Continuing the Evolution of System Solutions to Support Post MA Contraceptive uptake in Kenya

Post Medication Abortion Contraception (PMAC) Project Kenya Emerging Learning Brief (#2)

June - October 2023

LEARNING BRIEF #1

Context

In order to ensure women's access to contraceptive information and care after self-managed medication abortion (MA) outside of health facilities, the Post Medication Abortion Contraception (PMAC) project in Kenya adopted a market systems design approach to test, refine and/or design solutions. The solutions were designed to impact four areas of importance within the post MA Family planning (FP) market.

- **Product & Place:** A digital health marketplace, askNivi, tailored to MA and contraceptive users to provide quality FP information, counseling and referrals to service providers.
- **Price:** A three-pronged supply-side strategy (seed stock, supply chain strengthening, advocacy to Ministry of Health (MOH) for free FP commodities) to ensure a consistent supply of quality affordable contraceptive methods to pharmacists, at a reduced cost to users.
- **Promotion:** A combination of health promotion and behavior change models implemented by Community Mobilizers (CM) and tailored to optimize post MA FP knowledge, leading to referrals to pharmacies for FP choice and uptake.
- **Provider:** A standardized package of quality post MA FP services, to support service delivery, referral and training.

This Emerging Learning Brief, the second in the series, builds upon the insights presented in Learning Brief 1, which reviewed learnings from the period from January to May 2023. This second Emerging Learning Brief focuses on the adaptations and learnings between June and October 2023. For each solution (i.e., intervention) this brief explores:

- Experience in applying proposed adaptations: how implementation of adapted solutions differed from the adaptations proposed in Learning Brief 1.
- Intervention insights: what appears to be working well and what is not.
- What's next: what needs to be adapted and why, across all interventions based on learnings to date.

The brief concludes with the **Final PMAC Intervention Package** which is being implemented in the project based on learnings across all four levers.

Product & Place Solution

A Digital Health Marketplace, askNivi

What is the solution evolution?

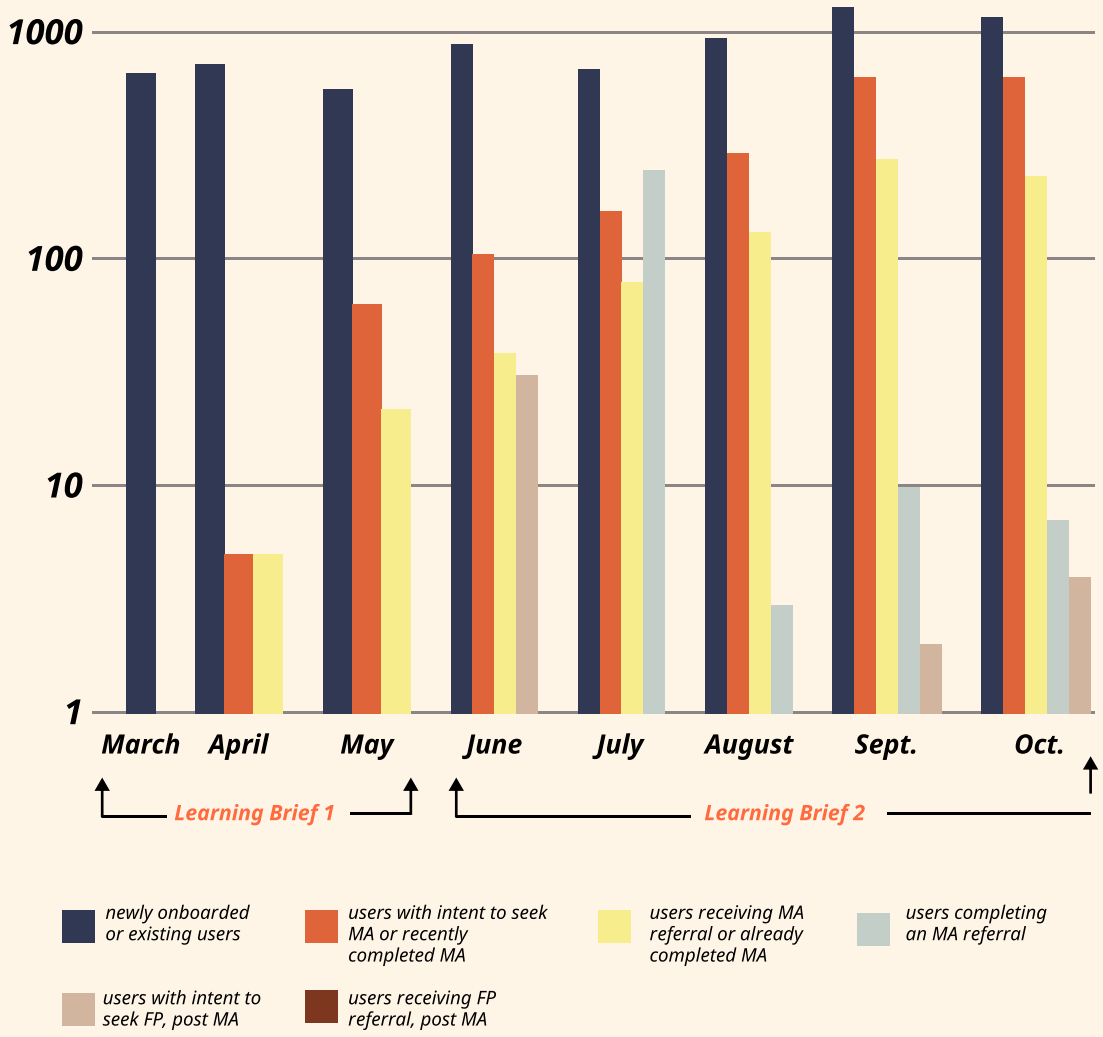
The original solution was implemented from March - May 2023 with performance reviewed and five adaptations proposed to:

1. **Identify provider motivations** to deploy unique QR codes to optimize the user's experience post-pharmacy visit and increase the number of onboarded users linked to PMAC providers for repeat referrals.
2. **Develop new digital pathway** to support method choice, autonomy, and options on viable service delivery points.
3. **Support FP uptake and continuation** for clients using askNivi, depending on their needs, and ensure askNivi captures data for all clients who purchase FP at the time of purchasing MA.
4. **Build a business case** for the providers to demonstrate askNivi's value proposition.
5. **Segment market** by age, knowing that 18-30 year olds are more likely to use the chatbot for SRH services. askNivi will target marketing to multiple segments including university students to deepen engagement and improve inbound referral to the pharmacy for MA.

What adaptations were implemented in practice?

Adaptations explored different marketing, content, and provider strategies to drive engagement with askNivi throughout the PMAC project. For example, several months after QR codes with unique keywords were launched, pharmacists were encouraged to onboard a minimum of 50 users using their unique keyword to leverage askNivi for reengaging customers, fostering customer loyalty. Concurrently, CM were encouraged to onboard users with an emphasis on utilizing the platform for family planning education. This approach aimed to educate users on available choices tailored to their individual needs, ultimately resulting in the referral of well-informed customers. Pharmacists and CM were encouraged to invite all clients to scan the askNivi QR code to help onboard clients new to askNivi, as well as confirm clients referred by askNivi.

Figure 1: Patients' journeys from askNivi onboarding to MA and FP use



What's working and what's not working?

What's working?

Growing use of askNivi to support women with MA and post MA journey: Figure 1 shows increasing numbers of women from project areas are using askNivi (navy bar) with intent to seek MA or recently completed MA (orange bar), receiving MA referral (yellow bar), completing an MA referral (grey bar) and intent to seek FP (beige bar). While askNivi has not yet captured FP referral or post MA FP completion in the reporting period, this could be an attribution problem, rather than a conversion problem, as anecdotal evidence indicates that many women are offered and/or purchase FP at the time of purchasing MA and therefore do not report FP referral or FP uptake through the bot. Follow-up with MA clients to confirm the details of their MA visit including whether they were counseled for and/or purchased FP is a critical next step. Tighter integration with providers, perhaps via provider-facing apps, could also improve the askNivi conversion tracking FP uptake.

Interactive and informative chatbot: The interactive nature of the chatbot and the informative content seem to be engaging for users who access it. Users are showing interest in the information provided. Among users just onboarded to Nivi, 75% spend just under 10 minutes to complete onboarding and begin reading content in an exchange of 17 messages. For users who generate a referral on Nivi, 75% reach that stage in an exchange of 54 messages. For users who report taking up care, 75% reported their provider visit within 13 days of joining Nivi on WhatsApp.

Targeted marketing campaigns to drive use of the chatbot: The project implemented targeted digital (FB and other social media platforms) and on the ground (through CM) marketing campaigns around Naivasha and Nakuru, narrowing down the focus to age groups most likely to use social media.

What's not working?

Low reported conversion rates to FP: As indicated above, reported conversion to FP is low, but this could be a reporting error, as many women purchase FP at the time of purchasing MA. Improvements to the chatbot conversational prompts are underway to better record completed FP uptake, especially when taking place during an MA purchase.

Unmotivated providers: More work can be done so that pharmacists see the value of askNivi to their business. Higher conversation rates (actual and reported, as discussed above) would make it easier to demonstrate askNivi's business case to pharmacists.

Digital divide: While most Kenyans have cell phones, and cell phone penetration is increasing year by year, not all targeted women have WhatsApp-enabled phones and/or can pay for data bundles, which can limit their ability to engage with the service.

What's next?

The PMAC project and askNivi are pursuing several adaptations to enhance the user experience, reporting, and referrals to PMAC pharmacies for MA and post MA products and services, specifically:

- Improve **documentation of referral**s to post MA FP, including those from Nena na Binti (a hotline and virtual counselors linked to the askNivi app).
- Explore **new prompts that meet askNivi users where they are**, i.e., whether a consumer uses the chatbot for general health information, referrals to clinical care for side effects or danger signs, or curiosity around FP information. This could help build askNivi's reputation as a referral partner and therefore demonstrate the business values to clients and pharmacies.
- Build **demand and acceptability of the chatbot**, including by exploring how best to motivate pharmacists to refer back to askNivi.

Price Solution

A Three-Pronged Supply-Side Strategy

What is the solution evolution?

The original solution was implemented from January - May 2023 with performance reviewed and two adaptations proposed:

1. **Ensure participating pharmacists maintain a continuous safe stock level** and align with MOH annual procurement processes.
2. **Consider requiring participating pharmacists to obtain the MOH HealthFacility List code**, a unique facility identification number that MOH gives to accredited facilities/clinics/health centers that meet QA measures, to ensure quality assurance (QA) certification.

What adaptations were implemented in practice?

These adaptations were implemented from May - October 2023. All pharmacies established weekly safe stock levels with the ambition to move to monthly safe stock levels to support better prediction of consumption. Furthermore, DMPA-SC was successfully introduced to 34 pharmacies to broaden the method mix and create a new income stream within the pharmacy. Additionally, efforts to strengthen referral and linkages to MOH facilities to improve method mix were implemented. However, it is acknowledged that unforeseen pricing structures that vary across MOH health facility levels impacted users' ability to access methods.

The PMAC project explored the possibility of requiring participating pharmacists to obtain the MOH Health Facility list code to certify the facility. Since this is a lengthy process led by the MOH, the MOH advised that as an interim measure the pharmacists should still report as MOH outreach sites and will be reimbursed for commodities based on their contributions to the MOH facility caseloads.

What's working and what's not working?

What's working?

Safe Stock Levels: The concept of establishing safe stock levels for contraceptive products in pharmacies seems to be effective. This ensures that providers have a consistent supply of products, reducing the risk of stockouts and allowing them to serve clients more reliably.

DMPA-SC introduction: The introduction of DMPA-SC has the potential to create both a new business opportunity for pharmacies and an alternative method choice for women seeking contraception services.

Commodity management: Given the regular supply chain technical assistance to pharmacists, most providers have initiated prudent commodity management to minimize wastage that could potentially lead to a stockout.

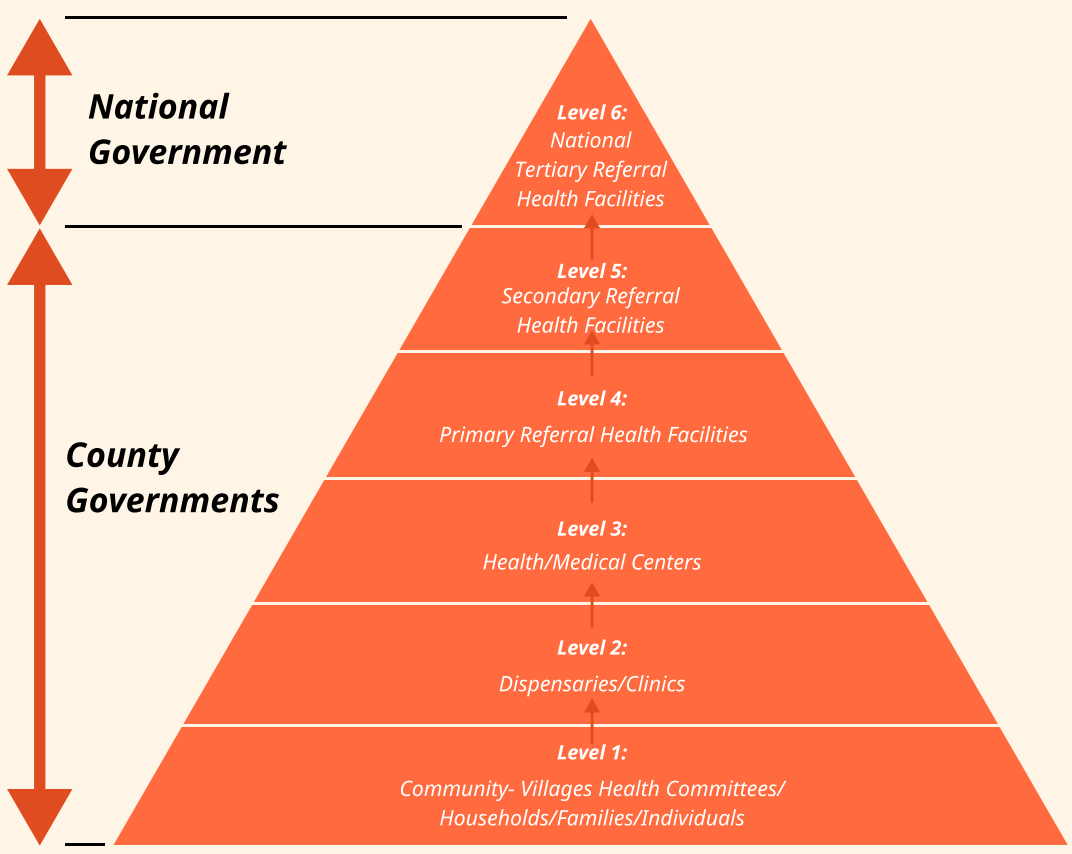
What's not working?

Linkages and referrals to MOH facilities: MOH level 4 facilities (see Figure 2) have introduced user charges for health care services including FP services, to support operational functions of the facilities. This creates a financial barrier for some users.

Operational pressure on MOH facilities: Level 1, 2 and 3 facilities (see Figure 2) face perennial shortages of commodities including FP, which negatively impact service delivery. In addition, these facilities have high caseloads, which is undesirable to post MA FP clients, thereby impacting access.

Need for business training support: While DMPA-SC has been successfully introduced, further support could enhance pharmacists' ability to leverage this new commodity into a wider business model.

Figure 2: Kenya health system levels



What's next?

The PMAC project is applying learnings from this intervention to **support business growth of pharmacists.** This will be accomplished by supporting commodity management, strengthening referrals through better quality of care delivered by pharmacists, and leveraging DMPA-SC to expand the range of contraceptive options offered by pharmacists which should build their reputation and support client retention.

Promotion Solution

A Combination of Health Promotion and Behavior Change Models implemented by Community Mobilizers (CM)

What is the solution evolution?

The original solution was implemented from January - May 2023 with performance reviewed and three adaptations proposed to:

1. **Enhance regular support to pharmacists** to better appreciate the CM role in terms of improving the overall experience of women and girls and to allay any concerns that pharmacists may have vis-a-vis the CM being a "threat" to the pharmacist's business.
2. **Enable CM referral to other health facilities** for expanded method choice. Through regular advocacy work with MOH, identify government facilities, train specific providers on post-pregnancy FP and work with them to complement pharmacists' efforts in providing expanded post MA FP. Expand the CM role to supporting verbal/escorted referrals to the MOH sites as well.
3. **Integrate community FP in the county health strategy** thereby sustaining CM involvement by transitioning CM to the Community HealthVolunteer (CHV) model as part of the community health strategy/CHV model.

What adaptations were implemented in practice?

These adaptations were implemented starting in May (with the exception of integrating community FP into the country health strategy). However, the overall CM intervention was dropped following a co-creation workshop with pharmacists in September as the program determined that pharmacists with the support of the Balanced Counseling Strategy (BCS) and Medical Eligibility criteria tools could lead comprehensive counseling and referrals without the support of CM, which was an expensive intervention.

What's working and what's not working?

What's working?

CM refer clients for MA: Pharmacy registers show that CM are a significant pathway for MA, with 40% of MA clients derived from CM referrals. However, this was not an effective referral pathway for FP, given the considerably smaller profit margins for FP compared to MA and other products.

What's not working?

Low utilization of CMs: Data shows low utilization of group sessions by adult women who prefer one-to-one consultation with their regular pharmacist. This may be related to a significant number of users questioning the CM's competency to comprehensively address their FP concerns, especially regarding the medical eligibility of some methods.

High cost of the intervention: This is the most expensive solution implemented for the project with an estimated monthly cost of 1M KSH. This is unsustainable beyond the life of the project and it is unlikely that this could be financially supported by the government if the CM role was transitioned to Ministry of Health in the future.

Coordination challenges: Coordination challenges were evident, especially for CM linked to more than three pharmacies. For example, two groups from different pharmacies may choose to meet at the same time, making it difficult for the CM to lead the sessions.

Lack of tailored counseling: CM counseling was general and in instances could not meet specific client needs. Pharmacists had to complement this to meet the needs of the clients.

What's next?

While this intervention successfully supported referrals to pharmacies for MA, ultimately there were too many challenges for this intervention to be sustained in the long run (e.g., low referrals for FP, high cost, coordination challenges and lack of tailored counseling). The PMAC project is exploring how to support pharmacists to counsel clients directly with the support of a checklist, and thereby transition part of the role originally envisioned for the CM in a more sustainable way and at a lower cost.

Image 1: Project Supported Community Mobilizers

Provider Solution

A Standardized Package of Quality Post MA FP Services

What is the solution evolution?

The provider solution was co-created with pharmacists during the adaptive learning phase to understand how best to support pharmacists to offer standardized quality post MA FP services across implementation sites.

What was implemented during this reporting period?

Co-creation with pharmacists continued through this reporting period (May-October 2023) to inform what should be included in a PMAC guidance document or checklist. Contraceptive counseling was successfully integrated into pharmacists' skill set through training on BCS and Medical Eligibility Criteria (MEC) tools. Through the implementation of BCS and MEC wheels, the potential for coercive care is reduced, and pharmacists support comprehensive counseling to empower the user to make informed decisions about their method choice. Additionally, in collaboration with the Department of Family Health, Division of Reproductive and Maternal Health (DRMH), pharmacists received capacity building to provide two options of injectable, subcutaneous and intramuscular, with the hope that this will open a new business stream for the pharmacists. Lastly, all solution facilities were briefed and trained to act as MOH satellite sites for data reporting into Kenya Health Information System (KHIS).

What's working and what's not working?

What's working?

Pharmacist capacity building: The project involved collaborating with the DRMH to provide training to pharmacists to offer injectable contraceptive options (subcutaneous and intramuscular). This new capability opens up new business opportunities for pharmacists, enabling them to provide services such as Sayana Press (DMPA-SC) that they were not offering before.

Comprehensive contraceptive counseling: The project integrated contraceptive counseling using BCS and MEC tools to empower clients to make informed decisions about contraceptive methods, ensuring they understand potential side effects and implications before making their choice.

MOH satellite sites and data integration: All facilities involved in the project were designated as maternal health satellite sites, and data from these sites are shared with the KHIS. This data will help identify barriers and challenges related to the solution's implementation, which can be addressed using strategies gained from training.

What's not working?

Coercion concerns: Concerns persist about women experiencing coercion to select an FP method that the pharmacist can provide. While the introduction of BCS and MEC tools should address this concern, continuous monitoring is advised to minimize coercive care.

Image 2: Project Supported Pharmacists

What's next?

As the first point of contact for many low-income health consumers seeking healthcare, pharmacists and pharmaceutical technologists remain critical players in improving access to abortion self-care and post abortion contraception. Going forward, pharmacists' support will be the primary intervention for the PMAC project with renewed attention to:

- Training on post MA contraceptive counseling and service delivery
- Utilization of post MA contraceptive care guidance
- Aligning pharmacist technical assistance (TA) on contraceptive service delivery, commodity management and waste management needs with county annual workplans; and
- Referral linkages to other facilities for expanded method choice.

Furthermore, the project will continue advocacy efforts to support integration of PMAC learning into the Kenya health system, focused on:

- Integration of MA and post MA FP into MOH FP curriculum for pharmacists
- Inclusions of post abortion family planning (PAFP) into country primary care intervention packages and networks; and
- Linkages to MOH for free commodities, technical support and data reporting opportunities.

Final PMAC Intervention Package

As the learning and adaptation phase of the PMAC project in Kenya draws to a close, rich learning has emerged for all four solutions originally proposed to impact the post MA FP market. As the project moves into its final phase, the final implementation package still addresses all four levers (product and place; price; promotion; and provider) but with varying levels of emphasis, given the implementation experience in 2023. The final implementation package contains a primary intervention, secondary intervention, and advocacy activities for sustainability to support pharmacies in Nakuru County, Kenya to sustainably provide quality post MA FP in mixed health systems. An infographic of the Final PMAC Intervention Package is available here.

Enhancing Quality of Care

Primary Intervention

- Training on post MA contraceptive counseling and service delivery (including counseling for choice and addressing infection prevention/control and pharmacovigilance), MA client follow-up, and documentation (Provider)
- Utilization of post MA contraceptive care guidance, Information Education and Communication (IEC) materials and job aids (Promotion)
- Monthly technical support, including aligning pharmacists TA needs with county annual workplans for seamless onsite mentorship support (Provider & Price)
- Referral linkages between MOH facilities and private pharmacies for expanded method choice (especially long term methods) (Provider)

Building a Business Case

Secondary Intervention

- Increased client-driven referrals and client loyalty due to enhanced quality of care (Provider)
- askNivi marketed as a source of MA and post MA FP information and referrals to PMAC pharmacies for products and services (Product & Place)
- Better business model through improved commodity management (Provider)

Sustainability Efforts

Advocacy Activities

- Advocacy for integration of Combipack guidelines and post abortion family planning (PAFP) into Ministry of Health (MOH) FP curriculum for pharmacists and pharmaceutical technicians (Provider)
- Advocacy with Nakuru County MOH for inclusion of PAFP in the County primary care intervention package and integration of private pharmacies into the primary care network (Provider & Promotion)
- Linkages to MOH for free commodities, technical support and data reporting opportunities through the District Health Information System (DHIS) (Provider & Price)

Have questions?

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