Sexual & Reproductive Health Commodities: Measuring Prices, Availability & Affordability

Findings and recommendations – Kenya (2017)

Overview

Good sexual and reproductive health (SRH) is a state of complete physical, mental and social well-being in all matters relating to reproduction for both men and women, including adolescents. Maintaining good SRH means people need access to accurate information and to safe, effective, affordable and acceptable reproductive health services and commodities. People must be informed and empowered to protect themselves from sexually transmitted infections and, when necessary, receive timely and affordable treatment. And when they decide to have children, women must have access to services that ensure they have a fit pregnancy, safe delivery and healthy baby. Poor reproductive health constitutes a significant portion of the disease burden in developing countries, yet essential reproductive health commodities often are not available to the majority of the population in low and middle-income countries.

Although the government of Kenya's commitment to ensuring reproductive health services are accessible to all Kenyans is established in the National Reproductive Health Policy, availability and access to reproductive health commodities remains limited. Kenya is indeed faced with the challenge of stock-outs of contraceptives and other reproductive health supplies at the health facility level due to various factors, including a lack of an efficient logistics management system that would ensure an adequate and timely supply of commodities and medicines in all health service provision sites. The Government of Kenya renewed its commitment to Reproductive Health Commodities at the London Family Planning Summit held on July 11, 2017. These commitments included;

- Working with the national supply agency (Kenya Medical Supplies Authority) to ensure family commodities are costed before distribution to counties.
- To review barriers to some contraceptive methods at community level health facilities, especially in remote locations, and to reform the Kenya Medical Supply Authority (KEMSA) to end stock outs and improve the supply chain for all medical commodities including FP.
- The government commits to increase demand for and access to family planning among those counties in the northern arid lands (NAL) with the lowest mCPR and highest unmet need and to improve contraceptive commodity security working closely with development partners to secure increased financing for family planning commodities and services

Methodology

The objective of the SRHC methodology was to generate reliable information on the price, availability, and affordability of a basket of important SRHC that appear on the WHO essential medicines list, which should be available in the public, private and mission sectors. It also assessed health provider perspectives on access to SRHC beyond the medicines supply chain. The ultimate goal of the methodology is to inform policy that will improve access to affordable SRHC for all.[1]

[1] The Health Action International (HAI) methodology *SRHC: Measuring Prices, Availability and Affordability* is adapted from the HAI/WHO standard methodology to assess the price, availability, and affordability of medicines.

DRAFT

The report provides data relating to the following questions:

- What price do people pay for SRHC?
- Do the prices and availability of the same medicines vary across the public, private and mission sectors?
- How affordable are SRHC?
- What do health providers see as the main barriers to accessing medicines?
- Stock-outs?

In August 2017, the survey was conducted at 'health post' levels and above facilities belonging to public, private and mission sectors in both urban and rural areas. The selection of provinces to survey was random to provide a representative picture for the country. The districts selected for data collection were: Meru, Nairobi, Mombasa, Uasin Gishu, Kisumu and Western (Kakamega and Vihiga). A total of 120 facilities were surveyed using this approach, which were evenly distributed across the public, private and mission sectors and across urban and rural areas.

Key findings

In general, availability of SRHC was low as only 46% of commodities were available in the facilities. Moreover, 20% of the commodities researched were available at only a quarter of the facilities, while an average of only 45% of commodities were available at more than half of the facilities.

Availability of contraceptives was in general highest in the public sector, lower in the private sector, and evidently lowest in the mission sector. In Kenya, the most commonly used contraceptives are injectable and implants[2]. Medroxyprogesterone acetate, an injectable contraceptive, was commonly available in the public sector (95%), moderately available in the private sector (76%), and scarcely available in the mission sector (24%). Implants were also more commonly available in the public sector (around 80%), and had the worst availability in the mission sector (around 20%). The suboptimal availability of contraceptives makes it difficult to access the commodities, which likely contributes to the 18.5% of women still have unmet needs for family planning[3].

Some antenatal and post-natal commodities, such as oxytocin and gentamicin, had relatively high availability across all sectors (70 - 80%). Other antenatal and post-natal commodities were often available in around 60% to 70% of public sector facilities, with the exception of misoprostol, which was available in only 36% of public facilities. Access to these commodities is important to ensure a healthy pregnancy and life for both the mother and the baby, and when they are not available, it can lead to serious morbidity and mortality. Since the maternal mortality rate is still high in Kenya (360 per 100,000 live births), it is crucial to improve the availability of these commodities.

Commodities to treat sexually transmitted infections (STIs) were in general available in more than 60% of facilities. Important medical devices and procedures such as ultrasound scans, incubators, and antiseptic had a lower availability, even though they have a significant impact on the health outcomes of mothers and babies as it affects the quality of treatment offered to the clients.

[2] United Nations, Department of Economic and Social Affairs, Population Division. *Trends in Contraceptive Use Worldwide 2015*. (Geneva: United Nations, 2015), p. 1-63.
[3] United Nations, Department of Economic and Social Affairs, Population Division. p. 1-63.

Across the sectors the number of stock-out days differed. The average number of stock-out days in the private sector was lowest (2 days), followed by the public sector (6 days) and the mission sector (10 days). When stock-outs occurred, almost 11% of the commodities in the public sector were stocked-out for more than 20 days a month, which went up to 30% of commodities in the mission sector. Since availability of SRHC is already suboptimal, stock-outs can have a more significant impact on access to SRHC than presented with these numbers.

In the public sector the most expensive SRHC cost a lowest-paid government worker 0.15 days of wages, and in the private and mission sector it cost 1.62 days and 1.31 days, respectively. Nevertheless, costs to patients were mentioned to be a major challenge in access to SRHC.
This is not surprising, as Kenya's lowest-paid government worker earns the equivalence of USD 3.93[4] a day, while the last reported poverty rate of people living below the international poverty line of USD 1.90 was 33.6%[5].

Not only stock-outs and costs to patients were thought to be key challenges affecting access to SRHC, other challenges were lack of staff training on SRH, logistical issues for supply, and the fact that requested commodities are not supplied.

Recommendations

To improve access to SRHC, the following recommendations were made:

- **Improve the supply chain**
    - An efficient logistics infrastructure at all stages of the pharmaceutical supply chain is important in ensuring the quality, security and efficacy of the drugs. A key objective of Kenya's National Pharmaceutical Policy is to ensure continuous availability of safe and effective essential medicines through the full network of supply chain management system which involves the public sector, NGOs, development partners and private organisations.
    - The Health Sector Strategic and Investment Plan prioritizes supply chain efficiency with the aim of ensuring an effective and reliable drug procurement, distribution and storage system. The Kenya Medical Supplies Authority (KEMSA) is the government body mandated by law to procure, warehouse and distribute drugs and medical supplies for prescribed public health programs and is the largest supplier of medicines to public health facilities in the country.
    - Availability of sexual reproductive health commodities needs to be improved across all regions and facility types. For this to happen, the supply chain related issues affecting the timely requisition of medicines by service delivery points the timely delivery of the same will need to be addressed.
    - These issues include delays in making requisitions, use of logistics forms, delays in delivery of supplies, and delivery of inadequate supplies. Again the Ministry of Health at

[4] Based on currency conversion of KES to USD for the value of KES in USD on 13 August, 2017 via https://www.oanda.com/currency/converter/.
[5] The World Bank. *Poverty & Equality Data Portal: Kenya*. Accessed 23 November, 2017: http://povertydata.worldbank.org/poverty/country/KEN

both national and county levels should take the lead in ensuring that this is implemented.

- **Move to a 'pull system' of SRHC stock ordering**
    - The GOK mainly procures medicines through the Kenya Medical Supplies Authority (KEMSA). **KEMSA is the sole public sector supplier of pharmaceuticals.** KEMSA's supply system has traditionally followed a push model, where medicines and health products are delivered as part of an 'essential package' regardless of actual need.
    - Inefficiencies in terms of stock management, such as over and undersupply resulted. Recently KEMSA began employing a pull model, where deliveries are based on demand, in most regions. KEMSA has set up a distribution structure with the capacity to reach all public hospitals, rural health centres, and dispensaries throughout the country.
    - A process has begun to integrate parallel programmes, such as reproductive health commodities into KEMSA's overall distribution process.
    Ultimately, this will cut down on distribution costs and ensure medical commodities are managed within one supply chain resulting in greater reach and efficiency whilst better utilizing limited available resources.

- **Provide (continuous) staff training and increase the number of trained staff**
    - It is strongly recommended that staff who make supply orders are trained, mentored and supervised in supply chain and stock management, including the filling in of order forms in the respective formats. Also important is to ensure that more than one staff has the ability to make the orders to cater for periods when another staff is either on leave, sick or when they leave the facility. The Facility in-charges, especially at the primary level facilities, have to manage exclusively the supplies unit and to continually monitor its performance to ensure internal processes do no lead to drug stock-outs
    - Staff sensitization and continuous education is also needed to ensure clients feel comfortable accessing SRH services at facilities. For this, it is important that staff is sufficiently knowledgeable about SRH and services available, that they are professional in their approach, and that no stigmatization occurs within the facility.
- **Provide client education and outreach**
    - Improving knowledge in the community about SRH will tackle the statistic given, that 56% of clients are reluctant to access SRH services. For instance, comprehensive education on SRH will improve the general knowledge about SRH, which will in turn target the myths, superstitions and religious factors negatively influencing SRH services use. Also, client and community education can lead to a reduction in stigmatization of SRH service users by family and the community.
    - Related to community education is staff sensitization. Staff sensitization and continued education is needed to ensure clients feel comfortable in accessing SRH services at facilities.
- **Fund and make Sexual Reproductive Health commodities affordable**
    - The Kenyan government through the Ministry of Finance and the Ministry of Health Finance Department should increase its budget allocation for the purchase of sexual reproductive health commodities. This will avert future stock outs through increased budget allocations that will to increase accessibility and availability of reproductive

DRAFT

health commodities to all persons in the reproductive age group. Measures to avoid delayed financial disbursements that contribute to stock outs of all commodities must also be considered.

- The Kenyan national government budget for family planning has increased from US $6 million in 2011 to US $8 million for 2012-2013. Budget allocation for family planning commodities has grown from US $2.5 million for 2005-2006 to US $6.6 million in for 2012-2013. This leaves Kenya an estimated funding gap of 60 percent.

- **SRH commodities and industry (generics and the role of the pharmaceutical industry)**
  - Support for local production of SRH commodities could improve availability and affordability. By working with the Ministry of Finance through a tax incentive system, local manufacturers could produce SRH commodities that would form part of the government contribution over and above the purchases that are done eternally. This will significantly increase availability.

DRAFT

Suggested Targets for Advocacy

Technical Working Groups **FP TWG** **ASRH TWG** **ACSM TWG** **M&E TWG** **MNCH TWG**	**Parliamentary groups**	**Opportune moments for Advocacy**	**Policies and strategies specifically for SRH in Kenya**
		• Council of Governors annual conference. • County level TWG mtgs (commodities security) • Pharmaceutical Society of Kenya scientific conference • Kenya Medical Association conference • MoH conferences (RMHSU)	
Parliamentary Committee on Health	Ministry of Gender and Social Development	International Women's Day	Constitution of Kenya (2010): enshrined therein is the right of each individual "to the highest attainable standard of health, which includes the right to health care services, including reproductive health care".
MNCH Technical Working Group	Kenya Women Parliamentary Association (KEWOPA),	National Safe Motherhood Day	Kenya Vision 2030:
	Parliamentary Committee on Health		Kenya Health Policy (2012-2030):
	Kenya Women Senators Association (KEWOSA) and Women in the National Assembly		Kenya Health Sector Strategic and Investment Plan (KHSSP) (2013–2017):
	Gender Directorate and its two divisions: the Gender Mainstreaming division and the Socio-Economic Empowerment division	World AIDS Day	National Reproductive Health Policy (2007):
	National Gender Equality Commission	Presentation on Commitment by Parliament to the Issues of Maternal Health	National Reproductive Health Strategy (2009 – 2015):
	Committees responsible for accountability include the Public Accounts Committee, the Public		National Road Map for Accelerating the Attainment of MDGs Related to Maternal and

DRAFT

	Investments Committee, the Budget and Appropriations Committee		Newborn Health in Kenya (2010):
	Standing Committee on Budget		Reproductive Health Commodity Security Strategy (2013-2017)
	Standing Committee on HIV/AIDS		National Family Planning Guidelines for Service Providers
	Parliament Sessional Committee on Health		KENYA REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (RMNCAH) INVESTMENT FRAMEWORK

DRAFT

References

- file:///C:/Users/rreynolds/Desktop/DSW_Kenya-Budget-Study_30062014.pdf
- https://www.usaid.gov/sites/default/files/documents/1866/WiP%20-%20Kenya%20Case%20Study%20Report.pdf
-