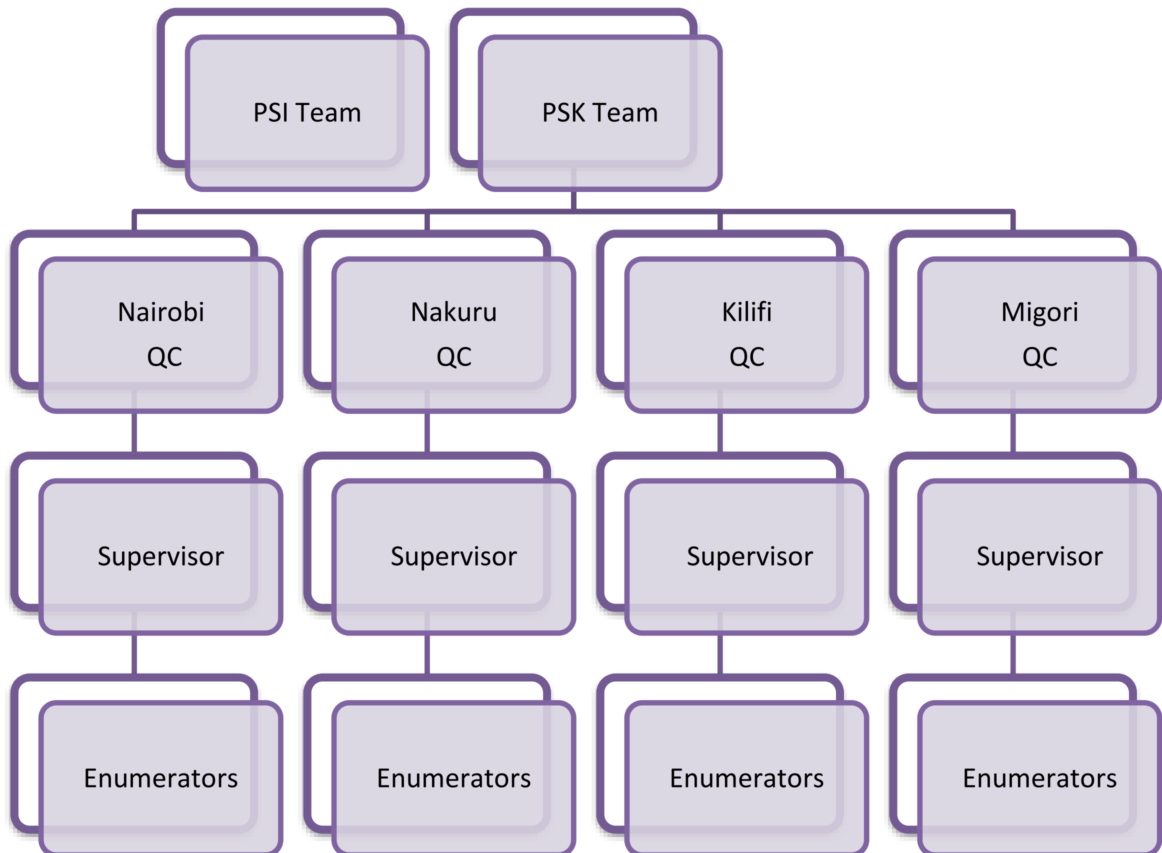
# Project Report

## Consumer's Market for Family Planning (CM4FP), Kenya

## 31th December 2020

*The purpose of this report is to provide an overview of how the surveys were conducted, challenges faced, and decisions made. The information will be instrumental in interpreting results, drafting reports and planning future studies. Please fill in this report using the instructions provided. Information for some of the sections may need to be obtained from PSI.*

## 1. ***Team structure***



### 1.a) Study team

*(List the names, positions and key duties of respective team members who played a role in this round of fieldwork, including those from PSI, PS Kenya, consultants, local research agency, and external partners)*

CM4FP core team

| *Name* | *Position* | *Key Duties on CM4FP during Round 4* |
|---|---|---|
| Dr. Nkemdiri Wheatley | Principal Investigator | • Provided oversight during development of Covid-19 risk mitigation plan for resumption of in-person field data collection<br>• Provided oversight during data cleaning, development of analysis plans identification and refinement of analyses indicators. |
| Mark Conlon | Data Analyst | • Supported budgeting, financial reporting and contracting processes.<br>• Conducted data cleaning and perfomed geo-spatial analysis<br>• Developed Covid-19 risk mitigation plan for resumption of in-person field data collection |
| Brett Keller | Regional Researcher | • Provided oversight during development of Covid-19 risk mitigation plan for resumption of in-person field data collection<br>• Provided technical input during the development of analysis plans identification and refinement of analyses indicators. |
| Eden Demise | Research Coordinator | • Project administrative work and supported with analyses work |
| Hoda Elmasry | Data Analyst | • Developed Covid-19 risk mitigation plan for resumption of in-person field data collection.<br>• Provided oversight during data cleaning, development of analysis plans identification and refinement of analyses indicators |
| Dr. Amanda Kalamar | Project Director | • Provided overall strategic oversight, particularly on Covid-19 risk mitigation plan for resumption of in-person field data collection, data analysis plans and study indicators. |

PS Kenya team

| *Name* | *Position* | *Key Duties on CM4F* |
|---|---|---|
| Dr. Hildah Essendi | Research Director | Overseeing the project |
| Harmon Momanyi | Research Lead Quality Control Officer | • Developed Covid-19 risk mitigation plan for resumption of in-person field data collection<br>• Data Quality control<br>• Project administrative work<br>• Conducted data cleaning tasks |
| Julius Njogu | Research Manager | • Developed Covid-19 risk mitigation plan for resumption of in-person field data collection<br>• Oversaw all aspects of the project, including budget processes and project administration work<br>• Cleaned outlet survey datasets, participated in development of analysis plans and outlet survey analysis.<br>• Wrote project reports |

Local research agency team

| *Name* | *Position* | *Key Duties on CM4FP* |
|---|---|---|
| N/A | N/A | • N/A |
| N/A | N/A | • N/A |

External partner teams (e.g., MoH personnel)

| *Name* | *Position* | *Key Duties on CM4FP* |
|---|---|---|
| N/A | N/A | • N/A |
| N/A | N/A | • N/A |

**1.b) Field team and quality assurance structure**

(*Please describe the field team structure, including names of team members and roles undertaken, numbers of teams sent out, quality assurance procedures followed and any deviations from the plan in terms of team structure and fieldwork procedures. Please also briefly describe the nature of any involvement from the PSI and PS Kenya teams in providing quality assurance oversight*)

Section not applicable, data collection was suspended indefinity due to on-going Covid-19 pandemic

***2. Ethical Approval***

*(PS Kenya to complete. Describe whether any issues were encountered in obtaining ethical approval in the 1st round of data collection and in obtaining any necessary amendments in the subsequent rounds. Was ethical approval received in a timely manner? If not, what was the effect on the training and data*

*collection timeline? Attach a copy of the ethics approval letter and any other supporting letters. Provide the information requested below.)*

There is an active IRB approval in place until April 20th, 2021. However, we will need to lodge for an amendment should there be future changes to the survey timelines, scope, data collection tools or field approaches.

| | |
|---|---|
| *Ethical review committee name:* | *AMREF Ethics & Scientific Review Committe (ESRC)* |
| *Date ethical clearance granted:* | *8th April 2019 (initial clearance) and 22nd October2019 (1st amendment to the protocol); 2nd amendment on* 21st April 2020. |

### ***3. Sampling***

*Study geographies and sampling methodology will be pre-determined by the study team and laid out in the study protocol ahead of fieldwork. The section below is for summarizing the sampling methodology and outcomes at the cluster level for both the household and outlet surveys, as well as to describe any deviations from the original plans*

Section not applicable, data collection was suspended indefinity due to on-going Covid-19 pandemic. No sampling changes have occurred in the recent past, apart from a few outlets which were excluded from the sample based on the Maplet boundary determination. More details are available in the March/April 2020 Report

### ***4. Training***

*(Complete the table below for each type of training that took place- e.g., TOT, interviewer training, and supervisor and QCs training, and specify whether training is for outlet survey or household survey. Insert as many tables as needed. Attach pictures and additional training report(s) if available.)*

Section not applicable, data collection was suspended indefinity due to on-going Covid-19 pandemic. No training occurred in this reporting period.

### ***5. Data collection***

Section not applicable, data collection was suspended indefinity due to on-going Covid-19 pandemic. Although there were no field data collection during this period. PS Kenya closely monitored Covid-19 situation in the country and how local IRB and research organizations were navigating field data collection during the pandemic.

In readiness of resumption of data collection, PS Kenya project staff together with other country teams and PSI core team held a series of weekly meetings which discussed Covid-19 risk mitigation plans, including protection of respondents, field staff and possible implication on survey objectives, timelines and cost. These meetings led up to finalized Covid-19 mitigation plans that will be presented to PSI REB for resumption of in person data collection in 2021.

***6. Data management***

*(Describe challenges faced with electronic data collection and data management. In what ways did electronic data collection help or hinder quality assurance?)*

As, we waited decision to resume in-person data collection, we achieved several data related tasks including the following:

i) Data cleaning guidelines: PS Kenya Research Manager participated in a series of weekly meeting which extensively discussed the project's data cleaning, including building consensus on general process philosophy and assumptions and documentation of specific actions to be taken. These meetings led up to finalized outlet and household survey data cleaning manuals.

ii) Back-check (BC) questionnaires: During Round 1 and 2, the QCs completed OS and HH back-checks using paper questionnaires. We scanned all these paper BC surveys and archived them on PSI SharePoint folder as directed by the PI. However, we documented and communicated a loss of Round 1 Outlet Survey Back-check questionnaire, specifically from Migori county, for reporting to PSI REB.

iii) Data cleaning queries: We processed all the data cleaning requested as received from PSI team and these included, conducting a detail review of the Outlet and Sub-outlet information as pulled from all the surveys, reviewing the questionnaires to ensure the final translated paper survey match up with the fielded Survey CTO form, responding to various HH data cleaning issues which related detailed review of HH verbatim and outlet matching sections, etc.

iv) Data cleaning: By the end of 2020, Research Manager managed to fully clean Round 1 Outlet survey dataset, including all the steps stipulated in the cleaning guidelines. Round 2 Outlet survey was nearly complete, and only a few provider sections were left pending when the decision was made to focus on data analysis request from the donor. Respective reproducible Stata cleaning codes are available on PSI SharePoint for referencing.

v) Data analysis: By the end of 2020, Research Manager managed to create dummy tables, in an Ms Excel format, for reporting descriptive outlet-level indicators for the assigned research question 1. These indicators included, survey flow chart, contraceptive market composition, method-specific availability indicators and selected provider readiness indicators. Research Manager managed to complete most analyses from the Nigeria Round 1 OS dataset and plans were underway to complete the remaining analyses in January 2021. Respective reproducible Stata analyses codes and populated dummy tables are available on PSI SharePoint for referencing.

## ***7. Country context***

*(Provide a brief narrative of the country context that may be useful for interpreting the data. Topics to consider are listed below. You do not need to present information for all these topics for every round of data collection. The first round should cover as many of these topics as possible, while rounds 2-4 can cover any changes to the context (i.e., the latter four bullets below).*

- Country and region demographics and socio-economic status

Kenya is a country of many contrasts, from its landscape to demographics, and more so its social and economic inequalities. It is one of the most unequal countries in the sub-Saharan region. Forty two percent of its population of 44 million, live below the poverty line. Access to basic quality services such as health care, education, clean water and sanitation, is often a luxury for many people. Large segments of the population, including the burgeoning urban poor, are highly vulnerable to climatic, economic and social shocks (https://www.unicef.org/kenya/overview_4616.html) .

A map of Kenya showing 47 counties.

*Map adapted from wikimedia.org*

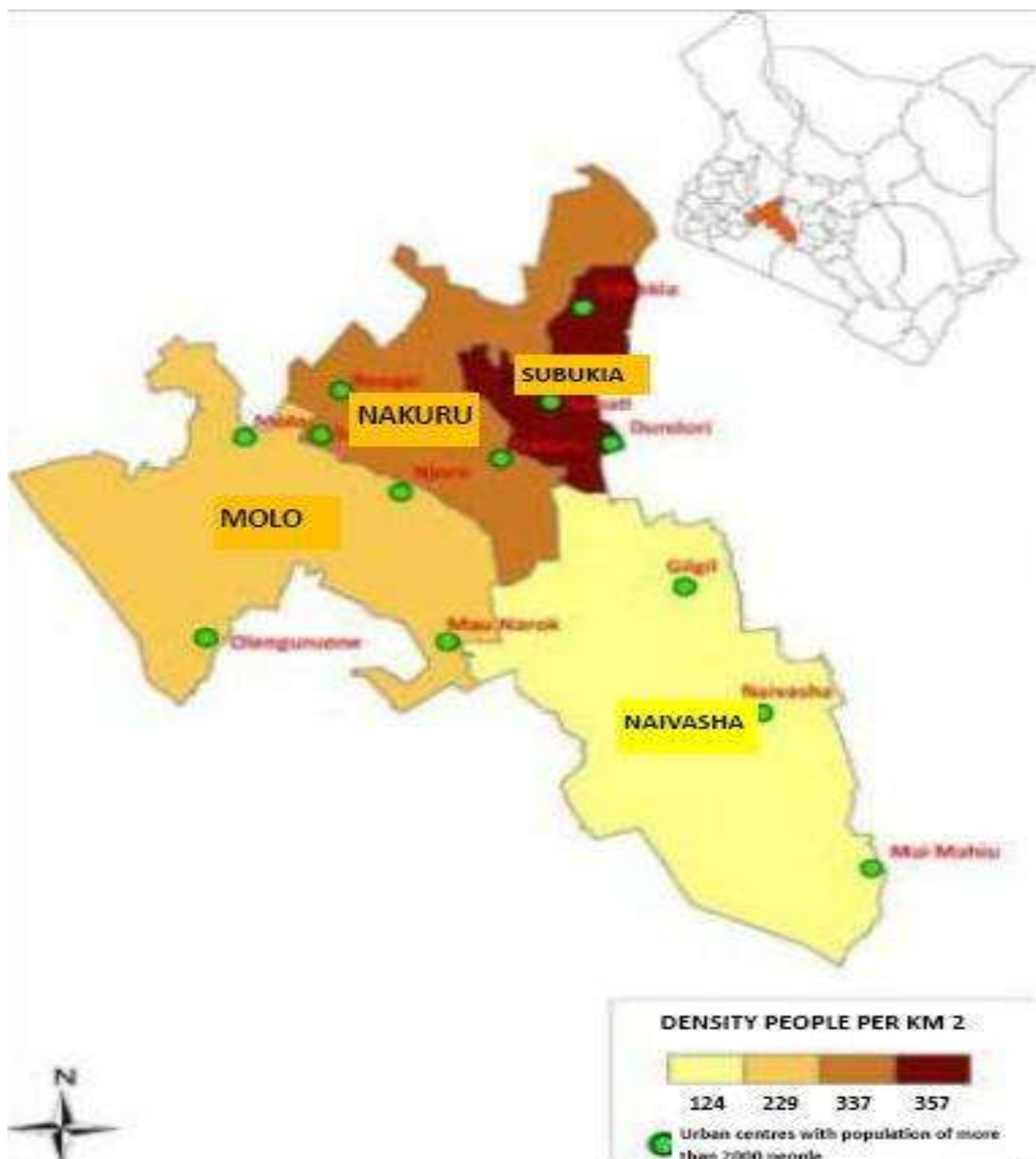
Nakuru County:

Nakuru County's population is multicultural and profoundly diverse. The county ranks fourth as the most populous County in Kenya behind Nairobi, Kakamega and Kiambu respectively. The county population was estimated at 1,603,325 in 2009 and with a population growth rate estimated at 3.05% the projected population is approximated at 2,046,395 (https://nakuru.go.ke/about-us/).

The major economic activities include subsistence and commercial farming, tourism, geothermal power generation, small-scale trade, dairy farming and flower farming.

Administratively, Nakuru County is subdivided into eleven sub-counties and fifty 55 wards

A map showing position of Nakuru County




*Map adapted from* http://assembly.nakuru.go.ke

Nairobi County

The county hosts the capital city and the largest city of Kenya. It is the most populous city in East Africa, with an estimated population of 3.5 million. This makes it the 14th largest city in Africa (https://nairobiassembly.go.ke/who-we-are/). Nairobi accounts for 50% of formal employment in Kenya and generates over 50% of the country's GDP. Labour migration from the rural areas in search for jobs is the main reason for the huge population with the working age population of between 15-64 years, forming 68% of the total population. A total of 51% of Nairobi County residents have a secondary level of education or higher (https://www.knbs.or.ke/download/nairobi-county/). The county is composed of 17 Administrative Sub-Counties consisting of 85 Wards.

A map showing position of Nairobi County

*Map adapted from* https://www.kenyacountyguide.co.ke/

Kilifi County

The population of the county was estimated to be 1,217,892 in 2012 as projected in the 2009 Kenya Population and Housing Census. The population was projected to rise to 1,466,856 in 2017 respectively at growth rate of 3.1 percent per annum (http://www.kilifi.go.ke). Kilifi County has a child rich population, where 0-14-year olds constitute 47% of the total population. This is due to high fertility rates among women as shown by the highest percentage household size of 7+ members at 36%. Only 13% of Kilifi County residents have a secondary level of education or above (https://www.knbs.or.ke/download/kilifi-county/).

Kilifi County has a mix of cultures and is predominantly occupied by Mijikenda communities (Giriama, Digo, Duruma, Rabai, Chonyi, Jibana, Kambe, Kauma and Ribe). The major economic activities include tourism and fishing due to its extensive white sandy shores along the Indian Ocean which occupies 109Km$^2$ of the total County surface area. Agriculture activities, including crop farming and livestock farming are widely practiced

A map showing position of Kilifi County

*Map adapted from* https://www.kilifi.go.ke/

Migori County

The county is composed of 8 Administrative Sub-Counties consisting of 40 Wards. According to the 2019 census, the population of the county was estimated at 917,170 with an annual growth rate estimated at 3.8% (https://migori.go.ke/). Migori County has a child rich population, where 0-14-year olds constitute 50% of the total population. This is due to high fertility rates among women as shown by the highest percentage household size of 4-6 numbers at 41%. Only 15% of Migori County residents have secondary level of education or above (https://www.knbs.or.ke/download/migori-county/). The major economic in the county is agriculture and other economic activities include fishing, and minerals mining.

A map showing position of Migori County

*Map adapted from https://www.kenyacountyguide.co.ke/*

- MCPR and unmet need for FP

Kenya has made great progress toward increased uptake of family planning. Married women's use of modern contraceptives increased from 32% in 2003 to 39 % in 2008-09 and 53% in 2014 (KDHS, 2014). The country has recently exceeded its FP 2020 target of 58% modern contraceptive use by married women (http://www.familyplanning2020.org/kenya). However, unmet need for family planning in Kenya is still high estimated at 18% among general population and problem is pronounced in rural areas, youth population (23%) and in some of the counties, including Kilifi.

According to report of a recent survey conducted by PMA 2020, the use for modern family planning methods among women in union increased sharply from 44% in 2016 to 61% in 2018, however, in the same period, the use of modern methods among all women (in union and not in union) remained at 44%[1]. 2019 PMA report showed a continued shift towards long acting family planning methods among all users, from 11% in 2014, 17% in 2017 and to 20% in 2019 [2].

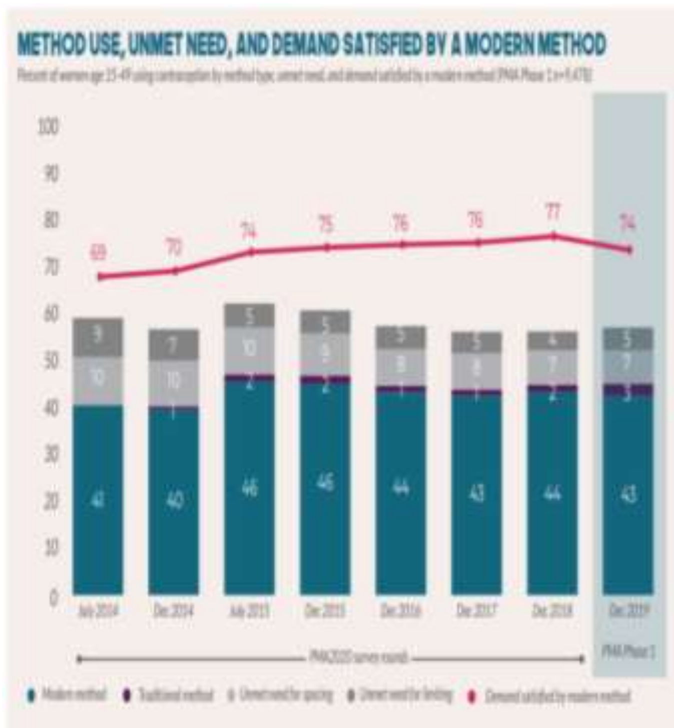
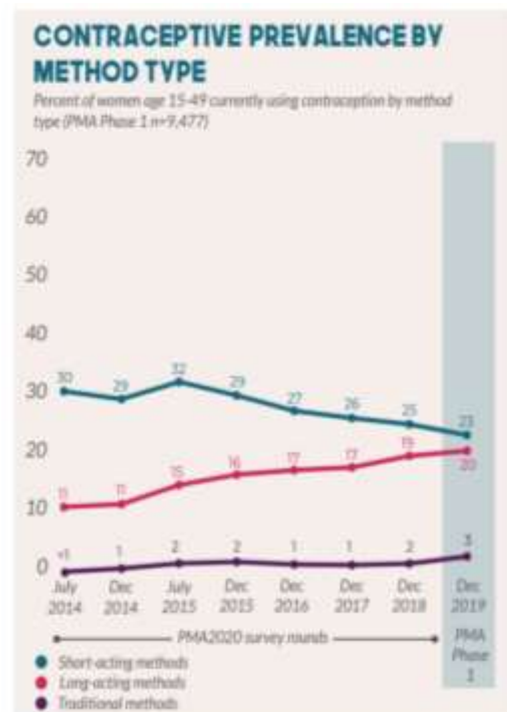



Chart adopted from https://www.pmadata.org/




Adopted from https://www.pmadata.org/

- Structure of health system

[1] PMA 2020/Kenya (2018). November -December 2018 (Round7). https://www.pma2020.org/sites/default/files/PMA2020-Kenya-R7-FP-brief.pdf

[2] PMA Kenya (2019). Results from phase 1 baseline survey. https://www.pmadata.org/sites/default/files/data_product_results/Kenya%20Phase%201%20Results%20Brief_Final.pdf

In 2010, Kenya promulgated a new constitution which included establishment of 47 semi-autonomous county governments, with substantial devolution reforms and transfer of responsibility for health service delivery from the central government to these counties[3]. Under devolved system, county governments are responsible for allocating resources for and procurement of pharmaceutical commodities for public health facilities within their areas[4].

The Kenyan health system defines six levels of the hierarchy, as follows: level 1, community services; level 2, dispensaries and clinics; level 3, health centres and maternity and nursing homes; level 4, sub-county hospitals and medium-sized private hospitals; level 5, county referral hospitals and large private hospitals; and level 6, national referral hospitals and large private teaching hospitals. PHC services are primarily provided at levels 1 to 3[5]. According to the master health facility list, there are 10,861 registered health facilities, including 4,895 (45%) government facilities, 4,273 (40%) private facilities and 1,339 (12%) not-for-profit owned either by NGOs, CBO or FBOs.

Figure 1 showing levels of care and regulatory structures

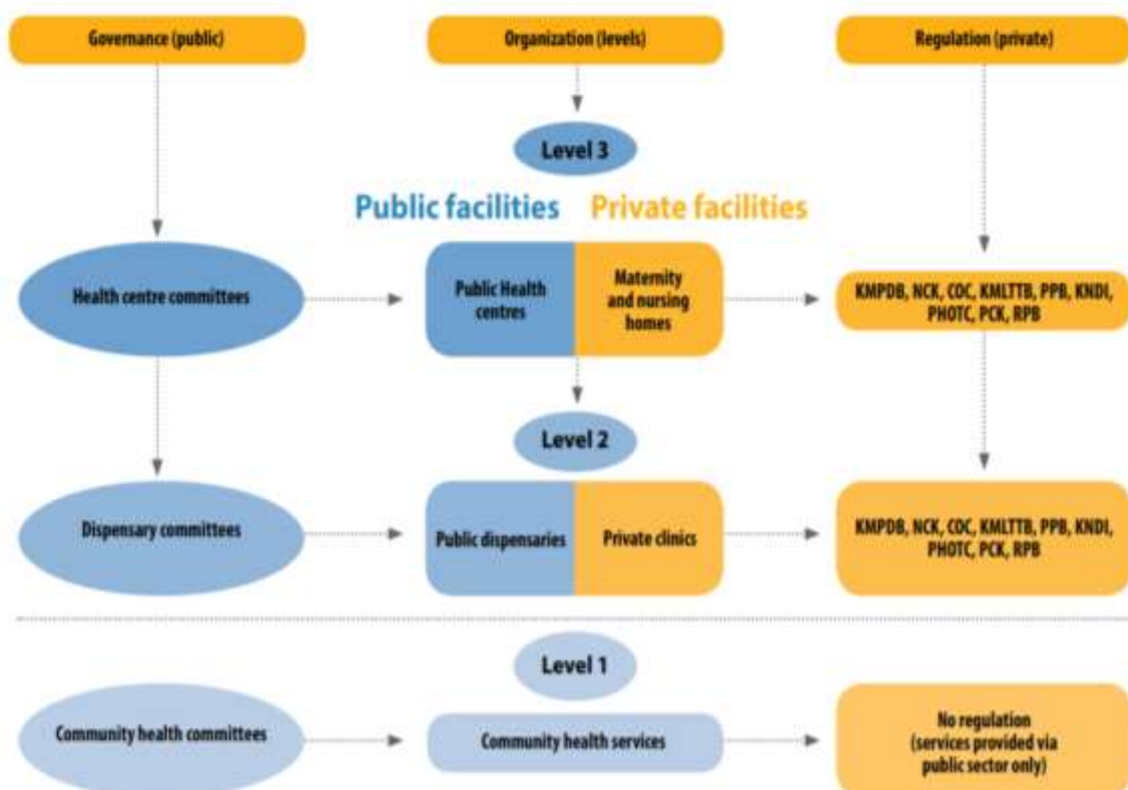



*Figure adopted from Primary health care systems, 2017*

- Private health sector and pharmaceutical sector

3 *Government of Kenya, The constitution of Kenya. 2010*

4 *Tsofa et al (2017) Devolution and its effects on health workforce and commodities management – early implementation experiences in Kilifi County, Kenya. International Journal for Equity in Health (2017) 16:169*

5 *Primary health care systems (PRIMASYS): case study from Kenya, abridged version. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.*

According to the national guidelines, FP services can be provided at various tiers of the health care system and by several healthcare carders that have received necessary training. Medical doctors are permitted to provide full range of services, Nurses/Midwife and Clinical Officers are permitted to provide full range of services with exception of female and male VSC (should counsel and refer). Notably, among other cadres including Pharmaceutical staff the scope of FP service provision is limited to specific FP method (table 1).

These guidelines further notes, injectables such as Sub Cutaneous Depot-medroxyprogesterone Acetate (DMPA-SC) have been approved for self-injection. This is dependent on training of healthcare workers to train clients for self- injection.

Table 1 showing provision of FP methods by different carders of service providers

| Provider /method | Male condom | Female condom | LAM | Pills (COC, POP) | Injectable | IUCD | Implant | Standard Days Method (SDM)[ii] | Other FAMs (Two Days Method, Ovulation) | Female and male VSC |
|---|---|---|---|---|---|---|---|---|---|---|
| Medical doctor | Trained medical doctors can provide full services related to the above | | | | | | | | | |
| Nurse Midwife | Trained nurse-midwives (including community midwives) can provide full range of services related to the above. | | | | | | | | | Counsel refer |
| Clinical Officer | Adequately trained Registered Clinical Officers (RCOs)[iii] can provide full range of services related to the above | | | | | | | | | Counsel refer RH Trained RCOs can offer methods |
| CHEW[iv] | CHEWs provide an interface between CHVs and SDPs | | | | | | | | | |
| CHV[v] | Counsel Provide | Counsel Provide | Counsel Support Provide Refer | Counsel Provide* Refer | Counsel Provide* Refer | Counsel Refer | Counsel Refer | Counsel Provide Refer | Counsel Refer | Refer |
| Pharmacists and Pharmaceutical technologists | Counsel Provide | Counsel Provide | Counsel Refer | Counsel Provide | Counsel Dispense Provide* | Counsel Dispense Refer for insertion | Counsel Dispense Refer for insertion | Counsel Provide Refer | Counsel Refer | Refer |

*Only if specifically trained to do so

*Table adopted from National Family Planning Guidelines for Service Providers (6th Edition).*

Kenya Medical Supplies Authority (KEMSA) is the largest procurement entity for public medical supplies in the country. KEMSA supplies family planning commodities to all public health facilities in the country at no cost from. Although, public facilities are given priority when distributing KEMSA family planning commodities, private facilities are also supplied if they are registered with a Master Facility List number and are required to provide monthly service reports to MOH. Figure 3 illustrates commodity supply and information flow system to ensure uninterrupted supply of contraceptives.

Figure 3 showing FP commodity and Information flow

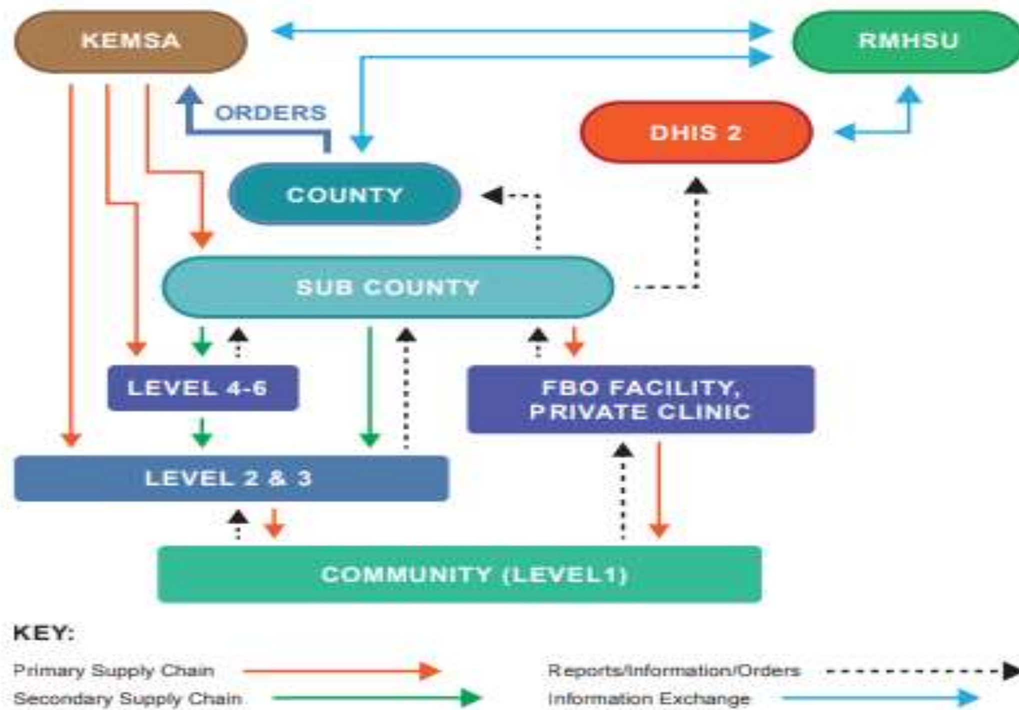



*Figure adopted from National Family Planning Guidelines for Service Providers (6th Edition).*

In 2010, Kenya promulgated a new constitution which included establishment of 47 semi-autonomous county governments, with substantial devolution reforms and transfer of responsibility for health service delivery from the central government to these counties[6]. Under devolved system, county governments are responsible for allocating resources for and procurement of pharmaceutical commodities for public health facilities within their areas[7]. There have been problems with some counties breaching their financial commitments amounting to tens of billions with KEMSA [8,9] leading to interrupted supply of essential pharmaceutical commodities in the counties.

The Mission for Essential Drugs and Supplies (MEDS) is the second largest distributor of drugs and medical products to the private not-for-profit health facilities (https://www.meds.or.ke/). MEDS is a Christian not-for-profit organisation registered as a Trust of the ecumenical partnership of the Kenya Conference of Catholic Bishops (KCCB) and Christian Health Association of Kenya (CHAK). However, MEDS does not procure or distribute any contraceptives commodities because of its religious orientation.

- Drug regulations, taxes and tariffs

*6 Government of Kenya, The constitution of Kenya. 2010*

*7 Tsofa et al (2017) Devolution and its effects on health workforce and commodities management – early implementation experiences in Kilifi County, Kenya. International Journal for Equity in Health (2017) 16:169*

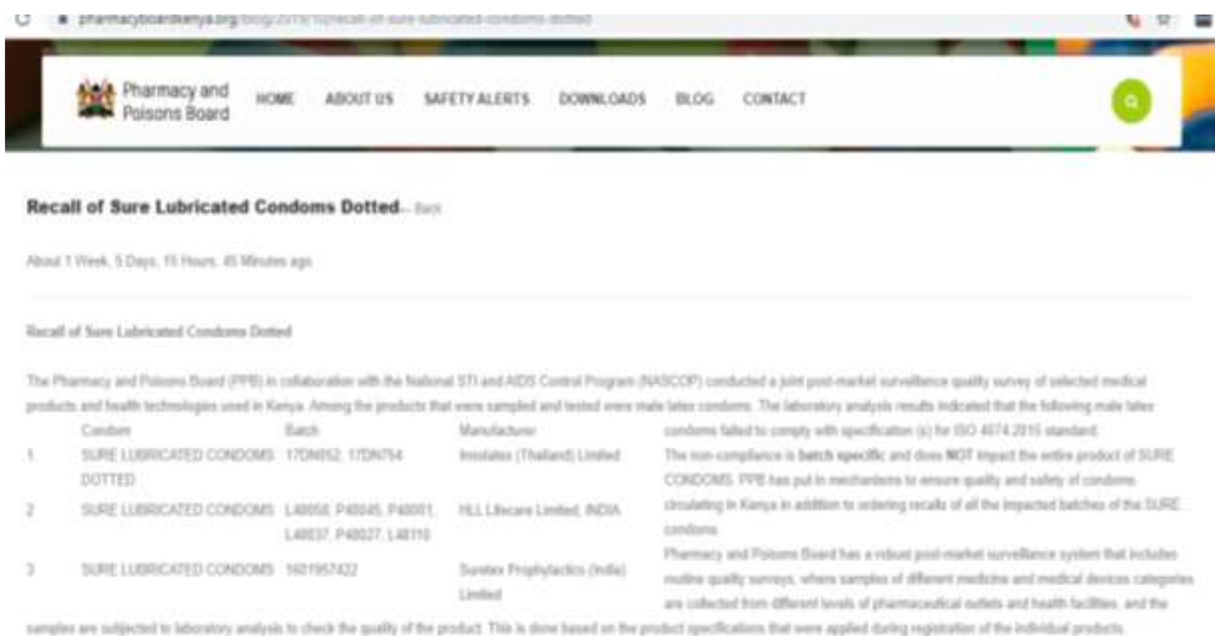
*8 https://www.nation.co.ke/news/Debts-owed-to-Kemsa-prove-costly-for-counties/1056-5104778-ermnqk/index.html, accessed on 3rd March 2020*

*9https://www.standardmedia.co.ke/article/2001290216/counties-grappling-with-huge-debts, accessed on 3rd March 2020*

The Pharmacy and Poisons Board (PPB) is responsible for drug regulation in the country, including importation and registration of medical supplies.

In early October 2019, the PPB pronounced that routine joint post-market surveillance activities with PPB, National STI and AIDS Control Programme (NASCOP) revealed that a brand of male condom "Sure" had failed laboratory quality tests as per the specifications for ISO 4074:2015. "Sure brands" of condom are procured through KEMSA and widely distributed to clients free-of-charge through public and private facilities. The Pharmacy and Poisons Board (PPB) further issued directive orders to recall Sure lubricated condoms, manufactured by Thailand by Innolatex Limited, India and those manufactured by HLL Lifecare Limited, India as well as those from Suretex Prophylactics (India) Limited. The recall order affected specific batch numbers including, 17DN052, 17DN754, LP8058, P48045, P48001, L48037, P48027, L48110 and 1601957422 (https://pharmacyboardkenya.org/blog/2019/10/recall-of-sure-lubricated-condoms-dotted). Other batches of condoms which had failed quality test included, Durex (1 condom per pack) (https://www.standardmedia.co.ke/article/2001290678/durex-recalls-condoms-over-burst-concerns – accessed on 27th February 2020) and Fiesta condoms (https://www.the-star.co.ke/news/2019-03-29-fiesta-condoms-valued-at-sh10m-destroyed-over-poor-quality/– accessed on 27th February 2020)

Figure 4 showing recall order of Sure condoms



Pharmacy and Poisons Board HOME ABOUT US SAFETY ALERTS DOWNLOADS BLOG CONTACT

**Recall of Sure Lubricated Condoms Dotted** ... Back

About 1 Week, 5 Days, 15 Hours, 45 Minutes ago

Recall of Sure Lubricated Condoms Dotted

The Pharmacy and Poisons Board (PPB) in collaboration with the National STI and AIDS Control Program (NASCOP) conducted a joint post-market surveillance quality survey of selected medical products and health technologies used in Kenya. Among the products that were sampled and tested were male latex condoms. The laboratory analysis results indicated that the following male latex condoms failed to comply with specification (s) for ISO 4074:2015 standard.

| | Condom | Batch | Manufacturer |
|---|---|---|---|
| 1 | SURE LUBRICATED CONDOMS DOTTED | 17DN052, 17DN754 | Innolatex (Thailand) Limited |
| 2 | SURE LUBRICATED CONDOMS | L48058, P48045, P48001, L48037, P48027, L48110 | HLL Lifecare Limited, INDIA |
| 3 | SURE LUBRICATED CONDOMS | 1601957422 | Suretex Prophylactics (India) Limited |

The non-compliance is **batch specific** and does **NOT** impact the entire product of SURE CONDOMS. PPB has put in mechanisms to ensure quality and safety of condoms circulating in Kenya in addition to ordering recalls of all the impacted batches of the SURE condoms.

Pharmacy and Poisons Board has a robust post-market surveillance system that includes routine quality surveys, where samples of different medicine and medical devices categories are collected from different levels of pharmaceutical outlets and health facilities, and the samples are subjected to laboratory analysis to check the quality of the product. This is done based on the product specifications that were applied during registration of the individual products.

*Figure adopted from https://pharmacyboardkenya.org*

- FP seeking behaviour/ provider behaviour

According to a recent demographic survey the public sector is the major source of contraceptive methods in Kenya, providing contraception to 60% of current users. Thirty-four percent of modern contraceptive users obtain their methods from the private medical sector, mainly from private hospitals/clinics, 21%, and pharmacies, 10%, (KDHS, 2014).

Past studies have reported many barriers to use of family planning among Kenyan women, including myths and fears that contraceptive renders women infertile, fears of causing birth malformation and side effects such as bleeding and reduced sexual desire.[10] Other documented barriers, include health system setbacks such as lack of FP commodities and equipment, lack of trained skilled providers especially in the provision of LARC, lack of necessary infrastructure as private rooms for FP service delivery.[11]

[10] *Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., & Kays, M. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. BMC public health, 15, 118. doi:10.1186/s12889-015-1483-1*

[11] *Ontiri, S., Ndirangu, G., Kabue, M., Biesma, R., Stekelenburg, J., & Ouma, C. (2019). Long-Acting Reversible Contraception Uptake and Associated Factors among Women of Reproductive Age in Rural Kenya. International journal of environmental research and public health, 16(9), 1543. doi:10.3390/ijerph16091543*

- Effects of COVID-19

The index case of Covid-19, of a 27-year-old woman who flew in from the US via London, was reported in the country on 13th March 2020. Following the confirmed Covid-19 case, the Kenya government instituted various containment measures, including a national-wide curfew to curb night movements, targeted partial lockdown of counties with high number of confirmed cases, closure of schools and places of worships, banned large social gatherings, banned international travel, mandatory use of masks when out in the public amongst other measures.

In Kenya, similar to other geographies, Covid-19 disrupted access and delivery of essential health services, including family planning. For instance;

i) Many private sector facilities were faced with difficulties meeting their operational cost and were increasingly closing businesses or laying-off health workers to cope up with the decreased business due to the Covid-19 situation.
ii) Covid-19 preparedness and response efforts took centre stage all levels of health system, from the national, county and health facility levels. Routine health services, including sexual reproductive health, received less attention including having resources diverted to curb Covid-19[12].
iii) General public shunned hospital visit due to Corona virus related fear and stigma. There were concerns that Hospital related stigma was likely to erode public health gains achieved over the years, including access to contraceptives. A qualitative study conducted among women in Nairobi informal settlement area, reported 40% of the respondents were hesitant to visit health facilities due to fear of contracting Covid-19 - they described uncertainty regarding meeting people with COVID-19 at the health facility, and stigma if they their body temperature were found to be high[13].
iv) Gender based violence against women exacerbated during the Covid-19 pandemic, including other harmful cultural practices such as FGM and early child marriages[14]. There were fears of an upsurge of underage pregnancy was reported in the leading media during the pandemic. However, according to AFIDEP, these fears were not founded on verifiable data sources[15]
v) Health service delivery through the public sector was seriously impeded by the health workers strike across the country. One of the concern included lack of adequate personal protective equipment (PPE) among other grievances[16]. Although Medical Doctors strike was called off after a few days, Nurses and Clinical Officers strike has now persisted for weeks.
vi) Socio-economic impacts of Covid-19 pandemic affected many sectors including, tourism, transport, aviation and shipping business affecting global supply chain systems.[17]. A survey by the Kenya Private Sector Alliance (KEPSA) (2020) on the Covid-19 pandemic impact on Kenya's economy indicates that

[12] https://untf.unwomen.org/en/news-and-events/stories/2020/08/responding-to-increased-violence-against-women-and-girls-during-covid-19-in-kenya
13 Oluoch-Aridi et al. COVID-19 Effect on Access to Maternal Health Services in Kenya. Front. Glob. Womens Health, 26 November 2020 | https://doi.org/10.3389/fgwh.2020.599267
14 https://news.un.org/en/story/2020/10/1075522
15 https://www.afidep.org/news-release-teen-pregnancy-in-kenya-verifying-the-data-and-the-facts/
16 https://kemri-wellcome.org/zp-content/uploads/2020/08/Health-worker-strikes-in-Kenya-policy-brief___.pdf
[17] https://www.undp.org/content/dam/rba/docs/COVID-19-CO-Response/Socio-Economic-Impact-COVID-19-Kenya-Policy-Brief-UNDP-Kenya-April-2020.pdf

61% of businesses had been affected by the measures being taken around the world to contain the virus. Kenya Shilling weakened to a five-month low on 17 March 2020. The local currency was traded at 103.38 against the dollar at the close of business, the lowest since October 30 2019, when it exchanged at 103.40 to the US Dollar[18].

- Funding received for FP supply-side and demand-side activities

Kenyan government pledged to increase financial and programme support to achieve FP 2020 targets. Specifically, the government committed to increase the portion of the national budget for family planning services, specifically through a budget line allocated to the family planning. According to the cost implementation plan, the Ministry of Health estimates KES 7 billion annual funding will be required to finance six thematic areas, including commodity supply, demand creation, service delivery among other thematic areas. Other commitments included programmatic support such as , 1) Ensuring contraceptives are included in the National Health Insurance Fund (NHIF) to increase access among insured individuals, 2) Ensuring post-partum family planning services are included as part of its Free Maternity policy (Linda Mama programme) which the Government invest KES 3 billion annually to ensure mothers access free care at the point of delivery, 3) Broadening family planning access and choice, especially in counties with lowest mCPR and highest unmet need , 4) Rolling out capacity building programs to equip providers with adequate skills on provision of long-acting methods (http://www.familyplanning2020.org/KENYA), (https://www.familyplanning2020.org/sites/default/files/Kenya_FP2020_Commitment_2017_1.pdf)

According to the Ministry of Health speeches during the contraceptive day in 2020[19], the following were listed as the key sources for family planning financing in the country.

i) DFID has supported Ministry of Health through UNFPA to procure implants worth $ 1.3 million and these commodities were to arrive on (27/09/2020) at the port of Mombasa.
ii) UNFPA in 2019 and 2020 supported the MOH to procure contraceptives worth $4.8 million and $3.1 million, respectively.
iii) In the current financial year, the government committed 800 million Kenya Shillings towards direct purchase of contraceptives for the public sector.

Figure 4 showing Kenya national family planning costed implementation plan 2017-2020

[18] https://www.undp.org/content/dam/rba/docs/COVID-19-CO-Response/Socio-Economic-Impact-COVID-19-Kenya-Policy-Brief-UNDP-Kenya-April-2020.pdf
19 https://youtu.be/-T3L3uquoig

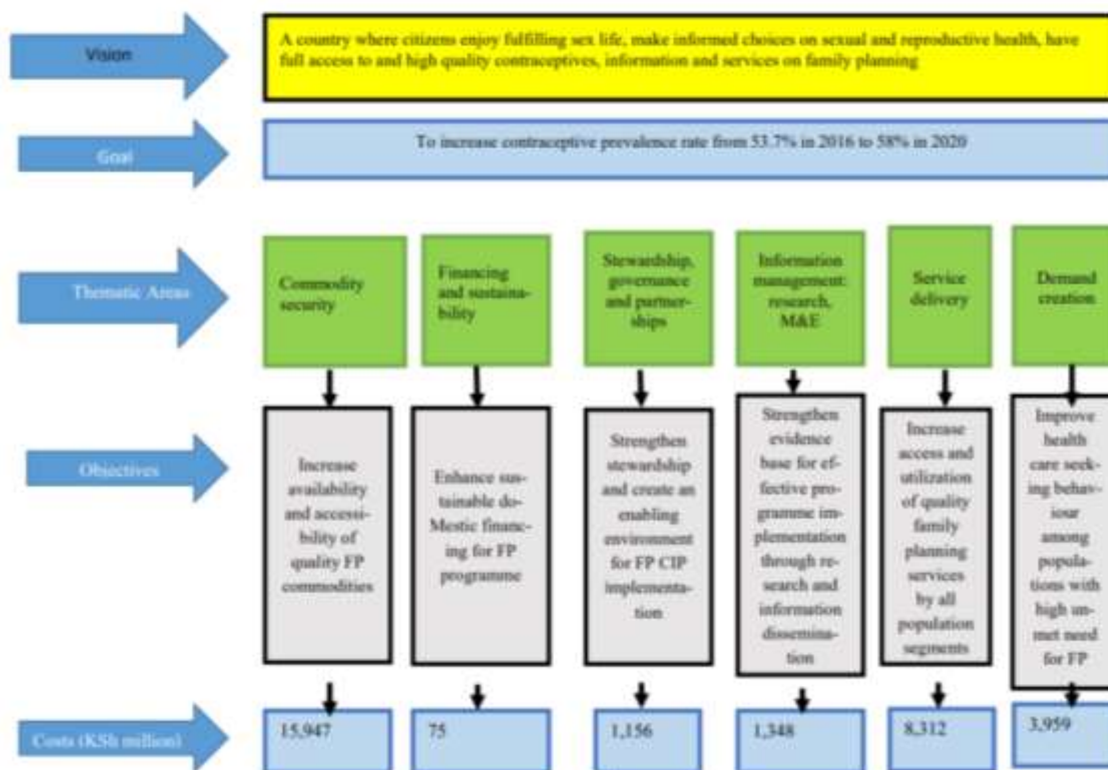



*Figure adopted from Kenya National Family Planning Costed Implementation Plan 2017-2020*

Although Kenya government is committed to ensuring universal access to family planning services to all Kenyans irrespective of places of residence. However, implementation of family planning services has faced numerous challenges at the national level, including those affecting commodity security as summarized below[20];

- Limited availability and access to FP commodities and reproductive health medicines in health facilities due to supply chain setbacks leading to stockouts
- Fluctuation of FP budget line over the years and diminishing donor support
- Loss of FP budget line post devolution leading to donor dependence

- FP-related SBCC interventions underway at the time of fieldwork

  *Maverick Project – Kilifi: The Maverick project seeks to advocate and train carefully selected CHEWS to deliver a range of contraceptive services at level one which is the overarching goal of the project. Utilizing the Community based distribution (CBD) approach in Kilifi County, the Maverick project will seek to narrow the gap of missed opportunities for family planning by increasing both quality and access of FP services in the community. The project will also seek to document an integrated approach utilizing the community health strategy structures, community organization and institutions to deliver a full range of contraceptive options to the women in Kilifi County. The project has achieved the following:*
  - *Rolled out in all the 7 Sub-counties*
  - *Trained 36 CHEWs for four months, using a CHEW training manual for community-based FP services*

[20] *Ministry of Health (2017). Kenya National Family Planning Costed Implementation Plan 2017-2020*

- *Sensitized 720 CHVS for FP demand creation at the community, through strategies such as door-to door household visits, community dialogue meetings, male champion engagement, etc*
- *SBCC to addressed insights documented during emersion, including mobilization posters (Market places, community administrative offices), Posters (Motorcycle shades/stages, Barber shops, dispensaries) and leveraging on mass media.*
- *The project has served FP 2921 clients, of these uptake methods were as follows: injectable Depo (52%), implant (38%), COC (6%), POP (2%) and male condoms (2%)*

- Other health related SBCC interventions underway at the time of fieldwork (e.g., Afya Halisi is a five-year USAID funded project that was awarded in October 2017 to strengthen the capacity of national, county, and sub-county leaders and systems so that they can enhance the efficiency of existing health systems to increase sustainability, prioritize populations most in need, increase equity, and scale-up high impact interventions and practices to improve quality. The project improves family planning/reproductive, maternal, newborn, child and adolescent health (FP/RMNCAH), nutrition, and water, sanitation and hygiene (WASH) in Kitui, Kisumu, Kakamega and Migori counties, as well as the at the national Ministry of Health. The project is implemented, led Jhpiego, with Save the Children and Population Services Kenya.)
- Recent events within the counties of interest which could affect findings (e.g., new policies, guidelines, change in county leadership including at the ministerial level)

The national family planning guidelines for service providers were recently updated to reflect the 2015 medical eligibility criteria of the World Health Organization[21]. The new guidelines place more emphasis on improving access to quality FP services including expansion of method mix, ensuring there are no missed opportunities, reduction in unmet FP need and increasing the numbers of new users; thereby sustaining the gains made. Harmonizing the guidelines with the WHO's Medical Eligibility Criteria (MEC), addressed several other issues and adopted new strategies to increase access (e.g. Community Based Family Planning, postpartum FP packages and comprehensive Post Abortion Care (PAC) services which includes FP), services for persons with special needs (e.g. PLwD. mobile populations, adolescents and youth), integration of FP with other RH services (including HIV and AIDS and screening for cancers of reproductive organs), new contraceptive choices and male engagement.

Kenya celebrated the World Contraception day in Kisumu County on September 26th. Between 13th and 15th November 2019 Nairobi will host a high level global International Conference in Population Development (ICPD) https://www.unfpa.org/press/nairobi-summit-advance-icpd-programme-action). The Kenyan Cabinet Secretary of Health pronounced that the government will take stock, re-energize and accelerate the promise made in Cairo 25 years ago (https://www.unfpa.org/press/nairobi-summit-advance-icpd-programme-action).

[21] *Ministry of Health, Division of Family Health, Family Planning Program. National Family Planning Guidelines for Service Providers 6th Edition. Nairobi, Kenya: RMHSU, Oct 2018. Print*

## 8. List of Attachments

(Provide a list of key documents attached to this report)

| | *Attachment* | *Attached Y/N* | *If not attached, why not?* |
|---|---|---|---|
| 1 | Ethical approval letter(s) | No | Shared on PSI one drive folder to manage the size of this report |
| 2 | Copy of sampling frame and selected sample | No | Shared on PSI one drive folder to manage the size of this report |
| 3 | Cluster-level monitoring sheets | No | Shared on PSI one drive folder to manage the size of this report |
| 5 | List of country context docs with attachments | No | Shared on PSI one drive folder to manage the size of this report |
| 7 | *Summary statistics* | No | There was no fieldwork that coincided with the current reporting quarter |
| 8 | KEMRI IRB Guidelines during Covid-19 pandemic | No | Shared on PSI one drive folder to manage the size of this report |
| 9 | PSI/PS Kenya Covid-19 mitigation plans for resumption of in-person data collection | No | Shared on PSI one drive folder to manage the size of this report |
| 10 | Contraceptive Day speeches | No | Shared on PSI one drive folder to manage the size of this report |
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