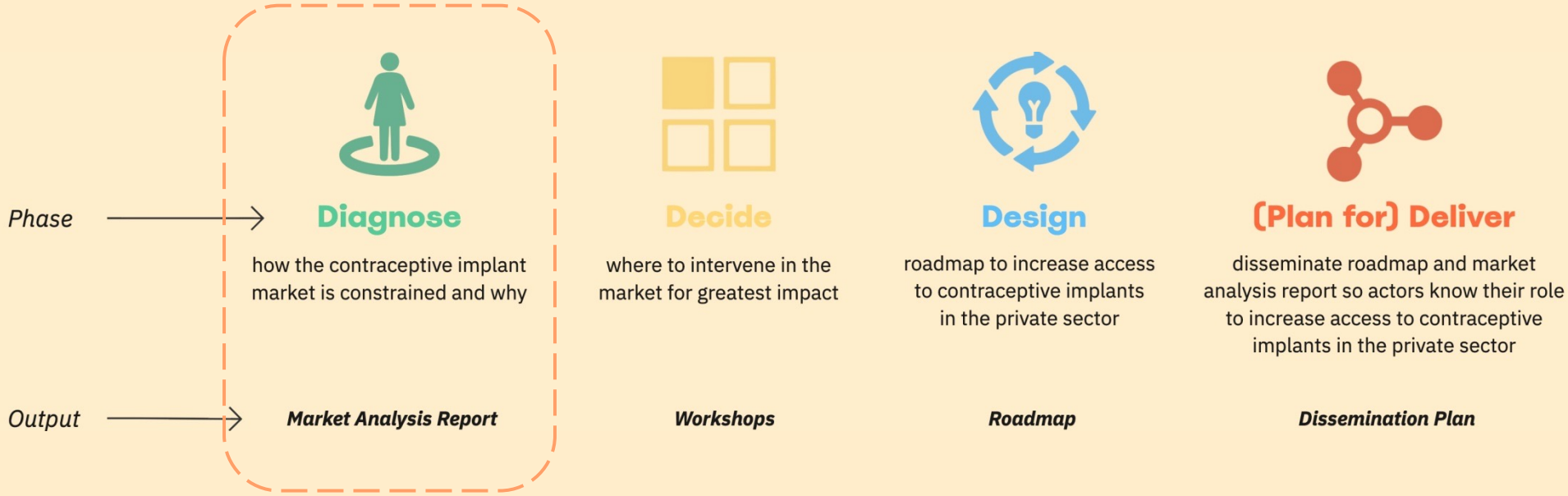
# Kenya Contraceptive Implants Market Analysis Report

October 2023

# Keystone Design Framework

We've adapted the Population Services International (PSI) Keystone design framework for this Market Analysis Report, and subsequent deliverables. In doing so, we commit to sharing our learnings, both on content and process, with PSI and the wider community of practice.

This Market Analysis Report represents the first phase of the Framework: **Diagnose**




KEYSTONE

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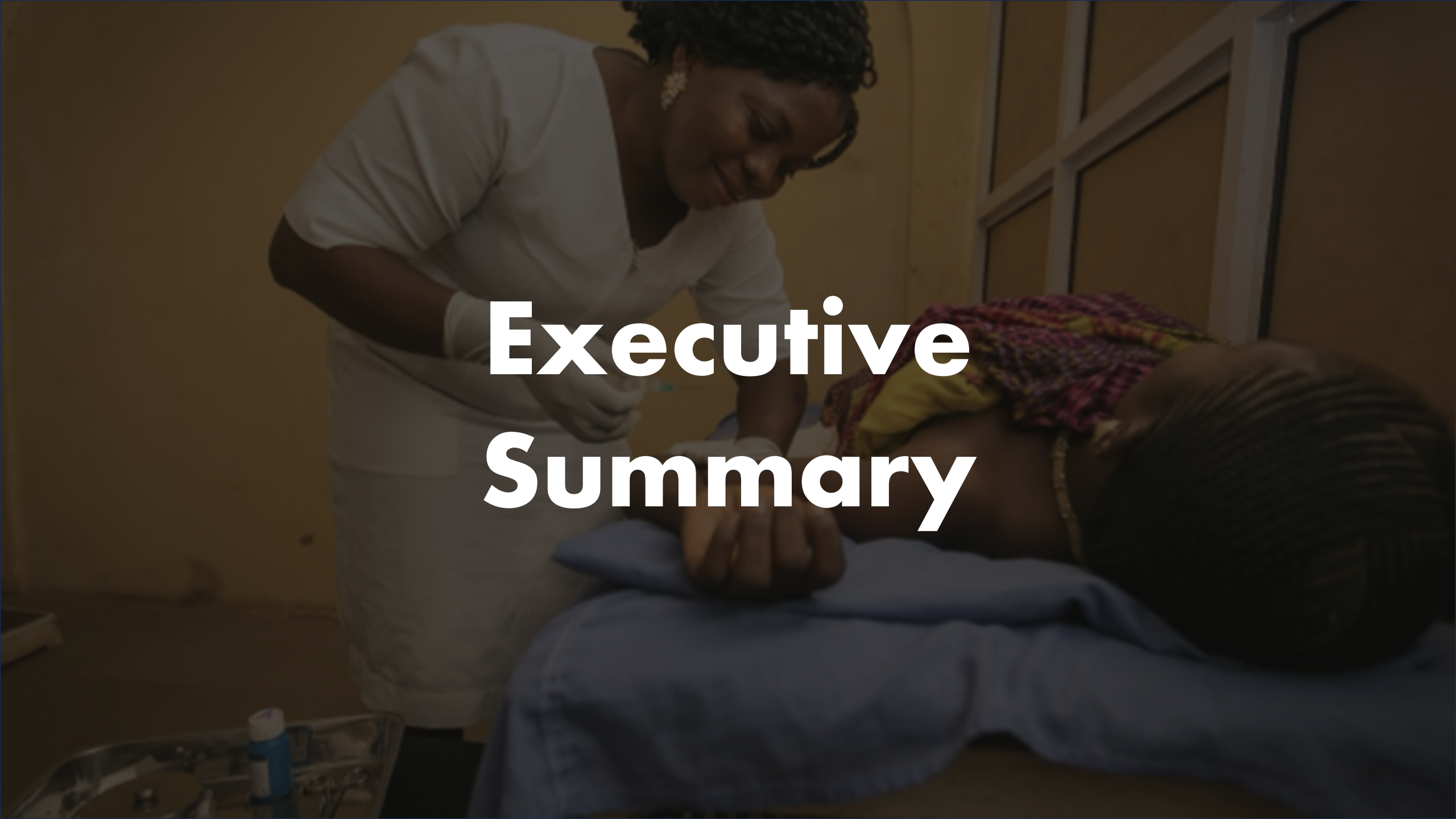
# Acronym List

| | |
|---|---|
| **BMGF** | Bill and Melinda Gates Foundation |
| **CHEW** | Community Health Extension Worker |
| **CHV** | Community Health Volunteer |
| **CHW** | Community Health Worker |
| **CPR** | Contraceptive prevalence rate |
| **CYP** | Couple-years of protection |
| **DKT** | DKT International |
| **DOH** | Department of Health |
| **ECHN** | Enrolled Community Health Nurse |
| **EFPC** | Expanding Family Planning Choices |
| **FBO** | Faith-based organization |
| **FCDO** | Foreign, Commonwealth & Development Office (UK) |
| **FHI** | FHI 360 (formerly Family Health International) |
| **FHM** | Frontier Health Markets |
| **FP** | Family planning |
| **FY** | Fiscal year |
| **GOK** | Government of Kenya |
| **IAP** | Implant Access Program |
| **IPR** | Intellectual Property Right Unit (part of KEMRI) |
| **IUD** | Intrauterine device |
| **KDHS** | Kenya Demographic and Health Survey |
| **KEMRI** | Kenya Medical Research Institute |
| **KEMSA** | Kenya Medical Supplies Authority |
| **KHF** | Kenya Healthcare Federation |
| **KHIS** | Kenya Health Information System |
| **KII** | Key informant interview |
| **KMTC** | Kenya Medical Training College |
| **KPA** | Kenya Pharmaceutical Association |
| **LARC** | Long-acting reversible contraceptive |
| **mCPR** | Modern contraceptive prevalence rate |
| **MIC** | Middle income country |
| **MMR** | Maternal mortality ratio |
| **MOU** | Memorandum of understanding |
| **MRP** | Maximum retail price |
| **MSS** | Marie Stopes Society |
| **MWRA** | Married women of reproductive age |
| **NCK** | Nursing Council of Kenya |
| **NGO** | Non-governmental organization |
| **NHIF** | National Health Insurance Fund (Kenya) |
| **(N)MoH** | (National) Ministry of Health |
| **OOP** | Out-of-pocket |
| **PHT** | Public Health Technician |
| **PPB** | Pharmacy and Poisons Board (Kenya) |
| **PSE** | Private sector engagement |
| **PWD** | Population Welfare Department |
| **QCL** | Quality Care Lab |
| **RH** | Reproductive health |
| **SAGA** | Semi-autonomous government agency |
| **SAM** | Short-acting method |
| **SDG** | Sustainable Development Goal |
| **SMO** | Social movement organization |
| **TBA** | Traditional Birth Attendant |
| **TGB** | Total Government Budget |
| **THE** | Total Health Expenditure |
| **TMA** | Total Market Approach |
| **TWG** | Technical Working Group |
| **UHC** | Universal health coverage |
| **UNFPA** | United Nations Population Fund |
| **USAID** | United States Agency for International Development |
| **USD** | United States Dollar |
| **VG** | Volume guarantees |
| **WHO** | World Health Organization |
| **WRA** | Women of Reproductive Age |



# Executive Summary

# Executive Summary

***Kenya is well-poised to expand its private contraceptive implant market – with a proven record as an FP first mover in Africa, a comprehensive 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 embrace the private sector by weaning private providers off free commodity, replacing it with a sustainable supply chain that makes business sense.***

## Context

Kenya has made **impressive progress in meeting women's FP needs.** Women like and use implants with **implants** becoming the **most popular method** since their introduction. **Maintaining this progress** as Kenya approaches middle income country (MIC) status and the total resource envelope (government and donor funding) available for FP declines may be **challenging**, since **private providers do not currently operate a truly commercial business model for implants.** Currently, private providers access implants for free through the public supply chain and subsequently provide the commodity to users for free, only charging service fees. In exchange for free commodities, private providers are supposed to report data to KHIS (Kenya Health Information System), but this happens inconsistently, blurring the true contribution of the private sector.

In line with international policy shifts, **Kenya is moving towards task sharing for implant provision** which could pave the way for more private sector providers as implant access points. Furthermore, Kenya's comprehensive **Total Market Approach (TMA)** for FP Strategy could be an important tool to create a robust and sustainable FP market as donor funding declines.

## Health Problem

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. Our preliminary analysis of the market indicates that reaching three priority audiences – FP new users (focusing on young women), wealthy women previously accessing FP in the public sector switching to the private sector, and method discontinuers – could double the number of implant users in the private sector in support of achieving FP2030 goals.

## Consumer Behavior

**Implants are highly favored in Kenya.** To tap into this demand, promotion efforts should build on existing FP user archetypes and user journeys to better understand the needs, wants and desires of consumers.

## Market Performance and Structure

**13%** of Kenyan women **use implants**; with **86%** of them obtaining their implants **from the public sector** and the **remaining 14%** primarily obtaining them from **non-NGO private medical facilities**. **Jadelle** and **Implanon NXT dominate** the contraceptive implant market with **40% market share apiece.**

Historically, the private sector has benefitted from a robust contraceptive implant supply chain from the public sector, but as Kenya moves towards MIC status and donor funding continues to decline, the **country's overdependence on free commodity represents a significant risk both to method uptake** (as stockouts become more common) **and to a sustainable private supply chain that makes business sense.**

# Background

# Rationale



***Despite the success of contraceptive implant introduction in the public sector, implant provision by the private sector remains underutilized. This project aims to develop a roadmap for the private sector provision of contraceptive implants in Kenya, building on previously identified global barriers and recommendations.***


## Implant Access Program (IAP) (2013-2018)

The IAP led to the establishment of volume guarantees (VG) with two manufacturers, which led to implants being available at a 50% reduced price through 2018 to country governments and some partners procuring implants for FP2020 countries [1]. Pricing levels under the VG were not available to private for-profit buyers [1]. Reduced pricing was extended until mid-2020s to low-income countries by Merck and Bayer [2]. **In spite of IAP's contribution to the success of contraceptive implants introduction and scale-up in the public sector over the past decade, it did not address private sector constraints impacting implant provision, which remains underutilized.**

## Private Sector Engagement for Contraceptive Implant Service Delivery (2022)

As a part of the Expanding Family Planning Choices (EFPC) project, Jhpiego and Impact for Health collaborated to **understand the barriers to effective engagement of the private sector as a partner on contraceptive implant service delivery** and how engaging the private sector for contraceptive implant service delivery can overall impact FP users and/or the uptake of contraceptive implants.

These findings outline a set of global barriers and recommendations (see slide 9) to support global and/or country stakeholders to adopt and adapt the findings from the review to expand private sector contraceptive implant service delivery.

## Country Roadmaps for Private Sector Provision of Contraceptive Implants (2023)

The Country Roadmaps for Private Sector Provision of Contraceptive Implants activity aims to identify what market constraints and opportunities for private sector provision of contraceptive implants exist in Kenya, to inform the **development of a roadmap of longer-term interventions to support the private sector in the provision of contraceptive implants in Kenya.**

This project will offer valuable lessons and recommendations that can be applied to other countries with a similar FP private sector market and contraceptive implant market.

# Global Review Findings



***The previous project outlined a set of global barriers and recommendations to expand private sector contraceptive implant service delivery by strengthening: sustainably financed supply, demand for service delivery, government stewardship capacity, provider sector capacity, and quality of care.***

## Barriers

Figure 1 provides an overview of the key private sector engagement (PSE) barriers for contraceptive implant service delivery in reference to the Health Market System Framework (developed by The Springfield Centre (2015)).

## Recommendations

In response to these barriers, a set of recommendations were developed, informed by key informant interviews and a co-creation session with experts on implants and PSE.

The recommendations include:

- → Build a sustainable financed implant supply
- → Build demand for private sector service delivery
- → Build government stewardship capacity
- → Build private sector engagement capacity
- → Build private sector quality of care capacity

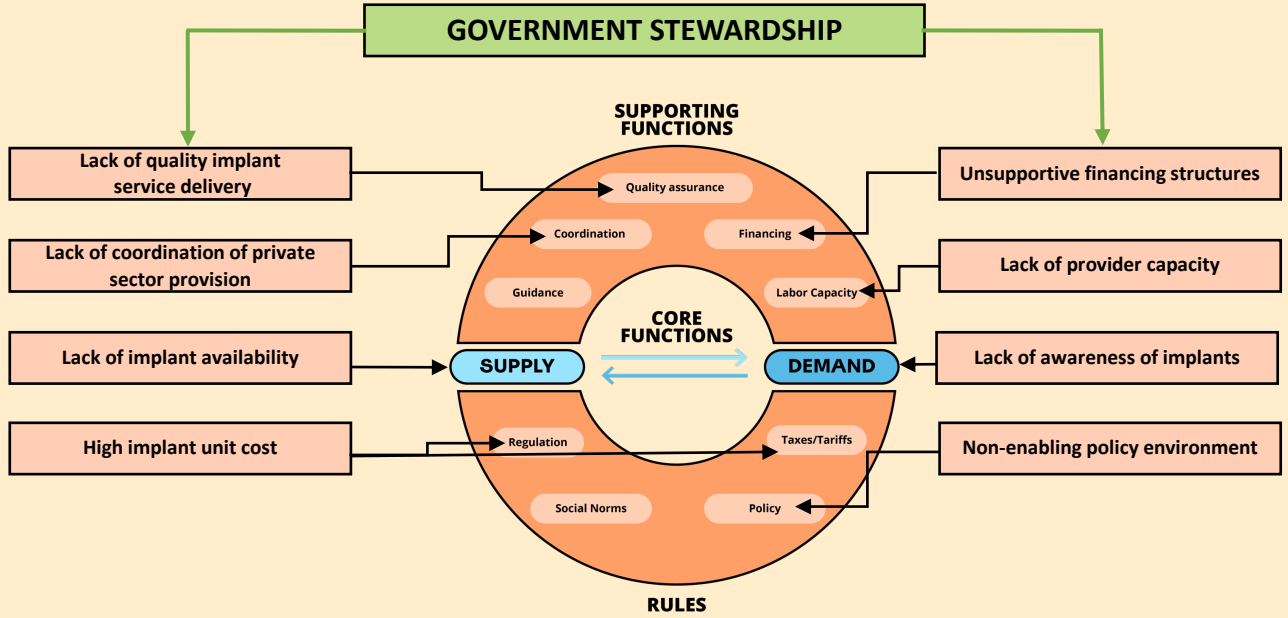



*Figure 1: Overview of key PSE barriers for contraceptive implant service delivery*

To learn more, check out the suite of strategic and shareable products summarizing the findings of this project here

# Project Aims



***This project aims to answer three key questions about the vision of success, key market constraints, and key measures to improve the private sector contraceptive implant market in Kenya.***

How can the growth of implants in the private sector **support broader goals/aims/strategies** in Kenya?

What current **market constraints** exist for the provision and scale-up of implants in the private sector in Kenya?

What **key measures** can government, donors, implementing partners, manufacturers, distributors, private providers, and other stakeholders across the value chain take to support the private sector to overcome current market constraints in the provision of implants in Kenya?

# Methodology



***A literature review and key informant interviews conducted June-Aug 2023 informed this report. Findings will be further validated through an in-country workshop to support the development of the roadmap.***

## Rapid literature review

- Developed search criteria (see box 1).
- A total of 55 **peer reviewed and grey literature** articles were reviewed and prioritized for analysis.

**Search Criteria:**
*Scope:* 2012-2022 (10-year period);
*Country/Province:* *Kenya*
*Search terms:* Long-acting reversible contraceptives (LARC), Contraceptive implant, Private sector, Challenge and/or opportunity, Best practice and/or lessons learned, Service delivery, Provider or provision, Coverage/reach, Feasibility, Health impact, Sustainability, Cost, Market, Product and/or Method introduction, Jadelle and/or Levoplant and/or Implanon and/or Nexplanon and/or Implanon NXT.
*Sources:* PubMed and Google Scholar were used to review and extract peer-reviewed articles. Organizational websites were used to review and extract grey literature alongside survey data such as Kenya DHS data.

*Box 1: Search Criteria*

## Key informant interviews (KIIs)

- A total of **12 KIIs** were conducted with stakeholders representing different market functions (core, supporting and rules).
- Tailored interview guides (for each market function) were developed to frame the questions.
- All KIIs were recorded and transcribed for data analysis.

## Data analysis

- Findings were collated and analyzed to inform the development of this **Market Analysis Report** deck, which outlines the current private market for contraceptive implants in Kenya.
- The findings in this report will be further refined with insights gathered from the in-country workshop.

# Conceptual Framing



***Both the Kenya Contraceptive Implants Market Analysis Report (2023) and the Global PSE for Contraceptive Implant Delivery Report (2022) organize findings around the same conceptual framework: the Health Market System Framework.***

The **Global PSE for Contraceptive Implant Delivery Report (2022)** framed its findings using the Health Market System Framework (see Figure 2), developed by the Springfield Centre (2015). This framework provides a means to understand the interrelated nature of issues impacting a health market which in turn highlights the need to adopt a holistic approach to address barriers in a health market system.

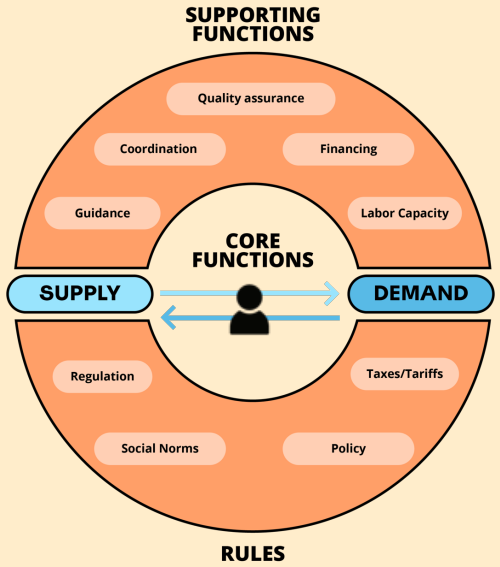



*Figure 2: Health Market System Framework*

The **Kenya Contraceptive Implants Market Analysis Report** situates the Health Market System for contraceptive implants in Kenya within the broader health system context and health problem. The report then describes the market from the 'inside out', starting with the user (consumer behavior), followed by an analysis of core market trends (market performance), and finally an articulation of all market functions (market structure). See Figure 3.

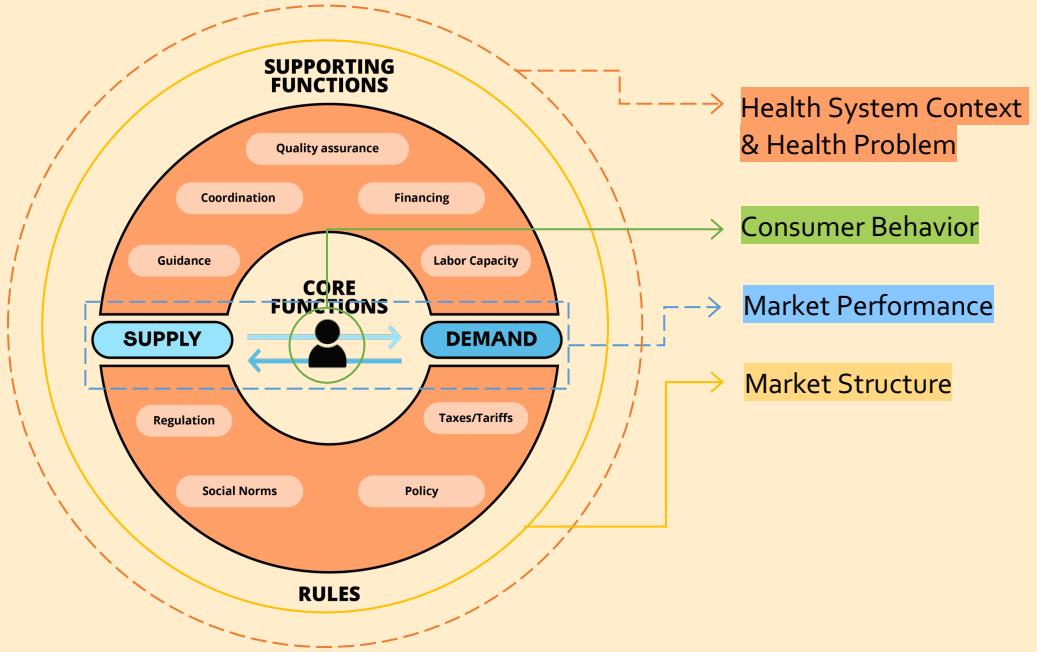
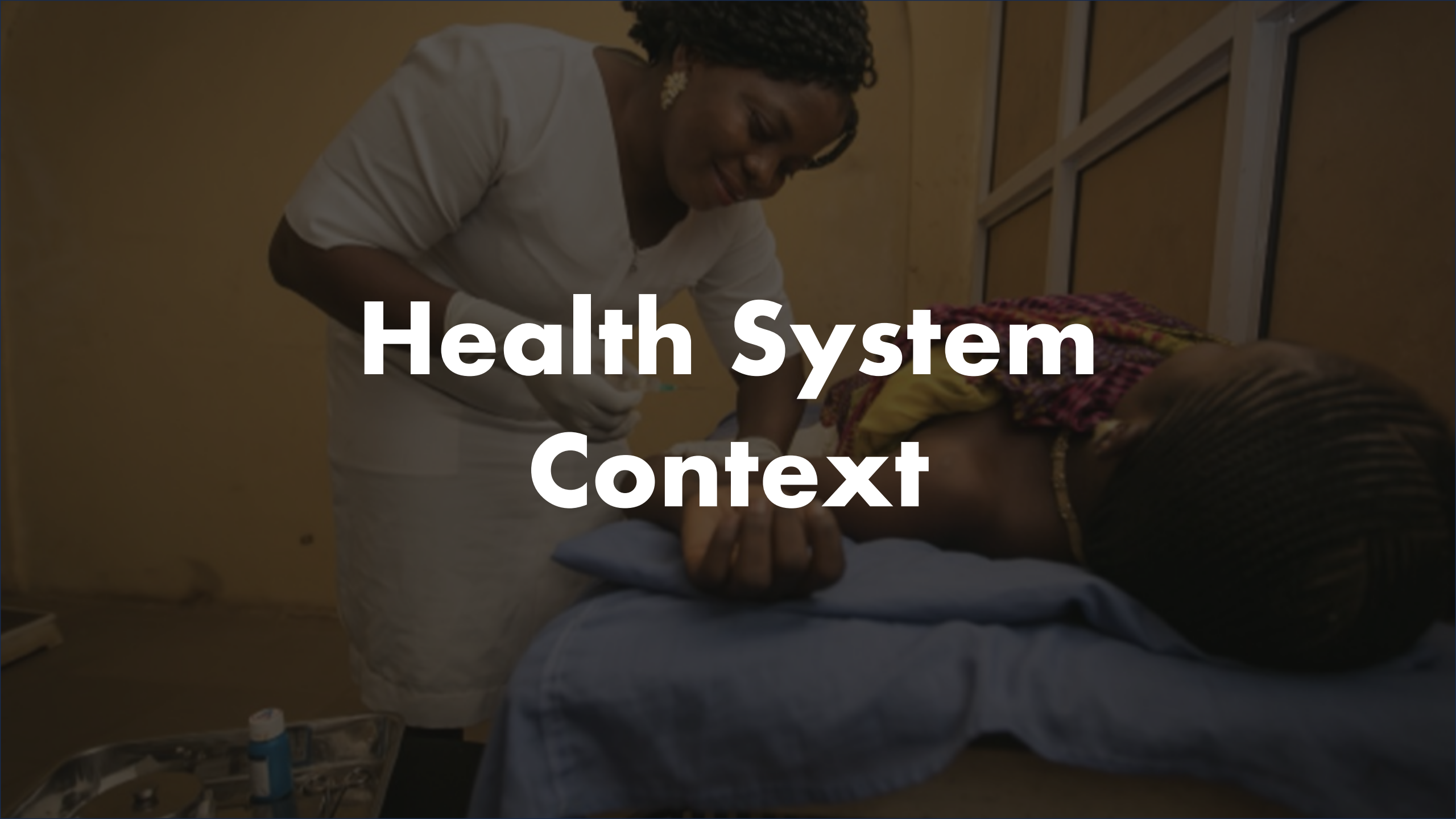



*Figure 3: Market Landscape Report Framework*



# Health System Context

# Section Purpose



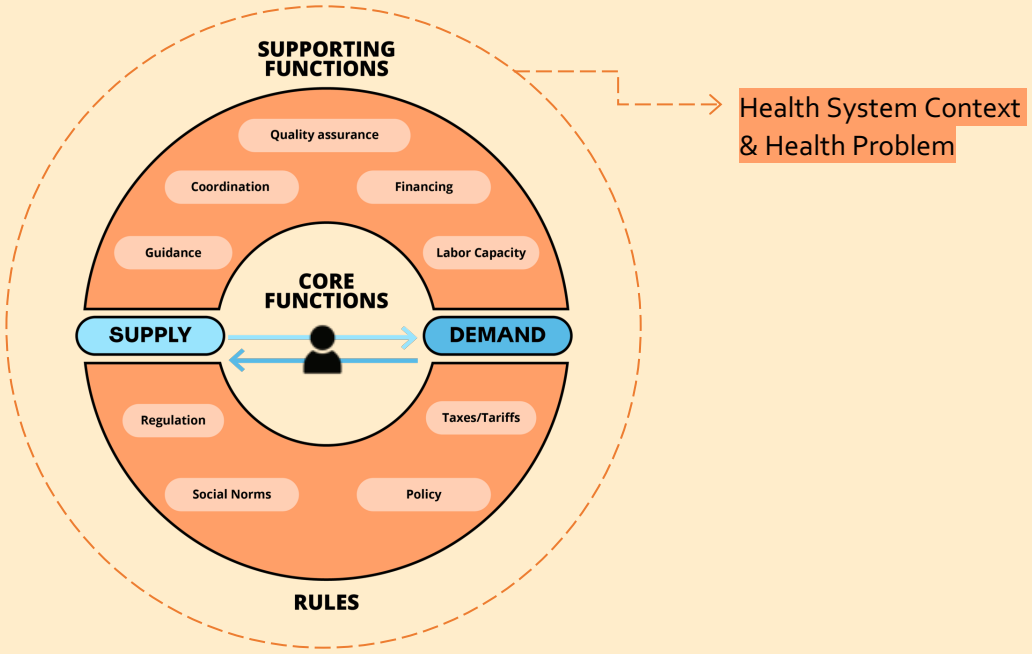



*Figure 4: Market Landscape Report Framework - Health System Context & Health Problem*

This section analyses the health system context for Kenya in which the contraceptive implant market operates. Specifically, it answers:

- *What are the **historical** trends of FP in Kenya?*
- *What is the **structure of Kenya's health system** including the **private sector**?*
- *What is the current status of the **contraceptive implant market** in Kenya?*
- *What is the **task sharing** context vis-à-vis implants in Kenya?*
- *How might **FP financing trends** impact the contraceptive implant market?*
- *How might existing **coordination mechanisms** be an opportunity or a threat for improved access to contraceptive implants in the private sector?*

This section draws primarily on the desk review, and to a lesser degree, the key informant interviews.

# Historical trends: FP first mover in Africa



***Kenya has been an FP first mover in Africa, making significant progress to meet women's FP needs. But the trajectory of growth is unknown in the context of a reduced total envelope (government and donor funds) for FP.***

## Kenya has been a first mover in Africa in terms of FP

- In Kenya, the percentage of currently married women of reproductive age (15-29 years) using any modern contraception has **increased over time**, from 32% in 2003 to 39% in 2008/9 to 53% in 2014 [3] and on to 57% in 2022 (see Figure 5) [4].
- This increase is largely attributed to the use of **modern methods - specifically implants**, which increased from <2% among **all** married women of reproductive age (WRA) in 2003 to **19% in 2022** [4], one of the **highest rates of contraceptive implant prevalence globally** [3].
- **Well-funded donor programs** such as the IAP, UNFPA Supplies Partnership, and bilateral donor contributions have **allowed the GOK to obtain free implants** and distribute them to Kenyan women.

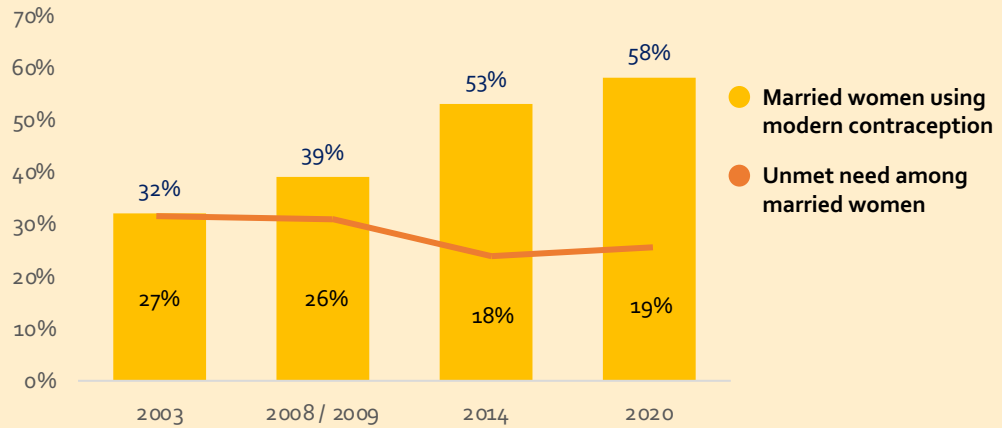



*Figure 5: Family Planning Achievements in Kenya. Sources: DHS, n.d.; 2020 data from Track20, n.d.*

## Diminishing donor support

- Kenya's **health financing landscape is changing** with the government's role increasing (see Figure 6) [3].
- In 2019, a memorandum of understanding (MOU) between NMoH & donors underscored the need to scale up domestic financing for FP commodities with the ambition that **NMoH will fully finance FP commodities by FY 2025/26**, with donor funding declining accordingly. Estimates of required contributions are shown in Figure 6 [3].
- Based on these estimates, the **NMoH needs to almost quadruple domestic FP commodity funding** from FY 2019/20 (about USD 5.4 million) to FY 2025/26 (about USD 21.5 million).
- Given the challenging economic climate globally, NMoH's ability to continue to fulfill this contribution is **unclear.** Thus far, in 2019/20 the NMoH allocated only USD 2.45M (45% of its commitment), and USD 5.5M (77%) in 2020/21 [5].

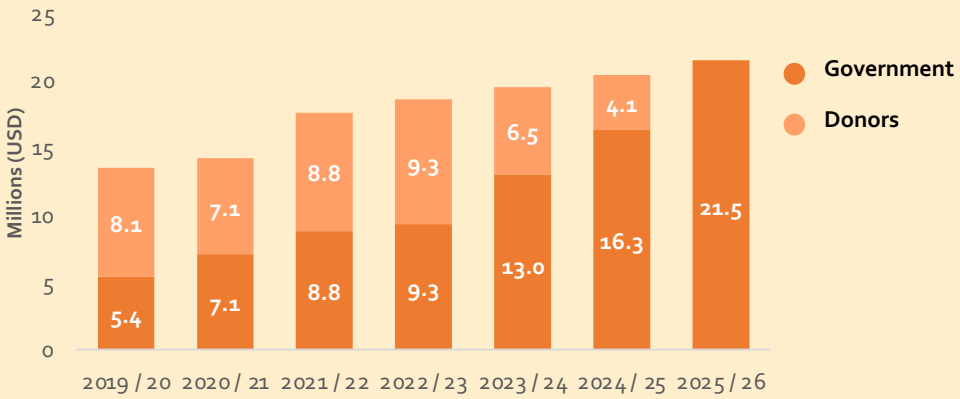



*Figure 6: Estimated Family Planning Commodity Funding Commitments, 2019–2026.*
*Note: Figures derived from MOU ratios were translated into estimated costs using the government's family planning forecasting and quantification data, October 2021. Projections do not include supply chain costs such as warehousing and distribution.*

# Devolved Health System Structure



***Understanding how health care is decentralized across different geographic levels (from national to county), within various government departments, and among semi-autonomous agencies like PPB and KEMSA is crucial. This insight allows an understanding of key actors and their responsibility for providing and regulating healthcare services, including family planning (FP), in Kenya.***

## Devolved six-level healthcare system of service delivery

- As shown in Figure 7 [7], **national government** and **47 county governments** work at **different levels** to set policy and provide defined levels of care, requiring significant coordination [7].
- While devolution was established to decentralize power, combat inequality, and mismanagement of resources [8], evidence suggests that it may have contributed to FP commodity insecurity with implications for equity and access [9].
- A broad range of government stakeholders (Figure 8) [10] are involved in the devolved reproductive health (RH) system, highlighting the complexity of coordination required to move RH strategies forward.

## National regulation

- **National Ministry of Health (NMoH)** sets national health policies which are codified into national strategies, guidelines, and associated targets and disseminated to the County Health Depts, which the NMoH supervises.
- Many other **semi-autonomous government agencies (SAGAs)** control research (KEMRI, IPR), procurement/warehousing/distribution of medical supplies (KEMSA), medical training (KMTC, NCK), medical insurance (NHIF), regulation and licensing (PPB), and more.

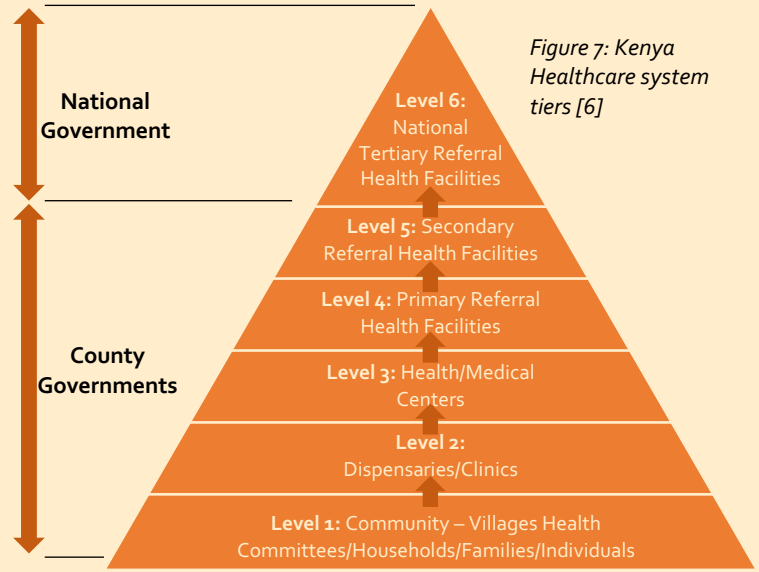



*Figure 7: Kenya Healthcare system tiers [6]*

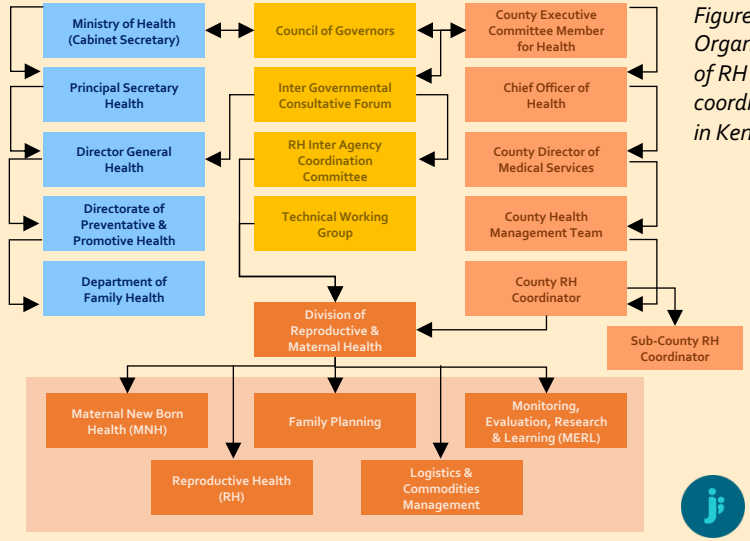



*Figure 8: Organogram of RH coordination in Kenya*

# Private Sector in Health



***The private health sector in Kenya - comprised of NGOs and commercial entities - is an essential and well-used resource for meeting health needs, including FP needs, with 33% of women obtaining their modern contraceptive method from the private sector.***

## Defining the private sector

- This report uses the global definition of the **private sector**, which acknowledges that the sector is made up of variety of actors that are **not government owned or controlled**, including for profit and not for profit, formal and informal, domestic and international [11].
- This report **aims to highlight the commercial private sector as the priority sector for growth.**
- This report analyzes provision of contraceptive implants in *all* channels (public and private including private hospitals, faith-based organizations, NGOs, etc.) compared to provision of other FP products in *all* channels to understand the unique constraints contraceptive implants face and how the full private sector market can be leveraged to increase access to this method (see Figure 9).

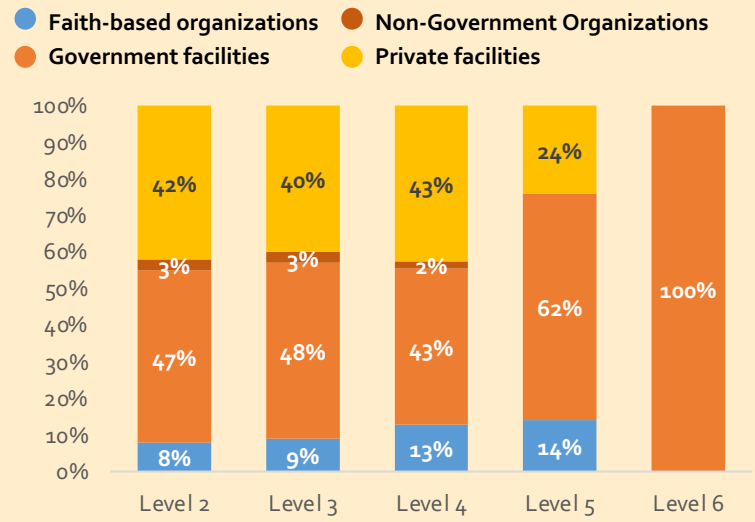



*Figure 9: Distribution of Health Facilities by Level and by Ownership Type (2019)*

## Private sector key stats and issues

- Compared to other countries in the region, **Kenya is advanced in its approach and willingness to integrate the private sector in its UHC goals** and implementation.
- About **33% of all FP users access care through the private medical sector** (private pharmacies, hospitals and clinics) compared to **62% who access FP care in the public sector** (see Figure 10) [4].
- Private sector facilities benefit from **access to surplus free FP commodities**, including implants, from district level public facilities and are **permitted to charge client fees for relevant service provision**, **but not for commodities themselves** [KII analysis]. In exchange for free commodities, private clinics/FBOs are required to report to the KHIS [12]. Outside of a small pilot, pharmacies do not yet report to KHIS[13].
- The **private sector** may **also access implants through parallel, informal supply channels** and these are **generally not reported to KHIS**, thus **national data is incomplete** [KII analysis] [12].

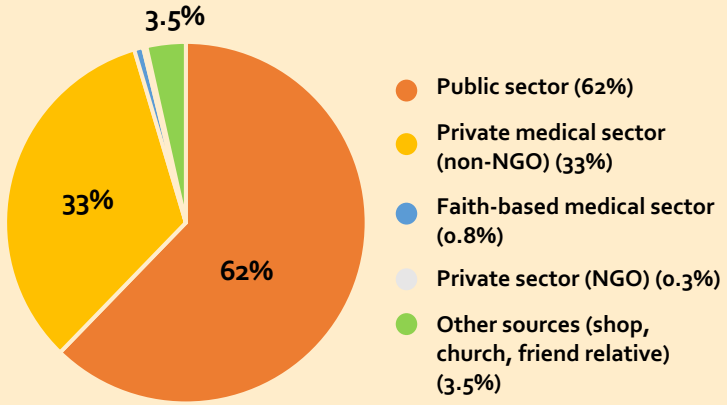



*Figure 10: Proportion of women using public and private sector sources for contraceptives (KDHS 2017-2018)*

# Contraceptive Implant Market



***Free, publicly procured contraceptive implants dominate the market and are provided to public and private facilities. Most women access implants from the public sector, where it is one of the most popular methods. Private sector reporting of implant data is inconsistent, making it challenging to fully appreciate volumes flowing to the private sector.***

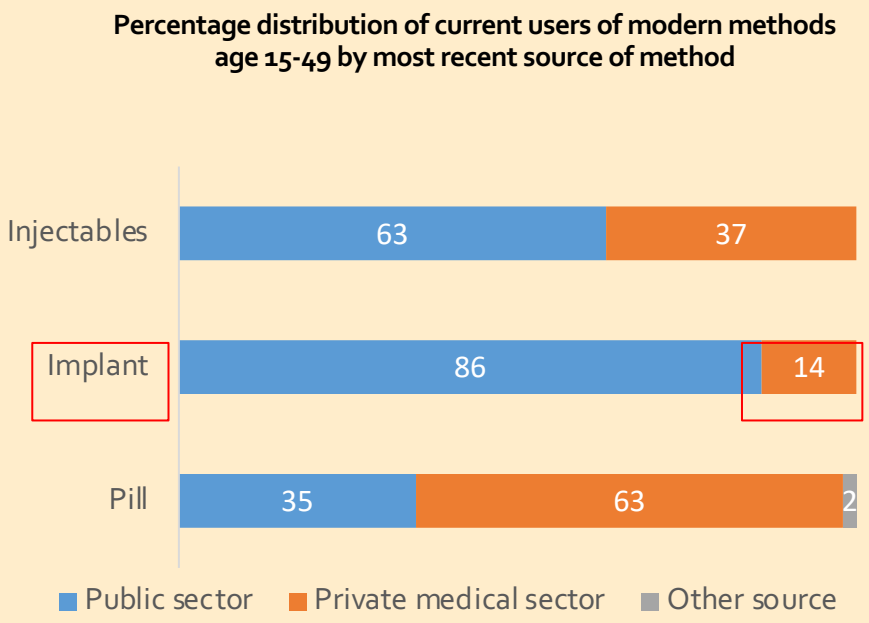



*Figure 11: Source of supply of modern methods users by method, (KDHS 2022)*

## The private sector appears to have a smaller share of the implant market compared to other methods

- Of modern contraception users 37% use implants, of which **14% accessed them through the private sector**, equating to approx. 217,214 WRA currently using implants from the private sector [4] (see Figure 11).
- Source of private implant provision: 8% from private hospitals, 4% from private clinics, 0.5% pharmacies, and 0.6% FBO/mission or mobile clinics, and smaller rates in other outlets [4].

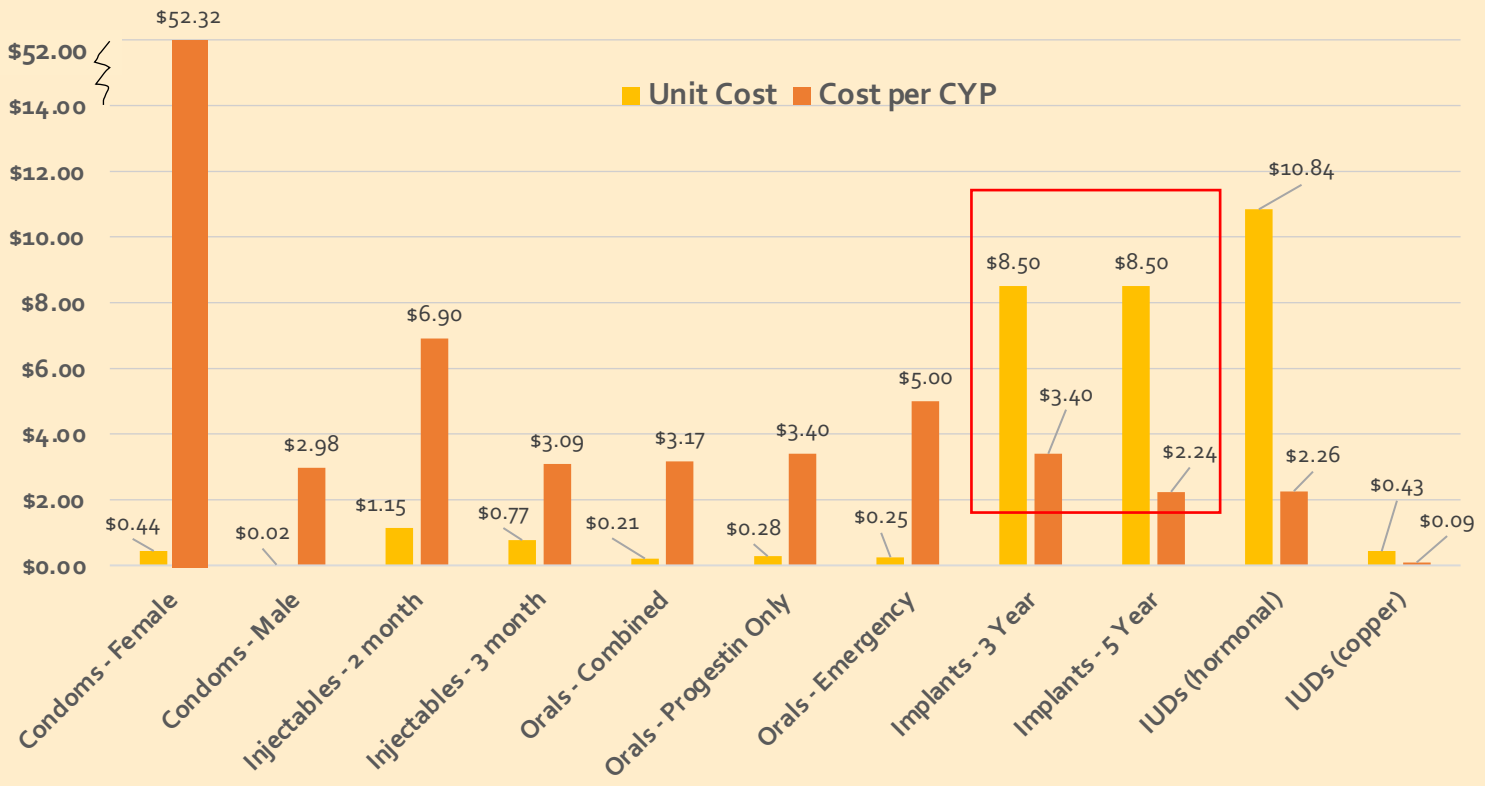
## The contraceptive implant market in Kenya is driven by free products

- **Private facilities are permitted to source free government-procured FP products**, including implants, from public facilities and stock them in their facilities [14]. Through this formal route, in return, they are expected to report data to KHIS.
- However, unknown volumes of implants enter the private sector from the public sector through informal channels. As this goes unreported, the number of implants accessed in the private sector could be greater than 14%.
- **In cases where publicly procured implants are being provided to private sector clients, clients should not be charged for government FP commodities**, only for auxiliary fees, however, this is poorly regulated [15].
- An unknown quantity of "purely commercial" implants (i.e., with fully loaded costs, and not sourced through the public sector) are sold through the private sector; however, as these are sourced through parallel supply chains, they are generally not reported to KHIS [KII analysis].

# Comparative cost of contraceptive methods



***Although the unit cost of implants is higher than other contraceptive methods, when the cost is accounted for per CYP, its price is comparable to other SAMs and LARCs. In addition, the 5-year implant may be more cost-effective than condoms, pills and injectables.***




- The initial upfront cost of implants is high in comparison to other short-term methods, yet it is similar to other LARCs such as hormonal IUDs. (Figure 12) [16].
- However, when accounting for the couple-years of protection (CYP), the cost of implants is comparable to other short-term methods (Figure 12).
- The 5-year implant is one of the most cost-effective methods per CYP at $2.24 (Figure 12) [16].
- The implant cost used in this UNFPA Contraceptive Price Indicator uses the IAP implant price of $8.50. It is worth noting additional implant products have now entered the market at $6.90 / unit.
- It is important to consider that the cost per CYP to the user could be higher based on additional costs including importation, distribution and the cost of insertion and removal of implants.
- The price of implants is further explored in the subsequent sections of this deck.

*Figure 12: Cost per contraceptive unit and cost per CYP by method in 2021 [16, 17] (Reproductive Health Supplies Coalition, FP Market Report 2022)*

# Task Sharing



***Only qualified providers located in facility settings are authorized to insert and remove implants; however, in line with international policy shifts, there are opportunities to look towards additional cadres of healthcare workers to assist with the provision of implants in Kenya.***

## WHO Normative Guidance

- **Associate Clinicians and Doctors, Nurses and Midwives, Auxiliary Nurses and Auxiliary Nurse Midwives** (under monitoring and evaluation), Doctors of complementary systems of medicine under specific circumstances can insert and remove implants [18].
- Guidelines **do not recommend** that implants be provided by **pharmacists and pharmacy workers** [18].
- Removal of implants can require higher and other skills than insertion, and **any health worker trained to independently insert implants should also be trained in removal** [18].

> *"Over 70% of Kenyan healthcare-seeking begins at the community pharmacy level. They first seek help there before they go to the hospital or other facilities. Policymakers are cognizant of this fact. If we allow pharmacists to insert implants, we will reach a much larger proportion of the population"- Provider Association*

## Kenya-specific guidelines on task sharing to CHWs and pharmacists

- **Only qualified providers are allowed to insert *and* remove implants**, in line with WHO normative guidance [18]. In Kenya that translates to Doctors, trained Midwives, Clinical Officers, and other HCWs such as trained Public Health Technicians (PHTs), Enrolled Community Health Nurses (ECHNs), and Community Midwives. Pharmacists and pharmaceutical technologists can dispense implants but must refer them for insertion. Community Health Volunteers (CHVs) can only counsel and refer [19].
- A recent pilot in Kilifi County trained and permitted Community Health Extension Workers (CHEWs) on **implant** insertion, with promotion efforts led by CHVs, with positive results [20, 21].
- In the most recent national annual working plan, stakeholders spoke optimistically about the **potential for scale-up of implant provision through pharmacies**, though no formal policy has been drafted [KII analysis].
- BMGF and others are partnering in Kenya to align the service provision of implants through pharmacies [KII analysis].

## International influences on task-sharing

- Major policy shifts in recent years toward **expanded access to implants and injectables at the community level** indicate that drug shops and pharmacies can play an important role in the provision of new methods for certain populations [22].
- The IntegratE project in Nigeria, a collaboration between FMoH, BMGF, SFH, and the Pharmacists Council of Nigeria, successfully **piloted implant insertions by community pharmacists** and PPMVs (Patent and Proprietary Medicine Vendors) with a medical background [23, 24, 25].

# FP Financing Trends



***Kenya's participation in UNFPA Supplies Partnership enables access to free/heavily subsidized FP commodities that are provided to public and private actors; however, with reducing donor support, it is unclear how the Kenyan government will plug the financial gap to avoid service delivery disruption even when commodity is available.***

**Table 1: Sources (potential & actual) of finance for FP**

| UN (Potential) | National Govt | County Govt | Donors | Out-of-Pocket |
|---|---|---|---|---|
| **Kenya participates in the UNFPA Supplies Partnership,** which provides access to free/heavily subsidized FP commodities [26]. Earlier this year, a Steering Committee meeting took place to take stock of progress [27].<br><br>In 2022, UNFPA Kenya received **KES 69.8 Million** from UKAid **for reproductive health commodity security strengthening** [28]. | The Ministry of Health is working with the Foreign, Commonwealth & Development Office (FCDO), UNFPA and other stakeholders to **increase the national budget allocation for the procurement of family planning commodities up to 100% in 2026** [28].<br><br>**NHIF** (financed through member contributions and government subsidies) **covers FP** commodities through the Linda Mama program but only in the 6 weeks after childbirth, excluding many women. Since 2016, Linda Mama has also been available to private providers [29] but many providers (public & private) are not aware of this provision [9]. | On average, the 47 devolved governments allocate **27% of the total county budgets to health care** [31].<br><br>As of 2023, only 11 out of 47 counties have established **FP budget lines** [32]. | Although development partners financing for health has oscillated in absolute terms over the last 20 years, their contribution to health financing as a percent of Total Health Expenditure (THE) **declined from 32 percent in 2009/10 to 18 percent in 2018/19**.<br><br>This **trend is expected to persist** in the medium to long term, suggesting Kenya will need to appropriately **plan for a transition phase** to avoid disruptions in the delivery of key health services [33]. | In 2020, **Out-of-pocket (OOP) expenditure for health was 24.06%** (as a % of current health expenditure [34], highlighting that **even in a context of high subsidy considerable personal resources are still applied.**<br><br>**50% of WRA (15-49) in the wealthiest quintile,** who currently use modern FP **access implants from the public sector**, indicating that health subsidies could be applied in a more efficient and targeted manner with women from wealthy quintiles encouraged to use the private sector [35]. |
| | The proportion of total government budget (TGB) allocation to health at **both national and county levels has ranged from 7.8% in 2012/2013 to 9.2% in 2018/19** [30]. | | | |

# Coordination of FP through the TMA

Health System Context

***A Total Market Approach (TMA) for FP is an important tool in re-imagining how the FP market can function as donor funding continues to decline. While a comprehensive national TMA for FP Strategy exists, it has failed to gain meaningful traction due to a lack of leadership and resources.***

## TMA for FP National Strategy 2020-2025

- **TMA Strategy Vision:** By 2024 Kenya's total FP market is more sustainable, efficient and equitable for its people.
- **Expected outcomes**: (1) Improved high-quality FP services, products and technologies, (2) Greater access and choice and (3) Improved cost effectiveness and affordability.
- **Main outputs:** Better quality, regulation and compliance; Diversified FP supply chain; Increased number of FP players operating in a segmented market; and Improved stewardship of the FP market.
- **Status:** Ambitious strategy developed and launched in 2020. Whilst the TMA rollout has stalled since 2020, there are new efforts to realize its full potential and MoH has recently initiated a new dedicated TMA task force to lead this. However, TMA is not yet fully incorporated into the FP Technical Working Group (TWG) [KII analysis].

## Challenges to TMA implementation [KII analysis]

- **Accountability**: Not embedded in national guidelines or associated with trackable deliverables.
- **Decentralization**: Devolved health care negatively impacts traction of TMA strategy at sub-national level.
- **Data collection:** Commercial actors do not consistently report to KHIS.
- **Equity challenges**: Variations in price dependent on perceived wealth of client difficult to implement in commercial sector.
- **Funding gap:** Lack of financial investment to realize strategy.
- **Overwhelming in nature**: Hard to know where to start.
- **Politics**: Ownership is dependent on political leadership and changes with elections.

***Implications for the implant market***

1. *There is no need to create new coordination bodies or frameworks to enhance support to the private market for implants. It already exists and should be leveraged.*
2. *Compared to other LARCs, implants are likely to have the most success in the private sector through TMA, given their popularity nationwide and the relative ease of administration.*
3. *The full TMA pilot in a few counties has been too intensive to succeed. How about piloting TMA for only one product (implants) in a few counties and then taking the learnings from there?*


Health
Problem

# Section Purpose

Health Problem

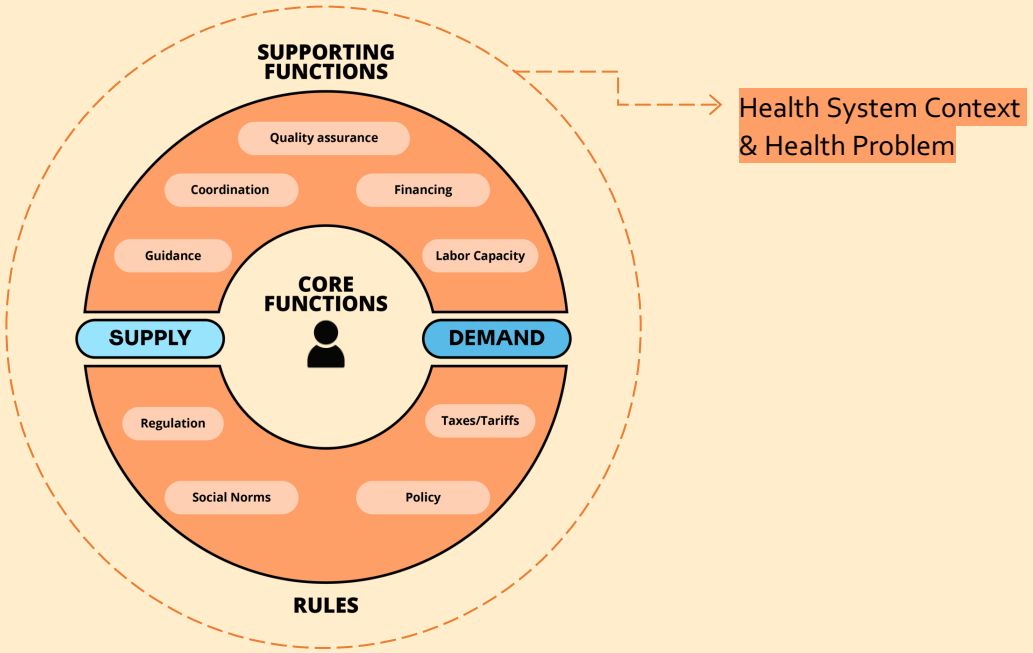



*Figure 4: Market Landscape Report Framework - Health System Context & Health Problem Framework (As per slide 14)*

This section analyses the health problem that the contraceptive implant market is meant to address, specifically:

- *What is the **health need** (and **scale of the health need)** that the contraceptive implant market is meant to address?*
- *Who are the **priority segments** and **key consumer audiences** for the contraceptive implant market?*
- *What is the **potential size of the contraceptive implant market?***

This section draws primarily on the desk review.

# Health need: trends in maternal mortality

Health Problem

***MMR in Kenya remains high and the rate of decline is insufficient to achieve the Sustainable Development Goals' (SDG) maternal morbidity target. Expanding access to modern FP, including contraceptives implants, is critical to achieving the SDG.***

- Kenya has committed to **reducing the maternal mortality ratio (MMR) to less than 70 per 100,000 live births** by 2030 [36].
- MMR in Kenya is **355 per 100,000 live births** (2019) [37].
- Despite the MMR remaining high, **key maternal indicators have improved** such as antenatal care and facility-based births. Yet these indicators vary by rural vs. urban geography and mother's level of education [4].
- It is widely recognized that **FP contributes to reducing maternal mortality** (see Figure 13) [4] by reducing the number of births and, therefore, the number of times a woman is exposed to the risk of mortality.

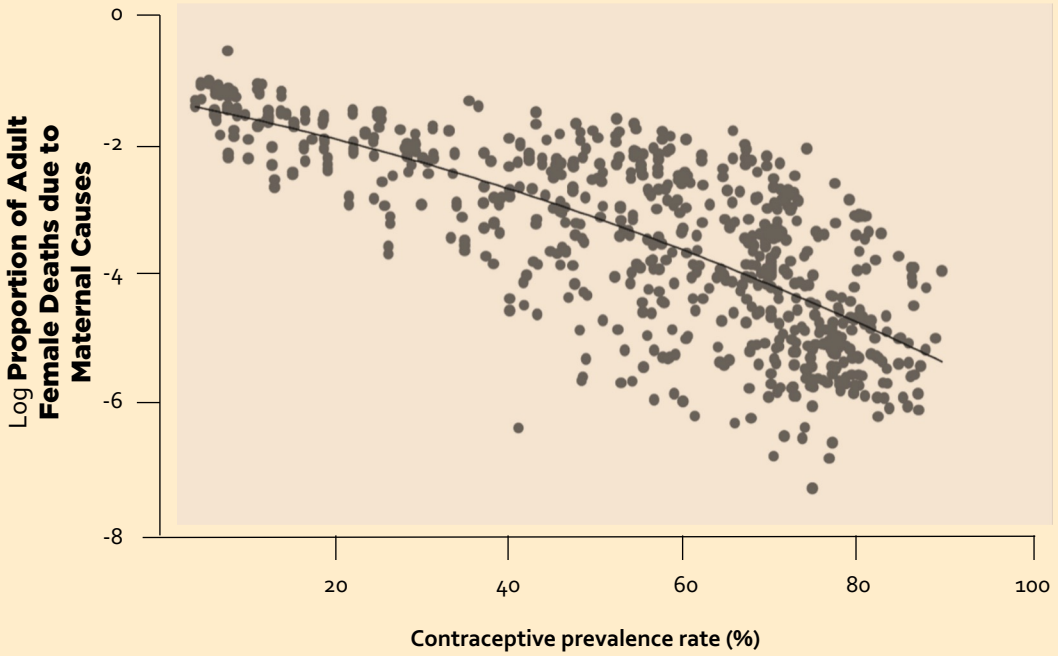



*Figure 13: Maternal deaths averted by contraceptive use: an analysis of 172 countries. The graph demonstrates the association between higher contraceptive prevalence rate and reduced maternal mortality (The Lancet) [38]*

# Health need: trends in mCPR

Health Problem

***Over the last 30 years, Kenya has made steady progress towards its mCPR goal; however, with donor funding declining since 2020, contraceptive use has stagnated, introducing uncertainty over Kenya's ability to achieve its FP2030 mCPR target.***

- At the 2012 London Summit on Family Planning, the Kenyan government made ambitious commitments to **increase the modern contraceptive prevalence rate to 66% by 2030** amongst married women [39](see Figure 14).
- Since the London Summit, the **prevalence of modern contraceptives in Kenya has increased** from 39% (2008/09) to 57% in 2022 [4].
- However, the most recent analysis (PMA Phase 3) suggests that **growth in the mCPR in Kenya has stagnated since 2020** [40].

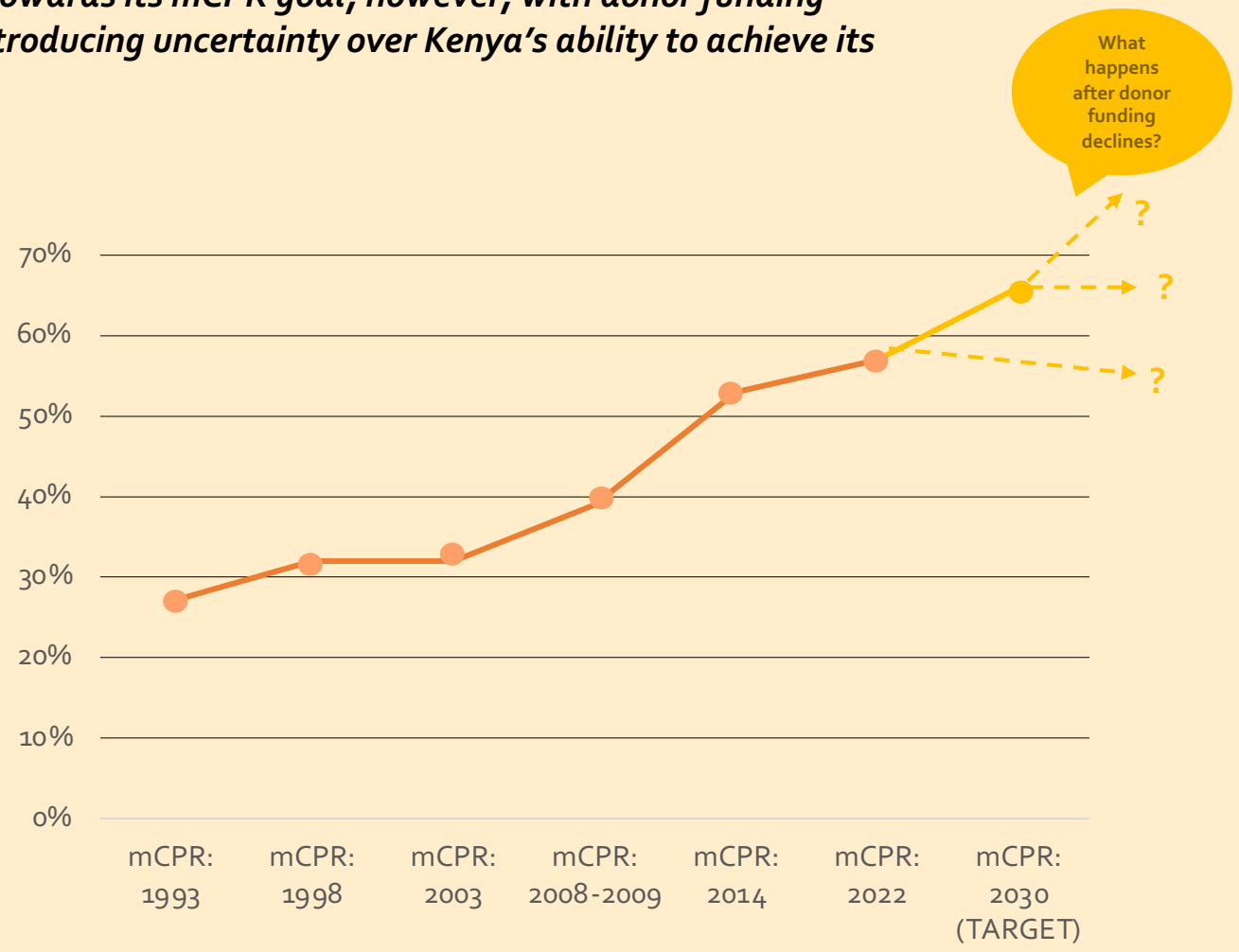



*Figure 14: Trends in **modern** contraceptive use among currently married women (KDHS 2022)*

# Health need: trends in method mix

Health Problem

***Kenya's method mix has changed over the last decade with implants rapidly becoming the most popular method following their introduction. However, implant coverage in the private sector appears to have remained relatively stagnant.***

- **Implants have become increasingly popular since their introduction.**
- Over the last decade, **implants** (regardless of facility source) **have increased** from 18% in 2014 to **37% in 2021** as a proportion of all modern methods (see figure 15) [40].
- Despite this, **implant coverage in the private sector appears to have remained relatively static** as a portion of all modern methods (see figure 16) [4].
- The apparent static implant coverage in the private sector may result from inconsistent reporting by private providers, making the true coverage difficult to quantify [KII analysis].
- Women with implants are less **likely to discontinue implants** within 12 months of insertion (13% compared with 42% for injectables and 56% with the pill) [40].
- **Implants and injectables have remained the dominant methods** of contraception among all women, accounting for over 70% of the method mix [40].

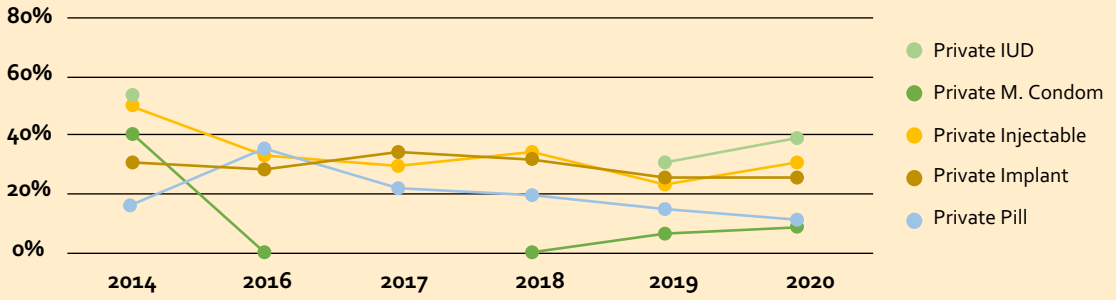



*Figure 16: Trends by method, Private Sector, 2014-2020 (KDHS)*

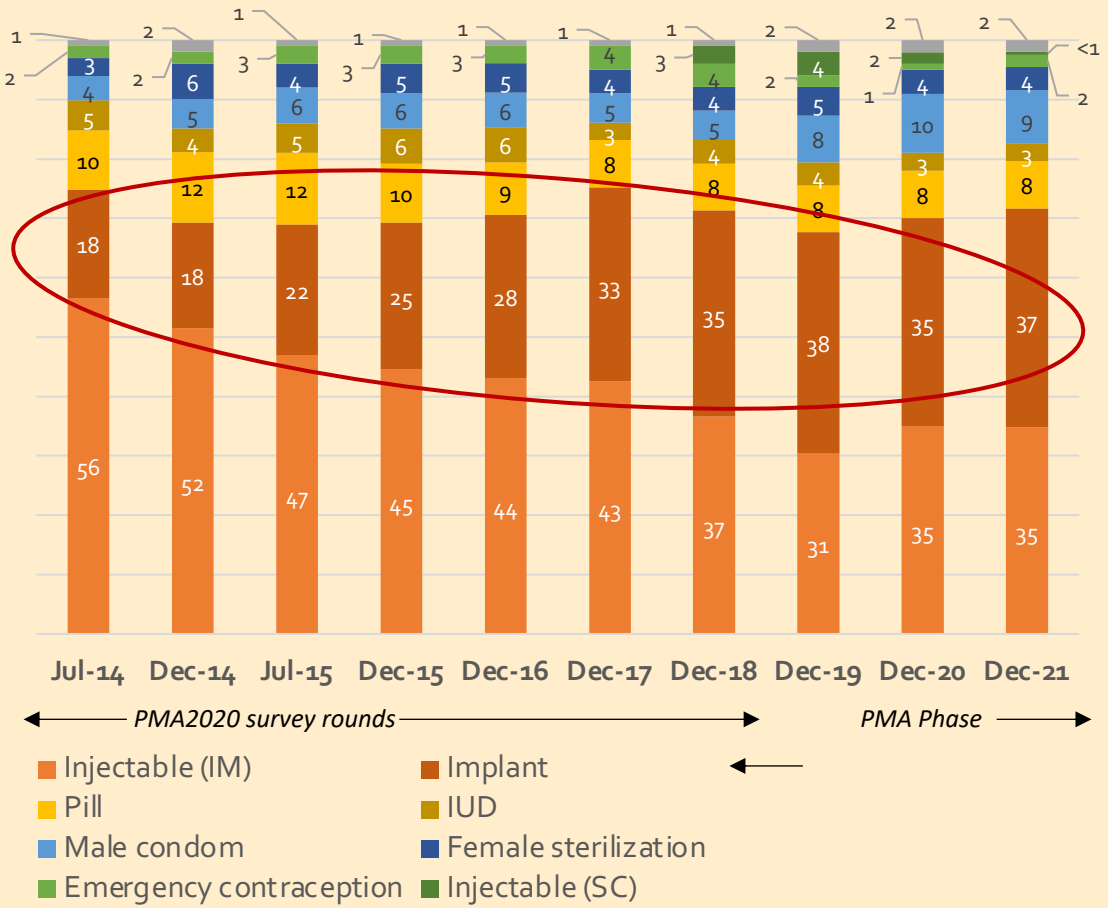



*Figure 15: Trends in Modern Contraceptive Mix (PMA Phase 3 cross-sectional survey)*

# Scale of health need: use/need analysis

Health Problem

***10% of all WRA have an unmet need for FP. Expanding the private contraceptive implant market is an opportunity to help address this unmet need and reach FP2030 goals.***

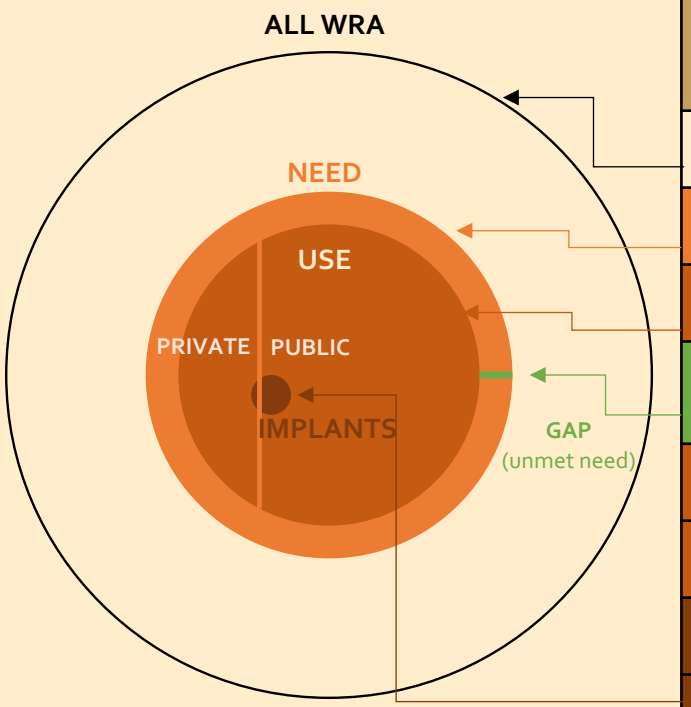



*Figure 16: Use/need analysis for contraception*

**Table 2: Use/need calculations**

Note: The percentages in this table are obtained from the 2022 KDHS [4] while the denominators are based on the 2019 Kenya Census.

| INDICATOR | All Women of Reproductive Age (15-49 years) | | | DEFINITION |
|---|---|---|---|---|
| | % | Denominator | # women | |
| **ALL WRA** | 100% | 12,094,679 | 12,094,679 | These calculations are based on the total population of all women of reproductive age in 2019 (Kenya Population and Housing Census (2019) totaling **12,094,679** [41]. |
| **NEED** | 56.8% | 12,094,679 | 6,868,778 | The sum of the unmet need for family planning and current use (CPR) [41]. |
| **USE** | 46.6% | 12,094,679 | 5,636,120 | Proportion of women who are currently using a contraceptive method (any method) [41]. |
| **UNMET NEED** | 9.9% | 12,094,679 | 1,197,373 | Proportion of women who are not pregnant [...] and want to delay their next pregnancy or do not want any more children; and are not using a contraceptive method [41]. |
| **PUBLIC USERS** | 62.1% | 5,636,120 | 3,500,031 | Proportion of contraceptive users who seek FP services from the public sector [41]. |
| **PRIVATE USERS** | 33.3% | 5,636,120 | 1,876,828 | Proportion of contraceptive users who seek FP services from the non-NGO private medical sector, NGO private medical sector and FBO medical sector [41]. |
| **IMPLANT USERS** | 13.2% | 12,094,679 | 1,596,498 | Proportion of contraceptive users who use implants [41]. |
| **PUBLIC IMPLANT USERS** | 86.1% | 1,596,498 | 1,374,585 | Proportion of implant users who seek implants from the public sector [41]. |
| **PRIVATE IMPLANT USERS** | 13.6% | 1,596,498 | 217,214 | Proportion of implant users who seek implants from the non-NGO private medical sector, NGO private medical sector and FBO medical sector [41]. |

# Who is most at need: key FP population segments

Health Problem

***In comparison to all women, poor women, rural women, and young women have higher unmet need for FP. However, given the challenges poor and rural women face accessing the private sector, young women are likely the priority audience for the private sector implant market to reach new FP users. Other key audiences for the private sector contraceptive implant market may include wealthy women accessing free public sector services and FP discontinuers.***

**Table 3: Key FP segments in need**

| Population | Unmet Need | | Implant use | | Priority audience for private sector implants? |
|---|---|---|---|---|---|
| **WRA** | 9.9% | | 13.2% | | |
| *Segmented by currently married women and sexually active unmarried women* | **Current married women** | **Sexually active unmarried women** | **Current married women** | **Sexually active unmarried women** | |
| | 13.9% [4] | 19.2% [4] | 18.5% [4] | 11.3% [4] | |
| **Young women** | **21.6% [4] (15-19 years)**<br>**16.9% [4] (20-24 years)** | **35.4% [4] (15-19 years)**<br>**21.1% [4] (20-24 years)** | **17.1% [4] ( 15-19 years)**<br>**20.6% [4] ( 20-24 years)** | **3.0% [4] (15-19 years)**<br>**8.5% [4] (20-24 years)** | **YES.** Young women have a high unmet need for family planning and are more reliant on the private sector for their contraceptive method [42], indicating a priority new segment for contraceptive implants in the private sector. |
| **Poor** (Lowest wealth quintile) | 21.6% [4] | 24.7% [4] | 16.9% [4] | N/A | **Unlikely. Poorer women**, while at greater need for FP, are unlikely to be a priority audience for private sector implants until the cost of implants reduces from current levels. Currently, the private implant market overwhelmingly serves women in higher wealth quintiles [35]. In contrast, wealthy women who currently access FP commodities in the public sector but are interested to access implants in the private sector are likely an important audience for the contraceptive implant market . |
| **Rural women** | 15.4% [4] | 21.8% [4] | 20% [4] | 15.5% [4] | **Unlikely.** While **rural women** have higher implant use than their urban counterparts [4], less than a third of rural users rely on the private sector for method choice [42]. |

*Discontinuation:*

- According to the KDHS 2022 report, discontinuation rate of FP users (across all FP methods and due to any reason) was **34.7%** [4].
- Across all methods, the most prevalent reason for discontinuation was "other side effects/health concerns", followed by "wanted more effective method", and for implants the most prevalent reason was also "other side effects/health concerns" [4].
- Therefore, discontinuers might be a key FP population segment, especially those who had concerns about a previous method choice and/or did not receive sufficient counseling.

# Potential Consumer Audiences for the Private Sector Implant Market

Health Problem

***Three consumer audiences for the private sector implant market are proposed: (1) contraceptive method new users (i.e., young women interested in LARCs); (2) wealthy women currently accessing FP from the public sector; and (3) women who discontinued their method within the private sector but are open to new methods.***

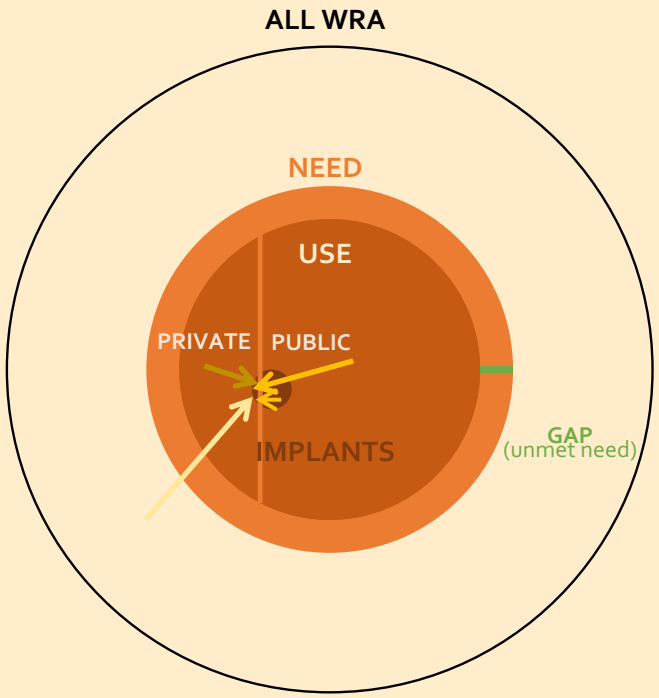



*Figure 17: Use/need analysis for implants*

**Table 4: Consumer audiences for private sector implant market**

| Potential Consumer Audience* | Rationale |
|---|---|
| **Private sector contraceptive method new users (young women)** | Women who want a form of contraception but haven't been able to access implants (or any form of contraception). This is the priority consumer audience from a *health need perspective* (i.e., to fill the use/need gap), but it is likely the smallest audience in terms of numbers (see next slide). |
| **Public sector switchers into private sector (wealthy women)** | Women who *were* using methods from the public sector and will now use the private sector to obtain their preferred method (implant), alongside other possible advantages (e.g., convenience, discretion, or quality of care). This could have an **impact on the overall cost-efficiency of the market** if wealthier women are now accessing implants in the private sector, thereby freeing up funds for public subsidy to go to poorer women. |
| **Method switchers (discontinuers)** | Women switching from another method to an implant, from public or private sectors. These users could have an impact on CYP if users are switching from a SAM. While discontinuation rate is high in Kenya (35% of episodes of contraceptive use in the 5 years before the survey were discontinued within 12 months), only 8% of episodes of contraceptive use were discontinued because the woman switched to another method [4]. |

# Potential Private Sector Implant Market Size

Health Problem

***Our preliminary analysis of the market potential is over 500,000 contraceptive implant users in the private sector annually, which more than doubles current users. These estimates are based on conservative assumptions to offer rough estimates of market growth until 2030, i.e., when FP2030 goals should be met. The circumstances of decreasing donor subsidy may necessitate a shift in the total market, affording an even greater opportunity for the private sector.***

**Table 5: Sizing of market segments for private sector implant**

| Scenarios | Implant consumer audience | Assumptions for calculation (NB: detailed calculations can be made available upon request) | Calculation (NB: detailed calculations can be made available upon request) | Annual Market Growth Estimation (assuming a 1.9% population growth per year) | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Y1 | Y2 | Y3 | Y4 | Y5 | Y6 |
| 1. No investment | **Current users** | No increase in CPR; 13% of all women use implants; 13% from the private sector | 217,214 (current women accessing contraceptive implants in the private sector) | 217,214 | 221,124 | 225,104 | 229,156 | 233,281 | 237,480 |
| 2. Some investment in private sector engagement for contraceptive implants | **Current users** | 13% of all women use implants; 13% from the private sector | 217,214 (current women accessing contraceptive implants in the private sector) | 217,214 | 221,124 | 225,104 | 229,156 | 233,281 | 237,480 |
| | **Private sector contraceptive method new users (young women)** | CPR for WRA increases 2.5% each year (i.e., CPR growth required from 2024 to reach 2030 target) 35% of new users use implants; 20% of new implant users access it in the private sector | 5,636,120 (current contraception users) *0.025 (new users) * .35 (implant users) * .2 (access in private sector) | 9,863 | 10,041 | 10,221 | 10,405 | 10,593 | 10,783 |
| | **Public sector switchers into private sector (wealthy women)** | 30% of women access contraceptive implants in the private sector (similar to the share of all FP methods offered by the private sector) | 1,596,498 (current implant users) * 0.3 (women accessing implants in the private sector) - 217,214 (current women accessing contraceptive implants in the private sector) | 261,735 | 266,446 | 271,242 | 276,125 | 281,095 | 286,155 |
| | **Method switchers (discontinuers)** | 35% of women discontinue their method in the private sector; 15% switch to another method; 35% choose implants | 1,876,828 (current private contraception users) - 101,180 (current private implant users) *.35 (discontinue their method); *.15 switch to another method *.35 choose implants | 32,627 | 33,214 | 33,812 | 34,421 | 35,040 | 35,671 |
| | **TOTAL** | | | 521,439 | 530,825 | 540,380 | 550,107 | 560,009 | 570,089 |

# Consumer Behavior

# Section Purpose

Consumer Behavior

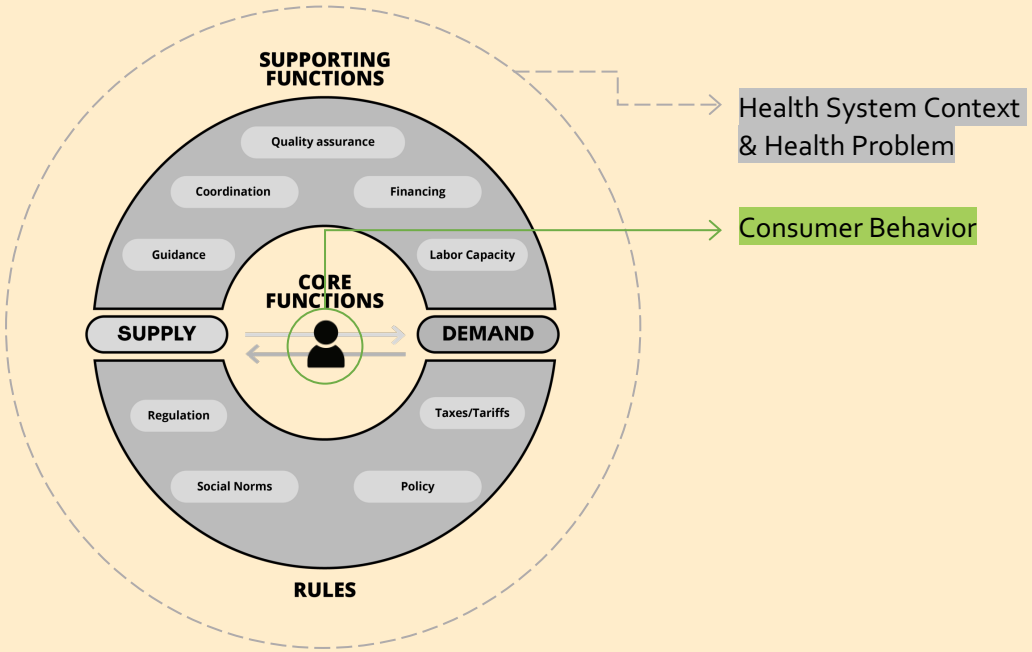



*Figure 18: Market Landscape Report Framework - Consumer Behavior*

This section aims to understand the current (or potential) *implant consumer* in Kenya so that a healthy market is designed around her needs and preferences. This section draws on the wealth of data available on FP consumers to infer:

→ *What might be **consumer preferences for implants**, based on what we know about FP consumers?*
→ *Who might be **implant user archetypes**, based on existing FP user archetypes, to better understand her needs, wishes, opportunities, and barriers?*

This section draws primarily on existing FP landscape data including consumer profiling in Kenya.

# Consumer Preferences

Consumer Behavior

***Implants and injectables are favored in Kenya. Negative beliefs about contraception deter some non-users, emphasizing the need for accurate information. The growing demand for implants presents an opportunity for private-sector involvement and informed decision-making.***

## Women's FP Preferences in Kenya

### Methods

- Amongst **all women 15-49** FP methods, in order of use are, **injectables**, **implants** and **oral contraceptive pill** [4].
- Amongst **Young Women**:
  - For **all adolescents 15-19**, the method use is **male condoms, implants and injectables.** For **married adolescents 15-19,** the predominantly used method is **implants**, followed by **injection** and **male condoms** [4].
  - For **all women, 20-24,** the method use is **implants**, **injections, and male condoms**, followed by oral contraceptive pills. For **married women 20-24**, the method use is implants, injection, followed by pills [4].

### LARCs vs. Short-acting methods (SAM)

- Many women **start their contraceptive journey by using SAM** [43].
- **Although injectables and implants are highly used methods of FP across multiple segments of consumers,** few women use IUDs [4, 43].

### Factors influencing choice

- **Public vs. Private:** Lack of availability (stockouts), long waits and the nature of interaction with a healthcare provider can impact FP use and be a driver for women to seek FP in private care [44].
- **Beliefs**: Beliefs about LARCs among non-contraceptive users are generally negative, such as it can cause serious health problems, unpleasant side effects, menstrual disruption, and be unsafe for long-term use [45].
- **Poverty:** Those in the lowest wealth quintiles are less likely to access contraception [4].
- **Educational attainment:** Those with lower educational attainment are less likely to access contraception [4].

## What could this mean for implants?

### Demand for implants is growing in Kenya

- Women in Kenya are increasingly using implants.
- The private sector could support this demand while easing the burden on the public sector, especially as donor FP subsidies reduce; however, competitive pricing is needed to ensure equitable access for all women [15].

### Opportunity to inform

- There remains the need to promote accurate information about implants to ensure myths and social beliefs do not act as a barrier to women's informed choice of contraceptives, particularly amongst non-FP users and those without higher levels of education.

### Empowering Youth

- Kenya has a booming youth population (adolescent girls and young women) who are already choosing implants as a method. Promoting implants through youth-friendly services could expand access and further empower females by providing long-acting and highly effective contraceptives.

# Implant Consumer Archetype

Consumer Behavior

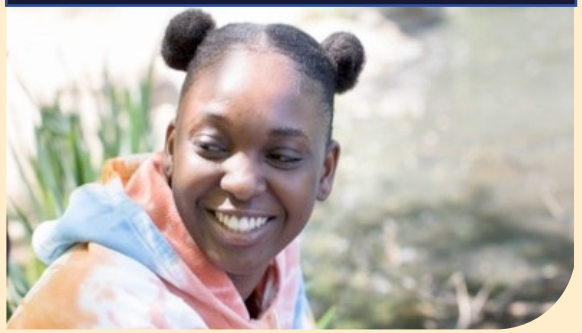
***A consumer archetype for implants is not defined in Kenya, although broader FP archetypes exist, offering insight into the needs, wants and desires of consumers. An FP archetype for young married women has been adapted as a proposed implant market priority audience. Archetypes should be developed for wealthy women currently accessing FP from the public sector and for women who discontinued their method as two other audiences for the contraceptive implant market.***

## Existing archetypes for young FP users in Kenya (Ipas, 2022)

### Shiru, the Mature Minor

Age: 15-17 years

"I have my future ahead of me and I'm not ready for pregnancy. I want access to discreet services and privacy which makes me feel safe. I trust the local pharmacist so I always go there for consultations."



**Size of segment:** 1,125,309 (2019 Census), 15-17 years
**Key influencers:** School health clubs, peers, boyfriend, social media, parents

### Wambui, the Married Adolescent

Age: 17-19 years

" I am young and not ready for pregnancy. I am afraid of potential side effects and the hesitancy from my partner.'

**Size of segment:** 1,474,133 (approx. 10.4% of married adolescents 15-19yr) (2019 Census), 17-19 years
**Key Influencers:** chama, CHVs, husband, social media, mass media

***Total combined size of segment:*** *2,599,442 (2019 Census), 15-19 years*

## What could this mean for implant users?

**Married adolescents are choosing implants**

- **Implants** are the most used method for **married adolescents**, in comparison to **all adolescents** where the current preference for contraception is for **condoms**, followed by implants and injectables [4].
- This demonstrates how married adolescents could show a **growing implant market** as users **promote** and **advocate** for the method.

**Opportunity to promote implants to sexually active adolescents**

- In sexually active 15-19, the method preference is for **condoms, injection, followed by implant,** there is an opportunity for the growth of implants in this archetype [4].
- Sexually active adolescents are more likely to use emergency contraception (often accessed at a private facility) and this could be an opportunity to offer implants as a highly effective long-term contraception.

**Creating an enabling environment for implants**

- For implants to be promoted to adolescents, they need to be affordable, available (no stockouts) and be accessed through discreet youth services.

# Consumer Journey: *Wambui, the Married Adolescent*

Consumer Behavior

***Kenya can build demand generation efforts based on existing consumer journeys like this one for Wambui, the Married Adolescent, developed by Ipas in 2023. Consumer journeys should be developed/adapted for other key archetypes, including women switching from the public sector to the private sector and method switchers.***

| | 1 AWARENESS | 2 DECISION | 3 UPTAKE | 4 MAINTENANCE | 5 ADVOCACY |
|---|---|---|---|---|---|
| **Ideal Journey** | Learns about contraception, including LARCs and implants, through multiple platforms. | Decides to use an FP method, having heard about it in a peer group session, digital health platform, and/or friend. | Starts contraceptive implants having received counseling on multiple methods, and chooses the option that's best for her. | Keeps implant (or reinserts) until she wants to have a(nother) child. | Informs friends/peers about the FP methods that worked for her, including implants. |
| **Actual Journey** | Aware of contraceptive implants, but not sure if it's available in her preferred outlet (private sector). | Open/curious to try a LARC to focus on her career first, but is nervous about discussing this choice with her husband. | Doesn't start an implant as she doesn't ask her provider about it, and the provider doesn't initiate counseling or discuss the options. OR doesn't choose an implant as it's too expensive, or unavailable. | If she starts on a contraceptive implant, she might discontinue (although is less likely to discontinue an implant than other methods such as injectables). | Is willing to tell her friends about the method if they ask. |
| **Key Influencers** | Social media / Husband / Peers / Healthcare providers | Family expectations / Best friends' opinions / Healthcare providers | Healthcare providers | Healthcare providers / Peers / Husband | Family member especially parents / Partner's preference / Friends / Healthcare providers |
| **Motivators / Barriers** | • Friends, social groups and social media<br>• Online sources<br>• Supportive husband | • Healthcare workers<br>• Well-informed through accurate information available digitally<br>• Inconsistent info<br>• Lack of discreet avenues to learn about contraceptives, including implants | • Discreet methods<br>• Discreet access points<br>• Desire for a successful future<br>• Costs<br>• Lack of sufficient counseling<br>• Implants not available | • Desire for a successful future<br>• Positive experience with healthcare provider<br>• Side effects<br>• Fear of removal of the implant | • Positive experience with implants (and healthcare provider)<br>• Fear of discrimination, fear of 'standing out' |

# Market Performance

# Section Purpose



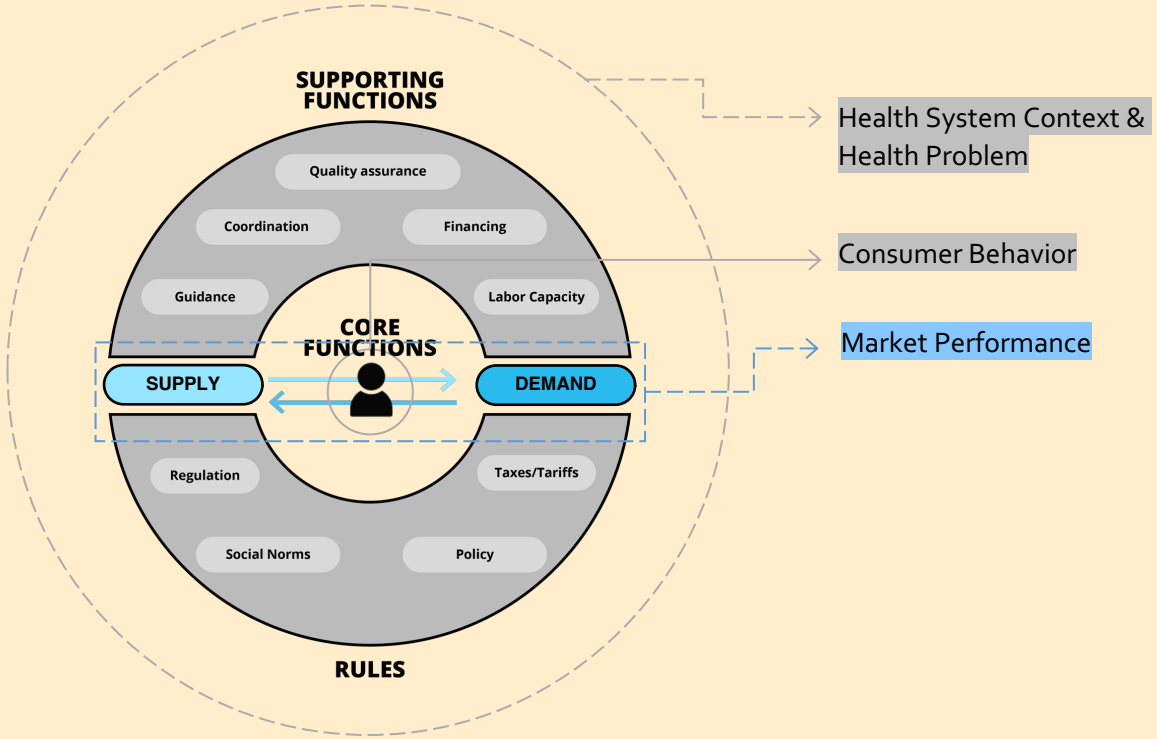



*Figure 19: Market Landscape Report Framework - Market Performance*

This section describes the performance of the core functions (supply and demand) of the implant market in two ways:

→ **Market Depth:** examines trends in the size of the market by looking at the total volumes and (where possible) value of FP products vs. implants by channel (public and private).

→ **Market Breadth:** examines the variety of implant products and services available in the public and private sector and the distribution outlets which make those products and services available by exploring trends in the 4Ps of the market (product, place, price, promotion).

This section draws primarily on the KIIs as well as the desk review.

# Market Depth: Volume Trends



***There has been a trend of increasing FP volumes and implant volumes in the Kenyan market, yet these volumes dipped in 2021. Whilst most implants directly enter the public sector, it is not clear how much of this volume enters into private markets. This is due to formal and informal donations of implants from the public sector to the private sector that may not be reported.***

**Table 6: Trends in FP and implant volumes by sector**

| Channel [4] | FP volume trends | Implant volume trends |
|---|---|---|
| **Public Sector:** government hospital, health center, dispensary, mobile clinic, community health worker (CHW) | • Volumes of FP in the market have **increased in trend since 2017**, yet a dip was seen in 2021, likely due to compounding factors of decreasing funding and COVID 19 [16].<br>• **The majority of FP volumes enter the public sector**, which reflects where the majority of users access FP (62% ) [4]. | • Implant volumes have grown from less than **300,000 in 2017** to peak at **1.5 million** in **2020**, however, this reduced to **700,000** in **2021** [16].<br>• The volumes of implants that pass from the public to the private sector are not well documented. Whilst it may be accounted for in the public sector data, it may be used in the private sector and not reported on as such [KII analysis]. |
| **Private Sector (All)** | • **Whilst the absolute volume of FP** in the private sector has grown in the last 5 years (as it has in the public sector) the % market share the private markets hold has remained static for the last decade at around **35%** [4, 46, 47]. | • The vast majority of implants entering the private market come through formal and informal channels from the public sector. Private providers are meant to report back the usage in exchange for free commodities, but this is inconsistent. It is therefore hard to establish the volume of implants entering the private sector [KII analysis].<br>• In the past decade, implant sales in the private sector have remained roughly steady, with a slight drop from 2018-2020 [48]. |
| **Private medical sector (non-NGO):** private hospital, clinic, pharmacy, private doctor, mobile clinic, CHW | • The highest volumes of FP entering the private medical sector (non-NGO) are condoms and pills, yet actual volumes of FP entering the private market are underreported/unknown [KII analysis]. | • The true volume of implants entering the private sector is unknown [KII analysis].<br>• ***"We provide a lot of implants in the private clinics, but it is not documented or reported to the government"*** [KII quote]. |
| **Private medical sector (NGO & FBO medical sector):** NGO hospital & clinic, FBO/mission clinic & mobile clinic | • Whilst multiple NGOs and FBOs work in FP, the volumes of FP are negligible in comparison to the public sector.<br>• Many NGOs & FBOs partner with the public sector, when promoting FP as the service is provided for free [KII analysis]. | • Within the negligible volume of the market, the trend is that there are almost zero recorded implants in this sector [4].<br>• Implants are distributed in the sector but often reported as from the public sector so data is inaccurate [KII analysis]. |
| **Other source:** shop, church, friends/relatives, other, unknown | • Shops account for where 2.5% of users obtain contraception. Shops primarily sell condoms and infrequently pills [4]. | • Shops do not sell implants [4]. |

# Market Breadth: Product



*Implants have been available in the Kenyan market for the last 30 years. Two products, Jadelle and Implanon NXT, each hold a significant market share of 40%, while the third product, Levoplant, holds the remaining share.*

**Table 7: Breadth of product in the market (past, current, and future)**

| Product | Duration of product | Manu-facturer | Availability in Kenya | Public sector trends | Private sector trends | Key insights |
|---|---|---|---|---|---|---|
| Jadelle | 5 years duration | Bayer | In market [49]<br>2004 – present | • **40%** of market share [KII analysis], imported by Bayer Kenya.<br>• Jadelle in Kenya is sold only to the MoH public sector [KII analysis]. | • Jadelle is **not sold directly to the private sector** in Kenya [KII analysis].<br>• The private sector accesses Jadelle via: 1) KEMSA procurement to a facility that can apply for a service number and receive free products, 2) via social marketing channels, and 3) via informal channels [KII analysis]. | • There have been frequent stockouts of Jadelle in Kenya over the last year [KII analysis].<br>• National data for public facilities for Jan 2023 showed Jadelle stockouts at 54%, with 34% overstocked and 9% adequately stocked [51].<br>• Jadelle takes 8-16 weeks from production to enter the country, **therefore poor forecasting can impact supply** [KII analysis]. |
| Implanon, Implanon NXT/ Nexplanon | 3 years duration | Organon / Merck/MSD | In market [49]<br>2004 - 2016 (Implanon)<br>2016 – present (Implanon NXT/Nexplanon) | • **40%** of market share [KII analysis].<br>• Imported by Imperial Logistic (Agent of KEMSA) [KII analysis]. | • Implanon NXT mostly enters the private market though indirect channels, described above. | • Implanon NXT supply is **more consistent** in the country [KII analysis].<br>• National data for public facilities for Jan 2023 showed Implanon NXT stockouts at 49%, 30% overstocked and 14% adequately stocked [51]. |
| Levoplant (Sino-implant II; Zarin) | 3 years duration | Shanghai Dahua Pharmaceuti cal Co., Ltd. | In market [49]<br>2008 – present | • **20 %** of market share [KII analysis], Imported by Imperial Logistic (Agent of KEMSA) [KII analysis].<br>• Introduced by FHI Project in 2008. | • Introduced in Kenya as a project spearheaded by FHI 360 2008 [50].<br>• Distributed by DKT Woman Care [50]. | • As Levoplant is cheaper (see section on pricing) and already distributed by social marketing organizations (segment of the private sector), could be an opportunity to distribute to other private sector segments (commercial). |
| Norplant | 5 years duration | Wyeth-Ayerst | Discontinued [49]<br>1992-2004 | • First implant introduced to the market in Kenya through national family planning program [49]. | • No longer available. | • The FP category of implants have been in the market since 1992. |

# Market Breadth: Place



***Women who obtain implants from the private sector access them from non-NGO private medical facilities with poor data reporting into the government system, which hampers the visibility into the private sector.***

**Table 8: Trends in FP and implant place/channel by sector**

| Channel | FP trends/issues | Implant trends/issues |
|---|---|---|
| **Public Sector:** government hospital, health center, dispensary, mobile clinic, CHW | • **62% of users obtained their preferred** method from the public sector through government hospitals and government dispensaries [4]. | • Public sector delivery points account for **86% of implant delivery** [4].<br>• *"Level 2, 3, 4 facilities distribute the biggest volumes of implants, not levels 5 and 6 (large national hospitals) and not level 1 (dispensaries)* [KII analysis]. |
| **Private (All)** | • The private sector accounts for **38% of the FP contraceptive market** [4]. | • **13.8%** of all implants are obtained throughout the private sector [4].<br>• *"Literature may say there aren't many implants in the private sector but one aspect of this is documentation, there's not much in the private sector"* [KII quote]. |
| **Private medical sector (non-NGO):** private hospital, clinic, pharmacy, private doctor, mobile clinic, CHW | • The non-NGO private sector accounts for **33 % of the contraceptive market** [4].<br>• *"Private pharmacies are often the first point of call for users of FP as they are discreet, they are quick to obtain healthcare services and have good coverage even in remote settings"* [KII quote].<br>• There are many unregulated private pharmacies in Kenya, which are. technically illegal. The data from these pharmacies is unavailable [49]. | • **The private medical sector (non-NGO) is the largest provider of implants in the private sector**, accounting for 12.7 % of the 13.8% private sector contraceptive market [4].<br>• Implants are mostly available in L4, L3 and L2 facilities and performed by nurses, yet research is currently taking place to assess the role of task sharing for CHW to insert implants in the community in Kilifi County Kenya [20].<br>• *"With reduced donor funding in the public sector, there are fewer implants available for the private sector, many get implants from distributing pharmacies, informal agreements with the public sector or through neighboring countries through the black market"* [KII quote]. |
| **Private medical sector (NGO & FBO medical sector):** NGO hospital, NGO clinic and FBO/mission clinic, FBO mobile clinic | • NGOs and FBOs account for just 1.1% of the contraceptive market [4].<br>• Their role is small for FP as large donor funding, for example, UNFPA procures FP for the public sector [KII analysis].<br>• Support FP distribution to rural areas where there is poor access to FP from other sectors [KII analysis]. | • **NGO & FBOs account for less than 1% of the implant market** [4].<br>• NGO and social marketing organizations have reported growth in implants in this sector since 2017, although this is not reflected in government data [KII analysis]. |
| **Other sources:** shop, church, friends/relatives, other, unknown | • Shops account for where 3.5% of users obtain contraception. Shops primarily sell condoms and infrequently pills [4]. | • Shops are not able to sell implants [KII analysis]. |

*"Implants in the private sector mostly come from the public sector. The public sector may share implants with the private sector, but this is often informal, the private sector should not charge for these, but this is poorly controlled."* [KII quote]

# Market Breadth: Price

Market Performance

***The private sector currently accesses free commodities, although this is expected to change as donor funding for commodity procurement drops. With significant fee variations in the private sector and limited insurance coverage, measures are needed to ensure affordability for implants in the private sector as the donor landscape transitions.***

**Table 9: Trends in FP and implant price by sector**

| Channel | FP price trends/issues | Implant price trends/issues |
|---|---|---|
| **Public Sector:** government hospital, health center, dispensary, mobile clinic, CHW | • The registration fees for users increase depending on the level of facilities, this is to encourage people to go to their local dispensary or facility rather than a referral facility [KII Analysis].<br>• NHIF does not cover FP although Linda Mama can cover FP postpartum for 6 weeks, however there are inconsistent practices across facilities [KII analysis].<br>• Injectable and implant users reported a mean OOP payment of Kenyan shillings (KES) 80 (US$0.91) and KES 378 (US$4.31), respectively, across all sectors [6]. | • **Commodity:** The implant commodity is **free in the public sector.**<br>• **Insertion:** Users may need to pay a **registration fee** (**100-600KSh** depending on the level of the facility), the **cost of a patient booklet** and **a fee for insertion.**<br>• **Removal:** The user may have to **pay a small fee for removal.**<br>• Jadelle and Implanon NXT **wholesale price is $8.50,** Levoplant **wholesale price is $6.90.**<br>• **Additional costs including** freight, insurance and taxes can increase the cost by 10-15% [KII analysis]. |
| **Private (All)** | • Most FP products in the private sector are received from the public sector at no or subsidized cost.<br>• The private sector sells a variety of FP products, those sold in the private sector, but originating from the public sector, are clearly labelled. The private sector may purchase other branded products to appeal to consumers [KII analysis]. | *"The price charged to the user varies a lot, it's completely at the discretion of the provider, with some private providers charging very high costs"* [KII quote].<br>• Research has indicated that the out-of-pocket (OOP) expenditure on implants is the same for consumers across certain public and private health facilities. This similarity arises from the requirement to cover both registration and insertion fees, even if the commodity is free [35]. |
| **Private medical sector (non-NGO):** private hospital, clinic, pharmacy, private doctor, CHW | • Medicine pricing in the private for-profit healthcare sector is guided by a free-market policy using informal societal price markups for profit margins and is not anchored in any legislation [6].<br>• Whilst providers are incentivized by increased profit margins, it can mean prices are inaccessible to the consumer. | • **Commodity:** If accessed from the public sector, private facilities are obligated to provide for free. "*Yet large facilities are charging up to 3,500KSh **even** when they receive it for free"* [KII quote].<br>• **Insertion**: Registration **5000-1500KSh, +/-** consultation **1000-2000 +/-** insertion **500-3500KSh.**<br>• **Removal:** Up to **1500KSh.** |
| **Private medical sector (NGO & FBO medical sector):** NGO hospital, clinic & FBO mission/ mobile clinic | • The poorest contraceptive users in the public sector are as likely to pay for FP services as wealthier users, therefore there is still a need for subsidized FP commodities to target those most in need [35]. | *"Providers often apply a sliding scale dependent on users' ability to pay"* [KII quote].<br>• **Commodity:** If accessed from the public sector, private facilities should be provided for free.<br>• **Insertion:** Often subsidized / free.<br>• **Removal:** Often subsidized / free (range 100-1000KSh). |
| **Other source:** shop, church, friends/relatives, other | • Condoms are often provided for free in churches and at low or subsidized rates in shops [KII analysis]. | • There are no implants sold in this sector. |

# Market Breadth: Promotion



***Implants are a demanded form of FP in Kenya, yet most are accessed from the public sector. Healthcare professionals, in particular nurses and CHWs, could be well positioned to promote implants in the private sector, yet inconsistent supply, a lack of training and minimal incentives for providers are a barrier to implant promotion in the private sector.***

*"There is a demand for implants, but the supply is a big challenge"* [KII quote]

**Table 10: Trends in FP and implant promotion efforts by sector**

| Channel | FP Promotion Trends/Issues | Implant Promotion Trends/Issues |
|---|---|---|
| **Public Sector:** government hospital, health center, dispensary, mobile clinic, CHW | • FP promotion is spearheaded by MoH (at national and county levels), the Kenya Community Health Strategy is tasked with demand creation [KII analysis] [52].<br>• 91% of all women are aware of implants as a method, vs. 94% injectables, 77% IUD, 96% male condom, 90% pill [4]. | • *"Healthcare providers are the ones who have driven the growth of the implant, but they can also be a barrier, e.g., if not trained, no time, lack knowledge"* [KII quote].<br>• Pharmaceutical manufacturers of implants have previously worked with the government to support training to promote implants [KII analysis]. |
| **Private medical sector (non-NGO):** private hospital, clinic, pharmacy, private doctor, mobile clinic, CHW | • Pharmacies have an opportunity to promote FP products to those who would not usually visit health facilities [KII analysis].<br>• Women may preferentially access FP in the private sector due to the promotion of quality services or due to the branding of the facility [KII analysis]. | • *"Private health providers (mostly nurses) are well positioned to drive uptake of implants in this sector, as long as they have a stock and are incentivized due to profit margins, however, they may prefer to deliver the injection which is a quicker and easier procedure"* [KII quote].<br>• Not all private sector workers have the same access to training opportunities [KII analysis]. |
| **Private medical sector (NGO & FBO medical sector):** NGO hospital & clinics, FBO/mission clinic, FBO mobile clinic | • Numerous NGOs and social marketing organizations carry out demand creation for FP through working with **CHW** and the use of **digital technology** [KII analysis].<br>• The Challenge Initiative has developed steps for demand creation for FP in an urban setting: 1) Improve the capacity of **CHW** to promote FP; 2) Strengthen **FP** and **Adolescent and Youth Sexual and Reproductive Health** interpersonal **communication skills** in CHW; 3) Use of **entertainment-education approaches**, such as radio engagement and community dialogues [53]. | • A recent research pilot study supported by NGOs/Social marketing organizations in Kenya, has shown a positive uptake of implants in target communities, through task sharing and community engagement by Community Health Extension Workers (CHEWs) and supported community engagement led by Community Health Volunteers (CHVs) [20]. |
| **Other source:** shop, church, friends/relatives, other, unknown | • Various family planning (FP) programs have aimed to involve faith leaders, encourage males to become advocates for FP, appoint youth champions for FP, and utilize popular social media platforms like TikTok and Instagram. These platforms have a significant number of young users in Kenya [KII analysis]. | • There is an opportunity for community promotion and advocacy of implants in the private sector [KII analysis]. |

# Market Structure

# Section Purpose



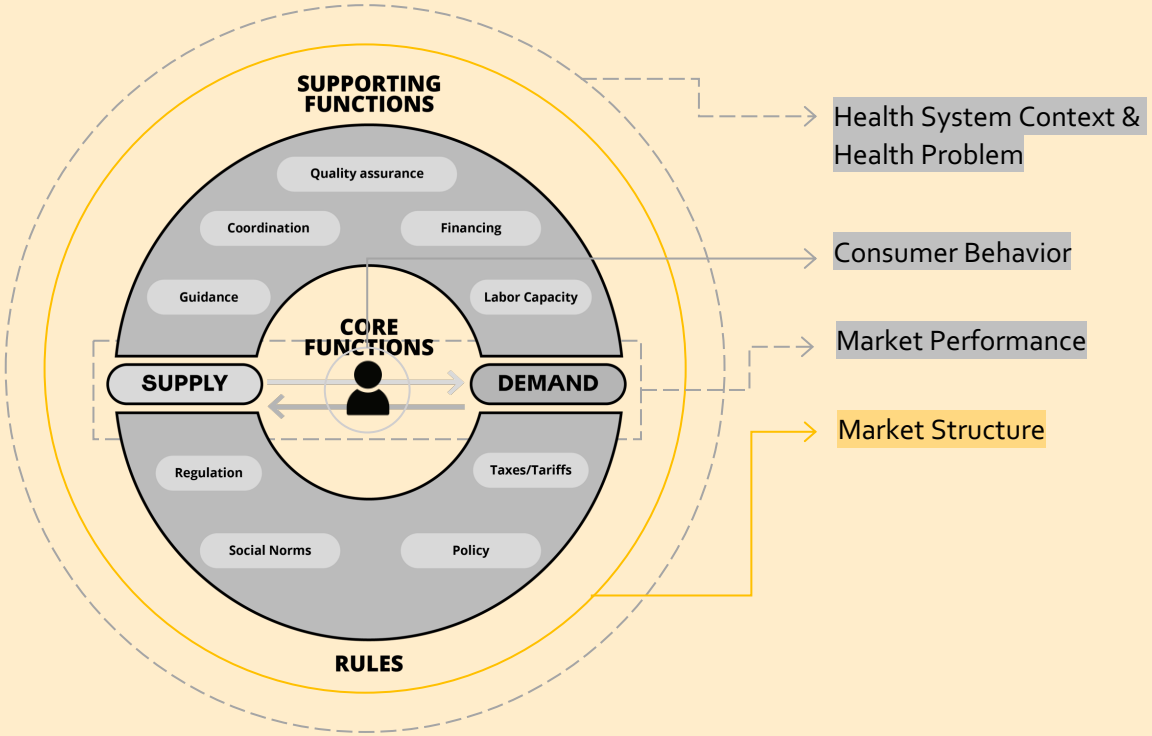



*Figure 20: Market Landscape Report Framework - Market Structure*

This section clearly describes all market functions (core, supporting, and rules) in order to understand the challenges to the effective functioning of the market. This section primarily describes the FP market structure in order to explore how contraceptive implants can best be introduced and scaled in Kenya's private sector for health.

Specifically this section answers:

→ *What is the **value chain** for the contraceptive implant market?*

→ *Who are the **key actors in the FP market,** what role are they doing, and what are their capacities and inceptives to play their role effectively?*

This section primarily draws on data from the KIIs and existing FP landscapes in Kenya.

# Value Chain for Contraceptive Implants

Market Structure

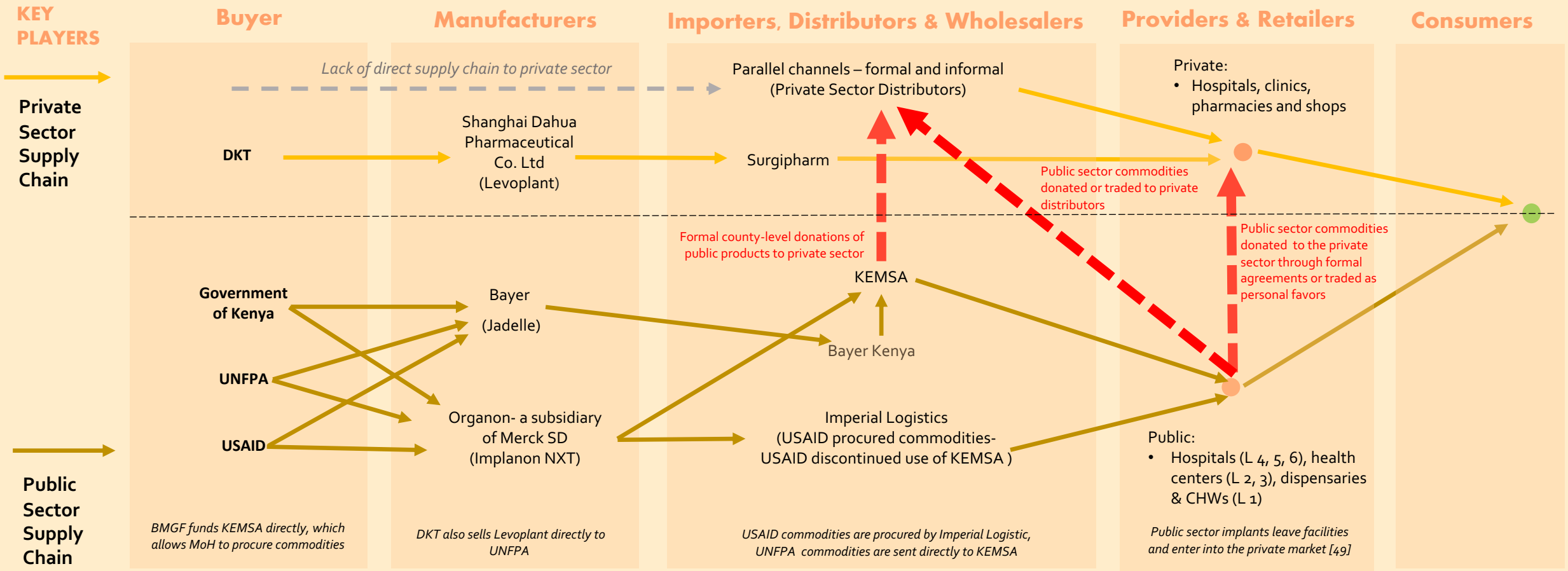
***The contraceptive implant supply chain is dominated by public sector commodities, supported by donors, with no established alternative in place and no compelling incentives for the private sector to invest in a contraceptive implant supply chain. With subsidies decreasing, the entire implant supply chain, and therefore the implant market, is vulnerable to an uncertain future supply.***

| KEY PLAYERS | Buyers / Funders | Manufacturers | Importers, Distributors, & Wholesalers | Providers & Retailers | Consumers |
|---|---|---|---|---|---|
| | • DKT<br>• BMFG<br>• UNFPA<br>• USAID<br>• Government of Kenya | • Shanghai Dahua Pharmaceutical Co. Ltd (Levoplant)<br>• Bayer (Jadelle)<br>• Organon – a subsidiary of Merck SD (Implanon NXT) | *Private*<br>• *Parallel channels – formal and informal*<br>• *DKT*<br>• *KEMSA ( as a wholesaler of free commodities)*<br>*Public*<br>• *Bayer Kenya*<br>• *Imperial Logistics*<br>• *KEMSA*<br>• *UNFPA* | *Private*<br>• *Hospitals, clinics, pharmacies and shops*<br>*Public*<br>• *Hospitals (L 4, 5, 6), health centers (L 2, 3), dispensaries & CHWs (L 1)* | *The private sector struggles to keep a consistent supply of implants, leading to unreliable access for private consumers [KII analysis].*<br>*"With stockouts of implants in the public sector, users will simply take any alternative method, typically a SAM, until it is available" [KII quote].* |
| **EMERGING FINDINGS** | *Donors, in addition to funding commodities, support supply chains through intermediaries who receive forecasts and requisitions and strategize about volumes and brands of commodities that are required.* | *Manufacturers provide implants to the government of Kenya, which is supported through funding from USAID and UNFPA [KII analysis].* | *Most implants are obtained through the public sector and are managed by organizations like KEMSA and Imperial Logistics. In contrast, there is limited direct procurement of implants into the private sector, and there are no established supply chains for this purpose. Private distributors of implants typically source their products from the public sector [KII analysis].*<br>*MEDS is private but does not procure implants* | *Public facilities are not authorized to purchase commodities except from KEMSA (Kenya Health Law 2019), counties are notified of method shortages when it is too late to plan [KII analysis].*<br>*Commodities can move to the private sector – but this should only be once the public sector is saturated, however in reality a lot of products move informally through favors and the black market [KII analysis].* | *Implants are very popular in Kenya but there are frequent stockouts, which impact both the public and private sectors [KII analysis].* |

# Supply Chain for Contraceptive Implants

Market Structure

***The value chain for contraceptive implants is a complex system involving multiple stakeholders. The private sector lacks a well-defined supply chain for these products, and the majority of contraceptive implants make their way into the private sector through the public sector. This transfer can occur through formal channels or informally as free commodities are traded by distributors on the black market.***




*This infographic is not an exhaustive summary of the supply chain but demonstrates the key players in both markets, the majority of implants that only have supply chains to the public sector and the movement of commodities from the public to the private sector*

# Core Function Description



***Implant supply to the private sector is dominated by volumes procured in the public sector. Existing donor and government agreements with pharmaceutical companies support the public supply chain, limiting the business case for the private sector.***

**Table 11: Role of key actors in the value chain regarding market supply and demand issues**

| Value Chain | Key players | Role | Supply and demand issues | Implications for implant market |
|---|---|---|---|---|
| Manufacturers | • Bayer [49]<br>• Merck/MSD [49]<br>• Shanghai Dahua Pharmaceutical Co. Ltd (Levoplant) [49] | • Supplies: Jadelle. Local office oversees sales and distribution to the public sector.<br>• Supplies: Implanon NXT.<br>• Supplies: Levoplant. Product handled by DKT. | • Currently, FP products are labelled 'MOH product – not for resale' when entering the public sector. Manufacturers would need to rebrand the product for the private sector and currently don't see the business case for doing so, as large volumes are procured through donor and government support [KII analysis]. | • There is a need for implants specifically branded for the private sector, once free commodities from the public to the private sector stop. |
| Importers, Distributor, and Wholesalers | • **KEMSA** - Kenya Medical Supplies Authority<br>• **Imperial Logistics -** Leading logistical supplier<br>• **Distributors** (#>20) who interface with wholesalers and importers, e.g., Chemonics, Surgipharm, Dawa Life Sciences<br>• Kenya Association of Pharmaceutical Distributors (Parallel channels)<br>• NGOs & SMOs: DKT Kenya, Marie Stopes Kenya, PSI [54] | • **KEMSA** - Carries out a competitive tender to procure commodities into the country and distributes products to public and private facilities (generally via the sub-county depots).<br>• **Imperial Logistics** - Acts as a local technical representative of the manufacturer, the only organization licensed to import Implanon NXT & Levoplant, however they are able to distribute to any actor. Currently acting as logistic partner for USAID procured products [KII analysis]. | • The public sector procurement process is central to the core function of the private FP market.<br>• There are many private distributors and the movement of commodities through multiple entities ultimately adds cost to the FP products entering the private markets.<br>• When there are stockouts of FP products in the public sector, this results in stockouts of FP in the private sector. Private distributors can take advantage of this situation by selling FP products in high demand within the private market at elevated prices [KII analysis]. | • **The private implant market is currently dependent on the public sector market** [KII analysis].<br>• The private sector sources implants for free from the public sector, and no truly commercial wholesalers or distributors can compete, there is therefore an underdeveloped private sector supply chain and over-reliance on the public sector supply chain [KII analysis] |
| Providers & Retailers | • **Private Hospitals/clinics/pharmacies**, e.g., Aga Khan, MP Shah, My Dawa, Kasha, Good Life Pharmacy, Pharmaplus, Pharmnet<br>• **Social Franchises**: PSI, MSK, DKT Kenya<br>• **NGOs (private** sector), e.g. , AMREF, Lwala, LivingGoods | • **Private providers:** Offering FP services including implants.<br>• **Social Franchises**: PSI supply a network of 353 clinics (Tunza), although these clinics obtain 75% of commodities through sub-county depots. DKT supply private pharmacies, clinics and small hospitals.<br>• **NGOs:** Promoting and offering FP services, often in partnership with MoH. | • Private providers don't have any consistent access to FP commodities [KII analysis].<br>• Counties must plan for local implant stock, yet the private markets are often left behind. Local governments do not usually consider PSE [KII analysis quote].<br>• NGOs often partner with MoH / advocate for access to FP for women through MoH. | • Private providers prefer to provide SAM and injectables due to **a skills gap**. Many private providers do not have the benefit of training, coaching, or quality assurance [KII analysis]. |
| Consumers | • Adolescent girls (15-19) and women (20-29) | • Key consumers are using implants as contraception and there is a demand for these products. | • Despite trends around FP access in the private sector, implants have been an exception and signal that demand for implants in the private sector is low. | • Contraceptive implants are popular and high in demand, yet there has been a lack of growth of implants in the private sector. |

# Supporting Function Description



***There is a lack of coordination in the private sector implant market. Given the diminishing donor support, private sector engagement will be key as the government strives for self-sustainability in FP financing by 2026.***

*"A Total Market Approach (TMA) strategy was developed in 2020. However, government budget allocation for family planning primarily focuses on commodities, resulting in a limited budget for implementing this strategy, especially at the county level"* [KII quote]

**Table 12: Key players in supporting market function: issues, capacities, incentives and implant market trends**

| Supporting Functions | Key players | Role | Issues, capacities and incentives | Implications for implant market |
|---|---|---|---|---|
| Coordination | • Kenya Ministry of Health<br>• Kenya Pharmaceutical Association (KPA)<br>• Kenya Medical Practitioners and Dentists Council<br>• Kenyan Healthcare Federation | • **MoH** - Working with donor partners to procure implants that supply both the public & private sector.<br>• **KPA** - Continuous professional development of members, supporting policy areas for pharmaceuticals and developing partnerships for training in the public & private sectors [55].<br>• **Kenya Healthcare Federation (KHF)** - Promotes strategic public-private partnerships toward achieving national access to quality health care [56]. | • There is a need to strengthen the county government stewardship to grow the private market [KII analysis].<br>• The government developed a TMA for FP strategy [57], with support from UNFPA & USAID. Although it has been developed at a national level, it has not been operationalized at county levels [KII analysis].<br>• KHF works to influence public policy and provide alternative solutions through public-private collaboration. | • With an inactive TMA strategy, the private sector implant market is not currently being engaged and there is no current coordination. [KII analysis]<br>• The complexity and volume of potential contracts between NHIF and private providers of FP services can stifle collaboration. [KII analysis]<br>• Potential opportunity to engage KHF in private sector implant market growth. |
| Quality Assurance | • Manufacturers: Bayer / Merck / Dahua<br>• NGOs & SMOs: DKT Kenya, Marie Stopes Kenya, PSI<br>• KEMSA<br>• Quality Care Labs (QCL) National & Private labs | • Manufacturers are responsible for post-market surveillance and pharmacovigilance of products [KII analysis].<br>• NGOs and social marketing organizations provide quality assurance mechanisms.<br>• KEMSA is responsible for ensuring the quality and authenticity of the drugs procured [KII].<br>• QCL exist for product testing for counterfeit products. | • Whilst KEMSA and manufacturers have quality assurance processes, due to the lack of coordination of the private sector, it is unclear where products are obtained from and what quality assurance channels these may pass through [KII analysis].<br>• No governing body is responsible for QA and reporting of FP use in the private sector [KII analysis]. | • Some implants are distributed by informal channels and favors through the public sector to private sector [KII analysis]. |
| Financing | • **Insurance: Private provider**<br>• **Out-of-pocket (OOP)**<br>• **Donors** – In 2021/2022 donors funded $10M of $22.5M budget for FP commodities for Kenya [3] | • **Insurance –** NHIF does not cover FP service, yet another large & costly private insurer may include FP cover.<br>• **OOP** – User OOP is often the source of FP financing in the private sector (and public sector).<br>• **Donors** – Support is to public sector procurement, yet these products end up in the private sector. | • USAID / BMGF – Have an MOU with the Kenyan government for domestic financing for FP commodities since 2019 -2026. Year by year the government should be taking a larger proportion of FP, and by 2027 the government needs to be fully sustainable for FP [KII analysis] [58]. | • USAID is due to reduce FP commodities by 2026 and UNFPA is also reducing funding to Kenya, as the government is unable to meet this funding gap we need to engage the private sector for the provision of implants [KII analysis]. |
| Labor Capacity | • Kenya Ministry of Health<br>• Kenya Healthcare Federation | • **MoH** – County governments are responsible for human resourcing for health and for providing training to public and private healthcare providers.<br>• **KHF** – Works to build capacity and ensure quality healthcare in the private sector. | • The density of doctors, nurses and clinical officers per 10,000 in Kenya in 2020 was 30.14, which represents about 68% of the SDG index threshold of 44.5 [59]<br>• 68% of healthcare providers work in the public vs. 34% in the private sector [59]. | • The private sector is invariably trained in the provision of implants as there is a lack of coordination of the private sector [KII analysis].<br>• Task sharing could expand the number of health workers able to deliver implants [KII analysis]. |

# Rules Function Description



***Current FP policy and regulation are in place, however, it is poorly regulated in the private sector. The upcoming revision of FP guidelines affords an opportunity for stakeholders to ensure an enabling environment for the private sector.***

**Table 13: Summary of key players of rules market function: capacities, incentives and implant market trends**

| Rules Market Function | Key players | Role | Capacities and incentives | Implications for implant market |
|---|---|---|---|---|
| Policy | • Ministry of Health (and department) MoH<br>• Kenya Pharmaceutical Association | • MoH – Ministry of health have procurement guidelines and the KEMSA Act agreement on government and donor funds for procurement [6].<br>• KPA – supporting and enhancing policy area for pharmaceuticals, Kenya National Pharmaceutical Policy [6] [KII analysis]. | • The government signed a circular allowing private-public referral channels, enabling **private clinics** to obtain government-registered products through facilities and in return filling in data booklets and return data to KHIS [KII analysis].<br>• **Private pharmacies** are not eligible in policy to obtain government-registered products, however, some counties provide public products to pharmacies [KII analysis]. | • There is a need to change policy and allow implants to be inserted at the community level [KII analysis].<br>• As for implants, pharmacy practitioners and community pharmacy policies allow for the sale of implants and counsel on all the FP methods and refer to a provider (health facility) who can insert the implant [KII analysis].<br>• The national FP guidelines are due for revision, offering a significant opportunity to advocate policy guidelines that create a more conducive environment for the realization of TMA as well as for enhanced access to contraceptive implants in the private sector [KII analysis]. |
| Regulation | • PPB - Pharmacy and Poisons Board (PPB)<br>• KEMSA | • PPB - Registration of product, surveillance, pharmacovigilance, storage standards and regulates pharmacies [KII analysis].<br>• KEMSA – Regulation of pharmaceuticals entering the market by setting quality and additional requirements that products must meet. | • Regulatory bodies monitor FP products entering the public sector of which many are then distributed to the private sector.<br>• Lack of coordination and regulation of private sector FP products being distributed and sold in the private sector. | • Regulatory bodies focus on the public sector, resulting in inadequate regulation of the private sector implant market. If the formal transfer of implants from the public to the private sector were to cease, the black market may persist in trading implants from the public sector or from unknown sources [KII analysis]. |
| Taxes/Tariffs | • Kenya revenue authority (KRA) | • USAID commodities are tax exempt, discussion around tax exemption and the procurement it would not support otherwise.<br>• If commercially procured, it would be subject to taxation. | • As FP products are tax-exempt when procured through government or donors [KII analysis]. | • If private providers were to try to procure implants directly, they may be subject to further taxation on the product. [KII analysis]. |

# Key Market Constraints

# Section Purpose



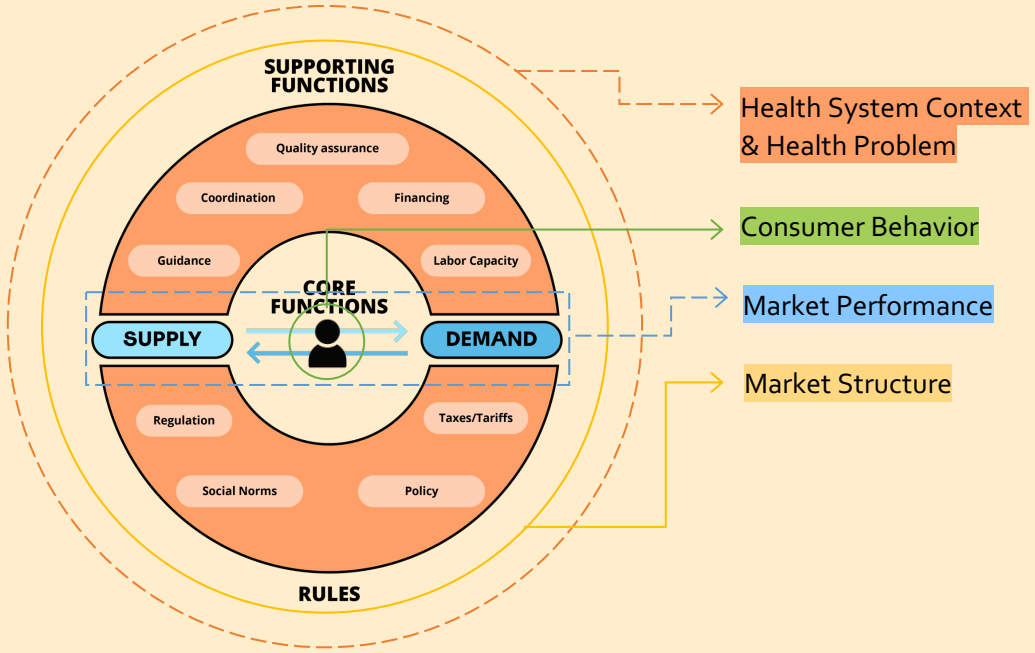



*Figure 21: Market Landscape Report Framework*

Based on a robust understanding of the health problem, indications about consumer behavior, and analysis of market trends, this section aims to articulate *why the contraceptive implants market is constrained*. We do this in two ways:

→ **Health Market System:** We map Kenya's key constraints against the broader, global constraints identified in the 2022 review

→ **Production to Use Spectrum:** We highlight the same key constraints within the Production to Use Spectrum to visualize with greater clarity where, specifically, in the market the constraint occurs.

# Kenya's Private Sector Implant Market Constraints

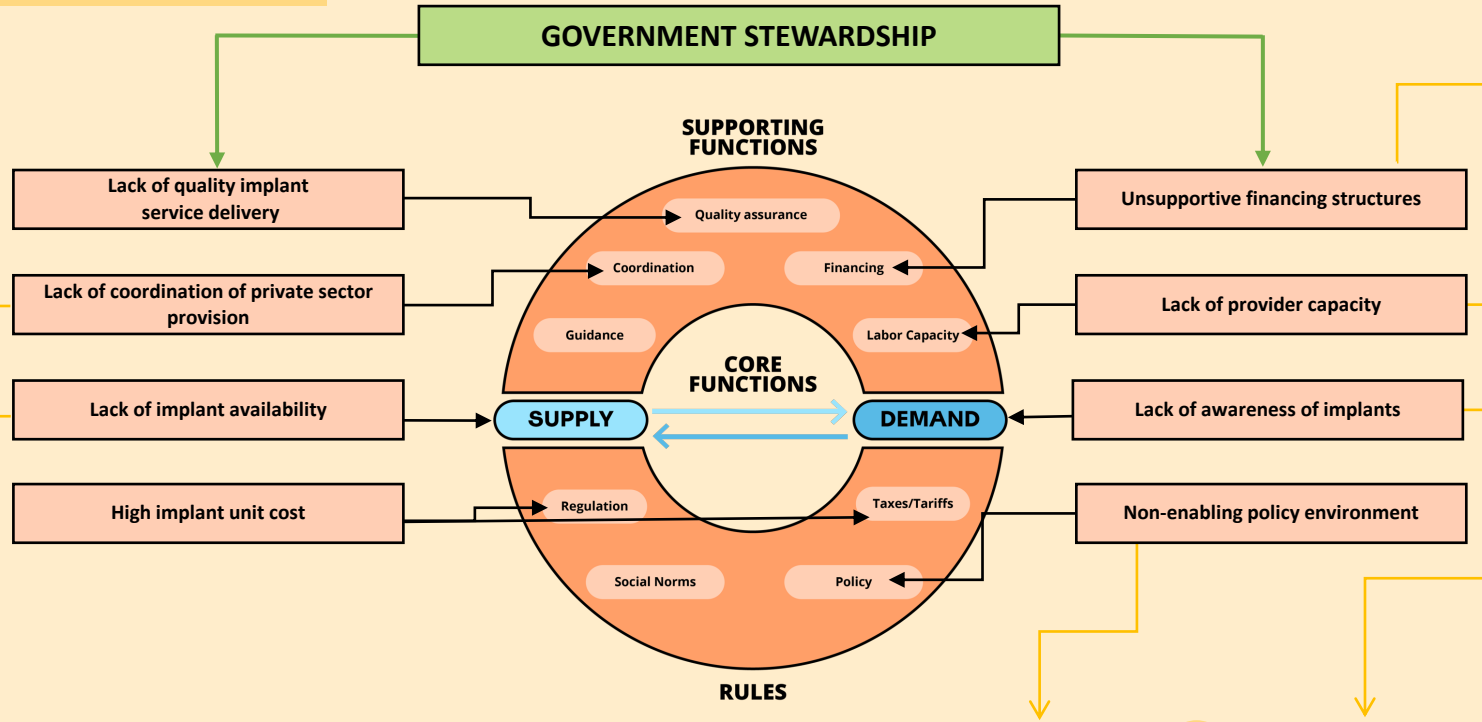
Key Market Constraints

***We've identified seven key constraints to Kenya's Private Sector Implant Market vis-à-vis: (1) government stewardship; (2) lack of coordination of private sector provision; (3) lack of *sustainable* implant availability; (4) unsupportive financing structures; (5) lack of provider capacity; (6) non-enabling policy environment; and (7) lack of awareness of implants.***

**1** As an FP first mover in Africa, Kenya has demonstrated ability in stewarding its FP agenda; but that stewardship has been limited to the public sector and neglected the private sector, a position that is no longer tenable with the reality of reducing donor subsidies and MIC status within reach.

**2** With an inactive TMA strategy, the private sector is not engaged and there is no coordination of this market, a situation which will hamper the government's ability to sustainably self-finance all FP by 2026.

**3** Historically, Kenya's private sector has had a secure implant supply chain through the public sector, but with reduced donor funding, stockouts are increasing – and dependence on public supply has created a 'false' and unsustainable business model.




**4** As Kenya progresses towards achieving Middle-Income Country (MIC) status and the landscape transitions from donors to government funding for commodities, this may lead to increased costs for private sector clients, potentially making implant services less affordable. Additionally, there is inadequate insurance coverage for FP to support OOP spending.

**5** The variable capacity of providers to promote and deliver implants stems from the inconsistency in standards among private market providers and the intermittent supply of implant products.

**6** FP delivery in the private sector isn't addressed in the national FP policy or UHC agenda, and the task-sharing policy doesn't include additional cadres of healthcare workers (e.g. pharmacists), who could provide implant services.

**7** While implants are a popular form of contraception in Kenya, inconsistent supply, a lack of training and minimal incentives for providers are a barrier to implant promotion in the private sector.

# Production to Use Spectrum



***These seven key constraints fall at different levels within the 'Production to Use Spectrum' providing more insight into where, exactly, the market is constrained and therefore who might need to be engaged to address these constraints.***

**Table 14: Market Constraints mapped against production to use spectrum**

| | Market Function | Manufacturers | Importers, Distributors, and Wholesalers | Providers | Consumers |
|---|---|---|---|---|---|
| CORE | Product | **3. Lack of implant availability:** Historically, Kenya's private sector has had a secure implant supply chain through the public sector, but with reduced donor funding, stockouts are increasing – and dependence on public supply has created a 'false' and unsustainable business model. | | | |
| CORE | Price | | | | |
| CORE | Place | | | | |
| CORE | Promotion | | | **7. Lack of awareness of implants:** While implants are a popular form of contraception in Kenya, inconsistent supply, a lack of training and minimal incentives for providers are a barrier to implant promotion in the private sector. | |
| SUPPORTING | Coordination | **1. Lack of government stewardship.** As an FP first mover in Africa, Kenya has demonstrated ability in stewarding its FP agenda; but that stewardship has been limited to the public sector and neglected the private sector, a position that is no longer tenable with the reality of reducing donor subsidies and MIC status within reach. | | | |
| SUPPORTING | Coordination | **2. Lack of coordination of private sector provision:** With an inactive TMA strategy, the private sector is not engaged and there is no coordination of this market, a situation which will hamper the government's ability to sustainably self-finance all FP by 2026. | | | |
| SUPPORTING | Quality Assurance | | | **5. Lack of provider capacity.** Inconsistent standards of private market providers and intermittent supply of implants leads to a variable capacity of providers to promote and deliver implants. | |
| SUPPORTING | Financing | **4. Unsupportive financing structures:** IAP did not focus on increasing private sector access, although it did reduce public sector costs and make procurement easier. As Kenya approaches MIC status, donor funding is reducing and alternative national FP financing structures are required to secure the public sector FP supply chain and support the development of a viable business case for implants, including sustainable supply. | | | |
| RULES | Policy, regulation, taxes & tariffs | | **6. Non-enabling policy environment:** Current FP policy and regulations are not consistently implemented in the private sector and therefore don't ensure an enabling environment in which the private sector can flourish. | | |

# Prioritized Constraints



***Four constraints were prioritized by participants in the Kenya workshop based on: the potential for impact, availability & motivation of stakeholders, and feasibility. Please read the Kenya Country Roadmap to understand how Kenya's value chain actors aim to tackle these four constraints over the next 7 years, in support of FP2030 goals.***

**CORE**

1. Lack of a **private sector supply chain** for contraceptive implants

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.

**SUPPORTING FUNCTIONS**

2. **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.

3. Insufficient **labor capacity and motivation**

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.

**RULES**

4. 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 policy and task-sharing.

***To access the roadmap, check out our landing page!***

# Annex

# Key insights

Annex

| *BACKGROUND* |
| --- |
| *Despite the success of contraceptive implant introduction in the public sector, implant provision by the private sector remains underutilized. This project aims to develop a roadmap for the private sector provision of contraceptive implants in Kenya, building on previously identified global barriers and recommendations.* |
| *The previous project outlined a set of global barriers and recommendations to expand private sector contraceptive implant service delivery by strengthening: sustainably financed supply, demand for service delivery, government stewardship capacity, provider sector capacity, and quality of care.* |
| *This project aims to answer three key questions about the vision of success, key market constraints, and key measures to improve the private sector contraceptive implant market in Kenya.* |
| *A literature review and key informant interviews conducted June-Aug 2023 informed this report. Findings will be further validated through an in-country workshop to support the development of the roadmap.* |
| *Both the Kenya Contraceptive Implants Market Analysis Report (2023) and the Global PSE for Contraceptive Implant Delivery Report (2022) organize findings around the same conceptual framework: the Health Market System Framework.* |
| ***HEALTH SYSTEM CONTEXT*** |
| *Kenya has been an FP first mover in Africa, making significant progress to meet women's FP needs. But the trajectory of growth is unknown in the context of a reduced total envelope (government and donor funds) for FP.* |
| *Understanding how health care is decentralized across different geographic levels (from national to county), within various government departments, and among semi-autonomous agencies like PPB and KEMSA, is crucial. This insight allows an understanding of key actors and their responsibility for providing and regulating healthcare services, including family planning (FP), in Kenya.* |
| *The private health sector in Kenya - comprised of NGOs and commercial entities - is an essential and well-used resource for meeting health needs, including FP needs, with 33% of women obtaining their modern contraceptive method from the private sector.* |
| *Free, publicly procured contraceptive implants dominate the market and are provided to public and private facilities. Most women access implants from the public sector, where it is one of the most popular methods. Private sector reporting of implant data is inconsistent, making it challenging to fully appreciate volumes flowing to the private sector.* |
| *Although the unit cost of implants is higher than other contraceptive methods, when the cost is accounted for per CYP, its price is comparable to other SAMs and LARCs. In addition, the 5-year implant may be more cost-effective than condoms, pills and injectables.* |

# Key insights



| |
|---|
| *Only qualified providers located in facility settings are authorized to insert and remove implants; however, in line with international policy shifts, there are opportunities to look towards additional cadres of healthcare workers to assist with the provision of implants in Kenya.* |
| *Kenya's participation in UNFPA Supplies Partnership enables access to free/heavily subsidized FP commodities that are provided to public and private actors; however, with reducing donor support, it is unclear how the Kenyan government will plug the financial gap to avoid service delivery disruption even when commodity is available.* |
| *A Total Market Approach for FP is an important tool in re-imagining how the FP market can function as donor funding continues to decline. While a comprehensive national TMA for FP Strategy exists, it has failed to gain meaningful traction due to a lack of leadership and resources.* |
| ***HEALTH PROBLEM*** |
| *MMR in Kenya remains high and the rate of decline is insufficient to achieve the Sustainable Development Goals' (SDG) maternal morbidity target. Expanding access to modern FP, including contraceptives implants, is critical to achieving the SDG.* |
| *Over the last 30 years, Kenya has made steady progress towards its mCPR goal; however, with donor funding declining since 2020, contraceptive use has stagnated, introducing uncertainty over Kenya's ability to achieve its mCPR target.* |
| *Kenya's method mix has changed over the last decade with implants rapidly becoming the most popular method following their introduction. However, implant coverage in the private sector appears to have remained relatively stagnant.* |
| *10% of all WRA have an unmet need for FP. Expanding the private contraceptive implant market is an opportunity to help address this unmet need and reach FP2030 goals.* |
| *In comparison to all women, poor women, rural women, and young women have higher unmet need for FP. However, given the challenges poor and rural women face accessing the private sector, young women are likely the priority audience for the private sector implant market to reach new FP users. Other key audiences for the private sector contraceptive implant market may include wealthy women accessing free public sector services and FP discontinuers.* |
| *Three consumer audiences for the private sector implant market are proposed: (1) contraceptive method new users (i.e., young women interested in LARCs); (2) wealthy women currently accessing FP from the public sector; and (3) women who discontinued their method within the private sector but are open to new methods.* |
| *Our preliminary analysis of the market potential is over 500,000 contraceptive implant users in the private sector annually, which more than doubles current users. These estimates are based on conservative assumptions to offer rough estimates of market growth until 2030, i.e., when FP2030 goals should be met. The circumstances of decreasing donor subsidy may necessitate a shift in the total market, affording an even greater opportunity for the private sector.* |

# Key insights



| *CONSUMER BEHAVIOR* |
| --- |
| *Implants and injectables are favored in Kenya. Negative beliefs about contraception deter some non-users, emphasizing the need for accurate information. The growing demand for implants presents an opportunity for private-sector involvement and informed decision-making.* |
| *A consumer archetype for implants is not defined in Kenya, although broader FP archetypes exist, offering insight into the needs, wants and desires of consumers. An FP archetype for young married women has been adapted* as a *proposed implant market priority audience. Archetypes should be developed for wealthy women currently accessing FP from the public sector and women who discontinued their method as two other audiences for the contraceptive implant market.* |
| *Kenya can build demand generation efforts based on existing consumer journeys like this one for Shiru, the mature minor, developed by Ipas in 2023. Consumer journeys should be developed/adapted for other key archetypes including women switching from the public sector to the private sector and method switchers.* |
| *MARKET PERFORMANCE* |
| *There has been a trend of increasing FP volumes and implant volumes in the Kenyan market, yet these volumes dipped in 2021. Whilst most implants directly enter the public sector, it is not clear how much of this volume enters into private markets. This is due to formal and informal donations of implants from the public sector to the private sector and parallel channels that may not be reported.* |
| *Implants have been available in the Kenyan market for the last 30 years. Two products, Jadelle and Implanon NXT, each hold a significant market share of 40%, while the third product, Levoplant, holds the remaining share.* |
| *Women who obtain implants from the private sector access them from non-NGO private medical facilities with poor data reporting into the government system, which hampers the visibility into the private sector.* |
| *The private sector currently accesses free commodities, although this is expected to change as donor funding for commodity procurement drops. With significant fee variations in the private sector and limited insurance coverage, measures are needed to ensure affordability for implants in the private sector as the donor landscape transitions.* |
| *Implants are a demanded form of FP in Kenya, yet most are accessed from the public sector. Healthcare professionals, in particular nurses and CHWs, could be well positioned to promote implants in the private sector, yet inconsistent supply, a lack of training and minimal incentives for providers are a barrier to implant promotion in the private sector.* |

# Key insights



| *MARKET STRUCTURE* |
| --- |
| ***The contraceptive implant supply chain is dominated by public sector commodities**, supported by donors, with no established alternative in place and no compelling incentives for the private sector to invest in a contraceptive implant supply chain. With subsidies decreasing, the entire implant supply chain, and therefore the implant market, is vulnerable to an uncertain future supply.* |
| *The value chain for contraceptive implants is a complex system involving multiple stakeholders. The private sector lacks a well-defined supply chain for these products, and the majority of contraceptive implants make their way into the private sector through the public sector. This transfer can occur through formal channels or informally as free commodities are traded by distributors on the black market.* |
| *Implant supply to the private sector is dominated by volumes procured in the public sector. Existing donor and government agreements with pharmaceutical companies support the public supply chain, limiting the business case for the private sector.* |
| *There is a lack of coordination in the private sector implant market. Given the diminishing donor support, private sector engagement will be key as the government strives for self-sustainability in FP financing by 2026.* |
| *Current FP policy and regulation are in place, however it is poorly regulated in the private sector . The upcoming revision of FP guidelines affords an opportunity for stakeholders to ensure an enabling environment for the private sector.* |
| *KEY MARKET CONSTRAINTS* |
| *We've identified seven key constraints to Kenya's Private Sector Implant Market vis-à-vis: (1) government stewardship; (2) lack of coordination of private sector provision; (3) lack of *sustainable* implant availability; (4) unsupportive financing structures; (5) lack of provider capacity; (6) non-enabling policy environment; and (7) lack of awareness of implants.* |
| *These seven key constraints fall at different levels within the 'Production to Use Spectrum', providing more insight into where, exactly, the market is constrained and therefore who might need to be engaged to address these constraints.* |
| *PRIORITIZED CONSTRAINTS* |
| *Four constraints were prioritized by participants in the Kenya workshop based on the filters of; the potential for impact, availability & motivation of stakeholders and feasibility. Please read the Kenya Country Roadmap to understand how Kenya's value chain actors aim to tackle these four constraints over the next 7 years, in support of FP2030 goals.* |

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