 1)**

Tupange will use information from the CSIP to develop a Tupange Contraceptive Security Framework for all Cities.

Tupange will also support the review and dissemination of Contraceptive Commodity Management Standard Operating Procedures (SOPs) and Job Aids to be used by all Tupange facilities.

Train city level facility staff on Reproductive Health Commodity management. This will strengthen their capacity to quantify and forecast commodity needs at the national and city levels as well as improve their inventory management and LMIS skills.

2. Financing and Procurement

Actively participate in the national FP commodity forecasting and quantification (F&Q) exercise. This will ensure contraceptive forecasts for Tupange intervention facilities are included in the national forecasts as well as advocate for inclusion of logistics costs (procurement, warehousing and distribution) and not just commodity costs in the national FP commodity F&Q.

Tupange will conduct a rapid review of selected facilities in Nairobi, Mombasa and Kisumu to establish actual average monthly consumption of contraceptives as well as factor in demographic realities. This information will be used to quantify quarterly city and facility needs and include an appropriate wastage factor and sufficient buffer stocks to accommodate supplier lead times and unanticipated delays.

In addition, using data from the 2009 Kenya Population and Household Census report that gives numbers of women of reproductive age in each of the target cities and tabulation of the current reproductive methods used in Nairobi, Nyanza, Coast, Eastern and Western provinces, Tupange has developed three year (2010-2013) draft contraceptives projections of Nairobi, Mombasa, Kisumu, Kakamega and Machakos. These projections will be shared by DRH, KEMSA and all the project sites for their buy-in and ownership and also ensure they are included into the national contraceptives projections. They will also be used for advocacy for target cities to request for/allocate funds for the contraceptives. The targets will be updated on an annual basis to ensure any and all variations are captured and factored in the national quantification.

3. LMIS and Capacity Building

Tupange, in collaboration with DRH and KEMSA, will roll out the Intrepid SMS Reporting and Ordering system. This system has been developed and is currently being piloted in 6 facilities to gather input from the service providers and users.

Intrepid allows access to both KEMSA headquarters, the DRH commodity monitoring Unit and cities to track contraceptives use. This system will enable Tupange, DRH, KEMSA and cities to identify the supply breakdowns and recommended actions to be taken to address them.

Once recommendations from service providers are included and the INTREPID system is finalized, Tupange will:

- Train 22 managers (DRH, KEMSA, and City) in the Intrepid SMS supply management system;
- Support data collection and analysis through the Intrepid system and provide airtime to those sending the reports.
- Provide onsite training to two inventory/Stores managers (300) from each facility (both public and private) in the target cities. This would be followed up with on job training (OJT) at the facilities by the Tupange City Logistics Officers and the Tupange National Contraceptive Logistics Officers.
- Develop action plans and follow up on intrepid results/recommendations.

To date a server has been procured and Intrepid SMS Reporting and Ordering system installed on the same. PAAL team has been trained on the same and will be used to initially train teams from KEMSA and DRH on the same. When the Tupange National Contraceptive Logistics Manager and the City Contraceptive Logistics Officers are on board they would be trained on intrepid system before the inventory/stores managers are trained on the same. A similar training would be carried out for District Reproductive Health Officers from target cities.

In collaboration with the District and Municipal Council RHC, organize and participate in quarterly support supervision to Tupange Intervention facilities and provide OJT where necessary

4. Distribution

In the short term, Tupange will support the DRH and KEMSA to quantify and distribute commodities to District Stores in Nairobi.

Tupange, in collaboration with DRH, KEMSA, city and district staff, will identify distribution gaps in all intervention cities and develop a quarterly distribution plan in order to minimize stock outs.

Based on the CSIP and actual contraceptive needs and projections, Tupange in collaboration with DRH and KEMSA will develop an action plan to address bottle necks and gaps for FP commodity distribution for Phase 2 urban centres.

Support Tupange intervention sites in redistribution and reverse logistics of contraceptives between high- and low-stocked facilities to prevent wastage and minimize stock outs.

5. Use

Tupange, in collaboration with the Pharmacy and Poisons Board and DRH, intends to train service providers from both the private and public sector in counselling on appropriate/rational use of contraceptives.

In addition, Tupange will also advocate for inclusion of contraceptives in the national pharmacovigilance data collection and analysis system.

6. Update and feedback meetings

Tupange, in collaboration with DRH and KEMSA, will develop a framework for monthly and quarterly contraceptive supply chain support supervision and feedback meetings for all intervention cities **(refer to Annex 1)**

OTHER ACTIVITIES

Participate in the DRH led National Family Planning Technical Working Group to ensure that Commodity Security Issues flagged by Tupange are addressed

Participate in the National FP Supply Chain Technical Committee where issues raised by Tupange supported facilities will be raised and addressed.

Participate in the Reproductive Health Interagency Coordinating Committee (RH ICC) through NCAPD to ensure all Tupange issues are articulated

In collaboration with NCAPD, DRH and other stakeholders, advocate for increased funding for contraceptives and associated logistics. In addition, Tupange intends to facilitate discussions between KEMSA, DRH, DOP and other relevant stakeholders to advocate for structural changes that will streamline the FP commodity Supply Chain System.

Leveraging for Contraceptives for Tupange from other sources

- China is the Chair of South – South Co-operation in Population and Development and Kenya serves as the Secretary. Last year, China donated a substantial amount of equipment as part of the Sino-Kenya Reproductive Health Centre Capacity Building

Program through NCAPD. Tupange is in discussion with NCAPD to advocate for a large donation of Sino Implant (ll) under a similar arrangement for the project.

- Tupange will explore the idea of establishing a Contraceptive Revolving Fund for the private sector. Tupange will approach development partners such as DFID, USAID, UNFPA, GIZ, China and India

- PAAL is negotiating with Population Services International to access the brands that are available in their social marketing programs.

- PAAL is in a position to access Family Planning equipment from Marie Stopes International which will be used to equip the Tupange facilities.

- PAAL has also been negotiating on the transfer of registration of the MSK brand of emergency contraceptive pills (Smart Lady) with an aim of supplying the non-profit facilities at no or minimal mark-up. This brand would end up being cheaper than the brands available in the Kenyan market.

- PAAL is also in discussion with two Indian manufacturers; one for emergency contraceptive pills and the other for IUCDs (Acme Formulations and Pregna respectively) with a view to registering their products in Kenya and increasing the variety of brands in the Kenyan market. These registrations should come through towards the end of 2011.

- Zarin (Sino Implant) has been registered in Kenya and procurement agreements have been signed with Marie Stopes International (MSI), Population Services International (PSI) and the International Planned Parenthood Federation (IPPF) subsidiary ICON. This cost effective contraceptive implant would ensure that current funds available to them can procure close to three times the quantity of implants. The pharmacological and clinical dossier for Zarin has also been submitted for inclusion in the list of World Health Organization (WHO) list of pre-qualified products to ensure that it can qualify for procurement by KEMSA. Zarin is also available to the private sector; in workplace clinics, franchised networks and programs that have finances to buy commodities. PAAL are currently working on a tender for PSI to procure Zarin through Crown Agents Kenya Limited for a DIFID funded project. Similar avenues will also be explored with other donors.

CONCLUSION

As seen above, increased uptake of family planning largely depends on an efficient and effective FP commodity supply chain system. Though there have been several initiatives to ensure contraceptive security in Kenya, it still remains one of the biggest challenges in family planning programming. For Kenya to achieve this success, it must be clearly understood by all stakeholders that commodity security is a dynamic process, dependent on many inter-related and inter-connected components and therefore, no single organization can succeed by working in isolation. Tupange is willing to work with and support the government and other stakeholders to ensure the contraceptive pipeline is always full, minimize losses due to expiries, damage etc., and build the capacity of service providers with a view to achieving contraceptive security.

This is a live paper that has taken a holistic, client centred and client driven approach to FP commodity security. It covers the entire Kenya Urban Reproductive Health Initiative. However,

if additional information is availed and/or changes occur in the current commodity security environment, necessary additions, alterations or deletions will be effected.

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KENYA URBAN REPRODUCTIVE HEALTH INITIATIVE

INTER-AGENCY COMMODITY SECURITY ACTION PLAN

May 2011

INTRODUCTION

This work plan intends to concretize specific duties, roles and responsibilities for key Tupange stakeholders at the national and district level. These stakeholders are categorized based on the level of activity; at the central level, the key stakeholders include DRH, KEMSA and Tupange national team while for the district teams, the key stakeholders are district RH coordinators, facility in-charges, service delivery personnel and Tupange city staff.

Most of the activities mentioned under each stakeholder are interdependent and will be conducted collaboratively between the different stakeholders. But for efficiency and accountability, the stakeholder under which the activity is mentioned retains the responsibility of ensuring the activity is completed at the appropriate time.

CENTRAL LEVEL

DRH ROLES AND RESPONSIBILITIES

1. Identify and assign a DRH officer to be the focal person for Tupange activities
2. Prepare a letter, addressed to the CEO of KEMSA, authorizing KEMSA to provide consumption and distribution reports to the Tupange contraceptive security (CS) team on a monthly basis.
3. Involve KEMSA and the Tupange CS team in the National Reproductive Health (RH) commodity forecasting, quantification and procurement planning exercise and ensure inclusion of projected quantities for Tupange intervention sites into the derived national quantities.
4. Provide input on the draft Tupange Contraceptive Issues Paper and the contraceptives mini-assessment, before finalization.
5. Prepare a letter addressed to the provincial RH coordinators for the three Tupange intervention cities, authorizing them to support the roll-out of the intrepid system.
6. Authorize Tupange intervention sites to utilize contraceptives from public sector stocks.
7. Introduce Tupange team to the provincial and district RH coordinators in the intervention cities for easy access to the necessary information and for ease of execution of defined activities. This has already been done through the implementation meetings
8. Be involved in the quarterly support supervision conducted in all Tupange intervention cities and conduct OJT where necessary- DRH will support provincial level, RH coordinators will support district and facility level.
9. Support facilitation of RH commodity Management trainings to ensure RH policy issues are well articulated

10. Chair monthly meetings to discuss commodity security issues affecting the Tupange intervention sites and to discuss findings from intrepid reports. Tupange to be incorporated to the Monthly CS meeting held with MSH & KEMSA.
11. Prepare a letter, addressed to the Nairobi provincial and Starehe district RH coordinators, authorizing Tupange to pilot the intrepid system in identified public health facilities.

KEMSA ROLES AND RESPONSIBILITES

1. Participate in the National RH commodity forecasting, quantification and procurement planning exercise
2. Warehouse all contraceptives in their central warehouse at Embakassi and male condoms in both the central and regional warehouses.
3. Distribute contraceptives to all Tupange sites on a quarterly basis for the "push" sites and every two months for the "pull" sites
4. Collaborate with DRH to distribute and ensure saturation of contraceptives in district stores on a quarterly basis
5. Provide the monthly contraceptive consumption data report and request (CDRR) forms, for all Tupange intervention facilities, to the national Tupange CS team
6. Provide a monthly distribution report to the national Tupange CS team
7. Participate in the quarterly support supervision exercise and conduct OJT where necessary
8. Participate in the RH commodity management trainings and facilitate understanding of the contraceptive supply chain system.
9. Provide input on the draft Tupange Contraceptive Issues Paper and the contraceptives mini-assessment, for finalization.
10. Attend monthly CS meetings with Tupange & DRH & MSH to discuss commodity security issues affecting the Tupange intervention sites and to discuss findings from intrepid reports.
11. Develop Plans to replenish buffer stocks that have been exhausted, as a result of out-/in-reach activities or any other emergency for Tupange intervention sites.

TUPANGE ROLES AND RESPONSIBILITES

1. Prepare and share the draft Contraceptive Security Issues Paper with the relevant stakeholders
2. Develop and share the Tupange contraceptive security framework
3. Develop/adopt and **disseminate** RH commodity management Standard Operating Procedures for national, district and facility personnel. This will require collaboration with MSH
4. Develop a quarterly distribution plan for all Tupange intervention facilities and share with KEMSA and DRH.
5. Participate and include Tupange contraceptive requirements in the national RH commodity forecasting, quantification and procurement plan
6. Develop a one-year consumption based quantification of contraceptives for Tupange intervention facilities and include it in the national RH commodity forecasting, quantification and procurement plan
7. Establish contraceptive buffer stocks and develop a storage system for Tupange cities
8. In collaboration with DRH, KEMSA and MSH/HCSM, train 120 Tupange intervention facility staff on Reproductive Health Commodity management (both Public and Private sector facilities).
9. Support Tupange intervention sites in quarterly redistribution and reverse logistics of contraceptives between high- and low-stocked facilities.
10. Support and participate in quarterly support supervision of contraceptives in Tupange intervention facilities and conduct OJT where necessary.
11. Conduct monthly follow-up activities from Tupange intervention facilities; reporting, stock status, supplies, feedback, etc.
12. Pilot the Intrepid SMS reporting system in 3 public sector facilities and collect reactions from the pilot sites for input and finalization of the system
13. Train 22 managers (DRH, KEMSA and City) in the Intrepid SMS supply management system
14. Provide onsite intrepid training to two inventory/Stores managers (300) from each facility (both public and private) in the target cities.
15. Implement the Intrepid SMS reporting system at all Tupange Intervention facilities and monitor the reporting outcomes
16. Analyse data from the Intrepid system, develop action plans and follow-up on the results/recommendations
17. Develop and implement a private non-profit system for the purchase of commodities and equipment for Tupange intervention facilities (private buffer stock)

18. Develop and implement a private for-profit system for the purchase of commodities and equipment for Tupange intervention facilities (private buffer stock)
19. Support storage and distribution of FP service delivery equipment as and when needed
20. Identify and negotiate with manufacturers of contraceptives to lower the costs of FP products to market, including leveraging complementary and on-going efforts to promote Zarin.
21. Advocate for Pro Poor policies with Government and other stakeholders through NCAPD.
22. Advocate for funding and support for contraceptive logistics with Government and other stakeholders through NCAPD.
23. Work towards setting up buffer stocks in case of National level stock outs (through partners such as MSK and PSI)

DISTRICT LEVEL

DISTRICT RH COORDINATORS – ROLES AND RESPONSIBILITES

1. Provide feedback to all Tupange intervention facilities on their monthly performance in terms of reporting, i.e. the reporting rate, timeliness, data quality and comparative performance.
2. Conduct monthly support supervision to Tupange Intervention facilities and provide OJT where necessary
3. Coordinate redistribution and/or reverse logistics for contraceptives between facilities and the district store, respectively.
4. Participate in the RH commodity management trainings of service delivery personnel (both in the public and private sector) in Tupange intervention facilities
5. Coordinate and participate in the training and roll-out of the Intrepid SMS reporting system in their respective districts

TUPANGE CITY LOGISTICS OFFICERS

1. Send reminders to all facility officers on regular reporting through the Intrepid SMS reporting system by the 3rd of every month
2. Coordinate provision of airtime to service delivery personnel in the Tupange intervention facilities
3. Support and participate in monthly support supervision to Tupange Intervention facilities and provide OJT where necessary
4. Analyse data from the intrepid system in the Tupange intervention facilities falling within the district.
5. Generate feedback reports from the analysed intrepid data and support the District RH Coordinator in the dissemination of these feedback reports. Provide Monthly feedback to the health facilities and city managers on reporting performance including the reporting rates, data quality and timeliness
6. On a monthly basis, calculate and support redistribution/reverse-logistics of surplus quantities between facilities in their respective cities
7. Participate in the RH commodity management trainings of service delivery personnel (both in the public and private sector) in Tupange intervention facilities
8. Support and participate in the training and roll-out of the Intrepid SMS reporting system in their respective cities
9. Generate monthly contraceptive security activity reports for each city for discussion in the central level Tupange contraceptive security meeting

CONTRACEPTIVE SUPPLY AND SECURITY IN KENYAN URBAN AREAS: A RAPID ASSESSMENT IN 3 URBAN SITES

APRIL 2011

PHARM ACCESS AFRICA LIMITED
For
TUPANGE PROJECT (KURHI)

ACRONYMS AND ABBREVIATIONS

BMGF	Bill and Melinda Gates Foundation
CDRR	Consumption Data Report and Request
COCs	Combined Oral Contraceptives
CPR	Contraceptive Prevalence rate
DRH	Division of Reproductive Health
FBO	Faith Based Organization
FP	Family Planning
IUCD	Intra-Uterine Contraceptive Device
ICRH	International Centre for Research in Health
KEMSA	Kenya Medical Supplies Agency
KII	Key Informant Interviews
KURHI	Kenya Urban reproductive Health Initiative
LAM	Lactational Amenorrhoea Method
MOPHS	Ministry of Public Health and Sanitation
MSK	Marie Stopes Kenya
POP	Progestin Only Pills
PSI	Population Services International
RH	Reproductive Health
SDP	Service Delivery Point
SOPs	Standard Operating Procedures
PAAL	Pharm Access Africa Limited

PURPOSE

To review how the public and private sector contraceptive supply systems function in the Tupange Project Phase 2 cities - Nairobi Mombasa and Kisumu with a view to identify the strengths and weaknesses of the supply chain system at the health facility level in order to provide important recommendations to inform commodity security interventions for Tupange.

As part of the government's poverty reduction strategy, the stated policy is to increase coverage of all health services, and to reduce the financial burden for poor households. Despite the continued commitment to the promotion and provision of adequate reproductive health services, the family planning (FP) commodities situation remains unreliable. There are concerns of frequent and prolonged stock-outs of contraceptives and other related commodities in health facilities and at district stores.

METHODOLOGY

A Purposive but not representative sample of public, private and faith-based health facilities and drug retail outlets were selected from five districts across the three urban areas: Nairobi, Mombasa and Kisumu. Both qualitative and quantitative methods were used to collect data. FP service providers at facilities responded to structured, interviewer-administered questionnaires on the availability, costs, and stock-out situation of contraceptives. Key informant interviews with stakeholders within the reproductive health sector were also conducted and their views on ways of improving the contraceptive supply and security system noted.

Data was collected between 14th and 22nd March, 2011 in 5 districts. 35 FP service providers at health facilities and pharmacists/pharmaceutical assistants at 13 retail outlet respondents were interviewed. Key Informant Interviews (KII) were conducted with the National Family Planning Program Manager at the Division of Reproductive Health (DRH) and .5 Ministry of Health District RH coordinators from sampled Districts

DESCRIPTION OF THE SAMPLE

Thirty five health facilities and 13 retail outlets in Nairobi, Mombasa and Kisumu were visited. Their distribution is presented in Annex III. Of the 35 health facilities, 18 (51.4%) were public high volume facilities (Ministry of Health (MOPHS/MOMS)), 12 (34.3%) were private and 5 (14.3%) were faith-based organization facilities (FBO's).

SUMMARY OF KEY FINDINGS

All district stores as well as most health facilities were out of stock for key short term and long term contraceptives commodities at the time of the survey. Both the district RH coordinators and Health facility staff were dissatisfied with the logistics and supply chain system for contraceptives.

There was a wide range of contraceptive methods offered in health facilities in terms of availability of services and capacity to offer the service at that particular facility, although reports of stock-outs of the required commodities of 5 or more days in the previous one year stood at 80% of the facilities.

In most health facilities, inventory management practices were followed with documentation of requisitions, receipts and consumption data accompanied by periodic summaries and submission of reports being up to date. However, storage practices and space was constrained. There were no Standard Operating Procedures (SOPs) in most facilities.

The supply system from Kenya Medical Supplies Agency (KEMSA) and district level depots was reportedly not working well, due to its unreliable nature, often resulting in frustration both at their level and at facilities level.

The main private actors in the supply chain system are Population Services International (PSI) and Marie Stopes Kenya (MSK). They distribute contraceptives at a subsidized cost, mainly to the private sector and help to fill in the gap by providing contraceptive methods that the public facilities had no capacity to offer, mainly the long acting methods.

Retail outlets are limited in the range of certain commodities, especially the long acting methods, which were not available at the time of the study. The picture is further complicated by the 'for profit' aspect because the costs of the contraceptives are shouldered by clients. Private practitioners however appear willing to partner with the government as stakeholders in improving access to FP services.

The supply system in its entirety was identified as weak, not clearly understood at facility level and unresponsive to the needs of its users.

There are frequent stock outs due to unreliable delivery schedules and also due to the failure to use consumption data from health facilities in making re-supply decisions. Stocks are therefore pushed to facilities ('push-system').

Documentation and inventory management systems are in place but need to be strengthened and made more efficient.

There is an overall need for commitment and coordination of contraceptive supply both short term methods and long term methods, logistics, and capital/financing for availability of contraceptives in Kenya.

SUMMARY OF RESULTS

Generally, health facilities exhibited a mixed family planning client workload. On average, facilities served a monthly median of 134 (range 1 – 762) family planning clients. As shown below, about a third of the health facilities served on average 100 or less clients per month, and slightly over a third (37.1%) received between 101 and 200 clients. Two facilities (5.7%) had a high number of clients (over 700).

TABLE 1: NUMBER OF FAMILY PLANNING CLIENTS AT FACILITIES (PRIVATE AND PUBLIC COMBINED)

Number of Clients	Number of Facilities	Percentage
100 or Less	12	34.3
101 - 200	13	37.1
201 - 300	4	11.4
301 - 400	4	11.4
701 and Above	2	5.7
Total	**35**	**100.0**

CHOICES FOR POST-PARTUM MOTHERS

POP has been the recommended method of FP for postpartum mothers for a long time however, it is no longer the first recommended method. All progestin only methods such as implants and

injectables, and barrier methods such as IUCDs and condoms are acceptable. This means that post-partum clients have a wider range of FP methods to choose from.
Nine (25%) out of 35 health facilities visited said they had never been out of stock for POP. 26 (75%) had experienced stock outs of POP and they had different options given to the clients, as shown in the table below.
TABLE 2: OPTIONS FOR POST-PARTUM CLIENTS

Option	Number of Health Facilities	Percentage
Offer alternative methods (Implants, Injectables, IUCD or condoms)	11	43
Refer to other Health Facilities	8	30
Give clients prescriptions to buy POP from chemists	5	19
Offered counseling on Lactational Amenorrhoea method	2	7
Total	26	100

COST OF CONTRACEPTIVES

FP service providers at facilities and retail outlet pharmacists were asked how much the clients had to pay for contraceptives. Because of the wide variation in costs at facility and retail outlet levels, the fact that some health facilities offer these services for free, and skewed nature of data, only the median costs per visit are presented below

TABLE 3: COST OF CONTRACEPTIVES PER CYCLE

	Health Facility Cost [KES]		Retail Sector	
FP Method	Median	Range	Median Cost	Range
Progestin Only Pills	20	0 – 100	240	20 – 1,200
Combined Oral Contraceptives	20	0 – 100		
IUCD	100	0 – 1500	Not on offer	Not on offer
Emergency Contraceptive Pills	0	0 – 120	120	70 – 120
Male Condoms (1 month supply)	0	0 - 20	97.5	10 – 200
Injectables	25	0 – 200	50	50 – 340

The data show that contraceptive pills were offered at a median cost of KES 20 in health facilities, with the cost ranging from free pills to KES 100 per cycle per client. Retail outlets were more expensive, with a median of KES 240 (range 20 – 1,200). At the facility level, IUCDs were the most expensive – median cost KES 100 [range 0 – 1,500], while condoms were relatively low cost with a median cost of 0 and ranging between KES 0 to 20. Male condoms at retail outlets cost almost KES 100 (range 10 – 200).

Note - None of the visited facilities independently offered surgical sterilization. 6 offered male sterilization and 11 offered BTL Bilateral Tubal Ligation on a monthly basis through visiting clinicians from MSK. One facility referred clients both for female and male sterilization to the district hospital.

SOURCES OF CONTRACEPTIVES AND CONSUMABLES

Facility Sources of Contraceptives

More than a half (56%) of the respondents from health facilities indicated that they got their supplies from the district stores while about a fifth (19%) sourced directly from KEMSA. Local retail outlets (chemists) made a significant contribution, at 13% of all sources. Other less significant sources of FP commodities for facilities included PSI (6%), Marie Stopes Kenya (4%) and Aphia II now Aphia plus (2%).

District sources of contraceptives

About a third of respondents (31%) sourced their FP commodities from KEMSA. At the district level PSI was a significant source of contraceptives, accounting for almost a quarter (23%) of contraceptives

However, this reflection is not entirely true because supplies from PSI were not routine and regular but were availed on request from district RH coordinators when they were stocked out or were donated by PSI when they were organizing an outreach or sensitization of FP services. The others included DRH (through KEMSA) and MSK (at 15% each) and local chemists and NGO's at 8% each.

STOCK OUTS OF CONTRACEPTIVES

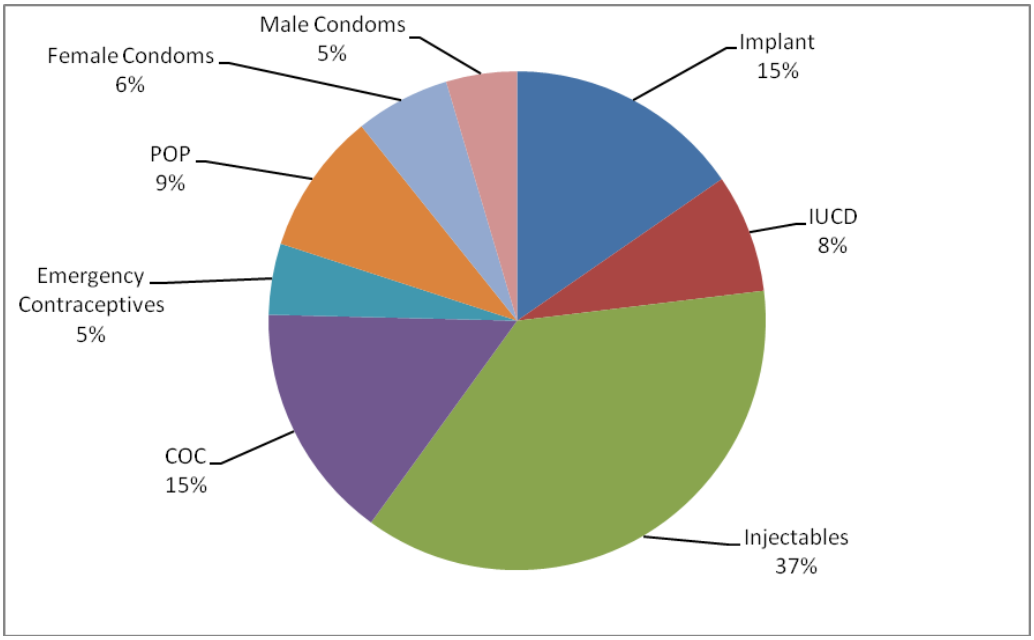
Facility staffs were asked if they had experienced a stock out of 5 days or more of FP commodities within the past one year. 80% of facilities reported experiencing stock outs lasting 5 or more days in the last one year. 6 facilities reported not experiencing such a stock outs while data was not obtained for one facility.

TABLE 4: FACILITIES EXPERIENCING 5 DAYS OF STOCK-OUTS

Stock out Experienced	Number of Facilities	Percentage
Yes	28	80
No	6	17
No response	1	3
Total	**35**	**100**

The 28 facilities that experienced stock outs were asked to mention the specific contraceptives that had been out of stock. The Figure below shows the proportion of contraceptives that were mentioned as being out of stock. Out of 65 responses, 37% cited stock outs of injectables, 15% cited stock outs of implants and COCs each. POP was out of stock in 9% of the cases while IUCDs were out of stock in 8% of the cases. Female condoms were stocked out 6% of the times while the male condoms were out of stock in 5% of the instances. Emergency contraceptives (EC) and condoms were the least stocked out items (5%).

CONTRACEPTIVES OUT OF STOCK



At the District level, 4 out of 5 district RH coordinators who were interviewed stated that the district store was NOT adequately supplied with contraceptives. They cited unreliable erratic supplies, inadequate supplies when they arrive and prolonged stock outs for over 6 months. Hence, the function of the district store as a buffer is negated. However, according to the National FP Manager at DRH, there were enough stocks of contraceptives in the country to supply demand for the next 18 months with the exception of IUCD's, Implants and female condoms. ***Stock outs, therefore are a major weakness and challenge in delivery of FP services.***

CIRCUMSTANCES LEADING TO STOCK OUTS

According to the staff at the health facility level, some of the circumstances leading to stock outs within their facilities are tabulated below. The main cause of facility level stock out was that the higher levels in the supply chain that are supposed to supply them were stocked out too .These stock outs were mostly experienced because the district store and KEMSA were stocked out (in 11 and 6 of 31 responses, respectively). Other reasons mentioned pointed to a lack of proper communication from the suppliers, under-supplying, delays in reporting and distribution, and high consumption of some commodities, pointing to the fact that consumption data was not well-utilized when managing stock orders. This is summarized in Table 5.

TABLE 5: CAUSES OF STOCK-OUTS AT HEALTH FACILITY LEVEL

Circumstances leading to stock outs	**Count**
The district store was stocked out	11
Nationwide (KEMSA) stock out of contraceptives	6
Poor supply chain management at national level	3
Orders placed but no explanation given for lack of supplies	3
Pharmaceutical suppliers were stocked out	2
Inadequate supplies when distribution is done	2
KEMSA delays in distribution	1
Long re-order period thus demand exceeds estimated need	1
Late reporting by facilities	1
High consumption of some FP commodities	1

Total Responses	**31**

AWARENESS OF THE NATIONAL LOGISTICS SUPPLY CHAIN SYSTEM

Health facility interviewees who consisted of the health workers dealing directly with FP service provision were asked if they were aware of the national supply chain/logistics system for FP commodities. The table below summarizes their responses.

Table 6: Awareness of the Supply Chain System

Aware of supply chain system	Number of facilities	Percentage (%)
Aware	20	57
Not Aware	14	40
No response	1	3
Total	**35**	**100**

These responses show that almost half of health facility staff have a very low and poor understanding of the national logistics system. This has a huge impact on the service providers' ability to work efficiently within the system, to quantify, order accurately and on time, document all transactions and report back.

A good logistics system is one where the players understand how it works, what is expected at every level and clear roles and responsibilities.

INVOLVEMENT OF THE RETAIL SECTOR OUTLETS

Currently there is no partnership between government and the retail outlets. However, there is a general feeling that this sub sector ought to be more engaged and be provided with contraceptives to increase access to FP by the public.

INVENTORY MANAGEMENT PRACTICES

A majority of facilities have authorized designated officer(s) responsible for requesting, receiving and storage of contraceptives. This however, differs for dispensing and reporting because the nursing staff who mainly offer the FP services on a rotational basis. The nurse on duty would assume the responsibility of dispensing and reporting. On the flip-side, this is good for the facility because it empowers all the staff to be able to ensure continuity of the services even in cases of attrition.

The assessment established that storage records on the other hand were a challenge as there were no designated storage records. Facilities improvised or used other records such as dispensing and reporting records as storage records.

Therefore, there is need to strengthen record keeping at the facility storage area.

Standard operating procedures (SOP's) were not available in most facilities especially for requesting, receiving and storage although, availability of SOPs for dispensing and reporting were available mainly because these were provided within the dispensing and reporting tools as a job aid.

GENERAL STORAGE CONDITIONS

Out of the 37 responses received, 54% indicated that the general storage conditions for contraceptives were good while 29% indicated poor storage conditions and the remaining 16% indicated having fair conditions.

Some limitations to good storage that were observed included inadequate storage space, which was indicated by non-availability of neither a store nor a cabinet/cupboard for storing the contraceptives; very tiny and crammed up stores/cupboards; poorly ventilated or no ventilation at all hence stuffy and hot stores; and lack of storage space hence contraceptives are placed in cartons on the floor of the room.

Good storage is essential for maintaining the contraceptives in good quality. It also plays a role in good stocks management because a good store is well organized and arranged for ease of accessing stock status.

KEY FINDINGS - STRENGTHS AND CHALLENGES FOR THE PUBLIC AND PRIVATE SECTOR FOR COMMODITY SECURITY COMPONENTS

STRENGTHS

1. Post-partum clients' options: Post-partum clients have a wider range of FP methods to choose from therefore giving the clients flexibility.
2. Cost to clients: Cost of contraceptives is minimal with a median cost of ksh.0 to kshs.100 for all the methods. IUCD's were the most expensive – median cost KES 100 [range 0 – 1,500], while condoms were relatively low cost with a median of 0 and ranging between KES 0 to 20. This is an indication of the commitment of health facilities to improve access to FP services by charging minimal fees for FP services.
3. Source of contraceptives: The largest single source of FP commodities at 75% is KEMSA.19% is provided directly by KEMSA and 56% from the District Store. This provides an opportunity to improve access to FP commodities because by Strengthening the operations and systems of the largest supplier-KEMSA, you reach 75% of target.
4. Inventory management practices: A majority of facilities have authorized designated officer(s) responsible for requesting, receiving and storage of contraceptives hence a level of accountability and focus exists.
5. Records availability and use is impressive which is an indicator that health facility staff appreciates the importance and usefulness of documentation. Records for requesting, receiving, dispensing and reporting were up to date.
6. The majority of facilities use similar records for receiving, dispensing and reporting.
7. The presence of district RH coordinators is a great opportunity for establishing contacts, mobilizing the facility teams and disseminating strategies to the FP facilities.

WEAKNESSES

1. Only (11.4%) of both private and public facilities offered the full range of contraceptives. This raises the question of access to a preferred method by clients.
2. Frequent prolonged stock outs of contraceptives. 80% of health facilities had experienced at least 1 stock out lasting 5 days or more. Stock outs are a major weakness and challenge in delivery of FP services.
    - The National FP manager maintains that there are enough stocks of contraceptives for the next 18 months with the exception of IUCD's, Implants and female condoms.
    - This is a situation of stocks availability at national level but lack of an efficient supply chain system to deliver the same to where they are needed.

3. The current Supply Chain system through KEMSA has been credited as being unreliable, inefficient and untimely, it means that a lot of the facilities and by extension clients are not assured of receiving the FP methods of their choice.
4. Awareness of the national logistics supply chain system: There are varying views of key players about the supply chain system.
   Health Facilities: among the staff at the facility level, there is a very low and poor understanding of the national logistics system. This has a huge impact on the service providers' ability to work efficiently within the system, to quantify, order accurately and on time, document all transactions and report back when they do not understand the system.
   District RH coordinators: At the district level, there is a different understanding of the system. This has serious consequence since the coordinators are the eyes and ears of the program at the grassroots. Therefore, when they do not understand how the system works, it makes it impossible for the facility staff whom they supervise, train and mentor to be abreast with how to manage the logistics and commodity security.
   National FP program manager: The national FP programme manager agrees that the system is complicated and confused, adding that some of the decisions are made at higher policy level over which the program has no control.
5. Storage records were a challenge as there were no designated storage records available. Facilities improvise or use other records such as dispensing and reporting records as storage records.

RECOMMENDATIONS

7. Increase Capacity of facilities to be able to provide services for all FP methods in order to improve access.
8. The supply chain and logistics system should be strengthened and streamlined to ensure that all facilities receive their supplies on a regular, reliable and timely basis either directly from KEMSA or the district store and to minimize the supply of contraceptives and avert stock outs.
9. Data collection and reporting tools to be availed and users trained on their use for consistent quality data.
10. Dissemination meetings for all stakeholders, district RH coordinators and Health Facility staff should be held to explain to all players how the system works, and their roles and responsibilities.
11. Storage facilities at health facilities should be improved either through provision of cabinets or renovations of existing stores, together with provision of specific storage records to be used at the storage area.
12. There is a need for the government and stakeholders to come up with strategies to partner with retail outlets and other private providers of FP services to improve access to FP commodities through increased capacity (logistics, procurement, forecasting, distribution, storage).

ANNEX 3: Tupange Contraceptive Security Staffing Portfolio

In order to build capacity for contraceptive management, Tupange will hire the following staff to enhance the existing staff within the system:

1. **Technical Advisor – Commodity Security:**

    - Liaise and Work Closely with DRH, KEMSA and NCAPD to ensure steady and sustained availability and supply of contraceptives within Tupange sites
    - Co-ordinate activities of city logistics officers
    - Co-ordinate training of two facility based inventory managers and DRH and KEMSA teams on the INTREPID system
    - Co-ordinate quarterly update meetings between facility based inventory/stores managers and Tupange managers and fine tune the INTREPID system to respond to their needs in a timely manner
    - Ensure that there is two way communication between facility based managers and the Tupange office
    - facilitate migration from the current push system at the public facilities to a pull system – it has been noticed that facilities that are using the latter system have fewer stock outs
    - Establish two ways communication between the facilities in target cities, DRH and KEMSA and address issues as and when they arise.
    - Ensure that low-levels/stock-outs at facility level are flagged up in good time to ensure response from various levels
    - ensure that facilities that are able to procure contraceptive commodities at negotiated/preferential prices (including workplaces and social franchise networks) have sufficient stocks from the buffer stocks held by PAAL

2. City Commodity Security Officers whose main duties are to:

- Co-ordinate training of two facility based inventory managers on INTREPID system
- Co-ordinate quarterly update meetings in target cities between facilities based inventory managers/stores managers and Tupange Managers and fine tune INTREPID system to respond to their needs in a timely manner.
- Maintain a two way dialogue with facilities in target cities to ensure good communication between facilities based inventory managers and Tupange staff.
- Facilitate migration from the current push system at public facilities to a pull system. It has been noticed that facilities that are using the latter have fewer stock-outs, e.g. Coast Province.
- Establish two way communications between district RH officers and facilities to ensure that there are proper inventory records for decision making.
- Ensure low stock levels and stock outs are flagged in good time to ensure response from various levels.
- Supply the private sector (workplace programs and social franchise networks) with contraceptive methods at negotiated/preferential prices. These prices will not be for profit but will only factor in the buying price and associated logistical costs (Warehousing, distribution, etc). The private sector organizations will cater for their needs.

Ensure that facilities that procure stocks at negotiated/preferential prices pay in good time to ensure that there are no bad debts and those supplies are not withheld due to accounting problems.