Kenya's Roadmap for the Provision of Contraceptive Implants in the Private Sector

NOVEMBER, 2023

Contents

Acronyms

CHW	Community Health Worker
CI	Contraceptive Implant
DHIS	Demographic Health Information System
DRMH	Department of Reproductive and Maternal Health
EFPC	Expanding Family Planning Choices
FP	Family Planning
IAP	Implant Access Program
IHI	Impact for Health
IRA	Insurance Regulatory Authority
IU(C)D	Intrauterine (Contraceptive) Device
KEMSA	Kenya Medical Supplies Authority
KHF	Kenya Healthcare Federation
KHIS	Kenya Health Information System
KII	Key Informant Interview
KMPDC	Kenya Medical Practitioners and Dentists Council
KPA	Kenya Pharmaceutical Association
KRA	Kenya Revenue Authority
LMIC	Lower Middle-Income Country
mCPR	Modern Contraceptive Prevalence Rate
MFL	Master Facility List
MIC	Middle-Income Country
MoH	Ministry of Health
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
PPB	Pharmacy and Poisons Board
QA	Quality Assurance
TMA	Total Market Approach
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VG	Volume Guarantee

Acknowledgements

We wish to acknowledge all partners and stakeholders who took part in this process, including Kenya Ministry of Health representatives, development partners, donors, manufacturers, private sector stakeholders and healthcare providers.

KENYA'S ROADMAP FOR PROVISION OF CONTRACEPTIVE IMPLANTS IN THE PRIVATE SECTOR

This roadmap was co-created by key stakeholders across Kenya's family planning (FP) value chain. The process involved an in-depth literature review, key informant interviews, and a country workshop. This roadmap offers a strategic vision and accompanying goals, priorities and interventions to motivate and expand provision of Contraceptive Implants (CI) in the private sector as a part of the method mix in support of FP2030 goals. While this roadmap offers a set of strategic priorities and goals based on prioritized constraints, all market functions need to be considered to expand access to contraceptive implants as a part of a mixed health system. It is neither exhaustive nor static, but a starting point for stakeholders to coalesce around a shared agenda.

2023 VISION OF SUCCESS
7 years

The private sector sustainably expands its coverage of affordable contraceptive implants as part of the method mix to address consumer needs in support of FP2030 goals.

MARKET GOALS
5 years

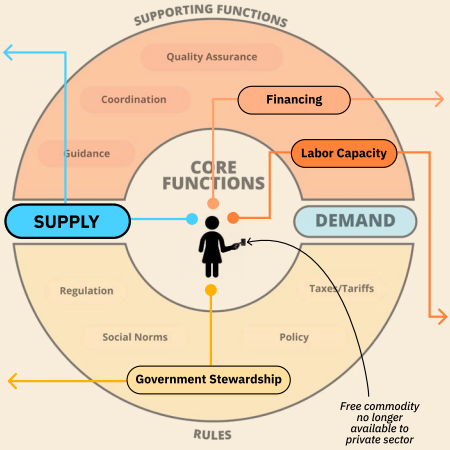
- Product(s) branded for the private sector are demanded through a clear supply chain.
- TMA Strategy is operationalized and informs revisions to Kenya's new FP Policy and UHC agenda to better address the private sector.
- Providers make a motivating profit from the provision of contraceptive implants which consumers can afford.
- Competent and diversified private sector workforce are motivated to report into the KHIS.

STRATEGIC PRIORITIES
3 years

- **Develop a viable private sector supply chain with branded product(s):** Stop provision of free commodity to the private sector; develop a business case for manufactures to (re)enter the private sector market; and consider registration of a rebranded product.
- **Strengthen Kenya's TMA FP execution:** Launch the Country Roadmap in collaboration with the TMA Task Force; operationalize the TMA strategy for CI in Nakuru County; and use data from implementation experience to advocate for private sector inclusion in FP policies.
- **Offset the anticipated cost increase once public commodities are withdrawn:** Form an expert group to explore mechanisms to offset the cost of an expensive commodity to consumers (i.e., inclusion in health insurance schemes) and purchasers (e.g., loan guarantee, guaranteed buyer, and/or pooled procurement).
- **Build capacity and motivation of a diverse private sector workforce:** Improve pre-service training curriculum for implants and integrate implants into quality assurance systems; leverage existing initiatives aimed to motivate private sector reporting into KHIS; review task sharing policy to explore feasibility of expanding provision of implants through other cadres.

CONSTRAINTS
Now

- **Lack of private sector supply chain:** The private sector primarily relies on free implants from the public sector, financed partly by the Kenya Government and donors like USAID and UNFPA, which are accessed from KEMSA, public hospitals and the black market.
- **Need for Government Stewardship:** The stagnant Total Market Approach strategy for FP underscores the lack of coordination in the private sector. There is a need for government stewardship, focusing on implementing the strategy and revising policies related to the role of the private sector in Kenya's FP and UHC agenda.



- **Lack of measures to offset the anticipated cost increase once public sector commodities are withdrawn:** There is no incentive for private providers to purchase CI since they can access them for free, and no mechanism to finance upfront capital or pool purchasing power on the horizon once the private sector loses access to free commodities. There is limited coverage of FP in social insurance schemes, like NHIF and Linda Mama.
- **Insufficient labor capacity to counsel, insert and remove implants, and no motivation to report services:** The pre-service training curriculum inadequately covers contraceptive implants; efforts to extend implant insertions through additional private providers (e.g., pharmacists) through task sharing have not been fully explored; and private providers lack motivation to report to KHIS.

Background

Rationale

Despite the success of contraceptive implant (CI) introduction in the public sector, implant provision by the private sector remains underutilized. The Implant Access Program (IAP) (2013-2018) established a volume guarantee (VG) agreement with manufacturers, through which the cost of implants to country governments and some partners procuring implants for Family Planning 2020 (FP2020) countries was reduced by 50%[1]. This made significant contributions toward the scale-up of implants in the public sector over the past decade, but it did not support private sector provision. In 2022, as part of the Expanding Family Planning Choices (EFPC) project, Jhpiego and Impact for Health (IHI) collaborated to understand the barriers to effective engagement of the private sector as a partner in CI service delivery. These findings outlined a set of global barriers and recommendations to support global and/or country stakeholders in expanding private-sector CI service delivery. **Kenya's Roadmap for Private Sector Provision of Contraceptive Implants** builds on this global review and identifies specific market constraints and opportunities for the private sector provision of CI in Kenya (See Figure 1).

Methodology

In June-August 2023, IHI and Jhpiego conducted a comprehensive literature review (55 articles, both peer-reviewed and grey literature) and 12 key informant interviews (KII) with actors from across Kenya's CI value chain who play critical roles in different market functions. This resulted in a private sector CI Market Analysis Report available here. In September 2023, Jhpiego and IHI hosted a Country Workshop in Naivasha, Kenya with 24 key stakeholders from across the value chain to validate the findings in the draft Market Analysis Report and co-create recommendations for how to improve uptake of CI as part of a comprehensive contraceptive method mix. The discussions and outputs from that workshop inform this Roadmap.

Purpose

This Roadmap documents a pathway for private sector provision of CI in support of FP2030 goals by answering the following questions:

- **Where are we now?** Summarizes the current state of CI in the private sector and key market constraints to expanding sustainable private sector provision of implants;
- **Where do we want to go?** Articulates the 2030 vision of success (in support of FP2030 goals) and five-year market goals to achieve that vision;
- **How do we want to get there?** Outlines the three-year strategic priorities and longer-term interventions to drive progress to achieve the goals and vision.

Figure 1 - Timeline illustrating projects focused on scaling up contraceptive implants.

[1] Braun, R. & Grever, A. (2020). Scaling Up Access to Implants: A Summative Evaluation of the Implants Access Program, Glob Health Sci Pract, 8(2): 205-219.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7326518/pdf/GH-GHSP200015.pdf

1

WHERE ARE WE NOW?

This section summarizes the key findings from the Market Analysis Report and outlines the four Key Market Constraints prioritized during the September 2023 workshop. Market Constraints were prioritized based on their potential impact, stakeholder availability and motivation, as well as feasibility. It is worth noting that the demand function does not feature as a key market constraint in Kenya. Key stakeholders/ experts agreed that there is already sufficient demand for CI and therefore prioritized supply side challenges (supply chain), supporting function challenges (financing and labor capacity) and the enabling environment (rules function).

These constraints are not exhaustive of all Kenya's CI market constraints but are considered critical entry points to tackle the market. The roadmap presents constraints and associated information sequentially for ease of presentation, while aiming to lay out the intersections between the constraints and interventions. Finally, this report weaves in the "Who Does, Who Pays" sustainability analysis in the current state of the market (where are we now?) and future state of the market (where do we want to go?), to ensure the final strategic priorities and interventions will lead to sustainable behavior change across Kenya's value chain actors (how do we get there?).

Kenya's CI Market Landscape Summary

Kenya is well-poised to expand its private CI market – with a proven record as a family planning (FP) first mover in Africa, a comprehensive FP Total Market Approach (TMA) strategy ready to implement, and women who know of and use the method, albeit mainly from the public sector. Kenya's challenge is to wean private providers off reliance on free commodity and identify the best financing vehicle to support sustainable private sector provision.

"There is a demand for implants, but the supply is a big challenge" - KII quote

Kenya has made impressive progress in meeting women's FP needs. Kenya's modern contraceptive prevalence rate (mCPR) of 57% has increased considerably over the last decade, thanks in part to the rapid uptake of implants[2]. Women like and use implants which constitute 37% of the modern contraceptive mix[3]. 86% of Kenyan women using implants access them for free from the public sector and the remaining 14% primarily obtain them from private medical facilities, including NGOs[4] (see Figure 2). Jadelle, Implanon NXT, and Levoplant are all present in private sector facilities, while Jadelle and Implanon NXT are the most common as they are provided for free. In exchange for free commodities (Jadelle and Implanon NXT), private providers are supposed to report data to the Kenya Health Information System (KHIS)[5], but this happens inconsistently, blurring the true contribution of the private sector. The private sector is expected to lose access to free commodities as Kenya's health financing landscape is changing, with the MoH expected to fully fund FP commodities by 2025 (see Figure 3). This presents an opportunity to expand a true private market.

In line with international policy shifts, Kenya is moving towards task sharing for implant provision which could pave the way for lower-level cadres (both public and private) to act as implant access points. Furthermore, Kenya's comprehensive TMA for FP Strategy could be an important tool to create a robust and sustainable FP market as donor funding declines. To learn more about Kenya's landscape for CI in the private sector, please read the full Market Analysis Report.

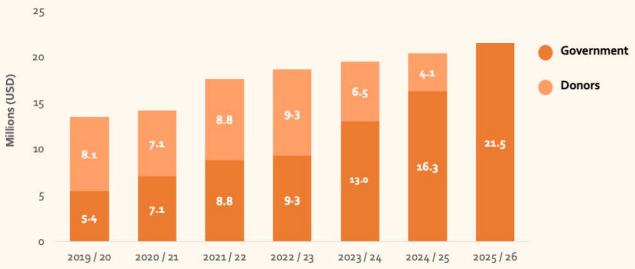


Figure 2 - Estimated Family Planning Commodity Funding Commitments, 2019–2026. Note: Figures derived from MOU ratios were translated into estimated costs using the government's family planning forecasting and quantification data, October 2021. Projections do not include supply chain costs such as warehousing and distribution.

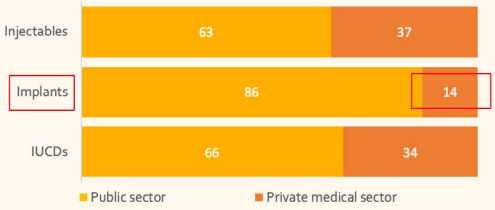


Figure 3 - Source of supply of modern methods users by method, (KDHS, 2022)

[2] Kenya National Bureau of Statistics and ICF international. (2023). Kenya Demographic and Health Survey (2022). https://dhsprogram.com/pubs/pdf/FR380/FR380bis.pdf
[3] Ibid.
[4] Ibid.
[5] Ministry of Health Kenya. (2017). National Family Planning Costed Implementation Plan 2017-2020. https://familyhealth.go.ke/wp-content/uploads/2018/02/National-FP-Costed-Imlementation-Plan-2017-2020.pdf

CORE: Lack of a private sector supply chain for CI

CONSTRAINTS *Now*

Reliance on public sector implant products means there is a limited supply chain for implants within the private sector. Private providers lack motivation to purchase CI since they can access CI commodities for free through the public sector supply chain. Most implants available in the private sector in Kenya are sourced from the public sector - through formal distribution channels, informal handouts, personal favors, and purchasing from black market distributors. Kenya's most prominent CI brands – Jadelle and Implanon NXT - are labelled "not for sale" in Ministry of Health (MoH) boxes. This branding limits private sector providers' ability to visually market the product. In order for the commercial private sector to establish itself, widespread access to free commodities from the public sector must cease.

WHO DOES?

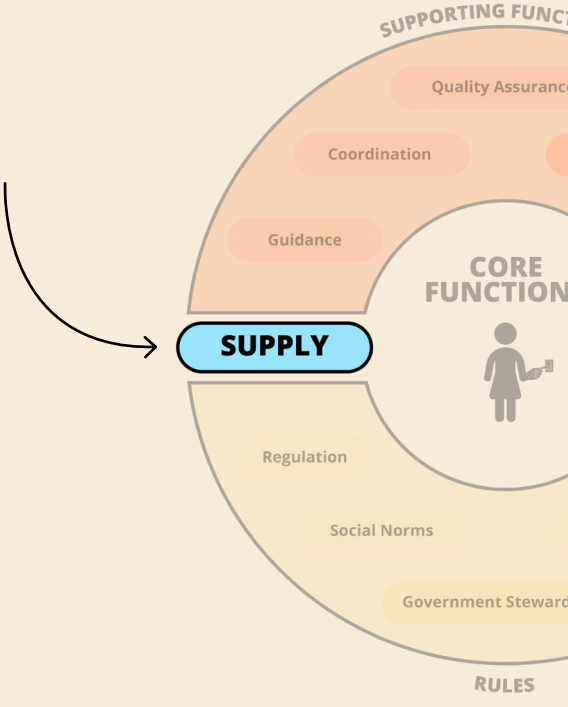
Incentives, motivations & capacities

The private sector currently accesses free commodities from the public sector, either through KEMSA, public hospitals, individuals or black-market distributors. The private sector distributors are currently locked out of procuring Jadelle and Implanon NXT directly.

WHO PAYS?

Incentives, motivations & capacities

Government budgets (supported by donor funding) pay for Jadelle and Implanon NXT. Some private providers pay a kickback fee in exchange for free commodities and some pay black market distributors for a guaranteed amount of public sector products.



SUPPORTING: Lack of measures to offset the anticipated cost increase once public sector commodities are withdrawn

CONSTRAINTS *Now*

There is no incentive for private providers to purchase CI as they can access them for free. In addition, there is no financing mechanism in place to support with upfront capital or to pool purchasing power across private providers once the private sector can no longer access free commodities. To the private provider, implants have a high investment cost per unit in comparison to other contraceptive methods. This cost is considered a risk and is therefore a barrier for private providers to engage in commercial purchasing. This is compounded by the high cost of clearance through levies, which makes it uneconomical for the private sector to import commodities. Private providers need a convincing business case to invest in implants. As providers will pass the high unit cost of implants to the consumers once they lose access to free commodities, the one-off cost of implants to the user will present a barrier to access, especially given limited coverage of FP (including implants) in private insurance and social insurance schemes like National Health Insurance Fund (NHIF) and Linda Mama.

WHO DOES?

Incentives, motivations & capacities

Bayer and Organon & Co sell implants (Jadelle and Implanon NXT, respectively) to the public sector at a fixed wholesale price through a voluntary continuation of the IAP agreement, relying on donor financing for large volume orders. As donor funding decreases, the MoH is likely to prioritize distributing publicly-procured CI to public sector sites, leading to a loss of free commodities for the private sector. DKT Womencare Global (referred to as DKT in the remainder of this report) distributes Levoplant through its distribution channels.

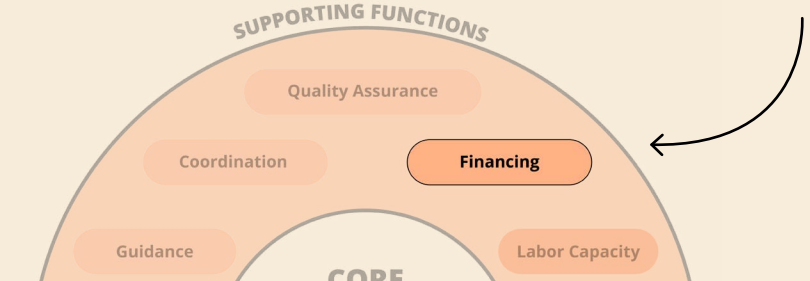
WHO PAYS?

Incentives, motivations & capacities

Government (supported by donors, such as United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID)) pay for the majority of the commodity in country (Jadelle and Implanon NXT). **Private providers** get products (Jadelle and Implanon NXT) for free, pay a small favor in exchange for products or purchase public products through black market distributors. Some purchase Levoplant through DKT's distribution system.

Few private-sector insurance providers cover FP. Only the most comprehensive (and costly) social insurance, such as NHIF, includes FP and there is limited coverage for the majority and those most in need. The Linda Mama (free maternity program) only covers FP for up to 6 weeks postpartum.

Clients currently pay for private health insurance coverage. NHIF is currently paid for through individual contributions and with some support from the government. The Linda Mama program is currently accessible for all women in Kenya. Clients without insurance are purchasing implants through out-of-pocket spending.



SUPPORTING: Insufficient labor capacity to counsel, insert and remove implants, and no motivation to report services

CONSTRAINTS *Now*

Current training programs prioritize public providers and the pre-service training curriculum inadequately covers CI (one-rod and two-rod (3 and 5 years)), all of which is compounded by the limited hands-on experience of private sector professionals with inserting and removing implants. These capacity issues lead to inconsistent and varying skills among health professionals in the private sector. These skill gaps, along with the inconsistent availability of implant stock in the private sector, hinder private providers from consistently offering implant services. Furthermore, efforts to extend implant insertions through additional private providers (e.g., pharmacists) by task sharing have not been fully explored. Lastly, there is a lack of motivation for providers to report on CI, which is a widespread issue across all healthcare services in the private sector. This shortfall is due to the perception that reporting to the MoH lacks meaningful impact or incentives for their work. While the MoH has previously shared a circular for private sector reporting, there is a requirement for strategic guidance on the reporting process, which should encompass standardized tools, linkage with public facilities, and the utilization of Master Facility List (MFL) codes for accessing KHIS.

WHO DOES?

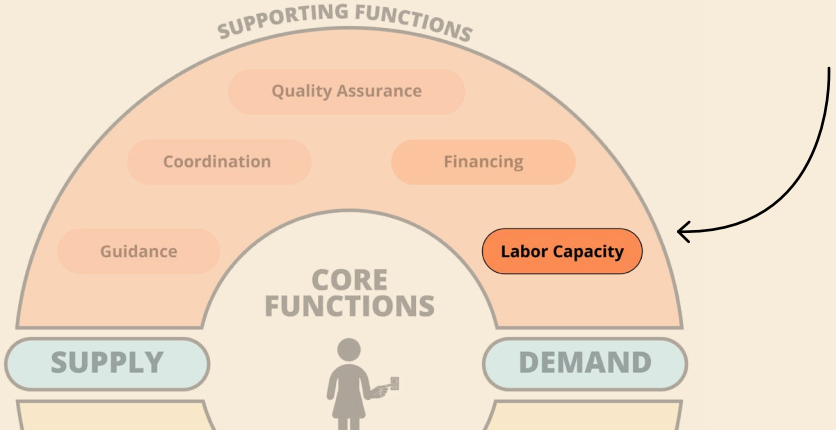
Incentives, motivations & capacities

MoH coordinates healthcare provider training for implants with support organizations such as Kenya Pharmaceutical Association (KPA), Kenya Medical Practitioners and Dentists Council (KMPDC) and Kenya Healthcare Federation (KHF), manufacturers, and implementing partners. Private practitioners are responsible for data reporting to MoH.
DKT organizes trainings for Levoplant.
Success in task sharing is a collaboration of the MoH, health cadres, communities, regulatory bodies, and professional organizations.

WHO PAYS?

Incentives, motivations & capacities

MoH, with the support of professional organizations, implementing partners and at times manufacturers, pays for the training of healthcare workers. Data reporting is largely funded by the MoH.



RULES: Need for government stewardship, coordination, and enabling policy for the private sector

CONSTRAINTS *Now*

The FP TMA strategy seeks to coordinate the private sector, public sector and NGOs to foster a thriving FP market through an efficient supply chain, good marketing principles, and reduction in distortions and stockouts. Although an FP TMA strategy was developed in 2020 with donor support, this has not resulted in a better coordinated private sector due to lack of funds for implementation and the need for strategic leadership for its operationalization and dissemination. While the strategy exists, more guidance is required to articulate roles and responsibilities across the value chain to operationalize the strategy (e.g., who regulates, who ensures quality, who leads on coordination), including detailed work plans and platforms for learning and accountability. In addition, the role of the private sector is insufficiently addressed in health policies such as the current FP Policy (which is due for revision) and the Universal Health Coverage (UHC) agenda. This, compounded with underutilized and disjoined reporting systems (described earlier), leads to a lack of full visibility and under-appreciation of the private sector's contribution to the health market.

WHO DOES?

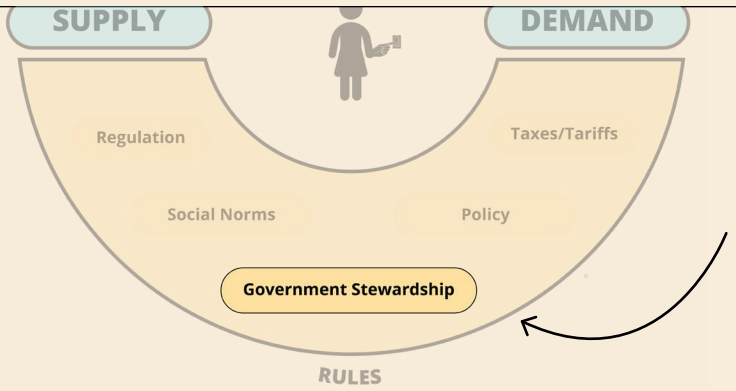
Incentives, motivations & capacities

The government, and regulatory bodies (Kenya Medical Supplies Authority (KEMSA), Pharmacy and Poisons Board (PPB), Kenya Revenue Authority (KRA), Insurance Regulatory Authority (IRA)), are currently responsible for the coordination of the private sector, but their support at present is suboptimal. The Kenya Healthcare Federation works to influence policy for an enabling private sector environment. The TMA Task Force, a group of key decision-making stakeholders, strategically lead by the MoH through DRMH (Department of Reproductive and Maternal Health) has a growing role, though it is still in its infancy and the funding and therefore capacity to do so is lacking.

WHO PAYS?

Incentives, motivations & capacities

Donors have funded the development of the TMA strategy for Kenya, in line with government support. Additional financial support and incentives for the government are through private partnerships. The Kenya Healthcare Federation is financed by its members.



2

WHERE DO WE WANT TO GO?

This section outlines the **vision** and **goals** for the CI market in Kenya in support of FP2030 goals. The market goals (5 years) presented directly respond to the four key constraints to sustainably improve access to CI in the private sector.

2030 Vision of Success:

The private sector sustainably expands its coverage of affordable CI as a part of the method mix to address consumer needs, in support of FP2030 goals

VISION OF SUCCESS
7 years

CORE Supply Chain: Product(s) branded for the private sector are available through a clear supply chain

MARKET GOALS
5 years

Manufacturers, in collaboration with distributors and with government oversight, promote CI branded for the private market, which are demanded by private healthcare providers and consumers. This could include the introduction of a newly branded CI for the private market; however, it is noted that any such branding efforts should be cost-efficient and not drive up the overall cost of CI in the private sector. Branded product(s) are readily available to private healthcare providers through clear supply chains, enabling consistent stock levels in private outlets. Product(s) are commercially appealing to consumers, increasing the sale of the product for the provider. The branded product(s) are differentiating from public-sector CI products, enabling the recognition of the source of implants sold in private facilities. This differentiation of products will be increasingly important as donor subsidies decrease, and products entering the public sector will be exclusively for public sector use.

WHO DOES?

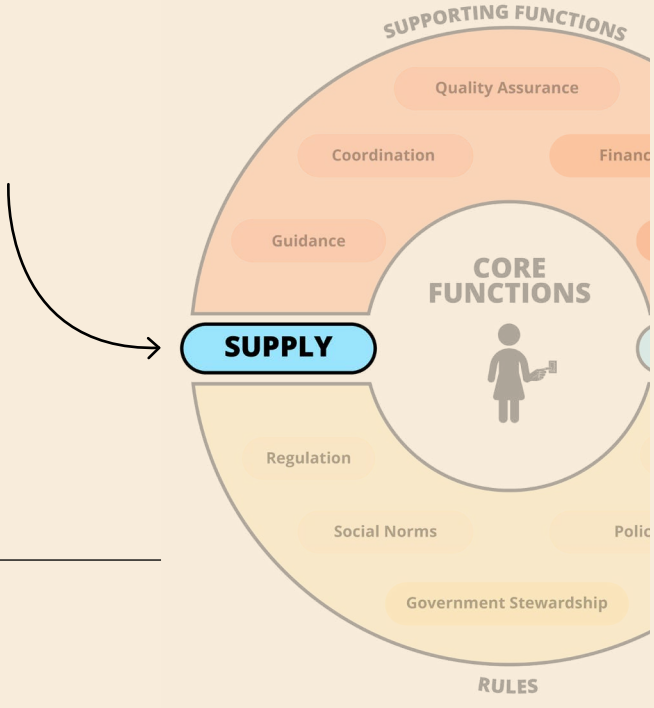
Incentives, motivations & capacities

Manufacturers (i.e., Bayer, Organon & Co and/or DKT) are motivated to sell branded implants, which are demanded by consumers and are handled by private sector distributors. It should be noted that DKT WomenCare has already registered Levoplant which does not have public sector branding.

WHO PAYS?

Incentives, motivations & capacities

Distributors purchase volumes of implants, because they are demanded by providers. Consumers are aware of and can purchase the branded implants at an affordable price point, based on their ability to pay, supported by health insurance.



SUPPORTING Financing: Providers make a motivating profit from the provision of CI which consumers can afford

MARKET GOALS
5 years

Private providers recognize the business case for investing in the newly branded implant, which is in demand among consumers at an affordable price point. These private providers are organized through associations and federations, such as the Kenya Healthcare Federation, and purchase the newly branded product from recognized private sector distributors. This clear procurement channel, without the involvement of multiple distributors that could inflate the product's price, allows private providers to access the product at a price close to that offered at wholesale. Insurance enables women who may not otherwise be able to afford implants to access the product as part of family planning services in a healthcare facility of their choosing. It also ensures that their method selection is based on informed choice, rather than being influenced by concerns of out-of-pocket spending.

WHO DOES?

Incentives, motivations & capacities

Private providers reliably offer CI as part of their method mix, driven by a compelling business case that demonstrates the importance of offering CI.

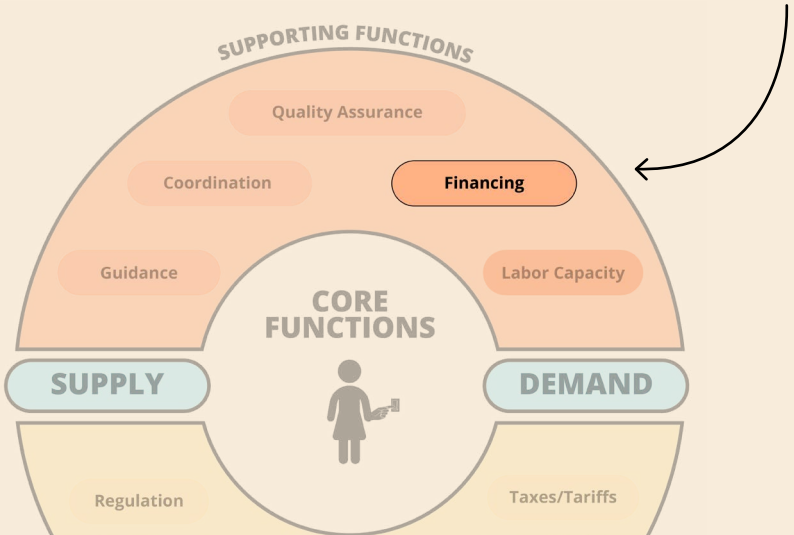
Private, social and primary health insurances cover CI as part of FP cover. NHIF covers FP in all of its packages.

WHO PAYS?

Incentives, motivations & capacities

Private providers purchase CI to meet high demand, profit from insertion and removal services, and attract more clients with their comprehensive family planning offerings and quality services.

Some clients pay for insurance and insurance providers pay health providers. Social insurance is means-tested so that those least able to pay or making small contributions are still able to access services. Other wealthy clients, who can afford implants, pay out of pocket.



SUPPORTING Labor Capacity: Competent and diversified private sector workforce are motivated to report into the KHIS

MARKET GOALS
5 years

Healthcare workers are well-trained, consistently have the knowledge and skills to counsel for 3- and 5-year CI, insert and remove all implants brands (i.e., one- and two-rod CI), and can offer and promote FP services to women. Additional cadres of healthcare workers, such as pharmacists, can offer CI in a variety of quality, clean and confidential healthcare spaces, which expands coverage through an updated task sharing policy. This approach ensures that even those in remote or underserved areas at the "last mile" can access these services. Private providers consistently report to the KHIS because it is a requirement for their facility registration and licensing. In addition, it may serve as a recognized quality measure for joining a private healthcare association or becoming eligible for NHIF accreditation.

WHO DOES?

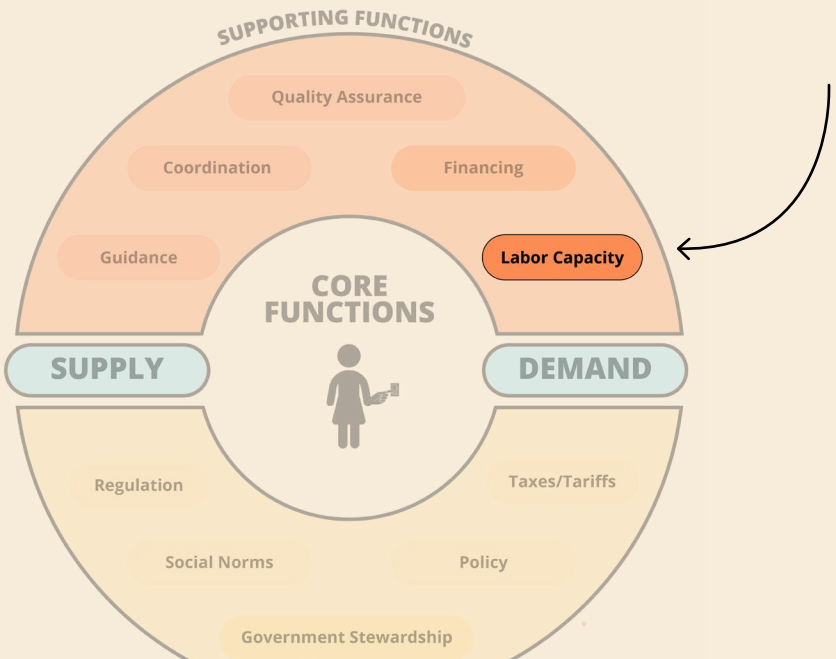
Incentives, motivations & capacities

MoH and associations (such as the KPA, Kenya Medical Practitioners and Dentists Council and Kenya Healthcare Federation) train private providers. Healthcare providers have a cohesive approach to task sharing and all private providers regularly report into KHIS.

WHO PAYS?

Incentives, motivations & capacities

A variety of private healthcare providers, including nurses, midwives, CHWs, and pharmacists, are willing to invest in delivering CI because they are well trained. MoH continues to invest in KHIS for usability as part of coordinating healthcare through a total market approach.



RULES Government Stewardship: TMA Strategy is operationalized and informs revisions to Kenya's new FP Policy and UHC agenda to better address the private sector

MARKET GOALS
5 years

The success of the TMA in Kenya is attributed to implementation efforts at the county level focused on CI. The experience in one county (Nakuru) is well documented and promotes a similar approach in other counties.

The leadership and advocacy work of the TMA Task Force contributes to policy change in Kenya, such as the private sector inclusion in the national FP policy and in Kenya's UHC agenda.

WHO DOES?

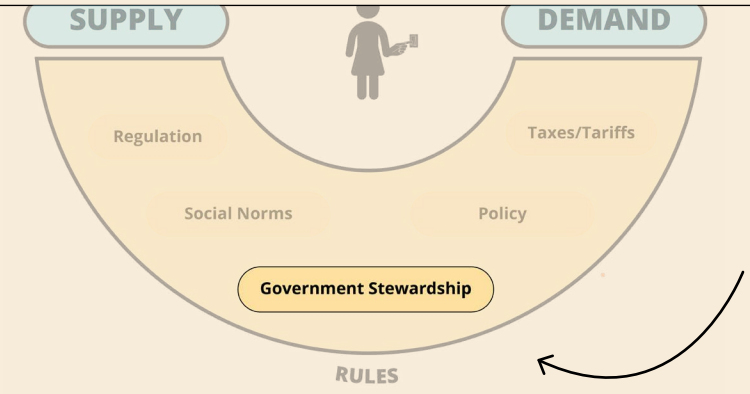
Incentives, motivations & capacities

A joint partnership between the government and private sector, with government leadership, allows for the total market to thrive. The TMA Task Force leads on advocacy work for FP and UHC agenda policy change.

WHO PAYS?

Incentives, motivations & capacities

The government and private sector co-fund this work as part of a public-private partnership.



3

HOW DO WE GET THERE?

This section outlines the strategic priorities for the next three years, aimed at advancing towards the five-year market goals and realizing the vision for CI in the private sector in Kenya. It should be noted that this section is neither exhaustive nor static, but is meant as a starting point to increase the sustainable delivery of CI in the private sector.

CORE Supply chain: Develop viable private sector supply chain with branded product(s)

STRATEGIC PRIORITIES
3 years

Stop provision of free commodity to the private sector

WHAT: While the private sector is expected to lose access to free commodities by 2025, it should be noted that this is a prerequisite to a true private market. Currently, the market is distorted by free commodities, and until they are withdrawn there is no incentive for private providers to purchase commodity and therefore no incentive for manufacturers to sell.

WHO: This is an opportunity for the MoH to expand its stewardship of the private sector market, by coordinating the timeline for the withdrawal of free commodities and to clearly communicate this path with manufacturers, distributors, and private sector providers. The TMA Task Force (described later) could be an ideal platform to plan for and communicate this transition.

Develop a business case for pharmaceutical manufactures to (re-)enter the private sector market

WHAT: Levoplant is currently registered in Kenya, but its market share is constrained by the volumes of free commodities given to private providers. As the MoH withdraws provision of free commodities, this presents an opportunity to create a business case to motivate (a) DKT to expand its market of Levoplant, and (b) Bayer and/or Organon & Co to enter the private market. A regional/Africa level business case should be considered for Bayer and/or Organon & Co given they currently only sell to country governments and rebranding/overbranding might be necessary to enter the private market (described below). The business cases tailored to the manufacturer should concisely outline: market volumes, projected demand, key players, policy regulatory barriers and facilitators, and potential profit for expanding and/or entering into the private market.

WHO: With oversight from the TMA Task Force and MoH, the business case should be developed by a technical implementing partner or a market research organization and informed by manufacturers, distributors, professional associations, regulators, and donors.

Where applicable, seek registration of a rebranded private sector product

WHAT: Use the business case for a private sector product to advocate to Bayer and/or Organon & Co to rebrand their existing product. It is important to note that even rebranded products require re-registration in each country (including Kenya) which is a lengthy and involved process. In the business case development described above, careful consideration should be paid to the feasibility of this approach, including the costs involved in rebranding. If this is pursued, a go-to-market strategy could support manufacturers to plan how the product reaches its target audience, establish distribution channels, and execute marketing efforts before launch, ensuring that it achieves its business objectives. Furthermore, Bayer and Organon & Co will need to identify the right distribution channels for the product as historically they've worked through public distribution channels for Jadelle and Implanon NXT.

WHO: Manufactures (Bayer and/or Organon & Co) with potential support from an implementing partner for the go-to market strategy.

SUPPORTING Financing: Offset the anticipated cost increase once public commodities are withdrawn

STRATEGIC PRIORITIES
3 years

Form an expert working group under the TMA Task Force to explore mechanisms to offset the cost increase that is to be expected when public sector commodities are withdrawn

WHAT: Once public sector commodities are withdrawn, a cost increase is to be expected. The TMA Task Force could develop a working group to explore mechanisms to offset this cost increase at multiple levels: distributors/wholesalers, private providers, and consumers.

WHO: TMA Task Force and financing experts, such as ThinkWell, and insurance companies.

Explore mechanisms to increase consumer affordability (inclusion in health insurance schemes)

WHAT: Kenya's health financing landscape is changing rapidly, especially considering the recent social health insurance bills and reforms which are expected to increase social health insurance coverage (currently at 24%, Demographic Health Survey 2022). The working group should monitor these trends, as well as progress toward addressing the entrenched challenges of Kenya's National Health Insurance Fund such as benefits pricing, explicit inclusion of FP services, and delayed payments to providers, to explore the extent to which national health insurance can be a mechanism to reduce the cost to the consumer and maintain/increase profit margins for the provider.

WHO: TMA Task Force health financing working group.

Explore mechanisms to finance upfront capital for distributors/wholesalers and pool procurement

WHAT: Distributors/wholesalers may lack the capital and/or the risk tolerance to purchase CI which are an expensive commodity compared to other FP methods. Mechanisms to consider include:

- **Loan guarantee:** empowers distributors to secure funds for purchasing implants in bulk, addressing working capital challenges and accessing favorable bulk pricing. The funding for these guarantees can come from various sources, including government budgets, international development organizations, and donor contributions. These funds are used to underwrite the loans provided by financial institutions to distributors, who should be able to pay the loan back based on a profitable product.
- **Guaranteed buyer:** Alternatively, if importers have sufficient capital, a guaranteed buyer model reduces risk by ensuring that unsold products can be purchased at a discounted rate by entities (such as USAID or other donors) and integrated into another supply chain that needs free or subsidized commodities. Despite its complexity and although it requires rigorous financial analysis and modelling to refine and assess feasibility, this approach could mitigate private sector constraints without subsidies.

In tandem with the approaches above, **pooled procurement** could be explored across private providers (including NGOs) to support economies of scale, reducing the overall cost of procurement. A designated procurement agency would need to lead this, including agreeing the cost-sharing mechanism in advance.

WHO: FP financing technical experts, banks (or other loan model), private distributors and guaranteed buyers such as international development organizations and donor contributions.

SUPPORTING Labor Capacity: Build capacity and motivation of a diverse private sector workforce

STRATEGIC PRIORITIES
3 years

Improve pre-service training curriculum for CI, and integrate CI into existing QA systems

WHAT: Working through the TMA Task Force, a group of actors could be convened who are committed to improving pre-service training curriculum for CI (one- and two-rod, 3 and 5 years; addressing counselling for continuation, insertions and removals) and integrating CI into existing quality assurance (QA) systems. This could include review of (a) existing curriculum in other regions/countries where CI is sufficiently covered and conducting a gap assessment of the existing curriculum in Kenya; and (b) review of supportive supervision, mentoring, and QA systems to map out how QA for CI can best be addressed within the existing systems.

WHO: TMA Task Force, implementing partners, provider associations, government, and donor support.

Leverage innovative approaches to motivate private sector reporting into KHIS

WHAT: While private sector reporting rates in Kenya have improved over time, data quality issues remain in reporting family planning services into KHIS. The challenges of private sector reporting into KHIS are not unique to CI, and there are many actors/initiatives in Kenya that aim to address these issues (e.g., what motivates private providers to report from a regulatory or eligibility for accreditation lens, and how to simplify what's often seen as duplicative and parallel processes?). One such example is Population Services Kenya's Health Network Quality Improvement System which enables health service quality improvements and integration of private sector data into Demographic Health Information System 2 (DHIS2). The TMA Task Force can dedicate a group of actors to leverage existing activities and innovations to improve reporting from the private sector.

WHO: TMA Task Force, Ministry of Health, implementing partners, healthcare workers.

Review FP Task Sharing Policy to explore feasibility of expanding access through other cadres

WHAT: In line with WHO normative guidance, in Kenya only doctors, midwives, clinical officers, trained public health technicians, enrolled community nurses, and community midwives can insert and remove implants. However, stakeholders in Kenya have spoken optimistically about the potential for scale up of implant provision through pharmacies. The task sharing policy review would seek to make the case for why piloting implant insertion and removals by pharmacists is viable in Kenya. If progress is made and stakeholders are on board, a proof-of-concept pilot could be conducted in Nakuru County to demonstrate that pharmacists can insert and remove CI safely and effectively, and furthermore can report into KHIS. This pilot could also be an opportunity to (a) test the new pre-service curriculum (described above) and determine its applicability to new healthcare providers, as well as (b) integrate the provider reporting innovations (described above) to demonstrate what works to motivate and capacitate pharmacists to report into KHIS.

WHO: TMA Task Force, Ministry of Health, implementing partners, healthcare workers, donors.

RULES Government Stewardship: Strengthen Kenya's TMA FP execution

STRATEGIC PRIORITIES
3 years

Launch Kenya's CI Country Roadmap through the TMA Task Force

WHAT: Launching Kenya's CI country roadmap through the TMA Task Force would deepen their understanding of the roadmap strategies and improve collaboration. To officially introduce the Country Roadmap to a wider audience and gain support, a stakeholder engagement forum can be held with the TMA Task Force, serving as the official launch platform for broad buy-in. This would also enable collaboration on other private sector FP products such as DMPA-SC within the TMA.

WHO: TMA Task Force, Ministry of Health, implementing partners.

Starting in Nakuru County, operationalize the TMA strategy with a focus on CI

WHAT: Clearer guidance, work plans and opportunities for learning and adaptation are required to operationalize the existing TMA strategy and, as a result, build a strong and functional partnership between the private and public health sector for the sustainable delivery of FP. With potential donor support, the TMA Task Force could convene to (a) map out roles and responsibilities across the value chain for CI (e.g., specifying clearly who regulates, who ensures quality, who leads on coordination); (b) develop strategic guidance for private sector reporting (i.e., standardized tools, linkages with public facilities, and the utilization of MFL (Master Facility List) codes for accessing KHIS, in line with the circulate for private sector reporting; (c) develop a detailed work plan; and (d) leverage their existing meetings as platforms for learning and adaptation.

WHO: Implementing partners, county governments and donor funding.

Use data from the implementation experience in Nakuru County to advocate for the private sector inclusion in FP Policy, private sector visibility in UHC agenda, and revised Task Sharing Policy

WHAT: Leveraging existing TMA Task Force meetings and platforms at the county and national level, data and insights from the implementation experience could be utilized to advocate for enhanced representation of the private sector in Kenya's revised Family Planning Policy (expected in 2024) and UHC Agenda. Through active stakeholder exchanges, the program will facilitate the sharing of successes and lessons learned, ultimately expanding strategies for TMA integration into more counties.

WHO: TMA Task Force, Ministry of Health, implementing partners, healthcare providers and donors.

Conclusion

While neither exhaustive nor static, this Roadmap represents a starting point for stakeholders to coalesce around, with a view to increasing the sustainable delivery of CI in the private sector in Kenya. By proactively addressing identified constraints concerning supply chain, financing, labor capacity, and government stewardship and coordination, this Roadmap supports stakeholders to move beyond simply identifying where the market is broken: it offers achievable ways forward.

The "How Do We Get There?" section of this Roadmap is built on learnings gained at the in-country workshop. It presents actionable steps to achieve the four 3-year Strategic Priorities, including what needs to be done and which key market actors are best placed to do this. Through implementation of this Roadmap, Kenya can create a viable private sector model for CI delivery that is built on:

- **A sustainable supply chain** for a branded product to replace reliance on free, public sector commodities;
- **Appropriate financing options** to make provision and uptake of CI financially viable for private providers and users, respectively;
- **Appropriate labor capacity** to deliver a quality service; and
- **Robust stewardship of a mixed health system** for CI to achieve FP2030 targets.

Although this Roadmap focuses on the increasing sustainable delivery of CI in Kenya's private sector, it offers potentially valuable insights for other lower middle-income countries (LMICs) at different stages of market development for CI and/or other FP products. As all countries strive towards UHC, the recognition that all health systems are mixed health systems highlights the need for governments to actively steward all stakeholders to achieve shared health goals and targets. Rather than seeing working with the private sector as an additional - possibly optional - task, this framing enables Governments to see private sector capacity as a valuable resource to achieve UHC. With this recognition comes the equally important realization that identifying sustainable financial solutions to support the private sector in delivering quality healthcare is an integral part of achieving a flourishing mixed health system.

Many LMICs find themselves challenged by a false dichotomy between a historic over-dependence on donor-supported commodities, delivered for free, and a more recent imperative to transition private sector providers to a cost recovery model with users paying a significant proportion of the associated cost, through insurance schemes or out-of-pocket expenses. This Roadmap shows that a middle path exists, where new and/or expensive commodities, such as CI, are initially made available in the public sector as a valuable step to de-risk such commodities for future private sector procurement by building demand and demonstrating a viable business case for investment. This also speaks to the role and importance of developing and implementing health insurance schemes in the context of mixed health systems.

Finally, while commonalities exist across countries, context always matters and countries should expect to learn from this work but also appreciate their own mixed health system context to ensure solutions and approaches are tailored to their needs. This Roadmap, used in tandem with the "How-to Guide" (which provides high level guidance for how to conduct a market landscape and create a roadmap for provision of sexual and reproductive health products in the private sector by adapting the Keystone Design Framework), offers valuable lessons and recommendations that can be applied to other countries with a similar FP private sector market and CI market.

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