The Private Sector's Contributions to Family Planning Market Growth

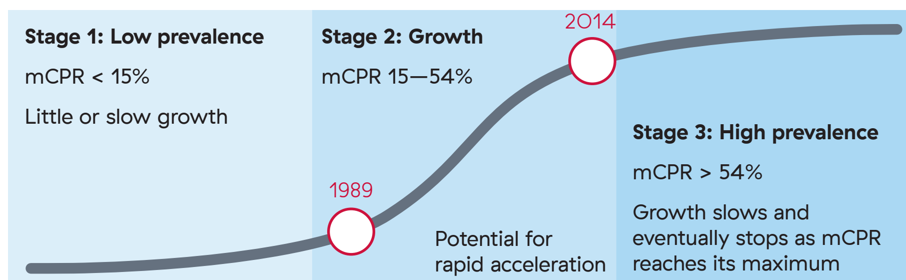
Kenya

The Kenyan family planning market experienced significant growth from 1989 to 2014, with the modern contraceptive prevalence rate among married women increasing from 17.9 percent to 53.2 percent. The private sector played a significant role in this market growth. A SHOPS Plus analysis revealed several economic, sociocultural, policy, and programmatic factors that facilitated the private sector's contributions to increase the modern contraceptive prevalence rate. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

A review of trends in the modern contraceptive prevalence rate (mCPR) across low- and middle-income countries has led stakeholders to develop a normative S-shaped pattern for growth (Figure 1). In this model, low prevalence and little growth occur on one end, with high prevalence and low growth on the other, and a period of potentially rapid growth in between (Track20 2017). While country growth patterns can vary substantially, the S-curve model serves as a framework to categorize countries to one of these three stages based on their mCPR (Feyisetan et al. 2017). The model can assist stakeholders in assessing the appropriate level of investment, type, and timing of interventions to help their countries' mCPR growth better mirror the S-curve, enabling more men and women to achieve their reproductive intentions.

Figure 1. The S-curve for family planning markets

Kenya's mCPR is marked in red



Program focus

Stage 1: Change norms to increase demand and provide services

Stage 2: Reduce barriers to access, improve quality, sustain demand generation

Stage 3: Sustain gains

Note: The mCPR percentages listed in this figure are among currently married women.
Source: Track20 (2017)

This is one in a series of briefs that examines family planning market growth since 1990.

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Understanding the types of interventions that work best at each stage of the S-curve is necessary to create optimal family planning outcomes. The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project sought to identify those interventions that could best harness the private health sector within each stage of the S-curve. The project examined countries where (1) the private sector has played a significant role in the family planning market and (2) the private sector role has increased as mCPR grew. This analysis revealed economic, sociocultural, policy, and programmatic factors that facilitated increased private sector contributions. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

Between 1989 and 2014, Kenya moved from Stage 1 to being just at the cusp of Stage 3 on the S-curve (STATcompiler 2019). To take the country well into Stage 3, family planning stakeholders will need to continue developing and implementing strategies to increase domestic financing of the national family planning program and transitioning components to sustainable models. This brief recommends strategies for stakeholders to leverage the private sector's contributions to growth.

Methods

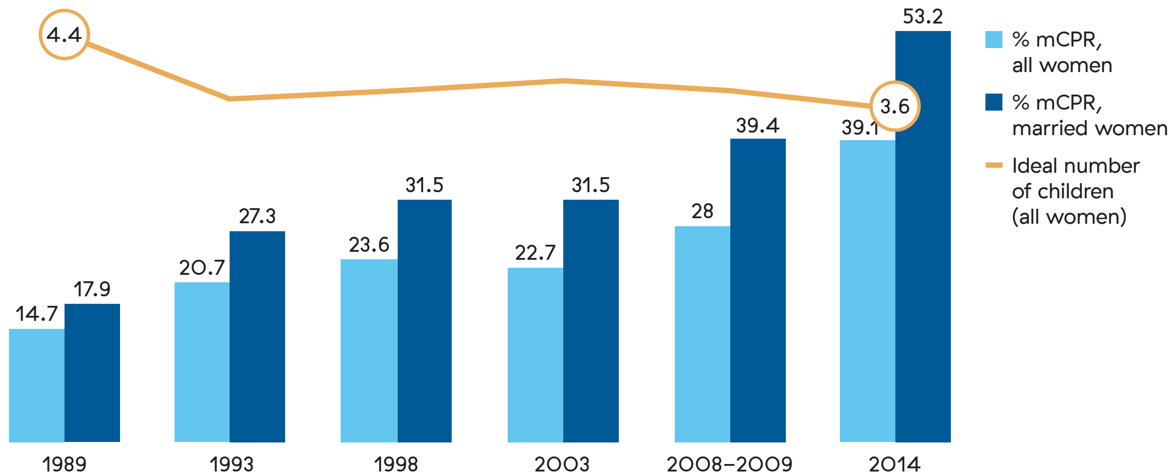
This is one in a series of briefs that examines the family planning markets in six countries since 1990. Five countries in Stages 2 and 3 (Bangladesh, Cambodia, Kenya, the Philippines, and Tanzania) saw increases in mCPR and private sector contributions. One country (Nigeria) saw substantial private sector contributions, but low growth in mCPR, and remained in Stage 1. Examining all six countries helps identify what factors are necessary for leveraging the private sector's contributions to growth.

SHOPS Plus conducted extensive secondary analyses of Demographic and Health Survey (DHS) data to examine trends in the use of modern contraceptive methods by reported sources of supply, translating use rates into absolute numbers of women through the use of United Nations Development Programme's World Population Prospects (2019 Revision) projections. The project conducted country-specific literature reviews and key informant interviews with experts who worked in Kenya's family planning market between 1989 and 2014 to explain the trends revealed through the DHS data analysis. The goal was to better understand factors that enabled or inhibited the private sector's contributions to mCPR growth.

Rapid family planning market growth

Compared to its neighbors in East and Southern Africa, Kenya's family planning market has grown at one of the fastest rates during the 25-year period between 1989 and 2014. During this time, mCPR among married women increased from 17.9 percent (early in Stage 2 of the S-curve) to 53.2 percent, placing the country at the verge of Stage 3 (STATcompiler 2019). This growth occurred in two stages: between 1989 and 1998, when mCPR among married women almost doubled, and between 2003 and 2014, when it increased by 69 percent. Between these two stages—from 1998 to 2003—the mCPR of married women remained consistent at 31.5 percent. The mCPR among all women—both married and unmarried—increased, albeit at a slower rate, from 14.7 percent to 39.1 percent. The ideal number of children a woman desired to have in her lifetime declined steadily from 4.4 in 1989 to 3.6 in 2014 (Figure 2), which signaled an increased desire to limit or space births. At this rate of desired fertility, Track20 modeling indicates that fertility preference is not a barrier to mCPR growth.

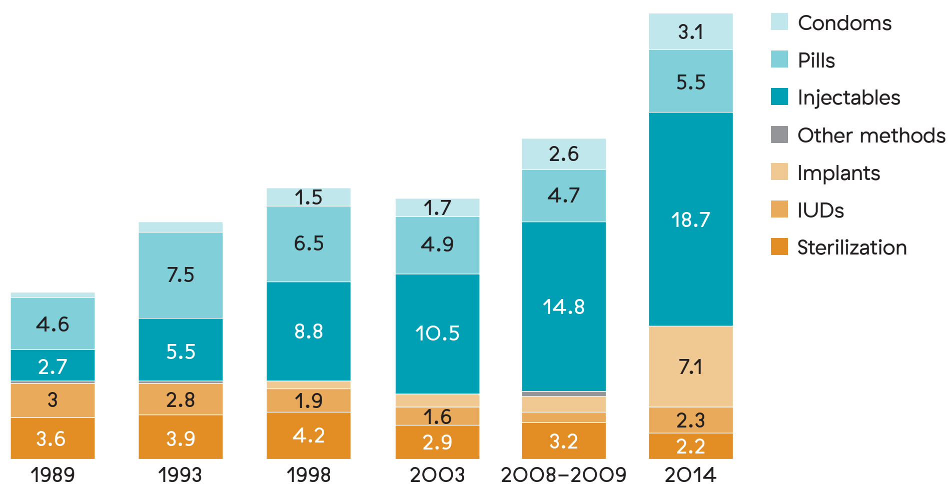
Figure 2. Changes in family planning use and childbearing preferences, 1989—2014



Among all women, mCPR growth was driven primarily by three methods—injectables, implants, and condoms (Figure 3).[1] Injectable contraceptives increased the most, by almost 600 percent, from 2.7 percent of all women in 1989 to 18.7 percent in 2014. Implant use experienced similarly high rates of growth, from 0 to 7.1 percent between 1989 and 2014. Similar to other countries in this series, most of the increase in uptake of implants occurred in the last decade. Condom use also increased during this period, though at a lower rate, from 0.4 percent to 3.1 percent. Use of IUDs declined steadily over the years and increased marginally in 2014, a trend that is similar to other countries in this series. Use of pills also declined steadily, as seen in both Nigeria and Tanzania, before increasing marginally in 2014.

Figure 3. Modern contraceptive use by method

All women (%)

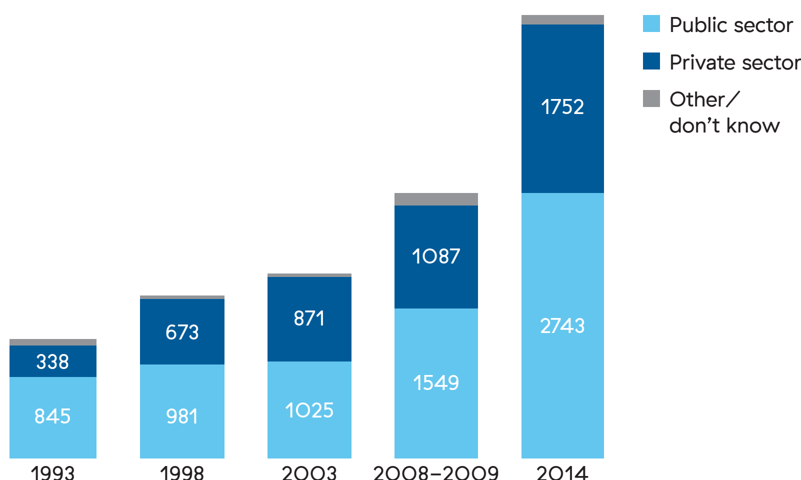


[1] Diaphragms, contraceptive foam or jelly, female condoms, and emergency contraception are included in graphs that show all modern contraceptives combined, but are not shown separately due to small sample sizes. This analysis excludes the lactational amenorrhea method, Standard Days Method, other fertility awareness methods, and DHS's category of other modern methods, as surveys do not systematically ask for sources of these methods.

When examining family planning sourcing patterns in Kenya, two distinct periods arise (Figure 4). During the first period of growth from 1989 to 1998, the private sector grew at much higher rates than the public sector. Private sources increased in both the absolute number of women served and market share. Between 1998 and 2003, while mCPR did not increase, both public and private sectors continued to add new users as the population grew. After 2003, both the public and private sectors increased the number of users served, though the public sector's contributions increased more rapidly.

Figure 4. Sources of modern contraceptive methods by absolute number of users

In thousands, by source



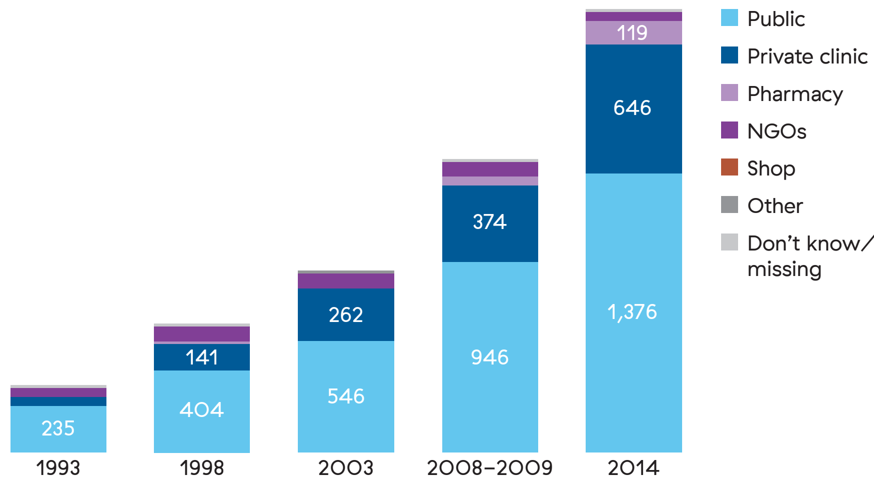
Trends in sources of methods

The private sector played a significant, though varied, role in the three methods—injectables, implants, and condoms—that drove mCPR growth in Kenya. Among injectable users, more women went to the public sector than the private sector. However, the rate of growth in the number of users accessing injectables was greater in the private sector (Figure 5). Between 1993 and 2014, users accessing injectables from private clinics and pharmacies increased from approximately 36,000 to 765,000 users.[2] During the same period, public sector injectable users increased from 235,000 to 1,376,000 users. This comparison highlights the private sector's important contributions to injectable use growth in Kenya.

[2] All absolute numbers of users presented in this brief are derived from a secondary analysis of DHS data applied to United Nations Development Programme's World Population Prospects (2019 Revision) projections.

Figure 5. Trends in number of injectable users

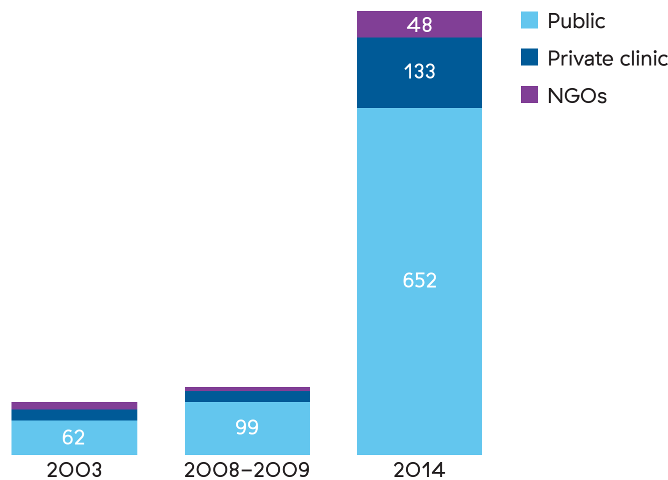
In thousands, by source



Trends in the use of implants exhibited more even growth across sources (Figure 6). More women accessed implants from the public sector than the private sector. However, both sectors saw implant provision grow at similar rates. Between 2008–2009 and 2014, the number of users accessing implants from private clinics and non-governmental organization (NGO)[3] facilities increased 540 percent, from 28,000 to 181,000 users. During the same period, the number of implant public sector users increased 560 percent, from 99,000 to 652,000.

Figure 6. Trends in number of implant users

In thousands, by source (all women)

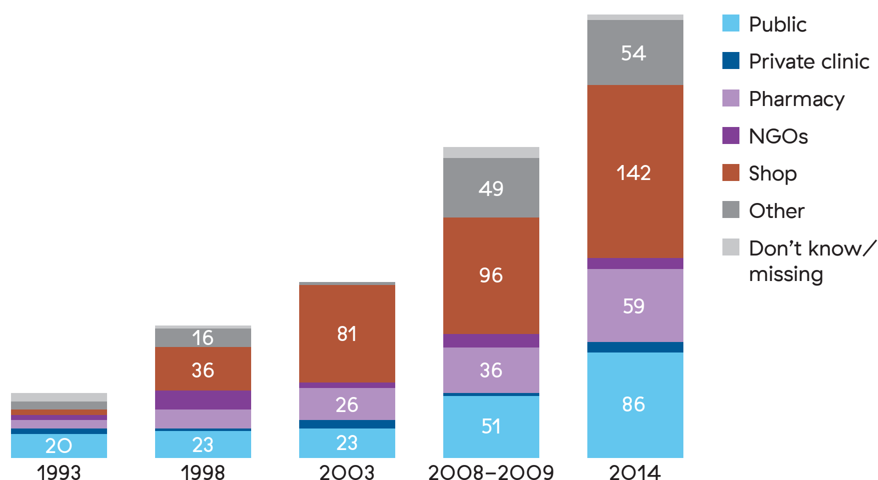


[3] In this brief, NGOs include faith-based organizations.

Among the three methods that drove mCPR growth, condoms were procured mostly from the private sector and growth of users accessing condoms was also greater in the private sector (Figure 7). Between 1993 and 2014, users accessing condoms from pharmacies and shops increased from approximately 13,000 to 201,000 users. During the same period, public sector condom users increased from 20,000 to 86,000. Similar to other countries in sub-Saharan Africa, more condom users obtained the method from shops than private pharmacies.

Figure 7. Trends in number of condom users

In thousands, by source (all women)



Private sector's contributions to growth in family planning provision

The private sector's role in Kenya's family planning market has shifted during the 25 years covered by this analysis. SHOPS Plus shared these trends with local family planning experts and conducted in-depth interviews to understand the underlying economic, sociocultural, policy, and program factors that influenced these trends. The interviews surfaced several insights into factors that shaped the trends in the number of private sector users of modern contraceptive methods.

1989—1998: Catalytic donor investments and private sector response to a market opportunity

Gaps in public sector services created unmet demand for family planning products. Kenya helped pioneer family planning in Africa. Family planning efforts from the 1960s to 1980s established the acceptance of and demand for family planning. Desired fertility rates fell from 5.8 children per women to 4.4 throughout the 1960s, 1970s, and 1980s, and mCPR reached 15 percent among all women by 1989. However, local experts report that gaps in public sector service delivery personnel and infrastructure and also frequent stockouts of commodities resulted in substantial unmet demand. This provided a fertile ground for the private sector to scale-up its products and services.

Ease of doing business facilitated entry of private sector products.
During the initial period of growth, Kenya's business environment was more conducive to marketing and distributing products than other countries in the region. There were few restrictions on the import of products, foreign exchange was available for import, and there was an extensive wholesale and retail network to support the scaling up of imported products. This, combined with the market potential due to high unmet demand, supported private sector entry and growth in the family planning market.

Donor investments in private sector approaches catalyzed private sector growth.
Donor investments supported improvements in the availability and quality of family planning services at private clinics and hospitals and in parastatal and commercial workplaces through the Private Sector Family Planning project. Support for social marketing of family planning products through the Contraceptive Social Marketing project helped introduce short-acting methods at affordable prices in private sector pharmacies and shops. Support to NGOs through the Family Planning Support and Service project helped establish a network of facilities offering family planning services at affordable prices throughout the country. These investments helped increase access to high quality, affordable contraceptives in the private sector, spurring growth in mCPR.

2003—2014: Reinvigorating family planning growth

Financing of family planning commodities made private sector sources more accessible to poor and remote populations.
In response to contraceptive use plateauing between 1998 and 2003, the government of Kenya reemphasized its commitment to providing family planning services to Kenyans by addressing gaps in public sector services and consciously engaging the private sector in a more comprehensive manner. Central to its approach of engaging the private sector, the government institutionalized and strengthened a longstanding program that allowed certain NGO partners to access free, publicly procured family planning commodities. During the 2000s, this access was expanded to private clinical facilities (both commercial and NGO facilities) as part of regular facility registration processes. As a result, more private providers were able to offer family planning at costs lower than a fully commercial model and were still able charge a service fee to cover the costs of delivering the commodity. This access to free commodities provided a financial motivation to private facilities to offer family planning services, thereby expanding the number of facilities offering family planning services, particularly in rural and remote areas. Local experts note that this strategy was critical in increasing the contribution of private sector sources in mCPR, though it has been detrimental to the growth of social marketing and to the supply of commercial commodities. As Kenya moves from Stage 2 to Stage 3 of the S-curve, and priorities shift to sustaining these gains, stakeholders will need to identify solutions that ensure the continued availability of quality products and services. Consequently, Kenya will need to develop strategies to either support free commodity supplies to the private sector through domestic financing or transition private facilities to affordable commercial supply chains.

Rapid economic growth increased purchasing power and further rapid expansion of private sector infrastructure.
Between 2003 and 2014, Kenya witnessed rapid growth in the economy. During this

period, the gross national income (purchasing power parity adjusted, in international dollars) increased by 30 percent from $2,055 to $2,676. The growth in Kenya's economy increased the purchasing power of Kenyans, making private sector services affordable to many more. Further, the growth also fueled a rapid expansion of private sector infrastructure—pharmacies, shops, and private clinics—making private sector sources more readily accessible.

Public-private engagement in community health promotion.
The Kenyan government initiated a new community health strategy in 2006–2007 to improve health seeking behaviors, including family planning, in rural remote and remote areas. Through this strategy, Kenya established and built capacity of a large cadre of community health workers (CHWs) supervised by community health extension workers (CHEWs). CHWs increased demand for family planning and received training to provide short-acting methods. Importantly, private sector actors were allowed to engage with CHWs and CHEWs, and they offered both free and private sector brands to community members. Social marketing organizations used the services of CHWs to promote underutilized methods and refer clients to private clinics while compensating the CHWs for services provided. By tapping the excess capacity of the CHEWs and CHWs, the private sector was able to expand its product and service coverage faster and at lower incremental costs, enabling growth.

Policies supportive of facilities operated by lower cadre of health workers increased availability of low cost private sector facilities.
From the late 1980s, Kenya formally permitted lower cadre of health workers—clinical officers, nurses, and midwives—to establish and operate private facilities. This type of task sharing, in conjunction with financing of commodities and donor investments, helped Kenya greatly increase the number of private sector service delivery points at lower prices.

Donor investments in expanding private sector family planning service delivery.
To catalyze demand and uptake of long-acting methods, which were underutilized in Kenya until 2003, donors significantly ramped up investments in IUDs and implants. They supported training and quality assurance of private providers, helped scale-up and improve the quality of social franchising networks, increased private providers' access to low-cost commodities (particularly through the Implant Access Program), and supported voucher programs to increase demand for these methods. These programs helped increase the choices of family planning methods accessible to clients who prefer private sector facilities, thereby helping the private sector contribute to Kenya's growth in long-acting method use and overall mCPR.

HIV prevention programming had a halo effect on condom use for family planning.
From the late 1990s on, donor-supported efforts to accelerate HIV prevention programming in sub-Saharan African countries, including Kenya, helped rapidly increase access to condoms and normalize their use. In the private sector these efforts expanded the availability of affordable condoms through shops and kiosks, and included extensive behavior change communication. These activities helped continue growth in condom use.

Conclusion

The family planning landscape in Kenya changed greatly between 1989 to 2014, as the country entered Stage 2 of the S-curve and reached the cusp of Stage 3. During this period, the private sector demonstrated its ability to contribute to mCPR growth on its own and in partnership with the government. In both cases, the private sector responded to market conditions that facilitated its growth. First, sustained government and donor investments in family planning promotion throughout the entire period created a significant potential client base for the private sector to serve. Second, broader economic and policy trends—increased consumer purchasing power, task sharing guidelines, and favorable regulations that supported a relatively well functioning commercial sector supply chain—helped the private sector work on its own to meet demand among target market segments. Finally, donor and government programs sought to further reduce costs and improve quality in the private sector, allowing them to serve an even broader swath of Kenya's family planning market. Countries looking to achieve similar levels of growth should examine how they could adapt these policies and programs in their own context while sustaining and expanding demand creation activities.

As Kenya enters Stage 3 of the S-curve, the focus will shift to sustaining the gains that it has made. This will mean developing and implementing strategies to increase domestic financing of the national family planning program and transitioning components to sustainable models. The experiences of other countries in this series point to the following recommendations:

- **Offer more lower cost generic family planning options to increase affordability of private sector products**. In the last two decades a number of generic manufacturers of pills, injectable contraceptives, IUDs, and implants have emerged. These are extensively available in many Asian countries, and their lower costs makes commercially viable private sector products affordable to more people. However, availability of generic contraceptives is still low in Kenya's private sector. Donors and the government should undertake market shaping efforts to increase sourcing and marketing of generic commodities, thereby increasing the sustainability of private sector supplies without adversely affecting their affordability.
- **Transition private clinics to commercial supply channels to avoid disruptions from the withdrawal of donor support**. While providing private clinics free commodities has increased access to private sources for poor and remote populations, the sustainability of the gains made can be disrupted by the withdrawal of donor support. To avoid disruption, Kenya should transition for-profit and nonprofit clinics currently accessing free commodities to commercial channels in phases and with clear timelines, starting with private clinics in urban centers. To mitigate the possibility of price increases of private sector services affecting affordability, this strategy should be implemented in conjunction with support for additional generic commodities in the market.

- **Reinvigorate the pills category through category promotion support to expand method choice, increase use among youth, and increase private sector contributions**. Experts believe that the use of pills has declined over the last two decades with a shift in donor investments towards HIV programming, injectables, and long-acting reversible contraceptives (LARCs). Wide availability of pills, in addition to expanding access and use of other methods, is important for expanding family planning options, sustainability, and addressing the contraceptive needs of youth. In many countries, including Kenya, the majority of pill users purchase the product from the private sector through out-of-pocket payments, reducing the need for government or external subsidies. In addition, youth may prefer to use short-acting methods such as pills and to obtain them from the private sector. For these reasons, Kenya should invest in reinvigorating the pills category.
- **Increase domestic financing for private sector access to LARCs**. The country's current drive to achieve universal health coverage through its National Hospital Insurance Fund (NHIF) and other programs presents one potential avenue for sustaining Kenyan's access to LARCs from the private sector without donor support. Like other countries in this series, such as the Philippines, Kenya has included family planning methods in the NHIF's benefits package. In practice, though, uptake of the benefit varies by provider. Increased NHIF population coverage, improved contracting with private providers, and more uniform acceptance of the family planning benefits package by private providers could further expand sustainable access to family planning.

Sources

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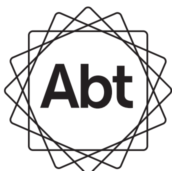

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