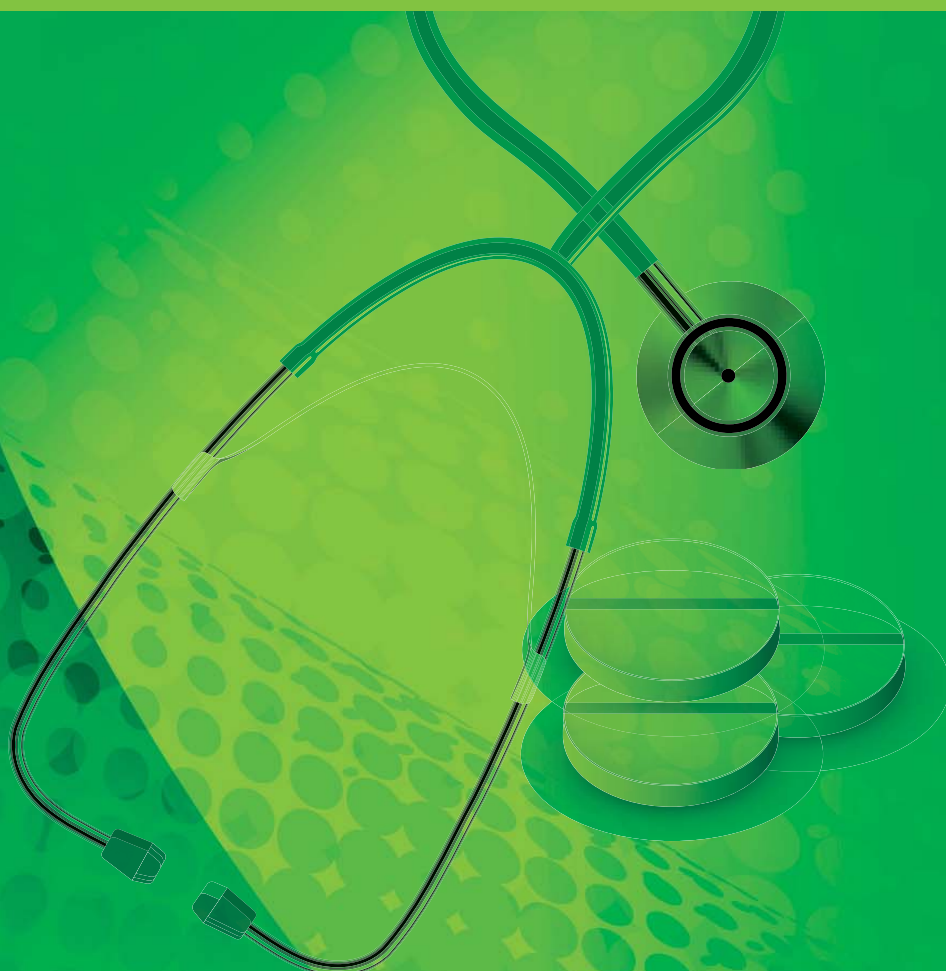




2015 Kenya Health Facility Assessment

AN ASSESSMENT OF AVAILABILITY OF FAMILY PLANNING AND MATERNAL/REPRODUCTIVE HEALTH COMMODITIES/MEDICINES AND SERVICES



2015 Kenya Health Facility Assessment:
An Assessment of Availability of Family Planning and Maternal/Reproductive
Health Commodities /Medicines and Services

Published by the Ministry of Health, Government of Kenya
Supported by UNFPA

National Council for Population and Development
Chancery Building, 4th Floor, Valley Road
P.O. Box 48994-00100, Nairobi, Kenya
Tel: 254-20-271-1600/01
Fax: 254-20-271-6508
Email: info@ncpd-ke.org
Website: www.ncpd-ke.org

©NCPD June 2016

Any part of this document may be freely reviewed, quoted, reproduced or translated in full or part, provided the source is acknowledged. It may not be sold or used in conjunction with commercial purposes or for profit.

2015 Kenya Health Facility Assessment:

An Assessment of Availability of Family Planning and Maternal/
Reproductive Health Commodities /Medicines and Services



National Council for Population
and Development

June 2016

TABLE OF CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS	iv
FOREWORD	v
ACKNOWLEDGEMENT	vi
EXECUTIVE SUMMARY	vii
PART 1: INTRODUCTION	1
1.1 Background	1
1.2 Rationale and Objective of the Study	1
1.3 Survey Organization and Management	2
1.4 Methodology and Limitations	2
1.5 Outline of Report	5
PART 2: NATIONAL GUIDELINES, PROTOCOLS AND LAWS	6
PART 3: SURVEY FINDINGS FOR AVAILABILITY OF COMMODITIES AND	9
3.1 General Information about the Facilities	9
3.2 Modern Contraceptives Offered by Facilities	10
3.3 Availability of Maternal and RH Medicines	17
3.4 Incidence of 'No Stockout' of Modern Contraceptives	22
3.5 Supply Chain, including Cold Chain	28
3.6 Staff Training and Supervision	43
3.7 Availability of Guidelines, Checklists and Job Aids	53
3.8 Use of Information Communication Technology (ICT) and Waste Disposal	55
3.9 Charges for User Fees	60
PART 4: SURVEY FINDINGS EXIT INTERVIEWS	64
4.1 Background Characteristics of Clients	64
4.2 Clients' perception of family planning service provision	69
4.3 Clients' Appraisal of the Cost of Family Planning Services	74

PART 5: CONCLUSION AND RECOMMENDATIONS	84
5.1 Conclusion: Summary of Findings	84
5.2 Recommendations	86
ANNEX I: LIST OF FIGURES	88
ANNEX II: LIST OF TABLES	89
Annex III: Additional Tables	92
A3.1 Modern contraceptives offered by primary facilities	92
A3.2 Modern contraceptives offered by secondary and tertiary facilities	93
A3.3 Incidence of 'No Stockout' of modern contraceptives in the last three months	94
A3.4 Incidence of 'No Stockout' of modern contraceptives on the day of the survey	96
A3.5 Supply Chain, including cold chain	96
A3.6 Staff training and supervision	97
Annex IV: 2015 KHFA sample design	105
A4.1 Introduction	105
A4.2. Sampling Frame	105
A4.3 Sample Size and Allocation	105
A4.4 Sampling of Facilities	105
Annex V: Survey personnel	108
Annex VI: Report authors	110
Module 1: HFA QUESTIONNAIRE	111
Module 2: HFA EXIT INTERVIEW	130

LIST OF ACRONYMS AND ABBREVIATIONS

ASAL	Arid and Semi-Arid Land	KSPA	Kenya Service Provision Assessment
ANC	Antenatal Care	LAN	Local Area Network
ASRH	Adolescent Sexual and Reproductive Health	LARC	Long-Acting Reversible Contraception
AU	African Union	MDGs	Millennium Development Goals
BTL/VS	Bilateral Tubal Ligation/Vasectomy	MFL	Master Facility List
CPCs	County Population Coordinators	MMR	Maternal Mortality Ratio
FBO	Faith-Based Organizations	MOH	Ministry of Health
FP	Family Planning	NCPD	National Council for Population and Development
GPRHCS	Global Programme to enhance Reproductive Health Commodity Security	NEMA	National Environment Management Authority
HIV	Human Immuno Deficiency Virus	NGO	Non-Governmental Organisations
HTSP	Healthy Timing and Spacing of Pregnancies	RH	Reproductive Health
ICT	Information Communication Technology	SDGs	Sustainable Development Goals
IUD	Intrauterine device	SDPs	Service Delivery Point
KDHS	Kenya Demographic and Health Survey	SPSS	Statistical Package for Social Scientist
KEMSA	Kenya Medical Supplies Authority	SRH	Sexual and Reproductive Health
KEPH	Kenya Essential Package for Health	UNFPA	United Nations Population Fund
KHFA	Kenya Health Facility Assessment	VCT	Voluntary Counseling and Testing
KHSSP	Kenya Health Sector Strategic and Investment Plan		
KNBS	Kenya National Bureau of Statistics		
km	kilometers		
Ksh	Kenya Shillings		

FOREWORD

Reproductive Health (RH) problems are among the leading causes of women's ill health and death worldwide. Many of the deaths resulting from these problems could be prevented or treated through the enhancement of access to quality reproductive health services.

Although the government of Kenya's commitment to ensuring that reproductive health services are accessible to all Kenyans is spelt out in the National Reproductive Health Policy, availability and access of family planning commodities and reproductive health medicines in health facilities is limited in many areas. Kenya is indeed faced with the challenge of stock out of contraceptives and other reproductive health supplies at the health facility level due to various factors such lack of an efficient logistics management system that would ensure an adequate and timely supply of commodities and medicines in all health service provision sites.

In the last decade, Kenya has achieved commendable progress in the reduction of maternal and child mortality. This has been due to government leadership, support from development partners and stakeholders, and a conducive policy environment. For further progress to be achieved, continual commitment by all stakeholders will be necessary.

The 2015 Health Facility Assessment for Family Planning Commodities and Maternal/ Reproductive Health Medicines and Services is the first such assessment to be conducted in Kenya as part of the UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). The goal of GPRHCS, which has since changed name to UNFPA Supplies, is to contribute to the achievement of universal access to family planning and reproductive health commodities and medicines. This was a nationwide assessment conducted between November and December 2015, and was conducted in a sample of 641 out of 10,062 health facilities in the country. The sampled facilities were of varying levels of care namely; tertiary, secondary and primary levels. Results of this assessment highlight both challenges and opportunities for strengthening health service provision in the country. I therefore encourage all stakeholders to make use of these findings to improve the existing policies and programmes for the better health of Kenyans.

Dr. Cleopha Mailu, EBS
Cabinet Secretary
Ministry of Health

ACKNOWLEDGEMENT

The 2015 Health Facility Assessment for Reproductive Health Commodities and Medicines is the first round of this assessment to be conducted in Kenya. The survey was conducted by the National Council for Population and Development (NCPD) in collaboration with the Ministry of Health and other stakeholders. Financial support for the assessment was provided by the United Nations Population Fund (UNFPA), Kenya Country Office. UNFPA also provided technical support for the assessment.

NCPD and the Ministry of Health wish to acknowledge the dedicated efforts and contribution by the National Steering and Technical Committees in providing policy and technical guidance to the assessment process. The Steering Committee members were: Dr. Josphine Kibaru (NCPD), Dr. Patrick Amoth (MoH), Joshua Opiyo (MoDP), William Komu (MoPGY), MacDonald Obudho (KNBS), Judith Kunyha-Karogo (UNFPA), George Kichamu (NCPD), Margaret Mwangi (NCPD), Maurice Opiyo (NCPD), and Taslim Wason (NCPD).

The Technical Committee members were: George Kichamu (NCPD), Vane Lumumba (NCPD), Dr. Silas Agutu (MoH), Dr. Dan Okoro (UNFPA), Teclar Kogo (MoH), Stephen Macharia (UNFPA), Samuel Ogola (KNBS), John Bore (KNBS), Jane Keeru (MoPGY), Purity Njuguna (MoDP), Catherine Ndei (NCPD), Francis Kundu (NCPD), Irene Muhunzu (NCPD), Reinhard Rutto (NCPD), and Seth Omondi (NCPD). The contribution of Dr. Peter Njoroge, who was appointed by UNFPA Kenya Country Office as the technical editor for this report, is also acknowledged.

Sincere thanks also go to in-charges of the various health facilities who responded to the assessment and allowed the research teams to interview their clients. Without their cooperation, the field activities would not have been completed within the allotted time frame.

Finally, we appreciate the team of field enumerators, who collected quality information; the NCPD County Population Coordinators, who supervised data collection all over the country, including remote and hard-to-reach areas, and the data clerks who endeavoured to capture the collected data accurately.

Dr. Nicholas Muraguri

Principal Secretary
Ministry of Health

Dr. Josphine Kibaru-Mbae

Director General
National Council for Population and Development

EXECUTIVE SUMMARY

I. BACKGROUND

The 2015 Kenya Health Facility Assessment is a national sample survey whose objective was to assess the availability of family planning commodities and maternal/reproductive health medicines in the country's health facilities. This survey also sought to identify the key reasons why some health facilities are not able to offer family planning (FP) and maternal/reproductive health (RH) services as expected. Information on client's perception on the quality of family planning services was also collected. This survey was implemented by the National Council for Population and Development (NCPD), Kenya National Bureau of Statistics (KNBS), and Kenya's Ministry of Health, with financial support from the United Nations Population Fund (UNFPA). A Steering Committee and a Technical Committee consisting of various stakeholders were set up to provide policy and technical input to the survey respectively.

Among the partners who have supported Kenya's efforts to improve the family planning and reproductive health services is the United Nations Population Fund (UNFPA). Through the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS), now known as UNFPA Supplies, UNFPA has over the years provided family planning commodities and reproductive health medicines to Kenya's health sector in an effort to improve access and quality of health services. The 2015 Kenya Health Facility Assessment (KHFA) therefore provides the Government, UNFPA, and other partners an opportunity to evaluate the impact of their efforts in improving access to, and quality of, family planning and reproductive health services.

II. METHODOLOGY

The 2015 KHFA was a national quantitative survey that was designed to collect data from a sample of health facilities in each of the 47 counties in the country. Standard UNFPA Service Delivery Point (SDP) data collection tools were used after minimal changes to suit the national policy guidelines. The sampling of the health facilities was guided by the UNFPA sampling methodology guide for SDP Surveys. The questionnaires were pre-tested in Nairobi.

Data for this survey was collected from a sample of 641 health facilities spread out over all the 47 counties. These facilities, which were sampled from the *Master Facility List* (MFL) dated May 2015 that had a total of 10,062 health facilities, were of different types (primary, secondary, and tertiary) and managing authorities (government, non-governmental organizations, faith-based organizations, and private for profit). A total of 22 teams, each consisting of two (2) research assistants (health workers) and a driver, were formed for the purpose of the field work. Each team was assigned between 1 and 3 counties from where they collected the data using a facility questionnaire and an exit interview questionnaire. For the exit interviews, the research assistants sampled the family planning clients who had come for family planning services on the day of the survey.

Data entry was done at NCPD headquarters using a data entry programme developed using CS Pro Version 6.3 software. Upon completion of data entry, the resulting dataset was checked for any errors and inconsistencies by running frequencies of all the variables. Data analysis was undertaken using the Statistical Package for Social Scientist (SPSS) software Version 20.

III. NATIONAL GUIDELINES, PROTOCOLS AND LAWS

National policies are critical for FP and RH programmes performance. The policies help in defining the national priorities and at the same time create frameworks for development of strategies and operational plans. Review of major policies and national strategic documents in Kenya identified that the policy environment in Kenya is both conducive and promotive of FP and RH programmes. Indeed, the Constitution of Kenya, Kenya Vision 2030, Kenya Health Policy and Strategic Plans, National Reproductive Health Policy and Strategic Plans, National Family Planning Guidelines and the National Adolescent Sexual and Reproductive Health Policy, all have a specific focus on Reproductive Health, including Family Planning.

IV. SUMMARY OF SURVEY FINDINGS

General Information about the Facilities

Most of the facilities that were surveyed were in the Rift Valley region (29%) – which also had the highest proportion of all the categories of health facilities - followed by the Eastern region (18%), with the Nairobi region (3.1%) having the least proportion. Three in every five health facilities that were surveyed are government-managed. Private facilities made up 23 percent of the sampled facilities, Faith-Based Organization (FBO) managed facilities were 12 percent while less than 3 percent of the facilities were managed by Non-Governmental Organizations (NGO). Slightly over half of the primary and about three quarters of the tertiary and secondary health facilities that participated in this survey are government-managed. Slightly over half of the facilities surveyed were 50 km or more from the source of their supplies. Secondary facilities have the highest proportion (62%) located 50 km or more away from their source of supplies, while tertiary facilities have the highest proportion (39%) located 4 km or less from their source of supplies.

Modern Contraceptives Offered by Facilities

The survey showed that 94 percent of the primary health facilities provided at least three modern contraceptives while 79 percent of secondary and 100 percent of the tertiary health facilities provided at least five modern contraceptive methods. The main reasons given by health facilities for not offering certain contraceptive methods were: low or nonexistent client demand for the contraceptive, delayed requests from the SDPs for contraceptive supplies, the lack of trained staff to provide certain methods such as insertion and removal of intrauterine devices (IUDs), implants, and female and male sterilization, and the lack of equipment for the provision of the contraceptives.

Availability of Maternal and Reproductive Health Medicines

The availability of maternal and reproductive health commodities is a prerequisite for good maternal and reproductive health programming. The 2015 KHFA assessed the availability of seven lifesaving maternal and reproductive health medicines (including two essential ones) at various SDPs. It was found that overall, 62 percent of SDPs, at the time of the survey, had available all the seven lifesaving maternal and reproductive health medicines while 38 percent did not have all the seven lifesaving medicines. The main reason given for not having these medicines is the delay on the part of the supplier/warehouse to deliver the medicines.

Incidence of ‘No Stockout’ of Modern Contraceptives

The KHFA Survey provides information regarding the incidence of ‘no stockout’ of modern contraceptives at the SDPs during the three months preceding the survey and at the time of survey. The results show that in the three months preceding the survey, 86 percent of the SDPs had a stockout of at least one or more of the modern contraceptives that they usually provide. On the day of the survey, only 19 percent of the SDPs had all the modern contraceptives that they usually provide.

The survey results show that an SDP’s nearness to a warehouse does not necessarily guarantee ‘no stockout’. The reasons for stockouts of each of the modern contraceptives were also explored. The stockout of commonly used contraceptives like the injectables, emergency contraception, male condoms and oral contraception is largely due to delay on the part of the main source to re-supply contraceptives to the SDPs or delays by the SDP to requisition more supplies. On the other hand, stockouts of methods such as female condoms, male sterilization, and female sterilization, are due to low demand.

Supply Chain, Including Cold Chain

The survey findings show that in 61 percent of the SDPs, the main people responsible for making orders for medical supplies are nurses. This situation is more evident in the primary level facilities (64%) than in secondary and tertiary levels. With regard to procedures for the resupply of commodities, the survey findings revealed that in about 3 out of every 4 facilities, quantification of resupplies is done by a staff member from the facility. Nairobi has the lowest (48%) proportion of facilities where quantification is done by staff members from the facilities, as well as the highest (48%) proportion of facilities where this function is performed by a non-staff member.

The main source of medical supplies was found to be the central medical stores (32%), closely followed by the regional/district warehouse (30%) and private suppliers (27%). The private suppliers are more active in the Central and Eastern regions (45%) while facilities in Nairobi mostly use the regional/district warehouse (83%). In 52 percent of the health facilities, the supplies and commodities are delivered by the suppliers while in 32 percent of the facilities, the delivery is by own transport.

The survey findings show that over 70 percent of the facilities use logistics forms for ordering supplies and reporting. All tertiary facilities were verified to be using the logistics forms. Ninety six percent of NGO managed facilities also use these forms.

The survey findings show that 47 percent of the facilities receive their orders within two weeks after ordering while 32 percent have to wait for more than a month before receiving their orders. Government facilities which mainly get their supplies from the central medical stores are the worst hit with majority (79%) waiting for more than one month. With regard to frequency of resupplies, the survey revealed that 41 percent of the facilities are resupplied on a quarterly basis while 30 percent are resupplied on a monthly basis. Government facilities are lagging behind in frequency of resupplies with 18 percent receiving supplies once every six months.

The survey findings show that overall, 16 percent of the facilities lack cold chains. Further, the survey findings show that over 70 percent of the health facilities store tetanus toxoid appropriately in cold chain. It was also found that 40 percent of the NGO managed facilities store other commodities within the same cold chain equipment.

For the facilities with cold chains, almost all (99%) use electric fridges while close to one percent use ice boxes. The main source of power for the electric fridges was found to be electricity from the national grid.

Staff Training and Supervision

Training of service providers is essential in building their capacity in terms of skills, technical competence and knowledge to provide efficient quality care. Supervision by external authorities helps to ensure that the trained staff at the facilities follow standards and protocols in the delivery of quality services, which also exposes them to the on-the-job training they require. The KHFA results show that 9 in every 10 SDPs in Kenya have staff trained to provide FP services including the insertion and removal of implants. Although the NGO-managed facilities (100%) have a higher proportion of facilities with staff trained to provide FP services, they have a lower proportion (77%) of staff trained in insertion and removal of implants compared to government facilities (96%).

Generally, the most recent training on FP for all facilities was done between two and six months ago (43%) and the training exercise in 9 out of every 10 of those facilities included the insertion and removal of implant contraceptives. The tertiary level has the highest proportion (50%) of facilities with staff who received their training in the last two months. Three out of 4 facilities in Nairobi received recent training for FP between two and six months ago. In total, 35 percent of facilities in Kenya were last supervised between one and three months ago while 13 percent were not supervised in the past 12 months before the survey. Facilities at tertiary level (33%) received the most recent supervision less than one month ago compared to secondary (28%) and primary (27%). Most facilities in Kenya receive supervisory visits after every three months (47%). Facilities at primary level (47%) have a higher proportion of supervisory visits every three months than facilities at secondary level (36%). Facilities in Nyanza (69%) registered a higher proportion of supervisory visits every three months compared to other regions. Issues on data completeness, quality, and timely reporting (88%) were included in most supervisions while issues on use of specific guidelines or job-aids for reproductive health (68%) were the least commonly included issues.

Use of Information Communication Technology (ICT) and Waste Disposal

About 68 percent and another 61 percent of SDPs had computers and mobile phones (basic handsets) respectively. Sixteen percent had smart phones and 13 percent had internet connectivity through a Local Area Network (LAN). Tablets and Wi-Fi were least available at the SDPs. Approximately 46 percent of SDPs acquired ICT equipment from the proprietor while around 33 percent received the equipment in form of a donation. Majority of SDPs use their ICT equipment for routine communication, facility record keeping and patient registration. In terms of waste disposal, more than half (57%) dispose medical wastes by burning, followed by central collection by specific agency for disposal away from SDP (35%) and by use of incinerator (34%). Less than 2 percent of the SDPs dispose medical wastes with regular garbage, a practice which is undesirable.

Charges for User Fees

Majority of SDPs (89%) charge a fee for delivery services consultation. Eighty seven percent of SDPs charge for consultation on care of sick children under 5 years and another 85 percent charge for consultation on antenatal care services. Approximately 8 out of 10 SDPs charge for consultation on

postnatal and newborn care services. About 61 percent of all SDPs charge user fees for consultation on family planning services, while half of SDPs charge for consultation on HIV care. There are no user charges for HIV care at tertiary SDPs. About 88 percent of all SDPs charge user fees for maternal health medicines, 87 percent for child health medicines and 83 percent for family planning commodities. Results show that majority of SDPs charge user fees for services provided by a qualified health care provider for caesarean section, delivery services, care of sick children under 5 years, newborn care services, antenatal care services, family planning services and postnatal care services.

Clients' Exit Summary Findings

Background Characteristics of Clients

Overall, the exit interview clients were mostly female (99.8%). Most of the clients interviewed fall within age groups starting from 15-44 years with the majority falling within the age group 25-29 (34%). The clients in age group 15-19 years were 5 percent, 35-39 years constituted 10 percent while those in 40-44 years formed only 3 percent of the interviewed clients. About 87% of the clients indicated that they were currently married while only 8 percent of these clients said that they have never married and 5 percent said that they were formerly married. Additionally, majority of the clients had primary education (48%), followed closely by those who had secondary and higher education (47%). About 5 percent of these clients had no education. The findings also show that majority of the clients visited the SDPs once in three months (70%) while 4 percent visited once every two months.

Clients' Perception of FP Service Provision

There was general adherence to technical aspects in provision of FP services. Ninety seven percent of the clients reported that they received a method of their choice, 98 percent were treated as they wished, 90 percent were taught how to use the family planning method of choice, 82 percent were told about the common side effects of family planning methods while 79 percent were informed about what can be done regarding the side effects of the FP method and 96 percent were given a date to return to SDP for check-up and /or additional supplies. The lowest satisfaction (66%) was on provision of information on what to do in case of any serious complications. About 96 percent reported that they were both satisfied with the cleanliness of the health facility and the privacy at the examination rooms while 97 percent were satisfied with time allocated to their cases. About 1 in every 5 of the clients interviewed perceived that the waiting time was too long.

Clients' Appraisal of Cost of Family Planning Services

Results show that overall, 36 percent of the clients paid for FP services. The percentage of clients reporting paying for services was highest in the Rift Valley and Central regions (43 and 42 percent respectively) and lowest in the Western and North Eastern regions (21 and 24 percent respectively). On average, FP services were generally more expensive in urban areas compared to rural areas. The average cost of contraceptives purchased from pharmacies was highest (Ksh. 71) among NGO facilities compared with government facilities (Ksh. 48). Most FP clients (69%) walked to the SDP for services. The average distance travelled and travel expenses was highest at 6.9 km and Ksh. 114 respectively for those accessing tertiary level facilities. Walking and motor cycle transport were the most widely used form of transport among the FP clients. Average time spend in seeking FP services was higher in rural areas compared to urban areas.

Over half of the FP clients reported that they would have been doing household chores during the time they spend receiving FP services. Majority of the currently married clients (52%) and formerly married clients (20%) reported that they would be involved in household chores and working on the farm respectively had they not come for the FP services. The average amount paid to those who were left to perform the chores on behalf of the FP clients was Ksh. 655. Over half (52%) of the FP clients reportedly paid for the FP services using their own resources while 48 percent were paid for by their spouses.

PART 1: INTRODUCTION

1.1 Background

Kenya's family planning and maternal health programmes have witnessed a lot of improvement over the years. According to the Kenya Demographic and Health Survey (KDHS), between 2003 and 2014, the adoption of modern contraceptive methods by married women improved from 32 to 53 percent, the proportion of pregnant women making at least 4 ANC visits during pregnancy increased from 52 to 58 percent, and pregnant women seeking skilled care during delivery increased from 42 to 62 percent. These improvements have contributed to the lowering of the country's maternal mortality ratio (MMR) from an estimated high of 520 maternal deaths per 100,000 live births in 2008/9 to a low of 362 deaths in 2014. One of the key factors that have contributed to these improvements are the efforts by the government and partners to scale up access and quality of family planning and reproductive health services.

According to the 2010 Kenya Service Provision Assessment (KSPA), 89 percent of health facilities in Kenya offer at least one temporary method of family planning. Among these facilities, 88 percent offer family planning services for 5 or more days per week. The same assessment also showed that in every 4 health facilities in the country, 3 provide ANC services while only 1 in every 3 provide normal delivery services. The availability of these services as well as the supporting infrastructure, commodities and medicines is important in ensuring that the quality of life of the country's citizens improves.

Among the partners who have supported Kenya's efforts to improve the family planning and reproductive health services is United Nations Population Fund (UNFPA). Through the Global Programme to enhance Reproductive Health Commodity Security (GPRHCS), UNFPA has over the years provided family-planning commodities and reproductive health medicines to Kenya's health sector in an effort to improve access and quality of health services. GPRHCS is now known as UNFPA Supplies.

From 2010 to 2012 UNFPA, through the GPRHCS, has supported the implementation of an annual survey on the availability and stockout of contraceptives and maternal health medicines in 12 countries. Starting 2013, the survey was expanded on two fronts, namely, to cover 46 countries and to include other key issues especially for family planning service delivery. Kenya was included among the 46 countries. The 2015 Health Facility Assessment (KHFA) conducted in Kenya therefore provides the government, UNFPA, and other partners a further opportunity to evaluate the impact of their efforts in improving access and quality of family planning and reproductive health services.

1.2 Rationale and Objective of the Study

Availability of family planning and maternal health commodities and services is critical in ensuring that the needs of the clients who access the health facilities are met. The performance of Kenya's family planning and reproductive health programmes depends on continuous monitoring and evaluation to identify strengths that need to be sustained and weaknesses that need to be addressed. It is for this reason that this assessment was done to assess the availability of FP and selected maternal health commodities in the health facilities across the country. The results of the assessment will inform policy and programme actions by both the national and county governments.

The specific objectives of the 2015 KHFA were to:

- i. Assess availability of at least 3 modern contraceptives in primary health facilities and at least 5 modern contraceptives in secondary and tertiary health facilities.
- ii. Outline the reasons why at least 3 modern contraceptives are not provided in some primary health facilities and why 5 modern contraceptives are not provided in some secondary and tertiary health facilities.
- iii. Assess the availability of maternal RH medicines in health facilities providing delivery services.
- iv. Outline the reasons why at least 7 maternal RH medicines are not provided in some facilities.
- v. Document the quality of family planning services in the health facilities.

I.3 Survey Organization and Management

The 2015 KHFA was spearheaded by NCPD in conjunction with various stakeholders. At the national level, a Steering Committee was formed to provide oversight and policy direction in the implementation of the survey. This Committee was made up of the following organizations:

- a. National Council for Population and Development
- b. Ministry of Health
- c. Kenya National Bureau of Statistics
- d. Population Studies and Research Institute
- e. Ministry of Devolution and Planning
- f. United Nations Population Fund

Technical input to the survey was provided by a Technical Committee that was constituted by technical officers from the organizations that formed the Steering Committee. The Technical Committee was responsible for validation of the data collection tools, supervision of field work, and development of the survey report. NCPD's technical officers from the Policy and Research division, under the direction of the NCPD Director General, provided secretariat services to the Steering and Technical Committees as well as the day to day management of the entire survey process. During the field work data collection, a total of 16 technical officers from the Technical Committee and from various divisions within NCPD worked together with 11 NCPD County Population Coordinators (CPCs) in making courtesy calls to relevant county officials, making appointments with the health facilities to be surveyed, and supervising the research assistants. Members of the Steering Committee also made field visits as part of quality assurance.

I.4 Methodology and Limitations

I.4.1 Survey design and sampling of facilities

The 2015 KHFA was a national quantitative survey that was designed to collect data from a sample of health facilities in each of the 47 counties in the country. Standard UNFPA Service Delivery Point (SDP) data collection tools were used after validation by the Technical Committee. Minimal changes were made to the tools by the Technical Committee to suit the national policy guidelines. These tools were:

- i. Module I Questionnaire (Availability of RH/FP Commodities and Services)

ii. Module 2 Questionnaire (Exit Interview - Clients' Perception and Appraisal of Cost for FP Services).

Before their use, the above tools were pre-tested in Nairobi County from 22nd to 24th October, 2015. Eight (8) research assistants participated in this exercise after receiving training.

The sampling of the health facilities was guided by the UNFPA sampling methodology guide for KHFA. In sampling the health facilities, the *Master Facility List (MFL)* of May 2015 that contained 10,062 health facilities was used. This list is compiled and maintained by the Ministry of Health. Some health facilities were dropped from the initial list, leaving a total of 8,905 eligible health facilities to form the sample frame for the assessment. The health facilities that were dropped included those that were non-operational, unclassified, and those that were not relevant for this assessment, such as eye clinics, laboratories, VCTs and those providing imaging services only. The first step in the sampling process was the stratification of the health facilities in the sample frame into primary, secondary, and tertiary health facilities. This stratification was done by using the levels in the *Kenya Essential Package for Health (KEPH)*. Level 2 and 3 facilities were categorized as primary, level 4 as secondary, and level 5 and 6 as tertiary health facilities. The sampling process also took into consideration the various managing authorities of the health facilities, namely government, private, NGO and FBO (see annex for more details).

Table 1.1: Distribution of sampled health facilities

	Primary	Secondary	Tertiary	Total
Total Facilities (HFL)	9,582	456	24	10,062
Sample Frame	8,437	448	20	8,905
Sampled Facilities	546	93	19	658

As shown in Table 1.1, a total of 658 health facilities were sampled for the assessment. This comprised 546 primary, 93 secondary, and 19 tertiary health facilities. For logistical purposes, the 47 counties were grouped into 22 clusters during the data collection field work. Each cluster was allocated one team for data collection.

1.4.2 Data collection

Data collection for the 2015 KHFA commenced on 9th November 2015 and ended on 8th December 2015. A total of 22 teams, each consisting of two (2) research assistants (health workers) and a driver, were formed for the purpose of the field work. Table 1.2 shows how the teams were allocated the 47 counties;

Table 1.2: Distribution of counties by team

Team	Cluster of Counties	Team	Cluster of Counties
1	Nairobi, Nakuru	12	Marsabit, Isiolo
2	Kakamega, Vihiga	13	Meru, Embu, Tharaka Nithi
3	Bungoma, Busia	14	Machakos, Makueni, Kitui
4	Kisumu, Siaya	15	Nyeri, Nyandarua, Kirinyaga*
5	Homa Bay, Migori	16	Muranga, Kiambu, Kirinyaga*
6	Kisii, Nyamira	17	Samburu, Laikipia
7	Kwale, Taita Taveta	18	Narok, Kajiado
8	Tana River, Kilifi	19	Kericho, Bomet, Baringo
9	Lamu, Mombasa	20	Uasin Gishu, Elgeyo Marakwet, Nandi
10	Garissa, Wajir*	21	West Pokot, Trans Nzoia
11	Mandera, Wajir*	22	Turkana

* Health facilities in these counties were shared between two teams.

Before commencing the field work, the research assistants were trained on how to administer the tools. This involved conducting mock facility and client exit interviews. Each team developed a movement plan based on the health facilities sampled in their respective counties, and using this plan, the teams collected data from the sampled facilities. On arrival at any facility, the teams sought permission from the in-charge to proceed with data collection. Once permission was granted, the teams would first administer the *Module 1 Questionnaire (Availability of RH/FP Commodities and Services)* and thereafter the *Module 2 Questionnaire (Exit Interview - Clients' Perception and Appraisal of Cost for FP Services)*. Module 1 was administered in all health facilities while Module 2 was only administered in the facilities that provide family planning services.

Before administering Module 2, the research assistants would first establish the average number of family planning clients who visit the health facilities on a daily basis. This number would then be divided by the number of exit interviews targeted in the health facilities to give the sampling interval. Using the sampling interval, the research assistants would randomly sample clients for the exit interview. The target was to conduct 3 exit interviews in the primary health facilities, 5 interviews in the secondary facilities and 10 interviews in the tertiary facilities.

At the end of each day, the research assistants reviewed the data collected for completeness and accuracy before submitting the same to their respective field supervisors for checking and submission for data entry. Table 1.3 shows the number of facilities surveyed and the response rate for data collection.

Table 1.3: No. of facilities surveyed and response rate

	Primary	Secondary	Tertiary	Total
No. of Sampled Facilities	546	93	19	658
No. of Facilities Surveyed	524	99	18	641
Response Rate (%)	96%	106%	95%	97%

The response rate for the 2015 KHFA data collection exercise is 97 percent. Out of the 658 facilities that were sampled for the survey, data was collected from 641 facilities.

1.4.3 Data analysis and presentation

Data entry was done at NCPD headquarters using a data entry programme developed using CS Pro Version 6.3 software. The questionnaires sent from the field were first checked for completeness and accuracy by the data entry team. Any questionnaires that required clarification or correction were referred to the concerned research assistants. All questionnaires that were cleared for data entry were entered twice using different data clerks so as to ensure accuracy of the keyed data. Upon completion of data entry, the resulting dataset was checked for any errors and inconsistencies by running frequencies of all the variables.

Data analysis was undertaken using the Statistical Package for Social Scientist (SPSS) software Version 20. This involved the production of 110 data tables both for facility and client exit interviews which were used to interpret the findings. The survey findings were summarized in tables. Bar and pie charts were used to complement the tabular presentation of the findings thereby adding to the variety of ways of presenting the assessment findings. The data was weighted before the commencement of the data analysis.

I.4.4 Limitation of the survey

The 2015 KHFA is mainly limited in two aspects:

- i. The number of health facilities sampled for this assessment is not adequate for conducting an analysis of the findings at county level. The findings are therefore presented in terms of regions so as to show the geographic performance of the various indicators.
- ii. This is a cross-sectional survey that sought to give a snapshot of the situation in terms of the availability of family planning commodities and maternal/reproductive health medicines as well as the quality of family planning services. An analysis of causal effects can therefore not be undertaken using the data from this survey.

I.5 Outline of Report

The report is divided into the following five parts:

PART 1

The first part gives the background to the study where rationale and objective of the study, survey organization and management, methodology and limitations, survey design and sampling of facilities, data collection, and data analysis are discussed.

PART 2

The second part summarizes findings on guidelines, protocols and laws for provision of modern contraceptives and provision of maternal/RH medicines in Kenya.

PART 3

The third part discusses survey findings on availability of commodities and services. This section provides general information about facilities, modern contraceptives offered by facilities, availability of maternal and RH medicines, incidence of 'no stockout' of modern contraceptives, supply chain (including a cold chain), staff training and supervision, availability of guidelines, check-lists and job aids, use of Information Communication Technology (ICT) and waste disposal and charges for user fees.

PART 4

The fourth part discusses the findings from exit interviews, including clients' background characteristics, clients' perception of family planning service provisions, clients' appraisal of the cost of family planning services provision, and clients' appraisal of the cost of family planning services.

PART 5

Lastly, **part five** gives the summary of findings and recommendations.

PART 2: NATIONAL GUIDELINES, PROTOCOLS AND LAWS

This section of the report provides a summary of guidelines, protocols and laws for the provision of modern contraceptives and maternal/RH medicines. In general, each of these documents deals with both family planning and maternal/RH issues. It is therefore difficult to present them as either family planning or maternal/RH documents.

Constitution of Kenya (2010): This is Kenya's supreme law. Among the rights enshrined therein is the right of each individual "to the highest attainable standard of health, which includes the right to health care services, including reproductive health care". The guidelines, protocols, and laws governing the provision of health services in the country promote the spirit of the constitution.

Kenya Vision 2030: This is the national development blueprint which aims to transform Kenya into a "newly industrialising, middle-income country providing a high quality life to all its citizens by the year 2030". The Vision is anchored on three pillars: economic, social and political. Under the social pillar, the country aims to provide an efficient and high-quality health care system with the best standards. This will be done through the devolution of funds and management of health care and shifting the bias of the national health bill from curative to preventive care. Among other things, special attention will be paid to lowering childhood and maternal deaths.

Kenya Health Policy (2012-2030): This policy has, as a goal, the attainment of the highest possible health standards in a manner responsive to the population needs. The policy aims to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. It seeks to attain a level and distribution of health at a level commensurate with that of a middle-income country, through the attainment of specific health impact targets. The policy gives focus to reproductive health services program interventions with improvements in availability of maternal and RH commodities and range of modern contraceptives methods. Community involvement in advocacy and distribution is a key emphasis of the strategies, leading to increased access, availability and use of the FP services. This has contributed to the drop in the fertility rates in most regions of the country.

Kenya Health Sector Strategic and Investment Plan (KHSSP) (2013– 2017): This is the second medium term plan for health and its focus is guided by the goal of Vision 2030 that aims to "transform Kenya into a globally competitive and prosperous country with a high quality of life by 2030" through the transformation of the country into an industrialized, middle income country. Its actions are grounded in the principles of the 2010 constitution, specifically aiming to attain the right to health, and to decentralize health services management through a devolved system of governance. The constitution of Kenya has devolved provision of health services under 47 county governments and one national government. The Health Sector strategic plan guides both county and national governments on the operational priorities they need to focus on with regard to health. The sector plan puts a lot of emphasis on maternal and newborn health, in which little progress was made in the previous strategic plan.

This strategic plan has realigned the KEPH where health services including RH and FP services can be offered at community level, primary care level comprising dispensaries, health centers, maternity/Nursing homes, County level and National level.

The KHSSP also outlines a wide range of health facilities distributed all over the country where services are provided by various stakeholders like the government, Faith-Based Organizations (FBOs), Non-

Governmental Organizations (NGOs) and private institutions. Under this plan, the ministry intends to increase the percentage of women of reproductive age receiving family planning services from 44 percent in 2013 to 80 percent by 2017. The plan also intends to increase the percentage of women receiving skilled birth attendance from 44 percent (2013) to 65 percent by 2017.

National Reproductive Health Policy (2007): The goal of this policy is to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services, improving quality, efficiency and effectiveness of service delivery at all levels and improving responsiveness to client needs. The policy has prioritized safe motherhood, maternal and neonatal health, family planning, adolescent/youth sexual and reproductive health, and gender issues, including sexual and reproductive rights. Other priority components of RH addressed in this policy are: HIV/AIDS, reproductive tract infections, infertility, cancers of reproductive organs and RH for the elderly.

The priority reproductive health needs and related intervention measures will be implemented in line with the KHSSP through a multi-sectoral approach including collaboration with civil society and the private sector. The goal is to reduce inequalities in health resource allocation and improve access to RH services by poor, 'hard to reach' and vulnerable groups. All health care facilities, from the community level to national level institutions, have a role to play in the provision of sexual and reproductive health services.

National Reproductive Health Strategy (2009 – 2015): The overall goal of this strategy is to facilitate the operationalization of the National Reproductive Health Policy through a national multi sectoral approach. The goal echoes the overall goal of the National Reproductive Health Policy that is “to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs”.

Reproductive health is a development issue as it contributes to death and disability, which affect many families. Access to reproductive health care is crucial to achieving the targets of the Sustainable Development Goals (SDGs), population, development and health goals as well as realizing Kenya Vision 2030. The strategy calls for enhanced multi-sectoral participation at all levels and has provided the necessary framework for the requisite multi-sectoral approach towards the enhanced reproductive health status of all Kenyans.

National Road Map for Accelerating the Attainment of MDGs Related to Maternal and Newborn Health in Kenya (2010): This road map is adapted from the Africa Regional Road Map following an agreement by all African Union (AU) countries to accelerate the attainment and sustenance of Millennium Development Goals (MDGs) 4 and 5. The implementation framework of the strategies adopted for the Road Map require concerted efforts by all stakeholders in the health sector from national level down to the community and across the political, social, and corporate divide.

The key strategies proposed to accelerate the attainment and sustenance of MDG 4 and 5 include improving the availability of, access to, and utilization of quality maternal and newborn health care; reducing unmet needs through the expansion access to good quality family planning options for men, women and sexually active adolescents; strengthening the referral system; advocating for increased commitment and resources for MNH and FP services; strengthening community based maternal and newborn health care approaches; and strengthening the monitoring and evaluation system and operations research.

Reproductive Health Commodity Security Strategy (2013-2017): This strategy has been developed to guide the planning, implementation, coordination, supervision, monitoring and evaluation of reproductive health commodities in Kenya in order to ensure “uninterrupted, accessible and affordable supply of reproductive health commodities to all people that need them, whenever and wherever they need them.”

The development of this strategy has been necessitated by the growing numbers of the reproductive age population, hence the increased demand for contraceptives. This requires well-coordinated and efficient logistics systems and contraceptive security at all levels to ensure smooth supply, as well as the control of costs by eliminating overstocks, spoilage, pilferage and other forms of waste. This strategy is implemented in accordance with KHSSP and both the Reproductive Health Policy and Strategy.

National Family Planning Guidelines for Service Providers: In Kenya, several policies and strategies have been developed with the goal of strengthening the demand for and supply of FP services. The KHSSP recognizes RH (including FP) as an essential priority in the KEPH. Since the development of the National Family Planning Guidelines, the capacity of health workers to provide comprehensive family planning services has been enhanced. In addition, a lot of progress has been achieved with the Total Fertility Rate dropping from 4.9 to 3.9 over the last decade. The contraceptive prevalence rate has risen to 58 percent surpassing the projected 56 percent and use of modern contraceptive having risen from 32 percent in 2003 to 53 percent in 2014. About 60 percent of the contraceptives are offered in government health facilities. The unmet need for family planning has also reduced to 18 percent in 2014.

National Adolescent Sexual and Reproductive Health Policy (2015): The National Adolescent Sexual and Reproductive Health (ASRH) Policy aims to enhance Sexual and Reproductive Health (SRH) status of adolescents in Kenya and contribute towards realization of their full potential in national development. The policy intends to bring adolescent sexual and reproductive health and rights issues into the country's mainstream health and development agenda.

Adolescents comprise about 24 percent of Kenya's population. This large adolescent population has implications on the country's health and development agenda as it is likely to put increasing demands on provision of services. The Adolescent Sexual and Reproductive Health (ASRH) Policy provides guidance to government ministries and development partners working with the Ministry of Health on how to respond to adolescents SRH needs. Responding to the multifaceted changes of Adolescent Sexual and Reproductive Health requires a clear understanding of their circumstances and issues.

The policy has outlined principles, objectives, priority areas and actions for ASRH in Kenya. The objectives of this policy include promotion of an enabling legal and socio-cultural environment for the provision of SRH information and services for adolescents; enhancing equitable access to high quality, efficient and effective adolescent-friendly information and services; increasing gender equity and equality in SRH amongst adolescents; strengthening inter-sectoral coordination and networking, partnership and community participation in adolescent SRH; supporting adolescent participation and leadership in SRH planning and programming at all levels; and strengthening collection, analysis, and utilization of age and sex disaggregated data on adolescents.

PART 3: SURVEY FINDINGS ON AVAILABILITY OF COMMODITIES AND SERVICES

3.1 General Information about the Facilities

This section of the report presents the distribution of facilities by region, management authority, and distance from the source of supplies.

3.1.1 Regional distribution of facilities

Table 3.1 shows that most of the facilities that were surveyed were in the Rift Valley region (29%) followed by the Eastern region (18%). Nairobi (3.1%) had the least proportion of facilities that were surveyed.

Table 3.1: Percentage distribution of facilities by region

Region	Type of SDP (Percentage)			All SDPs	No. of Facilities (Unweighted)
	Primary	Secondary	Tertiary		
Central	11.3	11.1	11.1	11.2	72
Coast	11.1	13.1	5.6	11.2	72
Eastern	17.9	15.2	16.7	17.5	112
Nairobi	2.7	2.0	22.2	3.1	20
North Eastern	5.9	6.1	5.6	5.9	38
Nyanza	13.9	13.1	11.1	13.7	88
Rift Valley	28.8	29.3	22.2	28.7	184
Western	8.4	10.1	5.6	8.6	55
Total	100.0	100.0	100.0	100.0	641

Nairobi (22%) and Rift Valley (22%) had the highest proportion of tertiary health facilities that were surveyed. Of the surveyed health facilities, the highest proportion of secondary (29%) and primary facilities (29%) were found in the Rift Valley region.

3.1.2 Management of facilities

The various managing authorities of the health facilities that were surveyed were categorized as Government, Non-Governmental Organization (NGO), Faith Based Organization (FBO), and Private. Table 3.2 indicates that 3 in every 5 health facilities that were surveyed were government-managed. Private facilities were 23 percent of the sampled facilities while the FBO managed facilities were 12 percent. Less than 3 percent of these facilities were managed by NGOs.

Table 3.2: Percentage distribution of facilities by managing authority

Management	Type of SDP (Percentage)			All SDPs	No. of Facilities (Unweighted)
	Primary	Secondary	Tertiary		
Government	58.6	75.8	77.8	61.8	396
Private	25.6	15.2	5.6	23.4	150
FBO	12.8	9.1	11.1	12.2	78
NGO	3.1	0.0	5.6	2.7	17
Total	100.0	100.0	100.0	100.0	641

Slightly over half of the primary and about three quarters of the tertiary and secondary health facilities that participated in this survey were government-managed. Private facilities made up for 25 percent of the primary facilities that were surveyed. The NGO-managed facilities were about 3 and 6 percent of the primary and tertiary facilities that were surveyed respectively.

3.1.3 Distance of SDPs from source of supplies

Table 3.3 shows that slightly over half of the facilities surveyed were 50 kilometers (km) or more from the source of their supplies. For the tertiary, secondary, and primary facilities, about 39, 62, and 49 percent of them respectively are 50 km or more away from their source of supplies.

Table 3.3: Percentage distribution of facilities by distance to source of supplies

Distance	Type of SDP (Percentage)			All	No. of Facilities
	Primary	Secondary	Tertiary		
0-4 km	23.9	20.2	38.9	23.8	152
5-9 km	6.7	5.1	22.2	6.9	44
10-14 km	4.2	2.0	0.0	3.8	24
15-19 km	3.4	2.0	0.0	3.1	20
20-24 km	3.6	3.0	0.0	3.4	22
25-29 km	2.3	2.0	0.0	2.2	14
30-34 km	2.9	1.0	0.0	2.5	16
35-39 km	1.1	0.0	0.0	0.9	6
40-44 km	2.7	3.0	0.0	2.7	17
45-49 km	0.4	0.0	0.0	0.3	2
50+ km	48.8	61.6	38.9	50.5	323
Total	100.0	100.0	100.0	100.0	640

Table 3.3 also shows that about 39 percent of tertiary, 20 percent of secondary, and 24 percent of primary health facilities surveyed are 4 km or less from their source of supplies.

3.2 Modern Contraceptives Offered by Facilities

Service Delivery Points (SDPs) in Kenya provide modern contraceptives across the different levels of health facilities. These facilities comprise the public system — with major players including the Ministry of Health (MOH) and parastatal organisations — and the private sector, which includes private for-profit, NGO, and FBO facilities. Health services are provided through a network of over 8,300 health facilities countrywide, with the public sector system accounting for about half of these facilities (SARAM 2013). Modern contraceptive methods that are provided in Kenya’s health facilities are: male and female condoms, oral contraceptives, injectables, emergency contraception, IUDs, implants, and male and female sterilization. The range of methods offered in the SDPs depends on the level and capacity of the facilities (FP Guidelines 2010).

3.2.1 Modern contraceptives offered by each facility type

The 2015 KHFA sought to establish the type of contraceptives offered at the different levels (primary, secondary and tertiary). The modern FP methods included in the assessment were nine, namely; male condoms, female condoms, oral contraception, injectables, emergency contraception, IUDs, implants, sterilization for

females (Bilateral tubal ligation), and sterilization for males (Vasectomy). Figure 3.2.1 shows the distribution of facilities by number of modern contraceptive methods offered. Among the primary health facilities, 94 percent provide at least 3 modern contraceptive methods. As for the secondary and tertiary facilities, 80 percent provide at least 5 modern contraceptive methods.

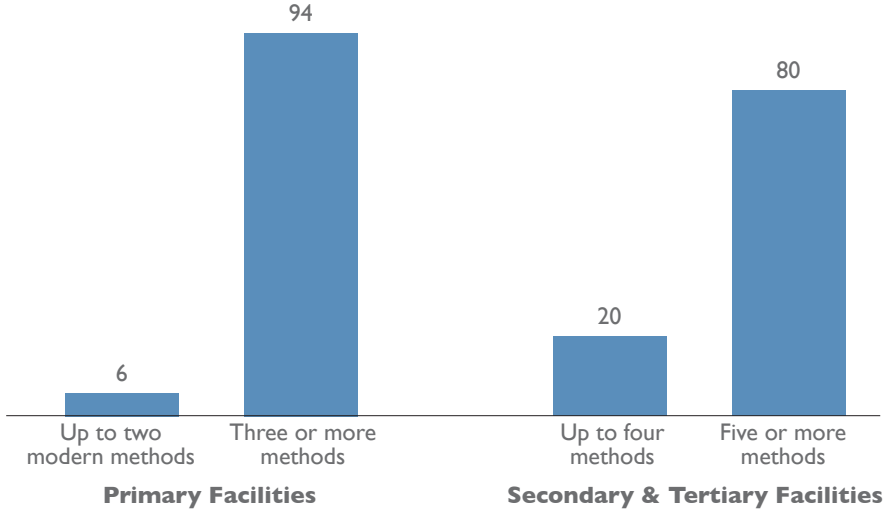


Figure 3.2.1: Distribution of SDPs by the number of modern contraceptive methods provided

3.2.2 Modern contraceptives offered by primary facilities

Primary care facilities are the first physical level of the health system, and include dispensaries, health centres and maternity homes for both public and private providers (KHSSP II 2005-2010). This facility level offers a range of FP and Healthy Timing and Spacing of Pregnancies (HTSP), counselling and provision of condoms, pills and injectable, implants, IUDs in some facilities (subject to training), Bilateral Tubal Ligation/Vasectomy (BTL/VS), outreach services, and referrals for other methods (FP Guideline 2010).

The 2015 KHFA assessed the percentage distribution of Primary SDPs offering at least three modern contraceptives. The findings are shown in Figure 3.2.2.

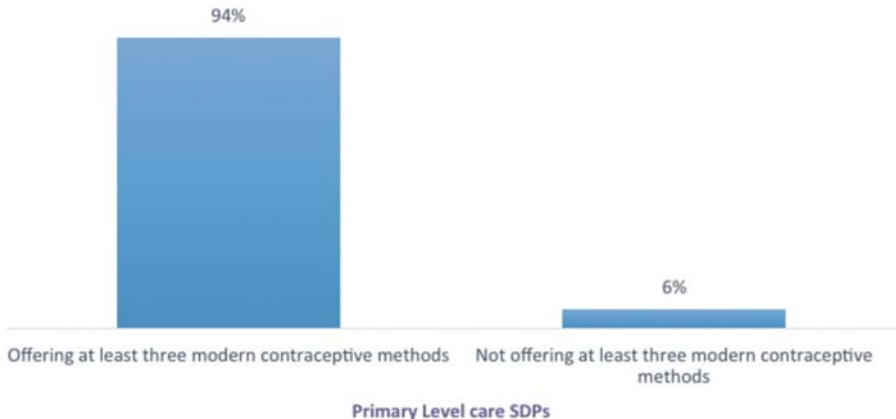


Figure 3.2.2: Percentage distribution of primary SDPs offering at least three modern contraceptives at primary level of care

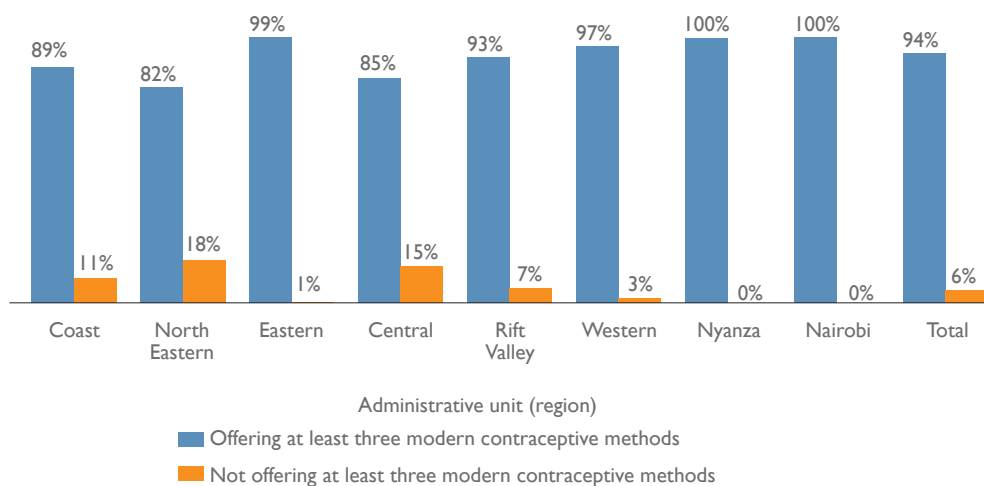


Figure 3.2.3: Percentage distribution of service delivery points offering at least three modern contraceptive methods by Region

The percentage of Primary SDPs offering at least 3 modern contraceptive methods is 94 percent as shown on Figure 3.2.2. In terms of region, Figure 3.2.3 shows that in all regions, nearly all the primary facilities offer at least 3 modern contraceptives. All the primary facilities in the Nyanza, and Nairobi regions provide at least 3 modern methods, followed by Eastern (99%), Western (97%) and Rift Valley (93%). The regions with the highest percentages of SDPs not providing at least three modern methods are North Eastern (18%) and Central (15%).

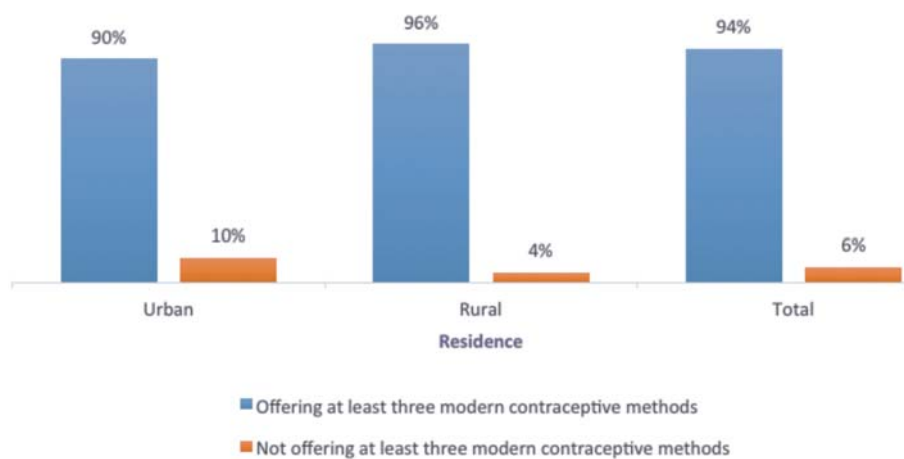


Figure 3.2.4: Percentage distribution of Primary service delivery points offering at least three modern contraceptive methods by urban/rural residence

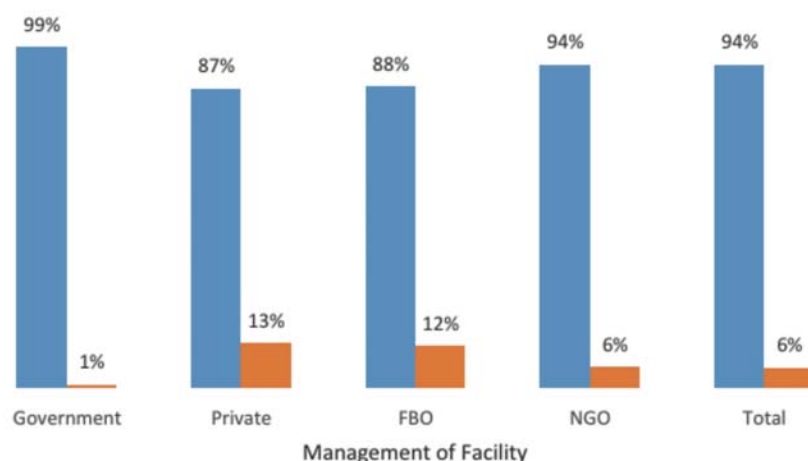


Figure 3.2.5: Percentage distribution of Primary service delivery points offering at least three modern contraceptive methods by management of facility

In terms of residence as shown in Figure 3.2.4, 96 percent of the rural based SDPs provide at least 3 modern family planning methods, compared to 90 percent in the urban areas. Regarding ownership, the findings show that Government-owned SDPs that provide at least 3 modern contraceptive methods are 99 percent while those managed by NGOs, FBOs and Private are 94, 88, and 87 percent respectively as shown in Figure 3.2.5.

The distance from the SDPs to the source of supplies is an important aspect in service delivery as it affects adequate and timely availability of the commodities. Table 3.2.1 shows the average distance in kilometers from the primary SDPs offering at least 3 contraceptive methods to the source of supplies does not appear to impact the provision of family planning services. Ninety percent or more of the primary SDPs within a distance of 45 km are providing at least 3 modern methods of contraceptives.

Table 3.2.1: Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by distance from nearest warehouse/source of supplies

Distance from nearest warehouse/ source of supplies (in km)	Percentage		
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	Total
0-4	90	10	100
5-9	96	4	100
10-14	95	5	100
15-19	94	6	100
20-24	100	0	100
25-29	92	8	100
30-35	80	20	100
35-39	100	0	100
40-45	100	0	100
45-49	0	100	100
50 and over	98	2	100
Total	94	6	100

3.2.3 Modern contraceptives offered by secondary and tertiary facilities

The secondary level of care facilities provides a more comprehensive set of services, including internships for medical staff and research. They also serve as training centres for paramedical staff. The tertiary level of care facilities provide services that are highly specialized and complete the set of care available to persons in Kenya. Services at the tertiary level also include training for specialists and biomedical research. Tertiary level facilities also serve as internship / apprenticeship centres for specialists. For FP, the secondary and tertiary facilities offer counselling and a full range of FP methods (Family Planning Guideline 2010).

The 2015 KHFA assessed the percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods. The findings are shown in Figure 3.2.6

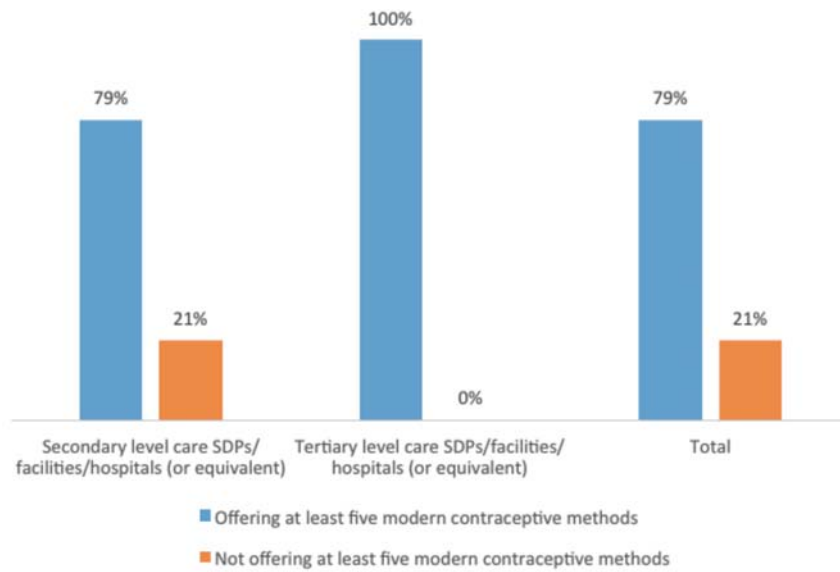


Figure 3.2.6: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods

In Figure 3.2.6, the findings show that all tertiary facilities offer at least 5 modern contraceptive methods while 79 percent of the secondary facilities offer at least 5 modern methods. Overall, 4 in every 5 tertiary and secondary facilities combined provide at least 5 modern FP methods.

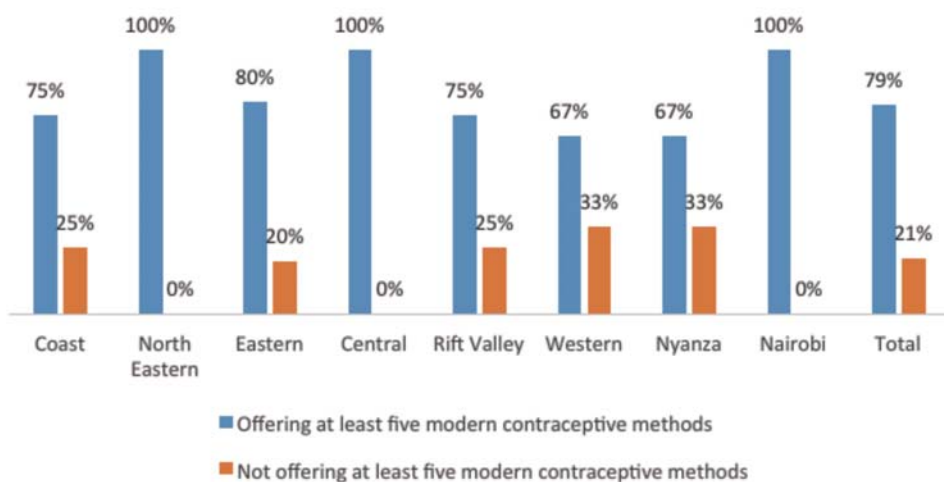


Figure 3.2.7: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by Region

In terms of region, all the secondary and tertiary facilities in the North Eastern, Central, and Nairobi regions provide at least 5 modern methods of contraceptive followed by Eastern (80%), Coast (75%) and Rift Valley (75%). About one-third of the secondary and tertiary health facilities in Western and Nyanza regions do not provide at least 5 modern FP methods.

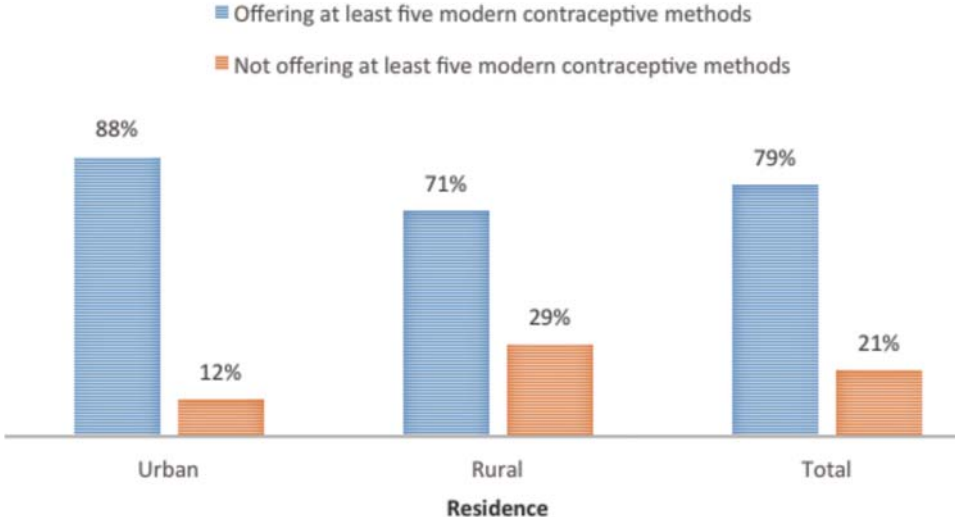


Figure 3.2.8: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by residence

Figure 3.2.8 shows that about 9 in every 10 of the SDPs located in the urban areas offer 5 or more modern contraceptive methods while in the rural areas it is 7 in every 10 SDPs.

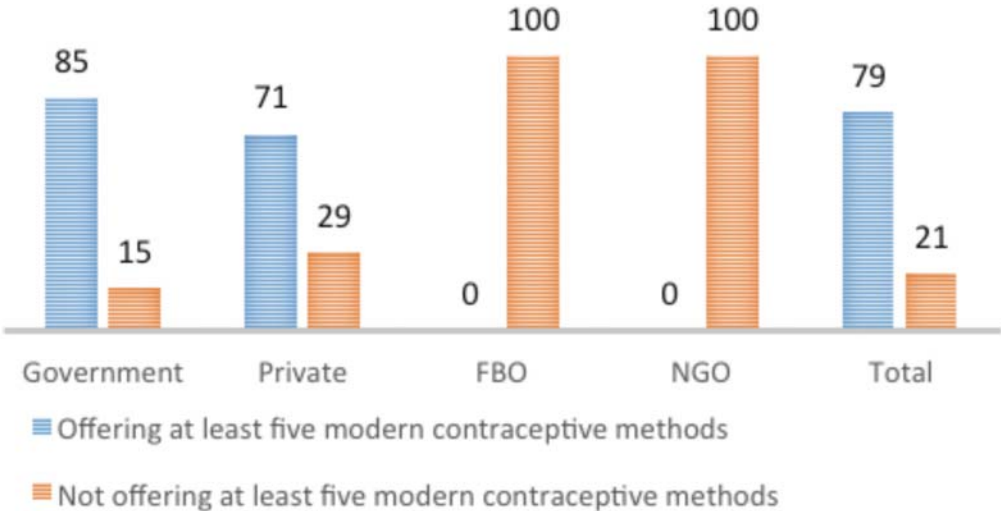


Figure 3.2.9: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by management of facility

According to Figure 3.2.9, 85 percent of the government secondary and tertiary SDPs provide at least 5 modern contraceptive methods compared to 71 percent of privately owned SDPs. None of the FBO- and NGO-managed SDPs provide five or more modern FP methods.

Table 3.2.2: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by distance from nearest source of supplies

Distance from nearest warehouse/ source of supplies (in Km)	Percentage		
	Offering at least five modern contraceptive methods	Not offering at least five modern contraceptive methods	Total
0-4	88.9	11.1	100.0
5-9	66.7	33.3	100.0
10-14	100.0	0.0	100.0
15-19	100.0	0.0	100.0
20-24	100.0	0.0	100.0
25-29	100.0	0.0	100.0
30-34	0.0	0.0	0.0
35-39	0.0	0.0	0.0
40-44	100.0	0.0	100.0
45-49	0.0	0.0	0.0
50 and over	75.0	25.0	100.0
Total	81.8	18.2	100.0

From Table 3.2.2, the results of the survey show that distance to the source of supplies is not a major factor in the distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods.

3.2.4 Reasons for not offering certain contraceptives

The 2015 KHFA sought reasons as to why some SDPs were not offering certain contraceptive methods while the national guidelines and protocols required them to do so. A range of reasons had been pre-coded and respondents were expected to choose which one applied to each specific method. The results are shown in Table 3.2.3.

The main reason given for not providing male condoms was low or no client demand for the male condoms (44%), followed by delayed requests from the SDPs for contraceptive supplies (26%). For female condoms, 56 percent of the SDPs indicated that the main reason for not offering the method is low or no client demand for the contraceptive, followed by 21 percent of the facilities that blamed this on delays on the part of the main source institution/warehouse to resupply SDPs with this contraceptive.

The reasons for not offering oral pills was mainly because of low or no client demand for the contraceptive (40%) and delays by the SDP to request for supply of contraceptive (35%). Thirty three percent of the facilities indicated an insufficient supply of injectables as the main reason for not offering this method while 17 percent mentioned delays on the part of main source to re-supply this contraceptive. As for emergency contraception, 36 percent of the facilities reported delays on the part of the main source to re-supply the contraceptive while 29 percent of the facilities mentioned low or no client demand for the contraceptive.

For the long term methods, the 2015 KHFA found that there were different reasons for not offering these contraceptives. In the case of IUDs, the main reasons given for not offering was low or no client demand for

the contraceptive (37%) and lack of equipment for the provision of contraceptive (21%). For the implants, the main reason given was the lack of trained staff to provide the service (32%) and lack of equipment for the provision of the contraceptive (22%). As shown in Table 3.2.3, the main reasons for not offering female and male sterilization is the lack of equipment for the provision of these contraceptives as reported by 47 and 41 percent of the SDPs respectively. The second reason is the lack of trained staff to carry out female and male sterilization as reported by 38 percent and 34 percent of the health facilities respectively.

Table 3.2.3: Reasons for not offering certain contraceptive

Main reason why the health facility does not offer the FP method to clients yet SDP is supposed/ expected to offer it, in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery	Family Planning method								
	Male Condom	Female condoms	Oral contraceptives	Injectables	Emergency contraception	IUDs	Implants	Female sterilization	Male sterilization
Delays on the part of main source to re-supply with contraceptive	9.2	21.3	11.9	17.2	35.6	4.6	9.4	0.0	0.0
Delays by the SDP to request for supply of contraceptive	25.5	8.4	35.1	0.0	18.3	8.5	10.4	0.0	0.0
Low or no client demand for the contraceptive	44.0	56.0	40.4	10.3	29.1	37.3	28.6	11.9	25.0
Insufficient supply for the contraceptive	14.3	2.5	0.0	33.3	10.6	2.5	1.9	0.0	0.0
Contraceptive is not available in the market	0.0	9.7	0.0	0.0	3.4	2.8	9.0	0.0	0.0
No train staff to provide the service	0.0	0.0	0.0	0.0	0.0	19.0	32.1	38.2	33.5
Lack of equipment for the provision of contraceptive	0.0	0.0	0.0	0.0	0.0	21.9	6.7	47.1	41.0
Other (specify)	7.0	2.0	12.5	39.2	2.9	3.4	1.9	2.9	0.5
Total	100	100	100	100	100	100	100	100	100

3.3 Availability of Maternal and RH Medicines

Maternal and Reproductive health medicines are important elements in ensuring that mothers and babies are treated according to the recommended treatment guidelines to reduce both maternal and child morbidity and mortality to achieve the country target indicators. The 2015 KHFA assessed the availability of seven maternal and reproductive health medicines (including the 2 essential/mandatory – Magnesium Sulphate and Oxytocin) from the following seventeen lifesaving maternal and reproductive health medicines in the WHO list.; Ampicillin, Azithromycin or Erythromycin, Benzathine penicillin, Betamethasone or Dexamethasone, Calcium gluconate, Cefixime or Ceftriaxone, Gentamicin, Hydralazine, Magnesium Sulphate, Methyl dopa, Metronidazole, Mifepristone, Misoprostol, Nifedipine, Oxytocin, Sodium lactate or Sodium chloride, and Tetanus toxoid. Alternate medicines means either of the two medicines is counted as one.

3.3.1 Maternal and RH medicines available by types of facilities

In terms of availability of maternal and reproductive health medicines (including two essential maternal and reproductive lifesaving medicines), 62 percent of the facilities have all the seven while 38 percent do not have all the seven (including two essential) medicines as shown in Table 3.3.1. In terms of level of care, all tertiary level care facilities and over 90 percent of secondary level care facilities offer seven (including 2 essential) lifesaving medicines.

Table 3.3.1: Percentage distribution of SDPs with seven (including two essential) life-saving maternal/reproductive health medicines available by type of facility

Type of Facility	Percentage		
	Seven (including 2 essential) life-saving maternal/reproductive health medicines available	Seven (including 2 essential) life-saving maternal/ reproductive health medicines not available	Total
Primary Level Care	59	41	100
Secondary Level Care	91	9	100
Tertiary Level Care	100	0	100
Total	62	38	100

3.3.2 Availability of seven essential life-saving maternal and RH medicines by region

The health facility survey also assessed regional distribution of service delivery points stocking seven life-saving maternal and reproductive health medicines. As shown on table 3.3.2, all regions except Western had more than half of the SDPs having seven (including 2 essential) life-saving maternal and reproductive health medicines. North Eastern region had all the facilities offering seven (including 2 essential) life-saving maternal and reproductive health medicines.

Table 3.3.2: Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by Region

Region	Percentage		
	Seven (including 2 essential) life-saving maternal/reproductive health medicines available	Seven (including 2 essential) life-saving maternal/ reproductive health medicines not available	Total
Coast	67	33	100
North Eastern	100	0	100
Eastern	63	37	100
Central	59	41	100
Rift Valley	61	39	100
Western	46	54	100
Nyanza	63	37	100
Nairobi	56	44	100
Total	62	38	100

In terms of rural-urban divide, according to Table 3.3.3, 58 percent of SDPs in the urban areas compared to 64 percent of those in the rural areas stocked the seven life-saving maternal and reproductive health medicines, including the two essential medicines.

Table 3.3.3: Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by residence

Residence	Percentage		
	Seven (including two essential) life-saving maternal/reproductive health medicines available	Seven (including two essential) life-saving maternal/reproductive health medicines not available	Total
Urban	58	42	100
Rural	64	36	100
Total	62	38	100

Service delivery points were also assessed on the availability of the seven lifesaving medicines based on their ownership. Table 3.3.4 shows that two-thirds of government and FBO owned facilities offer seven life-saving maternal and reproductive health medicines, including the 2 essential drugs. Among the NGO and private owned facilities, 57% and 45% respectively offer the seven medicines.

Table 3.3.4: Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by management of facility

Management of facility	Percentage		
	Seven (including two essential) life-saving maternal/reproductive health medicines available	Seven (including two essential) life-saving maternal/reproductive health medicines not available	Total
Government	66.7	33.3	100
Private	45.0	55.0	100
FBO	67.5	32.5	100
NGO	57.1	42.9	100
Total	62.4	37.6	100

Service Delivery Points were also assessed on the availability of seven lifesaving medicines based on their distance from the warehouse that supplies them. Based on the results in Table 3.3.5, there does not seem to be a clear pattern between the availability of the seven lifesaving medicines at the SDP and its distance from the warehouse/ source of supply.

Table 3.3.5: Percentage distribution of service delivery points with seven (including two essential) life-saving maternal/reproductive health medicines available by distance from nearest warehouse/source of supplies

Distance from nearest warehouse/source of supplies (in Km)	Percentage		
	Seven (including two essential) life-saving maternal/reproductive health medicines available	Seven (including two essential) life-saving maternal/reproductive health medicines not available	Total
0-4	58	42	100
5-9	72	28	100
10-14	44	56	100
15-19	67	33	100
20-24	67	33	100
25-29	67	33	100
30-35	50	50	100
35-39	100	0	100
40-45	33	67	100
45-49	0	0	0
50 and over	66	34	100
Total	63	37	100

3.3.3 Reasons for not stocking certain lifesaving maternal and RH medicines

Overall, the main reason given for not stocking all the required seven maternal and reproductive health medicines is the delays on the part of the warehouse/supplier as shown in Table 3.3.6. The delay on the part of the supplier affected mainly Gentamicin (81%), Cefixime/Ceftriaxone and Metronidazole both at 69 percent and Azithromycin/ Erythromycin at 60 percent. Delays by the SDP to request for supply of medicines and insufficient supply of the medicines are the other main reasons cited by the SDPs for not stocking some of the maternal and reproductive health medicines.

Table 3.3.6 Percentage distribution of main reasons why SDPs are not offering some of the maternal and reproductive health lifesaving medicines

Main reasons why the SDP does not offer maternal/RH medicines yet the SDP is supposed/expected to offer medicines according to the guidelines	Ampicillin	Azithromycin/ Erythromycin	Benzathine Penicillin	Betamethasone/ Dexamethasone	Ca Gluconate	Cefixime/ Ceftriaxone	Gentamicin	Hydralazine	magnesium sulphate	Methyl Dopa	Metronidazole	Mifepristone	Misoprostol	Nifedipine	Oxytocin	Sodium Lactate/ Sodium Chloride	Tetanus toxoid
Delays on the part of the main source to re-supply the medicine	55.6	59.8	32.4	47.0	41.3	68.6	80.7	38.9	44.6	40.5	69.3	22.8	27.7	40.0	49.1	54.1	211.6
Delays by the SDP to request for supply of the medicine	26.2	26.8	56.1	33.6	38.5	18.3	8.0	36.4	39.9	30.1	9.7	43.7	44.8	42.6	20.8	41.3	19.7
The medicine is not available in the market	2.1	0.0	0.0	1.5	1.3	0.0	0.0	0.5	1.8	4.4	0.0	4.7	2.0	0.0	0.0	0.0	0.0
Low or no client demand for the medicine	2.5	3.2	2.0	2.0	7.6	0.5	3.8	14.3	7.4	14.2	0.0	15.0	6.3	8.4	1.1	0.0	0.0
No train staff to provide the medicine	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.2	0.0	0.0	0.0	6.3	5.8	0.6	0.0	0.0	0.0
Insufficient supply for the medicine	10.9	10.2	7.9	10.1	5.8	11.0	7.3	2.0	4.3	8.2	20.8	1.9	4.9	5.3	26.6	0.0	7.5
Other (specify)	2.7	0.1	1.5	6.0	5.2	1.6	0.2	7.7	2.0	2.6	0.2	5.6	8.6	3.1	2.4	4.6	511.2
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

3.4 Incidence of ‘No Stockout’ of Modern Contraceptives

The goal of the RH commodity security strategy is to ensure “uninterrupted, accessible and affordable supply of RH commodities to all people that need them, whenever and wherever they need them”. This requires proper logistics management to ensure adequate supply of commodities in the respective sites. It also requires capacity building of the various stakeholders to be able to forecast the supply of commodities to accommodate provision of relevant supplies at each service provision site.

‘No Stockout’ refers to a situation in which a family planning service delivery facility/Service Delivery Point (SDP) does not run out of supplies of any one or more of the modern methods of contraceptives that the SDP is expected/supposed to provide to clients in line with national guidelines and protocols at any point in time over the last 3 months. Therefore a ‘stockout’ is occasioned by an event where the requirement of any one or more of the modern methods of contraceptives cannot be fulfilled from the current inventory.

3.4.1 ‘No-Stockout’ in the last three (3) months

The integrated Family Planning Performance Standards Assessment Tool requires that among other things, a health facility has sufficient provisions available for three months of operation. The 2015 KHFA therefore sought to establish the prevailing scenario with regard to ‘No Stockout’ in SDPs at different levels. The sections below presents the findings from the assessment.

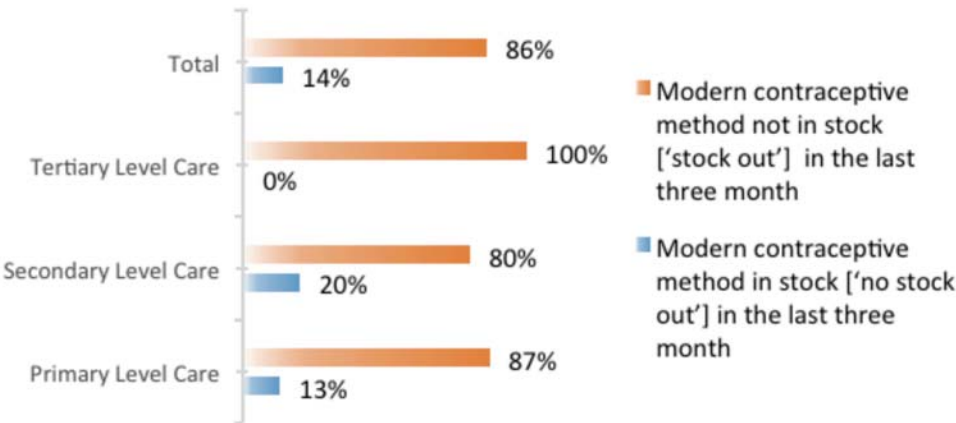


Figure: 3.4.1: Percentage distribution of service delivery points with ‘no stockout’ of a modern contraceptive method in the last three months by type of facility

Figure 3.4.1 shows that in the primary level facilities, about 1 in every 10 had 'no stockout' of any modern method during the three months preceding the survey. Among the secondary level care SDPs, one (1) in every five (5) had 'no stockout' of any modern method while all tertiary facilities had stockout of at least one modern method in the last three months.

The 2015 KHFA data was further analysed to provide an indication of the distribution of SDPs with ‘no stockout’ in the last three months across all the eight (8) regions in Kenya. This is important to stakeholders in the Family Planning Program implementation as it highlights regional disparities in contraceptive commodity security and can facilitate informed decision making.

Table 3.4.1: Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by Administrative Unit (Region)

Administrative Unit (Region)	Percentage		
	Modern contraceptive method in stock ['no stockout'] in the last three month	Modern contraceptive method not in stock ['stockout'] in the last three month	Total
Coast	11	89	100
North Eastern	25	75	100
Eastern	20	80	100
Central	11	89	100
Rift Valley	8	92	100
Western	30	70	100
Nyanza	15	85	100
Nairobi	6	94	100
Total	14	86	100

Table 3.4.1 shows that over 80 percent of the health facilities experienced stock-out of at least one FP commodity in the preceding 3 months. Nairobi and Rift Valley regions had the least no-stockout at 6 and 8 percent respectively. Western Region leads with 30 percent of its SDPs reporting 'no stockout' in the three months before the survey. The results show that only three regions, namely Eastern, North Eastern and Western had at least 20 percent of SDPs with 'no stockout' three months before the survey.

The data collected in the KHFA survey, was also used to determine the differences in 'no stockout' levels between rural and urban residences. This is important for planning/programming for contraceptive commodity security in urban and rural areas.

Table 3.4.2: Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by urban/rural residence

Residence	Percentage		
	Modern contraceptive method in stock ['no stockout'] in the last three month	Modern contraceptive method not in stock ['stockout'] in the last three month	Total
Urban	12	88	100
Rural	15	85	100
Total	14	86	100

In the three months preceding the survey, as shown in Table 3.4.2, only 12 percent and 15 percent of health facilities in the urban and rural areas respectively did not experience stock-out of any commodity.

The Commodity Security Strategy recommends that FP forecasts should include commodity requirements for both public and non-public sectors. The findings of this assessment provide an indication of progress made towards achieving contraceptive commodity security in both public and non-public health sectors.

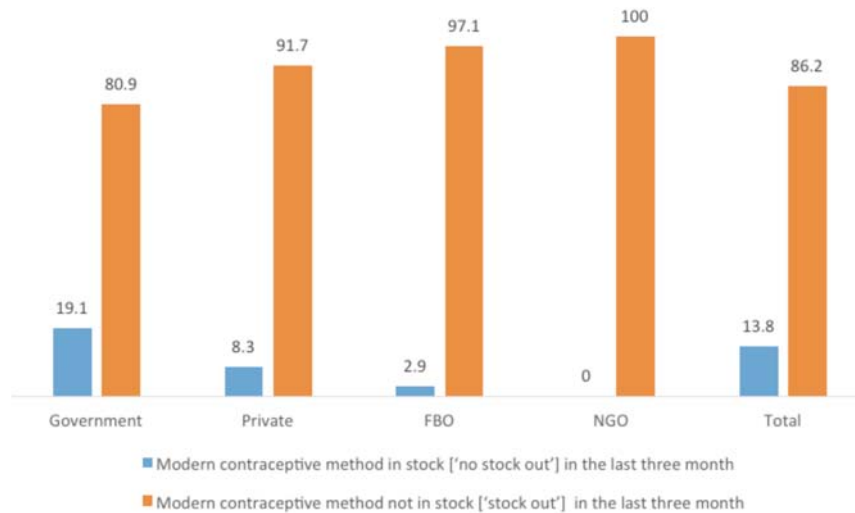


Figure 3.4.2: Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by management of facility

Figure 3.4.2 shows that about one in every five Government SDPs reported 'no stockout' of modern contraceptive methods in the three months preceding the survey. Over the same period, all NGO-owned SDPs had stockouts while about 1 in every 10 of the Private SDPs reported 'no stockout'. Less than 3 percent of the FBO facilities reported no stockout over the 3 months.

The distance from the SDPs to the nearest warehouse/source of supplies is important as it affects the time taken to deliver supplies. It would be expected that SDPs close to a warehouse/source of supply have relatively higher 'no stockout' compared to those far away.

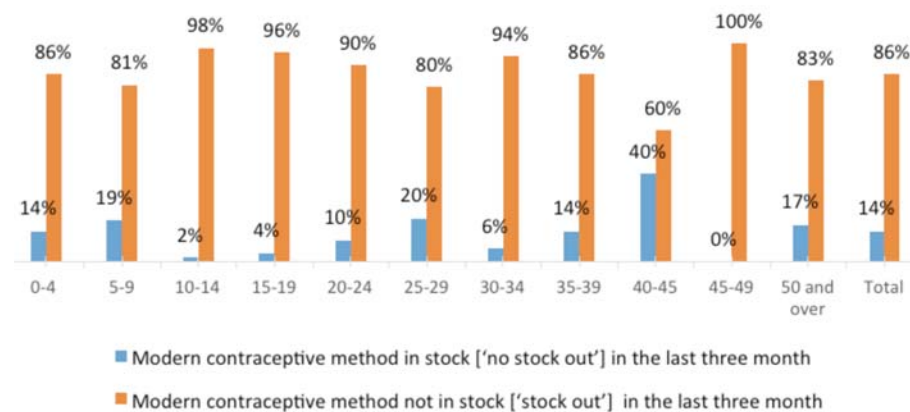


Figure 3.4.3: Percentage distribution of SDPs with 'no stockout' of a modern contraceptive method in the last three months by distance from nearest warehouse/source of supplies

Overall, the SDPs assessed were located at distances ranging within 4 km to over 50 km from the nearest warehouse/source of supply. Figure 3.4.3 shows that only 14 percent of facilities within 4 km from a warehouse/source of supply, reported 'no stockout' in 3 months before the survey compared to 17 percent of SDPs located more than 50 km away from the nearest warehouse. Furthermore, only 2 percent of SDPs within a radius of 10 to 14 km have 'no stockout' compared to 40 percent of SDPs that are 40 to 45 km away. The findings show no clear pattern relating SDPs' stock levels to their distance from the nearest warehouse. SDPs close to a Warehouse did not necessarily have 'no stockout' of modern contraceptive.

3.4.2 'No-Stockout' at time of Survey

Table 3.4.3 Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by type of facility

Type of Facility	Percentage		
	Modern contraceptive method in stock at the time of the survey ['no stockout']	Modern contraceptive method not in stock at the time of the survey ['stockout']	Total
Primary Level Care	18	82	100
Secondary Level Care	30	70	100
Tertiary Level Care	50	50	100
Total	19	81	100

Analysis of 'no stockout' by type of facility, as shown in Table 3.4.3, indicate that at the time of survey, half of the tertiary level care facilities reported 'no stockout'. Eighteen percent and 30 percent of the primary and secondary SDPs reported 'no stockout' on the day of the survey respectively. At the time of the survey 81 percent of the health facilities were missing at least one commodity. Most affected were the primary health facilities.

Table 3.4.4: Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by Administrative Unit (Region)

Administrative Unit (Region)	Person Responsible for Ordering Medical Supplies (Percentage)		
	Modern contraceptive method not in stock at the time of the survey ['stockout']	Modern contraceptive method in stock at the time of the survey ['no stockout']	Total
Coast	22	78	100
North Eastern	14	86	100
Eastern	24	76	100
Central	16	84	100
Rift Valley	14	86	100
Western	31	69	100
Nyanza	18	82	100
Nairobi	17	83	100
Total	19	81	100

Findings presented in Table 3.4.4 show that at the time of the survey, the Rift Valley and North Eastern regions reported the lowest percentage of SDPs (14%) with 'no stockout', while the Western region had the highest proportion with about one third of its facilities reporting 'no stockout'. In three regions, namely, Coast, Eastern and Western regions more than 20 percent of the facilities had 'no stockout'. Compared to three months preceding the survey, Nairobi recorded improved levels with 17 percent of SDPs reporting 'no stockout' at the time of the survey.

Table 3.4.5: Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by urban/rural residence

Residence	Percentage		
	Modern contraceptive method in stock at the time of the survey ['no stockout']	Modern contraceptive method not in stock at the time of the survey ['stockout']	Total
Urban	20	80	100
Rural	18	82	100
Total	19	81	100

Table 3.4.5 shows that on the day of the survey, 20 percent of the SDPs in urban areas compared to 18 percent in rural areas reported 'no stockout'. Although the urban SDPs showed improved 'no stockout' levels at the time of survey compared to 3 months preceding the survey, the results generally show little variation of 'no stockout' between urban and rural residences.

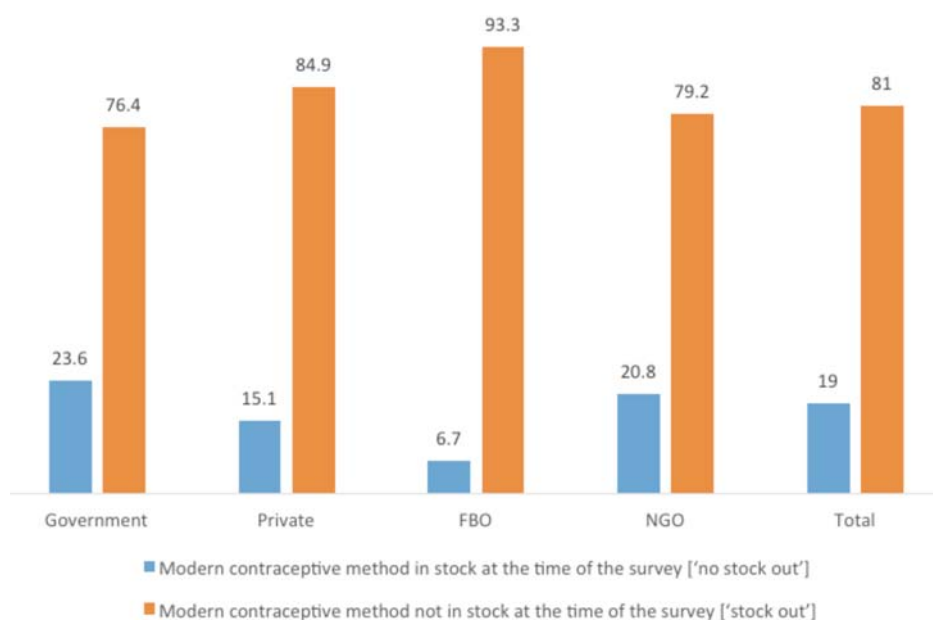


Figure 3.4.4: Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by management of facility

Figure 3.4.4, shows that 24 percent of Government SDPs, 21 percent of NGO-owned SDPs, and 15 percent of privately managed SDPs reported 'no stockout' on the day of the survey. Less than 7 percent of FBO facilities reported no stockout on the day of the survey. The findings show that all facility types recorded an improvement in the 'no stockout' levels at the time of the survey compared to three months prior to the survey.

Table 3.4.6: Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by distance from nearest warehouse/source of supplies

Distance from nearest warehouse/ source of supplies (in km)	Percentage		
	Modern contraceptive method in stock at the time of the survey ['no stockout']	Modern contraceptive method not in stock at the time of the survey ['stockout']	Total
0-4	18	82	100
5-9	17	83	100
10-14	2	98	100
15-19	29	71	100
20-24	12	88	100
25-29	27	73	100
30-35	10	90	100
35-39	17	83	100
40-45	46	54	100
45-49	0	100	100
50 and over	23	77	100
Total	19	81	100

Table 3.4.6 shows that only 18 percent of facilities within 4 km from a warehouse/source of supply reported 'no stockout' compared to 23 percent of SDP located over 50 km away. Similarly, 2 percent of SDP within a radius of 10 to 14 km had no stockout compared to 46 percent of SDP located 40 to 45 km away from the nearest warehouse. These findings present no clear pattern of relationship between SDPs distance from nearest warehouse and 'no stockout' levels.

3.4.3 Reason for Stockout

Table 3.4.7 provides the main reasons for stockouts for each modern contraceptive. An important reason for stockouts of all modern FP methods, except female and male sterilization, is delays on the part of the main source to re-supply contraceptives to the SDP. The delays in re-supply emerge as the main cause for lack of injectables (67%), emergency contraception (56%), male condoms (54%) and oral contraception (47%). On the other hand, scarcity of female condoms (40%), female sterilization (33%), vasectomy (33%), implants (25%) and IUDs (25%) is largely due to low demand. However, lack of trained staff on procedures such as female sterilization, male sterilization, and IUD insertion has contributed to low service availability at SDPs. To a lesser extent, lack of equipment for implants (9%) and IUD (5%) insertion contributes to low service availability.

Table 3.4.7: Reason for Stockout by Type of FP Method

Reason	Male condom	Female condom	Oral contraception	Injectable	Emergency contraception	IUDs	Implant	Female sterilization	Male sterilization
Delay to resupply	53.7	32.9	46.8	67.2	56.3	21.8	27.4	0.8	0.8
Delay to request	13.5	15.5	20.5	5.7	13.8	11.6	13.2	2.2	2.2
No Contraceptives	7.0	8.8	8.2	13.9	2.2	6.6	4.1	0.0	0.0
Low demand	21.2	39.5	17.3	5.4	19.6	24.5	25.3	32.8	33.1
Insufficient supply	1.5	1.7	2.8	7.6	0.1	14.5	17.5	26.7	26.6
Other (specify)	3.1	1.7	4.4	0.2	1.9	5.5	2.5	8.2	8.0
No trained staff	0.0	0.0	0.0		6.1	10.2	1.2	29.3	29.3
Lack of equipment	0.0	0.0	0.0	0.0	0.0	5.3	8.8	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.1	100.0	100.0	100.0

Overall, the assessment shows that an average of 14 percent of SDPs had ‘no stockout’ of modern contraceptives in the three months preceding the survey and 19 percent at the time of the survey. This is quite low to support the achievement of the goal of the RH commodity security strategy. There is need for a deliberate effort to improve the ‘no stockout’ levels to achieve the goal and guarantee of uninterrupted supply of RH commodities to all people that need them, whenever and wherever they need them.

3.5 Supply Chain, including Cold Chain

An efficient logistics infrastructure at all stages of the pharmaceutical supply chain is important in ensuring the quality, security and efficacy of the drugs. One of the policy objectives of the Sessional Paper on National Pharmaceutical Policy, 2010 is to ensure continuous availability of safe and effective essential medicines especially in the public sector. In line with this policy, the Health Sector Strategic and Investment Plan (KHSSP) 2013-2017 also identifies improvement of the supply chain efficiency as one of the priority areas aimed at ensuring an effective and reliable drug procurement, distribution and storage systems. Drug supply channels are varied and the Pharmaceutical Policy affirms the importance of stakeholder involvement in the pharmaceutical sector. The network of supply chain management involves the public sector, NGOs, development partners and private organisations. The Kenya Medical Supplies Authority (KEMSA) is the government body mandated by law to procure, warehouse and distribute drugs and medical supplies for prescribed public health programs and is the largest supplier of medicines to public health facilities in the country. To increase efficiency, KEMSA has established regional warehouses in 10 regions namely Mombasa, Garissa, Meru, Nyeri, Nakuru, Eldoret, Kisumu, Kakamega and Nairobi.

This chapter presents findings on the persons responsible for ordering the supplies, frequency and transportation of supplies and storage including use of cold chains.

3.5.1 Resupply of medical supplies

The 2015 KHFA sought to identify the main person designated for ordering medical supplies at facility level and the findings are presented in Figures 3.5.1 and Tables 3.5.1 (a and b) and 3.5.2. Overall, nurses make the orders for the medicines in over 60 percent of the facilities, followed by clinical officers in 17 percent

of the facilities and pharmacists in 15 percent of the facilities. However, as Figure 3.5.1 shows, in secondary and tertiary level facilities, the pattern is fairly different whereby the pharmacists are the ones responsible in 89 and 100 percent of these facilities respectively. This is explained by the relatively well-established pharmacy units in the secondary and tertiary level facilities as opposed to the primary level facilities where the pharmacy sections are not distinct and pharmaceutical personnel are scarcely available.

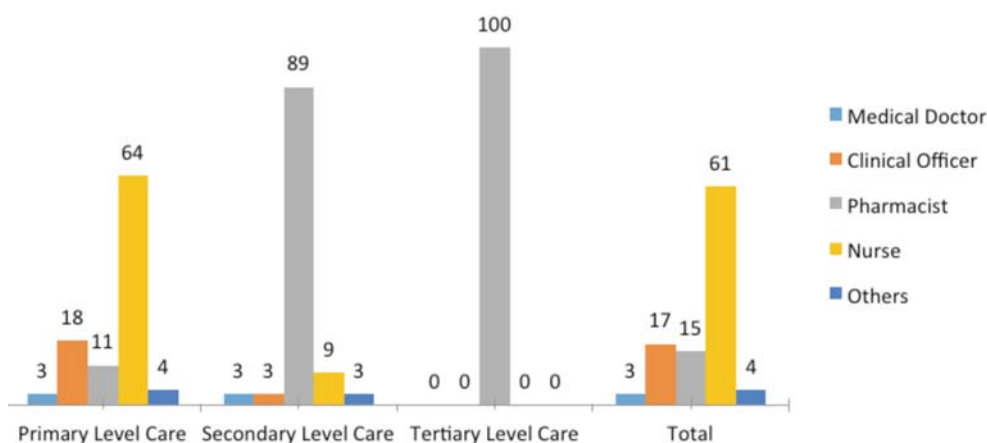


Figure 3.5.1: Percentage distribution of SDPs with persons responsible for ordering medical supplies by type of SDPs

Table 3.5.1a: Percentage distribution of SDPs with persons responsible for ordering medical supplies by Region

Administrative Unit (Region)	Person Responsible for Odering Medical Supplies (Percentage)					Total
	Medical Doctor	Clinical Officer	Pharmacist	Nurse	Others	
Coast	5	25	17	47	8	100
North Eastern	0	0	42	58	0	100
Eastern	0	19	13	65	3	100
Central	8	9	9	70	4	100
Rift Valley	4	19	16	59	2	100
Western	0	24	15	61	0	100
Nyanza	1	8	22	69	0	100
Nairobi	0	29	9	53	10	100
Total	3	17	15	61	4	100

The pattern of making orders for medical supplies at regional level resembles the national situation across all the regions as Table 3.5.1b shows. This can be explained by the fact that the majority of the health facilities are primary-level, hence the nurses are mainly the ones making the orders. There are observed variations among the regions with, for instance, North Eastern recording that no orders are made by clinical officers, a situation that is unique to the region. In the Nairobi and Coast regions, which are the major cities, there are slightly higher proportion of orders made by persons outside the medical field, probably due to the high number of private clinics where orders are more likely to be made by the management.

Table 3.5.1b: Percentage distribution of SDPs with persons responsible for ordering medical supplies by urban/rural residence

Residence	Percentage					Total
	Medical Doctor	Clinical Officer	Pharmacist	Nurse	Others	
Urban	6	26	20	41	7	100
Rural	2	12	13	72	2	100
Total	3	17	15	61	4	100

With regard to residence, Table 3.5.1b shows that the situation is similar to that at the national level as over 70 percent of the facilities in rural areas make orders through nurses. In urban areas, nurses form the highest percentage (41%) of the personnel making orders. Urban areas have more facilities (20%) making orders through pharmacists than the ones in rural areas (13%). The situation is almost similar for orders made by clinical officers and doctors since there is higher concentration of these staff in urban areas compared to rural areas.

Table 3.5.2: Percentage distribution of SDPs with persons responsible for ordering medical supplies by management of facility

Management of facility	Percentage					Total
	Medical Doctor	Clinical Officer	Pharmacist	Nurse	Others	
Government	1.2	9.6	16.8	72.0	0.3	100
Private	6.4	30.3	15.1	43.6	4.6	100
FBO	1.4	12.5	12.5	59.7	13.9	100
NGO	0.0	14.3	7.1	71.4	7.1	100
Total	3.0	17.2	15.3	60.9	3.6	100

Table 3.5.2 shows that in over two-thirds of government- and NGO-owned facilities, nurses are responsible for ordering medical supplies. In FBO (60%) and privately (44%) owned facilities, nurses are also the ones who are mainly responsible for making these orders. Clinical officers are responsible for making medical supplies orders in 30 percent of the private facilities while in 17 percent of Government facilities, pharmacists are the ones responsible. Private facilities have the highest proportion of SDPs where the responsible person is a medical doctor.

The respondents were required to give the procedure for determining re-supplies for contraceptives at the SDP. The questions sought to know whether it is determined by staff member(s) within the facility or by institution/warehouse that re-supplies them or any other method. The results are shown in Table 3.5.3, 3.5.4, 3.5.5 and 3.5.6.

Table 3.5.3: How re-supply is quantified by type of SDPs

Type of Facility	Percentage			
	By staff member of the SDP	By institution or warehouse responsible for re-supply	Others	Total
Primary Level Care	76.0	8.0	15	100
Secondary Level Care	91.0	3.0	6	100
Tertiary Level Care	100.0	0	0	100
Total	76.8	7.8	15.4	100

Generally, re-supply in health facilities is conducted by a staff member of the facility in 3 out of 4 of the facilities while the institution or warehouse responsible for re-supply is responsible for 8 percent as indicated in Table 3.5.3, 3.5.4, 3.5.5 and 3.5.6.

According to Table 3.5.3, at tertiary-level facilities, quantification of orders is entirely the prerogative of staff members of the facilities. The primary- and secondary-level facilities' mode of quantification of re-supply is different with 91 percent of the secondary level facilities using staff members of the facility and 76 percent of primary level facilities using the same method. On the other side, primary-level facilities recorded a higher percentage (15%) of facilities using institutions or warehouses for quantification. It can therefore be easily deduced that the higher the level of facility, the more likely it is to use staff members to quantify orders.

Table 3.5.4: How re-supply is quantified by Region

Region	Percentage			
	By staff member of the SDP	By institution or warehouse responsible for re-supply	Others	Total
Coast	87.7	0.0	12.3	100
North Eastern	60.0	4.0	36.0	100
Eastern	92.4	4.2	3.4	100
Central	88.2	3.0	8.8	100
Rift Valley	67.7	11.8	20.5	100
Western	56.1	41.5	2.4	100
Nyanza	87.5	4.2	8.3	100
Nairobi	48.3	3.4	48.3	100
Total	76.9	7.9	15.2	100

Quantification of resupplies across the regions closely resembles the national level situation but with moderate variations as indicated in Table 3.5.4. From the results, it is observed that Nairobi recorded the lowest percentage (48%) of facilities making quantification by staff members while Eastern has the highest (92%). At the same time, Nairobi recorded the highest percentage (48%) of facilities using other means followed by North Eastern (36%). The Western region has the highest (42%) of facilities where quantification of resupplies was done by institution or warehouse responsible for resupply. Under this modality, all other regions recorded below 12 percent with the Coast region having no facility using the supplier.

Table 3.5.5: How re-supply is quantified by urban/rural residence

Residence	Percentage			
	By staff member of the SDP	By institution or warehouse responsible for re-supply	Others	Total
Urban	69.9	3.5	26.6	100
Rural	80.7	10.0	9.3	100
Total	76.9	7.7	15.4	100

The survey revealed that more (81%) rural facilities use staff members to quantify supplies compared to the urban facilities (70%) as shown in Table 3.5.5. This is expected since there are more private facilities in the urban localities which are likely to use other means such as management or individual operators. This is confirmed by the survey results showing that 27 percent of the urban facilities use other channels as opposed to 9 percent of the rural based facilities which are mainly government-managed.

Table 3.5.6: How re-supply is quantified by management of facility

Management of facility	Percentage			
	By staff member of the SDP	By institution or warehouse responsible for re-supply	Others	Total
Government	86.0	10.6	3.4	100
Private	66.8	3.7	29.4	100
FBO	68.1	7.2	24.7	100
NGO	70.4	7.4	22.2	100
Total	76.9	7.7	15.4	100

In terms of facility management, the survey findings show that government facilities almost entirely make quantifications using staff members (86%) as shown in Table 3.5.6. At the same time, only about two-thirds of NGO, FBO and privately managed facilities have their quantifications done by a staff member. About 1 in every 10 government, NGO, and FBO-managed facilities have left the quantification of their supplies to the institution or warehouse responsible for resupply. Among the private, FBO, and NGO facilities, almost 1 in every 4 have their quantifications done by other people.

The survey sought information on the main source of routine medicines and supplies for the SDP. It is expected that the facilities may receive medicines and supplies from many sources and in such cases, the respondents were asked to state the source from which the facility gets the largest consignment. The findings are presented in Tables 3.5.7, 3.5.8, 3.5.9 and 3.5.10.

Table 3.5.7: Main source of supplies by type of SDPs

Type of Facility	Percentage						
	Central Medical stores	Regional/district warehouse	Local medical store on site	NGO	Donors	Private source	Total
Primary Level Care	31	30	1	2	8	28	100
Secondary Level Care	47	25	0	6	6	16	100
Tertiary Level Care	0	100	0	0	0	0	100
Total	32	30	1	2	8	27	100

Generally, most of the facilities received supplies from three main sources, namely, central medical stores (32%), regional/district warehouses (30%) and private sources (27%) as indicated in Table 3.5.7. All the tertiary level facilities receive medical supplies entirely from regional/district warehouse while the sources of supplies for primary and secondary levels are distributed across central medical stores, regional/district warehouse and private sources.

Table 3.5.8: Main source of supplies by Administrative Unit/Region

Administrative Unit (Region)	Percentage						
	Central Medical stores	Regional/district warehouse	Local medical store on site	NGO	Donors	Private source	Total
Coast	27	25	0	5	12	22	100
North Eastern	54	17	0	0	8	21	100
Eastern	39	8	1	3	5	45	100
Central	21	26	0	0	8	45	100
Rift Valley	27	40	1	3	11	18	100
Western	40	38	0	5	5	13	100
Nyanza	62	11	6	0	1	20	100
Nairobi	7	83	0	0	0	11	100
Total	32	30	1	2	8	27	100

As can be seen in Table 3.5.8, the main sources of medical supplies across regions are almost similar and follow the national trends. However, Nairobi is the exception where 83 percent of the supplies are sourced from the regional/district warehouse leaving only 7 percent and 11 percent to source from central medical stores and private sources respectively. The Eastern and Central regions also show a marked divergence with most of the supplies (45%) coming from private sources.

Table 3.5.9: Main source of supplies by urban/rural residence

Residence	Percentage						
	Central Medical stores	Regional/district warehouse	Local medical store on site	NGO	Donors	Private source	Total
Urban	12	31	1	4	11	41	100
Rural	43	30	2	1	6	19	100
Total	32	30	1	2	8	27	100

Table 3.5.9 shows that the place of residence has an implication on the main source of supplies. In urban areas, the main source of medical supplies is the private sector (41%) while in rural areas it is central medical stores (43%).

Table 3.5.10: Main source of supplies by management of facility

	Percentage						
	Central Medical stores	Regional/district warehouse	Local medical store on site	NGO	Donors	Private source	Total
Government	55.3	36.5	0.9	1.6	1.3	4.4	100
Private	3.6	21.4	2.3	0.9	15.5	56.4	100
FBO	16.7	30.6	0.0	1.4	15.3	36.1	100
NGO	30.8	23.1	0.0	19.2	0.0	26.9	100
Total	32.1	30.0	1.3	2.0	7.7	26.9	100

Health facility management plays a major role in determining the main source of medical supplies as shown in Table 3.5.10. The government-managed facilities are more biased towards receiving supplies from central medical stores (56%) and regional/district warehouses (37%) than any other category. Over half of private and 36% of faith-based facilities mainly source their supplies from the private sector.

3.5.2 Frequency and transportation of supplies for SDPs

The time taken between ordering medical supplies and receiving the same is critical in determining the efficiency in handling cases as they occur at the facility. The survey investigated the approximate time, on average, between ordering and receipt of products at the SDP and the findings are as presented in Tables 3.5.11, 3.5.12, 3.5.13, and 3.5.14.

Table 3.5.11: Estimated length of time between order and receiving of supplies by type of SDPs

Type of Facility	Percentage						Total
	Less than 2 weeks	More than 2 weeks but not up to 1 month	More than 1 month but not up to 2 months	More than 2 months but not up to 4 months	More than 4 months but not up to 6 months	More than 6 months	
Primary Level Care	48	9	10	20	9	3	100
Secondary Level Care	31	16	19	25	6	3	100
Tertiary Level Care	100	0	0	0	0	0	100
Total	47	10	11	20	9	3	100

The survey revealed that majority (47%) of the facilities received their orders in less than two weeks as shown in Table 3.5.11. All tertiary-level facilities receive the supplies within two weeks of ordering. This is possibly because the supplies for these facilities are all ordered from the regional level as shown earlier. Most primary-level facilities (48%) receive their orders in two weeks compared to the secondary-level facilities (31%).

Table 3.5.12: Estimated length of time between order and receiving of supplies by Administrative Unit (Region)

Administrative Unit (Region)	Percentage						Total
	Less than 2 weeks	More than 2 weeks but not up to 1 month	More than 1 month but not up to 2 months	More than 2 months but not up to 4 months	More than 4 months but not up to 6 months	More than 6 months	
Coast	45	13	12	15	5	10	100
North Eastern	16	24	12	28	20	0	100
Eastern	40	12	4	32	12	1	100
Central	76	5	10	9	0	0	100
Rift Valley	38	11	16	23	9	2	100
Western	20	12	27	15	22	5	100
Nyanza	26	6	10	29	9	10	100
Nairobi	95	0	0	5	0	0	100
Total	47	9	11	20	9	3	100

Across the regions, the time taken to receive supplies after ordering is varied as depicted in Table 3.5.12. In Nairobi, 95 percent of the facilities receive their orders in less than two weeks making it the region with the highest percentage of facilities that receive supplies in this duration. This is followed by the Central region (76%) which is closest to the capital city. The North Eastern region, which is in the Arid and Semi-Arid Land (ASAL) areas, has the lowest percentage (16%) of facilities receiving their supplies within two weeks. Conversely, the North Eastern and Western regions recorded the highest proportion of facilities that receive their supplies more than four months after ordering.

Table 3.5.13: Estimated length of time between order and receiving of supplies by urban/rural residence

Residence	Percentage						Total
	Less than 2 weeks	More than 2 weeks but not up to 1 month	More than 1 month but not up to 2 months	More than 2 months but not up to 4 months	More than 4 months but not up to 6 months	More than 6 months	
Urban	78	7	4	6	3	3	100
Rural	30	11	14	28	13	3	100
Total	47	9	11	21	9	3	100

With regard to residence, the survey revealed that the majority (78%) of the facilities in urban areas receive supplies within two weeks as indicated in Table 3.5.13, compared to 30 percent of the facilities in rural areas. Over half of the facilities in rural areas receive their supplies one month or later after ordering.

Table 3.5.14: Estimated length of time between order and receiving of supplies by management of facility

Management of facility	Percentage						Total
	Less than 2 weeks	More than 2 weeks but not up to 1 month	More than 1 month but not up to 2 months	More than 2 months but not up to 4 months	More than 4 months but not up to 6 months	More than 6 months	
Government	12.5	9.3	18.7	37.4	17.1	5.0	100
Private	89.0	8.7	.5	0.5	1.4	0.0	100
FBO	67.1	12.3	6.8	8.2	1.4	4.1	100
NGO	66.7	7.4	3.7	14.8	3.7	3.7	100
Total	47.2	9.4	10.5	20.5	9.4	3.1	100

Government facilities rarely (13%) receive supplies within two weeks of ordering as compared to private (89%), FBO (67%) and NGO (67%) managed facilities as shown in Table 3.5.14. The Table further reveals that over half of government facilities have to wait for more than one month to receive supplies compared to less than a quarter of the facilities that are managed by other authorities.

The 2015 KHFA also sought to establish how frequently the facilities are re-supplied within a year. The findings are presented in Tables 3.5.15, 3.5.16, 3.5.17, and 3.5.18.

Table 3.5.15: Frequency of re-supply by type of SDPs

Type of Facility	Percentage					Total
	Once every two weeks	Once every month	Once every three months	Once every six months	Once a year	
Primary Level Care	16	30	41	12	2	100
Secondary Level Care	12	27	49	12	0	100
Tertiary Level Care	0	100	0	0	0	100
Total	16	30	41	12	1	100

As Table 3.5.15 shows, majority (41%) of the facilities in the country receive re-supplies once every three months. However, tertiary-level facilities are all re-supplied on a monthly basis. A small proportion of primary-level facilities (2%) receive resupplies once in a year.

Table 3.5.16: Frequency of re-supply by Region

Administrative Unit (Region)	Percentage					Total
	Once every two weeks	Once every month	Once every three months	Once every six months	Once a year	
Coast	20	32	31	12	5	100
North Eastern	4	44	39	13	0	100
Eastern	23	22	41	12	2	100
Central	32	39	28	1	0	100
Rift Valley	9	26	53	12	1	100
Western	5	15	60	20	0	100
Nyanza	11	12	47	26	4	100
Nairobi	10	66	24	0	0	100
Total	16	30	41	12	1	100

As shown in Table 3.5.16, facilities in most regions receive resupplies either once every month or once every three months. The Central region recorded the highest percentage (32%) of facilities receiving re-supplies once every two weeks followed by the Eastern (23%) and Nairobi (10%) regions. The Coast region has the highest (5%) of facilities that receive resupplies once per year.

Table 3.5.17: Frequency of resupply by management of facility

Management of facility	Percentage					Total
	Once every two weeks	Once every month	Once every three months	Once every six months	Once a year	
Government	3.8	9.8	65.1	18.4	2.9	100
Private	39.0	50.7	9.4	0.9	0.0	100
FBO	0.0	45.8	40.3	13.9	0.0	100
NGO	22.2	51.9	18.5	7.4	0.0	100
Total	16.1	29.7	41.3	11.5	1.4	100

Most government facilities (65%) receive resupplies on a quarterly basis as indicated in Table 3.5.17 followed by FBO facilities (40%). Government-managed facilities have the highest percentage (18%) and (3%) of facilities that receive resupplies once in every six months and once a year respectively, compared to less than 1 percent of private facilities. Nine in every 10 private and 3 in every 4 NGO-managed facilities receive the resupplies once every month.

The respondents were asked to indicate the mode of transportation for medical supplies from source to the SDP. The findings are presented in Table 3.5.18, 3.5.19, 3.5.20, and 3.5.21.

Table 3.5.18: Responsibility for transportation of supplies by type of SDPs

Type of Facility	Percentage					
	National/Central government	Local/district administration	By the facility	Suppliers	Others	Total
Primary Level Care	5.6	8.6	32.2	52.1	1.5	100
Secondary Level Care	15.2	12.1	18.2	54.5	0.0	100
Tertiary Level Care	0.0	0.0	50.0	50.0	0.0	100
Total	6.1	8.7	31.5	52.3	1.4	100

Generally, over half (52%) of the supplies to health facilities are transported by the supplier followed by the facility itself (32%) as shown in Table 3.5.18. At tertiary-level facilities, the transport is entirely offered by either the facility (50%) or the supplier (50%). The situation is quite different in primary and secondary level facilities, where over half of the transport is by suppliers.

Table 3.5.19: Responsibility for transportation of supplies by Region

Region	Percentage					
	National/Central government	Local/district administration	By the facility	Suppliers	Others	Total
Coast	8.3	1.7	16.7	73.3	0.0	100
North Eastern	4.0	8.0	12.0	76.0	0.0	100
Eastern	0.0	6.7	30.0	63.3	0.0	100
Central	2.0	3.9	49.0	42.2	2.9	100
Rift Valley	1.2	13.4	25.0	59.1	1.2	100
Western	12.5	17.5	17.5	52.5	0.0	100
Nyanza	30.6	13.9	13.9	37.5	4.2	100
Nairobi	1.7	3.4	79.3	15.5	0.0	100
Total	5.9	8.7	31.7	52.4	1.2	100

At the regional level, the responsibility of transporting the medical supplies falls mainly on the suppliers (52%), followed by the facility (32%), as can be seen in Table 3.5.19. Nairobi has the highest (79%) proportion of facilities that get their supplies through facility transport while in all the other regions, with the exception of the Central region, the main means of transport is suppliers.

Table 3.5.20: Responsibility for transportation of supplies by urban/rural residence

Type of Facility	Percentage					
	National/Central government	Local/district administration	By the facility	Suppliers	Others	Total
Urban	1.8	1.3	49.3	45.8	1.8	100
Rural	8.2	12.6	22.0	56.3	1.0	100
Total	5.9	8.6	31.6	52.6	1.3	100

Facilities in rural areas rely more on transport by suppliers. In the urban areas most facilities mainly rely on their own transport (49%) or on suppliers (46%) as indicated in Table 3.5.20.

Table 3.5.21: Responsibility for transportation of supplies by management of facility

Type of Facility	Percentage					
	National/ Central government	Local/district admin- istration	By the facility	Suppliers	Others	Total
Government	11.5	14.0	11.2	62.9	0.3	100
Private	0.50	2.70	60.0	34.5	2.3	100
FBO	1.40	4.20	29.2	61.1	4.2	100
NGO	0.00	3.70	44.4	51.9	0.0	100
Total	6.1	8.6	31.4	52.5	1.2	100

As indicated in Table 3.5.21, over half of government, FBO, and NGO facilities rely on suppliers for the transportation of their supplies while most private facilities use their own means to transport their supplies. At least 1 in every 10 government facilities rely either on the national or local administration for the transportation of their supplies.

3.5.3 Types of cold chain available at the SDPs and source of power

The respondents were asked whether the SDP has any form of cold chain that is functioning to store medicines and other items. If there was a cold chain, the researchers were to verify the physical existence. The results are presented in Tables 3.5.22, 3.5.23, 3.5.24, and 3.5.25.

Table 3.5.22: Availability of cold chain by type of SDP

Type of Facility	Percentage			
	No cold chain available	Type of cold chain available		
		Electric Fridge	Ice box (SDP have to regularly replenish ice supply)	Other (specify)
Primary Level Care	16.9	99.2	0.6	0.2
Secondary Level Care	2.9	100.0	0.0	0.0
Tertiary Level Care	0.0	100	0.0	0.0
Total	16.1	99.2	0.6	0.2

The results in Table 3.5.22 show that 16 percent of the facilities do not have any form of operational cold chain while 84 percent were verified to have the equipment. All tertiary level facilities had operational cold chain equipment while about 17 percent of the primary health facilities lacked these equipment. For the facilities with cold chains, almost all (99%) use electric fridges. The use of other types of cold chains, such as ice boxes, is negligible.

Table 3.5.23: Availability of cold chain by Region

Administrative Unit (Region)	Percentage				
	No cold chain available	Type of cold chain available			Total
		Electric Fridge	Ice box (SDP have to regularly replenish ice supply)	Other (specify)	
Coast	15.0	100.0	0.0	0.0	100
North Eastern	16.7	100.0	0.0	0.0	100
Eastern	20.8	100.0	0.0	0.0	100
Central	23.8	100.0	0.0	0.0	100
Rift Valley	9.7	98.0	2.0	0.0	100
Western	19.5	100.0	0.0	0.0	100
Nyanza	16.4	98.4	0.0	1.6	100
Nairobi	10.3	100.0	0.0	0.0	100
Total	16.2	99.2	0.6	0.2	100

The Central region has the highest percentage of facilities (24%) with no cold chain while Rift Valley had the lowest (10%) as shown in Table 3.5.23. Among the facilities with a cold chain, almost all (99%) have electric fridge except for Rift Valley region where some facilities (2%) use ice boxes.

Table 3.5.24: Availability of cold chain by urban/rural residence

Residence	Percentage				
	No cold chain available	Type of cold chain available			Total
		Electric Fridge	Ice box (SDP have to regularly replenish ice supply)	Other (specify)	
Urban	14.1	100.0	0.0	0.0	100
Rural	17.1	98.8	0.9	0.3	100
Total	16.1	99.2	0.6	0.6	100

Rural areas have a higher proportion (17%) of facilities with no cold chain compared to urban areas (14%) as shown in Table 3.5.24.

Table 3.5.25: Availability of cold chain by management of facility

Management of facility	Percentage				
	No cold chain available	Type of cold chain available			
		Electric Fridge	Ice box (SDP have to regularly replenish ice supply)	Other (specify)	Total
Government	10.9	98.9	1.1	0.0	100
Private	29.1	99.3	0.0	0.7	100
FBO	1.4	100	0.0	0.0	100
NGO	7.4	100	0.0	0.0	100
Total	15.9	99.2	0.6	0.2	100

Table 3.5.25 shows that 3 in every 10 private facilities and 1 in every 10 government and NGO managed facilities do not have a cold chain. Electric fridges are found in nearly all facilities, irrespective of ownership. The use of ice boxes as a cold chain is only found in government facilities.

The survey sought to document the main source of power for the facilities that use electric fridges. The findings are presented in Table 3.5.26.

Table 3.5.26: Source of power for Fridges used for cold chain by type of SDP

Type of Facility	Percentage					
	Electricity from national grid	Generator plant at the SDP	Portable generator at the SDP	Kerosene/paraffin fuel	Other (specify)	Total
Primary Level Care	79.5	0.0	0.0	0.0	20.5	100
Secondary Level Care	94.0	3.0	0.0	0.0	3.0	100
Tertiary Level Care	100.0	0.0	0.0	0.0	0.0	100
Total	80.5	0.2	0.0	0.0	19.3	100

Table 3.5.26 shows that a high percentage (81%) of facilities operate their fridges using electricity from the national grid while almost 1 out of every 5 facilities use other sources of power. All tertiary-level facilities use electricity from the national grid for their fridges, compared to 80 percent of primary level facilities. In addition, 20 percent of primary-level facilities obtained power from other sources.

3.5.4 Use of logistics forms

The respondents were asked if there were logistics forms for reporting and ordering supplies in the facilities and the same were verified. The findings are presented in Tables 3.5.27, 3.5.28, 3.5.29 and 3.5.30.

Table 3.5.27: Use of logistics forms for reporting and ordering supplies by type of SDPs

Type of Facility	Percentage		
	Yes, availability of the form verified	Yes, availability of the form not observed	No, there are no logistics forms in use
Primary Level Care	70.8	11.5	17.7
Secondary Level Care	87.5	9.4	3.1
Tertiary Level Care	100.0	0.0	0.0
Total	71.7	11.4	16.9

The findings as presented in Table 3.5.27 show that over 71 percent of the facilities use logistics form when reporting and ordering supplies against 17 percent which do not use logistics forms. All tertiary facilities have the forms in place while 88 percent of secondary facilities utilize the forms. Primary-level facilities form the bulk (18%) of the facilities without the forms.

Table 3.5.28 Use of logistics forms for reporting and ordering supplies by Administrative Unit (Region)

Administrative Unit (Region)	Percentage		
	Yes, availability of the form verified	Yes, availability of the form not observed	No, there are no logistics forms in use
Coast	84.7	6.8	8.5
North Eastern	64.0	12.0	24.0
Eastern	78.3	5.0	16.7
Central	62.0	9.8	28.3
Rift Valley	63.5	17.6	18.9
Western	75.0	20.0	5.0
Nyanza	73.2	19.7	7.0
Nairobi	80.7	0.0	19.3
Total	71.6	11.6	16.9

Findings by region as shown in Table 3.5.28 reveal almost similar trends across the administrative units with notable exceptions observed in the North Eastern and Central regions where 24 percent and 28 percent of the facilities respectively have no logistics forms.

Table 3.5.29 Use of logistics forms for reporting and ordering supplies by urban/rural residence

Residence	Percentage		
	Yes, availability of the form verified	Yes, availability of the form not observed	No, there are no logistics forms in use
Urban	69.4	6.5	24.1
Rural	72.8	14.2	13.0
Total	71.6	11.5	16.8

With regard to residence, the survey revealed that the verified availability of logistics forms was almost at par between urban (69%) and rural (73%) based facilities as shown in Table 3.5.29. However, almost a quarter of the urban based SDPs had no logistics forms. This could be explained by the fact that majority of the urban based health facilities are privately owned and do not use the logistics forms.

Table 3.5.30 Use of logistics forms for reporting and ordering supplies by management of facility

Management of facility	Percentage		
	Yes, availability of the form verified	Yes, availability of the form not observed	No, there are no logistics forms in use
Government	82.3	12.9	4.7
Private	55.0	9.0	36.0
FBO	62.9	17.1	20.0
NGO	96.3	0.0	3.7
Total	71.5	11.5	17.0

The NGO-owned SDPs recorded the highest percentage that had verified availability of logistics forms (96%), followed by government facilities (82%), as indicated in Table 3.5.30. Among the FBO and private SDPs, the verified availability of the logistics forms stood at 63 and 55 percent respectively.

3.6 Staff Training and Supervision

The National Family Planning Guidelines for Service Providers (4th edition) reflects the current policy and training guidelines for providing family planning services (MoPHS, 2008 and 2010). It incorporates the most up-to-date information on medical eligibility criteria for the use of various contraceptives as published by the World Health Organization in 2009. It covers strategies to improve access to high-quality family planning services, such as training and appropriate supervision of health workers. Appropriate and comprehensive training for all service providers and health care professionals is fundamental to the provision of quality family planning services. The training provided by the Ministry of Health includes packages on long-acting reversible contraception (LARC) for pre-service, in-service curriculum and on-the-job training. In addition, the training of health care workers on family planning methods requires follow up supervision and mentorship to ensure/ascertain competency. The national health team and/or the designated mentors conduct periodic regular supervision using standard tools/guidelines.

3.6.1 Availability of staff trained to provide FP services including implants

In order for service providers to provide efficient quality of care, they have to be updated with new information and trained to have the relevant knowledge, skills and technical competence they require. The 2015 KHFA assessed whether staff working at the SDPs were trained either through pre-service or in-service training to provide family planning (FP) services. It also assessed if they were trained specifically in the insertion and removal of implant contraceptive. The assessment looked at the recent training; the last time the staff at the SDPs were trained in provision of FP services and whether the exercise included the insertion and removal of implant contraceptives.

Table 3.6.1: Percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by type of SDP

Type of Facility	Percentage of SDPs with staff trained	
	To provide FP services	For the insertion and removal of Implants
Primary Level Care	93.7	89.7
Secondary Level Care	100.0	100.0
Tertiary Level Care	100.0	100.0
Total	94.1	90.3

Table 3.6.1 shows that 9 of every 10 SDPs in Kenya have staff trained to provide FP services including the insertion and removal of implants. All secondary (100%) and tertiary level (100%) facilities have available staff trained to provide FP services, including insertion and removal of implants. Primary level facilities are less likely than other facility types to have staff trained for the insertion and removal of implants (90%).

Table 3.6.2: Percentage distribution of SDPs with staff trained to provide FP services and for the insertion and removal of Implants by Region

Administrative Unit (Region)	Percentage of SDPs with staff trained	
	To provide FP services	For the insertion and removal of Implants
Coast	93.3	83.3
North Eastern	60.0	93.8
Eastern	100.0	92.5
Central	100.0	83.3
Rift Valley	85.8	88.5
Western	100.0	97.6
Nyanza	100.0	93.2
Nairobi	100.0	100.0
Total	94.2	90.2

Results in Table 3.6.2 show that SDPs in almost all regions have staff trained to provide FP services but about 10 percent of the facilities do not have staff who are trained on insertion and removal of implants. Only 60 percent of SDPs in North Eastern and 86 percent SDPs in Rift Valley had staff trained to provide FP services. The Nairobi, Western, and North Eastern regions had the highest proportion of health facilities with health workers trained on the insertion and removal of implants at 100, 98, and 94 percent respectively.

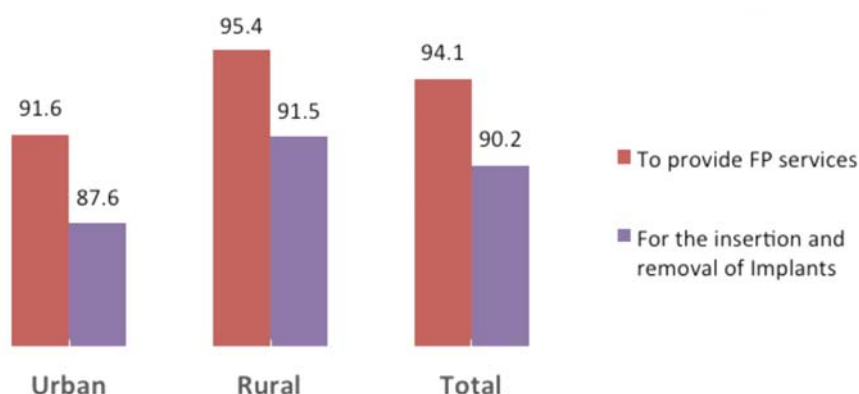


Figure 3.6.1: Percentage of SDPs with trained staff by residence

Figure 3.6.1 shows the percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by residence. Overall, SDPs in rural areas (94%) have more staff trained to provide FP services, insertion and removal of implants compared to SDPs in urban areas (90%).

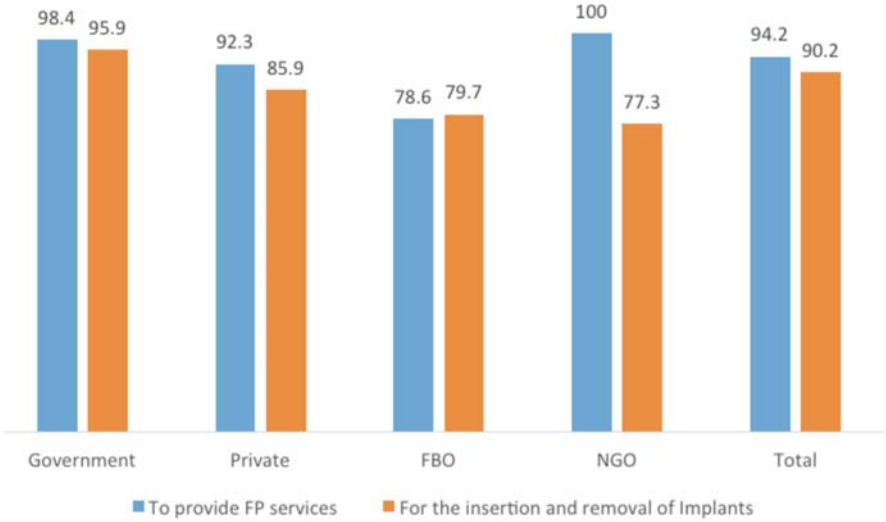


Figure 3.6.2: Percent distribution of SDPs with trained staff by facility management

Figure 3.6.2 shows the percentage distribution of health facilities with staff trained to provide FP services and for the insertion and removal of implants by management of facility. The findings show that NGO-managed facilities had the highest proportion of facilities with staff trained to provide FP services (100%) but the lowest proportion (77%) of facilities with staff trained in insertion and removal of implants, while government-managed facilities had the highest (96%) percent of facilities with staff trained in insertion and removal of implants.

3.6.2 Training of staff members for the provision of FP services including implants

As shown in Table 3.6.3, generally most of the SDPs with trained staff received their recent training for FP between two and six months ago (43%) and the training exercise in nine out of every ten of those facilities included the insertion and removal of implant contraceptive (91%). Tertiary-level facilities had the highest proportion (50%) of facilities with staff who received their training in the last two months. At all levels, the majority of the training was done between two and six months.

Table 3.6.3 Percentage distribution of the last time staff received training for FP including for provision of implants by type of Facility

Type of Facility	Most recent training for FP				Training exercise include the insertion and removal of implant contraceptive
	In the last two months	Between two and six months ago	Between six month and one year ago	More than one year ago	
Primary Level Care	22.8	42.7	11.0	23.6	90.2
Secondary Level Care	31.3	53.1	9.4	6.3	97.0
Tertiary Level Care	50.0	50.0	0.0	0.0	100.0
Total	23.2	43.2	10.9	22.7	90.5

Table 3.6.4 Percentage distribution of the last time staff received training for FP including for provision of implants by Region

Administrative Unit (Region)	Most recent training for FP				Training exercise include the insertion and removal of implant contraceptive
	In the last two months	Between two and six months ago	Between six month and one year ago	More than one year ago	
Coast	20.4	36.7	10.2	32.7	81.5
North Eastern	26.7	46.7	20.0	6.7	93.8
Eastern	15.0	30.8	14.0	40.2	94.0
Central	34.4	39.6	6.3	19.8	89.8
Rift Valley	12.4	46.3	9.9	31.4	87.4
Western	42.5	42.5	7.5	7.5	97.6
Nyanza	40.3	40.3	11.3	8.1	88.2
Nairobi	12.3	75.4	12.3	0.0	96.6
Total	23.2	43.2	10.9	22.7	90.5

Results in Table 3.6.4 show that majority of the facilities in Western (43%) and Nyanza (40%) received the most recent training for FP in the last two months. A remarkable proportion of the facilities in Nairobi (75%) compared to other regions reported to have received recent training for FP between two and six months ago including the insertion and removal of implants (97%). Facilities in Eastern, Coast and Rift Valley had most staff receiving training more than one year prior to the survey at 40, 33 and 31 percent respectively.

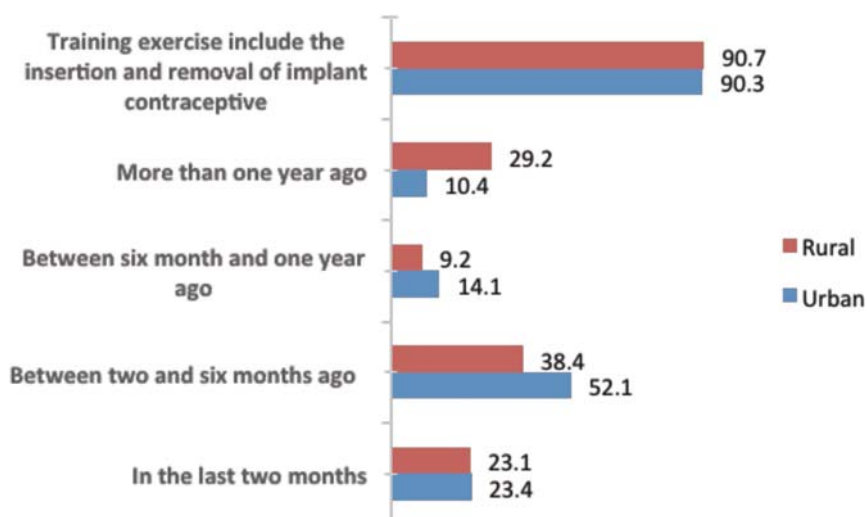


Figure 3.6.3: Percentage distribution of most recent FP training by residence

Figure 3.6.3 shows the percentage distribution of the last time staff received training for FP including for provision of implants by residence. Urban and rural (23% each) areas received the most recent training for FP, including the insertion and removal of implants, in the two months prior to the survey. However, a substantial proportion of facilities in urban areas (52%) than rural areas (38%) received their recent training for FP between two and six months prior to the survey.

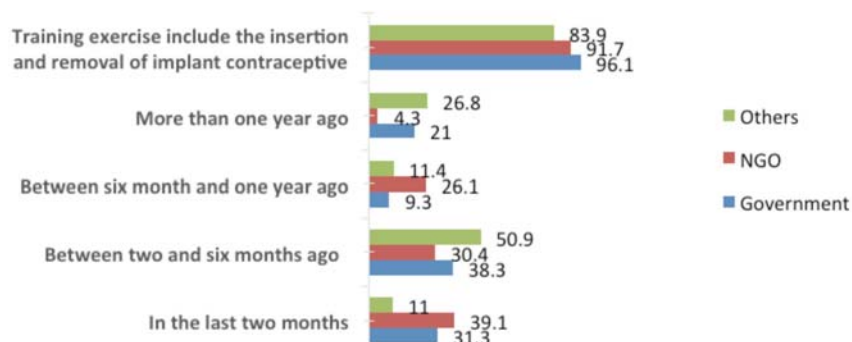


Figure 3.6.4: Percentage distribution of most recent FP training by facility management

Figure 3.6.4 shows the percentage distribution of the last time staff received training for FP including for provision of implants by management of facility. NGO-managed facilities (39%) have more staff who have received most recent training for FP compared to government facilities (31%). Majority of the facilities included training in insertion and removal of implants.

3.6.3 Time and Frequency of staff supervision

According to the National Family Planning Guidelines for Service Providers (MoPHS, 2010), staff at facility level are expected to implement standards and protocols in delivery of health services. Supervision by external authorities is important because it helps to ensure that system-wide standards and protocols are followed at the facility level and provides an opportunity to expose staff to a wider scope of ideas and relevant experiences, including on-the-job training. It can also motivate service providers, especially if the supervisor is supportive. In order to determine how well SDPs are provided with oversight and guidance, the 2015 KHFA assessed the occurrence of supervision: the last time the facility was visited by supervisory authorities in the past 12 months with respect to RH provision including FP services, the frequency: how frequently the facility received visits from supervisory authorities and what issues were included in the supervision.

Table 3.6.5: Percentage distribution of the last time the facility was supervised in the past 12 months by type of facility

Type of Facility	Last time the facility was supervised in the past 12 months				Not supervised in the past 12 month
	In less than one Month	Between one and three Months ago	Between three and six months ago	Between six month and one year ago	
Primary Level Care	26.5	35.6	14.4	10.7	12.9
Secondary Level Care	28.1	31.2	12.5	18.8	9.4
Tertiary Level Care	33.3	0.0	33.3	0.0	33.3
Total	26.7	35.2	14.4	11.0	12.8

As shown in table 3.6.5, overall, majority of the facilities in Kenya reported they were last supervised between one and three months ago (35%) during the past 12 months. In total, about 13 percent of health facilities in Kenya were not supervised in the 12 months before the survey. Facilities at tertiary level (33%) were mostly supervised less than one month before. Facilities at primary (36%) and secondary level (31%) were supervised between one and three months prior to the survey.

Table 3.6.6: Percentage distribution of the last time the facility was supervised in the past 12 months by Administrative Unit (Region)

Administrative Unit (Region)	Last time the facility was supervised in the past 12 months				Not supervised in the past 12 month
	In less than one Month	Between one and three Months ago	Between three and six months ago	Between six month and one year ago	
Coast	31.6	31.6	17.5	10.5	8.8
North Eastern	29.2	37.5	8.3	0.0	25.0
Eastern	20.2	42.0	14.3	19.3	4.2
Central	17.8	27.7	14.9	12.9	26.7
Rift Valley	26.7	35.4	11.8	10.6	15.5
Western	43.9	39.0	12.2	4.9	0.0
Nyanza	34.2	35.6	19.2	9.6	1.4
Nairobi	27.6	34.5	13.8	3.4	20.7
Total	26.7	35.3	14.2	11.0	12.8

Table 3.6.6 shows that health facilities in Western and Nyanza received supervision less than one month (44% and 34% respectively) prior to the survey and between one and three months ago (39% and 36% respectively). Nearly one quarter of facilities in Central (27%), North Eastern (25%) and Nairobi (21%) had not been supervised in the 12 months prior to the survey.

Table 3.6.7: Percentage distribution of the last time the facility was supervised in the past 12 months by residence

Residence	Last time the facility was supervised in the past 12 months				Not supervised in the past 12 month
	In less than one Month	Between one and three Months ago	Between three and six months ago	Between six month and one year ago	
Rural	23.7	33.0	13.4	12.1	17.9
Urban	28.2	36.5	14.8	10.5	10.0
Total	26.6	35.3	14.3	11.0	12.8

According to Table 3.6.7, about 28 and 37 percent of the facilities in urban areas were supervised less than one month and between one and three months before the survey respectively. About 18 percent of facilities in rural areas and 10 percent in urban areas were not supervised in the 12 months prior to the study.

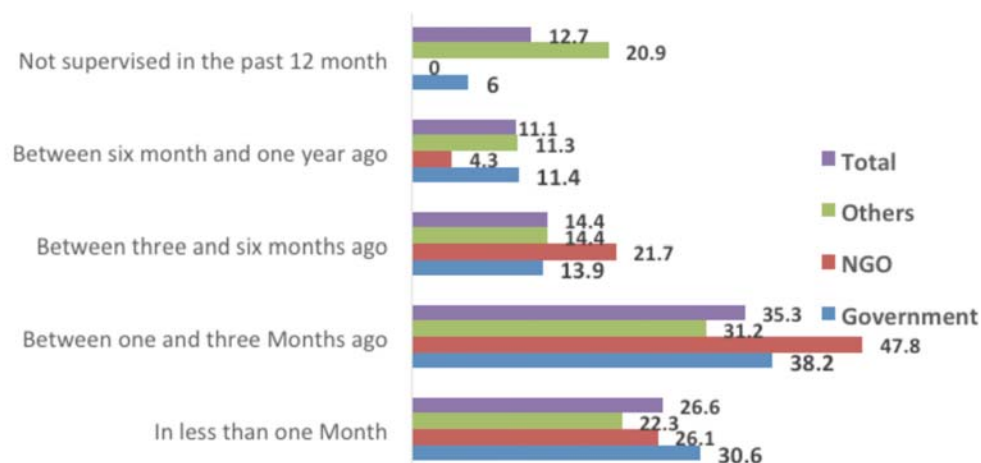


Figure 3.6.5: Percentage distribution of last time facility was supervised in the past 12 months by type of facility management

Figure 3.6.5 shows the percentage distribution of the last time the facilities were supervised in the past 12 months by management of facility. About a third of government facilities (31%) were supervised in the period of less than one month compared to 26 percent of NGO managed facilities and 22 percent of others. About half of NGO managed facilities (48%) were supervised between one and three months before the survey. Twenty-one percent of facilities managed by other authorities were not supervised in the previous 12 months.

Table 3.6.8: Percentage distribution of the frequency of supervisory visits by type of Facility

Type of Facility	Frequency of supervisory visits					Not supervised
	Weekly	Monthly	Every three months	Every six months	Once a year Never	
Primary Level Care	1	18	47	14	10	10
Secondary Level Care	3	24	36	15	12	9
Tertiary Level Care	0	0	0	0	0	100
Total	1	18	47	14	10	10

Table 3.6.8 shows that generally, most facilities in Kenya receive supervisory visits after every three months (47%). All the sampled facilities at tertiary level (100%) reported that they were not supervised in the previous 12 months. A higher proportion of primary-level facilities (47%), compared to secondary-level facilities (36%), had supervisory visits every three months.

Table 3.6.9: Percentage distribution of the frequency of supervisory visits by Region

Administrative Unit (Region)	Frequency of supervisory visits					Not supervised
	Weekly	Monthly	Every three months	Every six months	Once a year Never	
Coast	0	19	32	21	21	7
North Eastern	0	33	38	4	0	25
Eastern	0	21	51	18	8	3
Central	1	8	28	14	14	30
Rift Valley	1	12	51	7	12	10
Western	0	37	56	14	0	0
Nyanza	0	14	69	2	4	0
Nairobi	0	35	40	14	12	11
Total	1	19	47	14	10	10

According to table 3.6.9, facilities in Nyanza (69%) are more likely than facilities in other regions to receive supervisory visits every three months. Conversely, facilities in Coast (32%) are less likely than other regions to receive supervisory visits every three months. Notably, facilities in Western (37%) and Nairobi (35%) are more likely than facilities in other regions to receive monthly supervisory visits.

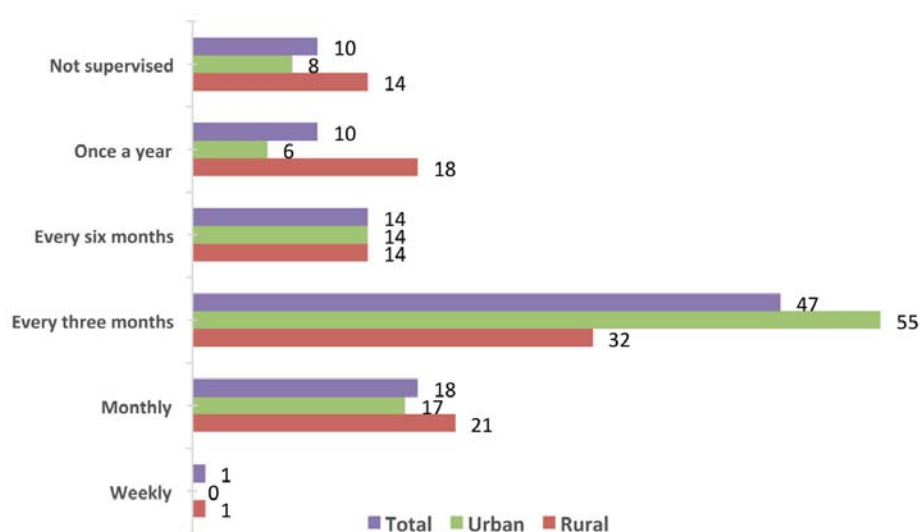


Figure 3.6.6: Frequency of supervisory visits by residence

Figure 3.6.6 shows the percentage distribution of the frequency of supervisory visits by residence. More than half of the facilities in urban areas (55%) received supervisory visits every three months compared to only one-third of facilities in rural areas (32%). Fourteen percent of facilities in rural areas were not supervised in the past 12 months compared to 8 percent of the urban facilities.

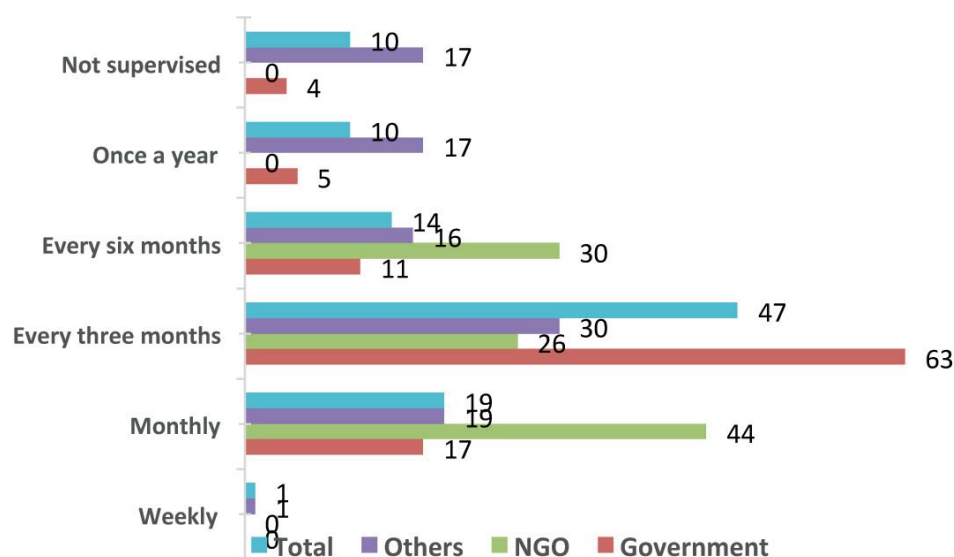


Figure 3.6.7: Frequency of supervisory visits by facility management

Figure 3.6.7 shows the percentage distribution of the frequency of supervisory visits by management. About two-thirds of government facilities (63%) had supervisory visits every three months compared to only about a third of both NGO-managed facilities (26%) and other non-public (30%) facilities. NGO-managed facilities (44%) recorded a remarkable proportion of facilities receiving monthly visits compared to government (17%) and non-public (19%) facilities.

3.6.4 Issues included in staff supervision

The survey assessed whether the following issues were included in the supervision: staff clinical practices; drug stockout and expiry; staff availability and training; data completeness, quality and timely reporting; and review and use of specific guideline or job aids for reproductive health. Table 3.6.10 shows the percentage of SDPs with issues included in supervisory visits by type of SDP.

Table 3.6.10: Percentage of SDPs with issues included in supervisory visits by type of Facility

Type of Facility	Issues included in supervisory visits					
	Staff clinical practices	Drug stockout and expiry	Staff availability and training	Data completeness, quality, and timely reporting	Review use of specific guideline or job aid for reproductive health	Others
Primary Level Care	80.1	85.0	75.8	88.5	67.8	33.5
Secondary Level Care	78.8	87.9	81.8	93.8	75.0	36.4
Tertiary Level Care	50.0	50.0	50.0	100.0	50.0	0.0
Total	79.9	85.1	76.1	88.8	68.2	33.6

Table 3.6.10 shows that issues on data completeness, quality, and timely reporting (88%) were the most frequently included issues during supervision. Issues on use of specific guidelines or job aids for reproductive health (68%) were least commonly addressed in the supervisory visits.

Table 3.6.11: Percentage of SDPs with issues included in supervisory visits by Administrative Unit (Region)

Administrative Unit (Region)	Issues included in supervisory visits (Percentage)					
	Staff clinical practices	Drug stockout and expiry	Staff availability and training	Data completeness, quality, and timely reporting	Review use of specific guideline or job aid for reproductive health	Others
Coast	76.1	76.1	65.2	80.4	56.5	30.5
North Eastern	71.4	81.0	68.2	76.2	40.9	9.5
Eastern	72.6	82.1	69.5	90.5	60.6	42.6
Central	79.2	72.2	66.7	79.2	63.9	43.1
Rift Valley	80.0	85.6	79.3	86.3	65.5	29.5
Western	100.0	96.8	96.8	100.0	83.9	16.1
Nyanza	83.3	93.3	80.0	98.3	75.0	53.3
Nairobi	86.5	100.0	88.5	100.0	100.0	15.4
Total	80.1	85.1	76.1	88.7	68.2	33.5

According to Table 3.6.11, the Western, Nairobi and Nyanza regions record the highest proportion of the five categories of issues included in the supervisory visits ranging 80-100 percent on each category.

Table 3.6.12: Percentage of SDPs with issues included in supervisory visits by urban/rural residence

Residence	Frequency of supervisory visits (Percentage)					
	Staff clinical practices	Drug stockout and expiry	Staff availability and training	Data completeness, quality, and timely reporting	Review use of specific guideline or job aid for reproductive health	Others
Urban	79.1	81.2	74.3	82.1	69.1	28.8
Rural	80.7	87.3	77.1	92.7	67.7	36.4
Total	80.1	85.1	76.1	88.9	68.2	33.7

Table 3.6.12 shows that on average, more issues are covered in the supervisory visits of facilities in rural areas than urban areas. Issues on data completeness, quality and timely reporting are most frequently included in the supervisory visits, followed by drug stockout and expiry. Issues on use of specific guidelines or job aids for reproductive health are comparatively less covered during the supervisory visits.

Table 3.6.13: Percentage of issues included in supervisory visits by management of facility

Management of facility	Issues included in supervisory visits (percentage)					
	Staff clinical practices	Drug stockout and expiry	Staff availability and training	Data completeness, quality, and timely reporting	Review use of specific guideline or job aid for reproductive health	Others
Government	85.7	90.7	81.7	93.2	72.0	34.6
Private	69.3	70.5	59.0	74.2	49.1	30.9
FBO	72.5	79.7	75.4	91.4	64.3	34.3
NGO	85.2	74.1	63.0	85.2	74.1	15.4
Total	78.6	81.9	72.4	86.2	63.4	32.5

According to Table 3.6.13, the supervision of Government, Private, FBO, and NGO facilities mainly include issues on data completeness, quality and timely reporting compared to other issues. The review of guidelines for RH was the least included item during supervision irrespective of the facility managing authority. The performance of private facilities was lower across all supervision items when compared to government, NGO and FBO facilities.

3.7 Availability of Guidelines, Checklists and Job Aids

Guidelines, checklists and job aids are important tools that facilitate quality health care provision by acting as reference materials for health care workers while providing services to clients. These tools ensure that the health care worker offers quality services according to the recommended guidelines and protocols. The 2015 KHFA assessed the availability of these tools and the results are shown in Table 3.7.1.

Table 3.7.1: Percentage of SDPs with guidelines, check-lists and job aids

Characteristics	Percentage				
	Family planning guidelines (national or WHO)	Family planning check-lists and/or job-aids	ANC guidelines (national or WHO)	ANC check-lists and/or job-aids	Waste disposal guidelines
Type of Facility					
Primary Level Care	42.6	53.1	27.4	38.6	30.0
Secondary Level Care	62.5	72.7	57.6	66.7	62.5
Tertiary Level Care	100.0	100.0	50.0	100.0	100.0
Region					
Coast	33.9	36.7	23.3	28.8	31.7
North Eastern	33.3	44.0	56.0	52.0	48.0
Eastern	59.7	71.7	30.8	59.7	44.2
Central	26.5	47.5	11.2	41.2	12.9
Rift Valley	37.3	45.0	28.6	24.1	24.7
Western	65.9	70.7	53.7	67.5	38.1
Nyanza	59.5	53.4	47.9	49.3	52.8
Nairobi	36.2	66.7	9.4	21.1	22.0

Characteristics	Percentage				
	Family planning guidelines (national or WHO)	Family planning check-lists and/or job-aids	ANC guidelines (national or WHO)	ANC check-lists and/or job-aids	Waste disposal guidelines
Residence					
Urban	40.7	50.4	22.1	26.9	30.0
Rural	45.3	56.2	32.5	47.5	32.8
Management					
Government	54.4	67.7	38.9	55.3	35.2
Private	31.7	34.1	11.0	19.0	26.4
FBO	29.4	48.5	38.0	45.7	32.4
NGO	48.1	66.7	25.9	18.5	33.3
Total	43.7	54.2	29.0	40.3	31.8

3.7.1 Family planning guidelines, checklists and job aids

Family planning guidelines and checklists/job-aids were available in 44 and 54 percent of the health facilities in Kenya respectively. These documents are available in all tertiary facilities, about two-thirds of secondary facilities, and about half of the primary facilities. At the regional level, guidelines for FP were mostly available in Western (66%), Eastern (60%), and Nyanza (60%) regions while they were least available in Central (27%) region. Availability of checklists/job-aids is highest in the Eastern (72%), Western (71%), and Nairobi (76%) regions while it is lowest in Coast (37%).

Less than half of the facilities in both rural (45%) and urban (41%) areas had guidelines for FP. As for the checklists/job-aids for FP, these were available in slightly more than half of the facilities in rural (56%) and urban (50%) areas. Guidelines for FP were more available in about half of the government- and NGO-managed facilities and in less than one-third of the private and FBO facilities. The checklists/job-aids were available in 2 out of every 3 government and NGO health facilities. Only one-third of private facilities had these documents.

3.7.2 Antenatal guidelines, check-lists and job aids

Guidelines for ANC were available in less than one-third of the health facilities in the country as shown in Table 3.7.1. These guidelines were more available in secondary-level facilities (58%) compared to tertiary (50%) and primary (27%) facilities. Generally, checklists/job-aids for ANC were more widely available compared to the guidelines. All the tertiary-level facilities, 68 percent of the secondary, and 39 percent of primary facilities had checklists/job-aids for ANC.

Guidelines for ANC were available in half of the health facilities in North Eastern, Western and Nyanza regions. In the other regions, less than one-third of the facilities had these guidelines. The availability of checklists/job-aids for ANC was generally better than the availability of guidelines in the regions. Western (68%), Eastern (60%), and North Eastern (52%) regions had the highest proportion of facilities with ANC checklists/job-aids. The availability of both guidelines and checklists/job-aids was lowest in Nairobi at 9 and 21 percent respectively.

The availability of guidelines for ANC was low but much better in rural areas (33%) compared to urban areas (22%). About half of the health facilities in the rural areas had checklists/job-aids compared with slightly

over a quarter of the urban facilities. Government facilities were more likely to have guidelines (39%) and checklists/job-aids (55%) compared with NGO and other non-public health facilities.

3.7.3 Waste disposal guidelines, check-lists and job aids

Overall, Table 3.7.1 shows that 32 percent of the facilities had waste disposal guidelines. These guidelines were available in all the tertiary-level facilities, about two-thirds of secondary and one-third of primary level facilities. Regional comparison shows that Nyanza had the highest (52%) proportion of facilities with these guidelines followed by the North Eastern (48%) and Eastern (48%) regions. Nairobi (22%) and Central (13%) had the lowest proportion of facilities with guidelines for waste disposal.

In both the urban and rural areas, about one-third of the facilities had these guidelines. The situation was similar among the government, FBO and NGO facilities. Only a quarter of the private facilities had these waste disposal documents.

3.8 Use of Information Communication Technology (ICT) and Waste Disposal

The availability and quality of ICT services are growing rapidly leading to increased investments, decreased operation costs and rapid growth in technology-enabled services. The 2015 KHFA sought to examine the current use of ICT in advancing family planning/reproductive health and other health programs, and to identify the enabling conditions for further ICT use and scale-up. This section gives a description of SDPs reporting the availability of ICT, how the ICT was acquired and the main purpose for which it was used.

3.8.1 Availability of ICT and how it was acquired

Table 3.8.1: Percentage of SDPs with types of Information Communication Technology available

Characteristics	Percentage						
	Computer	Mobile phones - basic handsets	Mobile phones - smart phones	Tablets	Internet facilities – through Local Area Network (LAN)	Internet facilities – through Wi-Fi	Others
Type of Facility							
Primary Level Care	65.4	59.3	16.7	2.5	11.8	7.9	9.3
Secondary Level Care	100.0	72.7	6.1	6.1	24.2	21.2	9.1
Tertiary Level Care	100.0	50.0	0.0	0.0	50.0	50.0	0.0
Region							
Coast	76.9	53.8	25.6	0.0	15.4	20.0	0.0
North Eastern	81.8	30.0	9.1	9.1	0.0	18.2	0.0
Eastern	57.5	76.2	17.5	0.0	10.0	3.8	15.0
Central	71.4	50.8	22.2	0.0	15.9	14.3	11.1
Rift Valley	75.0	52.6	3.2	6.3	11.6	5.3	12.6
Western	48.1	65.4	3.8	0.0	3.8	0.0	7.7
Nyanza	58.8	82.4	12.0	5.9	6.0	4.0	6.0
Nairobi	82.9	45.7	37.1	5.7	40.0	25.0	0.0

Characteristics	Percentage						
	Computer	Mobile phones - basic handsets	Mobile phones - smart phones	Tablets	Internet facilities – through Local Area Network (LAN)	Internet facilities – through Wi-Fi	Others
Residence							
Urban	83.6	56.7	16.5	1.8	20.1	17.1	6.7
Rural	57.6	63.1	15.7	3.4	8.5	3.8	11.0
Management							
Government	67.0	61.0	13.7	3.8	13.2	6.0	9.3
Private	66.4	61.1	23.5	2.0	11.4	10.1	11.4
FBO	85.1	61.7	2.1	0.0	8.7	2.2	4.3
NGO	60.9	50.0	13.6	8.7	30.4	45.5	0.0
Total	68.3	60.5	15.9	2.8	13.1	9.3	9.2

Overall, about seven out of ten facilities have a computer as is shown in Table 3.8.1. Another two-thirds have mobile phones while a modest three percent make use of tablets as part of communication in improving health care service delivery. All secondary and tertiary level care facilities have computers that are used to advance health services compared to 65 percent of primary level care facilities. There were regional variations in availability of computers with facilities in Nairobi having the highest proportion of about 83 percent followed by North Eastern at 82 percent. Only 48 percent of facilities in the Western region have computers as part of their health system strengthening.

Internet and wireless communication, which is crucial in improving health information, diagnostics, and service delivery, seems to be low among SDPs assessed during the survey, with only 13 and 9 percent respectively reporting to have these facilities. Half of the tertiary health institutions have access to the internet through both a local area network and Wi-Fi connectivity. About 2 out of 5 SDPs in Nairobi have access to internet facilities and a quarter has access to Wi-Fi connectivity.

Table 3.8.2: Percentage of SDPs by how ICT was acquired

Characteristics	Percentage			
	Provided by government	Provided by proprietor of SDP	Received as Donation	Others
Type of Facility				
Primary Level Care	17.3	46.3	32.6	4.4
Secondary Level Care	42.4	36.4	30.3	9.1
Tertiary Level Care	50.0	50.0	50.0	0.0
Region				
Coast	15.4	30.8	35.9	15.4
North Eastern	18.2	45.5	54.5	0.0
Eastern	15.0	62.5	16.0	6.2
Central	28.6	59.4	9.4	1.6
Rift Valley	21.1	41.1	32.6	2.1
Western	23.1	48.1	30.8	11.5
Nyanza	8.0	33.3	64.7	4.0
Nairobi	28.6	28.6	58.3	0.0

Characteristics	Percentage			
	Provided by government	Provided by proprietor of SDP	Received as Donation	Others
Residence				
Urban	12.7	57.3	31.1	3.7
Rural	24.2	37.3	33.5	5.9
Management				
Government	40.7	16.5	47.3	5.5
Private	2.7	82.6	8.1	5.4
FBO	0.0	41.3	48.9	4.3
NGO	0.0	45.5	39.1	0.0
Total	19.4	45.5	32.5	4.8

Among the health facilities interviewed during the 2015 KHFA, about 2 out of 5 reported to have obtained the ICT from the proprietor; one-third reported to have received the ICT as part of donation, and in about 1 in 5 facilities this was provided by the government as is indicated in Table 3.8.2. Only 5 percent of the facilities reported to have acquired the ICT from other sources.

Half of all the tertiary-level care facilities report to have received the ICT from the government or a proprietor, or as part of donation. Majority of the health facilities in urban areas (57%) reported to have received the ICT from a proprietor.

Acquisition of ICT varies among the regions, with the Nairobi and Central regions each having about 29 percent of facilities that acquired ICT from government compared to only eight percent of health facilities in Nyanza. Interestingly, acquisition of ICT as part of a donation is high in Nyanza, with about 65 percent of health facilities reporting this, while it is low in Central, where only 9 percent of health facilities reported this.

Most of the government health facilities either received the ICT equipment from the government (41%) or as part of donation (48%), while privately managed facilities (73%) were provided with the ICT equipment by the proprietor.

3.8.2 Uses of ICT by SDPs

Table 3.8.3: Percentage of SDPs by main purpose for which ICT is used

Characteristics	Percentage											
	Patient registration	Facility record keeping	Individual patient records/ Electronic Medical Record	Health Insurance Claims and Reimbursement System	Mobile money cash transfers and payments	Routine communication	Awareness and demand creation activities	Supply chain management/ stock control	Health worker training	Clinical consultation (long distance communication with experts)	Others	
Type of Facility												
Primary Level Care	35.1	54.2	32.3	19.2	24.9	69.9	14.5	33.7	16.4	21.1	14.2	
Secondary Level Care	63.6	81.2	48.5	39.4	24.2	84.8	23.5	52.9	33.3	24.2	11.8	
Tertiary Level Care	100.0	100.0	100.0	50.0	50.0	100.0	50.0	100.0	50.0	50.0	0.0	
Region												
Coast	35.9	69.2	17.9	15.4	20.5	76.9	10.3	38.5	12.8	25.6	7.5	
North Eastern	45.5	72.7	27.3	18.2	0.0	54.5	0.0	36.4	0.0	0.0	9.1	
Eastern	33.8	43.8	23.8	18.8	20.0	80.0	16.3	23.8	8.8	25.0	23.5	
Central	39.7	66.7	34.9	22.2	31.7	74.6	17.5	38.1	31.7	17.5	4.8	
Rift Valley	44.2	56.8	40.0	30.5	25.3	52.6	22.9	43.2	14.6	13.7	10.2	
Western	26.9	38.5	26.9	15.4	19.2	73.1	11.5	38.5	34.6	25.9	26.9	
Nyanza	24.0	39.2	32.0	7.8	6.0	84.3	11.8	13.7	15.7	30.0	23.5	
Nairobi	51.4	88.6	65.7	28.6	65.7	74.3	13.9	62.9	22.9	28.6	5.7	
Residence												
Urban	57.9	75.6	51.8	34.1	40.9	68.3	20.1	44.5	22.0	22.0	3.0	
Rural	24.2	43.6	21.6	11.9	14.0	73.3	12.3	29.2	15.6	21.6	21.3	
Management												
Government	22.5	53.3	28.0	8.2	5.5	73.1	13.7	33.0	17.6	23.6	23.2	
Private	49.7	55.7	34.9	32.2	47.3	77.9	18.1	33.6	14.2	26.2	5.4	
FBO	42.6	59.6	39.1	31.9	25.5	55.3	10.9	53.2	17.0	8.5	12.8	
NGO	73.9	86.4	68.2	30.4	34.8	45.5	22.7	31.8	47.8	4.3	0.0	
Total	37.8	56.7	34.1	21.1	25.0	71.1	15.6	35.5	18.1	21.6	13.9	

With regard to how ICT within the health facilities is utilized, Table 3.8.3 shows that 7 out of 10 health facilities use the ICT for routine communication, while 57 percent of the health facilities make use of the ICT for facility record keeping. A modest 16 percent of the health facilities use the ICT to effectively raise awareness and as part of demand creation activities.

All the tertiary level care facilities utilize the ICT for patient registration, facility record keeping, routine communication as well as for supply chain management and stock control while half of them use ICT for health insurance claim and reimbursement system, mobile money cash transfers and payments, awareness and demand creation activities, health worker training and long distance clinical consultations.

3.8.3 Methods of waste disposal

Health-care waste management refers to all the activities from administrative level, operational systems (which includes handling), on-site and off-site treatment, storage, transport, and final disposal of waste. When managed ineffectively, infectious hospital wastes can compromise the quality of patient care and create significant occupational, public and environmental health risks. The 2015 KHFA sought to examine how the various service delivery points dispose of their waste.

Table 3.8.4: Percentage distribution of SDPs by how health wastes are disposed

Characteristics	Percentage				
	Burning on the grounds of the SDP	Bury in special dump pits on the grounds of the SDP	Use of Incinerators	Centrally collected by specific agency for disposal away from the SDP	Disposed with regular garbage
Type of Facility					
Primary Level	57.9	27.4	32.1	35.0	1.2
Secondary Level	35.3	41.2	26.5	3.0	
Tertiary Level	50.0	50.0	100.0	0.0	0.0
Region					
Coast	40.0	5.1	38.3	26.7	1.7
North Eastern	29.2	32.0	58.3	24.0	0.0
Eastern	66.7	36.7	34.2	48.7	0.8
Central	59.8	28.7	33.7	23.8	2.0
Rift Valley	56.7	20.7	36.6	21.3	1.2
Western	58.5	65.9	39.0	36.6	4.9
Nyanza	68.5	30.1	32.9	34.2	1.4
Nairobi	42.1	24.1	8.6	74.1	0.0
Residence					
Urban	35.2	15.9	35.2	51.8	0.4
Rural	68.4	35.0	33.3	25.1	1.7
Management					
Government	68.0	35.4	33.9	23.3	1.2
Private	47.3	18.2	25.9	53.2	1.4
FBO	38.9	36.1	53.4	27.8	1.4
NGO	44.4	0.0	48.1	34.6	3.7
Total	56.6	28.2	34.0	34.5	1.3

Overall, about 57 percent of all health facilities burn their waste within the SDP grounds. Thirty five percent of the facilities interviewed mentioned that the waste is centrally collected by a specific agency and another 34 percent make use of incinerators as part of disposal. Twenty eight percent of the health facilities bury the wastes in special dump pits. Among the tertiary-level care health facilities assessed, none of them dispose of waste by use of a specific agency or through regular garbage collection. Table 3.8.4 presents the percentage distribution of SDPs by how health wastes are disposed.

Burning of waste within the health facility grounds varies across the regions with the highest reported in Nyanza (69%) followed by Eastern (67%) and the least was reported in North Eastern (29%). With regard to residence, about 68 percent of the health facilities in rural areas burn the wastes within the health facility grounds compared to 35 percent of the urban facilities. Sixty eight percent of government facilities, 47 percent of private facilities and 44 percent of the NGOs managed facilities reported that they burn their waste within the health facility grounds.

Half of the tertiary, 41 percent of secondary and 27 percent of primary level health facilities reported that they bury their waste in special dump pits on the facility grounds. Burying of the hospital wastes vary across regions, with 66 percent of the health facilities in Western reporting this practice, followed by Eastern with about 37 percent and the least being Coast with about 5 percent. Thirty five percent of the health facilities from rural areas reported that they bury hospital waste in special dump pits compared to only 15 percent of those in the urban areas. None of the health facilities managed by NGOs bury medical waste in special dump pits while about 36 percent of health facilities managed by government and FBOs respectively engage in this practice.

Use of incinerators varies across the regions, with about 58 percent of health facilities from North Eastern reporting to use the same as a way of waste disposal. Interestingly, only 9 percent of health facilities in Nairobi reported the use of incinerators. The use of incinerators was also reported in half of FBO and NGO managed health facilities, 34 percent of government, and 26 percent of private health facilities.

Collection of hospital wastes by a specific agency also varies by region. Seventy four percent of health facilities in Nairobi indicated the use of an agency to dispose their waste. This practice was found to be lowest in Rift Valley (21%). More than half (52%) of the health facilities in urban areas use a specific agency to dispose their waste compared with one-quarter of the health facilities from rural areas. About half of private health facilities reported using a specific agency to dispose their waste. This was the case with about one-third of health facilities managed by NGOs and one-quarter of government facilities.

About 3 percent of secondary and 1 percent of primary level care health facilities reported disposing their medical waste with regular garbage. Disposal of hospital wastes with regular garbage varies across the regions with 5 percent of health facilities from Western region reporting this practice followed by 2 percent of facilities from Central. None of the health facilities in North Eastern and Nairobi engage in this practice. This practice is also rare among rural (2%) and urban (1%) health facilities. About 4 percent of health facilities managed by NGOs disposed their waste with regular garbage. This is also the case with one percent of government health facilities.

3.9 Charges for User Fees

Due to structural adjustment policies and severe government budgetary constraints, the Government of Kenya introduced user fees for inpatient and curative outpatient care at its hospitals and health centres in December 1989, with exemptions for children under the age of five and for specific ailments, but health care at dispensaries would still be delivered free of charge. The new and revised user fees in public health

facilities represented a major policy change from a policy of "free" health services for all at the time of independence. In 1990, as a result of early implementation problems, the user fee policy was reformed with outpatient registration fees being removed, while keeping the other fees. This was later reversed after pressure from some development partners. In 1991, the Ministry of Health initiated a programme of management improvement and gradual re-introduction of an outpatient fee, but this time as a treatment fee in phases, first in national and provincial hospitals and then district hospitals and health centres. In June 2004, there was a policy statement by the Minister of Health, stipulating that health care at dispensary and health centre level would be free for all citizens, except for a minimal registration fee in government health facilities.

3.9.1 Charges for user fees – consultation

Table 3.9.1: Percentage distribution of SDPs by issues for which user fee is charged for consultation according to the type of facility, region, residence and management

Characteristics	Percentage							
	Family planning services	Antenatal care services	Delivery services	Post natal care services	Newborn care services	Care of sick children under 5 years	HIV care (e.g. HTC and ART)	Other (specify)
Type of Facility								
Primary Level Care	61.3	85.5	91.9	82.7	77.5	89.6	52.0	79.8
Secondary Level Care	55.0	55.0	50.0	55.0	57.1	55.0	25.0	75.0
Tertiary Level Care	100.0	100.0	100	100	100.0	50.0	0.0	100.0
Region								
Coast	83.3	80.0	79.2	79.2	79.2	84.0	70.8	100
North Eastern	57.1	71.4	57.1	71.4	75.0	75.0	71.4	71.4
Eastern	39.5	81.6	84.2	92.1	84.2	78.9	47.4	89.5
Central	66.7	85.7	95.2	76.2	76.2	95.2	61.9	57.1
Rift Valley	56.5	80.4	91.3	84.8	74.5	91.3	55.3	69.6
Western	44.4	55.6	77.8	55.6	44.4	44.4	11.1	88.9
Nyanza	57.1	64.3	76.9	69.2	78.6	71.4	23.1	78.6
Nairobi	77.1	100.0	100.0	75.0	68.6	97.1	36.1	80.6
Residence								
Urban	67.7	88.2	89.8	84.1	78.0	90.6	58.3	78.7
Rural	47.8	71.0	83.8	72.1	70.6	76.8	31.9	79.7
Management								
Government	40.0	41.4	46.7	53.3	36.7	36.7	17.2	80.0
Private	64.2	89.5	96.2	90.6	93.3	95.2	55.7	80.2
FBO	55.6	86.7	93.3	77.8	62.2	91.1	48.9	84.4
NGO	93.3	100	93.3	60.0	60.0	100	60.0	53.3
Total	60.8	82.4	87.5	79.7	75.3	85.7	49.1	79.1

Overall, as shown in Table 3.9.1, more than 88 percent of service delivery points charge for consultation for delivery services, care of sick children under 5 years and antenatal care services. Seventy five percent charge for consultation for newborn care services while about 61 percent and 50 percent charge for Family Planning services and HIV care consultations respectively.

All the tertiary level care facilities charge consultation fee for all the services provided except for HIV care and care for sick children under 5 years. Half of the tertiary facilities charge for the care of sick children under 5 years. More than half of the secondary level care health facilities charge consultation for all the health services provided except a quarter that charge for HIV care. Majority of the primary-level care facilities charge consultation for all the health services provided in the facilities.

There are regional variations with regard to consultation charges for health care services provided by health facilities. All the health facilities in Nairobi region charge consultation for antenatal care services and delivery services.

Charges for consultation for health care services provided by service delivery points also differ across residence. All the NGOs managed facilities charge consultation for antenatal care services as well as care of sick children under 5 years. Less than half of the government facilities charge for the FP and RH services.

3.9.2 Charges for user fees – medication

Table 3.9.2.: Percentage distribution of SDPs by issues for which user fee is charged for medication (No Exemptions)

Characteristics	Percentage			
	Family planning commodities	Maternal Health medicines	Child health medicines	Other (specify)
Type of Facility				
Primary Level Care	85.5	91.7	91.7	65.9
Secondary Level Care	54.8	53.1	45.2	64.5
Tertiary Level Care	50.0	100.0	50.0	50.0
Region				
Coast	93.1	93.1	93.1	89.7
North Eastern	63.6	80.0	81.8	63.6
Eastern	81.8	90.9	89.4	64.6
Central	81.8	87.9	88.1	59.7
Rift Valley	82.4	83.8	81.3	56.8
Western	58.8	76.5	70.6	76.5
Nyanza	69.2	80.8	84.6	42.3
Nairobi	100.0	97.9	97.9	83.0
Residence				
Urban	89.2	90.9	90.3	72.6
Rural	74.2	84.1	83.3	57.3
Management				
Government	41.3	53.2	45.7	67.4
Private	93.5	95.0	96.0	69.3
FBO	77.9	88.1	85.3	47.1
NGO	83.3	95.7	100	87.0
Total	82.6	88.0	87.2	65.7

Overall, as shown in Table 3.9.2, more than 80 percent of health facilities charge for maternal health medicines, child health medicines and family planning commodities, and about two-thirds charge for medicines for other health care services. About half of all the secondary and tertiary level care facilities charge for medicines for all the health care services provided.

Regional variations with regard to charges for medicines for health care services provided by health facilities is evident as shown in the Table 3.9.2. It is noteworthy that all health facilities in Nairobi region charge for family planning commodities and that all the NGOs managed facilities charge for child health medicines with no exemption. Less than half of the government facilities charge for FP commodities and child health medicines.

PART 4: SURVEY FINDINGS EXIT INTERVIEWS

This section focuses on the results of the FP clients' exit interviews. It provides a description of the respondents who were interviewed in the exit interview, information on the clients' perception regarding various aspects of service delivery and clients' estimation of the cost of family planning services. The exit interviews were administered to both male and female clients who had received family planning services from the SDPs. This information is useful in understanding client's views on the services offered and the context of provision of family planning services and commodities discussed in the previous chapters of this report. Data provided for the main background characteristics include; type of facility, region of residence, type of place of residence as well as management of the SDPs.

4.1 Background Characteristics of Clients

4.1.1 Age and sex distribution

The sex distribution of the exit interview clients showed that they were mostly females (99.8%), and with an exception of Western where two percent were males and 98 percent females, all the other regions had only female clients. The exit interview clients in the urban areas were all females while in the rural areas females made up over 99 percent of the clients. Additionally, all the clients interviewed in the Private, NGO and FBO facilities were females.

Table 4.1.1 presents the percentage distribution of the clients by age groups according to the background characteristics. Analysis of the clients' age groups is necessary because it helps identify age groups of the clients associated with uptake of family planning services and commodities.

The majority (64.4%) of exit clients were aged 20-34 years. The clients in age group 15-19 years constituted only five percent; 35-39 years constituted 10 percent while those aged 40 years and above formed only four percent of the interviewed clients. Majority of the clients interviewed were those in the reproductive age bracket who are normally associated with uptake of family planning services. Since the 2015 KHFA focused on those clients who are actively engaged in child bearing and family planning services, it was expected that those below 18 years and above 40 years would be few. There is an observed variation on the percentage distribution of clients' age group by the type of facility, region, residence and management of SDPs as shown in Table 4.1.1.

Table 4.1.1: Age distribution of clients

Characteristics	Age group								
	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
Type of Facility									
Primary Level Care	0.0	4.8	26.0	34.9	20.1	10.0	3.3	0.8	0.2
Secondary Level Care	0.0	5.5	32.8	30.5	17.2	10.9	2.3	0.8	0.0
Tertiary Level Care	0.0	0.0	30.0	30.0	20.0	10.0	10.0	0.0	0.0
Region									
Coast	0.0	9.0	30.3	25.2	18.1	7.7	7.1	2.6	0.0
North Eastern	0.0	5.9	17.6	23.5	23.5	23.5	5.9	0.0	0.0
Eastern	0.0	3.7	29.5	36.1	18.4	9.0	2.0	1.2	0.0
Central	0.0	1.0	19.5	32.8	25.1	17.9	3.6	0.0	0.0
Rift Valley	0.0	1.9	24.3	36.0	20.8	11.4	4.7	0.9	0.0
Western	0.0	14.9	29.8	41.2	11.4	1.8	0.9	0.0	0.0
Nyanza	0.0	7.9	33.8	29.5	21.0	5.7	1.9	0.0	0.5
Nairobi	0.0	0.0	13.0	50.0	20.3	15.9	0.0	0.0	0.0
Residence									
Urban	0.0	3.8	22.4	38.0	20.3	11.7	2.8	1.1	0.0
Rural	0.0	5.4	28.9	32.4	19.6	9.3	3.5	0.6	0.2
Management									
Government	0.0	6.2	30.2	31.5	19.0	9.1	3.3	0.4	0.2
Private	0.0	3.2	20.1	36.3	22.1	12.7	3.5	2.1	0.0
FBO	0.0	1.9	21.5	49.5	21.5	5.6	0.0	0.0	0.0
NGO	0.0	1.6	25.0	34.4	15.6	17.2	6.2	0.0	0.0
Total	0.0	4.9	26.6	34.4	19.8	10.2	3.3	0.7	0.2

4.1.2 Marital status of clients

The term 'married' as used in this survey refers to legal or formal marriage and/or union. The respondents in this study are categorized as: 1) never married/in union; 2) currently married/in union; or 3) formerly married. Marriage is a primary indication of regular exposure to the risk of pregnancy and therefore is one of the principal proximate determinants of fertility. As documented in many family planning studies, majority of women who are currently in marriages are bound to use contraceptives to either space or limit their births. Analysis of the current use of contraception by marital status of the exit interview clients is important because it helps identify subgroups of the clients to target with family planning services.

Figure 4.1.1 presents the percentage distribution of the clients by marital status. Table 4.1.2 shows the percentage distribution of exit interview clients by marital status according to the background characteristics. Majority of the clients interviewed (87%) indicated that they were currently married while only 8 percent of these clients said that they have never been married and 5 percent said that they were formerly married.

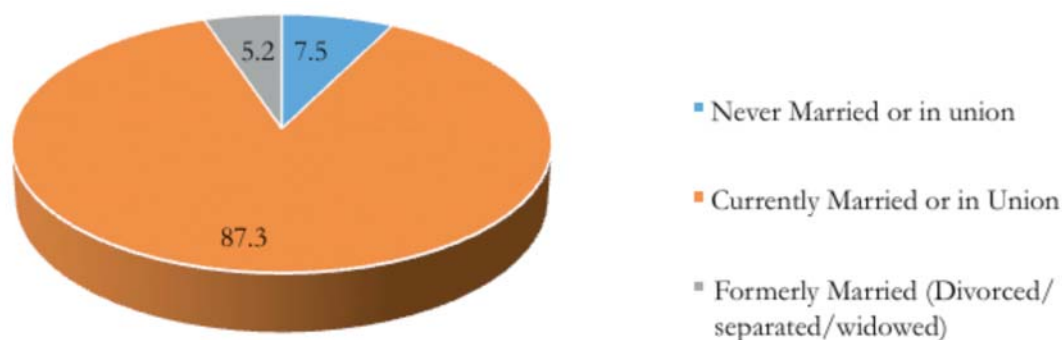


Figure 4.1.1: Percentage distribution of clients by marital status

Clients interviewed in the tertiary-level care facilities comprised 11 percent never married and 89 percent currently married with no client who was formerly married. In terms of regional distribution, Western (15%) and Rift Valley (12%) had the highest number of the never married clients interviewed while Nairobi had no such clients. All the clients interviewed in Nairobi were currently married compared to 79 percent in Rift Valley which also had the highest (10%) proportion of formerly married. There was no huge variation in the proportion of marital status of clients interviewed by their residence and the management of the SDPs where they sought family planning services.

Table 4.1.2: Marital status of clients

Characteristics	Percentage		
	Never Married or in union	Currently Married or in Union	Formerly Married (Divorced/separated/widowed)
Type of Facility			
Primary Level Care	7.6	87.1	5.3
Secondary Level Care	7.0	89.9	3.1
Tertiary Level Care	11.1	88.9	0.0
Region			
Coast	5.9	88.2	5.9
North Eastern	5.9	88.2	5.9
Eastern	2.9	93.2	3.7
Central	6.2	87.2	6.7
Rift Valley	12.0	78.5	9.5
Western	15.2	83.0	1.8
Nyanza	6.7	90.9	2.4
Nairobi	0.0	100.0	0.0
Residence			
Urban	8.5	86.6	4.9
Rural	7.0	87.7	5.3
Management			
Government	8.1	86.8	5.1
Private	7.4	88.5	4.1
FBO	6.5	88.8	4.7
NGO	3.2	84.1	12.7
Total	7.5	87.3	5.2

4.1.3 Education

There is documented evidence suggesting that an increase in the education level, especially for women, promotes the adoption of family planning services. Therefore, education level is important in explaining the reproductive behaviour of family planning users. Analysis of the education level helps us understand the categories of the clients who use family planning services.

Table 4.1.3 shows the percentage distribution of the family planning clients by education level according to their background characteristics. Majority of the clients had primary education (48%), followed closely by those who had secondary and higher education (47%). About 5 percent of these clients had no education.

Analysis of the clients based on regional distribution revealed that North Eastern had the highest proportion of clients with no education (53%) while Nairobi had no clients with no education. Coast region had the highest proportion of clients interviewed with primary education (59%) while Nairobi had the lowest proportion (10%) of such clients. On the other end, Nairobi had the highest proportion (90%) of clients with secondary and higher level of education while North Eastern had the lowest proportion (6%) of such clients.

In terms of the rural and urban divide, the percentage of clients with primary level education was higher in the rural areas (55%) while the percentage of clients with secondary and higher level of education was higher in the urban areas (62%). Over half (55%) of clients interviewed in Government SDPs had primary education. Majority of those interviewed in the Private (63%), FBO (52%), and NGO (51%) had secondary and higher levels of education.

Table 4.1.3: Percentage distribution of clients by education level

Characteristics	Percentage		
	No Education	Primary	Secondary and higher level
Type of Facility			
Primary Level Care	5.5	47.2	47.3
Secondary Level Care	4.7	54.3	41.0
Tertiary Level Care	0.0	25	75.0
Region			
Coast	12.3	57.8	29.9
North Eastern	52.9	41.2	5.9
Eastern	2.1	47.1	50.8
Central	1.1	44.8	54.1
Rift Valley	10.2	47.8	42.0
Western	1.8	48.2	50.0
Nyanza	1.0	56.3	42.7
Nairobi	0.0	10.0	90.0
Residence			
Urban	3.0	35.1	61.9
Rural	6.6	54.8	38.6
Management			
Government	6.1	54.8	39.1
Private	1.8	35.4	62.8
FBO	12.1	35.5	52.3
NGO	4.8	44.4	50.8
Total	5.4	47.8	46.9

4.1.4 Frequency of visits to SDPs for family planning services

Figure 4.1.2 shows the percentage distribution of clients by frequency of visit to the SDP for FP services while Table 4.1.4 shows the percentage distribution of clients by frequency of visit to the SDP for FP services according to their background characteristics. The findings show that majority of the clients (70%) visited the SDPs once in three months while 4 percent visited once every two months.

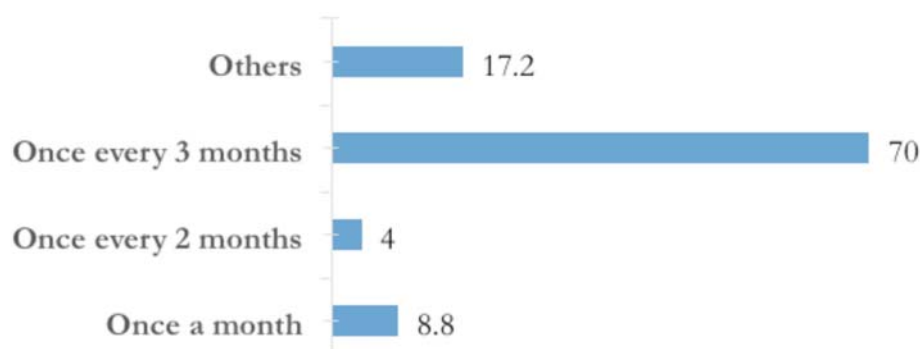


Figure 4.1.2: Percentage distribution of clients by frequency of visit to the SDP for FP services

Majority (70%) of the clients interviewed in the primary level facilities indicated that they visited the SDPs for FP services once every three months while about 56 percent indicated the same in the tertiary care facilities. About 69 percent of clients who visited the secondary level SDPs for FP services indicated that they visited the facilities once every three months. The North Eastern region recorded the highest proportion (82%) of clients while Central recorded the lowest proportion (57%) of clients who indicated that they visit the facility once every three months. The FP clients located in the rural areas who visited the SDPs once every three months were slightly higher (71%) compared to those in the urban areas (69%). About 3 in every 4 clients interviewed in the private, FBO, and NGO facilities indicated that they visit the SDPs once every three months for FP services.

Table 4.1.4: Percentage distribution of clients by frequency of visit to the SDP for FP services

Characteristics	Percentage			
	Once a month	Once every 2 months	Once every 3 months	Others
Type of Facility				
Primary Level Care	9.2	4.0	70.3	16.6
Secondary Level Care	4.7	4.7	68.8	21.9
Tertiary Level Care	11.1	0	55.6	33.3
Region				
Coast	9.3	0.0	81.3	9.3
North Eastern	5.9	0.0	82.4	11.8
Eastern	6.2	7.4	75.6	10.7
Central	14.2	4.2	57.4	24.2
Rift Valley	3.5	0.6	77.5	18.4
Western	14.3	5.4	58.9	21.4
Nyanza	12.1	6.8	58.9	22.2
Nairobi	8.6	8.6	71.4	11.4

Characteristics	Percentage			
	Once a month	Once every 2 months	Once every 3 months	Others
Residence				
Urban	9.8	5.6	68.8	16.2
Rural	8.2	3.2	70.9	17.7
Management				
Government	9.2	4.2	67.7	18.8
Private	8.9	4.2	72.9	14.0
FBO	6.8	0.0	78.6	14.6
NGO	5.0	5.0	71.7	18.3
Total	8.8	4.0	70.0	17.2

4.2 Clients' perception of family planning service provision

The policy guidelines with regard to provision of FP services are contained in the *National Family Planning Guidelines for the Service Providers*. The guidelines emphasize on improving access to quality FP services. It recognizes that RH and sexual health care, including FP information and services, is not only a key intervention for improving the health of women, men and children but also a human right. It states that, everyone has a right to access, choice, and benefits of scientific progress in the selection of FP methods. It also proposes a right-based approach in the provision of services by taking into account the clients' sexual and RH care needs and considering all appropriate eligibility criteria in helping clients choose and safely use an FP method.

The guideline also requires that all service providers should be competent in counselling for all methods of FP and should have basic counselling skills appropriate to individual client needs. It also requires that all clients who choose an FP method must be informed of the appropriate follow-up requirements and encouraged to return to the service provider if they have any concerns and that providers should follow the established referral systems. The service provider is expected to keep in mind that the provision of FP services involves both financial and opportunity costs and as such must consider the clients' financial circumstances and ensure that the client is aware in advance of any ongoing expenses. Service providers must therefore be prepared to discuss the cost-effectiveness of various available FP methods with their clients. Management of family planning SDPs should also have mechanisms to inform clients about the workings of the facilities including, working hours.

4.2.1 Provider adherence to technical aspects

The 2015 KHFA assessed FP providers' adherence to technical aspects during provision of FP services. Table 4.2.1 shows the percentage distribution of clients' perspective of service provider's adherence to technical issues in provision of FP services. There was general adherence to technical aspects in provision of FP services. Ninety seven percent of the clients reported to have received a method of their choice, 98 percent were treated as they wished, 90 percent were taught how to use the family planning method of choice, 82 percent were told about the common side effects of family planning methods while 79 percent were informed about what can be done regarding the side effects of the FP method and 96 percent were given a date to return to SDP for check-up and /or additional supplies. The lowest satisfaction (66%) was on provision of information on what to do in case of any serious complications.

In terms of the facility type, the FP clients in the tertiary level facilities reported the highest satisfaction (100%) with the date given to return to SDP for check-up and/or additional supplies while the lowest satisfaction (65%) was recorded in the primary care facilities in connection with FP providers informing clients about what to do in case any serious complications occur.

In Nairobi region, the clients' satisfaction level was high (100%) with regard to FP providers taking clients' preferences and wishes into consideration and also providers giving a date to return to SDP for check-up and/or additional supplies. In North Eastern region, satisfaction level was highest (100%) with regard to FP clients being provided with their method of choice and also providers giving a date to return to SDP for check-up and/or additional supplies. Satisfaction level was lowest (42%) in Western in connection with FP providers informing clients about what to do in case any serious complications occur.

There was minimal variation on the satisfaction level by the clients' perspective on FP service providers' adherence to technical aspects according to residence and management of SDPs. The general high satisfaction level by the different characteristics could be due to the availability of well trained and skilled staff, space and equipment while the lowest satisfaction level could be due to failure of service providers to provide adequate information.

Table 4.2.1: Percentage distribution of clients' perspective of service provider's adherence to technical issues in provision of FP services

Characteristics	Percentage						
	Provided with method of their choice	Provider took clients preference and wishes into consideration	Client taught how to use the method	Client told about the common side effects of the method	Provider informed client about what can be done regarding the side effects of the method	Provider informed client about what to do in case any serious complications occur	Client given date to return to SDP for check-up and /or additional supplies
Type of Facility							
Primary Level Care	96.5	97.7	89.8	81.8	78.7	65.2	96.3
Secondary Level Care	97.7	99.2	93.1	87.7	81.5	74.6	96.9
Tertiary Level Care	90.0	90.0	90.0	88.9	80.0	77.8	100.0
Region							
Coast	99.4	99.3	89.0	81.0	76.5	64.7	94.8
North Eastern	100.0	94.1	94.1	76.5	64.7	52.9	100.0
Eastern	96.7	99.6	97.1	86.9	83.7	63.9	98.4
Central	95.9	96.4	88.2	85.1	83.1	73.8	96.9
Rift Valley	98.1	97.5	91.8	84.8	83.5	69.5	96.8
Western	94.7	95.6	83.2	68.1	60.2	41.6	91.2
Nyanza	95.7	97.6	85.2	79.9	76.1	68.3	95.2
Nairobi	91.4	100.0	91.4	84.3	81.4	77.1	100.0
Residence							
Urban	96.2	98.5	92.3	84.2	80.2	65.5	96.6
Rural	96.8	97.4	88.9	81.5	78.4	66.5	96.3
Management							
Government	97.2	98.0	89.1	80.8	77.4	65.9	95.8
Private	95.3	97.9	94.4	87.9	83.4	71.3	96.5
FBO	96.3	97.2	84.1	80.4	77.6	57.9	100.0
NGO	98.4	95.3	90.5	78.1	77.8	57.1	98.4
Total	96.6	97.8	90.1	82.4	79.0	66.2	96.4

4.2.2 Organizational aspects

Table 4.2.2 presents information on the percentage distribution of clients' perspective of family planning services by organizational aspects according to their background characteristics. The findings show that most FP clients were satisfied with the organization aspects of the SDPs. For example, 96 percent reported that they were both satisfied with the cleanliness of the health facility and the privacy at the examination rooms while 97 percent were satisfied with time allocated to their cases. About 1 in every 5 of the clients interviewed perceived that the waiting time was too long.

Tertiary-level facilities recorded the highest satisfaction levels on each organizational aspect when compared to the other types of facilities. Regionally, North Eastern recorded the highest satisfaction levels on each organizational aspect when compared to the other regions. The observed high levels of satisfaction could be attributed to the training provided to the providers that enabled them to exercise professionalism in the provision of services.

Table 4.2.2: Percentage distribution of clients' perspective of FP service organizational aspects

Characteristics	Percentage			
	Client perceived waiting time as too long	Client satisfied with the cleanliness of the health facility	Client satisfied with the privacy at the exam room	Client satisfied with the time that was allotted to his/her case
Type of Facility				
Primary Level Care	19.1	96.3	95.8	97.4
Secondary Level Care	31.5	95.4	95.4	96.9
Tertiary Level Care	33.3	100.0	100.0	100.0
Region				
Coast	28.8	96.8	89.6	96.8
North Eastern	47.1	100.0	100.0	100.0
Eastern	20.5	96.7	93.9	98.0
Central	16.4	97.4	97.4	99.0
Rift Valley	14.8	98.1	99.1	96.5
Western	23.0	93.8	98.2	95.6
Nyanza	19.1	96.2	93.3	99.0
Nairobi	31.4	84.3	100.0	91.4
Residence				
Urban	20.9	94.3	93.8	97.4
Rural	20.2	97.2	96.8	97.2
Management				
Government	21.7	96.4	96.2	97.6
Private	15.6	96.8	95.0	98.2
FBO	22.4	94.4	98.1	92.5
NGO	27.0	93.7	90.5	96.8
Total	20.4	96.2	95.7	97.3

4.2.3 Interpersonal aspects

The exit interview clients were asked to give their perspective on the FP providers' interpersonal aspects. The results of the interview are presented in Figure 4.2.1 and Table 4.2.3. Figure 4.2.1 shows the percentage distribution of clients' perspective of FP service by interpersonal aspects. Generally, family planning service

providers exhibited great interpersonal skills during the course of service provision. Majority (98%) of the clients indicated that they were treated with both courtesy and respect and were also satisfied with the attitude of health care providers towards them. About 9 percent said that they had been coerced to accept a particular family planning method.

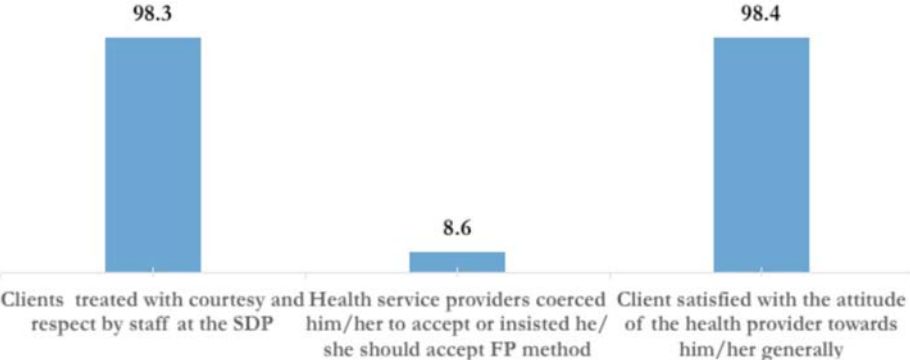


Figure 4.2.1: Percentage distribution of clients' perspective of FP service by inter-personal aspects

Table 4.2.3 shows the percentage distribution of clients' perspective of FP service by interpersonal aspects according to the background characteristics. The satisfaction was higher at the tertiary level (100%) on attitude, courtesy and respect. Analysis based on regions revealed that Nairobi had the highest satisfaction levels (100%) where clients indicated that they were treated with courtesy and respect by staff at the SDP and also satisfied with the attitude of the health providers towards them. In the Coast region, the satisfaction level was high (100%) where clients were treated with courtesy and respect. In North Eastern, the satisfaction level was also high (100%) with clients indicating that they were satisfied with the attitudes of the health providers towards them.

On the contrary, about 25 percent of the clients in North Eastern and 24 percent in Nairobi indicated that the service provider coerced them to accept an FP method. There was no major notable variation on the clients' satisfaction levels by type of residence (rural/urban). Among the NGO-managed SDPs, clients reported that they were highly satisfied (100%) with the attitude of the health providers towards them. Eleven percent of the clients who visited the NGO facilities indicated that the service provided coerced or insisted that the clients take a certain FP method. In the government and private facilities, 9 percent of the clients reported the same.

Table 4.2.3: Percentage distribution of clients' perspective of FP service by inter-personal aspects

Characteristics	Inter-Personal Aspects (Percentage)		
	Client indicated he/she was treated with courtesy and respect by staff at the SDP	Client indicated he/she health service providers coerced him/her to accept or insisted he/she should accept FP method	Client satisfied with the attitude of the health provider towards him/her generally
Type of Facility			
Primary Level Care	98.2	8.6	98.5
Secondary Level Care	98.5	8.5	96.9
Tertiary Level Care	100.0	11.1	100.0
Region			
Coast	100.0	2.6	99.3
North Eastern	94.1	25.0	100.0
Eastern	98.0	3.7	98.4
Central	98.5	2.6	97.9
Rift Valley	98.1	9.8	98.4
Western	98.2	11.5	100.0
Nyanza	97.6	14.4	97.1
Nairobi	100.0	24.3	100.0
Residence			
Urban	98.3	8.8	98.1
Rural	98.2	8.5	98.6
Management			
Government	98.8	9.0	98.8
Private	98.8	8.7	97.9
FBO	95.3	3.7	96.3
NGO	95.2	11.1	100.0
Total	98.3	8.6	98.4

4.2.4 Outcome aspects

During the health facility assessment, clients were also asked to give their perspective of FP service outcome. Table 4.2.4 shows the percentage distribution of clients' perspective of FP service outcome aspects according to background characteristics. Overall, most clients (99%) were satisfied with the services received, expressed willingness to return to the SDP in future, and indicated that they would refer relatives/friends to the SDP.

In terms of the facility type, all the clients (100%) in the tertiary level facilities reported that they were satisfied with the services received, expressed willingness to return to the SDP in future as well as refer relatives or friends to the SDPs. Regional analysis revealed that FP clients in North Eastern and Nairobi reported highest satisfaction levels (100%) in the three dimensions of clients' perspective of FP service outcome aspects. Analysis by management of SDPs showed that satisfaction level was highest (100%) in the NGO-managed institutions.

Table 4.2.4: Percentage distribution of clients' perspective of FP service outcome aspects

Characteristics	Perspective of FP Service Outcome (Percentage)		
	Client satisfied with the service received	Client will continue visiting this SDP in future	Client would recommend this SDP to relatives or friends
Type of Facility			
Primary Level Care	99.6	99.1	99.0
Secondary Level Care	98.5	98.5	99.2
Tertiary Level Care	100.0	100.0	100.0
Region			
Coast	100.0	100.0	99.3
North Eastern	100.0	100.0	100.0
Eastern	100.0	100.0	98.8
Central	98.5	98.5	98.5
Rift Valley	99.1	99.1	99.1
Western	100.0	96.5	98.2
Nyanza	99.0	98.6	99.0
Nairobi	100.0	100.0	100.0
Residence			
Urban	99.6	99.6	98.9
Rural	99.4	98.8	99.1
Management			
Government	99.8	99.1	99.3
Private	99.4	99.4	98.5
FBO	97.2	97.2	97.2
NGO	100.0	100.0	100.0
Total	99.4	99.1	99.0

4.3 Clients' Appraisal of the Cost of Family Planning Services

4.3.1 Payment for family planning service

The cost of FP has been observed to be a barrier to access FP services. Table 4.3.1 shows the percentage of clients reporting paying for service and the average amount they paid by type of SDP. The results show that 80 percent of clients accessing FP services in tertiary facilities paid for the services compared with about 34 percent of clients accessing primary facilities. The average amount paid for the services varies by type of facility and also by type of service provided. On average, clients paid Ksh. 83 for the card in tertiary facilities compared to Ksh. 57 and Ksh. 45 paid by clients in primary and secondary facilities respectively. Average charges for clients accessing laboratory test/x-ray services were Ksh. 117 in the primary facilities and Ksh. 373 in the secondary level facilities. For those who accessed contraceptives from pharmacies, the average cost paid was Ksh. 68 for clients attending the primary facilities and Ksh. 39 for clients attending the secondary facilities. The average cost of consultancy fees was highest at Ksh. 203 in secondary level facilities and lowest at Ksh. 48 in tertiary level facilities. For other services, the average cost was highest at Ksh. 113 in secondary facilities and lowest at Ksh. 81 in tertiary facilities.

Table 4.3.1: Percentage of clients reporting paying for service and average amount paid by type of SDP

Type of Facility	Percentage of clients reporting paying for service	Average amount paid (Kenya Shillings)					
		Card	Laboratory test/x-ray	Contraceptive received from service provider	Contraceptive purchased from pharmacy	Consultation fee	Others
Primary Level Care	33.5	57.30	117.18	188.10	67.46	101.83	98.16
Secondary Level Care	53.8	45.14	373.61	254.30	39.14	202.86	113.33
Tertiary Level Care	80.0	83.33	-	252.22	-	47.75	81.07
Total	35.9	53.51	147.05	193.93	60.36	116.57	96.01

The results also show that payment for services was influenced by region of residence. Table 4.3.2 presents results of the percentage of clients reporting paying for service and average amount paid by region of residence. The percentage of clients reporting paying for services was highest in Rift Valley and Central regions (43% and 42% respectively) and lowest in Western and North Eastern regions (21% and 24% respectively). On average, those from Rift Valley paid Ksh. 93 for the card compared to Ksh. 27 for those residing in the Western region. Charges for laboratory tests/x-rays were highest for those residing in Western (Ksh. 128.92) and lowest for those from Nyanza (Ksh. 100). For those who obtained contraceptives from service providers, the average cost was Ksh. 279 for those residing in the Rift Valley region compared with Ksh. 112 for those from the Nyanza region. The cost of contraceptives purchased from the pharmacies was on average highest in the Central region (Ksh. 100) and lowest for clients in the North Eastern region (Ksh. 50). The average cost of consultation fees was Ksh. 261 in the Rift Valley region compared to Ksh. 77 for the Eastern region. For those accessing other services, the average cost was highest in the Coast region (Ksh. 121) and lowest in Eastern (Ksh. 52).

Table 4.3.2: Percentage of clients reporting paying for service and average amount paid by Region

Administrative Unit (Region)	Percentage of clients reporting paying for service	Average amount paid for (Kenya Shillings)					
		Card	Laboratory test/x-ray	Contraceptive received from service provider	Contraceptive purchased from pharmacy	Consultation fee	Others
Coast	29.9	59.37	119.67	117.60	86.11	96.46	121.31
North Eastern	23.5	-	-	-	50.00	-	-
Eastern	38.9	49.27	-	195.92	70.50	76.91	51.93
Central	42.6	33.19	-	175.59	100.00	-	-
Rift Valley	41.6	92.45	-	278.49	70.38	261.01	-
Western	21.2	26.92	128.92	115.05	-	200.00	-
Nyanza	30.5	75.34	100.00	111.77	45.15	-	88.89
Nairobi	38.6	-	-	-	-	91.62	-
Total	35.9	53.51	147.05	193.93	60.36	116.57	96.01

The percentage of clients reporting to have paid for services is influenced by place of residence. Table 4.3.3 presents percentages of clients reporting paying for service and average amounts paid by urban/rural residence. More clients reported having paid for their services in urban areas (59.5 %) than in rural areas (22.9%). For all the services accessed by clients, urban residents paid more than their rural counterparts. For instance, the average amount paid for a card was Ksh. 62 in urban areas compared with Ksh. 39 for rural areas. Contraceptives purchased from the pharmacies were more expensive in urban areas (Ksh. 63) compared with rural areas (Ksh. 57) while consultation fees were highest in urban areas (Ksh. 125)

compared with rural areas (Ksh. 17). The amount paid for “others” was however higher in rural (Ksh. 118) compared to urban (Ksh. 85).

Table 4.3.3: Percentage of clients reporting paying for service and average amount paid by urban/rural residence

Residence	Percentage of clients reporting paying for service	Average amount paid for (Kenya Shillings)					
		Card	Laboratory test/x-ray	Contraceptive received from service provider	Contraceptive purchased from pharmacy	Consultation fee	Others
Urban	59.5	64.29	154.20	234.73	63.35	124.78	84.47
Rural	22.9	38.89	100.00	136.13	56.57	16.76	117.58
Total	35.9	53.51	147.05	193.93	60.36	116.57	96.01

The cost of services was also noted to differ by management of facility. Table 4.3.4 presents percentages of clients reporting paying for service and average amounts paid per visit by management of facility. Generally, the survey results show that clients were more likely to pay for services in private and NGO facilities (74% and 64% respectively) compared to government facilities (17%). The average amount paid for the card, laboratory test/x-rays, contraceptives purchased from service provider, and consultation fees was higher in private facilities when compared with NGO and government facilities. For instance, the average cost of laboratory test/x-rays was Ksh. 214 in private facilities while it was Ksh. 100 in NGO facilities. The average cost of consultation fees was Ksh. 152 in private facilities compared with Ksh. 30 in government facilities. The average cost of contraceptives purchased from pharmacies was highest (Ksh. 72) in private facilities compared with government facilities (Ksh. 47).

Table 4.3.4: Percentage of clients reporting paying for service and average amount paid visits by management of facility

Management of facility	Percentage of clients reporting paying for service	Average amount paid for (Kenya Shillings)					
		Card	Laboratory test/x-ray	Contraceptive received from service provider	Contraceptive purchased from pharmacy	Consultation fee	Others
Government	16.9	44.07	124.09	114.07	47.46	30.16	88.35
Private	73.5	63.35	214.42	216.12	72.04	152.08	100.00
FBO	44.9	-	-	258.84	56.60	63.40	-
NGO	63.5	57.31	100.00	190.15	71.07	98.92	-
Total	35.9	53.51	147.05	193.93	60.36	116.57	96.01

4.3.2 Travel cost

Distance to the health facility and the associated costs of travel have been found to be a barrier to access of health services. Table 4.3.5 presents percentage distribution of clients by mode of transportation, distance travelled and cost of transportation. The survey results show that the majority (69%) of those who accessed primary-level facilities walked to the facilities compared with 22 percent of those who accessed services at tertiary-level facilities. Motor cycle transport was more popular (25%) for those who accessed services at secondary-level facilities while bus/taxi was more common (56%) for those who accessed services at tertiary-level facilities. The average distance travelled was highest (7 km) while the highest average travel cost was higher (Ksh. 114) for those who accessed services at the tertiary level compared with those who accessed services at primary-level facilities (Ksh. 39).

The highest proportion of those who walked to access services was from North Eastern region (75%) while the lowest proportion was recorded in Nairobi region (60%). The highest proportion (9% and 28% respectively) of those who used bicycles and motor cycles to the health facilities were from Western region while those using bus/taxi to access services were from Nairobi region (40%). The average distance travelled was highest in Eastern region (3.8 km) while the highest travel cost to and from the SDP was recorded in North Eastern region of the country (Ksh. 57). There was a higher proportion of clients walking to access services in rural areas (70%) compared to urban areas (60%) while the proportion of those using motorcycles was higher in rural areas (23%) compared with urban areas (13%). Urban clients were more likely to use a bus/taxi than rural clients. The results also indicate that the average distance travelled to the SDP was highest among rural clients (3.15 km) while the average travel cost to and from the SDP was highest in urban areas (Ksh. 51). There were more clients walking to access government facilities (69%) compared to those who accessed NGO facilities (55%). The proportion of those using motorcycles and buses/taxis to access services was highest for those seeking FP services from FBO (26%) and NGO (23%) facilities. The average distance travelled to access services was highest (3.1 km) among those seeking services from government facilities while the average travel cost to and from SDP was highest (Ksh. 57) among those seeking services from NGO facilities.

Table 4.3.5: Percentage distribution of clients by mode of transportation, distance travelled and cost of transportation

Characteristics	Mode of transportation (Percentage)						Average Distance travelled (KM)	Average travel cost to and from SDP (Ksh.)
	Walked	Bicycle	Motorcycle	Bus/taxi	Private vehicle	Others		
Type of Facility								
Primary Level Care	68.5	1.4	19.0	10.0	0.9	0.2	2.72	38.74
Secondary Level Care	51.9	0.8	24.8	20.9	0.8	0.8	5.18	63.62
Tertiary Level Care	22.2	0.0	22.2	55.6	0.0	0.0	6.87	113.91
Region								
Coast	61.0	3.2	20.1	15.6	0.0	0.0	2.27	45.19
North Eastern	75.0	0.0	12.5	12.5	0.0	0.0	1.71	56.64
Eastern	67.8	0.0	13.9	16.7	1.6	0.0	3.80	36.41
Central	66.5	0.0	24.7	8.2	0.5	0.0	3.36	48.83
Rift Valley	69.8	0.6	18.4	9.2	1.9	0.0	3.38	52.74
Western	61.6	8.9	27.7	1.8	0.0	0.0	1.97	35.34
Nyanza	68.7	0.5	25.6	3.8	0.5	0.9	2.30	32.40
Nairobi	60.0	0.0	0.0	40.0	0.0	0.0	2.95	23.94
Residence								
Urban	59.9	1.5	12.8	23.0	2.3	0.4	2.70	51.21
Rural	70.0	1.3	23.4	4.9	0.2	0.1	3.15	36.67
Management								
Government	68.9	1.7	20.9	7.4	0.7	0.2	3.12	38.14
Private	64.3	0.9	14.2	18.9	1.8	0.0	2.72	48.07
FBO	62.3	0.0	25.5	12.3	0.0	0.0	3.34	42.16
NGO	54.7	1.6	23.4	18.8	1.6	0.0	2.18	56.57
Total	66.5	1.4	19.7	11.4	0.9	0.2	2.99	41.95

4.3.3 Time spent

The time spent by clients waiting for health services is an important aspect of accessibility of services. Table 4.3.6 presents average time spent by clients for FP services. Average time spent travelling from place of residence to SDP was slightly higher (0.55 hours) for those seeking service at secondary level facilities compared to those seeking services at primary level facilities (0.49 hours). Slight regional variations were observed in average time spent travelling from place of residence to SDP. Time spent was highest in the Nyanza region (0.55 hours) followed by the Eastern region (0.54 hours) and was lowest in the Western region (0.41 hours). The average time spent was highest for those seeking services in rural areas (0.54 hours) compared to those seeking services in urban areas (0.43 hours). The results show that average time spent travelling from place of residence to SDP was highest (0.54 hours) for those seeking services at facilities managed by the government and lowest (0.4 hours) for those seeking service in private facilities.

Average time spent waiting for and receiving services was highest (0.71 hours) for those seeking services at secondary level facilities compared to those seeking services at primary level facilities (0.45 hours). The findings indicate that the average time spent waiting for and receiving services was highest (0.74 hours) in the Nairobi region followed by the Coast region (0.64 hours) and North Eastern region (0.62 hours). It was lowest in the Rift Valley region (0.30 hours). Average time was noted to be lower for those seeking services in FBO facilities (0.36 hours) and those seeking services in NGO facilities (0.37 hours).

The results also show that the average travelling time from SDP to place of residence was highest (0.51 hours) for those seeking services at secondary level facilities. It was also highest for those seeking services in the North Eastern region (0.61 hours) and lowest for those seeking services in the Central region (0.41 hours). Average time spent from SDP to place of residence was higher (0.55 hours) in rural areas compared to urban areas (0.46 hours). It was also highest (0.60 hours) for those seeking services in health facilities managed by the government.

Table 4.3.6: Average time spent by client in hours for FP services

Characteristics	Average Time Spent in Hours			
	Travelling from place of residence to the SDP	Waiting for and Receiving Services	Traveling from the SDP to place of residence	Total
Type of Facility				
Primary Level Care	0.49	0.45	0.51	1.46
Secondary Level Care	0.55	0.71	0.57	1.83
Tertiary Level Care	0.52	0.95	0.53	2.00
Region				
Coast	0.52	0.64	0.57	1.73
North Eastern	0.50	0.62	0.61	1.74
Eastern	0.54	0.54	0.59	1.67
Central	0.41	0.46	0.41	1.28
Rift Valley	0.52	0.30	0.51	1.33
Western	0.43	0.44	0.43	1.30
Nyanza	0.55	0.50	0.58	1.62
Nairobi	0.47	0.74	0.43	1.63

Characteristics	Average Time Spent in Hours			
	Travelling from place of residence to the SDP	Waiting for and Receiving Services	Traveling from the SDP to place of residence	Total
Residence				
Urban	0.43	0.50	0.46	1.39
Rural	0.54	0.47	0.55	1.55
Management				
Government	0.54	0.52	0.60	1.62
Private	0.40	0.43	0.42	1.26
FBO	0.53	0.36	0.51	1.39
NGO	0.50	0.37	0.48	1.35
Total	0.50	0.48	0.52	1.50

When clients visit SDPs for services, they forego other activities. Table 4.3.7 shows percent distribution of clients by activities they would have engaged in during the time spent receiving FP services. Slightly over 50 percent of females would have been doing household chores, 20 percent would be working on the farm and 15 percent would be selling or trading during the time they spent receiving FP services. On the other hand, 50 percent of males said they would have been employed as unskilled labourers during the time they spent receiving FP services. Majority of those ages 15-19 and 40-44 (61.9% and 54.8% respectively) indicated they would have been engaged in household chores during the time they spent receiving FP services. Over 44 percent and 23 percent of those aged 45-45 and 30-34 respectively indicated they would have been involved in working on the farm and selling or trading while 22 percent said they would have been employed as skilled labourers during the time when they were receiving FP services. Majority of those currently married (52%) and formerly married (20%) reported that they would be involved in household chores and working on the farm respectively. Majority of the formerly married (25%) and those who had never been married (8%) would have been involved in selling or trading and being employed as unskilled labourers respectively. Those who were formerly married (6%) reported that they would have been involved in clerical or professional work.

Table 4.3.7: Percentage distribution of clients by activities they would have engaged in during the time spent receiving FP services

Respondents Background Characteristics	Percentage						
	Household chores	Working on household farm	Selling or trading	Employed as unskilled labourer	Employed as skilled labourer	Clerical or professional work	Others
Sex							
Male	0.0	0.0	0.0	50.0	0.0	0.0	50.0
Female	50.8	19.7	15.1	3.0	3.4	3.6	4.4
Age							
15-19	61.9	12.7	14.3	3.2	0.0	0.0	7.9
20-24	54.4	19.4	12.3	4.0	3.1	2.3	4.6
25-29	53.1	16.6	14.8	1.8	3.5	5.8	4.4
30-34	44.4	20.3	23.4	2.3	4.2	2.3	3.1
35-39	41.8	26.1	12.2	7.5	3.7	5.2	4.5
40-44	54.8	33.3	9.5	0.0	0.0	0.0	2.4
45-49	11.1	44.4	0.0	0.0	22.2	0.0	22.2
50+	0.0	100.0	0.0	0.0	0.0	0.0	0.0

Respondents Background Characteristics	Percentage						
	Household chores	Working on household farm	Selling or trading	Employed as unskilled labourer	Employed as skilled labourer	Clerical or professional work	Others
Marital status							
Never Married or in union	48.5	10.1	18.2	8.1	7.1	5.1	3.0
Currently Married or in Union	52.4	20.4	14.0	2.5	2.9	3.3	4.5
Formerly Married (Divorced/separated/widowed)	28.4	22.4	25.4	4.5	7.5	6.0	6.0
Total	50.7	19.7	15.1	3.1	3.4	3.6	4.5

Some of the clients left other people to perform their usual chores as they went to receive FP services. Table 4.3.8 presents percentage distribution of clients by the person who performed their activities while they were receiving FP services. The results show that 26 percent of females, 47 percent of those aged 40-44 and 41 percent of those who were formerly married left their chores to a family member. Some of those in ages 35-39, 45-49 and those who were formerly married left a co-worker to act on their behalf. Over 65 percent of females, all those aged 50 years and above, those 45-49 years and 68 percent of those who were currently married left nobody to do their chores. The average amount paid to those who were left to perform the chores on their behalf was Ksh. 655 for females, Ksh. 1062 for those aged 25-29 and Ksh. 761 for those who were currently married.

Table 4.3.8: Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were away receiving FP Services and the estimated average payment

Respondents Background Characteristics	Person who performed activities on behalf of client					Average amount paid by client (Ksh.)
	Family Member	Co-worker	Nobody	Others		
Sex						
Male	0.0	0.0	100.0	0.0	-	
Female	25.5	8.1	65.4	1.0	655.44	
Age						
15-19	15.6	1.6	82.8	0.0	-	
20-24	21.1	7.2	71.4	0.3	286.77	
25-29	21.8	8.6	68.1	1.5	1062.14	
30-34	34.5	8.8	55.9	0.8	199.73	
35-39	31.3	11.2	56.0	1.5	184.55	
40-44	46.5	2.3	51.2	0.0	-	
45-49	0.0	11.1	88.9	0.0	-	
50+	0.0	0.0	100.0	0.0	-	
Marital status						
Never Married or in union	24.0	16.0	58.0	2.0	127.54	
Currently Married or in Union	24.6	6.8	67.9	0.8	761.75	
Formerly Married (Divorced/separated/widowed)	41.2	19.1	36.8	2.9	375.93	
Total	25.4	8.0	65.6	1.0	655.44	

The average amount paid to persons who performed activities on behalf of clients by activities performed while client was away receiving FP services is presented in Table 4.3.9. The average amount paid to those who were selling or trading on behalf of a family member was Ksh. 134 while the average amount paid to those who were performing household chores on behalf of a co-worker was Ksh. 1,745. Those who were performing household chores for others were paid an average of Ksh. 1,144. The average amount paid was highest for those performing household chores Ksh. 1128 and lowest for those working on the household farm (Ksh. 475).

Table 4.3.9: Average amount paid to persons who performed activities on behalf of clients by activities performed while client was away receiving FP services

Respondents Background Characteristics	Average Amount paid to persons (Kenya Shillings)			
	Family Member	Co-worker	Others	Total Average Amount
Household chores	72.37	1744.71	1144.21	1127.79
Working on household farm	88.24	-	316.79	198.99
Selling or Trading	134.00	903.05	57.48	475.17
Employed as unskilled labourer	-	-	-	-
Employed as skilled labourer	-	-	-	-
Clerical or professional work	-	-	-	-
Others	-	500.00	-	500.00
Total	103.57	1064.58	707.30	655.44

4.3.4 Source of funds for family planning

Cost of FP services can determine whether or not clients access the services. Table 4.3.10 presents percentage distribution of clients by source of funds used to pay for FP services. Over 20 percent of females, those aged 35-39 (38%) and 30-34 (26%), and 35 percent of those who were formerly married paid for themselves. Females (17%), those aged 45-49 (24%), 25-29 (20%) and those who were currently married (19%) were paid for by their spouses. Less than 1 percent of females were paid for by other family members besides the spouse while 5 percent of those aged 15-19 and 3 percent of those who were never married were paid for by other family members. One-third of males, 9 percent of females, 13 percent of those aged 45-49 and 14 percent of those who were never married had their services paid for by other people.

Table 4.3.10: Percentage distribution of clients by source of funds used to pay for FP services

Respondents Background Characteristics	Source of funds used to pay for FP services			
	Client (self)	Spouse	Family Members other than spouse (husband or wife)	Others
Sex				
Male	0.0	0.0	0.0	33.3
Female	20.2	16.6	0.3	9.3
Age				
15-19	10.0	4.8	4.5	8.1
20-24	15.9	18.1	0.2	11.7
25-29	18.3	19.9	0.0	10.1
30-34	25.7	15.2	0.0	6.9
35-39	37.5	9.6	0.1	8.2
40-44	7.9	16.2	0.0	1.2
45-49	15.4	24.4	0.0	13.1
50+	3.2	3.2	0.0	3.2
Marital status				
Never Married or in union	27.7	5.1	3.4	13.5
Currently Married or in Union	18.8	18.5	0.0	9.4
Formerly Married (Divorced/ separated/ widowed)	35.5	2.0	0.1	2.3
Total	20.0	16.6	0.3	9.4

The results of the average amount paid from each source by background characteristics of clients is presented in Table 4.3.11. The results show that the average amount paid by females for themselves was Ksh. 172. The average amount paid for FP services also vary by age of clients. Average amount paid by self was highest for those aged 45-49 (Ksh. 625) followed by those aged 35-39 (Ksh. 250) and was lowest (Ksh. 70) for those aged 15-19. Average amount paid by self was highest for those formerly married (Ksh. 363) and lowest (Ksh. 148) for those currently married. The results also show that average amount paid for females by their spouse was Ksh. 208 while the average amount for those paid for by their spouses was highest (Ksh. 500) for those aged 45-49 followed by Ksh. 470 for those aged 35-39 and was lowest (Ksh. 71) for those aged 15-19. Furthermore, the results show that the average amount paid for by other family members was Ksh. 130 for females, Ksh. 131 for those aged 15-19 and Ksh. 154 for those who were never married. For those who were paid for by others, average amount was Ksh. 965 for females while it was Ksh. 1,011 for those who were currently married.

Table 4.3.1 I: Average amount paid from each source by background characteristics of clients

Respondents Background Characteristics	Average amount from each source used to pay for FP (Kenya Shillings)			
	Client (self)	Spouse	Family Members other than spouse (husband or wife)	Others
Sex				
Male	0	0	0	0
Female	172.47	208.02	130.13	965.62
Age				
15-19	69.64	71.40	130.78	0
20-24	188.18	213.24	0	0
25-29	170.93	187.46	0	0
30-34	121.33	119.37	0	0
35-39	250.36	469.52	0	0
40-44	176.01	410.69	0	0
45-49	624.72	500.00	0	0
50+	0	0	0	0
Marital status				
Never Married or in union	244.92	641.92	154.34	0
Currently Married or in Union	147.77	193.62	0	1010.60
Formerly Married (Divorced/ separated/widowed)	363.03	878.30	0	0

5.1 Conclusion: Summary of Findings

The main objective of the 2015 KHFA was to establish the level of availability of FP and maternal/RH commodities and medicines. In facilities where these commodities and medicines are not available, the survey sought to find out the reasons for this situation. In addition to the above, the survey also sought to document the quality of service provision in the country's health facilities. Based on the above objectives, the key findings of the 2015 KHFA were:

1. Primary-level health facilities offering at least 3 modern contraceptives are 94 percent while secondary and tertiary facilities offering at least 5 modern contraceptives are 79 percent.
2. The main reasons why certain FP methods were not offered in some SDPs who should be providing them were:
 - a. Delays in requesting for and receiving supplies. This mainly affects emergency contraception, injectables, oral contraception, and both male and female condoms
 - b. Low client demand for some of the methods especially condoms and oral contraception.
 - c. No trained staff and lack of equipment for the provision of long term methods i.e. male and female sterilization, IUDs, and implants.
3. Only 14 percent of the SDPs had no stockout (supplies were in stock) over the three-month period before the survey. On the day of the survey, only 19 percent of the facilities had no stockout, implying that 81 percent of the facilities did not have in stock all the methods they were supposed to have.
4. The main reasons given for stockout of modern FP methods were similar to those given for not offering certain methods as mentioned above.
5. Availability of 7 lifesaving medicines, including Magnesium Sulphate and Oxytocin, was 62 percent overall. All tertiary facilities had these medicines while only 59 percent of the primary facilities had these medicines.
6. The main reasons why some facilities that offer ANC and delivery services did not have the required 7 medicines were:
 - a. Delays in requesting or receiving supplies. This mainly affected the following medicines; Gentamicin, Metronidazole, Cefixime, Ceftriaxone, Benzathine Penicillin, Misoprostol, and Mifepristone.
 - b. Insufficient supply of medicines especially Oxytocin, Metronidazole, Cefixime, and Ceftriaxone.
 - c. Low or no client demand affected the availability of Mifepristone, Hydralazine, and Methyl Dopa.
 - d. The availability of Tetanus Toxoid was affected by other reasons.

7. Apart from the FP checklists and job-aids which were available in 52 percent of the SDPs, the FP guidelines, ANC guidelines, ANC checklists/job-aids, and waste disposal guidelines were available in less than half of the SDPs. ANC guidelines were the least available at 29 percent of the SDPs.
8. Most (57%) SDPs dispose of their medical waste by burning the same within their respective compounds. It's only about one-third of the SDPs that use incinerators to dispose their waste. One percent of the facilities dispose their medical waste alongside their regular waste.
9. In about two-thirds of the SDPs, nurses were responsible for ordering medical supplies. Pharmacists, clinical officers and doctors were responsible for this function in 15, 17, and 3 percent of the SDPs.
10. In at least three-quarters of the SDPs, the quantification of supplies was done by a staff member of the SDP.
11. The main sources of supplies were central medical stores, regional medical stores, and private sources.
12. About 57 percent of the SDPs receive their supplies within one month of ordering while 12 percent receive their orders after 4 months.
13. The availability of a cold chain was high at 84 percent. The Rift Valley region had the highest availability at 90 percent while Central had the lowest at 76 percent. The main form of cold chain used by the SDPs was fridges at over 99 percent.
14. Nine in every 10 SDPs have staff that have been trained on FP, including the insertion and removal of implants. Two-thirds of these SDPs received their last FP training within 6 months prior to the survey.
15. Two-thirds of the SDPs were last supervised within 3 months prior to the survey. Of concern is the fact that 1 in 10 SDPs had gone without supervision for more than 12 months especially in Central, North Eastern, and Nairobi regions. During supervision visits, the review of guidelines and job-aids for RH was least done.
16. Over two-thirds of the SDPs have ICT facilities such as computers, phones, and internet connections. Most of these facilities were provided by the respective proprietors of the SDPs and they were mainly used for routine communication (71%), facility record keeping (57%), patient registration (38%), and supply chain management (36%).
17. Most (99%) of those who participated in the FP client exit interviews were females between 15-49 years of age. About 87 percent of these women were married. The satisfaction of these clients with the adherence to technical aspects by the service providers was high. The only area of main concern to the clients was the low provision of information by the service providers on what clients should do in case of any complication.
18. On the organizational aspects of service provision, only 1 in every 5 clients was of the opinion that the waiting time to receive FP services was too long. Almost all the clients who received FP services were satisfied with the cleanliness, privacy of the consultation rooms, and time allotted for their cases.
19. On the interpersonal aspects of service provision, almost all the clients were satisfied with the attitude of the health workers and they indicated that they were treated with courtesy. About 9 percent of the clients felt that the service providers coerced or insisted that they take up a FP method that was not their choice.

20. Two in every 5 clients indicated that they paid for the FP services received. For the contraceptives received from service providers, the clients paid an average of Ksh. 193. Clients paid an average of Ksh. 63 for contraceptives received from pharmacies. Other services for which the clients paid were cards, laboratory tests, and consultation.
21. On the time and transport costs incurred by clients in traveling to and from the SDP, the clients took an average of 1.5 hours and paid an average of Ksh. 42. The average distance travelled by the clients to the SDP and back home was 3 kilometres.
22. Over half of the SDPs charge clients for FP/RH related consultation including delivery (89%), care of sick children under 5 years (87%), and ANC (85%) services. As for FP and HIV consultations, only 61 and 51 percent of SDPs respectively charge for this.
23. Maternal health medicines are charged for in 88 percent of the SDPs. Child health medicines and FP commodities are also charged for in 87 and 83 percent of the SDPs respectively.

5.2 Recommendations

Based on the findings of the 2015 KHFA, here below are the main recommendations:

1. Improve the availability of modern FP methods in SDPs, especially at secondary and tertiary levels, by addressing the supply chain related issues that affect timely requisitions by SDPs and timely delivery by suppliers. These issues include delays in making requisitions, use of logistics forms, delays in delivery of supplies, and delivery of inadequate supplies.
2. The training of more health workers and provision of equipment to all SDPs that provide long term methods such as implants, IUDs, and both male and female sterilization will also need to be undertaken. The Ministry of Health at both national and county levels should take the lead in ensuring implementation.
3. Availability of maternal/RH lifesaving medicines needs to be improved across all regions and facility types while maintaining the good performance of North Eastern region and tertiary facilities. For this to happen, the supply chain related issues affecting the timely requisition of medicines by SDPs and the timely delivery of the same will need to be addressed. These issues include delays in making requisitions, use of logistics forms, delays in delivery of supplies, and delivery of inadequate supplies. Again the Ministry of Health at both national and county levels should take the lead in ensuring that this is implemented.
4. The reasons affecting the availability of Tetanus Toxoid need to be investigated further. This is because more than half of the facilities that do not provide this medicine indicated that the reasons for the same are not supply chain related. Further research needs to be conducted on this matter by Ministry of Health and NCPD.
5. Demand by clients for methods such as male and female condoms, and oral contraception needs to be improved. This will require concerted efforts by various stakeholders to sensitize the public on the methods that are not widely used with a view of increasing uptake. The Ministry of Health at national and county levels should partner with NCPD to rally other players around this cause.
6. The few cases of disposal of medical waste with regular waste need to be eliminated. At the same time the proportion of SDPs using incinerators needs to be increased while those using contracted services for disposal should be assessed as to whether they are using contractors

approved by the National Environment Management Authority (NEMA). The Ministry of Health should partner with NEMA and other relevant organizations during implementation.

7. The availability of guidelines, checklists and job-aids is important as it helps service providers to adhere to the required standards and provide quality services. Unfortunately, the survey findings show that most of the FP,ANC, and waste disposal guidelines, checklists and job-aids are available in less than half of the country's health facilities. The Ministry of Health at both national and county levels need to ensure that these documents are available in all the health facilities. Several options can be explored in availing these documents including developing and distributing simple popular versions and availing the documents in softcopy through the Ministry of Health website. This should be reinforced through supervision visits.
8. There is need to eliminate situations where facilities go without supervision for over 1 year especially in North Eastern, Central and Nairobi regions. This calls for proper planning on the part of the Ministry of Health at both national and county levels so as to ensure that all facilities are visited more regularly. In addition to this, the supervision teams need to ensure that all aspects of supervision, especially the review of guidelines for RH, are tackled during each visit.
9. The use of ICT resources in health facilities needs to be improved through provision of more of these resources including the internet. ICT facilities will help SDPs to improve their record keeping and reporting as well as access to online information that is useful for health service delivery. Proprietors of the various health facilities should be encouraged to provide their respective SDPs with ICT facilities. The Ministry of Health at both national and county levels should take up this role.
10. The few male clients who participated in the exit interviews is a reflection of the low male involvement in the use of FP services. More concerted efforts are therefore required to improve male involvement in use of FP services. In order to achieve this, the Ministry of Health and NCPD should work together in implementing the recommendations of the 2014 National Survey on Male Involvement in Family Planning and Reproductive Health. This will contribute to improve the uptake of FP and RH services by both men and women.
11. Provision of information to FP clients' needs to be improved with regard to service providers giving FP clients information on the side effects of contraceptive methods and what they should do in case of any complications. The training of health workers and supervision of health facilities should put more emphasis on this.
12. A few of the clients interviewed upon exiting the health facilities after receiving FP services indicated that they felt that the service providers tried to coerce or insist on the clients taking up an FP method that was not of their choice. Such cases need to be eliminated through the continuous training and supervision of service providers. The Ministry of Health should be at the forefront in addressing this matter.
13. Further analysis of the survey findings needs to be conducted in order to bring out issues that are not in this report but were captured in the dataset. This will include examining the relationships between various variables of interest. Before undertaking this exercise, stakeholders will need to convene and agree on the issues to be researched further. The Ministry of Health and NCPD should lead this process.

ANNEX I: LIST OF FIGURES

Figure 3.2.1: Distribution of SDPs by the number of modern contraceptive methods provided	11	Figure 3.6.5: Percentage distribution of last time facility was supervised in the past 12 months by type of facility management	49
Figure 3.2.2: Percentage distribution of primary SDPs offering at least three modern contraceptives at primary level of care	11	Figure 3.6.6: Frequency of supervisory visits by residence	50
Figure 3.2.3: Percentage distribution of service delivery points offering at least three modern contraceptive methods by Region	12	Figure 3.6.7: Frequency of supervisory visits by facility management	51
Figure 3.2.4: Percentage distribution of service delivery points offering at least three modern contraceptive methods by urban/rural residence	12	Figure 4.1.1: Percentage distribution of clients by marital status	66
Figure 3.2.5: Percentage distribution of service delivery points offering at least three modern contraceptive methods by management of facility	13	Figure 4.1.2: Percentage distribution of clients by frequency of visit to the SDP for FP services	68
Figure 3.2.6: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods	14	Figure 4.2.1: Percentage distribution of clients' perspective of FP service by inter-personal aspects	72
Figure 3.2.7: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by Region	14		
Figure 3.2.8: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by residence	15		
Figure 3.2.9: Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by management of facility	15		
Figure 3.4.1: Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by type of facility	22		
Figure 3.4.2: Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by management of facility	24		
Figure 3.4.3: Percentage distribution of SDPs with 'no stockout' of a modern contraceptive method in the last three months by distance from nearest warehouse/source of supplies	24		
Figure 3.4.4: Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by management of facility	26		
Figure 3.5.1: Percentage distribution of SDPs with persons responsible for ordering medical supplies by type of SDPs	29		
Figure 3.6.1: Percentage of SDPs with trained staff by residence	44		
Figure 3.6.2: Percent distribution of SDPs with trained staff by facility management	45		
Figure 3.6.3: Percentage distribution of most recent FP training by residence	46		
Figure 3.6.4: Percentage distribution of most recent FP training by facility management	47		

ANNEX II: LIST OF TABLES

Table 1.1:	Distribution of sampled health facilities	3	Table 3.4.5:	Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by urban/rural residence	26
Table 1.2:	Distribution of counties by team	3	Table 3.4.6:	Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by distance from nearest warehouse/source of supplies	27
Table 1.3:	No. of facilities surveyed and response rate	4	Table 3.4.7:	Reason for Stockout by Type of FP Method	28
Table 3.1:	Percentage distribution of facilities by region	9	Table 3.5.1a:	Percentage distribution of SDPs with persons responsible for ordering medical supplies by Region	29
Table 3.2:	Percentage distribution of facilities by managing authority	9	Table 3.5.1b:	Percentage distribution of SDPs with persons responsible for ordering medical supplies by urban/rural residence	30
Table 3.3:	Percentage distribution of facilities by distance to source of supplies	10	Table 3.5.2:	Percentage distribution of SDPs with persons responsible for ordering medical supplies by management of facility	30
Table 3.2.1:	Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by distance from nearest warehouse/source of supplies	13	Table 3.5.3:	How re-supply is quantified by type of SDPs	31
Table 3.2.2:	Percentage distribution of secondary and tertiary service delivery points offering at least 5 modern contraceptive methods by distance from nearest source of supplies	16	Table 3.5.4:	How re-supply is quantified by Region	31
Table 3.2.3:	Reasons for not offering certain contraceptive	17	Table 3.5.5:	How re-supply is quantified by urban/rural residence	32
Table 3.3.1:	Percentage distribution of SDPs with seven (including two essential) life-saving maternal/reproductive health medicines available by type of facility	18	Table 3.5.6:	How re-supply is quantified by management of facility	32
Table 3.3.2:	Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by Region	18	Table 3.5.7:	Main source of supplies by type of SDPs	33
Table 3.3.3:	Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by residence	19	Table 3.5.8:	Main source of supplies by Administrative Unit/Region	33
Table 3.3.4:	Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by management of facility	19	Table 3.5.9:	Main source of supplies by urban/rural residence	34
Table 3.3.5:	Percentage distribution of service delivery points with seven (including two essential) life-saving maternal/reproductive health medicines available by distance from nearest warehouse/source of supplies	20	Table 3.5.10:	Main source of supplies by management of facility	34
Table 3.3.6:	Percentage distribution of main reasons why SDPs are not offering some of the maternal and reproductive health lifesaving medicines	21	Table 3.5.11:	Estimated length of time between order and receiving of supplies by type of SDPs	35
Table 3.4.1:	Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by Administrative Unit (Region)	23	Table 3.5.12:	Estimated length of time between order and receiving of supplies by Administrative Unit (Region)	35
Table 3.4.2:	Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by urban/rural residence	23	Table 3.5.13:	Estimated length of time between order and receiving of supplies by urban/rural residence	36
Table 3.4.3:	Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by type of facility	25	Table 3.5.14:	Estimated length of time between order and receiving of supplies by management of facility	36
Table 3.4.4:	Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by Administrative Unit (Region)	25	Table 3.5.15:	Frequency of re-supply by type of SDPs	36
			Table 3.5.16:	Frequency of re-supply by Region	37
			Table 3.5.17:	Frequency of resupply by management of facility	37
			Table 3.5.18:	Responsibility for transportation of supplies by type of SDPs	38
			Table 3.5.19:	Responsibility for transportation of supplies by Region	38
			Table 3.5.20:	Responsibility for transportation of supplies by urban/rural residence	38

LIST OF TABLES (cont.)

Table 3.5.21:	Responsibility for transportation of supplies by management of facility	39	Table 3.6.12:	Percentage of SDPs with issues included in supervisory visits by urban/rural residence	52
Table 3.5.22:	Availability of cold chain by type of SDP	39	Table 3.6.13:	Percentage of issues included in supervisory visits by management of facility	53
Table 3.5.23:	Availability of cold chain by Region	40	Table 3.7.1:	Percentage of SDPs with guidelines, check-lists and job aids	53
Table 3.5.24:	Availability of cold chain by urban/rural residence	40	Table 3.8.1:	Percentage of SDPs with types of Information Communication Technology available	55
Table 3.5.25:	Availability of cold chain by management of facility	41	Table 3.8.2:	Percentage of SDPs by how ICT was acquired	56
Table 3.5.26:	Source of power for Fridges used for cold chain by type of SDP	41	Table 3.8.3:	Percentage of SDPs by main purpose for which ICT is used	58
Table 3.5.27:	Use of logistics forms for reporting and ordering supplies by type of SDPs	42	Table 3.8.4:	Percentage distribution of SDPs by how health wastes are disposed	59
Table 3.5.28:	Use of logistics forms for reporting and ordering supplies by Administrative Unit (Region)	42	Table 3.9.1:	Percentage distribution of SDPs by issues for which user fee is charged for consultation according to the type of facility, region, residence and management	61
Table 3.5.29:	Use of logistics forms for reporting and ordering supplies by urban/rural residence	42	Table 3.9.2:	Percentage distribution of SDPs by issues for which user fee is charged for medication (No Exemptions)	62
Table 3.5.30:	Use of logistics forms for reporting and ordering supplies by management of facility	43	Table 4.1.1:	Age distribution of clients	65
Table 3.6.1:	Percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by type of SDP	44	Table 4.1.2:	Marital status of clients	66
Table 3.6.2:	Percentage distribution of SDPs with staff trained to provide FP services and for the insertion and removal of Implants by Region	44	Table 4.1.3:	Percentage distribution of clients by education level	67
Table 3.6.3:	Percentage distribution of the last time staff received training for FP including for provision of implants by type of Facility	45	Table 4.1.4:	Percentage distribution of clients by frequency of visit to the SDP for FP services	68
Table 3.6.4:	Percentage distribution of the last time staff received training for FP including for provision of implants by Region	46	Table 4.2.2:	Percentage distribution of clients' perspective of FP service organizational aspects	71
Table 3.6.5:	Percentage distribution of the last time the facility was supervised in the past 12 months by type of facility	47	Table 4.2.3:	Percentage distribution of clients' perspective of FP service by inter-personal aspects	73
Table 3.6.6:	Percentage distribution of the last time the facility was supervised in the past 12 months by Administrative Unit (Region)	48	Table 4.2.4:	Percentage distribution of clients' perspective of FP service outcome aspects	74
Table 3.6.7:	Percentage distribution of the last time the facility was supervised in the past 12 months by residence	48	Table 4.3.1:	Percentage of clients reporting paying for service and average amount paid by type of SDP	75
Table 3.6.8:	Percentage distribution of the frequency of supervisory visits by type of Facility	49	Table 4.3.2:	Percentage of clients reporting paying for service and average amount paid by Region	75
Table 3.6.9:	Percentage distribution of the frequency of supervisory visits by Region	50	Table 4.3.3:	Percentage of clients reporting paying for service and average amount paid by urban/rural residence	76
Table 3.6.10:	Percentage of SDPs with issues included in supervisory visits by type of Facility	51	Table 4.3.4:	Percentage of clients reporting paying for service and average amount paid visits by management of facility	76
Table 3.6.11:	Percentage of SDPs with issues included in supervisory visits by Administrative Unit (Region)	52	Table 4.3.5:	Percentage distribution of clients by mode of transportation, distance travelled and cost of transportation	77
			Table 4.3.6:	Average time spent by client in hours for FP services	78

LIST OF TABLES (cont.)

Table 4.3.7:	Percentage distribution of clients by activities they would have engaged in during the time spent receiving FP services	79	Table A3.5.1	Percentage distribution of SDPs with persons responsible for ordering medical supplies by type of SDPs	95
Table 4.3.8:	Percentage distribution of clients by persons indicated to have performed activities on their behalf while they were away receiving FP Services and the estimated average payment	80	Table A3.5.2	Frequency of resupply by urban/rural residence	95
Table 4.3.9:	Average amount paid to persons who performed activities on behalf of clients by activities performed while client was away receiving FP services	81	Table A3.5.3	Source of power for Fridges used for cold chain by Administrative Unit (Region)	96
Table 4.3.10:	Percentage distribution of clients by source of funds used to pay for FP services	82	Table A3.5.4	Source of power for Fridges used for cold chain by urban/rural residence	96
Table 4.3.11:	Average amount paid from each source by background characteristics of clients	83	Table A3.5.5	Source of power for Fridges used for cold chain by management of facility	96
Table A3.1.1	Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by type of facility	91	Table A3.6.1	Percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by urban/rural residence	96
Table A3.1.2	Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by Administrative Unit (Region)	91	Table A3.6.2	Percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by management of facility	97
Table A3.1.3	Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by urban/rural residence	91	Table A3.6.3	Percentage distribution of the last time staff received training for FP including for provision of implants by urban/rural residence	97
Table A3.1.4	Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by management of facility	92	Table A3.6.4	Percentage distribution of the last time staff received training for FP including for provision of implants by management of facility	97
Table A3.2.1	Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by type of facility	92	Table A3.6.5	Percentage distribution of the last time the facility was supervised in the past 12 months by management of facility	97
Table A3.2.2	Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by Administrative Unit (Region)	92	Table A3.6.6	Percentage distribution of the frequency of supervisory visits by urban/rural residence	98
Table A3.2.3	Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by urban/rural residence	93	Table A3.6.7	Percentage distribution of the frequency of supervisory visits by management of facility	98
Table A3.2.4	Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by management of facility	93	Table A3.6.8	Percentage distribution of service delivery points offering modern contraceptive method	99
Table A3.3.1	Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by type of facility	93	Table A3.6.9	Percentage distribution of service delivery points with any Maternal/RH Medicine Available Maternal/RH Medicines	100
Table A3.3.2	Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by management of facility	94	Table A3.6.10	Percentage distribution of service delivery points with any modern contraceptive method in stock (NO STOCK OUT) in the last three months	102
Table A3.3.3	Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by distance from nearest warehouse/ source of supplies	94	Table A3.6.11	Percentage distribution of service delivery points with modern contraceptive method in stock (NO STOCK-OUT) at the time of the survey	103
Table A3.4.1	Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by management of facility	95	Table A4.4.1:	Distribution of Health Facilities	105

Annex III: ADDITIONAL TABLES

A3.1 Modern contraceptives offered by primary facilities

Table A3.1.1 Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by type of facility

Type of Facility	Percentage		
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	Total
Primary Level Care SDPs/facilities/hospitals (or equivalent to country context)	94.1	5.9	100

Table A3.1.2 Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by Administrative Unit (Region)

Administrative Unit (Region)	Percentage		
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	Total
Coast	88.9	11.1	100
North Eastern	82.4	17.6	100
Eastern	99.1	0.9	100
Central	85.1	14.9	100
Rift Valley	92.9	7.1	100
Western	97.4	2.6	100
Nyanza	100.0	0.0	100
Nairobi	100.0	0.0	100
Total	93.9	6.1	100

Table A3.1.3 Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by urban/rural residence

Residence	Percentage		
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	Total
Urban	89.8	10.2	100
Rural	96.2	3.8	100
Total	94.1	5.9	100

Table A3.1.4 Percentage distribution of primary service delivery points offering at least three modern contraceptive methods by management of facility

Management of facility	Percentage		
	Offering at least three modern contraceptive methods	Not offering at least three modern contraceptive methods	Total
Government	99.0	1.0	100.0
Private	87.0	13.0	100.0
FBO	87.5	12.5	100.0
NGO	100	0.0	100.0
Total	93.9	6.1	100.0

A3.2 Modern contraceptives offered by secondary and tertiary facilities

Table A3.2.1 Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by type of facility

Type of Facility	Percentage		
	Offering at least five modern contraceptive methods	Not offering at least five modern contraceptive methods	Total
Secondary level care SDPs/facilities/hospitals (or equivalent)	78.8	21.2	100
Tertiary level care SDPs/facilities/hospitals (or equivalent)	100.0	0.0	100
Total	79.4	20.6	100

Table A3.2.2 Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by Administrative Unit (Region)

Administrative Unit (Region)	Percentage		
	Offering at least five modern contraceptive methods	Not offering at least five modern contraceptive methods	Total
Coast	75.0	25.0	100
North Eastern	100.0	0.0	100
Eastern	80.0	20.0	100
Central	100.0	0.0	100
Rift Valley	75.0	25.0	100
Western	66.7	33.3	100
Nyanza	66.7	33.3	100
Nairobi	100.0	0.0	100
Total	79.4	20.6	100

Table A3.2.3 Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by urban/rural residence

Residence	Percentage		
	Offering at least five modern contraceptive methods	Not offering at least five modern contraceptive methods	Total
Urban	88.2	11.8	100
Rural	70.6	29.4	100
Total	79.4	20.6	100

Table A3.2.4 Percentage distribution of secondary and tertiary service delivery points offering at least five modern contraceptive methods by management of facility

Management of facility	Percentage		
	Offering at least five modern contraceptive methods	Not offering at least five modern contraceptive methods	Total
Government	84.6	15.4	100.0
Private	71.4	28.6	100.0
FBO	0.0	100.0	100.0
NGO	0	0	0
Total	79.4	20.6	100.0

A3.3 Incidence of 'No Stockout' of modern contraceptives in the last three months

Table A3.3.1 Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by type of facility

Type of Facility	Percentage		
	Modern contraceptive method in stock ['no stockout'] in the last three month	Modern contraceptive method not in stock ['stockout'] in the last three month	Total
Primary Level Care	13.5	86.5	100
Secondary Level Care	20.0	80.0	100
Tertiary Level Care	0.0	100.0	100
Total	13.8	86.2	100

Table A3.3.2 Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by management of facility

Management of facility	Percentage		
	Modern contraceptive method in stock ['no stockout'] in the last three month	Modern contraceptive method not in stock ['stockout'] in the last three month	Total
Government	19.1	80.9	100
Private	8.3	91.7	100
FBO	2.9	97.1	100
NGO	0.0	100	100
Total	13.8	86.2	100

Table A3.3.3 Percentage distribution of service delivery points with 'no stockout' of a modern contraceptive method in the last three months by distance from nearest warehouse/source of supplies

Distance from nearest warehouse/source of supplies (in Km)	Percentage		
	Modern contraceptive method in stock ['no stockout'] in the last three month	Modern contraceptive method not in stock ['stockout'] in the last three month	Total
0-4	13.6	86.4	100
5-9	19.4	80.6	100
10-14	1.9	98.1	100
15-19	4.0	96.0	100
20-24	10.0	90.0	100
25-29	20.0	80.0	100
30-34	5.6	94.4	100
35-39	14.3	85.7	100
40-45	40.0	60.0	100
45-49	0.0	100.0	100
50 and over	16.7	83.3	100
Total	14.0	86.0	100

A3.4 Incidence of 'No Stockout' of modern contraceptives on the day of the survey

Table A3.4.1 Percentage distribution of service delivery points with 'no stockout' of modern contraceptive methods at the time of the survey by management of facility

Management of facility	Percentage		
	Modern contraceptive method in stock at the time of the survey ['no stockout']	Modern contraceptive method not in stock at the time of the survey ['stockout']	Total
Government	23.6	76.4	100
Private	15.1	84.9	100
FBO	6.7	93.3	100
NGO	20.8	79.2	100
Total	19.0	81.0	100

A3.5 Supply Chain, including cold chain

Table A3.5.1 Percentage distribution of SDPs with persons responsible for ordering medical supplies by type of SDPs

Type of Facility	Percentage					Total
	Medical Doctor	Clinical Officer	Pharmacist	Nurse	Others	
Primary Level Care	3.0	18.0	11.4	64.1	3.5	100
Secondary Level Care	3.0	3.0	81.8	9.1	3.0	100
Tertiary Level Care	0.0	0.0	100.0	0.0	0.0	100
Total	3.0	17.2	15.2	61.1	3.4	100

Table A3.5.2 Frequency of resupply by urban/rural residence

Residence	Percentage					Total
	Once every two weeks	Once every month	Once every three months	Once every six months	Once a year	
Urban	25.1	48.9	21.1	3.1	1.8	100
Rural	11.3	19.0	52.2	16.3	1.2	100
Total	16.2	29.6	41.2	11.6	1.4	100

Table A3.5.3 Source of power for Fridges used for cold chain by Administrative Unit (Region)

Administrative Unit (Region)	Percentage					Total
	Electricity from national grid	Generator plant at the SDP	Portable generator at the SDP	Kerosene/paraffin fuel	Other (specify)	
Coast	75.6	0.0	0.0	0.0	24.4	100
North Eastern	66.7	0.0	0.0	0.0	33.3	100
Eastern	74.5	0.0	0.0	0.0	25.5	100
Central	94.8	0.0	0.0	0.0	5.2	100
Rift Valley	71.0	0.0	0.0	0.0	29.0	100
Western	80.6	0.0	0.0	0.0	19.4	100
Nyanza	88.1	0.0	0.0	0.0	11.9	100
Nairobi	100.0	0.0	0.0	0.0	0.0	100
Total	80.7	0.0	0.0	0.0	19.3	100

Table A3.5.4 Source of power for Fridges used for cold chain by urban/rural residence

Residence	Percentage					Total
	Electricity from national grid	Generator plant at the SDP	Portable generator at the SDP	Kerosene/paraffin fuel	Other (specify)	
Urban	96.3	0.0	0.0	0.0	3.7	100
Rural	71.5	0.3	0.0	0.0	28.2	100
Total	80.5	0.2	0.0	0.0	19.3	100

Table A3.5.5 Source of power for Fridges used for cold chain by management of facility

Management of facility	Percentage					Total
	Electricity from national grid	Generator plant at the SDP	Portable generator at the SDP	Kerosene/paraffin fuel	Other (specify)	
Government	69.8	0.0	0.0	0.0	30.2	100
Private	100	0.0	0.0	0.0	0.0	100
FBO	81.9	1.4	0.0	0.0	16.7	100
NGO	79.2	0.0	0.0	0.0	20.8	100
Total	80.5	0.2	0.0	0.0	19.3	100

A3.6 Staff training and supervision

Table A3.6.1 Percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by urban/rural residence

Residence	Percentage of SDPs with staff trained	
	To provide FP services	For the insertion and removal of Implants
Urban	91.6	87.6
Rural	95.4	91.5
Total	94.1	90.2

Table A3.6.2 Percentage distribution of staff trained to provide FP services and for the insertion and removal of Implants by management of facility

Management of facility	Percentage of SDPs with staff trained	
	To provide FP services	For the insertion and removal of Implants
Government	98.40	95.90
Private	92.30	85.90
FBO	78.60	79.70
NGO	100.00	77.30
Total	94.20	90.20

Table A3.6.3 Percentage distribution of the last time staff received training for FP including for provision of implants by urban/rural residence

Residence	Most recent training for FP				
	In the last two months	Between two and six months ago	Between six month and one year ago	More than one year ago	Training exercise include the insertion and removal of implant contraceptive
Urban	23.4	52.1	14.1	10.4	90.3
Rural	23.1	38.4	9.2	29.2	90.7
Total	23.2	43.2	10.9	22.7	90.5

Table A3.6.4 Percentage distribution of the last time staff received training for FP including for provision of implants by management of facility

Management of facility	Most recent training for FP				
	In the last two months	Between two and six months ago	Between six month and one year ago	More than one year ago	Training exercise include the insertion and removal of implant contraceptive
Government	31.30	38.30	9.30	21.00	96.10
Private	12.50	51.60	10.90	25.00	83.90
FBO	4.70	48.80	14.00	32.60	83.70
NGO	39.10	30.40	26.10	4.30	91.70
Total	23.30	43.30	10.90	22.50	90.60

Table A3.6.5 Percentage distribution of the last time the facility was supervised in the past 12 months by management of facility

Management of facility	Last time the facility was supervised in the past 12 months				
	In less than one Month	Between one and three Months ago	Between three and six months ago	Between six month and one year ago	Not supervised in the past 12 month
Government	30.40	38.60	13.80	11.30	6.00
Private	21.40	30.00	13.20	10.90	24.50
FBO	25.70	34.30	17.10	12.90	10.00
NGO	26.10	47.80	21.70	4.30	0.00
Total	26.60	35.40	14.20	11.10	12.70

Table A3.6.6 Percentage distribution of the frequency of supervisory visits by urban/rural residence

Residence	Frequency of supervisory visits					
	Weekly	Monthly	Every three months	Every six months	Once a year Never	Not supervised
Urban	0.9	20.7	31.5	14.4	18.0	14.4
Rural	0.2	17.1	54.8	13.9	6.1	7.8
Total	0.5	18.5	46.5	14.0	10.3	10.2

Table A3.6.7 Percentage distribution of the frequency of supervisory visits by management of facility

Management of facility	Frequency of supervisory visits					
	Weekly	Monthly	Every three months	Every six months	Once a year Never	Not supervised
Government	0.30	16.60	63.10	10.60	5.00	4.40
Private	0.00	22.70	22.20	13.90	21.30	19.90
FBO	2.80	7.00	52.10	23.90	5.60	8.50
NGO	0.00	43.50	26.10	30.40	0.00	0.00
Total	0.50	18.60	46.50	14.00	10.50	10.00

Table A3.6.8 Percentage distribution of service delivery points offering modern contraceptive method

Characteristics	Modern contraceptive method							
	Male Condoms	Female Condoms	Oral Pills	Injectables	IUDs	Implants	Sterilization for Females	Sterilization for Males
Type of Facility								
Primary Level Care	92.5	49.8	94.8	98.4	63.7	83.2	2.5	2.1
Secondary Level Care	96.9	75.0	100.0	100.0	96.9	100.0	48.4	41.9
Tertiary Level Care	100.0	100.0	100.0	100.0	100.0	100.0	100.0	50.0
Administrative Unit (Region)								
Coast	87.9	52.5	89.8	89.8	46.6	89.7	12.5	10.7
North Eastern	94.7	37.5	89.5	100.0	40.0	60.0	0.0	0.0
Eastern	89.7	45.7	99.1	100.0	54.8	80.9	3.5	2.6
Central	91.1	37.8	87.5	97.8	72.5	72.5	4.0	4.0
Rift Valley	95.9	42.9	94.5	100.0	58.2	81.7	8.7	5.9
Western	94.9	65.8	100.0	100.0	86.8	92.3	2.9	2.9
Nyanza	89.9	49.3	98.6	98.6	71.0	91.3	6.0	6.0
Nairobi	100.0	100.0	100.0	100.0	100.0	100.0	1.7	1.7
Residence								
Urban	90.5	63.2	91.9	98.1	76.0	88.3	10.5	8.5
Rural	93.8	44.6	96.9	98.7	60.2	81.9	2.9	2.2
Management								
Government	97.5	57.9	99.7	100.0	67.3	90.6	5.1	4.3
NGO	100.0	61.5	100.0	100.0	69.2	92.6	22.7	22.7
Others	85.9	42.2	89.0	96.5	63.3	74.8	4.8	3.5
Distance from nearest warehouse/source of supplies (in Km)								
0-4	85.5	42.4	89.6	98.2	56.4	81.1	6.4	5.0
5-9	95.9	60.9	100.0	98.0	57.1	70.8	5.0	5.1
10-14	96.4	75.0	94.5	100.0	94.5	89.3	1.9	1.9
15-19	96.0	60.0	100.0	100.0	72.0	88.0	4.2	4.2
20-24	91.3	62.5	100.0	100.0	87.0	87.0	0.0	0.0
25-29	100.0	42.9	100.0	100.0	80.0	92.9	0.0	0.0
30-35	80.0	23.8	60.0	100.0	60.0	80.0	0.0	0.0
35-39	100.0	85.7	100.0	100.0	85.7	85.7	0.0	0.0
40-44	95.0	45.0	100.0	100.0	61.1	82.4	0.0	0.0
45-49	100.0	0.0	100.0	100.0	0.0	0.0	0.0	0.0
50 and over	96.7	51.0	98.6	97.6	64.7	87.9	9.2	8.1
Total	92.7	51.2	95.2	98.5	65.6	84.1	5.6	4.7

Table A3.69 Percentage distribution of service delivery points with any Maternal/RH Medicine/Available Maternal/RH Medicines

Characteristics	Maternal/RH Medicines																
	(1) Ampicillin	(2) Azithromycin	(3) Benzathine penicillin	(4) Eiter Betamethasone Or Dexamethasone	(5) Calcium gluconate	(6) Cefixime	(7) Gentamicin	(8) Hydralazine	(9) Magnesium sulfate	(10) Methyldopa	(11) Metronidazole	(12) Mifepristone	(13) Misoprostol	(14) Nifedipine	(15) Oxytocin	(16) Ether Sodium chloride Or Sodium lactate compound solution	(17) Tetanus toxoid
Type of Facility																	
Primary Level Care	51.6	77.9	87.5	42.0	41.5	67.6	88.5	52.0	65.1	52.3	90.8	19.0	36.5	62.7	92.5	95.9	91.4
Secondary Level Care	75.0	96.8	96.9	87.5	77.4	90.0	93.9	93.9	93.8	90.3	96.8	15.0	66.7	96.7	100.0	100.0	96.8
Tertiary Level Care	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	100.0	100.0	100.0	100.0	100.0
Region																	
Coast	70.6	94.7	78.9	73.1	47.1	91.9	94.7	72.2	80.6	62.2	92.1	31.8	43.5	85.7	89.7	100.0	89.7
North Eastern	42.9	94.1	100.0	81.3	75.0	82.4	100.0	87.5	93.8	100.0	100.0	40.0	40.0	100.0	100.0	100.0	94.1
Eastern	92.3	85.2	83.3	44.2	26.9	69.4	96.3	52.3	67.9	63.0	92.6	40.0	58.3	77.4	94.4	100.0	84.6
Central	58.8	77.8	100.0	75.0	47.1	86.7	100.0	78.6	66.7	83.3	100.0	100.0	57.1	100.0	100.0	94.4	89.5
Rift Valley	32.5	77.0	96.6	42.9	53.0	69.0	82.8	48.0	60.2	46.8	91.9	0.0	38.0	53.2	92.9	92.9	95.2
Western	40.7	57.1	91.2	31.0	50.0	48.4	71.4	72.0	64.7	64.3	80.0	18.8	30.0	44.0	94.3	97.1	77.1
Nyanza	43.8	75.8	85.9	30.0	40.6	60.6	92.1	41.1	70.8	33.8	87.5	15.0	31.6	45.8	87.9	95.5	98.4
Nairobi	75.0	87.5	64.7	75.0	40.0	81.3	88.2	64.7	56.3	81.3	100.0	13.3	43.8	88.2	100.0	100.0	100.0
Residence																	
Urban	69.0	80.2	85.9	78.3	54.3	83.3	97.7	75.0	64.3	75.0	97.6	27.7	58.1	78.6	97.6	96.5	94.1
Rural	48.4	79.3	89.4	35.1	42.1	65.3	86.0	50.0	69.6	49.8	88.8	12.2	30.6	61.3	91.4	96.7	90.8
Management																	
Government	37.9	76.1	88.3	31.6	44.6	58.3	84.4	47.7	74.6	51.4	86.7	9.2	23.9	55.0	89.7	95.3	91.4
NGO	100.0	100.0	100.0	80.0	70.0	100.0	90.0	87.5	70.0	77.8	100.0	50.0	62.5	100.0	100.0	100.0	100.0
Others	79.2	85.0	88.8	71.2	44.1	90.3	98.1	72.2	54.8	64.9	100.0	27.5	62.8	83.5	99.0	98.1	91.3

Characteristics	Maternal/RH Medicines																
	(1) Ampicillin	(2) Azithromycin	(3) Benzathine benzylpenicillin	(4) Either Betamethasone Or Dexamethasone	(5) Calcium gluconate	(6) Cefixime	(7) Gentamicin	(8) Hydralazine	(9) Magnesium sulfate	(10) Methyldopa	(11) Metronidazole	(12) Mifepristone	(13) Misoprostol	(14) Nifedipine	(15) Oxytocin	(16) Either Sodium chloride Or Sodium lactate compound solution	(17) Tetanus toxoid
	Distance from nearest warehouse/source of supplies (in Km)																
0-4	53.8	72.6	84.1	40.3	38.5	67.9	92.9	48.4	72.3	51.4	90.4	13.0	43.4	60.8	96.4	96.3	93.8
5-9	85.7	100.0	79.3	71.4	48.1	78.6	100.0	50.0	70.4	69.0	100.0	30.0	38.1	85.2	96.4	100.0	96.4
10-14	44.4	60.0	81.8	60.0	45.5	60.0	60.0	88.9	50.0	75.0	81.8	0.0	50.0	75.0	90.0	90.0	81.8
15-19	33.3	44.4	77.8	22.2	50.0	44.4	100.0	44.4	66.7	87.5	100.0	0.0	33.3	44.4	88.9	100.0	100.0
20-24	42.9	81.3	100.0	38.5	42.9	83.3	100.0	57.1	75.0	46.7	87.5	62.5	72.7	75.0	93.8	100.0	93.8
25-29	75.0	100.0	100.0	66.7	66.7	75.0	100.0	66.7	75.0	50.0	100.0	0.0	0.0	66.7	100.0	100.0	100.0
30-34	37.5	87.5	100.0	75.0	37.5	75.0	100.0	62.5	50.0	75.0	100.0	0.0	20.0	75.0	100.0	100.0	100.0
35-39	100.0	100.0	100.0	75.0	100.0	75.0	100.0	100.0	100.0	33.3	100.0	0.0		100.0	100.0	100.0	100.0
40-44	50.0	100.0	75.0	25.0	55.6	87.5	100.0	75.0	12.5	57.1	77.8	0.0	100.0	88.9	87.5	100.0	100.0
45-49																	
50 and over	50.4	80.0	91.9	47.0	47.1	68.6	84.0	58.1	68.4	54.0	90.5	18.3	36.5	63.3	91.1	96.2	89.2
Total	54.0	79.6	88.5	47.4	45.3	70.0	89.0	57.2	68.2	56.6	91.3	18.6	41.2	66.2	93.1	96.4	91.7

Table A3.6.10 Percentage distribution of service delivery points with any modern contraceptive method in stock (NO STOCK OUT) in the last three months

Characteristics	No stockout of any modern contraceptive method in the last three months							
	Male Condoms	Female Condoms	Oral Pills	Injectables	IUDs	Implants	Sterilization for Females	Sterilization for Males
Type of Facility								
Primary Level Care	79.4%	40.3%	84.0%	84.9%	63.2%	77.7%	15.9%	14.4%
Secondary Level Care	90.6%	59.4%	90.9%	90.9%	84.4%	90.6%	66.7%	63.6%
Tertiary Level Care	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Region								
Coast	81.4%	44.1%	86.4%	93.2%	60.3%	84.5%	21.4%	21.4%
North Eastern	84.2%	46.7%	78.9%	94.7%	50.0%	73.3%	0.0%	0.0%
Eastern	87.1%	40.9%	81.0%	81.9%	56.5%	83.6%	60.0%	60.0%
Central	71.1%	12.2%	74.4%	80.0%	56.2%	66.3%	50.0%	50.0%
Rift Valley	85.2%	38.5%	81.1%	87.2%	56.8%	67.3%	34.1%	29.3%
Western	77.5%	62.5%	95.0%	95.0%	87.5%	92.3%	100.0%	100.0%
Nyanza	74.6%	40.6%	91.2%	86.6%	76.1%	87.9%	6.3%	6.3%
Nairobi	70.7%	77.2%	100.0%	77.6%	89.7%	89.7%	50.0%	50.0%
Residence								
Urban	70.0%	48.3%	82.3%	84.7%	69.6%	82.4%	46.3%	43.1%
Rural	85.3%	37.6%	85.8%	85.6%	61.6%	76.4%	11.5%	10.4%
Management								
Government	88.6%	49.8%	90.8%	89.2%	69.9%	86.5%	17.7%	15.6%
NGO	81.5%	65.4%	100.0%	92.6%	85.2%	84.6%	50.0%	50.0%
Others	69.0%	28.6%	75.0%	79.3%	55.2%	67.7%	34.9%	31.7%
Distance from nearest warehouse/source of supplies (in km)								
0-4	72.6%	36.0%	75.0%	84.1%	56.4%	76.4%	22.0%	20.0%
5-9	92.0%	52.1%	90.0%	80.0%	61.2%	60.4%	22.2%	22.2%
10-14	70.9%	48.2%	92.7%	76.8%	90.9%	85.7%	25.0%	25.0%
15-19	60.0%	61.5%	88.0%	80.0%	56.0%	75.0%	20.0%	20.0%
20-24	75.0%	41.7%	95.8%	91.3%	82.6%	91.7%	33.3%	33.3%
25-29	80.0%	26.7%	100.0%	93.3%	80.0%	80.0%	0.0%	0.0%
30-34	61.9%	15.0%	61.9%	70.0%	60.0%	71.4%	0.0%	0.0%
35-39	87.5%	57.1%	71.4%	100.0%	85.7%	75.0%	0.0%	0.0%
40-44	89.5%	20.0%	94.7%	85.0%	38.9%	72.2%	0.0%	0.0%
45-49	100.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%
50 and over	87.9%	44.3%	86.9%	89.7%	66.0%	82.1%	37.7%	34.0%
Total	79.9	41.4	84.5	85.2	64.4	78.5	25.5	23.5

Table A3.6.11 Percentage distribution of service delivery points with modern contraceptive method in stock (NO STOCK-OUT) at the time of the survey

Characteristics	No stock out of modern contraceptive method at the time of the survey							
	Male Condoms	Female Condoms	Oral Pills	Injectables	IUDs	Implants	Sterilization for Females	Sterilization for Males
Type of Facility								
Primary Level Care	88.9%	43.8%	91.3%	93.9%	64.4%	81.4%	9.5%	7.6%
Secondary Level Care	93.5%	63.3%	96.8%	96.7%	87.1%	90.3%	63.6%	57.1%
Tertiary Level Care	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Region								
Coast	87.9%	49.2%	92.7%	94.5%	51.9%	84.9%	17.1%	17.1%
North Eastern	88.2%	50.0%	87.5%	100.0%	40.0%	46.7%		0.0%
Eastern	91.2%	51.8%	95.6%	96.5%	56.6%	83.2%	50.0%	50.0%
Central	87.2%	15.6%	77.9%	88.4%	61.3%	66.3%	33.3%	33.3%
Rift Valley	91.7%	36.6%	90.3%	93.8%	55.9%	76.4%	23.9%	18.2%
Western	87.2%	71.8%	92.3%	92.3%	84.6%	91.9%	100.0%	100.0%
Nyanza	86.6%	43.3%	96.9%	91.0%	84.6%	98.4%	6.5%	6.5%
Nairobi	89.3%	76.8%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%
Residence								
Urban	84.7%	52.7%	91.0%	95.5%	73.1%	86.7%	36.7%	34.0%
Rural	91.6%	40.5%	92.0%	93.4%	62.0%	79.5%	7.7%	6.4%
Management								
Government	96.1%	54.1%	95.7%	94.7%	72.4%	89.9%	15.3%	13.7%
NGO	88.5%	65.4%	100.0%	100.0%	74.1%	76.9%	50.0%	41.7%
Others	81.3%	31.8%	85.8%	92.7%	56.1%	72.6%	17.8%	15.9%
Distance from nearest warehouse/source of supplies (in km)								
0-4	83.5%	38.3%	86.5%	92.4%	56.1%	78.8%	15.8%	11.1%
5-9	93.8%	61.2%	91.3%	89.1%	53.2%	58.7%	22.2%	22.2%
10-14	87.0%	48.1%	90.9%	98.1%	90.0%	84.3%	25.0%	25.0%
15-19	96.0%	61.5%	100.0%	100.0%	72.0%	91.7%	20.0%	20.0%
20-24	87.5%	54.2%	100.0%	91.3%	78.3%	95.7%	0.0%	0.0%
25-29	86.7%	33.3%	100.0%	100.0%	80.0%	80.0%	0.0%	0.0%
30-34	80.0%	20.0%	66.7%	95.0%	70.0%	75.0%	0.0%	0.0%
35-39	100.0%	57.1%	100.0%	100.0%	85.7%	75.0%	0.0%	0.0%
40-44	89.5%	21.1%	100.0%	100.0%	44.4%	83.3%	0.0%	0.0%
45-49	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%
50 and over	93.2%	47.8%	94.6%	94.6%	68.2%	86.5%	32.7%	28.0%
Total	89.2	44.8	91.7	94.1	65.8	81.9	19.3	17.1

Annex IV: 2015 KHFA SAMPLE DESIGN

A4.1 Introduction

The sample design for 2015 Kenya GPRHCS survey was modeled based on the “Survey Methodology for GPRHCS” guidelines from Commodity Security Branch, Technical Division of UNFPA.

A4.2 Sampling Frame

The sampling frame for the 2015 Kenya GPRHCS survey was the Master Facility List of health facilities from the Ministry of Health. The list was updated in May 2015 and had a total of 10,068 facilities covering the whole country. The list was cleaned to remove the non-operational facilities as well as those that did not fall into category of provision of modern methods of contraceptives and maternal/RH services. A total of 8,905 facilities provided the base for sampling as shown in Table I.

A4.3 Sample Size and Allocation

The sample size was calculated as per guidelines as follows:

$$n = \frac{(Z^2 p(1-p))}{d^2}$$

where

n = minimum sample size for each domain

Z = Z score that corresponds to a confidence interval (95% confidence interval is 1.96)

p = the proportion of the attribute (type of SDP) expressed in decimal

d = per cent confidence level in decimal (i.e 0.05)

The 5 levels of Facilities (KEPH Levels) provided first level stratification. The above sample size formula was applied to each of these 5 levels. The sample for each KEPH level was further allocated into all 47 counties disproportionately using power allocation and rounded into the next integer. Finally all the facilities in KEPH level 5 and 6 were all included into the sample.

The sample size for this survey was 658 facilities, allocated as shown in Table A4.4.1

A4.4 Sampling of Facilities

Sampling of facilities were done independently from each stratum. Stratum for this survey was a combination of County and KEPH level. Within each stratum, the facilities were sorted by type and owner of facility. A systematic random sampling (with random start) was used to select the facilities for interviews.

Table A4.4. I: Distribution of Health Facilities

SN	County	Frame						Sample Allocation					
		KEPH Level					Total	KEPH Level					Total
		Level 2	Level 3	Level 4	Level 5	Level 6		Level 2	Level 3	Level 4	Level 5	Level 6	
1	Baringo	158	21	4			183	7	5	2	0	0	14
2	Bomet	100	16	4	1		121	6	5	2	1	0	14
3	Bungoma	122	21	12			155	6	5	2	0	0	13
4	Busia	71	14	7			92	6	5	2	0	0	13
5	Elgeyo Marakwet	84	22	8			114	6	5	2	0	0	13
6	Embu	142	14	7	1		164	7	5	2	1	0	15
7	Garissa	104	27	13	1		145	6	5	2	1	0	14
8	Homa Bay	135	51	13			199	7	6	2	0	0	15
9	Isiolo	40	7	3			50	5	4	2	0	0	11
10	Kajiado	231	32	12			275	7	5	2	0	0	14
11	Kakamega	178	54	13	1		246	7	6	2	1	0	16
12	Kericho	149	17	14			180	7	5	2	0	0	14
13	Kiambu	361	51	27	1		440	8	6	2	1	0	17
14	Kilifi	204	22	9			235	7	5	2	0	0	14
15	Kirinyaga	159	29	5			193	7	5	2	0	0	14
16	Kisii	102	33	19	1		155	6	5	2	1	0	14
17	Kisumu	126	38	21	1		186	6	6	2	1	0	15
18	Kitui	260	47	13			320	8	6	2	0	0	16
19	Kwale	91	11	5			107	6	4	2	0	0	12
20	Laikipia	91	10	8			109	6	4	2	0	0	12
21	Lamu	33	6	3			42	5	4	2	0	0	11
22	Machakos	238	34	8	1		281	7	6	2	1	0	16
23	Makueni	160	34	10			204	7	6	2	0	0	15
24	Mandera	38	27	5			70	5	5	2	0	0	12
25	Marsabit	79	21	3			103	6	5	2	0	0	13
26	Meru	341	34	21	1		397	8	6	2	1	0	17
27	Migori	143	33	13			189	7	5	2	0	0	14
28	Mombasa	264	21	14	1		300	8	5	2	1	0	16
29	Murang'a	218	19	9			246	7	5	2	0	0	14
30	Nairobi	630	141	26	4	3	804	9	7	2	4	2	25
31	Nakuru	297	52	22	1		372	8	6	2	1	0	17
32	Nandi	145	14	4			163	7	5	2	0	0	14
33	Narok	110	28	6			144	6	5	2	0	0	13
34	Nyamira	73	44	8			125	6	6	2	0	0	14
35	Nyandarua	115	25	3			143	6	5	2	0	0	13
36	Nyeri	350	33	9	1		393	8	5	2	1	0	16
37	Samburu	63	5	3			71	6	4	2	0	0	12
38	Siaya	113	41	8			162	6	6	2	0	0	14
39	Taita Taveta	60	18	8			86	6	5	2	0	0	13
40	Tana River	52	6	2			60	5	4	1	0	0	10

SN	County	Frame						Sample Allocation					
		KEPH Level					Total	KEPH Level					Total
		Level 2	Level 3	Level 4	Level 5	Level 6		Level 2	Level 3	Level 4	Level 5	Level 6	
41	Tharaka Nithi	100	14	7			121	6	5	2	0	0	13
42	Trans Nzoia	116	14	5			135	6	5	2	0	0	13
43	Turkana	122	16	6			144	6	5	2	0	0	13
44	Uasin Gishu	126	31	9		1	167	6	5	2	0	1	14
45	Vihiga	50	24	4			78	5	5	2	0	0	12
46	Wajir	89	30	10			129	6	5	2	0	0	13
47	West Pokot	95	7	5			107	6	4	2	0	0	12
	Grand Total	7,128	1,309	448	16	4	8,905	305	241	93	16	2	658

NOTE: The facilities used are the operational ones

Annex V: SURVEY PERSONNEL

Steering Committee	
Dr. Josephine Kibaru-Mbae	NCPD
George Kichamu	NCPD
Joshua Opiyo	Ministry of Planning and Statistics
Judith Kunyiha	UNFPA
Margaret Mwangi	NCPD
Macdonald Obudho	Kenya National Bureau of Statistics
Dr. Anne Khasakhala	Population Studies and Research Institute
Dr. Patrick Amoth	Ministry of Health

Technical Members	
Vane Lumumba	NCPD
Samuel Ogola	Kenya National Bureau of Statistics
Dr. Silas Agutu	Ministry of Health
Dr. Dan Okoro	UNFPA
Francis Kundu	NCPD
Purity Njuguna	Ministry of Planning and Statistics
Stephen Macharia	UNFPA
Jane Keeru	Ministry of Public Service, Youth and Gender
Seth Omondi	NCPD
Michael Oruru	NCPD
Irene Muhunzu	NCPD
Tecla Kogo	Ministry of Health
Catherine Ndei	NCPD
Andrew Mutuku	Population Studies and Research Institute
Reinhard Rutto	NCPD

Supervisors	
Sammy Tanui	Moses Ouma
Benard Kiprotich	Milicent Oluteyo
Enock Obuoloh	Victoria Mutiso
Maurice Oduor	Beatrice Okundi
Beatrice Mwaila	Ken Lwaki
Margaret Kung'u	Alex Juma
Janeth Lunayo	Lucy Kimondo

Data Entry Clerks	
Nancy G. Kiarie	Winnie A. Anyango
Feisal Hassan Adan	Shem Moturi
Turphose Lydia Atieno	Anthony Simwoto

Research Assistants	
John Gichuru	Meshack Mutua
Mary Chege	Loreen Wanja
Alexander Mwai	Elvis Wekesa
Calgan E. Chole	Firdavs Abdulrehman
David O. Omolo	Beatrice Mwakio
Elim Shadrack Lotonia	Pamela S. Mwakughu
Stella Sompot Nkouwua	Eliud Were
Evans Lepish Naimodu	Lumumba Vincent
Shem Nyanga Moturi	Sarah Nyamoita Morara
Yahya Mohamed	Tito Kwena
Abdul-Fatah Hassan	Muna Mohamud
Richard Lowoto	Monica C. Chirchir
Huka H. Halake	Makena W. Muriuki
Rollin Basara	Nambiro N. Jacqueline
Sylvia Chemnjor	Reuben Matolo
Sahra A. Liban	Jessicar C. Wanjiru
Hassan Guyo Gonossa	Fatuma Mohamed Omar
Katra Lelesiit	Roselyne D. Mwachunga
Winfridah Kasaya	Danvas N. Otara
Larisa Achieng'	Nicholas K. Rutto
Prisca Mayoli	Betty C. Chirchir
Evelyn Kagure	Francissa Kimirri

Drivers	
Peter Nganga	Jackson Murungi
Dishon Aluvayo	Peter Omari
Brenda Mumia	Patrick Manyagi
Ernest Ojoro	Stephen Munyao
Zacharia Atuya	Samuel Bett
Vincent Ndege Mobagi	Seif Kamau
Josphat Kabingu	Abdala Tsembea
Samuel Oduor	Evans Kitiabi
Sammy Ndeche Mtoro	Joshua Langat
Hamisi J. Chai	Samuel Kipngok
Luka Musau	Isaac Lumbasi
Sheikh M.Salah	Wilson Kandie
Andrew Saleh	

Annex VI: REPORT AUTHORS

Part	Section	Authors
1	Introduction	Francis Kundu Catherine Ndei
2	Guidelines, Protocols and Laws	Dr. Silas Agutu Teclar Kogo
3	General Information about the Facilities	Francis Kundu
3	Modern Contraceptives Offered by Facilities	Teclar Kogo
3	Availability of Maternal and RH Medicines	Dr. Silas Agutu
3	Incidence of 'No Stock Out' of Modern Contraceptives	Rose Wakuloba
3	Supply Chain, including Cold Chain	Stephen Macharia
3	Staff Training and Supervision	Irene Muhunzu
3	Availability of Guidelines, Check-lists and Job aids	Dr. Silas Agutu Teclar Kogo
3	Use of Information Communication Technology and Waste Disposal	Seth Omondi
3	Charges for User Fees	Purity Njuguna
4	Client Exit Interviews	Reinhard Rutto Dr. Andrew Mutuku
5	Technical Editor	Dr. Peter Njoroge

Module 1: HFA QUESTIONNAIRE



2015 KENYA FACILITY ASSESSMENT FOR REPRODUCTIVE HEALTH COMMODITIES AND SERVICES

SURVEY QUESTIONNAIRE

INFORMATION ABOUT THE INTERVIEW

County

Date of the Survey (DD/MM/YY)

Type of Health Facility

Code Number of Health Facility/SDP

Name of Interviewer

Interviewer Code

Questionnaire checked and attested to be properly completed

Name of Supervisor

Signature Date

GPS READING

1. Ensure you have a clear sky view before taking readings
2. Switch on the GPS device by pressing the power button
3. Press the page button 4 times to access the "Menu" page
4. While the "Mark" menu is highlighted, press the select button
5. Record the readings at the bottom of the screen
6. Once you have recorded the readings
switch off the GPS device to conserve battery power

ELEVATION

LATITUDE N/S

DEGREES/DECIM

LONGITUDE E/W

DEGREES/DECIM

CONSENT

The questionnaire is in two parts; Module 1 (sections 1 to 13) is for the health facility/SDP; and, module 2 (sections 14 and 15) is for exit interview of clients visiting the SDP.

To administer Module 1, the interviewer should find the person in charge of the facility or the most senior worker who is present at the facility on that day. It is recommended that the interviewer should greet the interviewee; introduce himself/herself; and, explain the purpose of the visit.

To ensure informed consent to the interview it is necessary to read the following statement to the interviewee:

My name is _____ and my colleague is _____

We are working for the National Council for Population and Development (NCPD) and the Ministry of Health. The NCPD and MOH are conducting Health Facility Assessment to determine the availability of reproductive health commodities and medicines in the country's health facilities and the quality of family planning services. This will help in enhancing Reproductive Health Commodity Security

Your facility was selected to participate in this study. We will be asking you questions about aspects of RH commodities and services in your facility including family planning. The information obtained from your facility and from other facilities will be used by the MOH, County Policy Makers and other partners to understand the situation and for better planning to improve on service provision

The survey is in two parts: The first part will be answered by you, the service provider, and the second part will be answered by the clients who are visiting the facility for family planning services. We will require your permission to carry on with the exit at the appropriate time.

*You are assured that your name, the name of any other health worker who will be designated to respond to this questions or the name of any client **WILL NOT** be mentioned or included in the data set or in any report of this survey.*

You may refuse to answer any question or choose to stop the interview at any time. However, we hope you will answer the questions, which will be of benefit to strengthen national efforts to provide RH services including family planning.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate it if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study?

Do I have your agreement to proceed? YES _____ NO _____ (TICK)

The interviewer can proceed with the interview once the consent of the interviewee has been obtained. At the end of the interview for the SDP [Sections 1 to 13]; please thank the interviewee for his/her time and the information provided; and, obtain his/her permission or the permission of the relevant authorities before carrying on with the Exit Interview of Family planning clients [Sections 14 and 15]

The interview is likely to take 1 hour.

(Rev – November 2015)

Availability of RH/FP commodities and services

Time Interview Started

SECTION 1: FACILITY IDENTIFICATION (Name, County and Distance)	
001	Code of Service Delivery Point
002	A) Sub-County B) Ward (Name of Administrative Unit)
003	Indicate geographic coordinates of the SDP if any system Global Positioning System (GPS) is used; ELEVATION LATITUDE N/S DEGREES/DECIM LONGITUDE E/W DEGREES/DECIM
004	SDP is located in an urban area or a rural settlement (as per your county's classification); 1 Urban <input type="checkbox"/> 2 Rural <input type="checkbox"/>
005	A) Where does this SDP mainly get regular RH/FP supplies (Main Source)? B) What is the distance in Kilometers between the location of the health facility and the nearest warehouse or store or facility which this SDP receives its regular supplies? /___/___/ KM

SECTION 2: SDP TYPE AND SERVICES PROVIDED	
006	Level of Service Delivery Point (Tick the option that is applicable) 1 Primary Level Care SDPs/facilities (level 2 and 3) <input type="checkbox"/> 2 Secondary level care SDPs/facilities/hospitals (level 4) <input type="checkbox"/> 3 Tertiary level care SDPs/facilities/hospitals (level 5 and 6) <input type="checkbox"/>
007	1 Management of Service Delivery Point: Government <input type="checkbox"/> 2 Private <input type="checkbox"/> 3 FBO <input type="checkbox"/> 4 NGO <input type="checkbox"/> 5 Others (please specify))
008	Does this facility provide Modern family planning services? 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> (If No ,then items in Section 3 and 4 (that is 011 to 020)should NOT be administered)
009	Does this facility provide maternal health including delivery services (e. g. with a maternity unit or section for delivery)? 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> (If No, then items in Section 9 (that is 041-044) should NOT be administered)
010	Does this facility provide any HIV/AIDS services (e.g.VCT, PMTCT,ART, etc.)? Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/>

SECTION 3: MODERN CONTRACEPTIVE METHODS OFFERED AT SDP									
Please note that for the SDP to respond to items in this section, it should have indicated in Item 008 above that 'Yes' it provides family planning services									
Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) Emergency contraception	(6) IUDs	(7) Implants	(8) Sterilization for Females	(9) Sterilization for Male
011 With respect to each of the contraceptive methods, please state whether the SDP is supposed/ expected to offer it, in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery. Please discuss with the respondent and then record your conclusion before proceeding. <i>(* Please recall SDP level as recorded in item 006 above)</i>	1 Yes , this SDP is expected/ supposed to provide this Method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)	1 Yes , this SDP is expected/ supposed to provide this method 2 No , this SDP is NOT expected/ supposed to provide this method (Tick only one option)
IF YES skip to next Method	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)
012 If 'Yes' in item 011 (i.e., this SDP is supposed/ expected to offer this method), please state whether the SDP actually offer it to clients on a regular basis IF YES skip to next Method	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 Not Applicable (because "No" to item 011) <input type="checkbox"/> (Tick only one option)
NOTE: FOR EACH OF THE METHODS - If this SDP is actually supposed/expected to OFFER the contraceptive method but it is currently out of stock or not available at the time of the survey, please record as "Yes" (i.e., the method is actually offered, although it is not currently in stock or available)									

Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) Emergency contraception	(6) IUDs	(7) Implants	(8) Sterilization for Females	(9) Sterilization for Male
<p>013 If this SDP is supposed/expected to offer this method to clients (in line with current national guidelines, etc.) but the response to 012 is "No", please indicate the main reason (Tick only one option [as the main reason] for each contraceptive)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>6 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>6 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>6 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution/warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>6 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>

SECTION 4: NO STOCK OUT OF MODERN CONTRACEPTIVE METHODS AT SDP

Please note that for the SDP to respond to items in this section, it should have indicated in Item 008 above that 'Yes' it provides family planning services

Item	(1) Male condoms	(2) Female Condoms	(3) Oral Contraception	(4) Injectables	(5) Emergency contraception	(6) IUDs	(7) Implants	(8) Sterilization for Females	(9) Sterilization for Male
<p>(i): NO STOCK-OUT IN THE LAST THREE MONTHS BEFORE THE SURVEY</p>									
<p>015 With respect to each of the contraceptive methods that the SDP is supposed/expected to provide in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery (as indicated in Item 011 above); please indicate whether it has been out of stock at this SDP on any given day, within the last 3 months preceding the survey, and therefore the contraceptive method was not available to give/ provide to clients at this SDP</p> <p>(* Please recall SDP level as recorded in item 006 above)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1. Yes; this method has been out-of-stock (STOCK-OUT) on a given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>2. No; this method has not been out-of-stock (NO STOCK OUT) on any given day at this SDP in the last 3 months <input type="checkbox"/></p> <p>(Tick only one option)</p>
<p>016 From responses provided to Item 015 above, please discuss with respondent and record the conclusion by ticking one of the following statements</p>	<p>One or more of the contraceptive methods offered by this SDP has been out-of-stock on a given day in the last three months preceding the survey</p> <p>Therefore, this SDP experienced stock out in the last three months [STOCK-OUT WITHIN THE LAST THREE MONTHS] <input type="checkbox"/></p> <p>All contraceptive method offered by this SDP has been available/ in-stock on all days in the last three months preceding the survey</p> <p>Therefore, this SDP did not experience stock out in the last three months</p> <p>[NO STOCK-OUT WITHIN THE LAST THREE MONTHS] <input type="checkbox"/></p>								

<p>017 If "Yes" to Item 015 (that this method has been out of stock (STOCK OUT) at this SDP on any given day within the last six months (in line with current national guidelines, etc.) please indicate the main reason</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>6. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>8. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>8. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>8. Any other Reason (please specify)</p>	<p>I. Delays on the part of main source institution/ warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>2. Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/> contraceptive <input type="checkbox"/></p> <p>3. The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4. Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>8. Any other Reason (please specify)</p>
<p>(ii): NO STOCK-OUT AT THE TIME OF THE SURVEY</p>									

<p>018 With respect to each of the contraceptive methods that the SDP is supposed/expected to provide in line with the current national protocols, guidelines and/or laws specific for this level* of service delivery (as indicated in Item 011 above); please indicate whether it is currently out of stock at this SDP and therefore the contraceptive method was not available to give/ provide to clients at this SDP</p> <p>(* Please recall SDP level as recorded in item 006 above)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes; this method is currently out-of-stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>2. No; this method is currently not out-of stock (NO STOCK OUT) at this SDP <input type="checkbox"/></p> <p>(Tick only one option)</p>	
<p>019 From responses provided to Item 018 above, please discuss with respondent and record the conclusion by ticking one of the following statements</p>	<p>One or more of the contraceptive methods offered by this SDP is currently out-of-stock at this SDP</p> <p>Therefore, this SDP is experiencing stock out on the day the survey [STOCK-OUT ON DAY OF SURVEY]</p>								<p>ALL contraceptive method offered by this SDP are currently in-stock/ available at this SDP.</p> <p>Therefore, this SDP did not experiencing stock out on the day of the survey [NOSTOCK-OUT ON DAY OF SYRVEY]</p>	

<p>020 If "Yes" to Item 18 (that this method is out-of-stock (STOCK OUT) at this SDP (in line with current national guidelines, etc.) please indicate the main reason (Tick only one option [as the main reason] for each contraceptive)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>6. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>8. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>	<p>1 Delays on the part of main source institution warehouse to re-supply this SDP with this contraceptive <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the contraceptive <input type="checkbox"/></p> <p>3 The contraceptive is not available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no client demand for the contraceptive <input type="checkbox"/></p> <p>5 No train staff to provide this contraceptive at the SDP <input type="checkbox"/></p> <p>6. Lack of equipment for the provision of this contraceptive <input type="checkbox"/></p> <p>7. Insufficient supply for contraceptive <input type="checkbox"/></p> <p>7. Any other Reason (please specify)</p>
---	--	--	--	--	---	---	---	---	---

INTERVIEWER VERIFICATION for ITEM 018									
Contraceptive	(1) Male condoms	(2) Oral Contraception	(3) IUDs	(4) Implants	(5) Injectables	(6) Female Condoms	(7) Sterilisation for Male	(8) Sterilisation for Females	(9) Emergency contraception
For each response provided for item 018 , the interviewer should validate the response by a physical inventory and note the appropriate finding	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>	1 Inventory taken, contraceptive is in stock <input type="checkbox"/> 2 Inventory taken, contraceptive is NOT in stock <input type="checkbox"/>

014 From responses provided to Item 012 , discuss with the respondent and record the conclusion by ticking one of the following statements	<p>IF THIS IS A PRIMARY SDPS (AS NOTED IN ITEMS 06) This SDP offers up to two modern contraceptive methods <input type="checkbox"/> This SDP offers three and more (at least three) modern contraceptive methods <input type="checkbox"/></p>	<p>IF THIS IS A SECONDARY OR TERTIARY SDPS (AS NOTED IN ITEM 06) This SDP offers up to four modern contraceptive methods <input type="checkbox"/> This SDP offers FIVE and more (at least five) modern contraceptive methods <input type="checkbox"/></p>
---	--	--

SECTION 5: STAFF TRAINING FAMILY PLANNING	
[To be responded to by all SDPs]	
021 Are there staff working at this SDP who are trained to provide family planning services? (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>
022 If yes; please indicate how many staff members are trained in provision of family planning services	* +
023 Is any staff member trained for the insertion and removal of implant contraceptive, specifically? (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>
024 If yes; please indicate how many staff members are trained for the insertion and removal of implant contraceptive	* +
025 Are the trained staff actually providing FP services (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>
026 If no to item 025 please indicate the reason why the staff is NOT actually providing FP services
027 When last did any staff at this SDP receive training in provision of family planning services (Tick only one option)	1 In the last two months <input type="checkbox"/> 2 Between two and six months ago <input type="checkbox"/> 3 Between six month and one year ago <input type="checkbox"/> 4 More than one year ago <input type="checkbox"/>
028 Did the training exercise include the insertion and removal of implant contraceptive (Tick only one option)	1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>
SECTION 6: STAFF SUPERVISION FOR REPRODUCTIVE HEALTH INCLUDING FAMILY PLANNING	
[To be responded to by all SDPs]	
029 When was the last time this facility was visited by a supervisory authority in the past 12 months? (Tick only one option)	1 In less than one Month <input type="checkbox"/> 2 between one and three Months ago <input type="checkbox"/> 3 Between three and six months ago <input type="checkbox"/> 4 Between six month and one year ago <input type="checkbox"/> 5 Not supervised in the past 12 month <input type="checkbox"/>
030 How frequently does this facility receive visits from supervisory authorities? (Tick only one option)	1 Weekly <input type="checkbox"/> 2 Monthly <input type="checkbox"/> 3 Every three months <input type="checkbox"/> 4 Every six months <input type="checkbox"/> 5 Once a year <input type="checkbox"/> 6 Never <input type="checkbox"/>
031 Which of the following were included in the supervision (Tick only one option)	1 Staff clinical practices <input type="checkbox"/> 2 Drug stock out and expiry <input type="checkbox"/> 3 Staff availability and training <input type="checkbox"/> 4 Data completeness, quality, and timely reporting <input type="checkbox"/> 5 Review use of specific guideline or job aid for reproductive health <input type="checkbox"/> 6 Any other please specify

SECTION 7: AVAILABILITY OF GUIDELINES, check-lists and Job aid [To be responded to by all SDPs]	
032 This facility has available any family planning guidelines (national or WHO)? (Tick only one option) Ask to SEE	1 Yes (enumerator verifies the availability of guidelines) <input type="checkbox"/> 2 Yes availability of guideline not verified <input type="checkbox"/> 3 Not available <input type="checkbox"/>
033 This facility has available any family planning check-lists and/or job-aids? (Tick only one option) Ask to SEE	1 Yes (enumerator verifies the availability of guidelines) <input type="checkbox"/> 2 Yes availability of guideline not verified <input type="checkbox"/> 3 Not available <input type="checkbox"/>
034 This facility has available any ANC guidelines (national or WHO)? (Tick only one option) Ask to SEE	1 Yes (enumerator verifies the availability of guidelines) <input type="checkbox"/> 2 Yes availability of guideline not verified <input type="checkbox"/> 3 Not available <input type="checkbox"/>
035 This facility has available any ANC check-lists and/or job-aids? (Tick only one option) Ask to SEE	1 Yes (enumerator verifies the availability of guidelines) <input type="checkbox"/> 2 Yes availability of guideline not verified <input type="checkbox"/> 3 Not available <input type="checkbox"/>
036 This facility has available any Waste disposal guideline or infection control guideline? (Tick only one option) Ask to SEE	1 Yes (enumerator verifies the availability of guidelines) <input type="checkbox"/> 2 Yes availability of guideline not verified <input type="checkbox"/> 3 Not available <input type="checkbox"/>

SECTION 8: AVAILABILITY AND USE OF INFORMATION COMMUNICATION TECHNOLOGY (ICT) [To be responded to by all SDPs]	
037 Does this facility use any form of Information and Communication Technologies (ICT) System (see list in 038 below) – (Tick only one option)	1 Yes (enumerator verifies availability) <input type="checkbox"/> 2 Yes (availability not verified) <input type="checkbox"/> 3 No ICT is not used <input type="checkbox"/>
038 If Yes; which of the following types ICTs are used in the SDP (Tick ALL the options that apply)	1 Computer <input type="checkbox"/> 2 Mobile phones - basic handsets <input type="checkbox"/> 3 Mobile phones – smartphones <input type="checkbox"/> 4 Tablets <input type="checkbox"/> 5 Internet facilities – LAN <input type="checkbox"/> 6 Internet facilities -Wi-Fi <input type="checkbox"/> 7 Other (specify)
039 How did the SDP acquire the ICT? (Tick ALL the options that apply)	1 Provided by government <input type="checkbox"/> 2 Provided by proprietor of SDP <input type="checkbox"/> 3 Received as Donation <input type="checkbox"/> 4 Other (specify)
040 What is the main purpose for which the SDP uses the ICT? (Tick ALL the options that apply)	1 Patient registration <input type="checkbox"/> 2 Facility record keeping <input type="checkbox"/> 3 Individual patient records/Electronic Medical Record <input type="checkbox"/> 4 Health Insurance Claims and Reimbursement System <input type="checkbox"/> 5 Mobile money cash transfers and payments <input type="checkbox"/> 6 Routine communication <input type="checkbox"/> 7 Awareness and demand creation activities <input type="checkbox"/> 8 Supply chain management/stock control <input type="checkbox"/> 9 Health worker training <input type="checkbox"/> 10 Clinical consultation (long distance communication with experts) <input type="checkbox"/> 11 Other(specify)

SECTION 9: AVAILABILITY OF MATERNAL/RH MEDICINES									
Maternal/RH Medicines									
Please note that for the SDP to respond to items in this section, it should have indicated in Item 009 above that 'Yes' it provides maternal health including delivery services									
Items	(1) Ampicillin	(2) Azithromycin or Erythromycin	(3) Benzathine benzylpenicillin	(4) Either Betamethasone Or Dexamethasone Or Both of these medicines	(5) Calcium-gluconate	(6) Cefixime or Ceftriaxone	(7) Gentamicin	(8) Hydralazine	(9) Magnesium-sulfate
041 With respect to each of the maternal/ RH Medicines, please state whether the SDP is supposed to have it available; in line with the current national protocols, guidelines and/ or laws specific for this level* of service delivery. Please discuss with the respondent and then record your conclusion before proceeding (*Please recall SDP level as recorded in item 006above)	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available these Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	1 Yes, this SDP is expected / supposed to have available this Maternal / RH Medicine <input type="checkbox"/>
	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available any or both of these Maternal /RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>	2 No, this SDP is NOT expected/ supposed to have available this Maternal / RH Medicine <input type="checkbox"/>
	(Tick only one option)	(Tick only one option)	(Tick only one option)	(Tick only one option)	(Tick only one option)	(Tick only one option)	(Tick only one option)	(Tick only one option)	(Tick only one option)

<p>042 If 'Yes' in item 041 (i.e., this SDP is expected/ is expected/ supposed to have available the maternal/ RH medicine) please state whether the medicine is currently available at the SDP</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes (for any or both) <input type="checkbox"/></p> <p>2 No (for any or both) <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>	<p>1 Yes <input type="checkbox"/></p> <p>2 No <input type="checkbox"/></p> <p>3 Not Applicable (because "No" to item 041) <input type="checkbox"/></p> <p>(Tick only one option)</p>
<p>043 If this SDP is supposed/ expected to have available this medicine (in line with current national guidelines, etc.) but the response to 042 is "No", please indicate the main reason (Tick only one option [as the main reason] for each medicine)</p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>	<p>1 Delays on the part of main source institution/ warehouse to re-supply this SDP with this medicine <input type="checkbox"/></p> <p>2 Delays by this SDP to request for supply of the medicine <input type="checkbox"/></p> <p>3 The medicine is available in the market for the SDP to procure <input type="checkbox"/></p> <p>4 Low or no demand/need for the medicine at this SDP <input type="checkbox"/></p> <p>5 No train staff to provide this medicine at the SDP <input type="checkbox"/></p>

	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)	6. Insufficient supply for Medicine <input type="checkbox"/> 7. Any other Reason (please specify)
044 From responses provided to Item 042 above, please discuss with respondent and record the conclusion by ticking one of the following statements	<p>1 Yes- this SDP has available the seven (7) lifesaving maternal/RH medicines (which included the two mandatory medicines [Magnesium Sulfate and Oxytocin] and any other five of the remaining medicines on the list - bearing in mind that; a) Sodium chloride and Sodium lactate compound solution alternate; and b) Dexamethasone is an alternate to Betamethasone <input type="checkbox"/></p> <p>2 No- this SDP does not have available the seven (7) lifesaving maternal/RH medicines (which included the two mandatory medicines [Magnesium Sulfate and Oxytocin] and any other five of the remaining medicines on the list - bearing in mind that; a) Sodium chloride and Sodium Lactate compound solution alternate; and b) Dexamethasone is an alternate to Betamethasone <input type="checkbox"/></p>								

INTERVIEWER VERIFICATION for ITEM 042									
Medicines	(1) Ampicillin	(2) Azithromycin or Erythromycin	(3) Benzathine benzylpenicillin	(4) Either Betamethasone Or Dexamethasone Or Both of these medicines	(5) Calcium gluconate	(6) Cefixime or Ceftriaxone	(7) Gentamicin	(8) Hydralazine	(9) Magnesium sulfate
For each response provided for item 042, the interviewer should validate the response by a physical Inventory and note the appropriate finding	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, any or both of the medicine(s) is/are in stock <input type="checkbox"/> 2. Inventory taken, any or both of the medicine(s) is/are NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>

INTERVIEWER VERIFICATION for ITEM 042								
Medicines	(10) Methyldopa	(11) Metronidazole	(12) Mifepristone	(13) Misoprostol	(14) Nifedipine	(15) Oxytocin	(16) Either Sodium chloride Or Sodium lactate compound solution	(17) Tetanus toxoid
For each response provided for item 042, the interviewer should validate the response by a physical Inventory and note the appropriate finding	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>	1. Inventory taken, any or both of the medicine(s) is/are in stock <input type="checkbox"/> 2. Inventory taken, any or both of the medicine(s) is/are NOT in Stock <input type="checkbox"/>	1. Inventory taken, Medicine is in stock <input type="checkbox"/> 2. Inventory taken, Medicine is NOT in Stock <input type="checkbox"/>

SECTION 10: SUPPLY CHAIN	
[To be responded to by all SDPs]	
045 Who is the main person responsible for ordering medical supplies at this facility? (Tick only one option)	1. Medical Doctor <input type="checkbox"/> 2. Clinical Officer <input type="checkbox"/> 3. Pharmacist <input type="checkbox"/> 4. Nurse <input type="checkbox"/> 5. Other (specify)
046 How are the resupplies for contraceptives for this facility determined? (Tick only one option)	1. Staff member(s) of this SDP makes request based on calculation of quantity needed using a formula <input type="checkbox"/> 2. Quantity is determined by the institution/warehouse responsible for supplying this SDP <input type="checkbox"/> 3. Any other method used (please specify)
047 Does this SDP use any logistics forms for reporting and ordering supplies? (Tick only one option)	1. Yes (enumerator verifies the availability of forms) <input type="checkbox"/> 2. Yes (but availability not observed by enumerator) <input type="checkbox"/> 3. No; there are no logistics forms in use <input type="checkbox"/>
048 What is the main source of your routine medicines and supplies? (Tick only one option)	1. Central Medical Stores <input type="checkbox"/> 2. Regional/district Warehouse or institution <input type="checkbox"/> 3. Local medical store on the same site <input type="checkbox"/> 4. NGO <input type="checkbox"/> 5. Donors <input type="checkbox"/> 6. Private Sources <input type="checkbox"/>
049 Who is mainly responsible for transporting products to your facility? (Tick only one option)	1. National/central government <input type="checkbox"/> 2. County administration <input type="checkbox"/> 3. This Facility Collects <input type="checkbox"/> 4. Suppliers <input type="checkbox"/> 5. Other(Specify)
050 On average, approximately how long does it take between ordering and receiving products? (Tick only one option)	1. Less than two weeks <input type="checkbox"/> 2. More than two weeks but not up to one month <input type="checkbox"/> 3. More than one month but not up to two months <input type="checkbox"/> 4. More than two months but not up to four months <input type="checkbox"/> 5. More than four months but not up to six months <input type="checkbox"/> 6. More than six months <input type="checkbox"/>
051 On average, how frequently is the facility resupplied? (Tick only one option)	1. Once every two weeks <input type="checkbox"/> 2. Once every month <input type="checkbox"/> 3. Once every three months <input type="checkbox"/> 4. Once every six months <input type="checkbox"/> Once a year <input type="checkbox"/>

SECTION 11: EXISTENCE OF COLD CHAIN AT SDP**[To be responded to by all SDPs]**

052 Does this SDP have its own cold chain to store medicines or items? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
053 If yes to 052, please give a list of the reproductive/ maternal health medicines or items that this SDP stores in cold chain?	1. Not Applicable (No to 052 above, SKIP to 056) <input type="checkbox"/> .
054 If yes to 052; what main type of cold chain does the SDP have? (Tick only one option)	1. Fridge <input type="checkbox"/> 2. Ice box (SDP have to regularly replenish ice supply) <input type="checkbox"/> 3. Other (specify)
055 If the main type of cold chain (in 054) is a fridge please indicate the main source of power for this (Tick only one option)	1. Electricity from national grid <input type="checkbox"/> 2. Generator plant at the SDP <input type="checkbox"/> 3. Portable generator at the SDP <input type="checkbox"/> 4. Kerosene/paraffin fuel <input type="checkbox"/> 5. Not Applicable (not a fridge in 054) <input type="checkbox"/> 5. Other(Specify)
056 If the SDP does not have its own cold chain, how does it preserve items that are supposed to be in cold chain?	

SECTION 12: WASTE DISPOSAL**[To be responded to by all SDPs]**

057 How does the SDP dispose of health waste? (Tick ALL Options that Apply)	1. Burning on the grounds of the SDP <input type="checkbox"/> 2. Bury in special dump pits on the grounds of the SDP <input type="checkbox"/> 3. Use of Incinerators <input type="checkbox"/> 4. Centrally collected by specific agency for disposal away from the SDP <input type="checkbox"/> 5. Disposed with regular garbage <input type="checkbox"/>
---	---

SECTION 13: CHARGING FOR USER FEE**[To be responded to by all SDPs]**

058 Does this facility charge patients for consultation (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
--	--

<p>059 If Yes; are there exemptions for any of the following services (Tick ALL the options that apply)</p>	<p>1. Family planning services <input type="checkbox"/> 2. Antenatal care services <input type="checkbox"/> 3. Delivery services <input type="checkbox"/> 4. Post-natal care services <input type="checkbox"/> 5. Newborn care services <input type="checkbox"/> 6. Care of sick children under 5 years <input type="checkbox"/> 7. HIV care (e.g. HTC and ART) 8. Other (specify)</p>
<p>060 Does this facility charge patients for any medication (Tick only one option)</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p>
<p>061 If Yes; are there exemptions for any of the following medicines and commodities (Tick ALL the options that apply)</p>	<p>1. Family planning commodities <input type="checkbox"/> 2. Maternal Health medicines <input type="checkbox"/> 3. Child health medicines <input type="checkbox"/> 4. Other(specify)</p>
<p>062 Does this facility charge patients for any service provided by a qualified health care provider (Tick only one option)</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p>
<p>063 If Yes; are there exemptions for the following services (Tick ALL the options that apply)</p>	<p>1. Family planning services <input type="checkbox"/> 2. Antenatal care services <input type="checkbox"/> 3. Delivery services <input type="checkbox"/> 4. Post-natal care services <input type="checkbox"/> 5. Newborn care services <input type="checkbox"/> 6. Care of sick children under 5 years <input type="checkbox"/> 7. HIV care (e.g. HTC and ART) 8. Other (specify)</p>

NOTE

At this stage;

1. Thank the interviewer for his/her time and for the information provided
2. Inform him/her that for the next part of the survey, as you informed him/her earlier, you would interview family planning clients who are visiting the SDP
3. Assure him/her that the responses of the clients will not be used against anybody or the SDP but will be used for a general understanding of the views of clients and for better service provision
4. Specifically ask for permission from the relevant authority of the SDP for you to carry on with the exit interview

Time Interview Ended _____

CLIENTS' PERCEPTION AND APPRAISAL OF COST FOR FP SERVICES

CONSENT NOTE

Please inform the respondent that:

- You are not a staff member of the SDP, rather, you are here to ask his/her opinion about the services he/she has just received
- Although the SDP staff has been informed about, and have given permission for the exercise, they will not be told any thing that the respondent says
- The questions are not personal and his/her name or particulars will not be recorded
- His/her response will not be used against anybody
- He/she may refuse to answer any question or choose to stop the interview at any time. However, you hope he/she will answer the questions, which will be useful to improve on the services that are provided.
- If he/she has any questions about the study, he/she can ask at this stage
- The interviewer can then ask the client, whether he/she agrees to proceed with the interview. Once the consent of the interviewee has been obtained, then the interviewer can proceed with the interview. Do I have your agreement to proceed?

YES _____ NO _____ (TICK)

Date of Interview (DD/MM/YY) _____

Name of the facility _____ Facility Code Number _____

Name of the interviewer _____ Interviewer Code _____

Client Code Number _____

Time Interview Started _____

SECTION 14: EXIT INTERVIEW - CLIENTS' PERCEPTION	
*To be administered to clients at SDPs offering FP services (indicating 'Yes' to Item 008 above)+	
14.1 Respondents Background	
064 Age	/ /
065 Sex (Tick only one option)	1. Male <input type="checkbox"/> 2. Female <input type="checkbox"/>
066 Marital status (Tick only one option)	1. Never Married or in union <input type="checkbox"/> 2. Currently Married or in Union <input type="checkbox"/> 3. Formerly Married (Divorced/separated/widowed) <input type="checkbox"/>
067 Level of Education (Tick only one option)	1. No Education <input type="checkbox"/> 2. Primary <input type="checkbox"/> 3. Secondary and higher level <input type="checkbox"/>
068 How often do you visit this SDP for FP services? (Tick only one option)	1. Once a month <input type="checkbox"/> 2. Once every 2 months <input type="checkbox"/> 3. Once every 3 months <input type="checkbox"/> 4. Others (please specify)
14.2 Provider adherence to technical aspects	
069 Were you provided with the family planning method of your choice at this SDP? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
070 Did the family planning service provider take your preference and wishes into consideration in deciding on the family planning method you received? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
071 Did the health worker teach you how to use the family planning method? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
072 Were you told about the common side effects of the family planning method? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
073 Did the health worker inform you about what you can do regarding the side effects of the family planning method should they occur? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
074 Did the health worker inform you about any serious complications that can occur, as a result of using the family planning method, for which you should come back to the SDP should such occur? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
075 Were you given any date when you should come back for check-up and/or additional supplies?(Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
14.3 Organizational aspect	
076 In your opinion did you wait too long for the service to be provided to you?(Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
077 Are you satisfied with the cleanliness of the health facility?(Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
078 Are you satisfied with the privacy at the exam room?(Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>

079 Are you satisfied with the time that was allotted to your case by the health care provider? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
14.4 Interpersonal aspect	
080 Did staff at the health facility treat you with courtesy and respect (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
081 Did any of the health service providers coerce you to accept or insisted that you should accept the family planning method that you received today? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
082 Are you satisfied with the attitude of the health provider towards you generally?(Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
14.5 Outcome aspect	
083 Are you satisfied with the service you received? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
084 Will you continue visiting this SDP in future? (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
085 Would you recommend your relatives or friends to come to this clinic (Tick only one option)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>

SECTION 15: EXIT INTERVIEW-CLIENTS APPRAISAL OF COST FOR FP SERVICES	
To be administered to clients at SDPs offering FP services (indicating 'Yes' to Item 008 above)	
15.1 Family Planning service payment	
086 For today's visit did you pay to receive any family planning service? (Tick only one option) - (If yes then continue with 087, but if No please skip to 088)	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
087 If you paid for anything today please how much did you pay for the following method (amount in local currency)? (Indicate for ALL that apply)	
1. Card <input type="checkbox"/> /	/
2. Laboratory test/x-ray <input type="checkbox"/> /	3. Contraceptive received from service provider <input type="checkbox"/> /
4. Contraceptive purchased from pharmacy <input type="checkbox"/> /	5. Consultation fee <input type="checkbox"/> /
Others (please specify) 7	
15.2 Travel cost	
088 What was the main mode of transportation for you to travel from your place of residence to this SDP (Tick only one option)	
1. Walked <input type="checkbox"/> 2. Bicycle <input type="checkbox"/> 3. Motorcycle <input type="checkbox"/> 4. Bus/taxi <input type="checkbox"/> 5. Private vehicle <input type="checkbox"/> 6. Others (please specify)	
089 What distance in Kilometer did you travel from your place of residence to this SDP/	KM
090 How much did it cost you to travel from your residence to this SDP/	/(amount in local currency) Ksh.
091 How much will it cost you to travel from this SDP back to your residence/	/(amount in local Kenya currency) Ksh.
15.3 Family Planning time spent and cost	
092 How long did it take for you to travel from your place of residence to this SDP today /	/ Hours:/ / Minutes
093 How long did it take for you to get the service at this SDP (time it took between your arrival at this SDP and the time you got the service today) /	/ Hours:/ / Minutes
094 How long will it take for you to travel back to your place of residence /	/ Hours:/ / Minutes
095 What is the main activity you would have been doing during the time you have been here receiving FP services at this SDP today (Tick only one option)	
1. Household chores <input type="checkbox"/> 2. Working on household farm <input type="checkbox"/> 3. Selling in the market/trading <input type="checkbox"/> 4. Employed as unskilled labourer <input type="checkbox"/> 5. Employed as skilled labourer <input type="checkbox"/>	
6. Clerical or professional work <input type="checkbox"/> 7. Others (please specify)	

096 From the activity you referred to in 095 , who took over this activity? (Tick only one option)	
1. Family member <input type="checkbox"/> 2. Co-worker <input type="checkbox"/> 3. Nobody <input type="checkbox"/> 4. Other (please specify) 7	
097 Did you have to pay the person who took over the activity on your behalf (Tick only one option)	Yes No 2
098 If yes please indicate or estimate the monetary value of the payment	/ / (amount in local currency)
15.4 Financing for FP	
099 Please indicate where you obtain the resources to pay for the cost of FP services you have received today? (Tick ALL the options that apply) - Please refer only to payments mentioned under 087 -(service payment)	
1. Paid for by myself 2. Spouse/partner (husband or wife) 3. Family Members other than spouse (husband or wife) 4. Others (please specify)	
0100 Please indicate the amount for each of the sources mentioned in 099 for payment for the cost of FP services you have received today? (Indicate for ALL the options that apply) – Indicate with reference to payments mentioned under 087 - service payment	
1. Paid for by myself <input type="checkbox"/> / / (amount in local currency) Ksh	2. Spouse (husband or wife) <input type="checkbox"/> / / (amount in local currency) Ksh
3. Family Members other than spouse (husband or wife) <input type="checkbox"/> / / (amount in local currency) Ksh	
4. Others (please specify)..... / / (amount in local currency) Ksh	

NOTE

At this stage;

1. Inform him/her that the interview has ended, and
2. Thank the interviewer for his/her time and for the information provided

Time Interview Ended _____

National Council for Population and Development

PO Box 48994 - GPO, Nairobi 00100, Kenya

Tel: 254 20 271 1600/01

Fax: 254 20 271 6508

Email: info@ncpd-ke.org

www.ncpd-ke.org

NCPD is a semi-autonomous government agency that formulates and promotes population policy and coordinates related activities for sustainable development in Kenya.

