Ministry of Public Health and Sanitation

# 2011Kenya Urban Reproductive Health Service Delivery Report

## Report of the 2011 Baseline Service Delivery Point Survey for Tupange, The Kenya Urban Reproductive Health Initiative

December 2011

KEMRI Kenya Medical Research Institute

MLE Measurement, Learning & Evaluation Project for the Urban Reproductive Health Initiative

This report presents some of the key findings from the service delivery point baseline survey, which was designed by the Measurement, Learning & Evaluation (MLE) project of the Urban Reproductive Health Initiative, the Tupange Project (Kenya Urban Reproductive Health Initiative), and executed by the Kenya Medical Research Institute-Research Care and Training Program (KEMRI-RCTP). Tupange is being implemented by a consortium led by Jhpiego with the following partners: Center for Communication Programs (CCP), Johns Hopkins University; Marie Stopes International (MSI); National Coordinating Agency for Population and Development (NCAPD); and Pharm Access Africa Limited (PAAL). The MLE project is implemented in Kenya by the Carolina Population Center (CPC) at the University of North Carolina at Chapel Hill (UNC) and the African Population and Health Research Center (APHRC).

The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the donor organization, the Bill & Melinda Gates Foundation.

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# Abbreviations

| | |
|---|---|
| APHRC | African Population and Health Research Center |
| CHW | Community Health Worker |
| COP | Combined Oral Pill |
| CPR | Contraceptive Prevalence Rate |
| CWS | Child Welfare Services |
| DRH | Division of Reproductive Health |
| EC | Emergency Contraception |
| FBO | Faith-Based Organization |
| FP | Family Planning |
| GSM | Global System for Mobile Communication |
| IEC | Information, Education and Communication |
| IMR | Infant Mortality Rate |
| IUD | Intrauterine Contraceptive Device |
| Jhpiego | An affiliate of The Johns Hopkins University and the lead Tupange Partner |
| JHU/CCP | Johns Hopkins University/Center for Communications Programs |
| KDHS | Kenya Demographic and Health Survey |
| KNBS | Kenya National Bureau of Statistics |
| KEMRI | Kenya Medical Research Institute |
| KEMSA | Kenya Medical Supplies Agency |
| KEPH | Kenya Essential Package for Health |
| KSh | Kenya Shillings |
| KSDP | Kenya Service Delivery Point Survey of the Kenya Urban Reproductive Health Initiative |
| KURHI | Kenya Urban Reproductive Health Initiative |
| LAPMs | Long-Acting and Permanent Methods |
| LMIS | Logistics Management and Information System |
| MMR | Maternal Mortality Ratio |
| MNCH | Maternal, Newborn and Child Health |
| MLE | Measurement, Learning & Evaluation of the Urban Reproductive Health Initiative |
| MoMS | Ministry of Medical Services |
| MOPHS | Ministry of Public Health and Sanitation |
| MSK | Marie Stopes Kenya |
| NCAPD | National Coordinating Agency for Population and Development |
| NGO | Nongovernmental Organization |
| NMR | Neonatal Mortality Rate |
| PAC | Post-abortion Care |
| PAAL | Pharm Access Africa Limited |
| PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| PNC | Postnatal Care |
| POP | Progestin-Only Pill |
| STI | Sexually Transmitted Infection |
| RH | Reproductive Health |
| TFR | Total Fertility Rate |

| | |
|---|---|
| Tupange | A Kiswahili word roughly translated to “let’s plan,” also the commonly used name for the Kenya Urban Reproductive Health Initiative |
| UNC | University of North Carolina |
| URHI | Urban Reproductive Health Initiative |
| U5MR | Under-Five Mortality Rate |
| VCT | Voluntary Counseling and Testing |

# Preface

The rapid growth of Kenya's population shown by the results of the 2009 Kenya Population Census released last year poses great challenges to the country's economic development, environmental conservation efforts and food security for its citizens. It is almost universally accepted in Kenya that slowing population growth has the potential to reduce poverty, hunger and maternal deaths while contributing substantially to women's empowerment, universal primary schooling and long-term environmental stability. Promoting family planning, therefore, has been identified as a key strategy in overcoming the challenges and achieving the Kenya Vision 2030 (a development plan for the economic, social and political pillars of Kenya). In line with this, the Government of Kenya has set the goal of increasing the use of family planning to 70 percent of women aged 15–49 years by 2015.

The Kenya Urban Reproductive Health Initiative (Tupange), initiated in 2009, therefore comes at an opportune time, as its aim is to increase both the quality and access of family planning services in specific urban areas of Kenya. Two baseline surveys have now been completed for this project. These are the 2011 Kenya Urban Reproductive Health Initiative Service Delivery Point (SDP) Survey, the results of which are presented in this document, and the Kenya Urban Reproductive Health Initiative Household Survey completed in December 2010. Together they establish a baseline for the use of family planning services in the five project urban centers.

The SDP Survey's focus on the urban poor is well-aligned with the national reproductive health strategy, which recognizes the poor as one of the vulnerable populations whose access to reproductive health services needs to be improved. Further, the results of this survey build on findings of other service provision assessment surveys conducted in Kenya, which also included a reproductive health services assessment component. The findings of this survey should not inform only the Tupange project intervention in the coming three years. My hope is that the findings of this survey will be widely used to inform Government policies, programs, project design and future research, as we all work together to attain the national and international reproductive health goals.

On behalf of the Government of Kenya, I wish to acknowledge the generous support of the Bill & Melinda Gates Foundation to the success of this survey. I also wish to thank the institutions and individuals who provided technical support to the survey process, including the Measurement, Learning and Evaluation project (led by the University of North Carolina with the African Population and Health Research Center as a partner), the Tupange team led by Jhpiego-Kenya, and the Research Care and Training Program of the Kenya Medical Research Institute (KEMRI-RCTP).

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# Foreword

The Bill & Melinda Gates Foundation launched the Urban Reproductive Health Initiative (URHI) as part of its Family Planning/Reproductive Health (FP/RH) Strategy, with the goal of significantly increasing modern contraceptive prevalence rates in selected urban areas of Kenya, Nigeria, Senegal and Uttar Pradesh, India. The Measurement, Learning & Evaluation (MLE) project is serving as the main source of support to implementing country consortia and the Bill & Melinda Gates Foundation in the collection, analysis, use and communication of evidence of URHI. Since its inception in early 2009, MLE has been providing technical assistance to country consortia and selected research agencies, and in taking the lead in planning and executing the comprehensive baseline surveys in the target countries.

We are delighted to present the baseline Service Delivery Point Survey Report for Kenya, whose initial drafts were designed and written by the Kenya Medical Research Institute with technical support from MLE. The final report of the survey was written by the MLE project constituents—the Carolina Population Center at the University of North Carolina at Chapel Hill (CPC-UNC) and the African Population and Health Research Center (APHRC)—in collaboration with and with inputs from the Kenya Urban Reproductive Health Initiative (Tupange).

The baseline service delivery point survey was executed in the five target cities and urban centers (Nairobi, Mombasa, Kisumu, Kakamega and Machakos) by the Research Care and Training Program (RCTP) of the Kenya Medical Research Institute (KEMRI) with oversight from MLE and Tupange. We would like to acknowledge the contributions of the RCTP-KEMRI staff at various levels, in particular Dr. Elizabeth Bukusi, the overall survey Technical Lead and Principal Investigator; Dr. Maricianah Onono, Survey Coordinator; Mr. Zachary Kwena, a Technical Lead in the survey implementation, Mr. Charles Kibaara, a Technical Lead in data management; Dr. Serah Gitome, Assistant Survey Coordinator, Ms. Mable Jerop, the Data Manager; and Mr. Bernard Majani, a GIS Specialist/Field Supervisor. We are grateful to Mr. Antony A.K.M. Kilele, the Director General for Kenya National Bureau of Statistics, Ministry of State for Planning and Vision 2030; Mr. George M. Obudho, the Acting Director of Population and Social Statistic, KNBS; and Dr. Boniface K'oyugi, Director General, National Coordinating Agency for Population and Development (NCAPD), Ministry of State for Planning and Vision 2030, for their leadership and technical advice. We wish to acknowledge Dr. Issak Bashir, Head, Division of Reproductive Health, Ministry of Public Health and Sanitation; and his team, including Dr. Shiphrah Kuria, Deputy Head; Dr. Jonah Maina, Head of FP Program; Cosmos Mutunga, Program Officer; Fatuma Dagane, Senior Program Officer; and Ruth Muia, Program Officer, for their valuable input during the survey.

We would also like to acknowledge the untiring effort by the entire MLE team at CPC-UNC and APHRC, namely, Prof. David Guilkey, Project Director; Dr. Ilene Speizer, Deputy Director; Mrs. Beverly Tucker, Deputy Director; Dr. Gwendolyn Morgan, Technical Lead; Mr. Paul Kuria, Kenya Country Manager; Mr. Joshua Davis, Technical Officer; Mr. Michael Mutua, Data Analyst; and Dr. Estelle Sidze, a Post-Doctoral Fellow.

The baseline survey and its report benefited greatly from the contributions of the Tupange team, namely, Dr. Janet Omyonga, Deputy Director Tupange; Dr. Linda Archer, Jhpiego Kenya Director of M&E; John Mark Udalang, formerly M&E Advisor at Jhpiego; MaryStella Barasa, Senior M&E Advisor; Debbie Gachuhi, Senior Demand Creation Advisor; Dr. John Kembe, Senior Private Sector Advisor; George Kichamu, Senior Advocacy and Policy Advisor; Parmindar S. Lotay, Senior Logistics Advisor; Boniface Njenga, Senior Technical Advisor – Commodity Security; Paul Nyachae, Technical Officer; and Alan Johnston, Advocacy Consultant. We are grateful for the leadership and management support provided by the Jhpiego

team: Nelson Keyonzo, Director, Tupange; Dr. Isaac Malonza, Kenya Country Director; Dr. Ronald H. Magarick, Director, Global Programs; Ronald Geary, Chief Financial Officer; Dr. Pamela Lynam, Kenya Senior Technical Director; Rajshree Haria, Kenya Director, Finance and Administration; Stuart Merkel, Kenya Senior Program Advisor; and Titus Wambua, Kenya Internal Auditor.

It is our sincere hope that this report, along with the 2010 Kenya Urban Household Baseline Survey and the recently published MLE Technical Working Paper 3-2011, which describes trends and differential in key family planning and reproductive health indicators in urban Kenya over the last 15 years, will help Tupange fine-tune its program of interventions geared toward significantly increasing the contraceptive prevalence rate in the intervention sites.

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# Executive Summary

## Background

This report summarizes the findings of a facility survey undertaken between August and November 2011 as part of the impact evaluation of Tupange, the Kenya Urban Reproductive Health Initiative. The survey, designed by Measurement, Learning & Evaluation (MLE) of the Urban Reproductive Health Initiative project, covered a wide range of health facilities in urban centers of Nairobi, Mombasa, Kisumu, Machakos and Kakamega. The survey findings provide baseline evidence for the anticipated health outcomes and impact of KURHI and complement findings of the household survey completed in 2011.

## Methodology

Data were collected from 279 health facilities (87 public and 192 private) and 223 pharmacies selected in the five intervention urban centers. At each of the health facilities, assessment teams conducted a health facility audit. Additionally, four service providers in each of the selected facilities were randomly sampled and interviewed. A random sample of women of reproductive age (15–49 years) from a selected number of health facilities were interviewed after receiving FP and other RH services. Data collection for all interviews was done face-to-face. In addition, observations were made on the facility physical infrastructure and family planning commodities. Data entry, cleaning and analysis were done by a team of trained staff.

## Summary of Findings and Programmatic Implications

Overall, most of the health facilities (93 percent) offered family planning and counseling services. In all the urban centers, all public facilities offered FP services and counseling. Generally, public facilities had a higher number of clients accessing their FP services than private facilities.

FP methods tend to be more widely available in public than private health facilities. Clients can generally access FP services at least five days a week at a reasonable cost and with ease of access, especially for oral pills and condoms. Between 74 percent and 100 percent of the facilities were offering antenatal care, and detection and treatment of sexually transmitted infections (STIs), HIV and AIDS, child welfare services, and postpartum care services, therefore providing opportunities for integration of FP services.

*Infrastructure and Commodity Security:* A majority of facilities have essential facility-level amenities and physical infrastructure components to provide FP services. Stock-outs were most common for injectables and condoms. Public facilities tended to use the Kenya Medical Supplies Agency (KEMSA) as their main source of FP commodities, followed by the District Store (DS). Poor staff capacity on monitoring and management of commodities can exacerbate an already tenuous supply chain. These findings point to a need to increase the regular supply of FP methods, improve distribution and redistribution of FP commodities from storehouses, and improve the logistics management and information system (LMIS).

*Integration of FP services:* Provision of FP services to clients seeking non-FP, MNCH services is inadequate due to sub-optimal integration of FP services with these services at the client level (HIV/AIDS, TB, STI, PMTCT services). The result of this situation is that the FP needs of some of the non-FP MNCH clients are not met.

*Service Provision Capacity:* Staffing for FP/MNCH in the facilities was dominated by nurses and clinic officers at the clinic and health center levels, with doctors being more prominent in hospitals. Among service providers, the interviews found high levels of pre-service education in

FP among doctors and clinical officers, but lower levels among nurses. All cadres had low levels of pre-service and in-service education on the 2006 (New) Comprehensive Reproductive Health Curriculum. There were disparities in pre-service training among cadres but no concomitant difference for in-service training in FP methods. The findings showed there is need for improvement in the scope, content and frequency of in-service training for nurses and other health provision staff.

*Community and the client:* Overall, the majority of the FP users reported that they would use the facility in the future or recommend it to family/friends. Improvement of various aspects of client satisfaction such as visual and aural privacy as well as client waiting time may improve retention of FP clients.

## Key Recommendations

- Work with DRH to ensure facilities in the intervention areas have necessary equipment and infrastructure to provide quality services.
- Strengthen KEMSA and district store supply chains to reduce stock-outs of various FP methods across the facilities and also distribute FP promotion materials in pharmacies.
- Improve the distribution of a mix of RH services in facilities and ensure their availability at all service delivery points.
- Ensure that the costs of FP services and methods are made affordable, whenever possible, in all facilities.
- Make FP information and clinical services readily available to all clients seeking MNCH services as the surest way of reducing missed opportunities in reaching potential FP clients.
- Improve pre-service and in-service training for all cadres on the New Comprehensive Reproductive Health Curriculum and provision of long-acting and permanent methods (LAPM).
- Encourage recruitment and training of community health workers (CHWs), especially in private facilities, in order to increase FP service provision at the community/individual level.
- Encourage interventions seeking to empower providers to initiate good provider-client relationships to improve service delivery and enhance client satisfaction.

**Map of Kenya Showing the Five Urban Areas Where the Tupange SDP Survey was Conducted**

# Chapter 1: Introduction

## 1.1 Overview and Objectives of Tupange/MLE Study

The global reproductive health community requires strong evidence to support the expansion and development of family planning programs in areas with high unintended pregnancy and maternal and infant mortality. The Bill & Melinda Gates Foundation (BMGF) Reproductive Health (RH) Strategy aims to reduce maternal and infant mortality and unintended pregnancy in the developing world by increasing access to high-quality, voluntary family planning (FP) services. The RH Strategy is implemented at the country level through the Urban Reproductive Health Initiative (URHI).

The Initiative aims to increase modern contraceptive use in selected urban areas of three countries in sub-Saharan Africa (Nigeria, Senegal and Kenya) and in South Asia (the state of Uttar Pradesh, India). In Kenya, Jhpiego, along with NCAPD, JHU/CCP, MSK and PharmAccess LTD, is undertaking the URHI project called Tupange in Nairobi, Mombasa, Kisumu, Machakos and Kakamega.

The main objective of the Service Delivery Point (SDP) survey is to collect information on the delivery of family planning services in the five Tupange intervention urban centers in Kenya in order to inform program interventions. The SDP survey examines family planning service provision and its integration with maternal, newborn and child health and HIV/AIDS services.

Key objectives of the Initiative include:

1) Integration of FP services with maternal and newborn health and HIV/AIDS services
2) Improvement in the quality of FP services in strategic facilities
3) Increased FP access through public-private partnerships
4) Creation of sustained demand for FP services among the urban poor
5) Creation of a supportive policy environment for increasing funding and financial mechanisms for family planning services for the urban poor

Information from the SDP survey will form part of the evidence required for an impact evaluation of the Urban Reproductive Health Initiative on the supply environment for modern contraceptives.

## 1.2 Overview of Health Systems in Kenya

The last two decades saw marginal improvements in the health status of Kenyans; however, certain health indicators suggest a worsening rather than an improvement in the situation (National Coordinating Agency for Population and Development, 2011). For instance, despite an improvement in the infant mortality rate (IMR) and under-five mortality rate (U5MR) between 2003 and 2008, the maternal mortality ratio (MMR) appears to have increased within the same time period. The current life expectancy, at 57 years, has only slightly improved since 1999, when it was 54.3 years (Bureau, 2010, National Coordinating Agency for Population and Development, 2011). High fertility, high incidence of infectious diseases, poverty and poor access to health services are some of the key contributing factors to the deteriorating health status of Kenyans (National Coordinating Agency for Population and Development, 2011, Kenya National Bureau of Statistics, 2009).

By 2009, Kenya's population stood at 38.6 million, a 33 percent increase since the last census (Statistics, 2010; KNBS, 2010), with women making up slightly more than half of the population

and nearly 64 percent of the population aged below 24 (Statistics, 2010). At present, Kenya's urban population is estimated at 32 percent of the country's total, with between 60and 80 percent of these living in slums (UN-Habitat, 2008). As is evident in several other sub-Saharan Africa countries, there is a disconnect between the speed of urbanization and the provision of essential health infrastructure and services, with the urban poor population having little to no access to basic health services. Urbanization and the attendant poverty, in particular,limit access to FP services. Although the contraceptive prevalence rate (CPR) is higher in urban than in rural areas (KNBS, 2010), 23 percent of the total demand for family planning still remains unmet in urban areas of Kenya (MLE, 2011). Kenya has a current fertility rate of 4.6 live births per woman and an annual population growth rate of 2.9 percent, with projections showing Kenya's population is likely to more than double by 2040. These trends threaten the country's capacity to achieve its Vision 2030 (Government of Kenya) and justify calls for heightened attention to the country's family planning program to ensure increased funding for FP services, enhanced availability of these services and strengthening of public-private partnerships to expand access to all who need FP services.

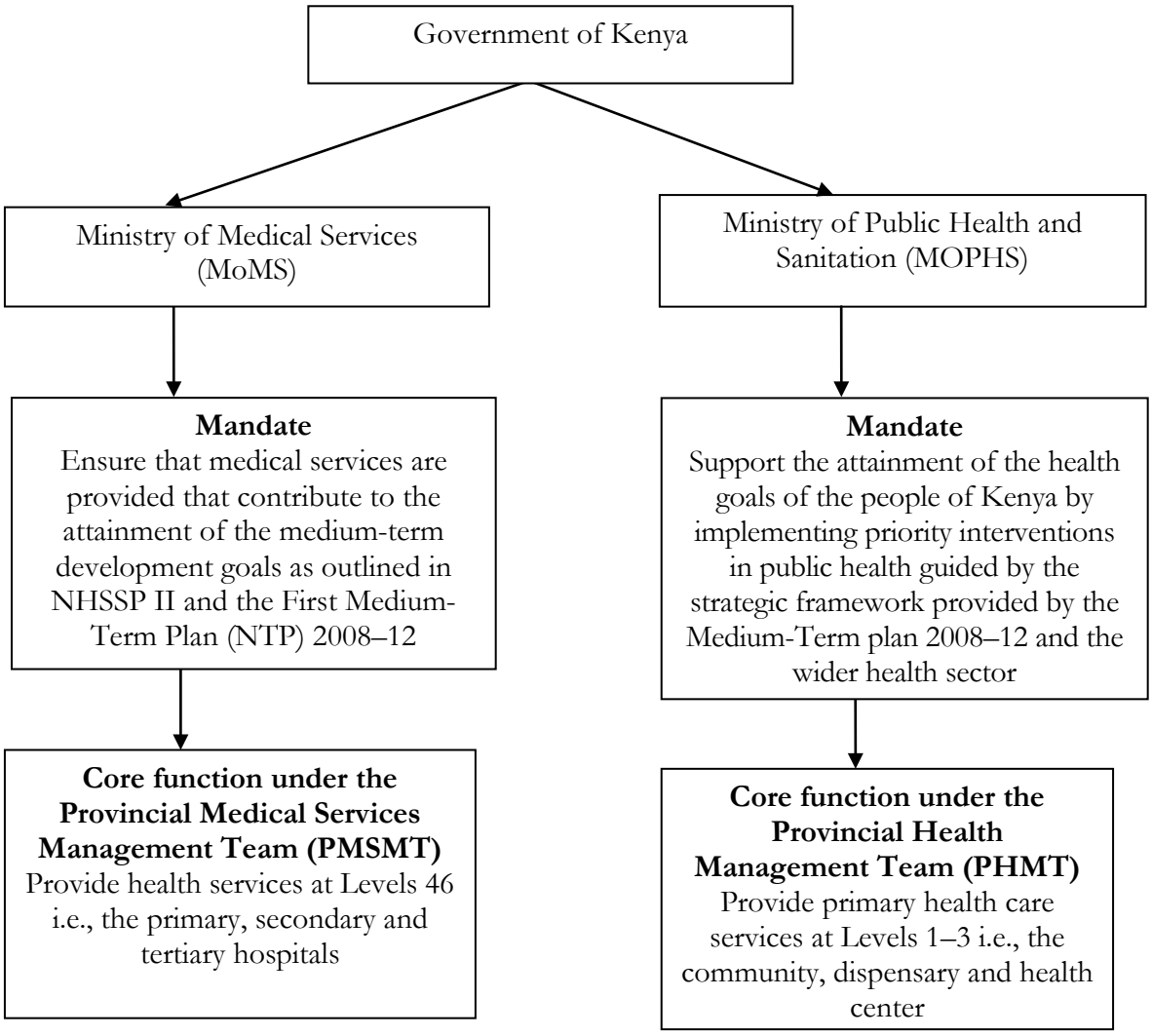
Since the adoption of the Primary Health Care (PHC) package in the 1970s as a service delivery approach, the Government of Kenya has continually adopted additional policies and strategies over the years in order to combat the ever-present social and economic challenges in health service delivery (National Coordinating Agency for Population and Development, 2011). A key national level strategy is the Kenya Vision 2030, the country's economic development blueprint, which seeks to transform Kenya into a newly industrializing, middle-income country providing a high quality of life to all its citizens by the year 2030 (Kenya, 2007). Under the social pillar, the country aims to improve the livelihoods of Kenyans through provision of an efficient and high-quality health care system with the best standards (Kenya, 2007). There is a special focus on improving areas where Kenya is still lagging behind the Millennium Development Goal targets such as lowering of the infant mortality rate and improvement of maternal health. The Kenya Vision 2030 is in line with the 2010 constitution of Kenya, which clearly stipulates that every Kenyan has a right to the highest attainable standard of health, including the right to life, reproductive health and other standards of well-being (Ministry of Medical Services, 2010a).

By focusing on reducing inequalities in health care and reversing the declining trend in health-related impact and outcome indicators, the second National Health Sector Strategic Plan (NHSSPII) (Health, 2005) is well-poised to execute the mandate of the new constitution and the Kenya Vision 2030 (Health, 2005, National Coordinating Agency for Population and Development, 2011). The NHSSP II vision of providing comprehensive, integrated, curative and preventive health services available and accessible to all at the first point of contact is also embodied in the Kenya Essential Package for Health (KEPH) (Health, 2005). This strategic plan represents a clear shift in focus from merely reducing the disease burden to promotion of healthy lifestyles of individuals and communities through enhanced collaboration with existing essential service packages under the KEPH system. Through developing relevant reproductive health policy, improving commodity security and scaling up the uptake of FP services to reach even the lowest wealth and education quintiles, the Division of Reproductive Health in the Ministry of Public Health and Sanitation plays a key role in steering the country toward improving maternal health and reducing childhood mortality in line with the Millennium Development Goal targets (Ministry of Medical Services, 2009).

The current Kenyan health system is anchored in the 1994 Health Sector Policy Framework and is organized as shown in Figure 1.1. Under the current constitution's proposed devolution plan, care will be focused at the county level as opposed to the existing provincial and district level structures. This will have important implications for various activities that pertain to reproductive health services, such as overall management of county health facilities, assets and liabilities, and the size of the health workforce at the county level, where a majority of clients will access these services and where procurement of supplies such as FP commodities will occur. A

smooth transition from the national to the county health service systems is imperative to ensure reproductive health services provision is not adversely affected, further delaying the achievement of key national and international reproductive health goals.

Figure 1.1: Organization of the Kenyan Health System 2008–2012 **(MOPHS, 2008, MoMS, 2008)**




## 1.3 Health Care Financing

The Kenyan health sector continues to be underfinanced, with the national budgetary allocation being well below the recommended target of 15 percent of the government budget as per the Abuja declaration (Ministry of Medical Services, 2009, National Coordinating Agency for Population and Development, 2011). In the 2010/11 financial year, 6.5 percent of the total budget was allocated to the health sector, a drop from 7.0 percent in the 2009/10 financial year (National Coordinating Agency for Population and Development, 2011). In terms of expenditure, the total health expenditure between 2001/2 and 2009/10 increased by 49 percent from KES 82.2 billion to KES 122.9 billion, translating to a total health expenditure per capita increase from KES 2,636 (US $ 34) to KES 3,203 (US $ 42) (Ministry of Medical Services, 2010b). However, against a backdrop of increasing total government expenditure, this reflected a decline in total health expenditure from 8.2 percent to 4.6 percent of the total expenditure (Ministry of Medical Services, 2010b).

The government is the chief financier of reproductive health expenditure in Kenya, contributing 40 percent of the total health expenditures on reproductive health while the private sector's role in financing has steadily declined from 41 percent in 2005/2006 to 38 percent in 2009/2010 (Ministry of Medical Services, 2010b). Public facilities continue to be the major managers of reproductive health expenditure in line with their contribution as the main providers of RH services. Interestingly, the utilization of total health expenditures on reproductive health resources by private pharmacies and community health workers, though marginal, increased by more than 1,000 percent between 2005/6 and 2009/10, implying that women were increasingly accessing RH services outside of the conventional health facilities in the public and private sectors (Ministry of Medical Services, 2010b).

Government allocation for procurement of family planning commodities steadily rose over the years from KES 150 million in 2005/6, to nearly KES 523 million in 2008/9. Comparatively, the cost of family planning commodities is projected to rise from KES 2.02 billion in 2009/10 to KES 3.5 billion in 2011/12, indicating that there might be a deficit of close to KES 7.0 billion in funding. This calls for enhanced government funding and strengthening of public-private partnerships in order to lower the unmet need for family planning.

## 1.4 Human Resources for Health and Health Information Systems

Kenya's health workforce is characterized by acute shortages of health workers as well as a mal-distribution of workers by urban/rural areas, regions and level of care, with more health care workers existing at higher levels of service delivery due to better incentives (Ministry of Medical Services, 2010a). This impairs service delivery across all levels of care. The Norms and Standards for Health Service Delivery 2006 define the need for different health care system levels in order to ensure an adequate and appropriate workforce for the workload (Health, 2006a).

Adequate availability of skilled health care workers at the first, second and third levels of care (i.e., the community, dispensary and health center) is vital to improving service quality and responsiveness in the delivery of reproductive health services (MOPHS, 2008).. In addition, it is reccomended that there be one clinical officer at each Level 3 facility who provides the first referral level and management for outpatients, and one medical officer at each Level 4 facility who receives referrals from Level 2 and 3 facilities and handles most of the RH issues (Ministry of Medical Services, 2009). Level 5 facilities, with more medical specialists, provide specialized care to clients and operate at least one outreach activity per month to Level 4 facilities in their area; this facilitates specialized care at Level 4 facilities and capacity-building for medical officers through on-the-job skills transfer (Ministry of Medical Services, 2009). Given this staffing recommendation, the KSDP assessment of the cadres of staff and the skill set currently available at Kenyan health facilities, as pertains to reproductive health provision, will provide information that is relevant to the implementation of strategies aimed at improving FP provision in urban areas.

Monitoring and evaluation of the KEPH is a crucial component of the NHSSP II and is coordinated by MOPHS and MoMS through the Division of Health Information Systems (DHIS). The DHIS contributes to evidence-based decision-making in the health sector by collecting, collating, analyzing and disseminating health and management data/information to both public and private stakeholders (Ministry of Medical Services). Utilization of Information, Communication and Technology (ICT) has been identified as a key component to improving communication and data transfer from the districts and service delivery points (MOPHS, 2008). Timely decisions at all levels of care, based on data collected, has the potential to greatly impact the overall implementation of the national reproductive health policy, real-time tracking of FP services access and FP commodity supply, all geared toward reducing the unmet need for family planning. A weak health information system, due to lack of policy and guidelines, unskilled

personnel handling data, staff inadequacies and poor coordination of data systems has been identified as a key challenge in the current national health information system.

## 1.5 Overview of Fertility and Family Planning in Kenya

Kenya's total fertility rate (TFR) has steadily declined from 8.1 births per woman in 1978 to an all-time low of 4.6 births per woman in 2008. However, the TFR has stagnated within a range of 4.6 to 4.9 for the last one and a half decades. There have been significant differences between the fertility rates in rural areas (5.2) and urban areas (2.9). Despite an increase in the overall number of women using contraception, a survey of women in urban areas found that between 18 and 33% of married women still had an unmet need for family planning (MLE 2011). Kenya's CPR stands at 46 percent, with 39 percent of married women using a modern method of family planning. An increase in uptake of modern family planning methods has been the driving force in rising CPR in Kenya since 2003, implying that any intervention to raise the CPR should include improving access to these modern methods of family planning for a majority of the women who need them.

### 1.5.1 Introduction to Family Planning Services in Kenya

A robust and comprehensive family planning program dating back to the 1960s in post-independence Kenya, coupled with a rising CPR, contributed to a decline in the total fertility rate from more than 8 live births per woman to approximately 5 live births in the mid-1990s (National Coordinating Agency for Population and Development, 2011). The effects of the HIV epidemic in the 1990s drew attention away from family planning programs, leading to stagnation in the CPR and TFR as donor funding declined and political focus shifted (Kenya Service Provision Assessment (KEPSA). According to the Kenya KSPA survey conducted in 2010, 85 percent of Kenyan health facilities offer modern contraception, with government-managed facilities taking the lead in the provision of FP services. A majority of public sector facilities, as well as a number of regulated private sector facilities, receive their family planning commodities from the Kenya Medical Supplies Agency (KEMSA). In a pilot program for FP provision, all facilities in Nairobi, Central and North Eastern provinces as well as all Level 5 and 6 facilities changed over to a "pull system," where they order their contraceptive stocks based on need from a central district store supplied by KEMSA. This contrasts with Levels 2 to 4 facilities, which receive a standard contraceptive pack of commodities from KEMSA on a quarterly basis, referred to as the "push system." The pilot program will be eventually rolled out in all provinces in Kenya.

## 1.6 National Reproductive Health Policy

In line with the Kenya Vision 2030, the goal of the Kenya National Reproductive Health Policy (NRHP) is to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to client needs including groups with special needs (Ministry of Medical Services, 2009). This policy, which was first adopted in 2007, aims to increase CPR to 56 percent by 2015, meet 70 percent of the total FP demand and contribute to the achievement of Vision 2030 and health related MDGs (Health).

The NRHP ensures the interlinking of reproductive health with other development sectors through a multisectorial approach. Specific to the maternal and newborn child health agenda, this strategy is designed to ensure that every pregnancy is wanted, all pregnant women and their infants access skilled care, and that every newborn has access to care (Ministry of Medical Services, 2009). The NRHP also recognizes the large unmet need for FP, which is projected to grow by 200,000 per annum between 2005–2015 (GOK DRH, 2011). The harmful impact of this unmet need is further compounded by a declining uptake of long-acting and permanent methods of family planning and the fact that uptake of FP services is lower among populations

in the bottom wealth quintiles (Kenya National Bureau of Statistics, 2009). The NRHP policy aims to reduce the unmet need for FP through an improved policy environment for FP services delivery and increased availability and uptake in utilization of FP services
The policy also has a mandate to improve integration of HIV/AIDS and RH information and services, as well as to promote utilization of information and services at all levels of health care. These efforts will contribute to the reduction of HIV/AIDS burden and improved reproductive health status of those infected and/or affected by HIV through improved integration of HIV/AIDS and RH information and services, as well as promoting utilization of information and services at all levels of health care (Kenya National Bureau of Statistics, 2009).

### 1.6.1 Family Planning and MNCH Services in Kenya

Maternal health is inextricably linked to child health and is more evident in developing countries where a mother's death at childbirth results in an increased likelihood of the newborns death (Bureau, 2006). With less than half of pregnant women in Kenya attending the four recommended antenatal care visits and only 44 percent receiving skilled birth attendance during delivery, the maternal mortality ratio has remained high at 488 per 100,000 live births (KDHS (2008/09). Low uptake of maternal and child health services severely hampers the country's progress toward reducing maternal deaths to 147 per 100,000 live births by 2015 in accordance with the Millennium Development Goals (MOPHS, 2008). Despite a 30 percent decline in the IMR and U5MR between 2003 and 2008, the neonatal mortality rate (NMR) only marginally decreased, implying the need to increase availability of and access to immediate skilled care for newborns (Kenya National Bureau of Statistics, 2009).

Increasing access to family planning has the potential to reduce MMR/IMR (Graham et al., 2006, Singh S, 2009). However, the quality of care is often poor and many women and their infants are not encouraged to seek care until six weeks after delivery. Effective counseling and provision of FP to individuals who want to delay or cease childbearing is expected to result in fewer unintended pregnancies and a decrease in mother-to-child transmission of HIV, illegal abortion and its sequelae, maternal and neonatal morbidity and mortality, as well as other health and societal costs related to unintended pregnancies and vertical transmission of HIV (Brocklehurst and French, 1998, Fleischman, 2006).

Global health initiatives such as the Partnership for Maternal, Newborn, and Child Health and the Alliance for Reproductive, Maternal and Newborn Health recognize the importance of an integrated approach to improving maternal health and reducing childhood mortality (Bureau, 2006, Alliance for Reproductive, 2011). Integration of maternal, newborn and child health services promotes more efficient and effective use of resources while accelerating progress toward achievement of the Millennium Development Goals (Alliance for Reproductive, 2011, Bureau, 2006). Under the Global Health Initiative, Kenya aims to coordinate an integrated approach to produce a positive, comprehensive public health outcomes effect for women, children and their families through health systems strengthening, integrated service delivery and demand creation for maternal and child health services (Development, 2011, USAID, 2011).

# Chapter 2: Study Methodology

## 2.1 Overview

The 2011 Tupange/MLE service delivery point (SDP) survey is a facility-based survey designed to provide information on the preparedness of the health facilities to deliver high-quality family planning services by examining provision of FP services and their integration with maternal, newborn and child health and HIV/AIDS services in five urban areas of Kenya. Information from the 2011 SDP survey will form a baseline for evaluation of the impact of the Urban Reproductive Health Initiative. Similar surveys are planned for in Senegal, Nigeria, and India.

## 2.2 Survey Organization

The Tupange/MLE Baseline SDP survey was implemented by the Research Care and Training Program (RCTP) of the Kenya Medical Research Institute (KEMRI), in collaboration with the Ministry of Public Health and Sanitation (MOPHS), and the Ministry of Medical Services (MoMS). The survey received technical assistance from the Measurement, Learning and Evaluation (MLE) Project, implemented by the University of North Carolina, Chapel Hill, which is represented in Kenya by the African Population and Health Research Center (APHRC). The study was funded by the Bill & Melinda Gates Foundation (BMGF) of the United States of America through Jhpiego, an international non-profit health organization affiliated with The Johns Hopkins University. Other partners and stakeholders of Tupange involved in this study include the Johns Hopkins University Center for Communications Programs (JHU/CCP), the National Coordinating Agency for Population and Development (NCAPD), Marie Stopes Kenya (MSK) and Pharm Access Africa Limited (PAAL).

The objectives of the 2011 KSDP were to:

a) Assess the preparedness of the health facilities and pharmacies in five urban areas of Kenya to provide quality family planning services
b) Estimate levels of integration of FP services with maternal and newborn child health and HIV/AIDS services
c) Assess the capacity of the health facilities, pharmacies and health personnel to provide FP services
d) Document current medical supplies management and record keeping practices
e) Examine storage conditions and frequency of stock-out of FP commodities
f) Document clients' satisfaction and perceptions on quality of FP services offered in health facilities
g) Describe the general processes used in providing FP services and the extent to which quality control procedures and accepted standards for quality service provision are followed

The 2011 KSDP survey is a baseline for a study that used a quasi-experimental longitudinal design (with mid-term and end-of-project at two-year increments), and was implemented in selected health facilities and pharmacies in Nairobi, Mombasa, Kisumu, Machakos and Kakamega. In 2009, Tupange identified Nairobi, Mombasa and Kisumu as the early or Phase I intervention areas; project activities in these cities began in July 2010. In these three cities, the KSDP was implemented in selected strategic[1] health facilities and pharmacies identified by Tupange as intervention outlets. MLE identified the comparison group to include health facilities

[1] The *Tupange* intervention strategy defines strategic health facilities and pharmacies as outlets with high volume of clients served for either one or more of the following services: FP, maternal, child and newborn, delivery, post-abortion care, STI, HIV and AIDS management services, or are geographically located in a strategic position to serve marginalized populations or urban poor.

and pharmacies from data collected through a household survey in 2010,[2] which provided a list of health facilities and pharmacies where women ages 15–49 obtained their current method of family planning *("preferred facilities")*.

Machakos and Kakamega are Tupange delayed or Phase II intervention areas, where the intervention will be scaled up in 2013 based on evidence and lessons learned from the three early intervention cities. In the scale-up urban centers, the KSDP survey was implemented in all facilities and pharmacies available. In all urban centers, both private and public health facilities were surveyed. The facilities and pharmacies included in this baseline survey will be followed up at two points in two years (at the midline), and four years (at the end line) to provide reliable and comprehensive data for an impact evaluation of the Tupange project.

### 2.2.1 Methods of Data Collection

Three main data collection tools were used: the facility audit questionnaires (separate tools for facilities and pharmacies), the exit interviews and the health care provider interviews.

The facility audit questionnaire was designed to collect the following:

- Information on the range and type of health services offered in the selected facilities
- The facility's human resource capacity
- Availability of qualified health providers to offer FP services
- Infrastructure elements necessary to provide a level of FP service that meets acceptable standards
- Availability and utilization of selected guidelines and procedures during delivery of FP services
- Type of health services available
- General procedures and practices followed when delivering FP services
- Availability of FP methods
- Procurement and management of medical supplies
- Frequency of FP commodities stock-outs
- Availability of information, education and communication (IEC) materials on FP
- Availability of community health outreach programs

The pharmacy audit tool was designed to collect data on operating hours, the presence of a trained pharmacist or medical personnel in the outlet, ordering and management of medical supplies, availability and stock-out levels of FP commodities, storage conditions of FP products, price of FP commodities by brand, record keeping and availability of FP IEC materials.

Using the service providers' questionnaires, interviewers collected information on providers' qualifications (pre-service training, experience and continued in-service training), supervision they received, and ability to integrate FP service provision in departments to which they are mainly assigned. All providers gave written informed consent prior to being interviewed.

2 For more information on the 2010 household survey methodology see the report MLE, Tupange and KNBS. 2011. *Report of the Baseline Household Survey for the Kenya Urban Reproductive Health Initiative (Tupange).* Measurement, Learning & Evaluation of the Urban Reproductive Health Initiative (MLE) [UNC, USA]; Kenya Urban Reproductive Health Initiative (Tupange) [Nairobi, Kenya]; and Kenya National Bureau of Statistics (KNBS) [Nairobi, Kenya].

Women leaving FP, delivery and maternal and child health departments, STI/HIV/AIDS management units and units offering post-abortion care (PAC) were asked to participate in an exit interview. The exit interview included questions on their interaction with providers, particularly on issues that the client and the provider discussed, and whether they received counseling or a method of FP. The interviewer also elicited the clients' perceptions of the service delivery environment. Prior to undertaking the exit interview, clients were asked to give their verbal consent to participate. All survey tools are included in Appendix A.

## 2.3 Sampling

Data were gathered from selected health facilities, health workers at each of the health facilities, a sample of pharmacies and clients from selected facilities who, on the day of the survey, had received family planning, maternal and child health-related services, STI/HIV/AIDS services or post-abortion care.

### 2.3.1 Sample of Health Facilities

The selection of facilities included in the 2011 KSDP varied from urban center to urban center. In Nairobi and Mombasa, the selection was made up of Tupange strategic facilities and facilities identified by women in the Individual Survey as locations where they go for FP methods and services (preferred providers). In Kisumu, the survey encompassed the Tupange strategic facilities plus all the other facilities in the District of Kisumu East. Finally, in Kakamega and Machakos, a census of functional health facilities was conducted.

A total of 286 out of a universe of 934 health facilities in the five urban centers representing 30.6 percent were selected to participate in this survey. Of the 286 facilities, the interview teams collected data from 279, representing a response rate of 98 percent. The persons in-charge in two of the seven non-participating facilities were unavailable at the time of interview or follow-up, while five facilities refused to participate. A total of 112 facilities were located in Nairobi, 60 in Mombasa, 56 in Kisumu, 32 in Machakos and 26 in Kakamega. The types of facilities included hospitals, health centers, dispensaries, private clinics, nursing/maternity homes, missions and NGO-based facilities as shown in Tables 2.1 and 2.2. The health facilities surveyed represent a similar mix of those that are available throughout the urban centers.

### 2.3.2. Sample of Health Service Providers

Service providers who deliver reproductive and child health services on a regular basis were randomly sampled from a list of permanent or regular staff present in the facility on the day of the survey. Providers were listed on a roster and assigned serial numbers, and the interviewers selected four respondents from each facility at random. In facilities with four or fewer providers, all of them were interviewed. A total of 694 service providers were surveyed, as shown in Table 2.1.

| Table 2.1: Distribution of Interview Respondents, by Type of Facility and Location | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Distribution of interviews by urban area, type of interview and result of contact, Tupange/MLE, Kenya, 2011** | | | | | | | | | | |
| **Urban area** | **Public facilities** | | **Private facilities** | | **Total provider interviews** | | **Total exit interviews** | | **Pharmacy outlets** | |
| | **Complete interview** | **Other result** | **Complete interview** | **Other result** | **Complete interview** | **Other result** | **Complete interview** | **Other result** | **Complete interview** | **Other result** |
| **Nairobi** | 43 | 0 | 66 | 3 | 303 | 1 | 1,397 | 6 | 57 | 5 |
| **Mombasa** | 16 | 0 | 44 | 0 | 144 | 0 | 881 | 2 | 39 | 1 |
| **Kisumu** | 18 | 0 | 36 | 2 | 129 | 0 | 1,053 | 0 | 53 | 3 |
| **Machakos** | 4 | 0 | 26 | 2 | 53 | 4 | 448 | 0 | 30 | 0 |
| **Kakamega** | 6 | 0 | 20 | 0 | 55 | 5 | 443 | 0 | 44 | 1 |
| **Total number** | 87 | 0 | 192 | 7 | 684 | 10 | 4,222 | 8 | 223 | 10 |

| 2.2 Sampling of Facilities | | | |
|---|---|---|---|
| **Distribution of facilities selected for interview in the 2011 KSDP as compared to the overall listing of facilities from the Government of Kenya Master Facility List*, Tupange/MLE, Kenya, 2011** | | | |
| **Nairobi** | **Surveyed** | **Overall** | **Percentage** |
| **TOTAL** | **112** | **457** | **24.5** |
| **Hospital** | 16 | 44 | 36.4 |
| **Maternity home** | 12 | 36 | 33.3 |
| **Clinic** | 36 | 146 | 24.7 |
| **Health center** | 37 | 71 | 52.1 |
| **Health post/Dispensary/Other** | 11 | 160 | 6.9 |
| **Mombasa** | **Surveyed** | **Overall** | **Percentage** |
| **TOTAL** | **60** | **338** | **17.8** |
| **Hospital** | 10 | 19 | 52.6 |
| **Maternity home** | 1 | 13 | 7.7 |
| **Clinic** | 35 | 259 | 13.5 |
| **Health center** | 4 | 9 | 44.4 |
| **Health post/Dispensary/Other** | 10 | 38 | 26.3 |
| **Kisumu** | **Surveyed** | **Overall** | **Percentage** |
| **TOTAL** | **56** | **72** | **77.8** |
| **Hospital** | 10 | 11 | 90.9 |
| **Maternity home** | 3 | 4 | 75.0 |
| **Clinic** | 24 | 16 | NA** |
| **Health center** | 6 | 9 | 66.7 |
| **Health post/Dispensary/Other** | 13 | 32 | 40.6 |
| **Machakos** | **Surveyed** | **Overall** | **Percentage** |
| **TOTAL** | **32** | **28** | **NA**** |
| **Hospital** | 3 | 3 | 100.0 |

| 2.2 Sampling of Facilities | | | |
|---|---|---|---|
| **Distribution of facilities selected for interview in the 2011 KSDP as compared to the overall listing of facilities from the Government of Kenya Master Facility List*, Tupange/MLE, Kenya, 2011** | | | |
| **Maternity home** | 1 | 1 | 100.0 |
| **Clinic** | 24 | 10 | NA** |
| **Health center** | 0 | 0 | NA** |
| **Health post/Dispensary/Other** | 4 | 14 | 28.6 |
| **Kakamega** | **Surveyed** | **Overall** | **Percentage** |
| **TOTAL** | **26** | **39** | **66.7** |
| **Hospital** | 2 | 2 | 100.0 |
| **Maternity home** | 3 | 5 | 60.0 |
| **Clinic** | 14 | 9 | NA** |
| **Health center** | 1 | 2 | 50.0 |
| **Health post/Dispensary/Other** | 6 | 21 | 28.6 |
| **TOTAL** | **Surveyed** | **Overall** | **Percentage** |
| **Health facilities from the five cities** | **286** | **984** | **30.6** |

*Accessed December 21, 2011.

**Where the surveyed number of sites exceeded the sample in the MFL, this could be due to an incomplete listing of private facilities in the MFL.

### 2.3.3 Sample of Exit Interviews

Exit interviews were conducted with female clients aged 15–49 years leaving reproductive health and child health departments or units. Exit interviews were limited to those facilities offering RH services on a routine basis and serving clients at the times of the survey. Deliberate efforts were made to ensure all Tupange facilities were included for exit survey. Interviews were completed in about half of (150/279) facilities included in the SDP survey. A total of 4,222 client exit interviews were conducted, as shown in Table 2.1. Efforts were made to distribute the sample equally between clients receiving family planning services and those receiving any other reproductive health services. Interviewers visited the facility as many times as necessary in order to reach the desired sample size of 40 women per facility. Women were interviewed by female interviewers in a private place after obtaining verbal consent.

### 2.3.4 Sample of Pharmacies

All pharmacies identified and targeted by Tupange for intervention were included in the 2011 KSDP survey, in Nairobi, Mombasa and Kisumu. In addition, pharmacies identified from a list of functional retail pharmacies in Nairobi and Mombasa from the Kenya Pharmacy and Poisons Board were included in the sample. Pharmacies in urban areas tend to be clustered in commercial districts, so the survey team chose 44 pharmacies at random from the two sub-locations (administrative unit) containing 80 percent of Nairobi's pharmacies. Along with the 18 Tupange strategic pharmacies, this resulted in the 62 selected. In Kisumu, Machakos and Kakamega, all pharmacies available (registered and open to the public) were listed and included in the survey. A total of 223 pharmacies were selected for interviews as shown in Table 2.1: 62 pharmacies were included in the study in Nairobi, 56 in Kisumu, 40 in Mombasa, 30 in Machakos and 45 in Kakamega.

## 2.4 Survey Implementation

### 2.4.1 Data Collection Instruments

The 2011 KSDP survey instruments were developed to specifically examine selected global indicators on health facility preparedness, provider capacity and the client experience—all key objectives of the Urban RH Initiative. The questionnaires were developed by MLE with consultation from Tupange, RCTP and other stakeholders. The pharmacy questionnaire was translated into Kiswahili. The women's exit questionnaire was translated into Dholuo, Kamba and Kiswahili, the three commonly spoken languages in the project areas. Questionnaires are attached in Appendix A.

## 2.5 Training and Supervision of Field Interviewers

Data collectors were primarily recruited in the month of May 2011 based on qualifications and experience, especially in conducting or managing past, large-scale, facility- or population-based surveys. Different categories of personnel were recruited and trained to undertake the different phases of the KSDP survey. The first phase of the KSDP survey was to verify the location and names of the pre-sampled facilities and pharmacies to be included in the survey. These facilities and pharmacies in Nairobi, Mombasa and Kisumu were determined by Tupange as the focus of the intervention. A similar activity involving a census of facilities and pharmacies available in Kakamega, Machakos and Kisumu was completed. The listing and verification activity involved taking the coordinates (latitude and longitude) of the facilities using hand-held GPS devices, recording the geographical location, landmarks and common names used for the outlets. The mapping activity was meant to ease the data collection process by ensuring that the field team had prior knowledge of the location of facilities and had built strong rapport with managers of the facilities or pharmacies. The mapping activity was conducted from 18–28 July 2011, by a team of 10 listers, two supervisors and five quality assurance staff. The second phase of the KSDP was the pilot survey. A team of four data collectors participated in a four-day pilot survey training held in Thika from 25–29 July 2011. Thika was selected for pre-test due to its accessibility, its urban population and the fact that it was not in any of the targeted survey areas. Technical staff from RCTP, MLE and the Division of Reproductive Health conducted the training. During the field work portion of the pilot, the teams visited a total of 12 facilities and 14 pharmacies, and interviewed 20 health workers and 91 clients. The lessons learned from the pilot were used to finalize the survey instruments and administrative and logistical arrangements of the main survey.

The main survey training was conducted from 14–19 August 2011 in Thika. A total of 70 people were trained to undertake the 2011 KSDP. These included six city level supervisors, 14 male research assistants, 39 female research assistants, five quality assurance personnel, four reserve research assistants, one data manager, one GIS specialist/field supervisor and one administrator. The trainers were program and technical staff from RCTP and MLE. The training covered interviewing techniques and research ethics, with a focus on the family planning program in Kenya. Specialized topics were presented during plenary sessions, while more in-depth training on questionnaires and interviewing skills was provided through class presentations, mock interviews and role plays. All trainees participated in day-long field pre-test activities in selected facilities and pharmacies located in the urban and peri-urban areas of Thika.

At the end of the training, a total of six final field teams were formed, one for each urban area except Nairobi, which was assigned two teams due to the high workload. Each team consisted of a city manager, female and male research assistants, and quality assurance personnel. The last day of the training was used to offer extra training to city managers who would act as field supervisors and would be in direct contact with the survey coordinators. The aim of this session was to train on the specific duties of field supervision to ensure that all teams were following a uniform set of survey procedures. Details of the survey personnel are attached in Appendix B.

## 2.6 Data Collection

Data collection in the five cities began on 22 August 2011 and was completed on 7 October 2011. RCTP, with support from Jhpiego, conducted social mobilization in facilities where the survey was to be conducted. Jhpiego obtained letters from the Ministries of Health supporting the survey and explaining the intention of the study. These letters were sent out to facilities before the field team came to conduct the survey. This process was very helpful in increasing the response rates and increased cooperation from the managers of the facilities.

Technical staff from MLE and RCTP conducted regular field supervision to ensure that high-quality data were gathered and that the field teams followed the specified survey procedures. RCTP assigned each urban area a survey coordinator to help the team plan adequately for the field work and ensure that field daily targets were met. The field supervisors received their assignments from the survey coordinators and reported back to them. The assignments included a list of facilities and pharmacies to visit and the expected targets.

Each interviewer was assigned a specific questionnaire type and a facility to visit each day. One facility audit was conducted each day because the tool used required keen observation of facility records and drug stores. Only female research assistants conducted client exit interviews. Interviewers were required to check their questionnaire for completeness immediately after the interview before handing it to the survey city manager. The survey city manager cross-checked sections of the questionnaires as a quality control measure. City-level quality assurance teams checked samples of completed questionnaires and conducted random checks to ensure that high-quality data were gathered by the field teams.

## 2.7 Data Processing

The data processing team was constituted and trained in September 2011 at the RCTP field offices in Kisumu. A total of 13 data clerks who also carried out office editing of the questionnaires, one reserve clerk and the data manager were involved. This team received technical assistance and training from MLE. Data processing commenced on 12 September 2011 and was completed on 28 October 2011. The CSpro data capture program designed by MLE was used to process the data.

Tabulation of the results of the KSDP was completed in November by MLE. RCTP in collaboration with MLE and Tupange took the lead in writing the report.

# Chapter 3: Capacity and Provision of FP Services in Health Facilities

## 3.1 Quality of Care and Capacity to Provide Family Planning

Quality of care for family planning involves a framework of elements such as choice of methods, technical competence, information given to clients and provider-client relations, among others. Using the information gathered from the facility audit, provider and exit interviews, this chapter provides detailed information on the health facility's preparedness and capacity to provide quality FP services.

### 3.1.1 Background Characteristics of Facilities, Health Providers and Clients

The KSDP completed surveys with a total of 279 public and private facilities. Close to two-thirds (62 percent) of facilities surveyed were either clinics (46 percent) or health posts/dispensaries (16 percent). The majority of the facilities were private (58 percent), followed by government-managed facilities (31 percent) or NGO/FBO-managed facilities (11 percent). About a half of the health facilities surveyed were Tupange intervention sites (53 percent) and the remaining 47 percent formed the comparison group of facilities. Table 3.1 provides summary information on the distribution of facilities by background characteristics.

**Table 3.1: Distribution of Health Facilities**

**Distribution of surveyed facilities by background characteristics, Tupange/MLE, Kenya, 2011**

| | Percentage distribution of interviewed facilities | Number of interviewed facilities |
|---|---|---|
| **Urban area** | | |
| Nairobi | 39.1 | 109 |
| Mombasa | 21.5 | 60 |
| Kisumu | 19.4 | 54 |
| Machakos | 10.8 | 30 |
| Kakamega | 9.3 | 26 |
| **Type of facility** | | |
| Hospital | 14.7 | 41 |
| Health center | 16.9 | 47 |
| Maternity home | 7.2 | 20 |
| Clinic | 45.5 | 127 |
| Health post/Dispensary/Other | 15.8 | 44 |
| **Managing authority** | | |
| Government | 31.2 | 87 |
| Private | 58.1 | 162 |
| NGO/ FBO | 10.8 | 30 |
| **Volume** | | |
| Strategic (Jhpiego)* | 23.3 | 65 |
| Strategic (MSK)** | 30.1 | 84 |
| Other | 46.6 | 130 |
| **Total** | **100.0** | **279** |

* Facilities selected mainly to test and validate Objective 1 of the Tupange initiative: Integration.
**Facilities selected mainly to test and validate Objective 3 of the Tupange initiative: Public-private sector initiative.

Out of the 279 facilities surveyed, a total of 684 health providers were contacted and interviewed. Nearly three-quarters of the providers (72 percent) were female. The percentage of providers interviewed in government facilities was almost equal to those in private facilities (44 percent); a majority of the providers were nurses (69 percent) and only 6 percent were doctors. About an eighth of the providers (14 percent) were clinical officers. At the time of the survey, most of the providers were working either in the outpatient (37 percent) or MNCH/FP/ANC departments (35 percent). Detailed results of provider distribution by background characteristics are presented in Table 3.2.

**Table 3.2: Distribution of Providers**

**Distribution of surveyed providers, by background characteristics, Tupange/MLE, Kenya, 2011**

| | Percentage distribution of interviewed providers | Number of providers interviewed |
|---|---|---|
| **Urban area** | | |
| Nairobi | 44.3 | 303 |
| Mombasa | 21.1 | 144 |
| Kisumu | 18.9 | 129 |
| Machakos | 7.7 | 53 |
| Kakamega | 8.0 | 55 |
| **Type of facility** | | |
| Hospital | 19.2 | 131 |
| Health center | 26.0 | 178 |
| Maternity home | 7.7 | 53 |
| Clinic | 29.2 | 200 |
| Health post/Dispensary/Other | 17.8 | 122 |
| **Managing authority** | | |
| Government | 43.3 | 296 |
| Private | 44.7 | 306 |
| NGO/FBO | 12.0 | 82 |
| **Department/Unit*** | | |
| Outpatient | 37.1 | 254 |
| MCH/FP/ANC | 35.2 | 241 |
| Maternity | 7.9 | 54 |
| Surgical | 0.9 | 6 |
| Medical wards | 1.9 | 13 |
| HIV service outlets | 7.6 | 52 |
| Other | 8.9 | 61 |
| Missing | 0.4 | 3 |
| **Cadre** | | |
| Doctors** | 5.6 | 38 |
| Pharmacists | 0.6 | 4 |
| Clinical officer | 14.0 | 96 |
| Nurses*** | 69.3 | 474 |
| CHW | 0.9 | 6 |
| VCT (voluntary counseling and testing) provider | 4.5 | 31 |
| Other | 5.1 | 35 |

| Table 3.2: Distribution of Providers | | |
|---|---|---|
| **Distribution of surveyed providers, by background characteristics, Tupange/MLE, Kenya, 2011** | | |
| | **Percentage distribution of interviewed providers** | **Number of providers interviewed** |
| **Sex of provider** | | |
| Male | 27.9 | 191 |
| Female | 71.9 | 492 |
| Missing | 0.1 | 1 |
| **Total** | 100.0 | 684 |

* Department/Unit the provider was working in at time of survey.
** Doctors include: Obstetrician/Gynecologist, Surgeon, Pediatrician, Physician and Medical Officers.
*** Includes Registered Nurse, Enrolled Community Nurse, BSc Nurse (Bachelor of Science).

A total of 4,230 women who had received any reproductive health service in the selected facilities were approached and requested to participate in an exit interview. Nearly all (4,220) of them agreed to participate and were interviewed; of these 62 percent had received health services in public facilities compared to 39 percent in private facilities. In Machakos and Kakamega, more exit interviews were completed in private facilities (65 percent and 55 percent, respectively) compared to public facilities (35 percent and 45 percent, respectively). The goal of attaining 50 percent of interview clients from FP was only achieved in Nairobi. In the other urban centers, it was between 20 and 30 percent. Demographic information for the clients is displayed in Table 3.3. The age distribution was largely homogenous with 20–24 years being the modal category in all urban centers. Education level varied between urban centers; two-thirds of women in Kakamega and Machakos attained at least a secondary education, compared to less than half of the women in Kisumu and Mombasa: Nairobi fell between these values. Parity was similar between urban centers; two-thirds of women in Nairobi and Mombasa had one or two living children, while slightly more than 55 percent of women in Kisumu and Machakos had one or two living children. At least three-quarters of the women in all the districts except Kakamega (62 percent) reported they were married at the time of interview.

| Table 3.3: Distribution of MNCH Clients in Facilities Surveyed | | | | | | |
|---|---|---|---|---|---|---|
| **Distribution of MNCH clients in surveyed facilities by background characteristics, Tupange/MLE, Kenya, 2011** | | | | | | |
| | **Nairobi** | **Mombasa** | **Kisumu** | **Machakos** | **Kakamega** | **Total percent** |
| **Main service received on day of interview** | | | | | | |
| Family planning | 47.0 | 22.8 | 21.8 | 30.6 | 20.8 | 31.2 |
| Antenatal care | 12.6 | 12.0 | 8.1 | 8.5 | 10.4 | 10.7 |
| Delivery services | 0.4 | 0.1 | 1.6 | 0.4 | 1.1 | 0.7 |
| Postnatal care | 1.2 | 0.2 | 2.3 | 1.6 | 0.7 | 1.3 |
| Post-abortion care | 0.1 | 0.3 | 0.3 | 0.2 | 0.0 | 0.2 |
| Growth monitoring | 11.6 | 7.7 | 8.0 | 6.9 | 0.9 | 8.3 |
| Child immunization | 14.8 | 22.1 | 20.3 | 5.4 | 12.6 | 16.5 |
| HIV/STI management | 1.1 | 4.4 | 5.6 | 0.4 | 0.9 | 2.8 |
| Curative services | 11.0 | 29.1 | 30.3 | 43.1 | 49.7 | 27.0 |
| Other | 0.4 | 1.1 | 1.7 | 2.9 | 2.9 | 1.4 |
| **Age** | | | | | | |
| 15–19 years | 7.0 | 5.3 | 16.2 | 4.2 | 9.3 | 8.9 |
| 20–24 years | 36.8 | 33.0 | 37.9 | 25.2 | 27.8 | 34.1 |
| 25–29 years | 31.9 | 32.8 | 23.8 | 26.6 | 23.9 | 28.7 |
| 30–34 years | 16.6 | 19.2 | 11.3 | 22.1 | 19.6 | 16.7 |
| 35–39 years | 5.7 | 7.0 | 6.0 | 13.8 | 8.8 | 7.2 |
| 40–49 years | 2.0 | 2.6 | 4.7 | 8.0 | 10.6 | 4.4 |

| Table 3.3: Distribution of MNCH Clients in Facilities Surveyed | | | | | | |
|---|---|---|---|---|---|---|
| **Distribution of MNCH clients in surveyed facilities by background characteristics, Tupange/MLE, Kenya, 2011** | | | | | | |
| | **Nairobi** | **Mombasa** | **Kisumu** | **Machakos** | **Kakamega** | **Total percent** |
| **Education** | | | | | | |
| No education | 0.8 | 5.9 | 1.1 | 0.0 | 2.0 | 2.0 |
| Primary incomplete | 9.7 | 14.5 | 22.6 | 4.7 | 15.8 | 14.0 |
| Primary complete | 34.6 | 33.4 | 30.1 | 23.9 | 14.9 | 30.0 |
| Secondary + | 54.3 | 45.7 | 46.2 | 71.0 | 67.0 | 53.6 |
| Missing | 0.6 | 0.5 | 0.0 | 0.4 | 0.2 | 0.4 |
| **Marital status** | | | | | | |
| Never married | 10.5 | 7.9 | 17.3 | 18.1 | 21.4 | 13.6 |
| Currently married | 80.5 | 78.0 | 75.6 | 76.3 | 62.1 | 76.4 |
| Living together | 4.4 | 8.7 | 1.0 | 2.0 | 10.8 | 4.9 |
| Widowed | 0.9 | 1.0 | 3.7 | 0.4 | 2.3 | 1.7 |
| Separated/Divorced | 3.4 | 3.9 | 2.4 | 2.7 | 3.2 | 3.1 |
| Missing | 0.4 | 0.5 | 0.0 | 0.4 | 0.2 | 0.3 |
| **Number of living children** | | | | | | |
| 0 | 9.3 | 11.5 | 11.8 | 15.4 | 22.3 | 12.4 |
| 1 | 35.9 | 32.1 | 28.9 | 32.8 | 26.0 | 32.0 |
| 2 | 31.1 | 29.7 | 27.0 | 24.1 | 21.4 | 28.0 |
| 3 | 14.7 | 11.9 | 16.0 | 18.1 | 13.5 | 14.7 |
| 4 | 6.1 | 7.3 | 8.3 | 5.8 | 5.6 | 6.8 |
| 5 | 2.0 | 4.4 | 3.9 | 2.5 | 5.0 | 3.3 |
| 6+ | 0.6 | 1.7 | 3.8 | 0.9 | 4.7 | 2.1 |
| Missing | 0.4 | 1.4 | 0.4 | 0.4 | 1.4 | 0.7 |
| **Poverty quintile** | | | | | | |
| Lowest (poor) | 11.0 | 22.6 | 34.8 | 18.5 | 19.4 | 21.0 |
| 2nd quintile | 19.4 | 16.9 | 19.9 | 19.9 | 18.5 | 19.0 |
| 3rd quintile | 22.9 | 16.8 | 19.3 | 16.3 | 22.8 | 20.0 |
| 4th quintile | 31.9 | 20.1 | 9.9 | 19.2 | 12.0 | 20.5 |
| Highest (rich) | 14.8 | 23.6 | 16.1 | 26.1 | 27.3 | 19.5 |
| **Managing authority** | | | | | | |
| Public | 79.5 | 63.0 | 54.5 | 35.3 | 45.1 | 61.5 |
| Private | 20.5 | 37.0 | 45.5 | 64.7 | 54.9 | 38.5 |
| **Total number of clients** | **1397** | **881** | **1053** | **448** | **443** | **4222** |

**Table notes:** Women's household wealth status presented here is a relative measure computed based on responses to two types of questions: 1. Household characteristics and amenities such as: type of roofing of main house, main source of drinking water in household, number of rooms and whether or not the women's household had electricity supply, among others. 2. Household ownership of assets such as: radio, electric/gas cooker, VCR/DVD, mattress, refrigerator, among others. Using principal component analysis as used in Demographic and Health Surveys (DHS), all data were reduced to an index that is a latent outcome (poverty), which is manifest in the above list of assets and characteristics of household as defined by the women. A lower score is associated with a poorer/worse-off household from which the women came, and a higher score is associated with households that are better off.The caveat here is that unlike in the DHS, which is household-based, these data were collected at facilities as women exited after service delivery. The responses were reported and not verified. Also, data were collected about a smaller set of household items and possessions as compared to other large-scale household surveys. Based on distribution of each item, the following items were used to compute the wealth scores: Type of roofing of main house, type of toilet used at the women's household, main source of drinking water in household, number of rooms and whether or not the women's household had electricity supply, mobile phone, radio, electric/gas cooker, television, electric iron box, VCR/DVD, mattress, refrigerator and electric fan. This index was then grouped to five almost equal portions such that each cluster/group contained approximately 20 percent of women nearest to each other in terms of their overall poverty index.

## 3.2 Basic Facility Infrastructure Supportive of Quality Service and Client Utilization

Both clients and health providers were most likely to be satisfied with a facility if basic amenities and infrastructure such as water, electricity, clean toilet facilities and private rooms for examinations were available. In addition to satisfaction, these components also help health workers provide better services. Table 3.4 provides information on the availability of functioning selected infrastructure items by urban area and facility type.

**Table 3.4: Physical Infrastructure of Facilities**

**Percentage of facilities with available and functioning selected infrastructure, by managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Piped water supply* | Electricity or back-up generator | Toilet facilities/ Latrine | Dedicated telephone/ Mobile | Storage area for drugs and supplies | Private exam-ination room | Gynecological exam table | Number of facilities |
|---|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | | |
| Public | 88.4 | 90.7 | 100.0 | 51.2 | 97.7 | 90.7 | 95.3 | 43 |
| Private | 84.8 | 98.5 | 92.4 | 51.5 | 89.4 | 93.9 | 97.0 | 66 |
| **Mombasa** | | | | | | | | |
| Public** | 62.5 | 93.8 | 87.5 | 37.5 | 87.5 | 75.0 | 81.3 | 16 |
| Private | 77.3 | 100.0 | 97.7 | 61.4 | 93.2 | 93.2 | 84.1 | 44 |
| **Kisumu** | | | | | | | | |
| Public | 55.6 | 77.8 | 83.3 | 38.9 | 77.8 | 55.6 | 50.0 | 18 |
| Private | 83.3 | 94.4 | 97.2 | 69.4 | 88.9 | 88.9 | 75.0 | 36 |
| **Machakos** | | | | | | | | |
| Public | 100.0 | 100.0 | 100.0 | 25.0 | 100.0 | 100.0 | 75.0 | 4 |
| Private | 65.4 | 92.3 | 100.0 | 76.9 | 96.2 | 92.3 | 84.6 | 26 |
| **Kakamega** | | | | | | | | |
| Public | 66.7 | 83.3 | 100.0 | 50.0 | 83.3 | 50.0 | 50.0 | 6 |
| Private | 100.0 | 95.0 | 95.0 | 85.0 | 85.0 | 85.0 | 75.0 | 20 |
| **Total** | | | | | | | | |
| Public | 75.9 | 88.5 | 94.3 | 44.8 | 90.8 | 78.2 | 79.3 | 87 |
| Private | 81.8 | 96.9 | 95.8 | 64.1 | 90.6 | 91.7 | 85.9 | 192 |

* Availability of running water all year round, supplied by a tap.
** 1 (6.3 %) public facility in Mombasa had missing data in piped water, back-up generator, toilet facility and telephone.

On average, only 76 percent of public facilities and 82 percent of private facilities had a piped water supply; availability was much lower for public facilities compared to private facilities in all the urban centers except in Machakos and Nairobi. Electricity or a back-up generator was available in 97 percent of private facilities and 89 percent of public facilities. Though necessary, toilet facilities/latrines were not 100 percent available in either the public or private facilities. Both public and private facilities suffer from a lack of a dedicated telephone. Nearly two-thirds of private facilities (64 percent) had telephone facilities compared to 45 percent of the public facilities.

Availability of a storage area for drugs and supplies was relatively higher in private facilities than the public facilities across all urban centers, except in Nairobi and Machakos. Across all urban centers, a private examination room was more readily available in private facilities than public ones, except in Machakos, where all the public facilities interviewed had a private room for examination. A gynecological examination table was more readily available in a private facility

than a public one in all the urban centers. Of note is that only about a half of the public facilities in Kakamega and Kisumu had a private examination room and a gynecological exam table.

### 3.2.1 Availability of Equipment and Supplies for Specific FP Methods

Facilities' ability to provide appropriate family planning services was assessed. Table 3.5 displays the distribution of facilities with selected general equipment and supplies.

**Table 3.5: Equipment and Supplies for Provision of FP**

**Percentage distribution of facilities with general selected equipment and supplies (available and functioning) needed to provide FP, and with capacity to provide implants and IUD, by urban area, Tupange/MLE 2010, Kenya 2011**

| | Nairobi | Mombasa | Kisumu | Machakos | Kakamega | Total percent |
|---|---|---|---|---|---|---|
| **General equipment and supplies** | | | | | | |
| Sharps container | 96.3 | 76.7 | 87.0 | 100.0 | 96.2 | 90.7 |
| Liquid/Powder soap | 89.9 | 93.3 | 87.0 | 100.0 | 84.6 | 90.7 |
| Hand washing soap | 89.0 | 93.3 | 92.6 | 96.7 | 92.3 | 91.8 |
| Chlorine (Jik) | 93.6 | 91.7 | 94.4 | 96.7 | 96.2 | 93.9 |
| Antiseptic solution | 89.9 | 86.7 | 81.5 | 76.7 | 92.3 | 86.4 |
| Sterilizer | 79.8 | 76.7 | 64.8 | 66.7 | 69.2 | 73.8 |
| Blood pressure machine | 96.3 | 100.0 | 94.4 | 93.3 | 88.5 | 95.7 |
| Examination light | 64.2 | 53.3 | 48.1 | 46.7 | 53.8 | 55.9 |
| Adult weighing scale | 94.5 | 93.3 | 94.4 | 66.7 | 84.6 | 90.3 |
| Gynecological examination tables/couch | 96.3 | 83.3 | 66.7 | 83.3 | 69.2 | 83.9 |
| Gloves – examination | 91.7 | 98.3 | 94.4 | 100.0 | 96.2 | 95.0 |
| Gloves – sterile | 76.1 | 65.0 | 81.5 | 83.3 | 80.8 | 76.0 |
| Infection control buckets | 90.8 | 86.7 | 68.5 | 83.3 | 80.8 | 83.9 |
| **Capacity to provide specific, long-term methods** | | | | | | |
| IUD insertion kits | 62.4 | 43.3 | 44.4 | 46.7 | 38.5 | 50.9 |
| Sealed implants pack | 58.7 | 41.7 | 38.9 | 40 | 26.9 | 46.2 |
| Number of facilities | 109 | 60 | 54 | 30 | 26 | 279 |

The majority (more than 80 percent) of the facilities had the general equipment and supplies necessary for FP provision except for a sterilizer (74 percent); sterile gloves (76 percent) and an examination light (56 percent). In particular, availability of an examination light was highest in Nairobi facilities (64 percent) and lowest in Machakos facilities (47 percent). Except in Nairobi where about 60 percent of the facilities had IUD insertion kits and complete implant insertion packs, less than half of the total facilities in all the other urban centers had these essential instruments, with Kakamega being the least equipped in this regard (IUD insertion kits, 39 percent and sealed implant packs, 27 percent).

### 3.2.2 Availability of Family Planning Commodities

The 2011 KSDP survey assessed the availability of FP services and client load in the health facilities surveyed, as well as the availability of short-term, long-acting and permanent FP methods (LAPMs).

Table 3.6 shows a breakdown of facilities that provide clients with specific modern FP methods by facility type and urban area. Generally, combined oral pills, progestin-only pills, male condoms, emergency contraceptives and injectables are available in most of the public and

private facilities that provide FP. On average, private facilities fare equally in terms of availability of FP services compared to public facilities in the provision of LAPMs such as implants (public, 56.3 percent; private, 56.1 percent), IUDs (public, 60.9 percent; private, 58.3 percent), and male sterilization (public, 11.5 percent; private, 11.6 percent), but public facilities fare a little better in accessibility to male sterilization (public, 27.6 percent; private, 17.9 percent). Public facilities in Kisumu perform particularly poorly in the provision of LAPMs. Machakos had the highest proportion of public facilities that provided female sterilization (50 percent) and male sterilization (25 percent). Nairobi had the lowest proportion of public and private facilities (about 7 percent) that provided male sterilization.

**Table 3.6: Provision of FP by Method**

**Among facilities providing modern family planning methods, the percentage distribution of facilities that provide clients with specific methods by managing authority, and urban area Tupange/MLE, Kenya, 2011**

| Urban area/ Facility type | Method Type | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Combined oral pill | Progestin-only pill | Emergency contraception | Male condom | Female condom | Injection | Implant | IUD | Female sterilization | Male sterilization | Percentage of facilities offering any LAPM* | Total number of facilities offering FP services |
| **Nairobi** | | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 97.7 | 97.7 | 81.4 | 100.0 | 72.1 | 81.4 | 30.2 | 7.0 | 83.7 | 43 |
| Private | 100.0 | 93.5 | 88.7 | 98.4 | 54.8 | 100.0 | 71.0 | 67.7 | 12.9 | 6.5 | 77.4 | 62 |
| **Mombasa** | | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 100.0 | 100.0 | 75.0 | 100.0 | 50.0 | 50.0 | 31.3 | 18.8 | 50.0 | 16 |
| Private | 97.7 | 90.7 | 90.7 | 90.7 | 53.5 | 100.0 | 58.1 | 55.8 | 11.6 | 11.6 | 62.8 | 43 |
| **Kisumu** | | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 100.0 | 100.0 | 38.9 | 100.0 | 27.8 | 27.8 | 16.7 | 11.1 | 27.8 | 18 |
| Private | 90.0 | 76.7 | 66.7 | 86.7 | 43.3 | 90.0 | 50.0 | 56.7 | 26.7 | 20.0 | 73.3 | 30 |
| **Machakos** | | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 100.0 | 100.0 | 25.0 | 100.0 | 75.0 | 50.0 | 50.0 | 25.0 | 75.0 | 4 |
| Private | 83.3 | 58.3 | 54.2 | 66.7 | 25.0 | 87.5 | 58.3 | 54.2 | 16.7 | 8.3 | 58.3 | 24 |
| **Kakamega** | | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 100.0 | 100.0 | 16.7 | 100.0 | 33.3 | 50.0 | 16.7 | 16.7 | 50.0 | 6 |
| Private | 85.7 | 50.0 | 57.1 | 85.7 | 21.4 | 92.9 | 42.9 | 57.1 | 21.4 | 21.4 | 57.1 | 14 |
| **Total** | | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 98.9 | 98.9 | 64.4 | 100.0 | 56.3 | 60.9 | 27.6 | 11.5 | 63.2 | 87 |
| Private | 91.3 | 73.8 | 71.5 | 85.6 | 39.6 | 94.1 | 56.1 | 58.3 | 17.9 | 11.6 | 68.8 | 173 |

## 3.3 Level and Composition of Staff

Teams interviewed the facility in-charges in regard to the level and composition of staff in various health units offering RH services on the day of the survey, the results of which appear in Table 3.7. Categories were compressed for ease of display, with the category "doctors" including all specialists as well as medical officers. Most facilities were staffed by nurses, with maternities and clinics having the highest proportion of nurses. It is noteworthy that 54 percent of the hospitals did not have doctors. As expected, health centers and clinics were staffed primarily by clinical officers and nurses.

**Table 3.7: Level and Composition of Staff**

**The percentage distribution of health providers* offering RH services at the time of the survey by cadre and facility type, Tupange/MLE, Kenya, 2011**

| | Hospitals | Health centers | Maternity | Clinics/ Dispensaries | Total | Number of facilities |
|---|---|---|---|---|---|---|
| **Physicians/Doctors** | | | | | | |
| At least 1 doctor | 48.8 | 0.0 | 25.0 | 22.8 | 22.9 | 64 |
| No doctors | 51.2 | 100.0 | 75.0 | 77.2 | 77.1 | 215 |
| **Clinical officers** | | | | | | |
| At least 1 clinical officer | 58.5 | 55.3 | 70.0 | 40.4 | 47.7 | 133 |
| No clinical officers | 41.5 | 44.7 | 30.0 | 59.6 | 52.3 | 146 |
| **Nurses** | | | | | | |
| At least 1 nurse | 100.0 | 100.0 | 95.0 | 77.8 | 86.0 | 240 |
| No nurses | 0.0 | 0.0 | 5.0 | 22.2 | 14.0 | 39 |
| **Other** | | | | | | |
| At least 1 other staff | 75.6 | 61.7 | 55.0 | 73.1 | 70.3 | 196 |
| No other staff | 24.4 | 38.3 | 45.0 | 26.9 | 29.7 | 83 |
| **Total number of facilities** | 41 | 47 | 20 | 171 | 279 | 279 |

Note: *Nurses include Registered Nurses, Enrolled Community Nurses, BSc Nurses.
**Other staff includes Community Health Extension Workers, Community Health Officers, VCT Counselors, and other providers

## 3.4. Maternal, Newborn and Child Health Services Offered

The provision of maternal, newborn and child health services in the same facility improves overall utilization of these services. Areas of service assessed by the teams included provision of antenatal profile,[3] prevention of mother-to-child transmission of HIV (PMTCT), child welfare, detection and treatment of STIs, normal and specialized delivery care, post-partum care, post-abortion care, youth friendly services[4] and cancer screening services. Table 3.8 shows the proportion of facilities providing specific services by urban area and type of managing authority.

[3] Antenatal profile consists of the laboratory tests a pregnant woman must undertake during the antenatal period.
[4] Youth friendly services are services that cater for the sexual and reproductive health needs of young people aged 10–24 years.

**Table 3.8: Provision of MNCH Services**

**Percentage of facilities that report providing specific MNCH services, by type of managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Antenatal profile | Detection and treatment of STIs | PMTCT | Child welfare | Specialized delivery care | Normal delivery care | Post-partum care | Post-abortion care | Cancer screening | Youth-friendly services | Number of facilities |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | | | | | |
| Public | 97.7 | 88.4 | 97.7 | 100.0 | 7.0 | 30.2 | 95.3 | 34.9 | 72.1 | 53.5 | 43 |
| Private | 95.5 | 92.4 | 65.2 | 93.9 | 7.6 | 51.5 | 86.4 | 54.5 | 25.8 | 47.0 | 66 |
| **Mombasa** | | | | | | | | | | | |
| Public | 100.0 | 93.8 | 93.8 | 100.0 | 12.5 | 56.3 | 87.5 | 31.3 | 37.5 | 43.8 | 16 |
| Private | 100.0 | 100.0 | 61.4 | 95.5 | 15.9 | 61.4 | 90.9 | 70.5 | 36.4 | 22.7 | 44 |
| **Kisumu** | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 83.3 | 100.0 | 11.1 | 38.9 | 88.9 | 27.8 | 22.2 | 38.9 | 18 |
| Private | 88.9 | 91.7 | 50.0 | 83.3 | 19.4 | 22.2 | 66.7 | 58.3 | 38.9 | 50.0 | 36 |
| **Machakos** | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 50.0 | 100.0 | 25.0 | 25.0 | 100.0 | 50.0 | 25.0 | 50.0 | 4 |
| Private | 88.5 | 96.2 | 30.8 | 65.4 | 11.5 | 11.5 | 30.8 | 50.0 | 46.2 | 34.6 | 26 |
| **Kakamega** | | | | | | | | | | | |
| Public | 100.0 | 100.0 | 83.3 | 100.0 | 16.7 | 16.7 | 83.3 | 66.7 | 33.3 | 33.3 | 6 |
| Private | 90.0 | 90.0 | 50.0 | 70.0 | 20.0 | 35.0 | 65.0 | 50.0 | 40.0 | 45.0 | 20 |
| **Total** | | | | | | | | | | | |
| Public | 98.9 | 93.1 | 90.8 | 100.0 | 10.3 | 35.6 | 92.0 | 35.6 | 50.6 | 47.1 | 87 |
| Private | 93.8 | 94.3 | 55.2 | 85.9 | 13.5 | 41.1 | 74.0 | 57.8 | 34.9 | 40.1 | 192 |

The most common services offered in facilities were antenatal care, detection and treatment of STIs, child welfare and postpartum care. Except for post-abortion care, normal delivery and specialized delivery care, the other services were more commonly offered in public than private facilities. Nearly all public facilities provided antenatal profile (antenatal care) and child welfare. The greatest disparities in the proportion of facilities providing various services between public and private facilities respectively were found in PMTCT (public, 91 percent versus private, 55 percent), post-abortion care (public, 36 percent, versus private, 58 percent) and postpartum care (public, 92 percent, versus private, 74 percent).

Machakos had the lowest number of facilities providing PMTCT services, while Nairobi had the highest. Child welfare services were provided in all the public facilities interviewed; a much lower proportion of private facilities provided this service in Machakos (65 percent) and Kakamega (70 percent) as compared to Nairobi (94 percent), Mombasa (96 percent) and Kisumu (83 percent).

Specialized delivery care was the least provided service across all urban centers with the service being relatively more readily available in Machakos public facilities (25 percent) and least readily available in Nairobi public facilities (7 percent). Mombasa had the highest proportion of facilities providing normal delivery care (public, 56 percent; private, 61 percent) followed by Nairobi (public, 30 percent; private, 52 percent) while in all the other urban centers, less than 40 percent of the facilities provided the service. Postpartum care provision was similar in public and private facilities in Nairobi and Mombasa, but differed greatly in Machakos (public, 100 percent; private, 31 percent); only about two-thirds of private facilities in Kisumu and Kakamega provided postpartum care compared to more than 80 percent of public facilities in the same urban centers.

Provision of post-abortion care services varied across urban centers, with private facilities in Mombasa being the greatest providers and Kisumu public facilities providing these services least often. Cancer screening was provided in less than half of all the facilities surveyed except in Nairobi, where 72 percent of the public facilities provided the service. On average, youth-friendly services were provided in less than 50 percent of the facilities interviewed, with a lower proportion of private facilities (40 percent) than public facilities (47 percent) providing the service.

**Table 3.9: MNCH Service Statistics**

**Among facilities providing specific MNCH services, mean number of days per week, and mean number of clients in past three months, by managing authority, and urban area, Tupange/MLE, Kenya, 2011****

| | Child immunization* | | Antenatal profile | | Labor and delivery services | | HIV testing and counseling | | Post-abortion care | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Mean number of days/week | Mean number of clients in past 3 months | Mean number of days/week | Mean number of clients in past 3 months | Mean number of days/week | Mean number of clients in past 3 months | Mean number of days/week | Mean number of clients in past 3 months | Mean number of days/week | Mean number of clients in past 3 months |
| **Nairobi** | | | | | | | | | | |
| Public | 5 | 1,873 | 5 | 659 | 7 | 888 | 5 | 1,223 | 5 | 14 |
| Private | 4 | 349 | 6 | 134 | 7 | 107 | 6 | 183 | 7 | 13 |
| **Mombasa** | | | | | | | | | | |
| Public | 5 | 2,334 | 5 | 1,243 | 7 | 476 | 5 | 1,187 | 6 | 17 |
| Private | 3 | 347 | 6 | 84 | 7 | 63 | 7 | 264 | 7 | 10 |
| **Kisumu** | | | | | | | | | | |
| Public | 5 | 1,185 | 5 | 417 | 6 | 269 | 5 | 645 | 6 | 84 |
| Private | 4 | 81 | 6 | 74 | 7 | 75 | 6 | 345 | 7 | 4 |
| **Machakos** | | | | | | | | | | |
| Public | 5 | 539 | 5 | 761 | 7 | 1,093 | 5 | 446 | 5 | 86 |
| Private | 6 | 70 | 6 | 47 | 7 | 115 | 6 | 111 | 6 | 30 |
| **Kakamega** | | | | | | | | | | |
| Public | 5 | 1,217 | 5 | 580 | 7 | 3,342 | 5 | 254 | 6 | 23 |
| Private | 7 | 26 | 6 | 22 | 7 | 18 | 6 | 63 | 7 | 12 |
| **Total** | | | | | | | | | | |
| Public | 5 | 1,709 | 5 | 716 | 7 | 714 | 5 | 1,002 | 6 | 31 |
| Private | 4 | 243 | 6 | 89 | 7 | 81 | 6 | 211 | 7 | 12 |
| **No. of facilities** | 167 | | 206 | | 105 | | 222 | | 102 | |

* Child immunization is used as a proxy of' child welfare services.
**Means are based on facilities where records were obtained.

For specific MNCH services, Table 3.9 further identifies mean number of days per week the facilities were open and the mean number of clients in the past three months preceding the survey according to urban area and facility type. Overall, public health facilities had higher client volume than private facilities. On average, labor and delivery services were provided seven days a week in both public and private facilities, antenatal profile and HIV testing/counseling was provided for five or six days, post-abortion care for six to seven days and child immunization for four to five days a week.

## 3.5. Frequency of Family Planning Services

Overall, 260 of 279 health facilities (93 percent) offered family planning and counseling services. Table 3.10 shows the proportion of these facilities, mean number of days per week when FP services are offered and mean number of clients in the past three months according to urban area and facility type.

In all the urban centers, all public facilities offered FP services and counseling. In comparison, a slightly lower proportion of private facilities offered these services. Kakamega had the lowest proportion of private facilities providing FP services (70 percent) followed by Kisumu (83 percent) and Machakos (92 percent). On average, private facilities offered FP services for a higher number of days per week (six or seven days) than public facilities (five or six days). Public facilities had a higher number of clients accessing their FP services than private facilities.

**Table 3.10: Provision of FP Services**

**Proportion of facilities providing family planning and counseling services, mean number of days per week family planning services are offered and mean number of family planning clients in past three months, by managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Percentage of facilities offering FP and counseling services | Mean number of days/week* | Mean number of clients in past 3 months* |
|---|---|---|---|
| **Nairobi** | | | |
| Public | 100.0 | 5 | 1,011 |
| Private | 93.9 | 7 | 264 |
| **Mombasa** | | | |
| Public | 100.0 | 6 | 494 |
| Private | 97.7 | 7 | 241 |
| **Kisumu** | | | |
| Public | 100.0 | 5 | 445 |
| Private | 83.3 | 6 | 119 |
| **Machakos** | | | |
| Public | 100.0 | 6 | 1,018 |
| Private | 92.3 | 6 | 140 |
| **Kakamega** | | | |
| Public | 100.0 | 5 | 924 |
| Private | 70.0 | 6 | 28 |
| **Total** | | | |
| Public | 100.0 | 5 | 793 |
| Private | 90.1 | 7 | 197 |
| **No. of facilities** | 260 | 231 | 231 |

*Means are based on facilities where records were obtained.

## 3.6 Integration of MNCH and Family Planning Services

Any two services are considered to be integrated when they are offered at the same facility during the same operating hours and the provider of one service actively encourages clients to consider using the other service during that visit (Foreit K, 2002). Integration of services ensures a wider reach of clients by using all opportunities for service delivery, thus necessitating fewer provider-client contacts. Integration of FP with MNCH has numerous benefits such as improved service delivery efficiency, reduced cost for clients and widened acceptability of the services provided. In assessing integration of different services within the facilities, teams asked the facility in-charge about what typically happens when a client who comes in for a service also wants FP information or an FP method.

The survey results indicate that 252 of 279 health facilities (90 percent) provided child health services, 239 facilities (86 percent) provided postpartum services, 142 facilities (51 percent) provided post-abortion health services and 274 facilities (98 percent) provided HIV, PMTCT, STI and TB care services.

### 3.6.1 Facilities Providing Integrated Family Planning Information

#### Child Health

Table 3.11 provides information on the percentage of facilities where family planning counseling services were integrated with child health services. Among facilities offering child health services across all the urban centers, the majority reported providing FP information on the same day that a woman accessed child health services. In all the urban centers, a higher percentage of public than private facilities provided FP information, FP pills and injectables on the same day as child health services.

On average, less than half of the facilities surveyed provided IUDs and implants on the same day as child health services, with the percentage distribution varying across the urban centers. In Nairobi and Kisumu, public facilities were more likely to provide IUDs and implants than private facilities, with the exact opposite being the case in Kakamega and Mombasa. Machakos had a mixed pattern of provision, with a higher percentage of private facilities providing IUDs, and a higher percentage of public facilities providing implants on the same day as child health services.

**Table 3.11: Integration of FP with Child Health Services**

**Among facilities offering any of child health services, the percentage distribution of facilities where family planning counseling services are integrated with child health services, by type of FP service, managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Number of facilities offering child health services | Percentage of facilities that always provide FP information on the same day | Percentage of facilities that always provide FP pills on the same day | Percentage of facilities that always provide injectable on the same day | Percentage of facilities that always provide IUD on the same day | Percentage of facilities that always provide implant on the same day | Percentage of facilities that always provide sterilization on the same day |
|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | |
| Public | 43 | 90.7 | 90.7 | 90.7 | 65.1 | 53.5 | 2.3 |
| Private | 62 | 83.9 | 87.1 | 85.5 | 43.5 | 41.9 | 4.8 |
| **Mombasa** | | | | | | | |
| Public | 16 | 100.0 | 93.8 | 100.0 | 25.0 | 18.8 | 0.0 |
| Private | 42 | 92.9 | 88.1 | 95.2 | 45.2 | 47.6 | 0.0 |
| **Kisumu** | | | | | | | |
| Public | 18 | 94.4 | 88.9 | 94.4 | 27.8 | 27.8 | 5.6 |
| Private | 30 | 80.0 | 60.0 | 60.0 | 26.7 | 23.3 | 6.7 |
| **Machakos** | | | | | | | |
| Public | 4 | 100.0 | 100.0 | 100.0 | 25.0 | 75.0 | 0.0 |
| Private | 17 | 88.2 | 76.5 | 82.4 | 52.9 | 52.9 | 11.8 |
| **Kakamega** | | | | | | | |
| Public | 6 | 100.0 | 83.3 | 83.3 | 16.7 | 16.7 | 0.0 |
| Private | 14 | 78.6 | 64.3 | 57.1 | 28.6 | 21.4 | 0.0 |
| **Total** | | | | | | | |
| Public | 87 | 94.3 | 90.8 | 93.1 | 44.8 | 40.2 | 2.3 |
| Private | 165 | 85.5 | 79.4 | 80.6 | 40.6 | 39.4 | 4.2 |

## Postpartum Services

Integration of FP counseling services with postpartum services showed similar trends as in the case of child health services. Results in Table 3.12 indicate that the majority of the health facilities surveyed provided FP information, FP pills and injectables on the same day as postpartum services in all the urban centers. Though the postpartum period offers an important opportunity for provision of IUDs and sterilization, the majority of the facilities did not provide these FP methods alongside the postpartum services. In particular, a higher percentage of private facilities provided IUDs on the same day as postpartum services in all the urban centers except Nairobi, where the percentage was higher among public facilities. Machakos had the greatest variation between public facilities (25 percent) and private facilities (82 percent) on the same day as postpartum services.

**Table 3.12: Integration of FP with Postpartum Health Services**

**Among facilities offering any of postpartum health services, percentage distribution of facilities where family planning counseling services are integrated with postpartum health services, by type of FP service, managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Number of facilities offering postpartum services | Percentage of facilities that always provide FP information on the same day | Percentage of facilities that always provide FP pills on the same day | Percentage of facilities that always provide injectable on the same day | Percentage of facilities that always provide IUD on the same day | Percentage of facilities that always provide implant on the same day | Percentage of facilities that always provide sterilization on the same day |
|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | |
| Public | 42 | 85.7 | 85.7 | 85.7 | 66.7 | 54.8 | 2.4 |
| Private | 61 | 83.6 | 83.6 | 82.0 | 42.6 | 39.3 | 3.3 |
| **Mombasa** | | | | | | | |
| Public | 16 | 87.5 | 81.3 | 75.0 | 31.3 | 18.8 | 6.3 |
| Private | 42 | 90.5 | 85.7 | 81.0 | 42.9 | 45.2 | 0.0 |
| **Kisumu** | | | | | | | |
| Public | 17 | 82.4 | 88.2 | 88.2 | 29.4 | 29.4 | 5.9 |
| Private | 27 | 74.1 | 70.4 | 59.3 | 29.6 | 25.9 | 11.1 |
| **Machakos** | | | | | | | |
| Public | 4 | 100.0 | 100.0 | 100.0 | 25.0 | 75.0 | 0.0 |
| Private | 11 | 81.8 | 90.9 | 90.9 | 81.8 | 72.7 | 18.2 |
| **Kakamega** | | | | | | | |
| Public | 5 | 100.0 | 100.0 | 100.0 | 40.0 | 0.0 | 0.0 |
| Private | 14 | 85.7 | 78.6 | 64.3 | 42.9 | 35.7 | 0.0 |
| **Total** | | | | | | | |
| Public | 84 | 86.9 | 86.9 | 85.7 | 48.8 | 40.5 | 3.6 |
| Private | 155 | 83.9 | 81.9 | 76.8 | 43.2 | 40.6 | 4.5 |

## Post-abortion Care

International and national guidelines recommend that a woman accessing post-abortion care be provided with FP counseling and a method prior to leaving the facility.[5] Only about a half of the facilities surveyed provided PAC services. A large majority of these facilities provided FP information on the same day as post-abortion services (public, 87 percent; private, 88 percent). However, fewer facilities provided FP methods (public, 77 percent; private, 78 percent), suggesting that there were missed opportunities to address post-abortion clients' FP needs. This discrepancy was particularly evident in Kakamega where, even though at least 90 percent of the facilities provided FP information on the same day as post-abortion care, only a half provided FP methods on the same day. Integration of post-abortion care with FP services was highest in Mombasa, where at least 90 percent of the facilities provided FP information and methods to post-abortion clients. Table 3.13 displays information on the percentage distribution of facilities where family planning counseling services are integrated with post-abortion care, by urban area and type of service.

**Table 3.13: Integration of FP with Post-abortion Care**

**Among facilities offering post-abortion health services, percentage distribution of facilities where family planning counseling services are integrated with post-abortion care health services, by type of FP service, managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Number of facilities offering post-abortion care | Percentage of facilities that always provide FP information on the same day | Percentage of facilities that always provide an FP method on the same day |
|---|---|---|---|
| **Nairobi** | | | |
| Public | 15 | 80.0 | 73.3 |
| Private | 36 | 88.9 | 83.3 |
| **Mombasa** | | | |
| Public | 5 | 100.0 | 100.0 |
| Private | 31 | 96.8 | 90.3 |
| **Kisumu** | | | |
| Public | 5 | 80.0 | 80.0 |
| Private | 21 | 81.0 | 66.7 |
| **Machakos** | | | |
| Public | 2 | 100.0 | 100.0 |
| Private | 13 | 76.9 | 76.9 |
| **Kakamega** | | | |
| Public | 4 | 100.0 | 50.0 |
| Private | 10 | 90.0 | 50.0 |
| **Total** | | | |
| Public | 31 | 87.1 | 77.4 |
| Private | 111 | 88.3 | 78.4 |

[5] USAID Report of the Post abortion Care Technical Advisory Panel, April 2007.

### HIV/AIDS, TB, STI and PMTCT Services

HIV/AIDS, TB, STI and PMTCT services are essential components of integration. The survey results in Table 3.14 indicate that a majority of the facilities across all urban centers provided FP information (public facilities, 91 percent, versus private facilities, 83 percent) on the same day that a client sought these services. Provision of FP information, FP pills and injectables to clients seeking HIV/AIDS, TB, STI or PMTCT services was higher in public than private facilities across all the urban centers. Of note was that Kisumu and Kakamega had the lowest percentage of private facilities providing these short-term methods. In all the urban centers, a greater proportion of facilities provided pills and injectables than IUDs and implants to clients seeking HIV/AIDS, TB, STI or PMTCT services on the same day.

**Table 3.14: Integration of FP with HIV/AIDS Services, TB, STI or PMTCT**

**Among facilities offering either HIV/AIDS services, TB, STI or PMTCT, percentage distribution of facilities where family planning counseling services are integrated with either HIV/AIDS services, TB, STI or PMTCT, by type of FP service, managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Number of facilities offering HIV, PMTCT, STI and TB care | Percentage of facilities that always provide FP information on the same day | Percentage of facilities that always provide FP pills on the same day | Percentage of facilities that always provide injectable on the same day | Percentage of facilities that always provide IUD on the same day | Percentage of facilities that always provide implant on the same day | Percentage of facilities that always provide sterilization on the same day |
|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | |
| Public | 43 | 90.7 | 90.7 | 90.7 | 65.1 | 53.5 | 2.3 |
| Private | 64 | 87.5 | 84.4 | 82.8 | 39.1 | 40.6 | 3.1 |
| **Mombasa** | | | | | | | |
| Public | 15 | 93.3 | 93.3 | 86.7 | 26.7 | 26.7 | 0.0 |
| Private | 44 | 93.2 | 86.4 | 81.8 | 40.9 | 47.7 | 2.3 |
| **Kisumu** | | | | | | | |
| Public | 18 | 83.3 | 83.3 | 83.3 | 27.8 | 27.8 | 5.6 |
| Private | 35 | 68.6 | 57.1 | 60.0 | 25.7 | 22.9 | 5.7 |
| **Machakos** | | | | | | | |
| Public | 4 | 100.0 | 100.0 | 100.0 | 25.0 | 75.0 | 0.0 |
| Private | 26 | 88.5 | 73.1 | 73.1 | 42.3 | 38.5 | 7.7 |
| **Kakamega** | | | | | | | |
| Public | 6 | 100.0 | 83.3 | 83.3 | 16.7 | 16.7 | 0.0 |
| Private | 19 | 63.2 | 47.4 | 47.4 | 26.3 | 21.1 | 5.3 |
| **Total** | | | | | | | |
| Public | 86 | 90.7 | 89.5 | 88.4 | 45.3 | 41.9 | 2.3 |
| Private | 188 | 83.0 | 74.5 | 73.4 | 36.2 | 36.7 | 4.3 |

### 3.6.2 Providers Offering Integrated Family Planning Information on a Routine Basis

Integration of FP with non-FP-related MNCH services was also assessed at the provider level. The data on the providers routinely offering FP information to clients seeking other services were analyzed according to the cadre of providers and the results are shown in Table 3.15.

Among MNCH service providers interviewed, 83 percent provided HIV/AIDS management services, 79 percent provided antenatal care, 77 percent provided child welfare services, 70 percent provided postnatal care and less than 40 percent provided delivery and post-abortion care services. Except for delivery and post-abortion care services, nurses were the cadre with the highest percentage of staff providing non-FP MNCH services; these were followed by clinical officers. More than 90 percent of providers of these non-FP MNCH services reported that they routinely provided FP information to clients seeking these services. Overall, the nurses had the highest proportion of staff who routinely provided FP information to clients seeking non-FP MNCH services, followed by clinical officers and lastly the medical doctors.

**Table 3.15: Family Planning Information to Clients Seeking Other Services**

**Percentage distribution of providers routinely offering family planning information to clients seeking other services, by type of service and cadre of the service providers, Tupange/MLE, Kenya, 2011**

| | Number of providers | Antenatal care | | Delivery services | | Postnatal | | Post-abortion care | | Child welfare | | HIV/AIDS management | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Percentage of providers offering ANC | Percentage of providers routinely providing FP info to ANC clients | Percentage of providers offering delivery services | Percentage of providers routinely providing FP info to delivery care clients | Percentage of providers offering postnatal care | Percentage of providers routinely providing FP info to postnatal clients | Percentage of providers offering PAC services | Percentage of providers routinely providing FP info to PAC clients | Percentage of providers offering child welfare services | Percentage of providers routinely providing FP info to child immunization/ child growth monitoring services clients | Percentage of providers offering HIV/AIDs management services | Percentage of providers routinely providing FP info to HIV/AIDS management services clients |
| Doctors | 38 | 71.1 | 74.1 | 34.2 | 53.8 | 68.4 | 92.3 | 57.9 | 86.4 | 63.2 | 70.8 | 81.6 | 87.1 |
| Clinical officers | 96 | 74.0 | 91.5 | 43.8 | 95.2 | 65.6 | 95.2 | 62.5 | 96.7 | 64.6 | 90.3 | 79.2 | 94.7 |
| Nurses | 474 | 86.1 | 92.2 | 38.8 | 95.1 | 75.3 | 99.4 | 33.1 | 99.4 | 83.8 | 95.2 | 84.6 | 96.5 |
| Other | 76 | 46.1 | 77.1 | 23.7 | 94.4 | 39.5 | 96.7 | 18.4 | 100.0 | 52.6 | 80.0 | 81.6 | 88.7 |
| Total | 684 | 79.1 | 90.2 | 37.6 | 93.0 | 69.6 | 98.3 | 37.0 | 97.6 | 76.5 | 92.4 | 83.3 | 94.9 |

## 3.7 Stocking and Ordering

To describe the current stocking and ordering process, facility respondents were asked their sources for FP commodities, length of time since the last routine supply of contraceptives was received, the length of time taken to receive ordered routine supplies and mode of delivery of stock. Responses were grouped according to type of FP method and type of facility. Table 3.16 provides information on the percentage distribution among facilities providing contraceptives.

KEMSA and the District Stores were the main suppliers of contraceptives in public facilities. Pharmacies/wholesalers/dealers were the major source of contraceptive supplies to private facilities for all methods except progestin-only pills, which were supplied by KEMSA. Generally, a higher proportion of private facilities (39-61 percent) than public facilities (34-41 percent) had received their last routine supply of contraceptives less than four weeks prior to the survey.

A higher proportion of public facilities than private facilities reported receiving their last routine supply of contraceptives more than 12 weeks before the day of the survey.

The length of time taken by a facility to receive ordered FP supplies often influences the frequency and duration of stock-outs for specific methods. Close to 90 percent of private facilities receive their ordered supplies within one week whereas public facilites often wait more than five weeks to receive their supplies (Table 3.16). For all FP methods, private facilities usually received most of their supplies directly from the suppliers. Furthermore, there were nearly as many public facilities that received their supplies directly from the suppliers, as KEMSA is the main supplier of health commodities to public hospitals.

**Table 3.16: Stocking and Ordering**

**Among facilities that provide contraceptives, percentage distribution of the routine sources of commodities; percentage distribution of facilities by length of time the last routine supply took; percentage distribution of facilities by length of time taken to receive ordered routine supplies; and percentage distribution of facilities by mode of delivery of stocks, by type of the FP method and managing authority, Tupange/MLE, Kenya, 2011**

| | Public | | | | | | Private | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Combined oral pill | Progestin-only pill | Male condom | Injectable | EC | Implant | Combined oral pill | Progestin-only pill | Male condom | Injectable | EC | Implant |
| **Source of contraceptive stock*** | | | | | | | | | | | | |
| KEMSA | 69.0 | 20.0 | 61.6 | 69.0 | 67.4 | 63.3 | 3.1 | 27.8 | 3.2 | 3.6 | 3.0 | 3.8 |
| District store | 59.8 | 57.5 | 58.1 | 52.9 | 53.5 | 44.9 | 62.0 | 66.7 | 68.8 | 54.8 | 62.2 | 58.7 |
| Other facility | 5.7 | 0.0 | 2.3 | 6.9 | 4.7 | 8.2 | 6.1 | 6.3 | 6.5 | 4.8 | 6.7 | 5.8 |
| International NGO | 0.0 | 0.0 | 8.1 | 0.0 | 0.0 | 6.1 | 5.5 | 2.7 | 8.4 | 4.2 | 5.2 | 8.7 |
| Local NGO | 1.1 | 0.0 | 2.3 | 1.1 | 1.2 | 2.0 | 1.8 | 1.8 | 4.5 | 1.8 | 2.2 | 1.9 |
| Pharm/Wholesale/DLR | 4.6 | 20.0 | 3.5 | 5.7 | 2.3 | 2.0 | 42.3 | 23.3 | 22.7 | 53.0 | 38.5 | 34.6 |
| Other | 2.3 | 1.1 | 3.5 | 1.1 | 0.0 | 0.0 | 3.1 | 2.8 | 5.8 | 3.6 | 0.0 | 0.0 |
| **Last routine supply of contraceptives** | | | | | | | | | | | | |
| Less than 4 weeks ago | 34.5 | 36.8 | 34.9 | 40.2 | 33.7 | 40.8 | 53.4 | 47.5 | 44.8 | 61.4 | 43.7 | 39.4 |
| 4–12 weeks ago | 25.3 | 24.1 | 23.3 | 26.4 | 15.1 | 18.4 | 17.8 | 25.5 | 20.1 | 16.9 | 19.3 | 22.1 |
| More than 12 weeks ago | 32.2 | 27.6 | 20.9 | 23.0 | 38.4 | 18.4 | 20.9 | 19.9 | 20.1 | 12.7 | 25.9 | 26.9 |
| No routine supply system | 6.9 | 10.3 | 11.6 | 10.3 | 10.5 | 12.2 | 7.4 | 7.1 | 12.3 | 9.0 | 10.4 | 10.6 |
| Don't know | 0.0 | 0.0 | 7.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.3 | 0.0 | 0.7 | 1.0 |
| Missing | 1.1 | 1.1 | 2.3 | 0.0 | 2.3 | 10.2 | 0.6 | 0.0 | 1.3 | 0.0 | 0.0 | 0.0 |
| **Average length of time to receive ordered supplies** | | | | | | | | | | | | |
| One week or less | 40.2 | 41.4 | 46.5 | 39.1 | 41.9 | 38.8 | 87.7 | 85.1 | 83.1 | 89.2 | 87.4 | 87.5 |
| 2–4 weeks | 18.4 | 17.2 | 14.0 | 18.4 | 16.3 | 18.4 | 6.1 | 7.1 | 9.1 | 6.0 | 5.9 | 5.8 |
| More than 5 weeks | 37.9 | 36.8 | 30.2 | 39.1 | 37.2 | 32.7 | 4.9 | 5.0 | 3.9 | 2.4 | 4.4 | 4.8 |
| Other | 1.1 | 1.1 | 1.2 | 1.1 | 1.2 | 0.0 | 0.6 | 1.4 | 1.3 | 2.4 | 0.7 | 1.0 |
| Don't know | 2.3 | 2.3 | 5.8 | 2.3 | 2.3 | 2.0 | 0.0 | 0.0 | 1.3 | 0.0 | 0.7 | 0.0 |
| Missing | 0.0 | 1.1 | 2.3 | 0.0 | 1.2 | 8.2 | 0.6 | 1.4 | 1.3 | 0.0 | 0.7 | 1.0 |

**Table 3.16: Stocking and Ordering**

**Among facilities that provide contraceptives, percentage distribution of the routine sources of commodities; percentage distribution of facilities by length of time the last routine supply took; percentage distribution of facilities by length of time taken to receive ordered routine supplies; and percentage distribution of facilities by mode of delivery of stocks, by type of the FP method and managing authority, Tupange/MLE, Kenya, 2011**

| | Public | | | | | | Private | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Combined oral pill | Progestin-only pill | Male condom | Injectable | EC | Implant | Combined oral pill | Progestin-only pill | Male condom | Injectable | EC | Implant |
| **Mode of obtaining ordered supplies** | | | | | | | | | | | | |
| Delivered | 58.1 | 56.3 | 54.7 | 58.6 | 55.8 | 55.1 | 13.0 | 12.8 | 11.0 | 11.4 | 11.9 | 15.4 |
| Must pick them up | 41.9 | 43.7 | 41.9 | 41.4 | 43.0 | 36.7 | 81.8 | 87.2 | 88.3 | 88.0 | 88.1 | 83.7 |
| Missing | 0.0 | 0.0 | 3.5 | 0.0 | 1.2 | 8.2 | 5.2 | 0.0 | 0.6 | 0.6 | 0.0 | 1.0 |
| **Total number of facilities which stock the method** | 78 | 81 | 79 | 74 | 78 | 39 | 148 | 126 | 133 | 148 | 110 | 89 |

*The source of contraceptive stock does not sum to 100% due to multiple responses.

## 3.8 Stock-Outs of Contraceptives, Contraceptive Method Mix and Method Availability

This section presents information from the five urban centers on stock-outs of contraceptives, in the past 30 days and past one year before the day of the survey. A stock-out refers to either a lack of availability of a method in a facility that lasts for at least 24 hours or current non-availability of the method. Facility respondents were asked whether the methods they reported providing were currently available, and if they had a stock-out for the method in the past 30 days and in the past one year. Analysis for this section is limited to a smaller number of facilities than the total. A few facilities, all from Nairobi, had received FP commodities with support of Tupange just before the survey was conducted. These facilities were excluded from the analysis in order to provide a more accurate estimate of indicators discussed in this section. Table 3.17 shows the distribution of facilities with a routine supply of contraceptives.

### 3.8.1 Overview of Stock-Outs

For stock-outs occurring in the past 30 days prior to the survey, the majority were for injectables in the public facilities (26 percent) and emergency contraceptives in the private facilities (25 percent). Regarding the past one year prior to the survey, the majority of the stock-outs were for injectables (public 60 percent versus private 50 percent). Nearly half of the facilities reported condom stock-outs in the past one year (public facilities, 49 percent versus private facilities, 47 percent).

### 3.8.2 Stock-Outs in Public Facilities

Overall, more than 75 percent of the public facilities reported having all the FP methods in stock at the time of the survey. In Kakamega, all the public facilities had current stocks of FP methods except implants (50 percent); in Machakos, all FP methods were available in all facilities except for progestin-only pills (75 percent) and IUDs (50 percent). Except for injectables (78 percent) and emergency contraceptives (89 percent), all other FP methods were available in more than 90 percent of the public facilities in Kisumu. At least 80 percent of the public facilities in Nairobi had current stocks of FP methods, while in Mombasa, IUDs and implants were the least likely methods to be currently in stock in the facilities (63 percent), compared to the combined oral pill, which was currently available in all the facilities at the time of the survey.

The most likely stock-outs in public facilities in the past 30 days prior to the survey were for injectables (25 percent), followed by implants (23 percent), while the smallest proportion of stock-outs in the past 30 days was reported for progestin-only pills (10 percent). Across the urban centers, in the past 30 days before the survey, Nairobi and Mombasa had stock-outs in all FP methods. Kisumu reported stock-outs in five methods (injectables, 28 percent; condoms, 28 percent; emergency contraceptives, 11 percent; combined pills and progestin-only pills, 6 percent each). Machakos facilities had stock-outs in three methods (implants, 33 percent; progestin-only pills and emergency contraceptives, 25 percent each). Kakamega facilities reported stock-outs only in implants (50 percent) and condoms (17 percent).

**Table 3.17: Current Stocks and Stock-Outs**

**Among facilities offering specific FP method, percentage of facilities that currently stock the method; percentage of facilities that have had a stock-out in the last 30 days; and percentage of facilities that have had stock-out in the past one year, by managing authority, method type and urban area, Tupange/MLE, Kenya, 2011**

| | Public | | | | Private | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of facilities providing method | Percentage of facilities that have method currently in stock | Percentage of facilities with a stock-out* in the last 30 days | Percentage of facilities with a stock-out* in the last one year | Number of facilities providing method | Percentage of facilities that have method currently in stock | Percentage of facilities with a stock-out* in the last 30 days | Percentage of facilities with a stock-out* in the last one year |
| **Nairobi** | **N = 38** | | | | **N = 54** | | | |
| IUD | 31 | 83.9 | 16.1 | 22.6 | 32 | 87.5 | 15.6 | 21.9 |
| Injectable | 38 | 81.6 | 28.9 | 68.4 | 50 | 86.0 | 18.0 | 56.0 |
| Implant | 26 | 76.9 | 19.2 | 46.2 | 36 | 80.6 | 19.4 | 36.1 |
| Combined oral pill | 38 | 81.6 | 18.4 | 42.1 | 50 | 88.0 | 18.0 | 42.0 |
| Progestin-only pill | 38 | 94.7 | 5.3 | 28.9 | 47 | 95.7 | 4.3 | 19.1 |
| Emergency contraceptive | 37 | 94.6 | 8.1 | 10.5 | 45 | 93.3 | 15.6 | 38.0 |
| Condom | 37 | 97.3 | 5.4 | 54.1 | 49 | 91.8 | 8.2 | 46.9 |
| **Mombasa** | **N = 16** | | | | **N = 39** | | | |
| IUD | 8 | 62.5 | 25.0 | 25.0 | 22 | 90.9 | 9.1 | 31.8 |
| Injectable | 16 | 87.5 | 31.3 | 62.5 | 38 | 92.1 | 21.1 | 50.0 |
| Implant | 8 | 62.5 | 37.5 | 50.0 | 23 | 87.0 | 17.4 | 30.4 |
| Combined oral pill | 16 | 100.0 | 6.3 | 25.0 | 37 | 97.3 | 16.2 | 32.4 |
| Progestin-only pill | 16 | 87.5 | 25.0 | 50.0 | 34 | 85.3 | 23.5 | 38.2 |
| Emergency contraceptive | 16 | 81.3 | 31.3 | 31.3 | 34 | 58.8 | 38.2 | 45.9 |
| Condom | 16 | 87.5 | 18.8 | 37.5 | 34 | 82.4 | 23.5 | 47.1 |
| **Kisumu** | **N = 18** | | | | **N = 36** | | | |
| IUD | 5 | 100.0 | 0.0 | 20.0 | 17 | 88.2 | 0.0 | 5.9 |
| Injectable | 18 | 77.8 | 27.8 | 38.9 | 27 | 92.6 | 22.2 | 48.1 |
| Implant | 5 | 100.0 | 0.0 | 20.0 | 15 | 100.0 | 6.7 | 20.0 |
| Combined oral pill | 18 | 94.4 | 5.6 | 5.6 | 27 | 92.6 | 11.1 | 29.6 |
| Progestin-only pill | 18 | 94.4 | 5.6 | 5.6 | 23 | 87.0 | 21.7 | 47.8 |

**Table 3.17: Current Stocks and Stock-Outs**

**Among facilities offering specific FP method, percentage of facilities that currently stock the method; percentage of facilities that have had a stock-out in the last 30 days; and percentage of facilities that have had stock-out in the past one year, by managing authority, method type and urban area, Tupange/MLE, Kenya, 2011**

| | Public | | | | Private | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of facilities providing method | Percentage of facilities that have method currently in stock | Percentage of facilities with a stock-out* in the last 30 days | Percentage of facilities with a stock-out* in the last one year | Number of facilities providing method | Percentage of facilities that have method currently in stock | Percentage of facilities with a stock-out* in the last 30 days | Percentage of facilities with a stock-out* in the last one year |
| Emergency contraceptive | 18 | 88.9 | 11.1 | 11.1 | 20 | 90.0 | 20.0 | 34.8 |
| Condom | 18 | 77.8 | 27.8 | 55.6 | 26 | 92.3 | 23.1 | 57.7 |
| **Machakos** | **N = 4** | | | | **N = 26** | | | |
| IUD | 2 | 50.0 | 0.0 | 0.0 | 13 | 84.6 | 15.4 | 38.5 |
| Injectable | 4 | 100.0 | 0.0 | 25.0 | 21 | 85.7 | 23.8 | 33.3 |
| Implant | 3 | 100.0 | 33.3 | 66.7 | 14 | 71.4 | 35.7 | 57.1 |
| Combined oral pill | 4 | 100.0 | 0.0 | 0.0 | 20 | 85.0 | 20.0 | 30.0 |
| Progestin-only pill | 4 | 75.0 | 25.0 | 25.0 | 14 | 78.6 | 21.4 | 50.0 |
| Emergency contraceptive | 4 | 100.0 | 25.0 | 25.0 | 13 | 76.9 | 30.8 | 22.2 |
| Condom | 4 | 100.0 | 0.0 | 25.0 | 16 | 62.5 | 37.5 | 50.0 |
| **Kakamega** | **N = 6** | | | | **N = 20** | | | |
| IUD | 3 | 100.0 | 0.0 | 0.0 | 8 | 100.0 | 0.0 | 25.0 |
| Injectable | 6 | 100.0 | 0.0 | 83.3 | 13 | 84.6 | 15.4 | 46.2 |
| Implant | 2 | 50.0 | 50.0 | 50.0 | 6 | 83.3 | 16.7 | 16.7 |
| Combined oral pill | 6 | 100.0 | 0.0 | 0.0 | 12 | 100.0 | 0.0 | 33.3 |
| Progestin-only pill | 6 | 100.0 | 0.0 | 0.0 | 7 | 100.0 | 0.0 | 14.3 |
| Emergency contraceptive | 6 | 100.0 | 0.0 | 0.0 | 8 | 75.0 | 25.0 | 27.3 |
| Condom | 6 | 100.0 | 16.7 | 50.0 | 12 | 75.0 | 25.0 | 25.0 |
| **Total** | **N = 82** | | | | **N = 175** | | | |
| IUD | 49 | 81.6 | 14.3 | 20.4 | 92 | 89.1 | 9.8 | 23.9 |
| Injectable | 82 | 84.1 | 25.6 | 59.8 | 149 | 88.6 | 20.1 | 49.0 |
| Implant | 44 | 77.3 | 22.7 | 45.5 | 94 | 84.0 | 19.1 | 34.0 |

**Table 3.17: Current Stocks and Stock-Outs**

**Among facilities offering specific FP method, percentage of facilities that currently stock the method; percentage of facilities that have had a stock-out in the last 30 days; and percentage of facilities that have had stock-out in the past one year, by managing authority, method type and urban area, Tupange/MLE, Kenya, 2011**

| | Public | | | | Private | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of facilities providing method | Percentage of facilities that have method currently in stock | Percentage of facilities with a stock-out* in the last 30 days | Percentage of facilities with a stock-out* in the last one year | Number of facilities providing method | Percentage of facilities that have method currently in stock | Percentage of facilities with a stock-out* in the last 30 days | Percentage of facilities with a stock-out* in the last one year |
| Combined oral pill | 82 | 90.2 | 11.0 | 25.6 | 146 | 91.8 | 15.1 | 34.9 |
| Progestin-only pill | 82 | 92.7 | 9.8 | 25.6 | 125 | 89.6 | 14.4 | 32.8 |
| Emergency contraceptive | 81 | 91.4 | 13.6 | 14.6 | 120 | 80.0 | 25.0 | 36.7 |
| Condom | 81 | 91.4 | 13.6 | 49.4 | 137 | 84.7 | 19.7 | 47.4 |

***** A "stock-out" refers to a lack of availability of a method in a facility that lasts **at least** 24 hours or current non-availability of the method.

Note: N=Total number of facilities.

For stock-outs in the past one year prior to the survey, Nairobi, Mombasa and Kisumu reported stock-outs in all FP methods, while Machakos reported stock-outs in five FP methods and Kakamega had only three methods with stock-outs. In all urban centers, injectables were the most commonly reported method with stock-outs (39 percent in Kisumu to 83 percent in Kakamega), followed by implants (20 percent in Kisumu to 67 percent in Machakos), condoms (25 percent in Machakos to 56 percent in Kisumu), emergency contraceptives (11 percent in Kisumu to 31 percent in Mombasa), progestin-only pills (6 percent in Kisumu to 50 percent in Mombasa), combined oral pills (6 percent in Kisumu to 42 percent in Nairobi) and IUDs (20 percent in Nairobi and Kisumu to 25 percent in Mombasa).

### 3.8.3 Stock-Outs in Private Facilities

On average, the majority of the private facilities (80 – 92 percent) reported having all the FP methods currently in stock at the time of the survey. Kakamega reported the highest proportion of facilities with IUDs, combined oral pills and progestin-only pills (100 percent of facilities for each), while Kisumu had the highest proportion of facilities with current implant stocks (100 percent). Nairobi had the highest proportion of facilities that currently stocked condoms (93 percent), while Machakos had the lowest proportion of facilities that had condoms in stock (63 percent). Current stocks in injectables ranged between 85 percent in Kakamega and 93 percent in Mombasa. Current stocks of emergency contraceptives varied considerably between the urban centers, with the highest proportion of facilities currently stocking the method being in Nairobi (93 percent) and the lowest proportion of facilities being in Mombasa (64 percent).

The majority of the stock-outs in private facilities in the past 30 days prior to the survey occurred for emergency contraceptives (25 percent) followed by injectables (20 percent), while the smallest proportion of stock-outs in the past 30 days were reported for IUDs (10 percent). Across the urban centers, in the past 30 days before the survey, the pattern of stock-outs varied as follows: Nairobi, Mombasa and Machakos had stock-outs in all FP methods; Kisumu had stock-outs in six methods, while Kakamega reported the least number of FP methods with stock-outs.

For stock-outs in the past one year prior to the survey, all urban centers reported stock-outs in all FP methods. In all the urban centers, injectables were the most commonly reported method with stock-outs in private facilities (33 percent in Machakos to 56 percent in Nairobi), followed by condoms (25 percent in Kakamega to 58 percent in Kisumu). The least commonly reported stock-outs were for IUDs (six percent in Kisumu to 39 percent in Machakos) and implants (17 percent in Kakamega to 57 percent in Machakos). The occurrence of stock-outs in private facilities in the last 30 days, one year and at th etime of the interview are documented in Table 3.17.

## 3.9 Mean Cost of FP Consultation and Method Provision

The cost of accessing FP methods and services is one of the determinants of the choice of FP method by a client. This section provides information on the costs of FP methods and procedures to the clients by urban area.

**Table 3.18: Cost of Family Planning Consultation and Method**

**Among facilities that offer the specified family planning method, mean cost of family planning consultation and method to client, and percentage of clients who pay the cost, by method and urban area, Tupange/MLE, Kenya, 2011**

| | Mean cost of consultation and method to client (KES) | Percentage of clients who pay for the method |
|---|---|---|
| **Nairobi** | | |
| IUD | 337 | 87.9 |
| Injectable | 75 | 93.6 |
| Implant | 456 | 84.0 |
| Combined oral pill | 46 | 94.0 |
| Progestin-only pill | 46 | 93.9 |
| Emergency contraceptives | 46 | 93.9 |
| Condom | 9 | 92.9 |
| **Mombasa** | | |
| IUD | 605 | 84.0 |
| Injectable | 113 | 90.4 |
| Implant | 752 | 85.0 |
| Combined oral pill | 91 | 92.1 |
| Progestin-only pill | 71 | 91.8 |
| Emergency contraceptives | 74 | 94.9 |
| Condom | 4 | 75.0 |
| **Kisumu** | | |
| IUD | 892 | 87.2 |
| Injectable | 130 | 93.2 |
| Implant | 791 | 83.1 |
| Combined oral pill | 76 | 94.1 |
| Progestin-only pill | 66 | 91.7 |
| Emergency contraceptives | 52 | 98.0 |
| Condom | 3 | 100.0 |
| **Machakos** | | |
| IUD | 767 | 100.0 |
| Injectable | 157 | 98.9 |
| Implant | 977 | 100.0 |
| Combined oral pill | 98 | 99.9 |
| Progestin-only pill | 159 | 99.7 |
| Emergency contraceptives | 135 | 100.0 |
| Condom | 16 | 100.0 |
| **Kakamega** | | |
| IUD | 385 | 87.3 |
| Injectable | 116 | 85.0 |
| Implant | 336 | 87.5 |
| Combined oral pill | 93 | 84.1 |
| Progestin-only pill | 25 | 57.3 |
| Emergency contraceptives | 91 | 83.0 |
| Condom | 38 | 39.0 |

**Table 3.18: Cost of Family Planning Consultation and Method**

**Among facilities that offer the specified family planning method, mean cost of family planning consultation and method to client, and percentage of clients who pay the cost, by method and urban area, Tupange/MLE, Kenya, 2011**

| | Mean cost of consultation and method to client (KES) | Percentage of clients who pay for the method |
|---|---|---|
| **Total** | | |
| IUD | 512 | 88.3 |
| Injectable | 105 | 92.9 |
| Implant | 620 | 86.1 |
| Combined oral pill | 70 | 93.8 |
| Progestin-only pill | 64 | 93.0 |
| Emergency contraceptives | 64 | 94.8 |
| Condom | 10 | 90.7 |

The in-charges at each facility were asked how much a new client pays for an FP method and procedure, and the percentage of clients that receive free services. There were significant differences in the mean cost per client across the urban centers. For example, IUD was KES 337 in Nairobi compared with KES 892 in Kisumu.

Kisumu had the lowest cost of condoms, at KES 3, while Kakamega had the highest cost at KES 38.

In all the urban centers except Machakos, oral pills (combined oral pills, progestin-only pills and emergency contraceptives) were relatively low, with a cost of less than KES 100 to the client. The prices were comparatively higher in Machakos, where the cost ranged from KES 98 (combined pills) to KES 159 (progestin-only pills). Nairobi had the lowest cost of pills, at KES 46 for each of the three types. While is expected that the cost of daily pills in Kenya should be lower than that of emergency contraceptives, the survey showed higher costs of daily pills, perhaps due to costs of consultation services. In all the urban centers, the implant was the most expensive method type (range of KES 336 in Kakamega to KES 977 in Machakos) followed by the IUD (range of KES 337 in Nairobi to KES 892 in Kisumu), except in Kisumu where the reverse was true. Injectables were the third most expensive method in all the urban centers, except in Machakos, where they were the fourth most expensive, after progestin-only pills (injectables cost range of KES 75 in Nairobi to KES 157 in Machakos).

## 3.10 Storage of Family Planning Commodities in Facilities

Proper storage and handling of contraceptive commodities is an important determinant of the quality of service. It is important for facilities to follow correct storage procedures but sometimes this may be hampered by factors such as lack of space or proper management procedures. Interviewers assessed, through observation, whether the storage of FP commodities met the required standards. These findings are presented in Table 3.19. The settings of the storage areas were included in this analysis.

On average, more than 80 percent of the public and private facilities met the required storage conditions; the public-to-private sector variations in storage conditions were unremarkable. More than 85 percent of the facilities in all the urban centers stored their contraceptives off the floor except in Kakamega, where only two-thirds of the public facilities, and in Machakos three-quarters of the public facilities, met this requirement. In Machakos, only a half of the public facilities and two-thirds of the private facilities had FP commodities protected from dampness.

**Table 3.19: Storage Conditions for FP Commodities**

**Percentage of facilities* currently offering family planning services that have correct storage conditions for FP commodities, by managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Contraceptives are stored off the floor | Contraceptives are protected from leaking roof | Contraceptives are protected from sun | Contraceptives are protected from pests | Injectables are stored upright** | Methods are protected from dampness | Room is well ventilated | Total number of facilities* |
|---|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | | |
| Public | 93.0 | 97.7 | 100.0 | 100.0 | 97.7 | 86.1 | 76.7 | 43 |
| Private | 96.8 | 95.2 | 98.4 | 95.2 | 98.4 | 90.7 | 82.3 | 62 |
| **Mombasa** | | | | | | | | |
| Public | 93.8 | 100.0 | 93.8 | 87.5 | 100.0 | 92.9 | 87.5 | 16 |
| Private | 97.7 | 100.0 | 100.0 | 97.7 | 100.0 | 90.0 | 95.3 | 43 |
| **Kisumu** | | | | | | | | |
| Public | 94.4 | 94.4 | 100.0 | 83.3 | 100.0 | 92.9 | 88.9 | 18 |
| Private | 89.3 | 89.3 | 92.9 | 92.9 | 89.3 | 92.0 | 89.3 | 28 |
| **Machakos** | | | | | | | | |
| Public | 75.0 | 100.0 | 100.0 | 100.0 | 75.0 | 50.0 | 100.0 | 4 |
| Private | 91.3 | 87.0 | 91.3 | 91.3 | 91.3 | 66.7 | 91.3 | 23 |
| **Kakamega** | | | | | | | | |
| Public | 66.7 | 100.0 | 83.3 | 100.0 | 83.3 | 100.0 | 100.0 | 6 |
| Private | 92.3 | 100.0 | 100.0 | 100.0 | 92.3 | 72.7 | 92.3 | 13 |
| **Total** | | | | | | | | |
| Public | 90.8 | 97.7 | 97.7 | 94.3 | 96.6 | 87.8 | 83.9 | 87 |
| Private | 94.7 | 94.7 | 97.0 | 95.3 | 95.9 | 86.5 | 88.8 | 169 |

* Based on 256 facilities offering any contraceptive method and where the method was available and storage areas were observable.
** These percentages are based on 222 facilities that offer injectables and where the stocking area was observable.

## 3.11 Service Providers' Training

Providers' training is likely to influence FP service provision in facilities considerably. Providers interviewed were asked questions on the type of FP training they received and the FP methods covered during the training. More than 95 percent of providers in both public and private facilities had received pre-service training on FP methods. However, only a third of providers interviewed had received in-service training on any FP method since 2010, with Nairobi having the highest proportion of providers with in-service training (public facilities, 33 percent; private facilities 35 percent) and Machakos having the lowest (public facilities, 14 percent; private facilities, 13 percent), as shown in Table 3.20.

**Table 3.20: Pre-Service and In-Service Training of Providers since 2010**

**Percentage of providers who received pre-service training on any FP methods; percentage of providers who received in-service training since 2010 on any FP methods, by managing authority and urban area, Tupange/MLE, Kenya, 2011**

| Urban area/ Facility type | Received pre-service training on any FP topic/method | Received in-service training on any FP topic/method since 2010 | Number of providers |
|---|---|---|---|
| **Nairobi** | | | |
| Public | 96.1 | 33.1 | 154 |
| Private | 95.3 | 34.9 | 149 |
| **Mombasa** | | | |
| Public | 98.4 | 29.5 | 61 |
| Private | 97.6 | 31.3 | 83 |
| **Kisumu** | | | |
| Public | 93.6 | 23.4 | 47 |
| Private | 92.7 | 15.9 | 82 |
| **Machakos** | | | |
| Public | 100.0 | 14.3 | 14 |
| Private | 89.7 | 12.8 | 39 |
| **Kakamega** | | | |
| Public | 100.0 | 30.0 | 20 |
| Private | 100.0 | 28.6 | 35 |
| **Total** | | | |
| Public | 96.6 | 29.7 | 296 |
| Private | 95.1 | 27.3 | 388 |

Regarding method-specific pre-service training, providers were asked if they had been trained on the following FP modules: contraceptive technology update (CTU), clinical skills on IUD, clinical skills on implant, clinical skills on female sterilization, clinical skills on male sterilization, post-abortion care and the 2006 (new) Comprehensive Reproductive Health Curriculum. As shown in Table 3.22, not all providers who reported to have received pre-service training had been trained on these key FP topics. Across all cadres, the new 2006 Comprehensive Reproductive Health Curriculum was the least-covered topic in pre-service training (21 percent), while clinical skills in IUD (76 percent) and contraceptive technology update (74 percent) were the most covered topics. For all pre-service training topics, doctors had the highest proportion of providers trained, followed by clinical officers and then nurses. A slight variation in this trend was noted in post-abortion care and clinical skills in female sterilization, where clinical officers had the highest proportion of providers trained, as shown in Table 3.21. Only 55 percent of the nurses had received pre-service training on post-abortion care compared to 85 percent of clinical

officers and 81 percent of doctors. This represents an important gap in training because nurses are the cadre of staff that is most directly involved in the care of the post-abortion client.

**Table 3.21: Method-Specific Pre-Service Training of Providers**

**Percentage of providers who received a pre-service training in FP, by cadre of the provider, and FP topic covered in the training, Tupange/MLE 2010, Kenya 2011**

| Training subject | Doctors | Clinical officers | Nurses | Other | Total |
|---|---|---|---|---|---|
| Contraceptive technology update | 86.8 | 82.3 | 75.9 | 44.7 | 74.0 |
| Clinical skills on IUD | 86.8 | 84.4 | 81.2 | 30.3 | 76.3 |
| Clinical skills on implant | 81.6 | 78.1 | 65.4 | 31.6 | 64.3 |
| Clinical skills on female sterilization | 84.2 | 62.5 | 64.3 | 27.6 | 61.1 |
| Clinical skills on male sterilization | 68.4 | 64.6 | 61.6 | 26.3 | 58.5 |
| Post-abortion care* | 81.6 | 85.4 | 55.1 | 18.4 | 56.7 |
| New RH curriculum** | 28.9 | 26.0 | 20.9 | 13.2 | 21.2 |
| Number of providers | 38 | 96 | 474 | 76 | 684 |

* Received training on management of incomplete abortion and manual vacuum aspiration (MVA).
* *Curriculum: 2006 (New) Comprehensive Reproductive Health Curriculum - The training on all reproductive health components including abortion care and cancer screening for about five months.

Providers were asked about their in-service training history on the same subjects since 2010. Table 3.22 shows that less than a quarter of the providers in each cadre had received in-service training on any of these FP topics. Across all cadres, CTU was the most covered module for in-service training (21 percent) followed closely by specific skills on clinical competencies in IUD (20 percent), while the 2006 (new) Comprehensive Reproductive Health Curriculum was the least covered module (4 percent). Doctors had the highest proportion of providers who had been trained on clinical skills in female sterilization, post-abortion care and the new Comprehensive Reproductive Health Curriculum, while nurses had the highest proportion of providers trained in the rest of the topics. Clinical officers had the least proportion of providers trained in any of the topics. In-service training on post-abortion care was least covered among nurses and clinical officers, at 7 percent, compared to doctors, at 18 percent.

**Table 3.22: Method-Specific In-Service Training of Providers**

**Percentage of providers who have received an in-service training in FP since 2010, by cadre of the provider and FP topic covered during the training, Tupange/MLE 2010, Kenya 2011**

| Training subject | Doctors | Clinical officers | Nurses | Other | Total |
|---|---|---|---|---|---|
| Contraceptive technology update | 21.1 | 15.6 | 23.6 | 10.5 | 20.9 |
| Clinical skills on IUD | 21.1 | 15.6 | 23.2 | 5.3 | 20.0 |
| Clinical skills on implant | 18.4 | 14.6 | 21.5 | 6.6 | 18.7 |
| Clinical skills on female sterilization | 13.2 | 7.3 | 12.9 | 7.9 | 11.5 |
| Clinical skills on male sterilization | 10.5 | 6.3 | 12.7 | 6.6 | 11.0 |
| Post-abortion care* | 18.4 | 7.3 | 7.0 | 3.9 | 7.3 |
| New RH curriculum** | 5.3 | 5.2 | 4.2 | 3.9 | 4.4 |
| Number of providers | 38 | 96 | 474 | 76 | 684 |

* Received training on management of incomplete abortion and MVA.
* *Curriculum: 2006 (New) Comprehensive Reproductive Health Curriculum - The training on all reproductive health components including abortion care and cancer screening for about five months.

## 3.12 Service Providers' Capacity to Offer Family Planning Services

Providers' level of knowledge to provide various family planning methods was assessed through the one-on-one interview process. For each method, providers were asked about their knowledge and ability/skills to provide the method. Table 3.23 provides information on service providers' level of knowledge to counsel and provide family planning methods according to cadre.

**Table 3.23: Providers by Level of Knowledge to Counsel and Family Planning Methods**

**Percentage distribution of service providers by level of knowledge to counsel and provide family planning methods, by cadre, Tupange/MLE, Kenya, 2011**

| Type of Provider | Method type | | | | |
|---|---|---|---|---|---|
| | All short-term methods | IUD | Implant | Female sterilization | Male sterilization |
| **Doctor** | | | **N = 38** | | |
| Can provide and counsel on method | 71.1 | 81.6 | 81.6 | 71.1 | 63.2 |
| Can counsel, but not provide method | 7.9 | 13.2 | 15.8 | 26.3 | 28.9 |
| Know little or nothing about the method/not comfortable counseling or providing | 21.1 | 5.3 | 2.6 | 2.6 | 7.9 |
| **Clinical officer** | | | **N = 96** | | |
| Can provide and counsel on method | 75.0 | 63.5 | 72.9 | 26.0 | 24.0 |
| Can counsel, but not provide method | 0.0 | 32.3 | 25.0 | 57.3 | 59.4 |
| Know little or nothing about the method/not comfortable counseling or providing | 25.0 | 4.2 | 2.1 | 16.7 | 16.7 |
| **Nurse** | | | **N = 474** | | |
| Can provide and counsel on method | 81.9 | 64.3 | 60.1 | 19.4 | 17.9 |
| Can counsel, but not provide method | 0.6 | 27.2 | 30.6 | 56.1 | 53.4 |
| Know little or nothing about the method/not comfortable counseling or providing | 17.5 | 8.4 | 9.3 | 24.5 | 28.7 |
| **Other** | | | **N = 76** | | |
| Can provide and counsel on method | 26.3 | 15.8 | 10.5 | 5.3 | 5.3 |
| Can counsel, but not provide method | 1.3 | 30.3 | 34.2 | 30.3 | 25.0 |
| Know little or nothing about the method/not comfortable counseling or providing | 72.4 | 53.9 | 55.3 | 64.5 | 69.7 |
| **Total** | | | **N = 684** | | |
| Can provide and counsel on method | 74.1 | 59.8 | 57.6 | 21.6 | 19.9 |
| Can counsel, but not provide method | 1.0 | 27.5 | 29.4 | 51.8 | 49.7 |
| Know little or nothing about the method/not comfortable counseling or providing | 24.9 | 12.7 | 13.0 | 26.6 | 30.4 |

The proportion of providers who could counsel and provide a FP method was highest for all short-term methods (74 percent), followed by IUD (60 percent) and implant (57 percent), and least for male sterilization (20 percent). Nevertheless, on average, a quarter of all the providers interviewed could not counsel/provide all short-term methods, and this was comparable to the proportion of providers who could not counsel/provide FP methods that require more technical skills such as female sterilization (26 percent of providers could not counsel/provide) and male sterilization (30 percent).

Not surprisingly, female and male sterilization had the highest proportion of providers who could counsel but not provide method (approximately 50 percent for both), reflecting the fact that only medical doctors can provide this service. Doctors had the highest proportion of providers who knew how to counsel and provide long-term and permanent methods (IUD, 82 percent; implant, 82 percent; female sterilization, 71 percent; male sterilization, 63 percent), while nurses had the highest proportion of providers who could counsel and provide all short-term methods (82 percent). Among other cadres of staff, nearly a third of them could counsel but not provide IUD, implant and female sterilization, a quarter of them could counsel on male sterilization, and a quarter could counsel and provide all short-term methods. These other cadres of staff are important in that they represent a category of providers who could be empowered to provide FP methods in the scale-up of service provision in areas where there is a shortage of clinical cadres of nurses, clinical officers and doctors.

## 3.13 Provider-Initiated Barriers to Provision of Family Planning Services

Although all individuals are entitled to their own RH choices, providers may restrict FP provision to clients for various reasons. For each method that health workers provide, they were asked if they would restrict a client's access to the method because of parity, marital status, age or availability of another person's consent. Providers working in private facilities were more likely to restrict across all methods and for any reason. In the public sector, there were high rates of restrictions for the three LAPMs (IUD, implant, female sterilization) on the basis of age. This was also true of condoms and injectables. Providers in private facilities are much more likely to require someone else's consent, with the totals ranging from 5 percent for condoms to almost 60 percent for female sterilizations. On the contrary, providers were generally least likely to restrict provision of any FP method based on marital status, with the exception of female sterilization. Restrictions on the use of injectables were high, especially for minimum age, given that this is a popular method among youth.

**Table 3.24: Providers' Barriers to FP Provision**

**Among service providers who report that they know specific FP methods to counsel and provide the method, percentage of providers who restrict FP provision to clients due to parity, marital status, need for another person's consent, or age by type of the method and managing authority, Tupange/MLE, Kenya, 2011**

| | Condom | Pill | Injectable | IUD | Implant | Female sterilization |
|---|---|---|---|---|---|---|
| **Parity** | | | | | | |
| Public | 0.0 | 18.6 | 21.1 | 7.9 | 9.0 | 34.5 |
| Private | 0.8 | 23.2 | 30.3 | 25.0 | 23.2 | 52.7 |
| **Marital status** | | | | | | |
| Public | 0.7 | 7.5 | 5.4 | 3.4 | 4.8 | 20.0 |
| Private | 1.6 | 11.4 | 13.4 | 12.1 | 12.3 | 38.7 |
| **Other's consent** | | | | | | |
| Public | 3.4 | 6.1 | 5.7 | 8.5 | 3.0 | 38.2 |
| Private | 5.1 | 12.0 | 12.8 | 19.8 | 21.5 | 58.1 |

**Table 3.24: Providers' Barriers to FP Provision**

**Among service providers who report that they know specific FP methods to counsel and provide the method, percentage of providers who restrict FP provision to clients due to parity, marital status, need for another person's consent, or age by type of the method and managing authority, Tupange/MLE, Kenya, 2011**

| | Condom | Pill | Injectable | IUD | Implant | Female sterilization |
|---|---|---|---|---|---|---|
| **Requires minimum age** | | | | | | |
| Public | 36.1 | 60.4 | 54.8 | 39.0 | 42.2 | 34.5 |
| Private | 43.0 | 68.1 | 64.1 | 59.5 | 61.0 | 47.3 |
| **Requires maximum age** | | | | | | |
| Public | 16.2 | 55.7 | 50.9 | 35.0 | 39.2 | 16.4 |
| Private | 19.9 | 60.8 | 57.9 | 44.8 | 48.7 | 25.8 |

## 3.14 Client Satisfaction with Services

One principal determinant of uptake and continued utilization of family planning services is overall client satisfaction with those services (Bruce, 1990). Client surveys can provide a quick and inexpensive way of determining areas of service where quality could be improved (Williams, 2000). Studies of contraceptive discontinuation rates, for example, have indicated that with the exception of the desire to become pregnant, the principal reason for contraceptive discontinuation is dissatisfaction with the quality of services (Blanc et al., 2002). Both private and public sector supply of FP services in urban areas of Kenya have different incentives to provide services of high quality and to ensure client satisfaction. As privatization and performance-based incentive schemes continue to become essential components for health strengthening in Kenya, the need for evidence-based assessment of quality differentials between private and public providers as well as the link between differentials in quality and client satisfaction has increasingly become important. This section presents information on various measures of client satisfaction of family planning and MNCH services in public and private facilities. Results for clients are presented in Table 3.25.

**Table 3.25: Client Waiting Time and Satisfaction with Services**

**Percentage distribution of MNCH clients, by selected measures of client satisfaction, type of client, and managing authority, Tupange/MLE, Kenya, 2011**

| | Public | | Private | | Total | |
|---|---|---|---|---|---|---|
| | Family planning clients | All other services | Family planning clients | All other services | Family planning clients | All other services |
| **Waiting time** | | | | | | |
| Less or equal to 15 minutes | 31.1 | 33.2 | 62.6 | 55.4 | 32.4 | 57.0 |
| 16-30 minutes | 25.4 | 25.2 | 23.6 | 23.2 | 25.3 | 23.3 |
| More than 30 minutes | 43.2 | 41.1 | 13.2 | 20.9 | 41.9 | 19.1 |
| Don't know/Missing | 0.3 | 0.5 | 0.5 | 0.6 | 0.5 | 0.6 |
| Waiting time is reasonable | 69.7 | 71.7 | 93.1 | 86.2 | 71.0 | 87.8 |
| Had visual privacy during their exam | 16.5 | 37.7 | 14.8 | 18.1 | 29.9 | 17.4 |
| Had aural privacy during their exam | 5.7 | 23.5 | 4.1 | 10.2 | 16.9 | 8.9 |
| Felt comfortable asking questions during their visit | 89.3 | 82.6 | 95.6 | 90.6 | 85.1 | 91.7 |
| Provider answered all of their questions | 75.9 | 73.5 | 87.1 | 82.7 | 74.4 | 83.7 |
| Information they shared with the provider will be kept confidential | 85.9 | 76.0 | 90.7 | 84.7 | 79.7 | 86.0 |
| Provider treated them "very well" during the visit | 30.0 | 28.9 | 42.0 | 39.1 | 29.3 | 39.8 |
| Reported overall satisfaction with their visit | 90.8 | 88.3 | 94.2 | 92.8 | 91.7 | 90.2 |
| Will use this facility for health care services in future | 98.8 | 96.2 | 98.9 | 96.5 | 98.9 | 96.3 |
| Would recommend it to family/friends | 98.1 | 95.7 | 97 | 96.4 | 97.8 | 96 |
| Will use this facility for health care services in future and would recommend it to family/friends | 97.5 | 94.3 | 96.7 | 94.7 | 97.3 | 94.5 |
| Total number of clients | 952 | 1,645 | 364 | 1,261 | 1,316 | 2,906 |

In the Kenyan MOH service charter, provision of timely health services is recognized as one of the ways of improving efficiency and effectiveness of service delivery in a bid to improve performance in the health sector (Health, 2006b). A larger proportion of clients seeking FP services waited for more than 30 minutes before they could be attended to in public facilities (43 percent), in comparison to 13 percent in the private facilities. A similar trend was observed in other non-FP MNCH clients, where the highest proportion of public facility clients waited for more than 30 minutes (41 percent), whereas the highest proportion of private facility clients waited for less than or equal to 15 minutes (55 percent). Irrespective of the length of the waiting time, about 70 percent of clients in public facilities reported that the waiting time was reasonable compared to those in private facilities (FP clients, 93 percent; non-FP MNCH clients, 86 percent).

FP clients reported less visual and aural privacy during their examinations than those seeking other services, with the percentages being lower in private facilities (visual privacy, 15 percent; aural privacy, 4 percent) than public facilities (visual privacy, 17 percent; aural privacy, 6 percent). In contrast, more than three-quarters of the clients believed the information they shared with the provider would be kept confidential. On average, 85 percent of FP clients and 92 percent of non-FP MNCH clients felt comfortable asking questions during their visit; however, slightly lower proportions of clients reported that the provider answered all of their questions (public facilities, 74 percent, private facilities, 84 percent). Less than a half of the clients reported that the provider treated them very well during their visit, with the proportions being lower in public facilities (FP clients, 30 percent; non-FP MNCH clients, 29 percent) than in private facilities (FP clients, 42 percent, non-FP MNCH clients, 40 percent). Overall satisfaction was high; close to 90 percent were "highly satisfied" or "satisfied," and most of the clients (at least 94 percent) reported they would use that facility for health care services in future and would recommend it to family/friends.

## 3.15 Access to Services and Choice of Health Facility

Clients seeking FP and MNCH services were asked to state various reasons for selecting the facility they had visited. As illustrated in Table 3.26, the reasons given by clients varied by the type of service sought, i.e., FP and other (non-FP MNCH) services. Among FP clients, the most commonly cited reasons for selecting the facility they visited were that the facility was close to their home (54 percent), it had a good reputation/good quality services (53 percent), and the providers of that facility treated patients well (24 percent). For other non-FP MNCH services, the most common reason cited by clients for selecting the facility visited was that it had good reputation/good quality services (60 percent), it was close to home (36 percent) and it provided the desired services (26 percent).

| Table 3.26: Reasons Cited by MNCH Clients for Selecting the Facility | | | |
|---|---|---|---|
| **Percentage distribution of reasons cited by MNCH clients for selecting the facility, by type of client, Tupange/MLE, Kenya, 2011** | | | |
| | **Family planning clients** | **All other services** | **Total** |
| **Reason for selecting this facility*** | | | |
| Close to home | 53.6 | 35.6 | 46.7 |
| Convenient/Close to place of work | 1.7 | 3.3 | 2.3 |
| Convenient operating hours | 2.5 | 6.2 | 3.9 |
| Good reputation/good quality services | 52.3 | 59.6 | 55.1 |
| Staff are discreet/Can remain anonymous | 3.0 | 4.5 | 3.6 |
| It is more affordable | 23.4 | 10.5 | 18.4 |
| Was referred to this facility | 5.3 | 10.6 | 7.3 |
| Far from home | 0.3 | 0.4 | 0.3 |
| Provide desired services | 21.4 | 25.7 | 23.0 |
| Facility accepts insurance | 0.2 | 5.5 | 2.3 |
| Providers treat patients well | 24.3 | 25.0 | 24.6 |
| Other reasons | 3.5 | 8.3 | 5.4 |
| Don't know | 0.0 | 0.1 | 0.1 |
| Total number of clients | 2,597 | 1,625 | 4,222 |

* Percentages don't sum to 100% because multiple responses can be given.

Of the clients interviewed, 60 percent reported that the facility was not the closest to their home (not shown). In order to determine why a client would bypass a facility that was closer to home to attend one that was farther away, respondents not seeking services from their nearest facility were asked to provide reasons for their decisions. Among clients at public facilities, the most commonly cited reason for not seeking services in the nearest facility was that the facility was more expensive (37 percent) and that it did not provide the desired services (15 percent). In comparison, among clients at private facilities, the most commonly cited consolidated reasons for not seeking services at the nearest facility were that the facility did not provide desired services (22 percent) and that the facility was of poor quality (10 percent).

Lack of trust in/dislike for facility or provider (6 percent), poor treatment of patients by providers (6 percent) and dislike for personnel (4 percent) were more commonly cited by clients interviewed at private facilities, implying that there was a need to improve provider-client relationships in private facilities. Inconvenient operating hours (7 percent) and crowding (6 percent) were more likely to be cited by private facility clients than public clients.

**Table 3.27: Reasons for Not Seeking Health Services in (Clients') Nearest Facility**

**Among clients who sought health service in a facility that was not closest to their home, percentage distribution of the main reason given for not seeking health services in their (client's) nearest facility, by managing authority, Tupange/MLE, Kenya, 2011***

| Main problem(s) with the nearest facility | Public | Private | Total |
|---|---|---|---|
| More expensive | 37.3 | 8.9 | 23.9 |
| Do not provide desired services | 14.5 | 22.0 | 18.1 |
| Don't like personnel | 2.9 | 3.7 | 3.3 |
| Facility of poor quality | 7.7 | 10.3 | 8.9 |
| Provider treats patients poorly | 5.0 | 5.8 | 5.4 |
| Prefers to remain anonymous | 2.7 | 2.4 | 2.5 |
| Inconvenient operating hours | 3.4 | 6.5 | 4.8 |
| Facility is crowded | 1.7 | 5.6 | 3.5 |
| Don't trust or like facility/ provider | 2.6 | 6.0 | 4.2 |
| Other | 15.4 | 25.0 | 19.9 |
| Don't know | 3.5 | 2.0 | 2.8 |
| Number of interviewed clients who report this is not the closest facility to their home. | 895 | 805 | 1,700 |

* Percentages do not sum to 100% because multiple responses can be given.

## 3.16 Exposure to Family Planning Messages among Clients Seeking Non-FP Services

To provide a basis for assessment of integration of FP services with other non-FP MNCH services at the client level, the survey collected data on clients who sought non-FP services and also received FP information and/or a FP method during their visit (Table 3.28).

Overall, 2,906 out of 4,222 interviewed clients (69 percent) had visited the facilities for reasons other than FP (public facilities, 63 percent: private facilities, 78 percent). Among these clients, 20 percent of those in public facilities received FP information as compared to 14 percent in private facilities. Nearly a third of the non-FP MNCH clients in both public and private facilities were already using a FP method, and approximately two-thirds of the clients did not receive any FP method or were in a facility that did not offer FP methods. Of clients who did not receive any FP method, 38 percent of those in public facilities and 31 percent in private facilities would have been interested in FP if the provider had offered it. Less than two percent of non-FP clients received any FP method or a referral for any method.

**Table 3.28: FP Information and Services Offered to Non-FP Clients**

**Total number of clients at facilities seeking information/services for MNCH that are not FP-related. Among those, percentage who received FP information and percentage who received FP services by type of service; and among clients who did not receive any FP service, percentage of those who would have been interested in FP, by managing authority, Tupange/MLE, Kenya, 2011**

| | Total number of clients | Number of clients at facility for services other than FP | Among clients at facility for other services, percentage who received FP information | Among clients at facility for other services, percentage of clients that received* | | | | | Among those who did not receive anything, percentage who would have been interested in FP if the provider had offered |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Any method | Referral for any method | Prescription | Did not receive anything or facility does not offer | Already using | |
| Public | 2,597 | 1,645 | 19.9 | 2.2 | 0.9 | 0.6 | 66.1 | 30.2 | 38.1 |
| Private | 1,625 | 1,261 | 13.7 | 0.9 | 0.2 | 0.4 | 65.7 | 32.7 | 31.1 |
| Total | 4,222 | 2,906 | 17.2 | 1.6 | 0.6 | 0.5 | 65.9 | 31.2 | 35.1 |

*Percentages may not sum to 100% due to missing cases.

## 3.17 Management Practices That Support Quality Assurance of FP Services

To improve FP service delivery standards and quality, health systems emphasize service management and supervision, quality assurance committees in facilities, periodic audits/reports and record-keeping.

Among facilities that provide FP, the survey asked for information on quality assurance practices and standard operating procedures, the results of which are shown in Table 3.29.

Private facilities were more likely to have quality assurance practices and standard operating procedures. Across all the urban centers, a lower proportion of public facilities (33 percent in Machakos to 46 percent in Mombasa) received at least four quarterly visits from external supervisors as compared to private facilities (55 percent in Mombasa to 67 percent in Machakos).

In all the urban centers, written guidelines/service protocols for FP service provision were more readily available in private facilities. The discrepancy was highest in Machakos, where four times as many private facilities as public ones had the guidelines/service protocols.

Across all urban centers, one and a half times as many public facilities as private ones had guidelines for FP/HIV integration except in Machakos, where these guidelines were available in all private facilities and in none of the public facilities. Guidelines/tools for pregnancy screening were available in facilities across the urban centers as follows: twice as many private facilities as public facilities in Nairobi and Kakamega; all private facilities and none of the public facilities in Machakos; almost half of public and private facilities in Kisumu; and nearly one and a half times as many private facilities as public facilities in Mombasa.

Periodic audits and quarterly service register compilations were done in nearly twice as many private facilities as public ones in Kisumu, Kakamega and Machakos while in Mombasa, nearly three times as many private facilities carried out these practices.

**Table 3.29: Presence of Standard Operating Manuals or Other Quality Assurance Documentation**

**Percentage of facilities providing family planning services with standard operating manuals or other quality assurance documentation, by type of protocol, managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Has QA committee or meetings for FP service delivery QA | Receives at least quarterly visits from external supervisors | Written guidelines/service protocols for FP service provision | Written guidelines for integration of FP and HIV | Guidelines/tools for pregnancy screening | Period audits/service registers compiled at least quarterly | Total number of facilities that offer FP |
|---|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | | |
| Public | 35.3 | 35.0 | 50.8 | 39.5 | 33.3 | 44.1 | 43 |
| Private | 64.7 | 65.0 | 49.2 | 60.5 | 66.7 | 55.9 | 62 |
| **Mombasa** | | | | | | | |
| Public | 57.1 | 45.5 | 36.1 | 37.5 | 37.9 | 27.9 | 16 |
| Private | 42.9 | 54.5 | 63.9 | 62.5 | 62.1 | 72.1 | 43 |
| **Kisumu** | | | | | | | |
| Public | 12.5 | 44.4 | 38.1 | 38.5 | 47.4 | 40.0 | 18 |
| Private | 87.5 | 55.6 | 61.9 | 61.5 | 52.6 | 60.0 | 30 |
| **Machakos** | | | | | | | |
| Public | 0.0 | 33.3 | 20.0 | 0.0 | 0.0 | 33.3 | 4 |
| Private | 100 | 66.7 | 80.0 | 100.0 | 100.0 | 66.7 | 24 |
| **Kakamega** | | | | | | | |
| Public | 0.0 | 40.0 | 33.3 | 40.0 | 33.3 | 40.0 | 6 |
| Private | 0.0 | 60.0 | 66.7 | 60.0 | 66.7 | 60.0 | 14 |

## 3.18 Outreach Programs

Outreach programs represent a significant strategy for increasing access to sexual and RH services, especially for the poor and "hard-to-reach" populations as outlined in the National Reproductive Health Strategy (Ministry of Medical Services, 2009). Tables 3.30 and 3.31 provide information on facilities that operate outreach programs and how they fund these programs.

**Table 3.30: Health Outreach Programs**

**Percentage distribution of facilities operating health outreach programs by, managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Percentage of facilities that operate a health outreach program | Total number of facilities |
|---|---|---|
| **Nairobi** | | |
| Public | 76.7 | 43 |
| Private | 34.8 | 66 |
| **Mombasa** | | |
| Public | 87.5 | 16 |
| Private | 25.0 | 44 |
| **Kisumu** | | |
| Public | 72.2 | 18 |
| Private | 33.3 | 36 |
| **Machakos** | | |
| Public | 100.0 | 4 |
| Private | 23.1 | 26 |
| **Kakamega** | | |
| Public | 66.7 | 6 |
| Private | 25.0 | 20 |
| **Total** | | |
| Public | 78.2 | 87 |
| Private | 29.7 | 192 |

Across all urban centers, more than twice as many public facilities as private ones operated a health outreach program. All public facilities in Machakos reported operating outreach programs, compared to only 23 percent of private facilities (the lowest proportion of private facilities across all the urban centers). Kakamega had the least proportion of public facilities operating an outreach program (public facilities, 67 percent; private facilities, 25 percent).

**Table 3.31: FP Method Distribution during Outreach**

**Among facilities that operate health outreach programs, percentage distribution of facilities providing FP methods during the outreach, and percentage distribution of facilities that self-fund the outreach program. by managing authority and urban area, Tupange/MLE, Kenya, 2011**

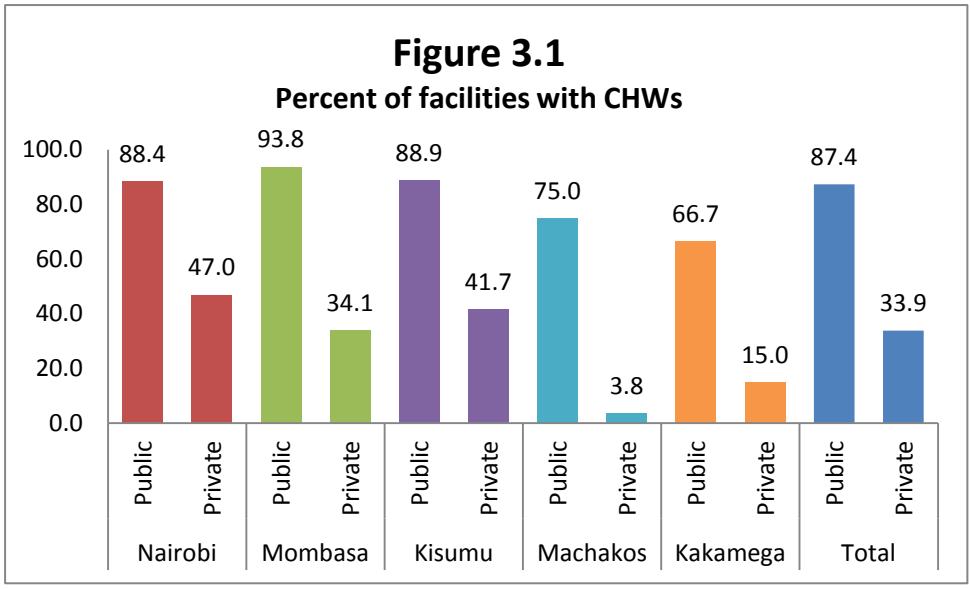
| | Percentage of facilities that offer at least one FP intervention during outreach | Percentage of facilities that report mainly self-funding for outreaches | Number of facilities operating health outreach programs |
|---|---|---|---|
| **Nairobi** | | | |
| Public | 93.9 | 24.2 | 33 |
| Private | 73.9 | 56.5 | 23 |
| **Mombasa** | | | |
| Public | 92.9 | 14.3 | 14 |
| Private | 18.2 | 63.6 | 11 |
| **Kisumu** | | | |
| Public | 76.9 | 38.5 | 13 |
| Private | 50.0 | 50.0 | 12 |
| **Machakos** | | | |
| Public | 100.0 | 75.0 | 4 |
| Private | 66.7 | 83.3 | 6 |
| **Kakamega** | | | |
| Public | 100.0 | 50.0 | 4 |
| Private | 80.0 | 60.0 | 5 |
| **Total** | | | |
| Public | 91.2 | 29.4 | 68 |
| Private | 57.9 | 59.6 | 57 |

Among facilities that operated an outreach program, more public (91 percent) than private facilities (58 percent) offered a FP method during the outreach. Mombasa had the highest public-private variation in provision of a FP method during outreach (public facilities, 93 percent; private facilities, 18 percent) whereas the least variation was seen in Nairobi and Kakamega.

Private facilities were more likely to self-fund their outreach; the variation was highest in Mombasa (public, 59.6 percent; private 29.4 percent).

## 3.19 Community Health Workers in Facilities

Under the National Health Sector Strategic Plan II, the community strategy seeks to enhance community access to health care to reduce health inequities and promote productivity (Health, 2005). The Plan proposes recruitment and/or capacity-building of community health workers as one of the strategies to increase access to RH services including FP services (Ministry of Medical Services, 2009). This section explores whether facilities had CHWs attached to them (Figure 3.1) and whether these CHWs were trained in family planning provision (Table 3.32).




Among facilities with any CHWs, less than half of CHWs (49 percent of public, 60 percent of private) had been trained in FP. In all the urban centers except in Mombasa, a higher proportion of private facilities than public facilities reported that their CHWs were trained on FP. In Mombasa, more public facilities than private facilities had CHWs trained in FP (public, 73 percent; private, 60 percent).

**Table 3.32: CHW Are Training on FP Distribution**

**Among facilities with CHWs attached, percentage distribution of facilities whose CHW are trained on FP, and percentage distribution of facilities whose CHWs offer FP methods, by managing authority and urban area , Tupange/MLE, Kenya, 2011**

| | Percentage of facilities that have CHWs trained on FP | Percentage of facilities where CHWs provide FP methods | Total number of facilities |
|---|---|---|---|
| **Nairobi** | | | |
| Public | 47.4 | 31.6 | 38 |
| Private | 67.7 | 41.9 | 31 |
| **Mombasa** | | | |
| Public | 73.3 | 53.3 | 15 |
| Private | 60.0 | 26.7 | 15 |
| **Kisumu** | | | |
| Public | 37.5 | 31.3 | 16 |
| Private | 40.0 | 20.0 | 15 |
| **Machakos** | | | |
| Public | 0.0 | 66.7 | 3 |
| Private | 100.0 | 100.0 | 1 |
| **Kakamega** | | | |
| Public | 50.0 | 50.0 | 4 |
| Private | 66.7 | 66.7 | 3 |
| **Total** | | | |
| Public | 48.7 | 38.2 | 76 |
| Private | 60.0 | 35.4 | 65 |

## 3.20 FP-Specific IEC Materials

To assess the need for information, education and communication (IEC) materials, respondents were asked to state whether IEC materials were displayed or available for use in their facilities. Table 3.33 shows the percentage distribution of facilities that have IEC materials for clients or service providers, according to the managing authority and the urban area.

**Table 3.33: Availability of FP-Specific IEC Materials for Clients or Service Providers**

**Percentage distribution of facilities that have IEC materials relating to FP for clients or service providers, by managing authority and urban area, Tupange/MLE, Kenya, 2011**

| | Percentage of facilities that have at least one IEC material for clients | Percentage of facilities that have at least one IEC material for providers | Percentage of facilities that have at least one IEC material for providers and clients | Total number of facilities |
|---|---|---|---|---|
| **Nairobi** | | | | |
| Public | 95.3 | 100.0 | 95.3 | 43 |
| Private | 71.2 | 81.8 | 69.7 | 66 |
| **Mombasa** | | | | |
| Public | 81.3 | 100.0 | 81.3 | 16 |
| Private | 70.5 | 70.5 | 52.3 | 44 |
| **Kisumu** | | | | |
| Public | 61.1 | 77.8 | 55.6 | 18 |
| Private | 47.2 | 52.8 | 41.7 | 36 |
| **Machakos** | | | | |
| Public | 100.0 | 100.0 | 100.0 | 4 |
| Private | 42.3 | 80.8 | 42.3 | 26 |
| **Kakamega** | | | | |
| Public | 83.3 | 66.7 | 66.7 | 6 |
| Private | 40.0 | 50.0 | 40.0 | 20 |
| **Total** | | | | |
| Public | 85.1 | 93.1 | 82.8 | 87 |
| Private | 59.4 | 70.3 | 53.6 | 192 |

Public facilities were more likely than private facilities to have at least one IEC material for clients (public, 85 percent; private, 60 percent), providers (public, 93 percent; private, 70 percent), and providers and clients (public, 95 percent; private, 76 percent).

All public facilities in Nairobi, Mombasa and Machakos reported having at least one IEC material for providers and one IEC material for providers and clients. The greatest public-private variation in availability of IEC materials was found in Machakos and Kakamega, where more than twice as many public facilities as private ones had at least one IEC material for clients.

# Chapter 4: Family Planning Provision in Pharmacies

## 4.1 Background Characteristics of Pharmacies

Pharmacies are an important source for accessing drugs and family planning products, so their quality and effectiveness is an important component of the FP supply environment. Up to 25 percent of women in the Nairobi area (MLE, 2011) and 40 percent of pill users nationwide (KDHS, 2010) use a pharmacy as their primary source for contraceptives. Examining the knowledge and practices of pharmacies, which largely fall under the private sector, is crucial to understanding this sector's provision of family planning services. Through public-private partnerships, implementers can make more efficient use of public resources by targeting and meeting the needs of specific populations and thus helping to increase access to family planning services and methods to all.

The KSDP interviewed staff in 223 pharmacies; the results are displayed in Table 4.1. The majority of the pharmacies are privately owned, open seven days a week and between 10 and 15 hours each day. About two-fifths (42 percent) of the pharmacies had been in operation for less than five years, 21 percent had been operational for five to 10 years and 27 percent had been operational for more than 10 years preceding the date of this survey.

**Table 4.1: Distribution of Pharmacies**

**Distribution of pharmacies, by background characteristics, Tupange/MLE, Kenya, 2011**

| | N | % |
|---|---|---|
| **Urban area** | | |
| Nairobi | 57 | 25.6 |
| Mombasa | 39 | 17.5 |
| Kisumu | 53 | 23.8 |
| Machakos | 30 | 13.5 |
| Kakamega | 44 | 19.7 |
| **Number of years open/in operation** | | |
| Less than 5yrs | 94 | 42.2 |
| 5 to 10 yrs | 47 | 21.1 |
| More than 10 yrs | 61 | 27.4 |
| Missing | 21 | 9.4 |
| **Number of operating days per week** | | |
| 5 days | 6 | 2.7 |
| 6 days | 102 | 45.7 |
| 7 days | 111 | 49.8 |
| Missing | 4 | 1.8 |
| **Number of operating hours per day** | | |
| Less than 10 hrs | 42 | 18.8 |
| 10 to 15 hrs | 172 | 77.1 |
| More than 15 hrs | 6 | 2.7 |
| Missing | 3 | 1.3 |

| Table 4.1: Distribution of Pharmacies | | |
|---|---|---|
| **Distribution of pharmacies, by background characteristics, Tupange/MLE, Kenya, 2011** | | |
| | **N** | **%** |
| **Sell family planning contraceptives** | | |
| Yes | 219 | 98.2 |
| No | 4 | 1.8 |
| **Ownership of pharmacy** | | |
| Private | 217 | 97.3 |
| Other | 6 | 2.7 |
| **Number of regular or permanent staff** | | |
| 1 | 30 | 13.5 |
| 2 | 73 | 32.7 |
| 3 | 47 | 21.1 |
| More than 3 | 70 | 31.4 |
| Missing | 3 | 1.3 |
| **Has a trained pharmacist/medical personnel who works at least part-time** | | |
| Yes | 149 | 66.8 |
| No | 74 | 33.2 |
| **Observed FP promotional materials on display** | | |
| Displayed | 109 | 48.9 |
| Not displayed | 113 | 50.7 |
| Missing | 1 | 0.4 |

Fifty-five percent of the pharmacies had two to three regular or permanent staff members, with almost a third of them having more than three regular or permanent staff. Two-thirds of the pharmacies had a trained pharmacist or medical personnel who worked at least part-time. Though more than 98 percent of the pharmacies reported that they sold FP, only about a half of them were observed to have displayed FP promotional materials at the time of the survey.

## 4. 2 Pharmacy Providers' Background Characteristics

Table 4.2 displays detailed results on characteristics of pharmacy respondents and their FP training history. Interview teams collected data from pharmacy technicians (42 percent) followed by pharmacists (22 percent), pharmacy attendants (14 percent) and pharmacist manager/ proprietor (12 percent).

| Table 4.2: FP Training and Experience of Staff | | |
|---|---|---|
| **Background characteristics and FP training experience of pharmacy respondents, Tupange/MLE, Kenya, 2011** | | |
| | **N** | **%** |
| **Person interviewed** | | |
| Non-pharmacist manager/proprietor | 13 | 5.8 |
| Pharmacist manager/proprietor | 26 | 11.7 |
| Pharmacist | 49 | 22.0 |
| Pharmacy technician | 95 | 42.6 |
| Attendants | 32 | 14.3 |
| Other | 7 | 3.1 |
| Missing | 1 | 0.4 |
| **Sex** | | |
| Male | 106 | 47.5 |
| Female | 115 | 51.6 |
| Missing | 2 | 0.9 |
| **Ever received any training on FP** | | |
| Yes | 127 | 57.0 |
| No | 95 | 42.6 |
| Missing | 1 | 0.4 |
| **Last training attended*** | | |
| 0-3 months ago | 9 | 7.1 |
| 4-6 months | 10 | 7.9 |
| One year ago | 34 | 26.8 |
| More than 1 year ago | 71 | 55.9 |
| Missing | 3 | 2.4 |
| **Topics covered in last training**** | | |
| Counseling skills | 69 | 54.3 |
| Male involvement in FP | 35 | 27.6 |
| Spacing/delay of pregnancy | 31 | 24.4 |
| Breastfeeding/LAM | 32 | 25.2 |
| Reproductive health goals | 39 | 30.7 |
| Benefits of FP | 68 | 53.5 |
| Side effects of FP methods | 80 | 63.0 |
| IUDs | 50 | 39.4 |
| Implants | 53 | 41.7 |
| Tubal ligation | 35 | 27.6 |
| Oral contraceptives | 85 | 66.9 |
| Barrier methods/condoms | 73 | 57.5 |
| Others | 9 | 7.1 |

* Among respondents who received training.
**Multiple responses possible.

### 4.2.1 Pharmacy Providers' Training on FP

Overall, 57 percent of pharmacies had at least one person who was trained in FP. Among those who had ever received training, 56 percent had received their last training more than a year prior to the survey, 27 percent within one year prior, and less than 10 percent had recently received training. The most cited topics in recent trainings were oral contraception (67 percent), side effects of FP methods (63 percent), barrier methods/condoms (58 percent), counseling skills (54 percent) and benefits of FP (54 percent).

## 4.3 Ordering and Management of Contraceptive Methods

Management practices at the service delivery points are essential for effective and efficient supply of FP methods. Table 4.3 provides information on management practices of medical supplies in pharmacies.

**Table 4.3: Management Practices of Pharmacies**

| Management practices of medical supplies, Tupange/MLE, Kenya, 2011 | | |
|---|---|---|
| | **N** | **%** |
| **Person responsible for ordering, receiving and controlling medical supplies** | | |
| Pharmacist | 141 | 63.2 |
| Dispenser | 12 | 5.4 |
| Non-pharmacist manager/proprietor | 26 | 11.7 |
| Other | 42 | 18.8 |
| Missing | 2 | 0.9 |
| **Pharmacy has a medical stock register** | | |
| Yes | 186 | 83.4 |
| No | 35 | 15.7 |
| Missing | 2 | 0.9 |
| **Frequency stock register is updated (among pharmacies with stock registers; n=186)** | | |
| Daily/Same day as items received/disbursed | 70 | 37.6 |
| Weekly | 67 | 36.0 |
| Monthly | 32 | 17.2 |
| Greater than monthly | 15 | 8.1 |
| Missing | 2 | 1.1 |

The person most commonly reported as being responsible for ordering, receiving and controlling medical supplies was the pharmacist (63 percent). A high proportion of pharmacies had a medical stock register (83 percent), but only 38 percent of these updated the register daily or on the same day as the items were received/disbursed; 36 percent of the pharmacies updated their registers on a weekly basis while 17 percent updated on a monthly basis.

## 4.4 Modern Family Planning Method Availability

The pharmacy respondents were asked to list the modern FP methods they routinely provide. Table 4.4 displays the results by urban area. Overall, a high percentage of pharmacies provide combined oral pills (98 percent), emergency contraceptives (93 percent) and male condoms (94 percent). Only about 15 percent provide progestin-only pills, and an even smaller proportion (6 percent) provide female condoms.

| Table 4.4: FP Provision | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Percentage of pharmacies providing specific modern FP methods, by urban area , Tupange/MLE, Kenya, 2011** | | | | | | | |
| | **Method Type** | | | | | | |
| | **Combined oral pill** | **Progestin-only pill** | **Emergency contraceptive** | **Male condom** | **Female condom** | **Injectable** | **Total number of pharmacies** |
| **Urban area** | | | | | | | |
| Nairobi | 100.0 | 26.3 | 98.2 | 98.2 | 12.3 | 52.6 | 57 |
| Mombasa | 97.3 | 5.4 | 97.3 | 83.8 | 2.7 | 70.3 | 37 |
| Kisumu | 100.0 | 15.1 | 88.7 | 98.1 | 5.7 | 83.0 | 53 |
| Machakos | 90.0 | 13.3 | 93.3 | 93.3 | 3.3 | 43.3 | 30 |
| Kakamega | 100.0 | 7.1 | 85.7 | 90.5 | 2.4 | 85.7 | 42 |
| Total | 98.2 | 14.6 | 92.7 | 93.6 | 5.9 | 68 | 219 |

One noticeable difference between urban centers was that Nairobi and Machakos (which are geographically close to each other) were less likely to provide injectable contraception. Given the assumption that the pharmacies provide what is in demand, this validates the finding from the 2010 MLE study showing that few women in these urban centers get injectables from pharmacies.

## 4.5 Sources and Resupply of Contraceptives in Pharmacies

Among pharmacies that currently sell FP and source their methods from a pharmaceutical wholesaler, distributor or manufacturer, more than 90 percent take one week or less to receive their ordered supplies except for implants. Two-thirds of the pharmacies reported that it takes one week or less, and a third reported that it takes more than a week, to receive the commodity. These results are displayed in Table 4.5.

| Table 4.5: Ordering and Time to Receive Supplies | | | | |
|---|---|---|---|---|
| **Among pharmacies that currently sell FP and source their methods from a pharmaceutical wholesaler, distributor or manufacturer, the percentage distribution of the length of time taken to receive ordered supplies, by method, Tupange/MLE, Kenya, 2011** | | | | |
| | **One week or less** | **More than one week** | **Don't know/Missing** | **Number of pharmacies that stock method** |
| **Method** | | | | |
| Combined oral pill | 97.7 | 1.4 | 0.9 | 215 |
| Progestin-only pill | 100.0 | 0.0 | 0.0 | 32 |
| Emergency pill | 97.0 | 1.5 | 1.5 | 203 |
| Male condom | 98.5 | 1.0 | 0.5 | 205 |
| Female condom | 92.3 | 0.0 | 7.7 | 13 |
| Injectable | 98.0 | 0.7 | 1.3 | 149 |
| Implant | 66.7 | 33.3 | 0.0 | 3.0 |

### 4.5.1 Common Procedures Followed during Emergency Resupply

The interviewers collected data on the action taken in the event of a stock-out between routine orders of FP commodities. Forty-four percent of the respondents reported informing their clients to purchase the method elsewhere. Other procedures followed by the pharmacies included the pharmacy making a special order for the stocked-out commodity (26 percent), purchasing the commodity (13 percent) and borrowing the commodity from elsewhere (9 percent). Table 4.6 provides information on the common procedures followed by outlets during stock-outs between routine orders.

**Table 4.6: Emergency Resupply**

**Among pharmacies who stock and sell FP, the percentage distribution of most common procedure followed, by outlet in the event of a stock-out between routine orders, Tupange/MLE, Kenya, 2011**

| Most common procedure followed by outlet in the event of a stock-out between routine orders | N=219 | % |
|---|---|---|
| Special order | 56 | 25.6 |
| Pharmacy procures from private market | 29 | 13.2 |
| Clients purchase elsewhere | 96 | 43.8 |
| Pharmacy borrows | 19 | 8.7 |
| None of the above | 19 | 8.7 |

## 4.6 Stock-Outs in Pharmacies

Table 4.7 shows the number of pharmacies that usually sell contraceptives; percentage of pharmacies that currently have any brand of FP method available; percentage of pharmacies that have had a stock-out in the last 30 days and one year; and mean number of days stocked out in past 30 days and one year, according to urban area and method.

The survey found that most FP methods were available in the majority of pharmacies at the time of survey. With the exception of injectables and progestin-only pills, over 90 percent of pharmacies reported having the FP method supplies in stock.

Stock-outs were reported for three FP methods in particular—combined oral pills, emergency contraceptives and male condom. Overall, less than 10 percent of the pharmacies audited had experienced a stock-out in the past one year or in the past 30 days preceding the survey. Stock-out patterns were similar for both the 30 days and one year prior to the survey as follows: Kisumu had the highest proportion of pharmacies reporting stock-outs, with 6 percent of the pharmacies reporting stock-outs in combined oral pills and 4 percent reporting stock-outs in male condoms; 3 percent of the pharmacies in Kakamega had stock-outs in male condoms and about 2 percent had stock-outs in combined oral pills; 3 percent of Mombasa pharmacies had stock-outs in male condoms and emergency contraceptives; while 5 percent of Nairobi pharmacies had stock-outs in male condoms. None of the pharmacies in Machakos had had stock-outs in any of the FP methods in the past 30 days or one year before the survey.

**Table 4.7: Stocking and Stock-Outs of Pharmacies**

**Number of pharmacies that usually sell contraceptives; the percentage of pharmacies that currently have any brand of FP method available; percentage of pharmacies that have had a stock-out in the last 30 days and one year, and mean number of days stocked out in past 30 days and one year, by type of method, and urban area Tupange/MLE, Kenya, 2011**

| | Number of pharmacies that usually sell any brand of method | Percentage of pharmacies that have any brand of method currently available** | Percentage of pharmacies with a stock-out* in the last one year | Among pharmacies with a stock-out in the last year, the mean number of days stocked out of all brands | Percentage of pharmacies with a stock-out* in the last 30 days | Among pharmacies with a stock-out in the last 30 days, the mean number of days stock 30 days out of all brands |
|---|---|---|---|---|---|---|
| **Nairobi** | | | | | | |
| Combined oral pill | 57 | 100.0 | 1.8 | 60 | 0.0 | - |
| Progestin-only pill | 15 | 53.3 | 0.0 | - | 0.0 | - |
| Emergency contraceptives | 56 | 96.4 | 1.8 | 48 | 0.0 | - |
| Male condom | 56 | 96.4 | 7.1 | 43 | 5.4 | 5 |
| Female condom | 7 | 100.0 | 0.0 | - | 0.0 | - |
| Injectable | 30 | 73.3 | 0.0 | - | 0.0 | - |
| **Mombasa** | | | | | | |
| Combined oral pill | 36 | 100.0 | 2.8 | 90 | 0.0 | - |
| Progestin-only pill | 2 | 50.0 | 0.0 | - | 0.0 | - |
| Emergency contraceptives | 36 | 100.0 | 2.8 | 14 | 2.8 | 3 |
| Male condom | 31 | 96.8 | 3.2 | 14 | 3.2 | 3 |
| Female condom | 1 | 100.0 | 0.0 | - | 0.0 | - |
| Injectable | 26 | 92.3 | 0.0 | - | 0.0 | - |
| **Kisumu** | | | | | | |
| Combined oral pill | 53 | 92.5 | 7.5 | 90 | 5.7 | 6 |
| Progestin-only pill | 8 | 62.5 | 0.0 | - | 0.0 | - |
| Emergency contraceptives | 47 | 91.5 | 0.0 | - | 0.0 | - |
| Male condom | 52 | 96.2 | 11.5 | 102 | 3.8 | 4 |
| Female condom | 3 | 100.0 | 0.0 | - | 0.0 | - |
| Injectable | 44 | 81.8 | 0.0 | - | 0.0 | - |

**Table 4.7: Stocking and Stock-Outs of Pharmacies**

**Number of pharmacies that usually sell contraceptives; the percentage of pharmacies that currently have any brand of FP method available; percentage of pharmacies that have had a stock-out in the last 30 days and one year, and mean number of days stocked out in past 30 days and one year, by type of method, and urban area Tupange/MLE, Kenya, 2011**

| | Number of pharmacies that usually sell any brand of method | Percentage of pharmacies that have any brand of method currently available** | Percentage of pharmacies with a stock-out* in the last one year | Among pharmacies with a stock-out in the last year, the mean number of days stocked out of all brands | Percentage of pharmacies with a stock-out* in the last 30 days | Among pharmacies with a stock-out in the last 30 days, the mean number of days stock 30 days out of all brands |
|---|---|---|---|---|---|---|
| **Machakos** | | | | | | |
| Combined oral pill | 27 | 96.3 | 0.0 | - | 0.0 | - |
| Progestin-only pill | 4 | 75.0 | 0.0 | - | 0.0 | - |
| Emergency contraceptives | 28 | 92.9 | 3.6 | 120 | 0.0 | - |
| Male condom | 28 | 100.0 | 0.0 | - | 0.0 | - |
| Female condom | 1 | 100.0 | 0.0 | - | 0.0 | - |
| Injectable | 13 | 76.9 | 0.0 | - | 0.0 | - |
| **Kakamega** | | | | | | |
| Combined oral pill | 42 | 90.5 | 2.4 | 30 | 2.4 | 2 |
| Progestin-only pill | 3 | 66.7 | 0.0 | - | 0.0 | - |
| Emergency contraceptives | 36 | 80.6 | 0.0 | - | 0.0 | - |
| Male condom | 38 | 89.5 | 7.9 | 55 | 2.6 | 3 |
| Female condom | 1 | 100.0 | 0.0 | - | 0.0 | - |
| Injectable | 36 | 91.7 | 0.0 | - | 0.0 | - |
| **Total** | | | | | | |

**Table 4.7: Stocking and Stock-Outs of Pharmacies**

**Number of pharmacies that usually sell contraceptives; the percentage of pharmacies that currently have any brand of FP method available; percentage of pharmacies that have had a stock-out in the last 30 days and one year, and mean number of days stocked out in past 30 days and one year, by type of method, and urban area Tupange/MLE, Kenya, 2011**

| | Number of pharmacies that usually sell any brand of method | Percentage of pharmacies that have any brand of method currently available** | Percentage of pharmacies with a stock-out* in the last one year | Among pharmacies with a stock-out in the last year, the mean number of days stocked out of all brands | Percentage of pharmacies with a stock-out* in the last 30 days | Among pharmacies with a stock-out in the last 30 days, the mean number of days stock 30 days out of all brands |
|---|---|---|---|---|---|---|
| Combined oral pill | 215 | 95.8 | 3.3 | 75 | 1.9 | 2 |
| Progestin-only pill | 32 | 59.4 | 0.0 | - | 0.0 | - |
| Emergency contraceptives | 203 | 92.6 | 1.5 | 61 | 0.5 | 1 |
| Male condom | 205 | 95.6 | 6.8 | 66 | 3.4 | 3 |
| Female condom | 13 | 100.0 | 0.0 | - | 0.0 | - |
| Injectable | 149 | 83.9 | 0.0 | - | 0.0 | - |

***** A "stock-out" refers to a lack of availability of **all brands** of a method category that lasts **at least** 24 hours.
** Currently available in stock is based on those that USUALLY stock method.

## 4.7 Contraceptive Storage at Pharmacies

The requirement that all medical supplies be stored in the correct condition was also assessed in the pharmacies. Table 4.8 provides detailed information on the distribution of pharmacies with the correct storage condition for FP commodities.

**Table 4.8: Storage Conditions for FP Commodities**

**Among pharmacies that provide FP, percentage distribution of pharmacies with correct storage condition for FP commodities*, Tupange/MLE, Kenya, 2011**

| | N | % |
|---|---|---|
| **Contraceptives are protected from water and dampness** | | |
| Yes | 201 | 91.8 |
| No | 2 | 0.9 |
| Cannot observe storage area | 14 | 6.4 |
| Missing | 2 | 0.9 |
| **Contraceptives are stored off the floor** | | |
| Yes | 201 | 98.1 |
| No | 2 | 1.0 |
| Missing | 2 | 1.0 |
| **Ceiling above contraceptives is intact and not leaking** | | |
| Yes | 192 | 93.7 |
| No | 8 | 3.9 |
| Missing | 5 | 2.4 |
| **Contraceptives are protected from sun** | | |
| Yes | 201 | 98.1 |
| No | 3 | 1.5 |
| Missing | 1 | 0.5 |
| **Contraceptives are protected from pests** | | |
| Yes | 195 | 95.1 |
| No | 8 | 3.9 |
| Missing | 2 | 1.0 |
| **Injectables stored upright** | | |
| Yes | 115 | 56.1 |
| No | 15 | 7.3 |
| Not applicable, don't stock | 62 | 30.2 |
| Missing | 13 | 6.3 |
| **Separate damaged and/or expired items from inventory (observed)** | | |
| Yes, damaged/expired item removed | 77 | 35.2 |
| Removed from shelves and no expired items present | 23 | 10.5 |
| Reported yes, but cannot observe | 19 | 8.7 |
| Never have damaged/expired FP products | 96 | 43.8 |
| Missing | 4 | 1.8 |

*Based on outlets where storage area was observable.

Among the pharmacies that provided FP methods, about 92 percent had the contraceptives protected from water and dampness, 98 percent kept their supplies off the floor and 94 percent had an intact, non-leaky ceiling above the supplies. Almost all of the pharmacies had their contraceptives protected from sunlight (98 percent) and pests (95 percent), while only about 56 percent stored the injectables upright. Only about a third of the pharmacies separated damaged/expired items from the inventory.

# Chapter 5: Summary of Findings, Conclusions and Programmatic Implications

This chapter presents a summary of key survey findings that document the baseline status and may be used to guide priority areas for health service delivery in urban Kenya and inform Tupange project activities. Furthermore the findings form a basis for comparison in future evaluations. The high response rate (98 percent) achieved from a sample of about 30 percent of all health facilities (public and private) in the five urban areas suggests the findings of this survey are representative and generalizable to the survey areas.

## 5.1 Availability of RH Services, Facility Infrastructure and Staff

Nearly all facilities and pharmacies surveyed in the five project areas were offering FP services. FP services are available in most facilities at least five days a week. Antenatal care, and detection and treatment of sexually transmitted infections (STIs), PMTCT, child welfare services and postpartum care were the most common additional health care services regularly available in the studied facilities, pointing to a range of potential health services with which FP can be routinely integrated.

*Recommendation: Tupange project should work closely with facility management teams to improve infrastructure and maintain the distribution of a mix of integrated FP/RH services in facilities and ensure their availability at or above the observed minimum frequencies.*

### 5.1.2 Availability of FP to Clients Seeking Other "Core" RH Services

Data on delivery of FP information and services and the extent to which clients seek specified RH services were assessed through facility, health worker and client interviews. The data from these three sources present mixed results. Generally, evidence from client exit interviews suggests that provision of FP services to clients seeking non-FP RH services is not happening as much as is reported by the managers of health facilities and by health workers who were interviewed. The results suggest there is inadequate integration of FP services with non-FP MNCH services at the client level (HIV/AIDS, TB, STI, PMTCT services) with a significant proportion of the non-FP MNCH clients having their FP needs unmet.. Depending on the type of FP method offered at the health facility, clients may receive FP services in the same room or, in the case of IUD and sterilization, they may be referred to the FP clinic within the same facility. Referral to the FP room after counseling constitutes a form of integration, especially if the clients receive FP method on the same day. The following are some of gaps in integrated FP service provision:

- Among facilities offering either one or more of the following services—child welfare services (CWS), delivery services, postpartum care, postnatal care, post-abortion care, HIV and AIDS, TB, STI management or PMTCT—over 80 percent of facility respondents reported always offering FP information on the same day to the clients who came to the facility seeking these MNCH services. More than 90 percent of health workers offering any of these MNCH services also reported that they routinely provided FP information to their clients.
- While a majority of facilities offering CWS were able to provide pills or injectables to their clients on the same day they came to the facility, only about 40 percent of them could provide IUDs or implants on the same day.

- Most of the facilities offering postpartum care services (between 77 and 87 percent) were able to provide pills or injectables to their clients on the same day. However, only between 40 and 49 percent of them could provide IUDs or implants on the same day. These results confirm findings of the KURHI 2010 baseline survey, in which over 60 percent of women reported not receiving comprehensive FP services the last time they sought maternal health services (MLE, 2011).
- Only 77 percent of facilities offering PAC are able to give a FP method to PAC clients, despite the fact that PAC guidelines defined FP service as a critical constituent /component of PAC.
- Between 73 and 90 percent of the facilities offering HIV/AIDS/STI/TB services were able to offer pills or injectables to their clients on the same day, while only between 36 and 45 percent of facilities were able to provide IUDs or implants on the same day. Data from client exit interviews show that 69 percent of clients had visited the facilities mainly in search of non-FP related services. Of these, only a handful (17 percent) received FP information during their visit. Among clients who did not receive FP information, 35 percent would have liked to.

The fact that only a small percentage of facilities are able to provide long-acting and permanent methods on the same day they see their clients suggests that there are many missed opportunities at the facility level for offering LAPM to clients seeking non-FP services and who may need contraception. For example, data show there are missed opportunities to provide postpartum FP services to clients seeking delivery and postnatal care services.

*Recommendations: Provision of FP in general health and MNCH services is difficult to operationalize unless providers are adequately trained and provided with the necessary protocols and guidelines. The findings present* Tupange *with the challenge to increase the provision of FP services to clients seeking core MNCH services such as CWS, delivery or post-partum servicesbut that actual provision rarely happens, especially for LAPMs. At a minimum, FP information and clinical services should be made readily available to all clients seeking MNCH services as the surest way of reducing missed opportunities in reaching potential FP clients.*

### 5.1.3 Facility Infrastructure Supportive of Quality FP Service and Client Utilization

Almost 80 percent of facilities have essential, facility-level amenities and physical infrastructure components such as running piped water, electricity or back-up generator, toilet facilities, storage area for drugs and supplies, examination rooms, and equipment such as blood pressure machine and adult weighing scale, to support provision of RH/FP services and assure clients' comfort. Between 35 and 55 percent of facilities lack a dedicated telephone, an amenity essential for administration functions and emergency communications especially in cases of referral. Half of the facilities lack IUD and implant insertion kits. The kits are least available in Kakamega. Across all urban centers, an examination light was the least available item despite its importance in delivery of RH services. Except in Machakos (67 percent), an adult weighing scale was available in more than 80 percent of facilities.

*Recommendation:* Tupange *should work with the DRH and advocate that all facilities in the project areas have access to the minimum set of amenities, equipment and physical infrastructure components essential in the delivery of quality FP/RH services.*

#### 5.1.3.1 Elements and Equipment for Infection Control

Infections acquired in health facilities often complicate the delivery of health care. The items considered relevant and necessary to prevent these infections where FP procedures most often take place include soap, running water, hand disinfectant, sharp boxes, disinfectant solution and

latex gloves. Availability of functioning equipment or chemicals for sterilization varied significantly by urban area. Sterilizer was the least available sterilizing element. The sterilizer was least available in Kisumu (35 percent) and Machakos (33 percent) and readily available in Nairobi (80 percent) and Mombasa (77 percent). Only 69 percent of facilities in Kisumu had infection control buckets compared to over 80 percent of facilities in all other urban centers. Nine out of 10 facilities had a sharps container.

*Recommendation:* Tupange *should work with DRH to ensure local authorities of county governments have adequate infection control equipment and consumables for all health facilities.*

### 5.1.4 Staffing

Almost 40 percent of health service providers interviewed were attached to the outpatient department and 35 percent to MNCH departments. Nearly 70 percent of the providers were nurses. Except clinics and dispensaries, over 85 percent of facilities had, at the time of the survey, one or more nurses designated to providing core MNCH services such as CWS, delivery and antenatal care, among other services. Clinical officers were mainly found offering RH services in maternity and nursing homes, while doctors were mainly offering these services at the hospital level. In a few health centers, maternity and nursing homes, VCT counselors and lab technologists reported providing some of the RH/FP services.

Most pharmacies (85 percent) had at least two regular or permanent staff working in the outlet. In 67 percent of pharmacies, there were trained pharmacists or medical personnel to support the running of the outlet. These findings provide an indication of availability of minimum human resources in pharmacies that future interventions can tap into to support provision of FP through private pharmacies.

*Recommendation: There is need for* Tupange*, with support from DRH, to facilitate more comprehensive dissemination of recent policy guidelines on task-shifting and task-sharing in RH/MNCH across all facility types, to motivate facility managers to utilize available cadre of health workers, albeit after adequate training, to offer a wide range of RH services and FP methods.*

## 5.2 Management Practices That Support Quality FP Services

Management practices for supporting quality family planning services include proper documentation and record keeping, practices related to user fees, and staff supervision and development.

### 5.2.1 Training

#### In-Service Training

Most of the health workers, irrespective of cadre, have not received contraceptive updates or any other in-service training on selected skills and topics required for delivery of quality FP services in the past year and a half prior to the survey. These findings are supported by providers' self-rating on their abilities to counsel and provide specific FP methods. Nearly two-fifths of clinical officers (37 percent) are not able to counsel on and provide an IUD, and another two-fifths of nurses are not able to counsel on and provide an implant. Furthermore, some providers said that they would restrict a FP method to clients based on consumers' personal characteristics such age, parity, marital status or lack of approval/consent from other persons. All cadres had low levels of in-service training on the 2006 (New) Comprehensive Reproductive Health Curriculum.

*Recommendations:* Tupange *and DRH should invest in in-service training on FP through mentorship programs, on-job training and regular FP updates, especially in the Medical Eligibility Criteria. Specifically, training in LAPM is urgently needed to minimize provider barriers to FP provision and improve method mix for clients.*

### Pharmacies

The 2010 MLE/Tupange/KNBS baseline survey and other past studies have shown that pharmacies, especially in urban areas, are useful entry points of potential FP clients to short-term methods and an agent for bridging behavior to routine FP methods. Pharmacies are also an important source of FP information.

Slightly over 40 percent of pharmacies had never had any of their staff trained on FP. However, among pharmacies that have ever received some training, 42 percent were trained less than a year prior to the survey. Pharmacy respondents were asked about the most common topics they were trained on during their most recent attended trainings. Topics on oral contraceptives (67 percent), side effects of contraceptives (63 percent), barrier methods (58 percent) and counseling skills, and benefits of FP (54 percent respectively) were most cited.

*Recommendation:* Tupange's *intervention program needs to support pharmacies to acquire minimal skills required to counsel, refer, provide a method or promote FP bridging behavior to routine FP methods.*

### Pre-Service Training

Generally, health workers have received FP pre-service training although not all providers who reported to have been so trained were trained on the key FP topics—contraceptive technology update (CTU), clinical skills on IUD, clinical skills on implant, clinical skills on female sterilization, clinical skills on male sterilization and post-abortion care. Doctors and clinical officers had higher levels of pre-service training in FP compared to nurses. All cadres had low levels of pre-service training on the 2006 (New) Comprehensive Reproductive Health Curriculum.

*Recommendation: DRH should advocate for medical training institutions and schools to continue to offer a comprehensive and examinable FP curriculum, and make follow-ups to ensure training curricula used in medical schools are up-date and reflect curricula used in practice/service delivery. The trainees should be empowered with skills for FP provision in order to reduce the cost incurred for in-service training*

## 5.2.2 External Supervision

Supervision by external managers is essential in assuring that FP standards and protocols are followed. External supervision also helps in exposing staff to a wide range of experiences of practice in the discipline, and increases staff technical competencies, especially when constructive feedback is routinely given to the supervisors.

Private facilities (between 56 and 67 percent) are more likely than public facilities (between 33 and 46 percent) to have received external supervision on a quarterly basis. Public facilities in Machakos (33 percent) and Nairobi (35 percent) are least likely to have received routine external supervision.

*Recommendation:* Tupange *intervention programs should include activities and support for regular supervision in target facilities as part of quality improvement for FP and other services.*

## 5.2.3 Availability of FP Information, Education, Communication (IEC) Materials

Public facilities were more likely than private facilities to have IEC materials for either clients or health service providers. Public facilities in Kisumu (61 percent) were least likely to have IEC for clients or health service providers. Private facilities in Nairobi and Mombasa (70 percent) were most likely to have IEC materials for clients, while private facilities in Kakamega (50 percent) were least likely to have the materials for providers. FP promotional materials were available and displayed in only one-half of pharmacies surveyed.

*Recommendations: There is a need to reprint and distribute FP IEC materials for both clients and providers to facilities across all cities. In addition to distributing FP IEC materials,* Tupange *interventions need to reinvigorate an awareness campaign in facilities on the role of IEC in increasing demand for FP services. Also,* Tupange *should partner with KEMSA and distributors of FP commodities to distribute FP promotional materials in pharmacies.*

### 5.2.4 FP User Fees

According to the Kenyan government policy, there should be no charge for any government-supplied contraceptive method, whether provided in a government or private facility. However, some facilities occasionally charge for registration and/or consultation fees. The mean costs charged for consultation, method or the procedure varied by FP method, urban area and type of facility. The highest average costs reported were for IUDs and implants. These costs were highest in Machakos and Kisumu compared to the other urban centers, probably due to the different brands of FP commodities and levels of user fees charged.

*Recommendation: In order to sustain and increase uptake of contraception, the costs of FP services and methods should be made affordable whenever possible in all facilities.*

### 5.2.5 Health and FP Outreach Programs

Most of the public health facilities (78 percent) operate a health outreach program compared to only 30 percent of the private facilities. Among these facilities, twice as many private as public facilities directly fund their outreach activities. Further, 91 percent of public and 58 percent of private facilities operating health outreach programs offer FP methods in the programs

*Recommendations:* Tupange *and the Ministry of Health should support both public and private facilities to adequately fund their outreach programs and promote provision of FP services in all outreach activities. Also,* Tupange *service delivery and demand creation programs for FP should support health facilities to implement in-reach and integrated out-reach activities.*

### 5.2.6 Community Health Services Program

Availability of a minimum number of trained Community Health Workers (CHWs) is a key determinant for successful implementation of health outreach programs. Most public facilities (87 percent) had CHWs attached to them, compared to only 34 percent of private facilities. However, more of the private facilities (60 percent) had their CHWs trained on provision of FP compared to public facilities (49 percent), and only about four-fifths of the facilities had their CHWs actively provide FP methods.

*Recommendations:* Tupange *needs to work closely with the Division of Community Health Services to support private facilities to introduce a CHW program. Further,* Tupange *has an opportunity to contribute toward the training of CHWs and empowering them to create demand for FP services and, where possible, distribute FP commodities.*

## 5.3 Quality Assurance (QA)

The survey gathered information on quality assurance activities and availability of quality assurance systems for FP service delivery, including existence of a QA committee or staff meetings, availability of service guidelines and protocols, and implementation of periodic audits of medical records or service registers. Only 13 percent of facilities have a QA committee or hold staff meetings to assure quality control for FP service delivery. One half of private facilities and 61 percent of public facilities conduct and compile audits of medical records at least on a quarterly basis. About two-thirds of public facilities (66 percent) and 45 percent of private

facilities have written guidelines to follow when offering FP services. About 30 percent of facilities have service protocols for integration of FP and HIV, and tools for screening pregnancy, respectively.

*Recommendations: Protocols and guidelines for FP provision and integration of FP and HIV/ AIDS should be reprinted, disseminated and made available to all relevant service sites. This is particularly important for providers working at lower-level facilities, such as health centers and clinics, which may be the first point of contact with the formal health sector for many potential FP clients.*

Tupange *should also work with the DRH and DHMTs to revive the QA committees to be able to oversee quality issues at the facilities. This can be done through orientation of committee members on quality improvement and supporting committee meetings .*

## 5.4 Availability of Family Planning Services

### 5.4.1 Contraceptive Method Mix and Method Availability

Nearly all facilities offering a modern method of family planning were providing one or more of the short-term methods. An injectable contraceptive was the most common method offered in health facilities. One half of the facilities were offering reversible, long-acting methods. One third of public facilities and 16 percent of private facilities were offering female sterilization. Most of the FP methods, except implants, were more likely to be offered in public facilities as compared to private facilities.

Overall, 98 percent of pharmacies were selling FP commodities. Over 80 percent of pharmacies were providing combined oral pills, male condoms or emergency contraceptives, and over 90 percent of these pharmacies had one or more brands of these methods available on the day of the survey. Approximately 70 percent of pharmacies except in Nairobi and Machakos were offering injectable contraceptives and of these, only 68 percent had injectable contraceptive available on the day of the survey. Though only a few pharmacies usually sell female condoms and progestin-only pills, a relatively small percentage had these commodities available on the day of the survey.

On the day of the survey, most facilities had in stock each of the FP methods that they usually provide or carry. Except for implants in public facilities, more than 80 percent of the facilities providing the specific FP methods had the commodities in stock. On the day of the survey, availability of FP methods varied by urban area and type of facility. The least commonly available commodities were implants in public facilities in Kakamega (50 percent did not have the method on day of survey); emergency contraceptives in private facilities in Mombasa (59 percent did not have); IUDs and implants in public facilities in Mombasa (63 percent); and condoms in private facilities in Machakos (63 percent).

Tupange may need to work with the district teams to ensure that data on FP acceptors in these private pharmacies are captured.

### 5.4.2 Stock-Outs of FP Commodities.

The percentage of facilities reporting stock-outs of the specific FP methods they carried, in the past 30 days or one year prior to the survey, varied largely by method and managing authority of facilities. In the past 30 days prior to the survey, the injectable contraceptive was the most stocked-out commodity in public facilities (26 percent), while emergency contraceptives was the most stocked-out commodity in private facilities (25 percent). Injectable contraceptives were also the most stocked-out commodity in the past one year in both public (60 percent) and private facilities (49 percent), followed by condoms (public, 49 percent; private, 47 percent).

Stock-outs may partly be attributable to the countrywide shortage of condom supplies experienced in the first quarter of the year 2011 due to high demand and poor distribution of the available condoms. Even in the month leading up to the survey, 14 percent of public facilities and 19 percent of private facilities had had condom stock-outs, implying that, though there are condoms in the country, the current supply chain needs to be strengthened to maximize efficiency in commodity delivery and minimize shortages in the facilities.

A majority of pharmacies had not experienced stock-out of commodities they usually sell, either in the past one year or 30 days prior to the survey.

### 5.4.3 Management of Stocks of FP Commodities

Data about the last time facilities received their routine FP supplies show that, at a minimum, one-third of the public facilities and between 40 and 61 percent of private facilities were supplied with stocks less than one month prior to the survey. These findings indicate that the distribution of FP commodities in Kenya has improved in the past one year. This improvement may be due to concerted efforts from the Government of Kenya, development partners, international NGOs and commodities procurement agencies, to eliminate stock-out of contraceptives through accurate product forecasting and quantifications, increased resource allocations for commodities, improved political good will, an improved supply system and timely monitoring of stocks, among other pharmaceutical management practices. Past studies have shown that between 2006 and 2010, the contraceptive commodity supply system in Kenya faced major challenges in meeting demand (USAID, 2011).

The survey also collected data from both health facilities and pharmacies on the management of stocks including the common sources of contraceptives, time taken to receive routine supplies and mode of delivery of stocks. Overall, nearly two-thirds of public facilities obtain stocks of contraceptives they carry from the Kenya Medical Supplies Agency (KEMSA), a state body, mandated by government, with the procurement, warehousing and distribution of all pharmaceutical and non-pharmaceutical commodities, including FP commodities, to all health facilities in Kenya. District stores were the second most common source of FP commodities. Between 23 percent and 53 percent of private facilities obtain stocks of commodities mainly from the pharmaceutical wholesalers or distributors. Most of the private facilities and pharmacies receive their routine stocks within a week or less after placing an order, as compared to only over one-half of public facilities. In slightly over one-half of the public facilities, the supplier delivers the stocks to the facility while most of the private facilities go to pick up the stocks from the suppliers.

### 5.4.4 Storage Conditions for FP Commodities

To prevent chemical deterioration and contamination, facilities must store contraceptives and medicines in dry conditions, above the ground in an area protected from water, sun, pests and rodents, and in a well-ventilated location. Most facilities and pharmacies offering FP services met the minimum standards set for storage conditions of commodities. However, between 67 and 75 percent of public facilities in Kakamega and Machakos, respectively, were likely to store contraceptives off the floor. One-fifth of public facilities in Machakos do not store injectable contraceptives facing upright, as instructed by the manufacturers. Also, one-half of public facilities and 68 percent of private facilities in this urban area do not have stored contraceptives protected from dampness. In pharmacies, correct storage of injectable contraceptive was the condition that was met least often, with only 56 percent of them reporting storing injectables as recommended 'facing upright'.

*Recommendations:* Tupange *needs to continue strengthening the KEMSA and DRH supply chain system through improvement of the LMIS and capacity-building.* Tupange *should also advocate for improvement of the FP commodity supply chain system and improvement of the LMIS at all levels, including the private sector supply chain.*

*More specifically,* Tupange *can:*

- Advocate for improved governance in the pharmaceutical sector, and advocate for reform of policies on tendering and procurement of FP commodities
- Advocate for increased resource allocation for FP commodities in county governments
- Provide technical support to strengthening pharmaceutical management systems for public health
- Provide technical advice on FP logistics and commodity management via logistics management and information systems (LMIS), in both privately and publicly managed facilities and pharmacies
- Support dissemination of commodity management and data for decision-making tools
- Support stock status monitoring tools for facilities and pharmacies with training and dissemination
- Support DRH with forecasting and quantification of FP commodities
- Support DRH and KEMSA to streamline the distribution and re-distribution of FP commodities to ensure availability of commodities at the central level (KEMSA) with an emphasis on "tracer commodities" such as injectables and male condoms

## 5.5 Client Satisfaction

Client satisfaction was measured using clients' responses to questions about service quality, rated as a discrete measure of reported experiences during the interactions of the client and the health service providers, and clients' overall perception about whether they would use the facility in the future or recommend it to a friend. Overall satisfaction was high; close to 90 percent were "highly satisfied" or "satisfied," and most of the clients (at least 94 percent) reported they would use that facility for health care services in future and would recommend it to family/friends.

### 5.5.1 Clients' Waiting Time to Receive RH/FP Services

Over one-half of clients seeking RH/FP services in private facilities were attended to in the first 15 minutes or less. About 40 percent of RH/FP clients in public facilities had to wait for more than 30 minutes to be attended to.

*Recommendations:* Tupange *should work closely with health facilities to reduce the amount of waiting time for FP clients and to honor patients' charter by working closely with service provides and facility managers to ensure that clients are attended to within the shortest time possible.*

### 5.5.2 Clients Perceptions on Privacy, Level of Interaction with the Provider, and Perceived Confidentiality

Generally, and irrespective of type of FP/MNCH services sought, most clients reported lack of visual or aural privacy when being examined. However, most clients felt comfortable asking questions of the health provider during the visit, and a majority of clients reported that health providers answered their questions.

### 5.5.3 Clients' Satisfaction with Services

An overwhelming majority of clients (over 95 percent) reported being satisfied with their visit and almost a similarly high percentage of clients would either use the facility for health care services in future or would recommend it to a family member or a friend.

*Recommendations:* Tupange *needs to identify facilities offering services at the highest level of client satisfaction, ensuring client privacy and confidentiality. Such facilities should be used as model sites from which other facilities can learn how to deliver health services that honor privacy and generate high client satisfaction rates.* Tupange *interventions should pilot use of "satisfied FP clients" to influence uptake of FP.*

### 5.5.4 Clients' Motivations to Seek Health Services from Clients Nearest Health Facility

Slightly over one-half of clients seeking FP and MNCH who were interviewed said that they sought health services in the facility of interview because the facility had a good reputation or had good quality services. The other most commonly cited reasons for choosing the facility of interview include that the facility is close home, provides the desired health services, has providers who treat clients well, and is affordable.

Among clients not visiting the closest facility, about one-fourth (24 percent, most of whom were in a public facility on the day of the interview), cited high costs as the main reason for not visiting the closest facility , and 18 percent cited unavailability of desired services at the facility closest to their home

*Recommendations: In supporting facilities to offer high-quality services in a friendly manner,* Tupange *should encourage providers to initiate good provider-client relationships. Through implementation of a health facility recognition scheme,* Tupange *can help build and develop the reputations of facilities in urban areas, and ultimately improve the client flow, client volume and uptake of FP/RH services in urban facilities.*

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