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POPULATION COUNCIL
Ideas. Evidence. Impact.

POST MEDICATION ABORTION CONTRACEPTION IN PHARMACIES KENYA

Market Analysis Report

April 2024

KEYSTONE

We have adapted PSI's Keystone design framework into this strategy design process. Keystone combines human-centered design with market systems development.

We're committed to sharing our insights from this process with PSI and the broader community of practice.

KEYSTONE

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ACRONYMS

AGYW	Adolescent Girls and Young Women
CHV	Community Health Volunteer
CIFF	Children Investment Fund Foundation
CM	Community Mobilizer
DTC	Direct-to-Consumer
EML	Essential Medicines List
FP	Family planning
IUD	Intra Uterine Devices
KDHS	Kenya Demographic Health Survey
KEMSA	Kenya Medical Supplies Agency
LARC	Long-Acting Reversible Contraceptive
MA	Medication Abortion
mCPR	Modern Contraceptives Rate
MoH	Ministry of Health
MSDP	Market Systems Development Plan
MSI	Marie Stopes International
MSK	Marie Stopes Kenya
MVA	Manual Vacuum Aspiration
NGO	Non-government Organization
OOP	Out of pocket
PMAC	Post medication abortion Contraceptive
PPB	Pharmacy and Poisons Board
PSI	Population Services International
QA	Quality Assurance
QoC	Quality of Care
SRH	Sexual and Reproductive Health
SMA	Self-Managed Abortion
SMO	Social Marketing Organization
TCA	To come again
TOC	Theory of change
WRA	Women of Reproductive Age

TERMINOLOGY ALIGNMENT

In this deck we:

- Refer to '**outside of health facilities'** not outside the health system, as pharmacies and drug shops are not considered health facilities but are still part of the health system;
- Refer to **'medication abortion'** vs medical abortion to emphasize the product-based nature of self-managed abortion;
- Refer to '**PMAC'** as the project and '**post MA Contraception'** as the health need/service, to avoid confusion between the two;
- Emphasize **choice vs uptake** of contraception/FP to represent the fact that informed choice and non-coercion underpins our analysis.

1 Background

POST MEDICATION ABORTION ACCESS TO CONTRACEPTION (PMAC) PROJECT

PMAC aims to pilot and scale innovations to sustainably increase choice for post MA FP to prevent unintended pregnancies

WHY PMAC?

In Kenya, **49% of all pregnancies are unintended**, of which 41% end in abortion (Mohamed et al., 2015). 13% of maternal mortality in Kenya is strongly associated with incomplete abortions alone (APHRC, 2019). Women and girls who **self-manage MA outside of health facilities** and want to prevent future unintended pregnancies may not have adequate opportunities for contraceptive services leading to **missed opportunities for post contraception care**.

What is happening specifically **in pharmacies and drug shops** is not well-documented but could present an undeveloped market to increase access to and continuation of contraception post-MA, thereby averting subsequent abortions and the associated morbidity and mortality.

WHAT DOES PMAC AIM TO ACHIEVE?

PMAC aims to increase post MA contraception choice (objective) to support the reduction of unintended pregnancy and the associated morbidity and mortality (goal).

HOW?

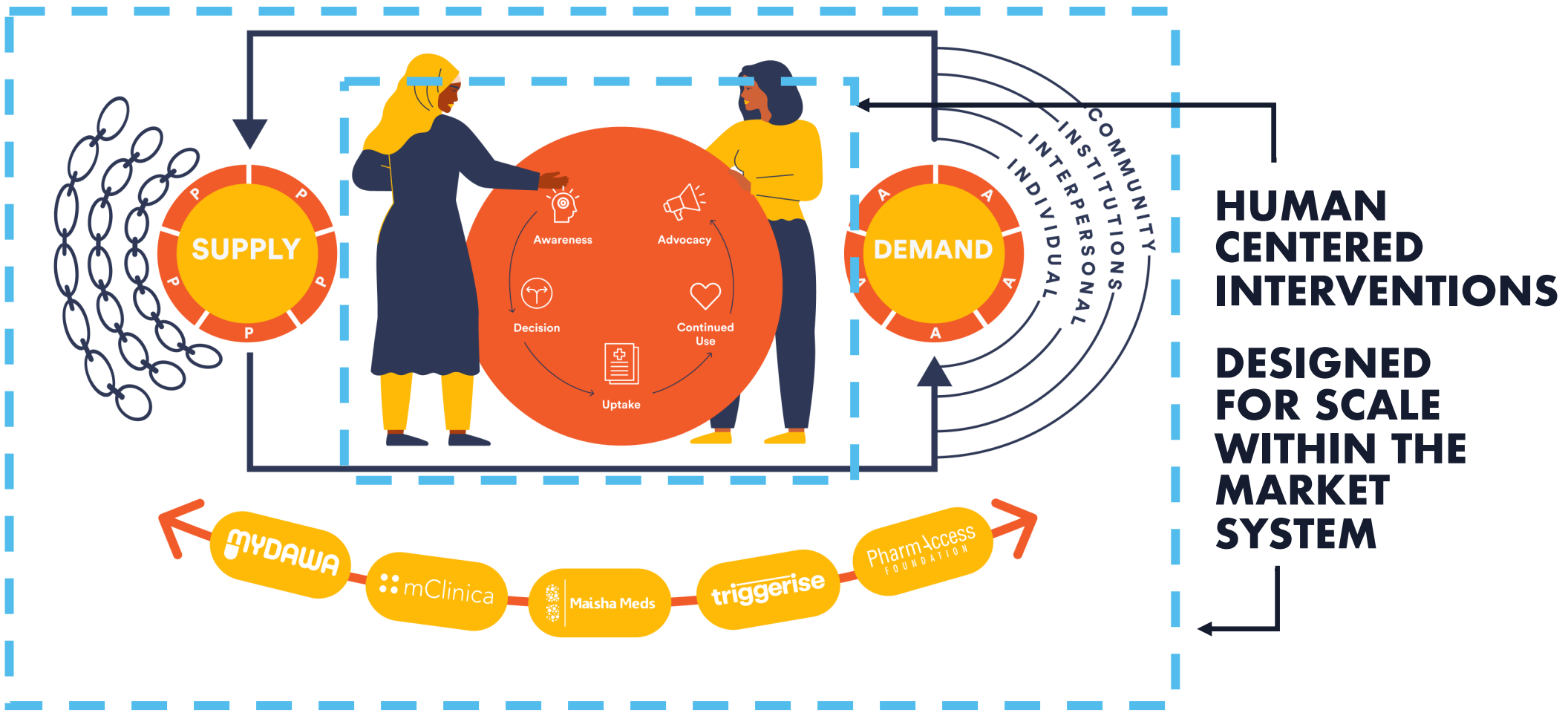
The PMAC project has partnered with pharmacists, pharmtechs (pharmacy technicians), community mobilizers, women and girls to develop and test scalable and evidence-based intervention solutions that accelerate contraceptive uptake and continuation after self-managed abortion. The final intervention package focuses on the **role of the pharmacist/ pharmtech** to sustainably increase access to quality post MA contraceptive care.

WHAT'S NEXT?

The PMAC project is actively **sharing lessons learned from this project**, including this market analysis, to support market actors to strengthen the role of the pharmacist and pharmtech to sustainably provide post MA contraception care.

MARKET SYSTEMS APPROACH

The PMAC project adopted a market system approach to define and adapt human centered interventions in the context of the MA and contraception markets to support desirable, feasible, and scalable solutions that can be sustained through committed market actors.



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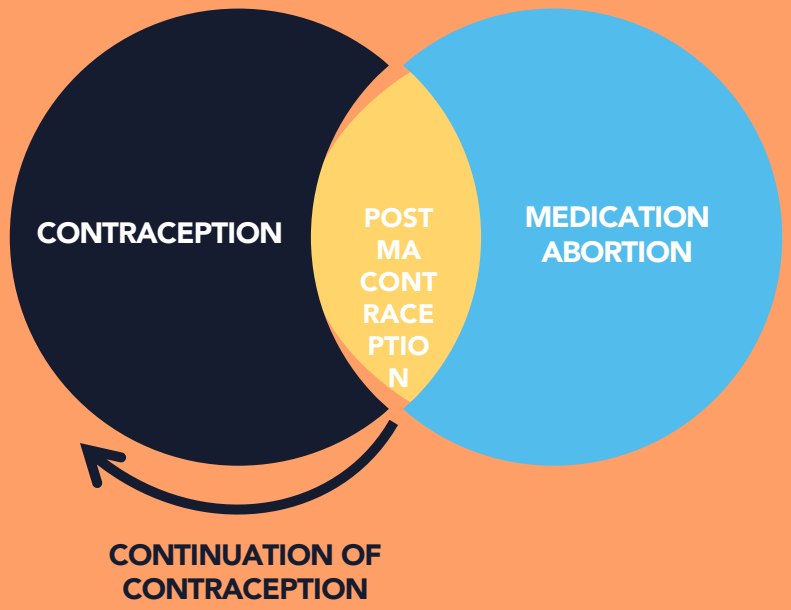
WHY are interventions for post MA contraception choice needed in Kenya, especially in pharmacies?

WHY are interventions for post MA FP choice needed in Kenya, especially in pharmacies?

"WHY" section purpose

This section analyses the health problem that the post MA contraception interventions are meant to address. For each of the three domains (contraception, medication abortion, and post MA contraception), it answers:

1. What is the health problem?
2. What are the associated behaviors?
3. Who is most at risk?



We have focused on pharmacists as the area of private sector delivery but using a total market approach to understand the wider issues for continuation of contraception.

"WHY" key takeaways

1. While progress has been made on mCPR in Kenya, **recent data suggests a stall.** Post MA contraception might be an **under-developed market** to curb unintended pregnancies and the resulting cycle of repeat abortions, a major contributor to maternal health risks in Kenya.

2. **Limited knowledge and stigma** are key cross-cutting barriers that prevent women from accessing contraception, MA, and post MA contraception.

3. Key segments to fill the use-need gap are likely **adolescent girls, unmarried women and those in low-income groups**.

HEALTH PROBLEM

While progress has been made on mCPR in Kenya, recent data suggests a stall. Post MA contraception might be an under-developed market to curb unintended pregnancies and the resulting cycle of repeat abortions, a major contributor to maternal health risks in Kenya.

Contraception

- **Kenya's mCPR for married women exceeded its 2020 target** of 58% (Track20, 2021), a key strategy to prevent unintended pregnancies (Jayaweera et al., 2018) yet latest analysis suggests mCPR has stalled. (SHOPS Plus, 2021).
- While Kenya's unmet need for contraception is declining, **14% of women of reproductive age (WRA) would like to delay or prevent pregnancy** but do not currently use any form of contraception (KDHS, 2014; Track20, 2021).
- In addition, teenage pregnancy continu es to be high at 15% across the country with Samburu, West Pokot and Narok at 50%, 36% and 28% respectively (KDHS, 2022).

Medication Abortion (MA)

- Unmet need has been evidenced to lead to induced abortion.
- In 2012, **49% of all pregnancies were unintended and 41% of unintended pregnancies end in abortion** (Mohamed et al., 2015).
- The percentage of unintended pregnancies that are ended with medication abortion (MA) is unknown.
- It is estimated that 120,000 women are t reated for abortion-related complications annually in Kenya and **13% of maternal mortality in Kenya strongly associated with incomplete** abortions alone (Mohamed et al., 2015; APHRC, 2019).

Post MA FP

- **Post MA FP could be an under-developed market** to reduce unintended pregnancies.
- More than **70% of women seeking postabortion care were not using a method of contraception** prior to becoming pregnant (Juma et al., 2022).
- Furthermore, **only 43% of facilities were able to deliver the full range of post-abortion care services**, which includes family planning counselling and contraceptive services (Juma et al., 2022).
- Since fertility returns soon post-abortion, **continuation of contraceptives is important** in preventing future unintended pregnancies and subsequent abortions.

KEYSTONE

HEALTH BEHAVIORS

Limited SRH knowledge, compounded by stigma, lack of education, perceived illegality, mistrust in health providers, and religious beliefs often turn to channels that are discrete, quick and easy to access MA such as pharmacies.

Contraception

- **Limited knowledge** of SRH information and **lack of access to contraception** led to unplanned pregnancy among women in their community (APHRC et al., 2021).

Medication Abortion (MA)

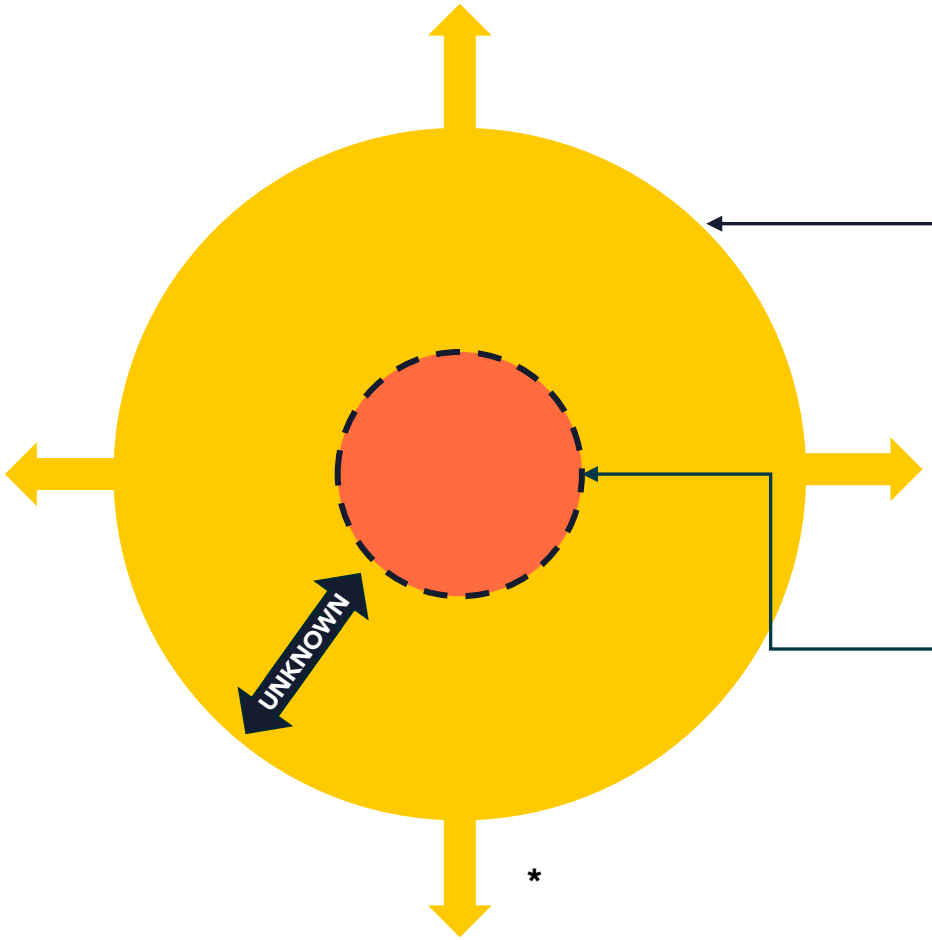
- For women and adolescents, **stigma was the predominant barrier** (Endline Evaluation, 2021). Other barriers included **lack of education about safe methods of abortion, perceived illegality of abortion, as well as limited access to services, fear of mistreatment, and mistrust of health providers and facilities** (Jayaweera et al., 2019).
- In public facilities, **provision of safe abortion services is often linked to provider attitudes and beliefs,** such as religious beliefs and the social stigma of abortion (Population Council et al., 2015).
- For pharmacists, the **most common reasons for denial of services were personal beliefs** or lack of a trained provider (Footman et al., 2018).

Post MA FP

- **Lack of adequate counselling from providers and the spread of misinformation prevents women from seeking** contraception soon after self-managed MA, as it is not expected that fertility can return as quickly as 8 days post-abortion (MSI, 2022).
- **At the time of MA purchase, some women are not receptive to hearing about contraception options.** Women may be focused on the MA information that is important in the moment and are not ready to receive contraception counseling (DKT employee consultation; APHRC, 2019).
- Women and girls sometimes feel that contraceptives are strenuous on the body, especially after MA. **Post MA, some users choose to disengage from sex and in effect, from contraceptive use** (ThinkPlace, 2022).

USE/NEED ANALYSIS

Data indicates that sales of MA drugs are increasing (proxy for need), but the scale of post MA FP choice outside health facilities is largely unknown. Better data are required to understand the potential scale of the post MA contraception market



Women using MA outside health facilities (Need)
Unknown

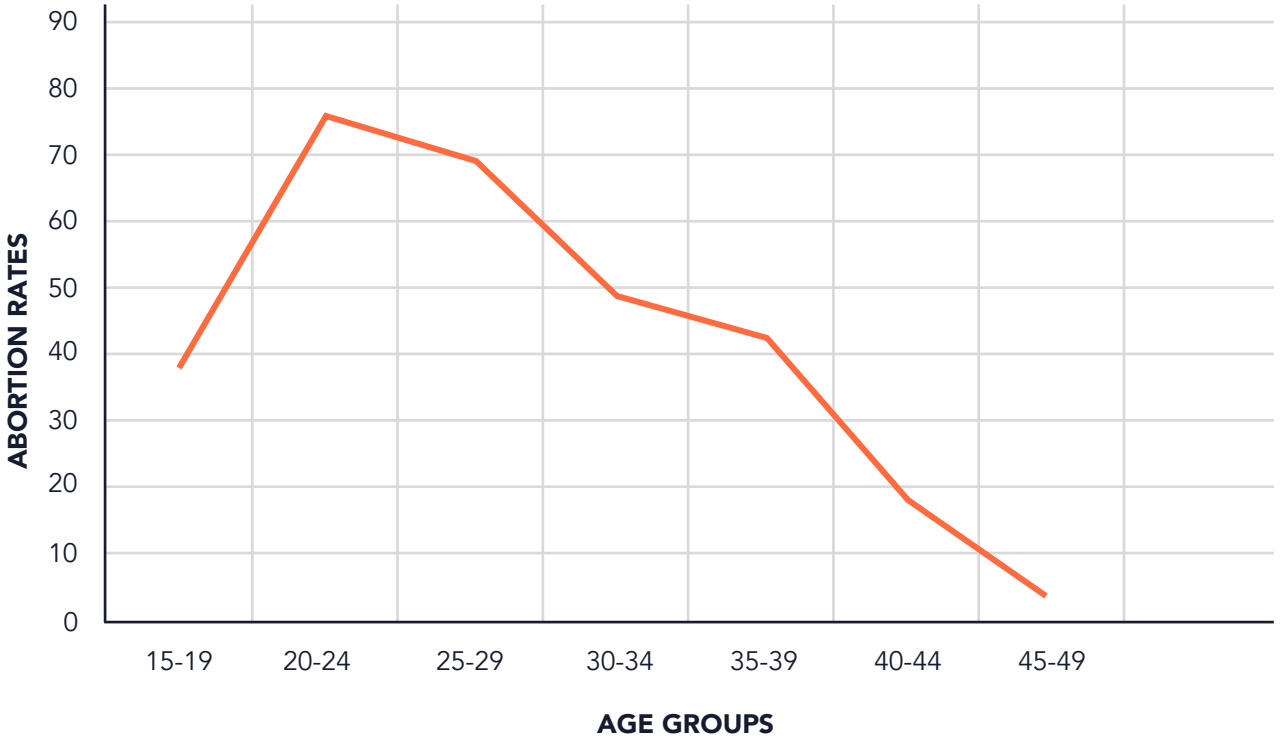
Post MA contraception outside health facilities (Use)
An estimated 60% of women obtaining MA from pharmacies also obtained contraception. This data point was from a small pilot led by Ipas in Nakuru County from July-October 2021 so it is an indicative number only and not definitive.

- Majority of the pharmacists strongly agreed that it was **difficult to know that a woman who was purchasing contraceptives does so after using MA,** unless the woman herself discloses this to the pharmacist. Such disclosures are rare. (APHRC, 2019).
- Using DKT MA drug sales as a proxy, the 'need' for post MA contraception could **range from 100K (combipack) to 500K (miso-only) per year.** This is a rough estimate. Sales numbers could double count some women, sales does not necessarily mean use, and **data are not collected on how products are used** (e.g. misosprostol for MA or PPH prevention and treatment) (DKT International, 2021; DKT employee consultation; Prata and Weidert, 2016).
- **Better data** are needed to understand the post MA contraception market, but this may be difficult as pharmacists do not keep records of who purchases MA drugs (APHRC, 2019) and MA is not captured in routine data sources such as the KDHS and KHIS.

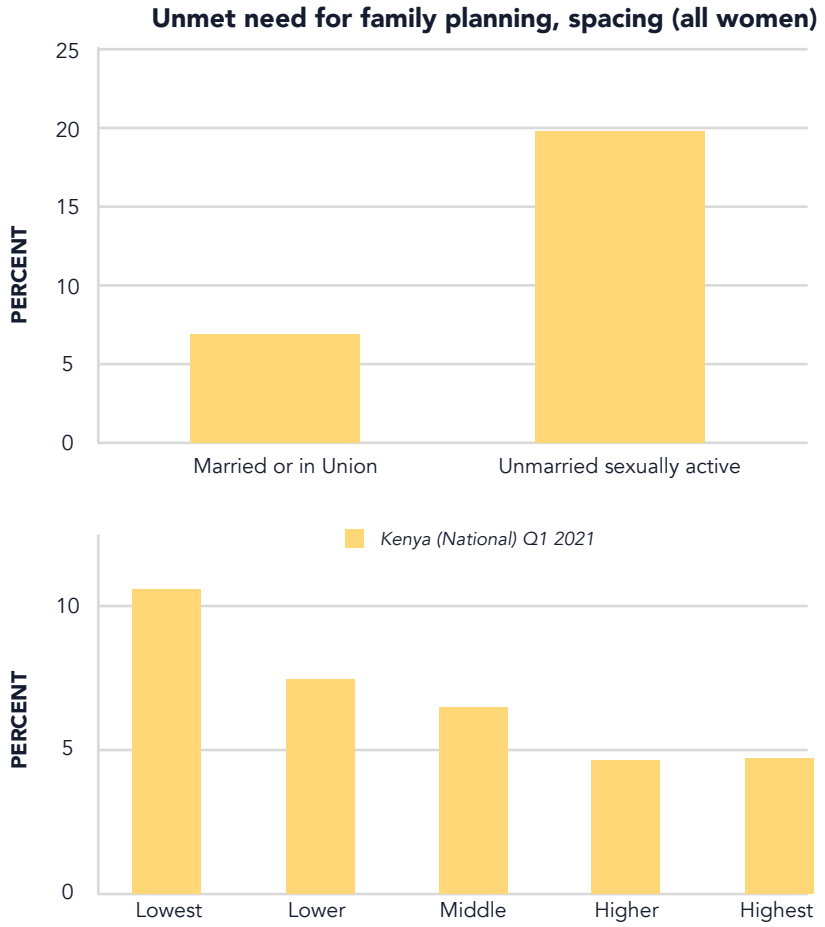
KEY POPULATION SEGMENTS AND POTENTIAL TARGET CONSUMERS:

Not all women are equally at risk. Key segments to fill the use-need gap are likely adolescent girls, unmarried women and those in low-income groups.

- Induced abortion rates increase rapidly among **adolescent girls** and are highest in **young women** aged 20-29, particularly in the 20-24 age bracket (Mohamed et al., 2015).



- Unmet need for FP is significantly higher for **unmarried women** and the women in very **low-income groups** (PMA, 2021).



KEYSTONE

3

WHAT is the current health system context in Kenya, and what does it mean for post MA contraception in pharmacies?

WHAT is the current health system context in Kenya, and what does it mean for post MA contraception in pharmacies?

"WHAT" section purpose

This section aims to analyse the health system context for Kenya in which the contraception and MA markets operate. Specifically, it answers:

1. What are the historical trends of contraception in Kenya?
2. What is the structure of Kenya's health system including the private sector? Who is at the "front line"?
3. What is the current status of the contraceptive and MA markets in Kenya?
4. How might contraception financing trends impact the contraceptive implant market?

"WHAT" key takeaways

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

2. **Misoprostol and combipack (solely used for abortion) are both on Kenya's EML,** indicating an enabling environment for the use of these products for abortion.

3. Kenya's devolved health system structure has potentially contributed to increased stock outs – **interventions require coordination of multiple actors involved in the system**.

4. **Pharmacies are first point of care** for many women in Kenya. There are approximately 12,000 pharmacies in Kenya.

5. The contraceptive market is still **dominated by free public products**, but the commercial sector and social marketing organizations **(SMOs) have played a critical role to expand the MA market**. Tapping into the post MA contraception market requires nimbly navigating the two sectors.

KENYA: FIRST FP MOVER IN AFRICA

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

Kenya has been a first mover in Africa in terms of contraception

- The increase in mCPR in recent decades in Kenya is **largely attributed to the use of modern methods** - specifically implants, which increased from <2% among all married WRA in 2003 to 19% in 2022, one of the highest rates of contraceptive implant prevalence globally (Abonyo, P., et al., 2022).
- Well-funded donor programs such as the IAP, UNFPA Supplies Partnership, and bilateral donor contributions have allowed the GOK to **obtain free contraceptive commodities and distribute them to Kenyan women**.

Diminishing donor support

- Kenya's health financing landscape is changing with the **government's role increasing** (see Figure 6) Abonyo, P., et al., 2022).
- In 2019, a memorandum of understanding (MOU) between MoH and donors underscored the need to **scale up domestic financing for contraceptive commodities** with the ambition that MoH will fully finance FP commodities by FY 2025/26, with donor funding declining accordingly. Estimates of required contributions are shown in Figure 6 Abonyo, P., et al., 2022).
- Based on these estimates, the MoH needs to **almost quadruple domestic contraceptive commodity funding** from FY 2019/20 (about USD 5.4 million) to FY 2025/26 (about USD 21.5 million).
- Given the challenging economic climate globally, **MoH's ability to continue to fulfill this contribution is unclear**. Thus far, in 2019/20 the MoH allocated only USD 2.45M (45% of its commitment), and USD 5.5M (77%) in 2020/21 (The Motion Tracker, 2021).

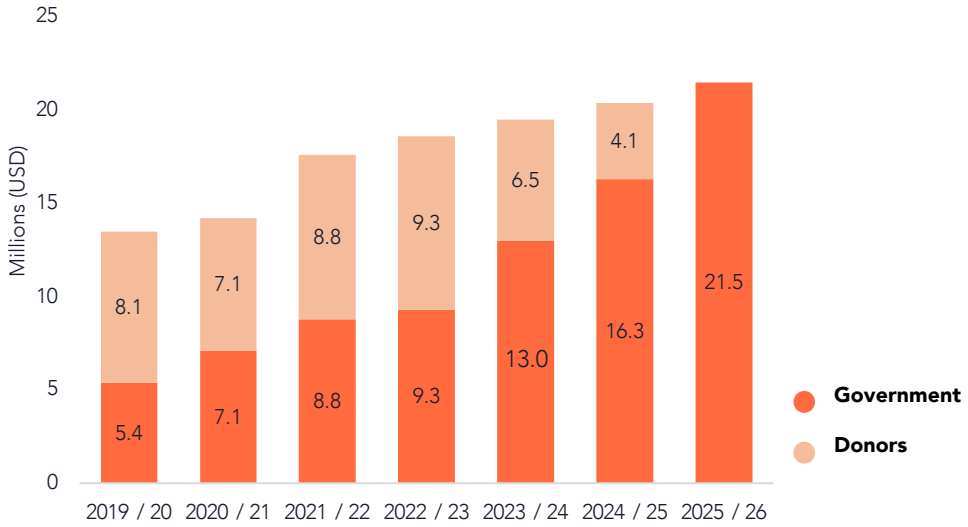


Figure 6: Estimated Family Planning Commodity Funding Commitments, 2019–2026.

Note: Figures derived from MOU ratios were translated into estimated costs using the government's family planning forecasting and quantification data, October 2021. Projections do not include supply chain costs such as warehousing and distribution.

REGULATORY CONTEXT

Mifepristone and Misoprostol are part of Kenya's EML and available through registered outlets and pharmacies. The recent registration of combipack, which is solely used for abortion, indicates an enabling environment for MA.

Medication Abortion (MA)

- **Mifepristone and Misoprostol are part of Kenya's essential medicines list (EML)** for distribution and sale through registered outlets including private pharmacies (Population Council et al., 2015). The combipack was recently registered, indicating an enabling environment for the use of these products for abortion.

- In 2010, Kenya passed a **new constitution that made abortion permissible** if "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law". There is ambiguity surrounding who exactly is a trained health professional but it is assumed to refer to doctors, nurses and trained midwives. **Pharmacists are able to dispense these drugs when the woman brings a doctor's prescription** (Government of Kenya, 2010; Mutua et al., 2018).

- However, the Kenyan Penal Code has yet to be revised in line with the new constitution and **many health practitioners may be uninformed about their legal status and hesitant to provide abortions**, let alone contraception counselling or contraception post-MA (Reiss et al., 2016).

Post MA contraception

- It has also been announced that the **East and Southern Africa FP2030 Hub will be hosted in Nairobi by Amref Health Africa, which may increase awareness and advocacy for post-abortion family planning (FP2030, 2022).** This is a great opportunity to advance and strengthen implementation of the post-abortion care guidelines that were operationalized in 2021. Advocacy workers could encourage county governments, for instance in Nakuru, to deliberately plan for and allocate resources for FP and PAFP.

DEVOLVED HEALTH SYSTEM STRUCTURE

While Kenya's devolved health system structure allows for counties to allocate health resources, slow and bureaucratic process can lead to stockout of contraception at a county level.

Devolved six-level healthcare system of service delivery

- National government and 47 county governments work at different levels to set policy and provide defined levels of care, **requiring significant coordination** (Masaba, B., et. al., 2020).
- While devolution was established to decentralize power, combat inequality, and mismanagement of resources (Ngigi, et. al., 2019), evidence suggests that it **may have contributed to contraceptive commodity insecurity** with implications for equity and access (Appleford, G., et. al., 2019).
- Kenya has developed primary health care network (PHCN) model to support access to services, such as contraception and MA, at a community level.

National regulation

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

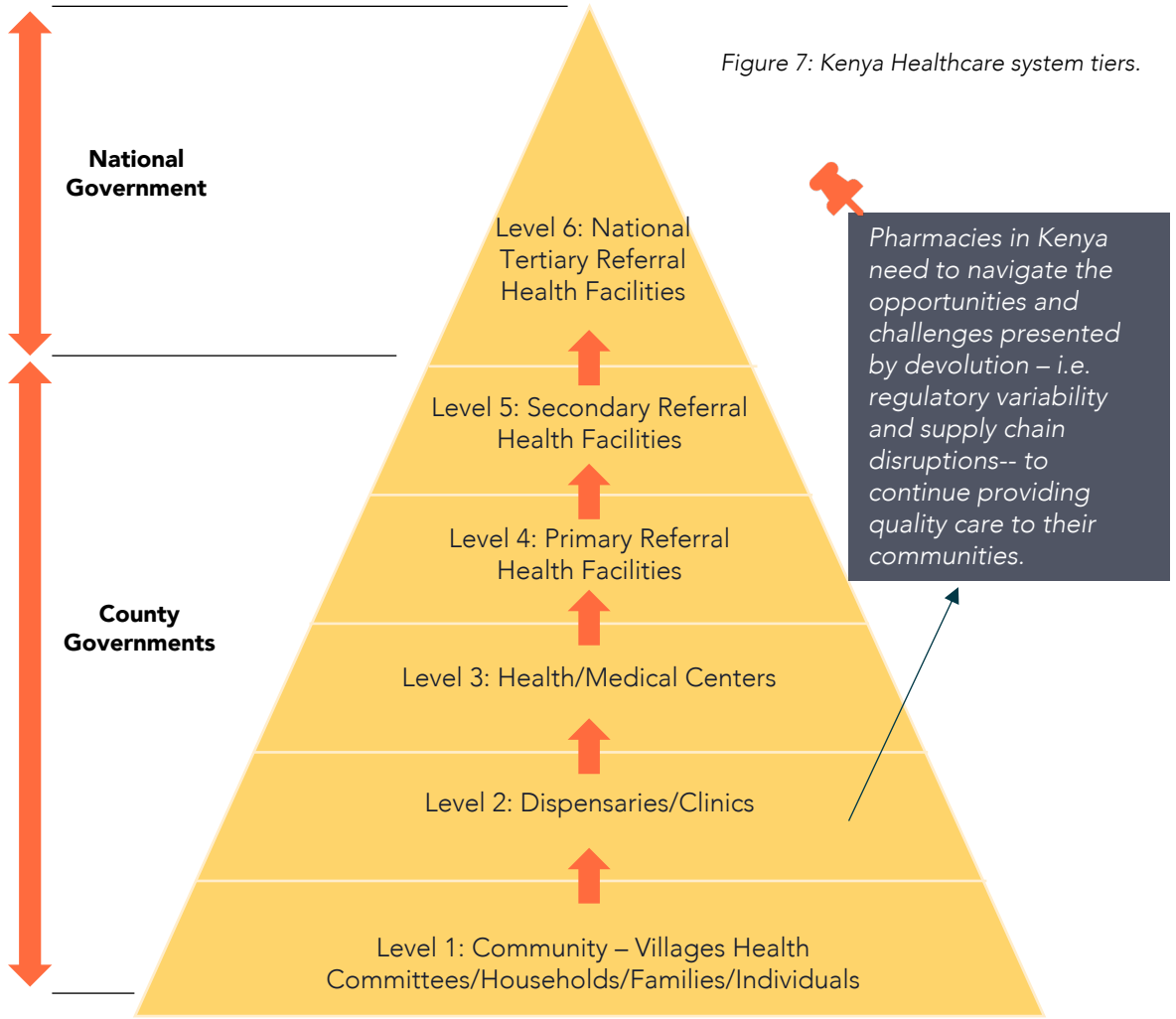


Figure 7: Kenya Healthcare system tiers.

KEYSTONE

PHARMACIST SEGMENTS

Pharmacies are often the first point of care for primary healthcare, which makes them an important player in access to MA and contraception.

With task sharing policies and coordinated support by government and stakeholders, these three models can help increase uptake of post MA contraception.

James, the profit driven Pharmacist/Nurse*

"We really want to help these girls, but it can be difficult if they beat around the bush. We hope that when they tell us their problem, they are telling us the truth so that we can properly guide them."

Size of segment: Approx. 12,000 private pharmacies.
Influencers: Peers, Network Management Organizations, regulators including Pharmacy and Poisons Board (PPB).
Opportunity to Reach: Medical detailing, trainings with continuing professional development, Pharmacy networks, social media, advertisement and branding.

Joan, the laidback pharmacist

Only provides short term methods

"I refer all LARC cases to a clinic/health facility. And I'm not all that concerned about following up with them."

Size of segment: Part of the 12,000 private pharmacies. Tends towards an informal pharmacy (66% of these). Interested in products that give her quick returns.
Influencers: Peers, medical detailers, regulators including Pharmacy and Poisons Board (PPB), suppliers
Opportunity to Reach: Medical detailing, trainings with Continuing Professional Development (CPD), social media, advertisement and branding

Ready Now, the opportunistic online pharmacy

"Registered with the Pharmacy and Poisons Board, we dispense MA and short-term contraceptive products. When women need a service, not a commodity - such as injections, implants and IUDs - we can refer them to a telehealth partner. Continuation and repeat orders are a challenge for us."

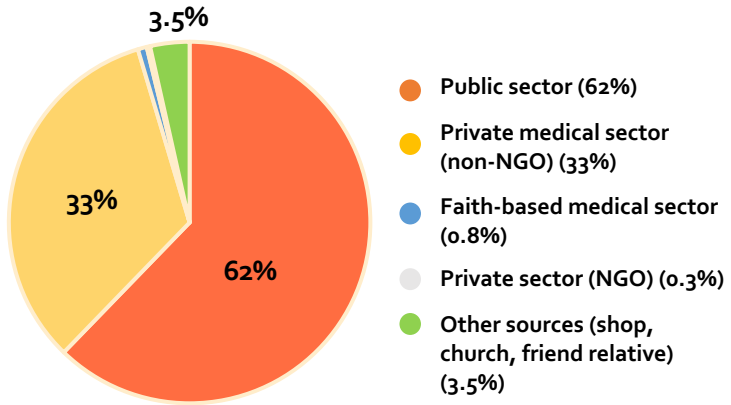
Size of segment: over 10 online pharmacies
Influencers: Regulators including Pharmacy and Poisons Board (PPB), Pharmaceutical Society of Kenya (PSK), Communications Authority of Kenya
Opportunity to Reach: Medical detailing, trainings with CPD, social media, advertisement and branding

FP AND MA MARKETS

The contraceptive market is still dominated by free public products, but social marketing organizations (SMOs) and commercial private actors have played a critical role to expand the MA market. Tapping into the post MA contraception market requires nimbly navigating the two sectors.

Contraception

- The contraceptive **market supply side is dominated by free public products,** socially marketed, social enterprise and a small percentage of completely fully commercial products (SHOP Plus, 2018).
- **38% of contraceptive users receive contraceptives in the private sector** (SHOP Plus, 2018).
- **Majority of private providers do not report contraceptive uptake through the District Health Information System,** making monitoring of contraception commodities in the private sector challenging.



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

Medication Abortion (MA)

- **Social Marketing Organizations (SMOs) such as DKT, MSI and PSI have created a market for MA**, having expanded access and brought prices down. But more work is needed to move to more affordable pricing and increased accessibility for quality-assured (QA) combipacks (CIFF, 2021).
- Comprehensive training on the correct regimen and availability of commodities for MA is sorely needed. **Although 80% of pharmacists sampled had heard of misoprostol, only 1.3% had heard of the combined regimen.** Moreover, of these pharmacists who had heard of the combination of misoprostol and mifepristone use, only 9.2% were able to mention the correct regimen for this combination. In pharmacies that provided information or methods on abortion, 66% of them had any brand of misoprostol available, while only 2% had any brand of mifepristone (Population Council et al., 2015).

Post MA contraception

- Although the magnitude of this missed opportunity for providing contraceptive services post MA is poorly documented and largely not known, **it is clear that women and girls who use MA outside of facilities need options for contraceptive products and related services** (APHRC, 2019).

KEYSTONE

4

WHO should be targeted for post MA contraception interventions in pharmacies and why?

WHO should be targeted for post MA contraception interventions in pharmacies and why?

"WHO" section purpose

This section aims to identify and prioritize target consumer segments and unpack their pathways to access. Specifically, it aims to answer:

1. Who are particularly important and why?
2. What is their actual vs ideal journey to meet the health need?
3. How does the consumer interact with the contraceptive market?

"WHO" key takeaways

1. The unmet need for contraception is **higher among unmarried adolescents and young women** and those from a **lower socioeconomic status** - targeting these groups with post MA contraception can help reduce subsequent unintended pregnancies.

2. User perceptions of the market **vary by demographics and need**. For example, AGYW want on-demand methods while married women are looking for durable, long-lasting methods.

3. **Individual and external factors influence post MA contraception demand**. AGYW are largely influenced by their peers, while spouses are key influencers of married women

TARGET CONSUMER SEGMENTS

The unmet need for contraception is higher among unmarried adolescents and young women and those from a lower socioeconomic status - targeting these groups with post MA contraception can help reduce subsequent abortions.

	Shiru, the Mature Minor Age: 15-17 years	**Wambui, the Married Adolescent** Age: 17-19 years	**Njeri, the Young Woman** Age: 20-24 years	**Mama Joni, the Prudent Mother** Age: 30
				
SIZE (2019 Census)	1,125,309	1,474,133	2,334,778	7,160,459
INFLUENCERS	School health clubs, peers, boyfriend, social media, and parents.	Chama, CHVs, husband, social media, and mass media.	College activations, peers, boyfriend/sponsor, and social media.	Chama, CHVs, husband, social media, and mass media.
OPPORTUNITY TO REACH	Friends, boyfriend, trusted family member, peer educators, teachers, social media, and digital platforms.	Social media, digital platforms, husband, CHV, and Chama.	Social media, peers, sponsor, boyfriend, and digital platforms.	Social media, digital platforms, husband, CHV, and Chama.

KEYSTONE

See Annex for full description of user journeys.

BEHAVIORAL PATHWAY: WOMEN & GIRLS UNDER 25

Women and girls under 25 have interest in contraception following MA but will rely on online research and referrals from peers rather than information during MA counselling.

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1 LIVES WITH PARENT(S)

- Currently in high school or heading to college

2 BECOMES SEXUALLY ACTIVE

- Worries about possible pregnancy
- Uses emergency contraception pills/condom/ safe days
- Worried about boyfriend's thoughts on her use of FP
- Worried about service providers thoughts on her use of contraception
- Wants a private or discreet method

3 CURIOUS ABOUT CONTRACEPTIVES

- Consults peer (close friend) or boyfriend/CM
- Researches online
- Listens to media
- May/may not use a contraceptive

4 PREGNANCY CRISIS

- Feels confused
- Worries about school
- Worries about parents
- Partner/boyfriend deserts her
- Consults close friend or older sister (close relative)
- Contemplates abortion

5 SEEKS SOLUTION

- Advised to see a herbalist or backstreet abortion provider
- Advised to see prescription for safe abortion
- Researches about safe abortion
- Concerned about MA cost

6 SEES A HERBALIST OR BACKSTREET PROVIDER

SUCCESSFUL

- Successful termination

UNSUCCESSFUL

- Illness
- Death
- Hospital
- Ineffective termination

7 SEEKS PX FOR MA

- Receives MA counseling
- Might receive some contraception information
- Friend or CM accompanies her
- Looks for discreet pharmacy
- Likely to be referred by a friend to a trusted pharmacist or CM.

Successful termination

8 1 WEEK POST MA

- Feels relieved
- Goes back to routine
- Feels guilty for termination but validates
- Distances herself from her partner

9 2-3 WEEKS POST MA

- Distances herself from partner/relationships
- Prefers to abstain to avoid pregnancy
- Feeling of guilt and shame
- Talks to close friend/CM

10 1-2 MONTHS POST MA

- Opens up to the possibility of sex/having a partner
- Curious about contraception/research online
- Likely to ask a peer or go back to the trusted CM or pharmacist for help
- Seeks a discreet method
- Desires privacy, and prefers one-on-one counseling but is also willing to go for peer group sessions if she trusts the CM.
- If the method is successful highly likely to refer the peer to CM or a trusted pharmacist.

KEYSTONE

Content from ThinkPlace: Driving uptake of contraceptives post medication abortion UCD Process Documentation

BEHAVIORAL PATHWAY: WOMEN OVER 25

Women over 25 are more likely to receive contraceptive counselling post MA and are more likely to pro-actively seek a convenient contraceptive method compared to those under 25.

ThinkPlace

1 SHE MIGHT BE MARRIED WITH CHILDREN OR UNMARRIED WITH CHILDREN.

- Worried that contraception might cause infertility challenges especially if she has not had any children yet.

2 SEXUALLY ACTIVE WITH HUSBAND/PARTNER

- Worried about getting pregnant
- Worried about side effects of contraception
- Worried about partners thoughts regarding her use of contraception
- Inconsistently uses Depo-Provera injection and daily pill

3 CONSULTS PEERS & PARTNER

- Researches about contraception from online sources, local CM and trusted Pharmacist
- Worried about method failure
- Concerned about credible service

4 DISCOVERS SHE IS PREGNANT

- Feels confused
- Worried about her finances
- May inform or fail to inform husband/partner
- Seeks advice from trusted CM or pharmacist

5 REFERED TO A HERBALIST

SUCCESSFUL
- Successful termination

UNSUCCESSFUL
- Illness
- Death
- Hospitalization
- Ineffective termination

6 RESORTS TO MA

- Receives MA counseling
- Receives contraceptive counseling
- Pro-actively seeks a more convenient contraception method
- Prefers discreet counseling services

Successful termination

7 1 WEEK POST MA

- Worried about her health/body
- Goes back to PX for check-up
- Goes to facility for an implant/IUD
- Resumes normal life

8 2 WEEKS POST MA

- Begins/continues using her preferred method
- Goes back to trusted pharmacists for continuation or to consult

KEYSTONE

Content from ThinkPlace: Driving uptake of contraceptives post medication abortion UCD Process Documentation

TARGET INTERMEDIARY SEGMENT

Community mobilizers earn the trust of adolescent girls and women, while also understanding the needs of their community.

Milka, the Community Confidant

Size of segment: currently unknown
Influencers: fellow intermediaries, programs, regulators (license issuing bodies), other volunteers
Opportunity to Reach: Medical detailing, trainings, program exchange meeting

The community mobilizer acts as the bridge between providers and consumers. They can be an important driver in reducing MA complication rates, especially among adolescent girls who have inadequate social support to carry out self-managed MA.

- Offers comprehensive contraceptive counselling.
- Refers women to health facilities and pharmacies.
- Safeguards privacy of clients.
- Well-connect with people and local facilities and is a trusted member of the community.
- Non-judgmental, fast.

Community mobilizers and health intermediaries are an important persona to understand, especially in the context of peer support and referrals. However, this persona was only included in a previous ThinkPlace report, not the most recent one.

Kenya has recently committed to formally supporting CHWs who will therefore have a growing role to play in supporting girls and women (Johnson & Johnson, 2023).

CONSUMER INTERACTION WITH THE CONTRACEPTIVE MARKET

User perceptions of the market vary by demographics and need. For example, AGYW generally want on-demand methods while married women are typically looking for durable, long-lasting methods.

Major barrier

Minor barrier

	SHIRU, THE MATURE MINOR (ADOLESCENT GIRL)	WAMBUI, THE MARRIED ADOLESCENT	NJERI, THE YOUNG WOMAN	MAMA JONI, THE PRUDENT MOTHER (ADULT WOMAN)
AVAILABILITY	• Products not available to minors • Providers hesitant to serve	• Products may not be provided by pharmacist without husband's consent	• Preferred method may not be provided by pharmacist (stock, personal bias towards young women)	• Preferred method may not be provided by pharmacist (stock, personal bias towards young women)
AFFORDABILITY	• No source of income and therefore products are not affordable	• May not be able to afford LARCs due to household budget	• No extra income for contraceptives • Relies on "sponsor" to finance a method • Attracted to vouchers and discounts	• May not be able to afford LARCs due to household budget
ASSURED QUALITY	• Unaware of the quality-of-care (QoC) standards • Relies on peer referrals as a yardstick	• Unaware of the quality-of-care (QoC) standards • Contraceptive counseling might be inadequate	• Unaware of the QoC standards • Relies on peer referrals as a yardstick	• Chooses a method with less side effects • Contraceptive counseling might be inadequate
APPROPRIATE DESIGN	• Daily pills are too cumbersome, injections are not appealing	• Looking for a product that won't require her to make frequent visits to pharmacy	• Prefers quick fixes like emergency contraceptives • Daily pills are too cumbersome	• Looking for a product that won't require her to make frequent visits to pharmacy • Looking for product with least 'failure' rates
AWARENESS	• Mostly unaware of contraceptive methods and perceives them as for married people • Exposed to myths and misconceptions	• Exposed to myths and misconceptions • Information sources include CHVs, peers, chama group, social media, husband, pharmacist	• Aware about contraceptives mostly from the internet and friends; does not know what to ask for • Exposed to myths and misconceptions	• Information sources include CHVs, peers, chama group, social media, husband, pharmacist

KEYSTONE

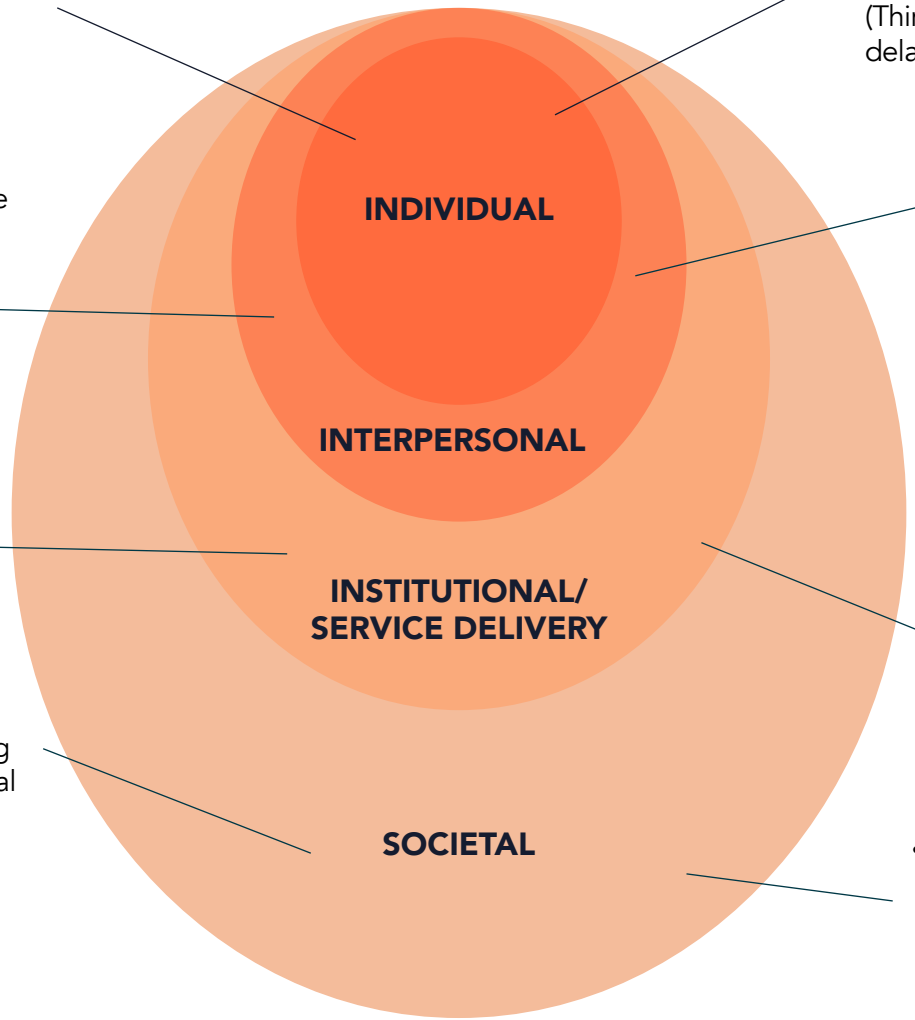
These findings are based on consumer journey mapping (see Annex 1)

DEMAND ECOSYSTEM

Individual and external factors influence post MA contraception demand. AGYW are largely influenced by their peers, while spouses are key influencers of married women

Contraception

Medication Abortion (MA) outside health facilities



- **Limited knowledge** in rural and slum settings (Sustainable Abortion Ecosystem Assessment, 2021)
- **Societal stigma** linked to contraceptive use among unmarried youth (Ochako et al., 2015)
- Health concerns
- **Emotional responses** to contraceptives after successful medication abortions, with some individuals associating the use of contraceptives with trauma (ThinkPlace, 2019, 2022)

- AGYW do not want to **disgrace their parents** or drop out of school and are motivated to take up contraceptives (Big Ideas, 2021).
- Adolescent girls feel the **need for support from a close contact** when faced with an unplanned pregnancy (ThinkPlace, 2022).

- **Service provider biases** in offering contraceptives to adolescent and young women (Ochako et al., 2015).
- Preference for **traditional methods** of contraceptives is common (Ochako et al., 2015).

- **Peer educators** important for awareness-creation, including using social media to provide accurate information on sexual and reproductive services to their peers (Big Ideas, 2021).

- Worry about **body recovery and future fertility** due to MA (ThinkPlace, 2019). Education motivation prompts some to delay childbirth (APHRC et.al., 2021).

- **Partner (dis)approval** influences MA uptake (ThinkPlace, 2022). **Reliance on "big sis"** and trusted friends for MA information and decision making.
- Pregnant girls **face stigma in school** despite the school re-entry policy 1994. They either quit or seek abortion (APHRC et.al., 2021).
- People **do not share their abortion stories** or experiences due to stigma.

- Informal conversations about "street ways" to conduct abortions happen, **spreading misinformation** (APHRC et.al., 2021).
- The law is ambiguous and **providers risk arrests** for botched or underage abortions, where providers were involved (Pop Council, 2015).
- Due to pervasive stigma, **MA is prefered by girls** as they can take it from anywhere and it is a short process, and it is a less painful process compared to manual vacuum aspiration (Big Ideas, 2021).

- Policy gaps and lack of policy statements on abortion **expose providers to harassment** by law enforcement agencies (Pop Council, 2015).

KEYSTONE

5

HOW are the MA and contraception markets performing in Kenya?

HOW are the MA and FP markets performing in Kenya?

"HOW" section purpose

This section aims to analyze the FP, MA and post MA contraception market performance and structure. Specifically, it aims to answer:

1. What is the size of the contraceptive / MA / post MA contraception market?
2. What is the variety of contraceptive / MA post MA contraception products and services available in the public and private sector?
   - **PRODUCT** **PRICE** **PLACE** **PROVIDER** **PROMOTION**
3. What is the value chain for the contraceptive implant market?
4. Who are the key actors in the contraception market, what role are they playing, and what are their capacities and inceptives to play their role effectively?

"HOW" key takeaways

1. The **MA market appears to be growing** which increases potential for women needing contraception choice post MA.
2. Kenya's **private value chain for contrcaeptive commodities is projected to grow in coming years** given the expected withdrawal of donor funding. Understanding the incentives and capacities of suppliers, distributors, and retailers to procure, distribute, and sell contraceptives is key to sustainable provision of post MA contraception.
3. Post MA contraception is **funded predominately through out-of-pocket expenditure** at pharmacies and this can be major barrier for women in the uptake of post MA contraception, when they might also be managing negative societal perceptions associated with MA and contraception.
4. While there are legal and regulatory frameworks in Kenya regarding cpntraception, MA, and reproductive health care, there are challenges such as **legal ambiguity, lack of enforcement, hidden fees, delays in import permits, and gaps in healthcare provider knowledge.**

MARKET DEPTH

The MA market appears to be growing which increases potential for women needing contraceptive choice post-MA.

Contraception

- The **public sector** remains the dominant provider of contraception, accounting for **60% of the contraceptive market. The private sector accounts for 38%**.

Medication Abortion (MA)

- DKT, the predominant provider of MA drugs, shows that **combipack sales are growing:** from 36,021 packs in 2020 to 58,385 in 2021. This is a markup of 62% (DKT International, 2021). But DKT Combipack volumes stagnated recently (54,158 packs in 2022) due to increasing competitions. This shows the **business case for MA products.**

- Market **players employ various strategies**, including on-the-job MA training for pharmacists, tele-medicine partnerships like Viya Health with MYDAWA, and encouraging pharmacy clusters for bulk ordering, aiming for scalable and sustainable support for contraception, particularly through digital pathways for women and girls.

	MSI sales	DKT sales
Misoprostol	496,300	316,908
Combipack	11,415	54,158

Post MA contraception

- **Nealy 60% of participants in the Ipas pilot study obtained contraception from the pharmacy when purchasing MA pills, including in the control group, in which uptake was 57%.** Continuation of contraception at the 30-day follow-up was even higher in all intervention groups (Ipas, 2021).

- However, in DKT's Mystery Client survey, virtually none of the women (MA users) were counselled on contraception.

MARKET BREADTH: PRODUCT

There is a diverse range of contraceptive products on the market, yet supply chain dynamics affect availability and therefore choice. Furthermore poor market tracking affects insights into the availability of QA MA.

CONTRACEPTION

There are a diverse range of contraceptive products on the market from condoms to LARCs, which are supported by donor funds, government budget and SMO e.g. DKT, MSK, PSI

- Short term methods such as condoms, EC, and pills, are most commonly accessed through pharmacies.
- The competitive landscape involves organizations like DKT, MSK, and PSI contributing to the contraceptive market with innovative products such as Lifeguard condoms and Avibela (Levonorgestrel IUD).
- DKT's diverse product range, including Kiss and Fiesta condoms, ECs, and LARCs, reflects a comprehensive approach to contraceptive options.
- Informal acquisition of Depo Provera from government facilities by some pharmacists poses challenges, leading to unreliable supply and frequent stockouts.

MEDICATION ABORTION (MA) OUTSIDE HEALTH FACILITIES

Quality Assured (QA) MA products, which are typically more expensive, face challenges in market tracking, regulatory packaging for correct dosage, and slow circulation due to profit-driven preferences of pharmacists, impacting user experience and privacy in MA use.

- QA products are pricier, impacting user access to MA options.
- Lack of mechanisms to monitor market share of QA drugs impedes understanding of their adoption and impact over time.
- Misoprostol's packaging for incorrect MA dosage creates regulatory challenges, yet serves as cover for MA use.
- Some MA products in circulation have short expiry dates, leading to periodic stockouts or unused stock going to waste.
- Profit-driven pharmacists prefer stocking cheaper Misoprostol-only regimens despite higher failure rates, impacting user privacy during administration.
- The need to enhance the supply chain is emphasized, especially in preventing stock-outs of essential drugs like combined Mifepristone and Misoprostol. This is particularly critical in private pharmacies providing abortion information or methods, underlining the urgency for systemic improvements.

WHAT DOES THIS MEAN POST MA CONTRACEPTION?

In the event of MA drug stockouts, pharmacists can offer family planning (FP) services and counsel clients, potentially earning commissions by referring them to alternative sources for MA drugs.

- DKT and MSK can make use of existing supply chains to support post MA contraception. If there is a stockout for MA drugs but contraception is available, pharmacists can use the opportunity to counsel clients in case they may wish to purchase contraception later or straightaway.
- If the pharmacist is unable to request quickly from distributor, they can give the client details of where to receive MA drugs, such as referring to an online pharmacy. An incentive for pharmacists to do this is for them to receive a commission for referral.

KEYSTONE

MARKET BREADTH: PRICE

Pharmacists are naturally incentivised to offer MA over contraception given the higher profit margins. Navigating access to post MA contraception requires directly addressing these incentives of private providers.

CONTRACEPTION

Despite free availability of family planning products in the public sector, financial barriers persist for women accessing related services, further compounded by limited insurance coverage.

- While contraceptive products are freely available in the public sector, many women still face financial hurdles when accessing related services, often equivalent to more than a day's wages.
- Family planning services lack sufficient coverage in most insurance programs, including the National Health Insurance Fund in Kenya. There's optimism that ongoing social insurance reforms might address this gap, offering potential improvements in accessibility.
- Even though family planning services are more expensive in the private sector, a significant 33% of women in Kenya express a willingness to pay for them, (KDHS 2022). This highlights the strong demand for private sector family planning services, despite the associated costs.

MEDICATION ABORTION (MA) OUTSIDE HEALTH FACILITIES

The lack of awareness of recommended retail prices, coupled with high trade margins and inconsistent pricing data, creates affordability challenges for consumers, disproportionately affecting adolescent girls in need of MA drugs.

- Lack of awareness of recommended retail prices leaves consumers vulnerable to unpredictable and potentially high costs for MA drugs.
- High prices are perceived as the 'cost of doing business' by pharmacists, with little business incentive to address affordability due to poor efficiencies of scale.
- There is significant variability in the selling price of MA drugs, with providers willing to negotiate based on client presentation and ability to pay, including the use of payment plans such as instalments. Better regulation of MA drug pricing is identified as a crucial need. According to the Ipas pilot, pharmacists were willing to sell MA from KES2,000 to 10,000.

WHAT DOES THIS MEAN POST MA CONRACEPTION?

Encouraging providers to offer deals and discounts for contraception with MA drugs may create a positive user experience, fostering client loyalty and potentially expanding their client base beyond MA.

- Recognizing the low profit margin of contraception, the business incentive for providers lies in leveraging positive MA experiences to expand their client base, potentially through peer-to-peer referral strategies.
- Providers open to instalment payment plans for MA clients have an opportunity to reinforce post MA contraception when clients return.
- During counseling, providers should be mindful of overwhelming consumers, addressing this by providing anonymized vouchers at the time of MA drug purchase. This ensures a post MA contraceptive discount, promoting return visits for comprehensive contraceptive counseling and purchases.

MARKET BREADTH: PLACE

Both brick-and-mortar and online pharmacies play vital roles in providing contraception and post-abortion care, but there's a need to enhance access to a wider range of contraceptive methods, especially in post-MA contraception.

CONTRACEPTION	MEDICATION ABORTION (MA)	WHAT DOES THIS MEAN POST MA CONTRACEPTION?
Both brick-and-mortar pharmacies (public or private) and online pharmacies contribute to the accessibility of FP products, catering to diverse consumer preferences and needs.	**Access to safe MA and PAC is facilitated by entities like the Reproductive Health Network, Marie Stopes, Family Health Options Kenya, and pharmacies, with prescriptions not universally required.**	**Private providers need dedicated spaces for post MA FP counseling, utilizing existing areas for injectable administration.**
• Online direct-to-consumer (D2C) companies prioritize 'fast-moving' goods such as oral contraceptive pills and condoms, emphasizing efficiency and convenience in meeting client demands. • Online retailers play a role in addressing challenges related to convenient access to contraceptive products, offering extended operating hours and aligning with providers eager to extend their services to the general public. • The business-oriented approach of online retailers reflects their intention to not only address health needs but also capitalize on the market demand for contraception, showcasing a symbiotic relationship with providers. • Organizations like InSupply Health, an independent supply chain advisory firm, collaborate across sectors to design resilient supply chain solutions, providing customized guidance to address stockout issues and enhance the efficiency of health product delivery	• A significant portion of pharmacy workers, with 87.5% aware of misoprostol but only 39.2% familiar with mifepristone, lack awareness of correct MA regimens. • Out of 765 surveyed outlets, only 12.7% stocked any MA drug, highlighting the challenge of accessing MA drugs due to limited availability in pharmacies. • While a prescription is not universally required, only 11% of pharmacy workers have denied abortion services due to a lack of prescription.	• Pharmacies can play a dual role in providing post-MA contraception directly or referring individuals to other healthcare providers for comprehensive services. Pharmacists can offer counseling, education, and dispensing of contraceptives, while also referring clients to clinics or specialists for additional care if needed.

KEYSTONE

MARKET BREADTH: PROVIDER

Intrinsic lack of incentives for contraceptive counseling in private pharmacies necessitates innovative approaches to demonstrate the business case for quality post-MA contraception counseling and service provision.

CONTRACEPTION	MEDICATION ABORTION (MA) OUTSIDE HEALTH FACILITIES	WHAT DOES THIS MEAN POST MA FP?
Hotlines like the KMET hotline, partnered with the Ministry of Health, provide crucial counseling opportunities, yet pharmacists often prioritize sales over counseling; therefore, digital counseling could offer a solution for pharmacists lacking information and physical space.	**Pharmacists exhibit varied practices in dispensing MA drugs, with gaps in prescription inquiry, follow-up advice, and provision of written instructions, influenced by beliefs, legal considerations, and a desire for profit.**	**Private pharmacies may lack intrinsic incentives to offer FP counseling (i.e. 'it's not my job;), and therefore more innovative approaches may be required for them to see the business case of quality post MA FP counseling and service provision.**
• Hotlines like the KMET hotline partnered with the Ministry of Health present valuable opportunities for comprehensive counseling, yet pharmacists may prioritize selling existing stock, potentially limiting counseling services. • Digital counseling could help as they often do not have access to the relevant information and they do not have the physical space to do counseling.	• A significant portion of pharmacy workers, with 87.5% aware of misoprostol but only 39.2% familiar with mifepristone, lack awareness of correct MA regimens. • Mystery clients report that 59% of providers explain MA thoroughly, indicating inconsistency in patient education practices. This is coupled with a predominant transactional approach, as nearly 80% of providers maintain a 'no questions' service. Some even dispense MA drugs without packaging to prevent misuse by adolescents (ThinkPlace, 2022). • Only 16% of pharmacy workers in outlets providing abortion information or methods received proper training, underscoring a need for improved competence in service provision (Population Council, 2015).	• Pharmacy workers need improved capacity to provide accurate information on medication use, family planning, and abortion services referrals. • Given that pharmacists are not able to commit time for comprehensive counseling, informational materials can be leveraged to help pass on crucial information to improve risk awareness levels. This is an opportunity for integration with digital counseling to create business case to the pharmacists. • Private pharmacies may lack incentives for consumer education, including proper medicine use counseling and referrals for appropriate care. • Inconsistent information provision highlights a potential barrier, underscoring the importance of a positive user experience in reinforcing trust for the delivery of post-medication abortion (MA) contraception services.

MARKET BREADTH: PROMOTION

Requirement of PPB approval for MA marketing materials can create barriers to effective communication on post-MA contraception; meanwhile, volunteers are an important workforce for educating their peers.

CONTRACEPTION

Developing contraception charts serves as a powerful tool for fostering behavioral change, providing crucial information through various channels, including social marketing campaigns, community engagement, and online platforms.

- Contraception charts are not only informative but also serve educational and communicative purposes, contributing significantly to accurate behavioral change messaging.
- Social marketing organizations like RESPEKT, NAYA, and Family Health Options Kenya conduct advocacy campaigns, employing community mobilizers to educate women and girls on safe sex practices both in physical sessions and online platforms.
- Online pharmacies play a role in disseminating information, offering a platform where individuals can access details about reproductive health.
  AskNivi, for instance, effectively screens, refers, and follows up with clients interested in contraceptives, as indicated on the Population Council website.

MEDICATION ABORTION (MA) OUTSIDE HEALTH FACILITIES

Barriers in marketing approval and supply chain inefficiencies pose challenges in disseminating crucial reproductive health information and drugs, particularly mifepristone and misoprostol.

- Marketing material approval by the Pharmacy and Poisons Board (PPB) faces hurdles, with instances like DKT posters being repeatedly rejected in pharmacies due to government hesitancy, highlighting regulatory barriers.

WHAT DOES THIS MEAN POST MA CONTRACEPTION?

A more lenient Pharmacy and Poisons Board (PPB) approval process for MA can lead to improved post MA contraception information dissemination. Challenges in relying on volunteers for education and the need for a referral tracking system underscore the importance of systematic approaches.

- A more lenient PPB approval process for MA opens avenues for pharmacies to display post MA contraception information on promotional material, enhancing access to crucial reproductive health information.
- The current reliance on volunteers from advocacy groups to educate peers about contraceptive bundling with MA drugs is deemed potentially unsustainable and unreliable. There is a need for a more structured and reliable approach to education in reproductive health.
- Integrating confidential SMS messaging for contraceptive options and reminders, customized for user interpretation, proves vital in promoting full choice and access.

VALUE CHAIN FOR CONTRACEPTIVES

Kenya's private value chain for contraceptive commodities is projected to grow in coming years given the expected withdrawal of donor funding. Understanding the incentives and capacities of suppliers, distributors, and retailers to procure, distribute, and sell contraceptives is key to sustainable provision of post-MA contraception.

	IMPORTERS	DISTRIBUTORS & WHOLESALERS	PROVIDERS & RETAILERS	CONSUMERS
KEY PLAYERS	• **Donors:** Contraceptive security in Kenya historically relied on donor funding primarily directed to the public sector's supply chain. However, the private sector is expected to play increased role in contraception provision as the government takes on FP commodity financing. • **Pharmacy Poisons Board:** PPB plays a crucial role in regulating imports, managing product registration, and overseeing import clearance for health commodities in Kenya.	• **Public:** KEMSA predominately supplies products to both public health facilities through sub-county depots. • **Commercial:** Surgipharm, Dawa Life Sciences and others predominately supply products to the private sector • **Not-for-profit:** PSI, DKT, MSI and others supply products through their franchised clinics.	• **All healthcare workers (including pharmacists):** can provide condoms and pills. • **Some healthcare workers:** Can provide injectables, implants, and IUDs. • **Pharmacies:** recently can offer Depo-Provera and Sayana Press without a prescription.	• **Adolescent girls (15-19) and young women (20-29) (see consumer segments in slide 27)**
ISSUES & INCENTIVES	• **Supply Chain Challenges:** Donor-funded projects benefit from purchases on scale, an option not available to private individual providers. However, bureaucratic processes between donors, governments, and manufacturers can delay forecasting, purchasing, and procurement of contraceptive products, disrupting supply chains and commodity availability. • **Taxes**: Contraceptive products are tax-exempt only when procured by government or donors, if private providers procure products directly they would be subject to additional taxation.	• **Limited number of commercial distributors & wholesalers:** There is a lack of incentives for private sector actors due to the availability of free public sector commodities that flood public sector supply chain. • **Public sector KEMSA procurement challenges:** Counties are restricted to purchasing commodities only from KEMSA, leading to infrequent communication and late notifications of method shortages • **Private sector resilience to KEMSA stockouts:** Private sector is not affected by public sector supply chain stock outs by KEMSA.	• **Profit margins:** Private providers, motivated by profit margins, may not be incentivized to offer across the method mix. This is especially true for pharmacists who can only offer a more limited number of methods (e.g., no LARCs).	• **Access and choice:** CPR is high in Kenya but declining. Ensuring access to a range of options at all channels is critical to supporting choice and access.

VALUE CHAIN FOR MEDICATION ABORTION

CIFF, 2021

The MA value chain faces challenges such as fragmented supply chains, competition among marketing organizations, and affordability issues. However, the recent introduction of more MA products increases competition, which could give women and girls more options and lower prices.

	MANUFACTURERS	IMPORTERS	DISTRIBUTORS & WHOLESALERS	RETAILERS & PROVIDERS	CONSUMERS
KEY PLAYERS	• **Manufacturers:** Combipack: Sun Pharma Industries Limited India, Naari Pte Limited, DKTRoyal Pharma, Lords, Benham Pharmaceuticals. Misoprostol: Naari Pharma Private Limited, India and DKT, Pfizer US	• **Pharmacy Poisons Board:** PPB plays a crucial role in regulating imports, managing product registration, and overseeing import clearance for health commodities in Kenya.	• **Public:** KEMSA • **Commercial:** Madawa Pharmaceuticals Limited, Maxima Pharmaceuticals Limited (mifepristone), Sun Pharma East Africa, Vita Health (combipack) • **Not-for-profit:** DKT is the major distributor in the MA drugs market with MSI providing Misoprotol.	• **Private pharmacy workers** • **MSI Reproductive Choices clinics**	• Adolescent girls (15-19) and women (20-29) • Women over 30 (small in number in pilot)
ISSUES & INCENTIVES	• **Market competition impact:** The increasing launch of products contributes to heightened market competition, providing more choices for women and girls and driving down prices.	• **Forecast challenges:** Due to a lack of accurate data on MA supply, forecasting for commodity security is constrained.	• **Fragmented Supply Chain:** The supply chain is highly fragmented with limited efforts to disintermediate and offer value-added Business-to-Business (B2B) services. • **SMOs competition:** SMOs compete for market share, particularly in urban areas. This competition can have a positive impact on prices, but the duration and extent of subsidies need consideration. • **Commercial distributors' perspective:** Commercial distributors and wholesalers may hesitate to enter a small, subsidized market. However, there's potential for entry into the market for specific products like Misoprostol and emergency contraceptives as volumes increase.	• **Prescription-related challenges:** The absence of prescriptions can lead to higher prices or refusal to dispense, highlighting the importance of proper prescription practices. • **Provider bias and judgment:** Providers' personal assessments of clients based on stories or appearance can result in varying prices for the same product at the same outlet.	• **Consumer values:** While consumers value discrete and inexpensive products and services, they are often forced to pay more for these services. • **Prescription challenges:** Difficulty in obtaining prescriptions can lead to treatment delays until the second trimester, emphasizing the need for streamlined prescription processes.

SUPPORTING FUNCTIONS

Healthcare is funded predominately through out-of-pocket expenditure at pharmacies and this can be major barrier for women in the uptake of post MA contraception, when they might also be managing negative societal perceptions associated with MA and contraception.

	CONTRACEPTION	MEDICATION ABORTION (MA) OUTSIDE HEALTH FACILITIES	WHAT DOES THIS MEAN POST MA CONTRACEPTION?
INFORMATION & COORDINATION	Procurement and forecasting of contraception quantities are carried out at a national level, based on forecasted public county data. Stockouts are also monitored at a county level. KEMSA coordinates the distribution of commodities to counties, and counties are not authorized to purchase commodities except from KEMSA (Kenya Health Law, 2019). County Departments of Health place commodity orders from KEMSA on a quarterly basis. Counties are not aware of any method shortages until placing an order.	There is a lack of accurate data on the use of products for MA, which hampers forecasting efforts. This in part is due to misoprostol having multiple medical uses and the variability of quality-assured products in the market where non-quality assured products are often not tracked or reported on. There is a lack of coordination at a national level to ensure availability of MA, and NGOs and SMOs play a key role in ensuring commodity security.	The availability of FP in the private sector, including pharmacies, is mostly sourced from public sector stocks from KEMSA or public local facilities, yet private sector providers also supplement their products from private distributors. However, there is a lack of information or data on all products sold in the private sector and pharmacies, due to a lack of coordination and private sector reporting.
QUALITY ASSURANCE	Insufficient regulatory oversight and enforcement mechanisms lead to concerns regarding the consistency, safety, and efficacy of contraceptive commodities available in the market.	Quality-approved products for MA are the gold standard which are labeled with the correct dosage and information for use. However, the market is still flooded with non-QA products, which may not have correct information for MA use and are often not tracked in the market. Providers are incentivized to sell products with the largest profit margins vs. QA products.	Poor counseling of correct misoprostol dosage may lead to a failed or incomplete abortion and erode trust, preventing the client from returning to the pharmacy for post MA contraception.
FINANCING	Contraception in Kenya is financed through government funding through the national budget, donor support from international organizations and NGOs, social health insurance schemes such as the National Hospital Insurance Fund (NHIF), and out-of-pocket payments by individuals accessing contraception services in both public and private healthcare facilities.	Almost all MA is purchased out-of-pocket, however, SMO organizations make efforts to subsidize the cost of products.	Innovative financing mechanisms are needed to ensure all women, especially the poor and disenfranchised, have access to affordable post MA contraception such as discount codes and increasing coverage of contraception in health insurance schemes.
LABOR CAPACITY	The lack of standardized training and certification for private FP providers leads to variability in service quality and accessibility across private facilities.	Pervasive negative attitudes and misconceptions among healthcare providers towards MA services lead to reluctance in offering or supporting these services and hindering access for individuals seeking them.	Training and certification for post MA – focusing on non-stigmatized choice across the method mix – is important to increase access to quality care.

RULES FUNCTIONS

While there are legal and regulatory frameworks in Kenya regarding contraception, medication abortion (MA), and reproductive health care, there are challenges such as legal ambiguity, lack of enforcement, hidden fees, delays in import permits, and gaps in healthcare provider knowledge.

RULES DESCRIPTION	CONTRACEPTION	MEDICATION ABORTION (MA) OUTSIDE HEALTH FACILITIES	WHAT DOES THIS MEAN POST MA CONTRACEPTION?
contraception	The Kenya Children's Act defines anyone under 18 years of age as a minor and the law does not protect a service provider who offers a contraceptive service to a minor. Consent that a purchaser of contraceptives is over 18 years of age is required, although there is limited enforcement of this in the value chain as no ID is necessary. The Kenya National Family Planning Guidelines, 6th Edition, 2019, places emphasis on method counseling to ensure client choice and to deter providers from pushing some methods over others. User fees were abolished in the public sector in 2004 but hidden fees still occur, including for commodities.	Article 43 (1) of the Constitution of Kenya (2010) states that 'every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care'. It states that abortion is permissible if "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law". There is ambiguity surrounding who exactly is a trained health professional but it is assumed to refer to doctors, nurses and trained midwives. Legal ambiguity or restrictions surrounding MA may hinder access to safe and legal abortion services, leading to reliance on potentially unsafe methods.	Due to a misalignment between the Kenyan Constitution and the Kenyan Penal Code, many health practitioners are uninformed about their legal status and hesitant to provide abortions, contraceptive counseling or post MA contraception.
REGULATION	Pharmacy and Poisons Board is responsible for clearing imported medicines. There are sometimes delays in securing import permits for health commodities. PPB also receives reports of poor quality medicines. There is a requirement for Pre- Shipment Verification of Conformity by the Kenya Bureau of Standards. Procurement regulations are governed by the Public Procurement and Disposal Act 2015. Pharmacies must register with PPB. Only location, address and email address are mandatory for website orders.	The Pharmacy and Poisons Board (PPB) in Kenya plays a crucial role in overseeing medication abortion (MA) by ensuring the safety, efficacy, and quality of MA drugs through registration, licensing, approval, inspections, and monitoring. Additionally, PPB develops and enforces guidelines and protocols for MA services while monitoring compliance and taking enforcement actions to uphold regulatory standards.	PPB is a key partner to ensure availability and quality assurance of post MA contraception methods in pharmacies by facilitating registration of products and pharmacies, monitoring product safety, and developing guidelines for service provision.
TAXES/ TARIFFS	The National Treasury and Kenya Revenue Authority provide tax exemptions for products procured by governments or donors. If private providers procure products directly, they would be subject to additional taxation.	The National Treasury and Kenya Revenue Authority (KRA) provide tax exemptions for products procured by governments or donors. If private providers procure products directly, they would be subject to additional taxation.	Incentivize suppliers, good for increasing stock availability.

6

WHERE do we go from here for post MA contraception in Kenya?

WHERE do we go from here for post MA FP in Kenya?

"WHERE" section purpose

Based on previous sections, key market constraints and opportunities have been identified to answer the question:

1. Where do we go from here for post MA contraception?

"WHERE" key takeaways

1. The contraception market is currently **fragmented and lacks coordination**. However, there is an opportunity to establish a coordinated national market that strengthens market data.

2. AGYW, particularly unmarried women, **face stigma around MA and contraception**. Leveraging community-based organizations (CBOs) to educate and empower women can address this challenge.

3. High and **inconsistent costs of FP in pharmacies** and limited business incentives for pharmacists pose challenges. However, there are opportunities to make contraception more affordable for consumers and provide incentives for pharmacists.

PRODUCTION TO USE SPECTRUM

Challenges across the contraception value chain, from stockouts to affordability and market fragmentation, underscore the need for a comprehensive, coordinated approach that incentivizes both providers and consumers

Market Function		FP Importers & Distributors	Post MA contraception Providers (Pharmacists)	Post MA Consumers
CORE	Product	1. Contraception stockouts are common across the value chain, although this is less common in the for-profit private sector		2. AGYW are time-poor, prioritizing 'easy' methods like EC vs. exploring the full method mix
	Price		3. Limited profit margin for contraception methods in pharmacies	4. High and inconsistent cost of MA to the consumer in pharmacies
	Place		5. Limited contraceptive commodity options in pharmacies	
	Promotion		6. Pharmacists do not see the business incentive to contributing to demand creation for contraceptive commodities	7. AGYW, especially unmarried women, experience stigma around MA and contraception, which prevents them from accessing care
	Provider		8. Pharmacists may not have the training or incentives to provide full contraception counseling for choice	
SUPPORTING	Information	9. Significant gaps in market data for stigmatized products and services, especially in the private sector		
	Coordination	10. Contraception market is fragmented and largely uncoordinated around a shared PMAC agenda		
	Financing		11. Lack of upfront capital for pharmacists to secure contraceptive commodities	
RULES	Formal rules		12. Unclear legality of MA creates hesitancy for pharmacists to provide post MA contraception, and for patients to request it	
	Informal rules		13. Limited community awareness around need for and availability of post MA contraception	

PRODUCTION TO USE SPECTRUM: CORE

Highlighting the opportunities and actors for post MA contraception uptake

	KEY CONSTRAINT	ASSOCIATED OPPORTUNITIES	KEY ACTORS
PRODUCT	1. Contraceptive stockouts are common across the value chain, although this is less common in the for- profit private sector	Prioritize partnerships with private pharmacies, as they advantageously mitigate the impact of stockouts at KEMSA, ensuring consistent distribution of paid-for product volumes by for-profit private sector wholesalers.	Pharmplus, Pharmnet, DKT International, Marie Stopes Kenya, Medic Mobile
	2. AGYW are time-poor, prioritizing "easy" methods like EC vs. exploring the full method mix	Educate community-based organizations (CBOs) on women and girls' post MA contraception options, including understanding of the side effects and dispelling misconceptions. Link CBOs more effectively and more widely to provider networks and telemedicine. Let community intermediaries develop rapport with clients, making it easy to discuss uptake/continuation of contraceptives clients post MA.	mPharma, Maisha Meds, triggerise, m-tiba, Shelf Life
PRICE	3. Limited profit margin for contraception methods in pharmacies	Expand pharmacists' contraceptive product range, provide private label or generic options, offer value-added services like counseling, bundle products with related items, and utilize promotions and discounts to attract and retain customers.	mPharma, Maisha Meds, triggerise, m-tiba, Shelf Life
	4. High and inconsistent cost of MA to the consumer in pharmacies	Support accountability mechanisms for pharmacists to sell MA at the approved price point.	mydawa, Kasha, JUMIA, Goodlife (online pharmacies)
PLACE	5. Limited contraceptive product options in pharmacies	Increase contraception choice in pharmacies by providers offering LARCs, seeking opportunities to direct clients to digital contraceptive platforms and providing informational materials for post medical abortion care.	mydawa, Kasha, JUMIA, Goodlife (online pharmacies)
PROMOTION	6. Pharmacists do not see the business incentive to contributing to demand creation for contraception commodities (limited profit margins)	Support pharmacists to see the business opportunity of offering FP through referrals from satisfied clients, commissions, and potential bundling with MA.	mydawa, Kasha, JUMIA, Goodlife (online pharmacies)
	7. AGYW, especially unmarried women, experience stigma around MA and contraception, which prevents them from accessing care	Integrate community empowerment activities and conversations (e.g., enhancing spousal support, and relationships) in peer sessions to enhance the capacity of women to deal with decision-making challenges.	Community-based organizations

PRODUCTION TO USE SPECTRUM: CORE

Highlighting the opportunities and actors for post MA contraception uptake

	KEY CONSTRAINT	ASSOCIATED OPPORTUNITIES	KEY ACTORS
PROVIDER	8. Pharmacists may not have the training or incentives to provide full contraceptive counseling for choice	Develop a training package for pharmacies to delivery quality post MA contraception, establishing trust among clients to return for continuous contraception.	SMOs
SUPPORTING	9. Significant gaps in market data for stigmatized products and services, especially in the private sector	Implement coordination efforts to strengthen market data, including alignment of data reporting needs across donor funded projects and exploring IQVIA similar retail supply chain or prescription audit approach.	Unknown, potential for government stewardship with SMO partnership
	10. Contraception market is fragmented and largely uncoordinated around a shared PMAC agenda	Establish a collaborative platform or consortium that brings together stakeholders from government agencies, non-governmental organizations (NGOs), healthcare providers, and community organizations. This platform could facilitate coordination, information sharing, and joint initiatives focused on advancing a shared agenda for contraception, including the provision of comprehensive reproductive health services, education, and advocacy.	All value chain actors
	11. Lack of upfront capital for pharmacists to secure contraceptive commodities	Provide credit for stock/seed stock as an incentive for providers to stock contraceptive commodities. Explore coordination of discount codes, subsidies, and free product provision for those unable to pay.	PharmAccess, Maisha Meds, Shelf Life, Triggerise Tiko, MSK
RULES	12. Unclear legality of MA creates hesitancy for pharmacists to provide post MA contraception, and for users to request it	Support widespread dissemination of the existing policies and guidelines among pharmacy workers to ensure that they provide services within existing regulations.	SMOs
	13. Limited community awareness around need for and availability of post MA contraception	Strengthen the role that parents and education systems can play to address both general contraception and post MA contraception.	Community-based organizations

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KEYSTONE

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Annexes

ANNEX 1: JOURNEY MAPPING

Joan, the laidback pharmacist: provides MA and short-term methods

	1 AWARENESS & DEMAND	2 ASSESSMENT OF GESTATIONAL AGE	3 MA DRUGS & CONTRACEPTIVE COUNSELLING	4 SELLING OF MA DRUGS & CONTRACEPTION	5 REFERRALS & FOLLOW UPS
Ideal Journey	Pharmacists create awareness of FP post MA through community mobilizers, in store advertisement and branding	Pharmacists are confident to assess and estimate clients ' gestational age	Confidently counsels client about different MA drugs and contraception options	Stocks a variety of products for MA and contraception. Sells to clients as per client choice and Quality of Care guidelines.	Refers clients for LARC or methods not offered. Follows up clients for TCA.
Actual Journey	Waits for clients to walk in. Peer referrals from satisfied clients · Clients from digital platforms with pharmacy locators	Trained (not trained new staff) in assessment and estimation of gestational age.	No pro-active client counselling as it is time consuming. Uses product inserts to inform client on how to use drugs and contraceptives. Not trained in contraceptives counselling.	Sells what is in stock, mostly fast-moving methods like pills, gives no options.	Neither refers upstream for contraceptives that he is unable to offer nor actively follows up clients for TCA.
Key Influencers	Programs / suppliers/ Social Marketing organizations	Programs support and incentives such as trainings and practicums.	Programs and SMOs, supplier incentives	Supply incentives, policy and guidelines	Program incentives
Barriers / Motivators	• Upskilling training · Peer pharmacists can be source of information sharing • Cost of marketing	• Program incentives such as user feedback • No formal training on contraceptives counselling · Struggle to do gestational assessment especially for AGYW • Time constraints to do counselling	• Consumer may purchase FP from them • Hesitant to serve AGYW due to religious/personal bias: fears selling MA to AGs because of high risk of complication and backlash from community in case of complications • No privacy for counselling in the usually small pharmacies • Counselling is time-consuming	• Profit margins (fluid prices), not wanting to lose clients to other providers • Contributing to reducing /avoiding repeat abortions · • Not wanting to lose clients to another service provider through referrals	• Incentives for referrals and follow up • Building trust for 'client for life' • Fear of losing clients to other providers

KEYSTONE

ANNEX 1: JOURNEY MAPPING

James the profit-driven nurse, or pharmacist with a nurse as staff: has hired a clinician to provide expanded services (LARCs)

	1 AWARENESS & DEMAND	2 ASSESSMENT OF GESTATIONAL AGE	3 MA DRUGS & CONTRACEPTIVE COUNSELLING	4 SELLING OF MA DRUGS & CONTRACEPTION	5 REFERRALS & FOLLOW UPS
Ideal Journey	Pharmacist creates awareness of contraception post MA through community mobilizers, in store advertisement and branding. Pharmacist requests current MA user to share contact details with friend who might need his/her (pharmacist) MA services.	Pharmacists are confident to assess and estimate clients' gestational age.	Confidently counsels client about different MA drugs and contraception options.	Stocks a variety of products for MA and contraception. Sells to clients as per client choice and Quality of Care guidelines.	Refers clients for LARC or methods not offered. Follows up clients for TCA
Actual Journey	Waits for walk-in clients and referrals, belongs to a network of pharmacies. Clients who mention previous MA clients as referral agents are not vigorously screened.	Trained (nurse) in assessment and estimation of gestational age	No pro-active client counselling as it is time consuming and not trained. Uses product inserts to inform client on how to use products.	Sells what is in stock mostly fast-moving methods like pills, gives no options.	Does not proactively follow up for contraceptives TCA.
Key Influencers	Programs/ suppliers/Social Marketing organizations/ good profit margins	Programs support and incentives such as trainings and practicums	Programs and SMO, supplier incentives.	Supplies incentives. Policy and guidelines.	Program incentives.
Barriers / Motivators	• Peer engagement, training. • Cost of branding • Pharmacists are sometimes not perceived as credible contraceptive service providers	• Winning AYGW trust before MA. • Time constraints to do counselling	• Counselling user ratings • Fear of community backlash: fears selling MA to AGs because of high risk of complications • Adequate space (pharmacy with clinic) to offer contraceptives beyond pills	• Profit margins (fluid prices), not wanting to lose clients to other providers • High staff turnover	• Building long-term trust with the client • Contraceptives have lower profit margins compared to other drugs and services like hypertension

KEYSTONE

ANNEX 1: JOURNEY MAPPING

Opportunistic online pharmacy: a PPB-registered platform with telehealth partners. Contraceptives continuation is a significant challenge.

	1 AWARENESS & DEMAND	2 ASSESSMENT OF GESTATIONAL AGE	3 MA DRUGS & CONTRACEPTIVE COUNSELLING	4 SELLING OF MA DRUGS & CONTRACEPTION	5 REFERRALS & FOLLOW UPS
Ideal Journey	Platform owners/clients (organizations) create awareness of contraception post MA. Support for prescription access. Example model: mydawa	Users have their gestational age assessed within platform.	Users are counselled on MA and contraceptive options.	The platform stocks wide variety of MA and Contraceptives and provides discreet delivery services.	Platform offers referral services for contraceptives requiring human-human skills.
Actual Journey	Clients hear about the platforms by chance or from friends or redirected from search engines.	In-platform Chatbots / counsellors	No pro-active client counselling Uses products instructions for use/descriptions to inform client on how to use drugs and contraceptives. Not trained in contraceptives counselling.	Stocks and sells fast moving products ,outsources order fulfilment partners or works with own delivery staff.	Have program/contract dependent referrals. May have loyalty programs but not robust for contraceptives.
Key Influencers	Programs/ suppliers/Social Marketing organizations/ good profit margins	Programs support and incentives such as trainings and practicums. Time spent on counselling. Cost of counsellors.	Programs and SMOs, supplier incentives	Supply incentives, policy and guidelines	Program incentives
Barriers / Motivators	• Peer engagement through WhatsApp groups • Peer pharmacists can be source of info • Upskilling training	• Winning AGYW trust before MA is an uphill task • No formal training on contraceptives counselling • Struggle to do gestational assessment especially for AGYW • Constraints due to online counselling	• Incentives for counselling • Hesitant to serve AGYW due to religious bias • Fear of community backlash • Underage clients using their services	• Profit margins • Contributing to reducing /avoiding repeat abortions • Not wanting to lose clients to another service provider • Programs/SMO incentives • Possible opposition and community backlash (at times leading to loss of business), given the sensitivity around medication abortion.	• Incentives for referrals and follow up • Building trust with clients • Loyalty program • Seamless interfacing/ handover of client to referral partners • Fear of losing clients to other online competitors • Consent issues • Client data sharing regulations

KEYSTONE

ANNEX 1: JOURNEY MAPPING

Shiru, the Mature Minor (Adolescent Girl)

"I'm not ready for pregnancy. I want access to discreet services in private. I trust the local pharmacist so I go there for consultations."

	1 AWARENESS	2 DECISION	3 UPTAKE	4 MAINTENANCE	5 ADVOCACY
Ideal Journey	Learns about post-MA contraception through peer-group sessions, digital platforms, including hotlines, mass media and community interventions/ fliers at MA point of purchase	Attends peer-group sessions, access digital platforms and reads fliers Client asks for 1:1 with Community mobilizer	Contraceptive bundled with MA product CM accompanies client Pharmacies and clinics locator for service delivery	TCA through digital platform CM reminds client of TCA Pharmacist follow up Stays on contraceptives and honors all TCA	Informs friends/peers about the products that worked for them.
Actual Journey	Unaware of post MA contraceptive / learn about post MA contraception through peers, digital /online sources of info	Prefer group counseling sessions over 1:1 sessions / Associate contraceptive use with promiscuity /Hesitant to carry fliers – opt. to take pictures of it instead / Clients more concerned about success of MA at point of purchase vs use of contraceptives	Less uptake due to image consciousness and fear of being seen buying contraceptives Frequent use of emergency contraceptive	Lack of engagement with CMs once linked to pharmacists who are perceived as experts	Stays secretive about contraception, except with very close trust friends. Prefers emergency contraceptives for convenience.
Key Influencers	Social media / Boyfriend / Peers / Best friend / CHV	Family expectations / Best friends opinions / Pharmacists	Instances of bundling MA with FP	Pharmacist / Peer educators	Family, especially parents / Partner's preference / Best friends / Experience with pharmacist
Barriers / Motivators	• Friends and social groups, Social media • Online sources • Partnership between pharmacists and community mobilizers • Community safe spaces	• Public health workers • Pharmacists validating FP information • Societal expectations wants to keep 'good girl' image • Uses emergency pill unsuccessfully • Inconsistent info • Lack of discreet avenues to learn about contraceptives • Contraceptives are for married people perception	• Affordability • Discreet methods • Discreet access points • Subsidies/ vouchers • Future focused and wants a successful future • Costs • Post MA trauma • Being recognized when buying contraception • Returning to the pharmacy • Lack of comfortable contraception access points post-abortion	• Want to talk and relieve the feeling of shame/grief/blame • Lack of discreet counselling tools • Safe spaces • Do not identify as sexually active* • Fear of being talked about	• Want to talk and relieve the feeling of shame/grief/blame

KEYSTONE

ANNEX 1: JOURNEY MAPPING

Wambui, the Married Adolescent

"I am young and not ready for pregnancy, I am afraid of potential side effects and my partner's hesitancy. I like going for peer support sessions. The CM is friendly and I can relate to her."

	1 AWARENESS	2 DECISION	3 UPTAKE	4 MAINTENANCE	5 ADVOCACY
Ideal Journey	Learn about post-MA contraception through peer-group sessions, digital platforms including hotlines, mass media and community interventions/ fliers at MA point of purchase	Attends peer-group sessions, access digital platforms and reads fliers Client asks for 1:1 with Community mobilizer	Contraceptive bundled with MA product CM accompanies client Pharmacies and clinics locator for service delivery Takes up LARC	TCA through digital platform CM reminds client of TCA, clients return and avail discount codes Pharmacist follow up Stays on contraceptives and honors all TCA Stays on LARC and goes for reviews	She shares her contraception journey in women forum
Actual Journey	Unaware of post MA contraceptive / learn about post MA contraception through peers, digital /online sources of info CMs preferred for psycho-social counselling and point of information vs pharmacists.	Has myths and misconceptions about contraception, hears about adverse side effects and method failure from peers Misconceptions surrounding contraceptive use and infertility	Limited on contraception since pharmacist has limited options Competing financial commitments that deter their use of contraception	Does not go for TCA	Not on contraceptives consistently
Key Influencers	Partner, neighborhood friends, business groups (chama), peers, community mentor	Public health workers or Pharmacists / Peers' opinions and experiences / Partners' needs, preferences and opinions / Economic status	Pharmacy branding , medical detailing, trusted pharmacists , best friend , Partner, clinician	Pharmacist clinicians/ CHV	Pharmacist clinicians/ CHV
Barriers / Motivators	• Partner needs/ preferences • Partnership between community mobilizers and pharmacists	• Partners' needs and preferences-support , economic status and lifestyle aspects • Confidentiality • Concerns around side effects / peer experiences, risk of future fertility	• Methods acceptable to husband or able to use without husband's knowledge, wants reliable info • Does not want more children • Attitudes of pharmacists and CMs • Privacy • Having to keep returning to pharmacy • Lack of discreet access points	• Want to be re-affirmed post MA • Lack of discreet counselling tools/safe spaces/ • Fear of being talked about	• Have no news

KEYSTONE

ANNEX 1: JOURNEY MAPPING

Njeri, the Young Woman

> "I have a preference for accessing information privately because of my busy life and competing priorities. However, if I need clarity, I go to a trusted pharmacists."

	1 AWARENESS	2 DECISION	3 UPTAKE	4 MAINTENANCE	5 ADVOCACY
Ideal Journey	Learn about post-MA contraception through peer-group sessions, digital platforms, including hotlines, mass media and community interventions/ fliers at MA point of purchase	Attends peer-group sessions, access digital platforms and reads fliers Client asks for one-on-one with Community mobilizer	Contraceptive bundled with MA product Community mobilizers accompany client Pharmacies and clinics locator for service delivery	TCA through digital platform CM reminds client of TCA Pharmacist follow up Stays on contraceptives and honors all TCA	Informs friends and peers about trustworthy pharmacists and the products that worked for them.
Actual Journey	Unaware of post MA contraceptive / learn about post MA contraception through peers, digital /online sources of info	Prefer group counselling sessions over 1:1 sessions Associate contraceptive use with promiscuity Hesitant to carry fliers – opt. to take pictures of it instead Clients more concerned about success of MA at point of purchase vs use of contraceptives	Less uptake due to fear of being seen buying contraceptives Frequent use of emergency contraceptive	Lack of engagement with CMs once linked to pharmacists who are perceived as experts	Clients do not engage with community mobilizers once linked with pharmacists, whom some consider as experts
Key Influencers	Social media / Boyfriend / Peers / Best friend / Activation sessions in colleges, schools, community youth groups etc.	Family expectations / Best friends opinions / Pharmacists / 'Sponsor'	Peers' opinions and experiences / Partners' needs, preferences and opinions / Best friends' opinions / Economic status and other lifestyle aspects	Pharmacist / Peer educators	Social media advocates / Peers
Barriers / Motivators	• Friends and social groups, Social media • Online sources/Pharmacist	• Public health workers • Pharmacists validate information • Societal expectations • Uses emergency pill unsuccessfully • Inconsistent info • Lack of discreet avenues to learn about contraceptives • Contraceptives are for married people perception	• Affordability • Discreet methods • Discreet access points • Subsidies/ vouchers • Bundling MA with contraception • Costs • Post MA trauma • Being recognized when buying contraceptives • Having to return to the pharmacy • Lack of comfortable access points post-abortion	• Attitudes of family, friends, partners and pharmacists • Privacy in the pharmacy • Lack of discreet counselling tools • Fear of being talked about	• Want to talk and relieve the feeling of shame/grief/blame

KEYSTONE

ANNEX 1: JOURNEY MAPPING

Mama Joni, the Prudent Mother (Married Woman)

> "My husband is out of a job, and he would take care of everything. How can I have another child when we cannot even afford to pay the rent?"

	1 AWARENESS	2 DECISION	3 UPTAKE	4 MAINTENANCE	5 ADVOCACY
Ideal Journey	Learn about post-MA contraception through peer-group sessions, digital platforms including hotlines, mass media and community interventions/ fliers at MA point of purchase	Attends peer-group sessions, access digital platforms and reads fliers Client asks for 1:1 with Community mobilizer	Contraceptive bundled with MA product CM accompanies client Pharmacies and clinics locator for service delivery Takes up LARC	TCA through digital platform CM reminds client of TCA, clients return and avail discount codes Pharmacist follow up Stays on contraceptives and honors all TCA Stays on LARC and goes for reviews	She shares her contraception journey in women forum
Actual Journey	Unaware of post MA contraceptive / learn about post MA contraception through peers, digital /online sources of info CMs preferred for psycho-social counseling and point of information vs pharmacists	Has myths and misconceptions about contraception, hears about adverse side effects and method failure from peers Misconceptions surrounding contraceptive use and infertility	Limited on contraception since pharmacist has limited options Competing financial commitments that deter their use of contraception	Does not go for 'TCA'	Discusses with close friends but mostly about price
Key Influencers	Partner, neighborhood friends, business groups (chama)	Public health workers or Pharmacists / Peers' opinions and experiences / Partners' needs, preferences and opinions / Economic status	Pharmacy branding, medical detailing, Pharmacists, best friend, Partner, clinician	Pharmacist or clinicians/ CHVs	Pharmacist or clinicians/ CHVs
Barriers / Motivators	• Partner needs/ preferences • Partnership between community mobilizers and pharmacists	• Partners' needs and preferences-support , economic status and lifestyle aspects • Confidentiality • Concerns around side effects / peer experiences	• Methods acceptable to husband or able to use without husband's knowledge, wants reliable info • Does not want more children • Attitudes of pharmacists and CMs • Privacy • Having to keep returning to pharmacy • Lack of discreet access points	• Want to be re-affirmed post MA • Lack of discreet counselling tools/safe spaces/ • Fear of being talked about	• Have no news

KEYSTONE

ANNEX 2: CORE FUNCTIONS

A notable number of market actors are focusing on improved SRH delivery in Kenya and there is potential to leverage them for increased post MA FP choice and use.

Promotion

Trains RH providers for provision of CSRHR, advocacy and service provision including comprehensive abortion care. Can provide hotline services to strengthen Ask Nivi.

Supports more effective and motivated health workers and focused on adolescent health

Provides services in ANC and PNC

Improves access to and quality of healthcare services for people living in rural and remote areas

Enhances capacity of youth advocates and YLOs and policy makers to undertake SRHR advocacy to improve quality, affordability and accessibility of SRHR information and services.

Promotes SRHR for teenagers, women and men and ensuring access to family planning services working closely with youth populations.

Product

Chatbot and WhatsApp that provides people with health information and services including SRH.

Uses AI and behavioural science to help our users change their habits, reduce the financial burden of managing their conditions, and improve their health.

Livia Health provides patients with access to prescription medicine at the best price with utmost convenience.

Women First Digital Network

Delivers range of SRH services: contraception, EC, ANC/PNC, and post-abortion care.

Price

Improves access to medicines by providing innovative financing solutions to pharmacies and patients.

Builds digital tools to help providers manage sales, source quality medication, and provide discounts and subsidies to help patients access high-impact health products.

An ecosystem of pharmacies, retailers, on-the-ground mobilisers, and clinics to increase SRH access. Subsidies or voucher offered to AGYW.

A client wallet, where clients use their savings for increased access to services (including post abortion care and contraceptives).

A pharmaceutical inventory management subscription service licensed by PPB offering pay as you sell services to pharmacies.

ANNEX 2: CORE FUNCTIONS

The rise of online pharmacy actors is significant for the post MA FP market, if they are well-regulated, coordinated, and trained.

Place

Mydawa. Online Delivery by pharmaceutical technicians for 'ethical products' like oral pills and injectables.

Kasha: mobile store that partners with pharmaceutical companies for pharma products

Online and 'brick and mortar'. sells Oral pills, EC, injectables.

Network of independent pharmacies Deals in health, beauty and lifestyle product

Provider

Leverages private sector infrastructure for distribution of pharma products. Supports government with training health providers.

Nationwide distribution of MA and FP commodities through private providers.

Conducts targeted private provider detailing and training. Provides a wide range of contraception, reproductive health and FP services.

Designs, delivers, and supports open-source software for health workers providing care in the world's hardest-to-reach communities.