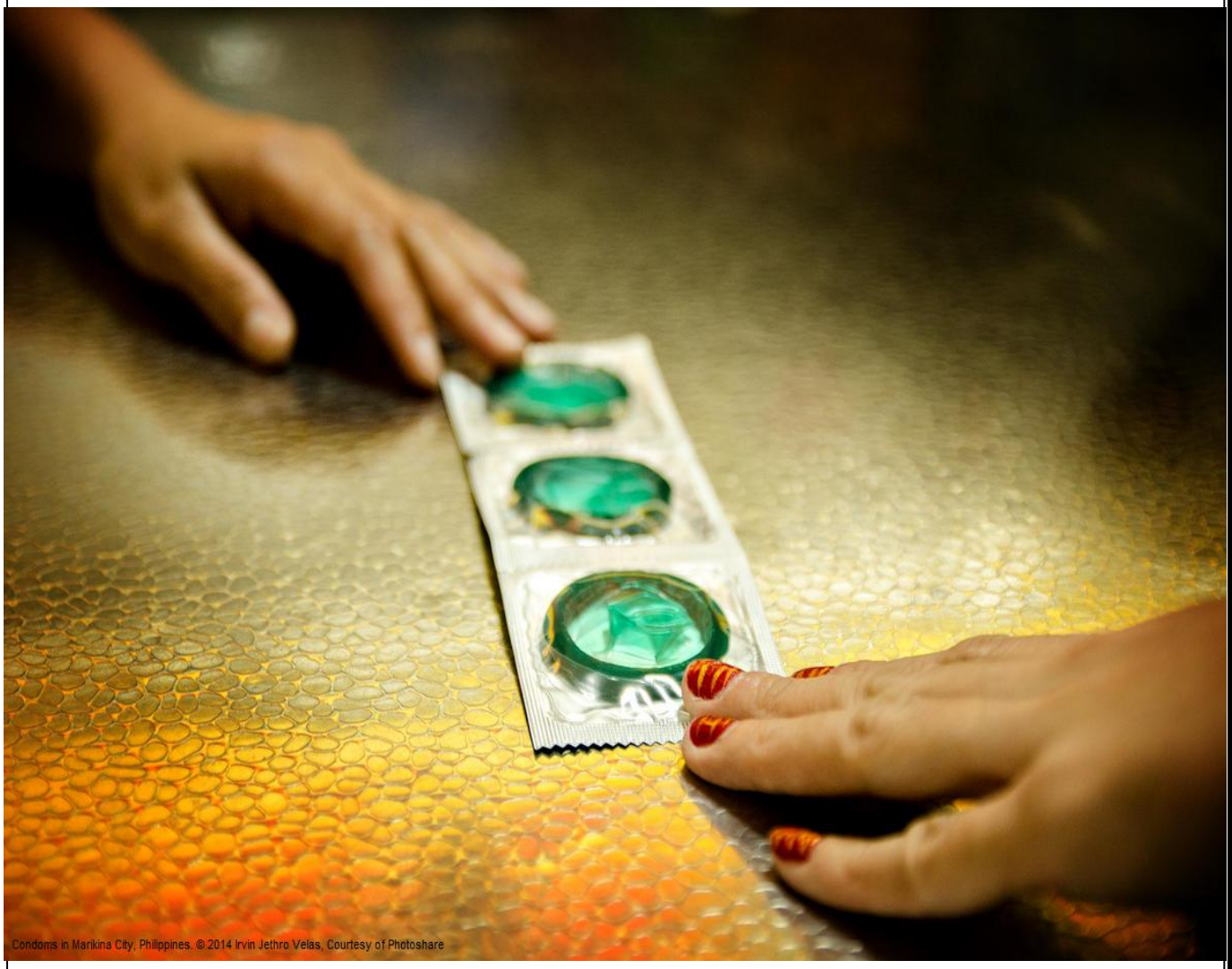

Condoms in Marikina City, Philippines. © 2014 Irvin Jethro Velas, Courtesy of Photoshare

WILLINGNESS TO PAY FOR MALE AND FEMALE CONDOMS AMONG URBAN KENYANS

STUDY REPORT

i+ solutions
universal access to essential medicines

mcdf
Muthaa Community Development Foundation

WILLINGNESS TO PAY FOR MALE AND FEMALE CONDOMS AMONG URBAN KENYANS

STUDY REPORT

We want to express our gratitude to the Ministry of Health, Kenya and all other public and private sector stakeholders who agreed to participate in the key informant interviews and share data/information.
The assignment would not have been possible without the support of local enumerators (data collectors) who conducted the consumer surveys and interviewed private sector providers.
We also thank all those who reviewed this report and provided feedback.

This document is a result of a study on willingness to pay for male and female condoms in Kenya conducted by i+solutions, Netherlands and Muthaa Community Development Foundation, Kenya to inform the development of strategies for enhanced private sector engagement in condom supply and distribution.
The study was funded by a research grant provided by Share-Net International.

July 2017

The following were involved in the assignment:

i+solutions

1. Diana Petrosyan
2. Judit Barniol
3. Marina Tiroyan
4. Manusika Rai

Muthaa Community Development Foundation

1. Emily Karechio
2. Esther Ngure
3. Martha Wanjiku
4. Mary Mbuo

CONTACT

i+solutions
Polanerbaan 11
3447 GN Woerden,
The Netherlands
www.iplussolutions.org

Muthaa Community Development Foundation
Jethalal Chambers,
Tubman Road,
00620 Nairobi, Kenya
www.muthaafoundation.org

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

ABBREVIATIONS & ACRONYMS

AIDS	Acquired immunodeficiency syndrome
CBO	Community-based organisation
DHS	Demographic and health survey
FC	Female condom
FP	Family planning
HIV	Human Immunodeficiency Virus
KEBS	Kenya Bureau of Standards
KEMSA	Kenya Medical Supplies Agency
KSH	Kenyan shilling
LMIS	Logistics management information system
MC	Male condom
MCDF	Muthaa Community Development Foundation
MDG	Millennium Development Goals
MOH	Ministry of Health
MSM	Men who have sex with men
NASCOP	National AIDS and STI Control Programme
NGO	Non-governmental organization
OBG	Oxford Business Group
PLHIV	People living with HIV
PPB	Pharmacy and Poisons Board
QC	Quality control
RH	Reproductive health
STI	Sexually transmitted infection
TMA	Total market approach
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WTP	Willingness to pay

CHAPTER 1: INTRODUCTION

RATIONALE AND OBJECTIVES

The condom is an effective barrier contraceptive method offering dual protection against unplanned pregnancies and sexually transmitted infections (STI), including HIV/AIDS. The condom is the only universal method of contraception, that is used by all ages, and not contraindicated by other medical conditions.

Condoms are universally available across the globe. They are available in the public sector, through government health facilities, as well as in the private sector, through private clinics and commercial retailers. Condoms are also offered at subsidized rates through non-governmental organisations (NGO) active in social marketing. However, despite being commercially available for decades (male condom was introduced in the early 1900s, with the female condom more recently available in early 1990s), condoms are still not as widely available in low and middle-income countries. It is estimated that there are less than eight condoms available per year per sexually active individual in Sub-Saharan Africa (UNAIDS 2014 Gap Report).

The UN 20 by 20 initiative is aimed at increasing private sector engagement in the supply and distribution of condoms in Sub-Saharan Africa. As donor funding for male and female condoms is declining globally, a large gap in the availability of free condoms supplied through public sector channels is now predicted. As a result, manufacturers and suppliers (wholesalers, distributors) have an opportunity to bridge this gap, by increasing their engagement in the private commercial market in these countries, in turn widening the channels through which consumers can access condoms.

In response to this opportunity, universal consensus was achieved on the formation of a group, or coalition, of condom manufacturers, suppliers and other stakeholders to more effectively develop a more sustainable commercial market for condoms. The group, currently represented by a steering committee (Private Sector Condom Group), with active support of the Reproductive Health Supplies Coalition, has identified one of its priorities as an improved understanding of the commercial market in terms of size, potential demand, willingness and ability of the consumer to pay for condoms, previously subsidized or supplied free of charge.

Therefore, this proposed study aims to generate evidence on potential market in the commercial sector by exploring the ability and willingness to pay among the condom users in urban Kenya. This will inform future condom pricing strategies based on population income quintiles. Based on the relevance and applicability of this study, it can be replicated in other settings and countries. The results of the study will be crucial in determining relevant strategies for expanding access to condoms across all sectors.

The aim of the study is to explore consumers' willingness to pay for condoms (both male and female) to more effectively inform estimation of potential demand and pricing strategies in the commercial market.

The intended outputs are:

- Evidence on the effect of price on demand to inform pricing strategies of male and female condoms for potential consumers;
- Estimated consumer market size that are able and willing to pay for condoms in Urban Kenya.

COUNTRY CONTEXT

Kenya is a lower middle-income country in East Africa, with an estimated population of 46 million in 2015[1]. Kenya is divided into 47 counties. Nairobi county is the smallest of these counties and the most populous.

Kenya has one of the fastest growing economies with an increasing average consumer spending. The rate of urbanisation in Kenya is among the highest in the world and is projected to increase in the coming years. Kenya's formal retail sector accounts for 30-40% of the market and since 2011 Kenya has recorded the fastest growth in average consumer spending on the continent, per Global consultancy Oxford Business Group (OBG)[2].

FIGURE 1: MAP OF KENYA

The country's health system is organised on a tiered basis consisting of primary care up until specialist referral hospitals. The public sector dominates the health system with a rapidly growing private sector. Despite the advances in Kenya's economy, it still faces challenges in its health sector. While Kenya has met a few of the Millennium Development Goals (MDG) targets, including reduced child mortality among others, HIV/AIDS is still one of the major causes of mortality, putting huge demands on the health system. As of 2015, there were about 1.5 million people living with HIV (PLHIV) with 78,000 new infections[3].

As per DHS 2014, knowledge of at least one family planning method is almost universal i.e. 98% among women and 99% among women. For both men and women, the most widely known contraceptives are male condoms, injectables and the pill. Awareness about female condoms are similar among men (79%) and women (75.6%). When it comes to use, the most popular methods are injectables (26%), implants (10%) followed by the pill (8%). Although condom (male or female) use is quite low at 2.2%, trends show that there has been an increase over the past 11 years (1.2%, 2003). This growth has been seen in the use of all modern contraceptives. Yet the unmet need for family planning is about 18% among women aged 15-49 years. A 2015 study found that despite high level of knowledge regarding condoms among PLHIV, several supply and demand side barriers contributed to low condom use[4]. For instance, use was notably low among 18-24 year olds who are financially dependent on their families and relatives, as well as during sex with casual and secondary partners. Another barrier is misconception that transmission risk lowers with use of biomedical interventions (such as voluntary male circumcision, ARV therapy and so on).

The public sector remains the main source of contraceptives in Kenya, accounting for almost 60% of the market through government facilities like hospitals, dispensaries and health centres. Women mostly go to the private medical sector for contraceptives like the pill and male condoms. These methods are widely sold in pharmacies/chemists. Almost half of the women who use male condoms obtain them from shops (39%).

[1] http://data.worldbank.org/indicator/SP.POP.TOTL?locations=KE
[2] http://www.oxfordbusinessgroup.com/news/kenya%E2%80%99s-retail-sector-ranks-second-most-formalised-africa
[3] https://www.dhsprogram.com/pubs/pdf/SR227/SR227.pdf
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676051/

REGULATION OF CONDOMS

The Pharmacy and Poisons Board (PPB), a semi-autonomous agency is responsible for regulation of pharmaceuticals including condoms. As per the regulation, all condoms must be registered, the procedure for which is made publicly available on their website. As of date, there are over 20 brands of male condoms and one female condom brand registered in the country. Community-based organisations, community health workers, entertainment joints and supermarkets/shops are licensed to sell/distribute condoms.

FINANCING MECHANISM

Procurement of condoms is fully financed by donors. For male condoms, these are UNFPA and the Global Fund whereas for female condoms, it is only UNFPA. Donor funding for condoms has seen a declining trend in the recent years. For instance, in 2016 US$ 1.48 million was allocated by UNFPA for condom procurement as compared to US$ 3.9 million in 2015, indicating a significant decrease in funding.

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

Procurement

Public sector procurement is done centrally by Kenya Medical Supplies Agency (KEMSA) on an annual basis using international competitive bidding. KEMSA procured 139 million pieces of male condoms in 2015-16. Condoms need to have 75% remaining shelf-life at the time of delivery in the country. Supplier performance is monitored using the following criteria: quality of goods and on-time delivery.

Warehousing and distribution

KEMSA's central warehouse is used for storage of condoms from where distribution to regional warehouses and subsequently to facilities take place. Distribution is done on a as and when needed basis using a distribution list developed by the National AIDS and STI Control Programme (NASCOP).

Inventory management

KEMSA has a web-based logistics management information system (LMIS) which captures information on condoms. However, it does not have functionality to allow central level to monitor stock status at the facility level. Health facilities submit monthly inventory reports.

Quality assurance

Kenya Bureau of Standards (KEBS) is fully equipped to carry out quality control (QC) testing of condoms. Condoms are subjected to pre-shipment inspection and testing is also done as part of post-marketing surveillance. Manufacturers and/or suppliers are asked to furnish proof of WHO prequalification, ISO certificate and certificate of conformity. Through the national post-marketing surveillance system, the quality of products placed on the market is monitored.

CHPATER 2: METHODOLOGY

OVERALL APPROACH

The overall approach was based on acquiring an in-depth knowledge about the condom market in Kenya, with a special focus on examining factors that influence access and uptake of condoms.

Supported by desk review of published and grey literature, the following methodology was adopted for the study:

a. *Key informant interviews* – An interview guide to understand from different stakeholders their perspectives on the opportunities and challenges for the private commercial sector in condom supply and distribution.

b. *Consumer interviews* - A semi-structured questionnaire comprising of a mixture of closed and open questions was designed for an explorative interview to assess consumer knowledge, attitude and practice towards condom use to get an insight into demand-side factors that affect condom access, acceptability and use. This also included consumers' willing to pay among different population segments and ideal price points.

c. *Provider interviews* – a semi-structured questionnaire to get providers' (retail pharmacies) perspective on consumer's willingness to pay for condoms.

SAMPLE SIZE AND SAMPLING PLAN

Given the nature and scope of the assignment, purposive sampling was adopted to select stakeholders and pharmacies for the study.

For the key informant interviews, relevant stakeholders involved in condom distribution and supply in the public sector were selected. The list of stakeholders interviewed are presented in Annex A.

A purposive sample of private retail pharmacies in Nairobi was selected for the provider interviews.

For the consumer interviews, respondents were sampled based on convenient sampling approach. Targeted efforts were made to ensure balance in gender distribution and youth respondents. The study focussed on population in the work places with disposable income and youths in universities (youth accounted for approximately 50% of new HIV infections across the globe (UNAIDS, 2008). Muthaa Community Development Foundation (MCDF) reached this population through its networks and respondents were sampled for consumer interviews.

Prior (verbal) consent was obtained from respondents before proceeding with the interviews.

Under the supervision of a supervisor, data collection was done by a team of 5 interviewers who were properly trained by MCDF staff.

DATA COLLECTION TOOLS

Specific data collection tools or survey instruments were designed for targeted respondents. Table 1 below summarises the tools and target audience used:

Target audience	Tool(s)
Stakeholders in public and private sector organisations	Form C: questionnaire on policies, regulations and condom supply chain in the public and private sector
Providers (In-charge) in facilities	Form B: questionnaire to explore provider's perspective on consumer behaviour and willingness to pay for condoms
Consumers	Form A: questionnaire to examine condom use behaviour and willingness to pay for male and female condoms

TABLE 1: DATA COLLECTION TOOLS

Willingness to pay was determined by estimating the potential number of respondents who are willing to pay a given price for male and female condoms. A series of questions were asked assuming a 10% increase in starter (current median price) price followed by a subsequent higher (20%) or lower (5%) increase. They were also asked about the maximum price one would be willing to pay and associated reasons.

All tools developed for data collection were pilot tested in a sample of facilities prior to the actual survey.

DATA QUALITY ASSURANCE AND ANALYSIS

Following data collection, all completed forms were checked and verified prior to data entry. The data validation process also comprised of contacting the data collectors to re-validate and/or collect missing data. All data entries done by one person were cross-checked by another person before analysis. Data analysis was performed using a combination of Microsoft Excel and SPSS.

LIMITATIONS

The study has some limitations related to purposive sampling of participants. The study was conducted only in Nairobi, therefore the results cannot be generalised to a larger or general population of the country. A few of the interviewed providers sold female condoms; however, information on brands, quantities sold and prices was missing or incomplete and thus could not be analysed as part of this study.

CHAPTER 3: FINDINGS

DEMOGRAPHIC PROFILE

CONSUMERS

Overall 127 consumers were interviewed for this study with about 46% of the respondents belonging to the age group of 18-24 years. As shown in Table 2 below, 54% were female and 46% were male. Among them, 22% of respondents were married, 34.6% were single, and 43.3% were in a relationship. University level of education was reported for 66.9% of participants (n=85). Most respondents belonged to protestant religion (48%).

Variable	Values % (N=127)
Age categories	
18-24 years	45.7 % (58)
25-29 years	29.1% (37)
30-34 years	20.5% (26)
>35 years	4.7% (6)
Gender	
Male	45.7% (58)
Female	54.3% (69)
Level of education	
None	1.6% (2)
Secondary	4.7% (6)
College	26.0% (33)
University	66.9% (85)
Marital status	
Single	34.6% (44)
Marred	22.0% (28)
In relationship	43.3% (55)
Religion	
Protestant	48.0% (61)
Catholic	33.1% (42)
Evangelical	14.2% (18)
Muslim	3.9% (5)

TABLE 2: DEMOGRAPHIC CHARACTERISTICS OF CONSUMERS

PROVIDERS

A total of 10 providers located in Nairobi were interviewed for the study. The majority (90%) were pharmacists and had working experience of more than 5 years (60%). Six of them represented retail pharmacies, 2 worked for wholesalers and 2 for distributors (Table 3).

Variable	Values % (N=10)
Type of facility	
Wholesaler	20.0% (2)
Distributor	20.0% (2)
Retail pharmacy	60.0% (6)
Position	
Pharmacist in-charge	90.0% (9)
Other (clinical officer)	10.0% (1)
Years of business	
<1 year	0% (0)
1-3 years	10.0% (1)
3-5 years	30.0% (3)
>5 years	60.0% (6)

TABLE 3: DEMOGRAPHIC CHARACTERISTICS OF PROVIDERS

Products sold in these premises were mainly sourced from local wholesalers (80%) and were produced by international and local manufacturers.

As shown in table 4, all providers sold male condoms but only 50% of them sold/distributed female condoms. Personal lubricants were stocked by 40% of providers. Around 40% of the providers stocked 3 different brands of male condoms with some keeping up to 4 brands. Commonly sold brands included "Trust" (47.6%), "Femiplan" (19.0%) and "Salama" (19.0%). Around 40% of the providers stocked 3 different brands of male condoms with some keeping up to 4 brands. Commonly sold male condom brands included "Trust" (47.6%), "Femiplan" (19.0%) and "Salama" (19.0%), and only one brand of female condoms "Glamorous". "Femiplan" was mistakenly cited as a female condom because of the "femi", but this was later corrected."

Variable	Values % (N=10)
Type of medicines and health products sold	
Medicines	100% (10)
Hormonal contraceptives	90.0% (9)
Condoms, male	100% (10)
Condoms, female	50.0% (5)
Personal lubricants	40.0% (4)
Medical devices	80.0% (8)
Main source of products	
International manufacturers	90.0% (9)
Local manufacturers	70.0% (7)
International wholesalers	50.0% (5)
Local wholesalers	80.0% (8)

TABLE 4: TYPES AND SOURCES OF PRODUCTS

The annual turnover from condom sales was ranged between 15,000 KSH and 90,000 KSH with the median of 24,000 KSH (US$ 232). Male condoms were sold at a median price of 17 KSH (US$ 0.16) with a mark-up of 30%. The unit price of female condoms ranged from 150 KSH (US$ 1.45) to 250 KSH (US$ 2.40) with a mark-up of 20%. The average number of MC units sold per month was 988. For FCs, the providers mentioned that they sold approximately one unit (sachet) in a month.

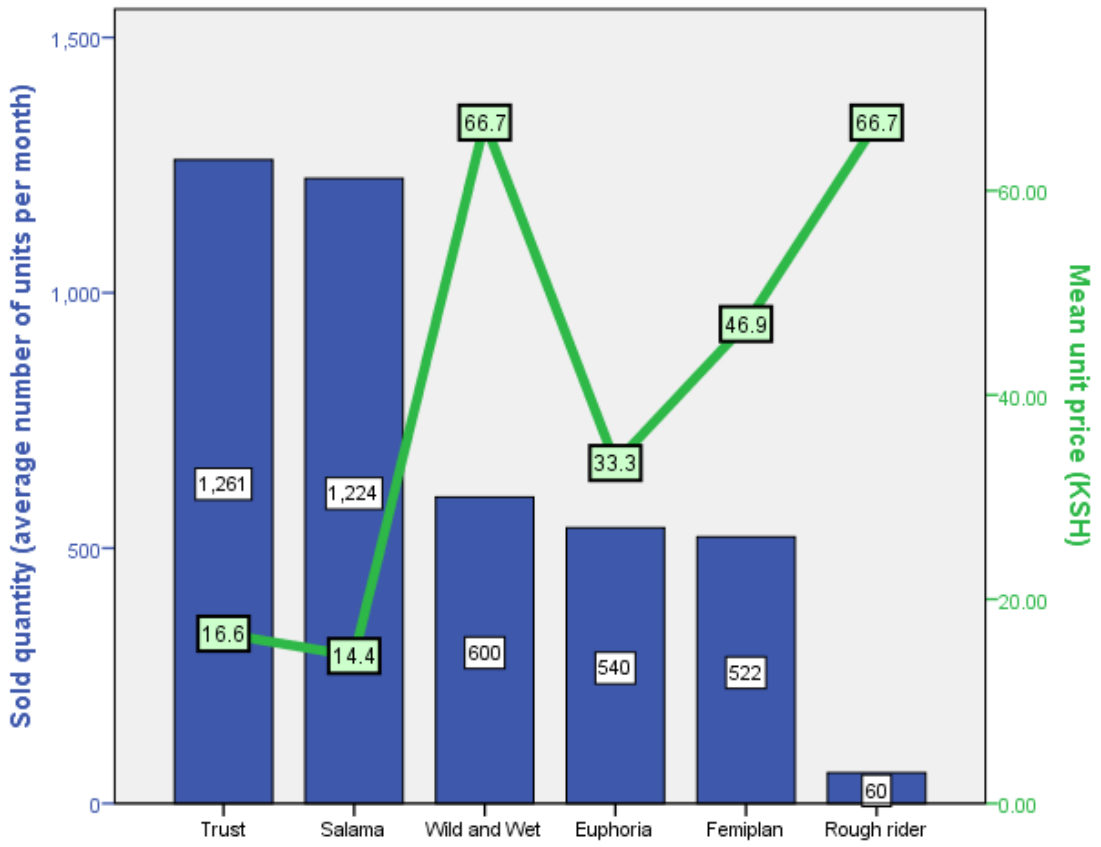

FIGURE 2: QUANTITIES SOLD AND UNIT PRICES OF MALE CONDOM BRANDS

STAKEHOLDER INTERVIEWS

A total of 5 stakeholders were interviewed. The list of stakeholders is provided below:

1. NATIONAL AIDS & STI CONTROL PROGRAM
2. KENYA MEDICAL SUPPLIES AUTHORITY
3. KENYA BUREAU OF STANDARD
4. PHARMACY AND POISONS BOARD
5. UNFPA

CONSUMERS' WILLINGNESS TO PAY FOR CONDOMS

SOCIOECONOMIC CHARACTERISTICS OF THE RESPONDENTS

Ability to pay for condoms among the consumers was determined by a set of questions on their socioeconomic status, namely employment status, household conditions, average monthly expenditures and the main financial provider in the household as shown in the table below. Overall 57.5% of respondents were employed, 34.6% were students and 7.1% were unemployed at the time of the survey. The number of self-employed participants amounted to 41.7%, while 28.3% were financially supported by parents. Half of respondents reported monthly expenditures of 5,000-20,000 KSH (US$ 47-190) and for 27.9% of participant's monthly expenditures amounted to 20,000-70,000 KSH (US$ 190-665).

Variable	Values % (N=127)
Occupation	
Not working	7.1 % (9)
Government service	12.6% (16)
Employee, corporate organization	8.7% (11)
Employee, small business enterprise	10.2% (13)
Self-employed	26.0% (33)
Student	34.6% (44)
Partner's occupation	**(n=83, 65.4%)**
(no stable partner cases are excluded)	
Not working	8.4% (5)
Government service	16.9% (14)
Employee, corporate organization	13.3% (11)
Employee, small business enterprise	7.2% (6)
Self-employed	28.9% (24)
Student	19.3% (16)
Financial provider(s)	
Self	41.7% (53)
Partner	9.4% (12)
Both	12.6% (16)
Parents	28.3% (36)
Education loans	4.7% (6)
Other	1.6% (2)
Respondent's total monthly expenditures	
< 5,000 KSH	18.0% (22)
5,000-20,000 KSH	50.0% (61)
20,000-70,000 KSH	27.9% (34)
70,000-120,000 KSH	1.6% (2)
> 120,000 KSH	2.5% (3)
Total number of the items in the household	
Mean	4.34
Median	5.0
SD	1.460
Min-Max	1.0-6.0

TABLE 5: SOCIODEMOGRAPHIC CHARACTERISTICS OF CONSUMERS

CONDOM USE BEHAVIOUR

Condom use

Among those interviewed, majority had used a male condom (85.8%, n=111) as compared to female condoms (18.9%, n=24). Table 6 below shows the frequency of condom use. Among those who ever used male condoms, 37% used it on a regular ("always") basis and 48% reported to have used it in the last 3 months. Frequency of use among FC users was relatively low with only 14 of them reporting to have ever used it in the last 3 months. Predominant users of MC fell in the age group of 25 – 29 years and FC users fell in the age group of 30 – 34 years.

Condom use	Male condoms	Female condoms*
Frequency of use condoms		
Never	9.4% (12)	76.4% (97)
Sometimes (less than 5 times/week)	32.3% (41)	11.8% (15)
Often (more than 5 times/week)	4.7% (6)	0.8% (1)
Always	37.0% (47)	0.8% (1)
Use of condoms during the last 3 months*		
Yes	48.0% (61)	11.0% (14)
No	35.4% (45)	7.1% (9)

TABLE 6: FREQUENCY OF CONDOM USE

*N=127; missing cases are not presented

Reasons for use

The main reasons for use of MCs were motivation to prevent pregnancy (81.7%), HIV/AIDS (70.6%), and STIs (67%). Several respondents mentioned using it for fun (Fig. 3). For female condoms, the leading reason for use was fun (70.8%) followed by prevention of STIs, HIV/AIDS (54.2%) and prevention of pregnancy (41.7%). The primary reason for those never using condoms (male and female) was that they trusted their partner.

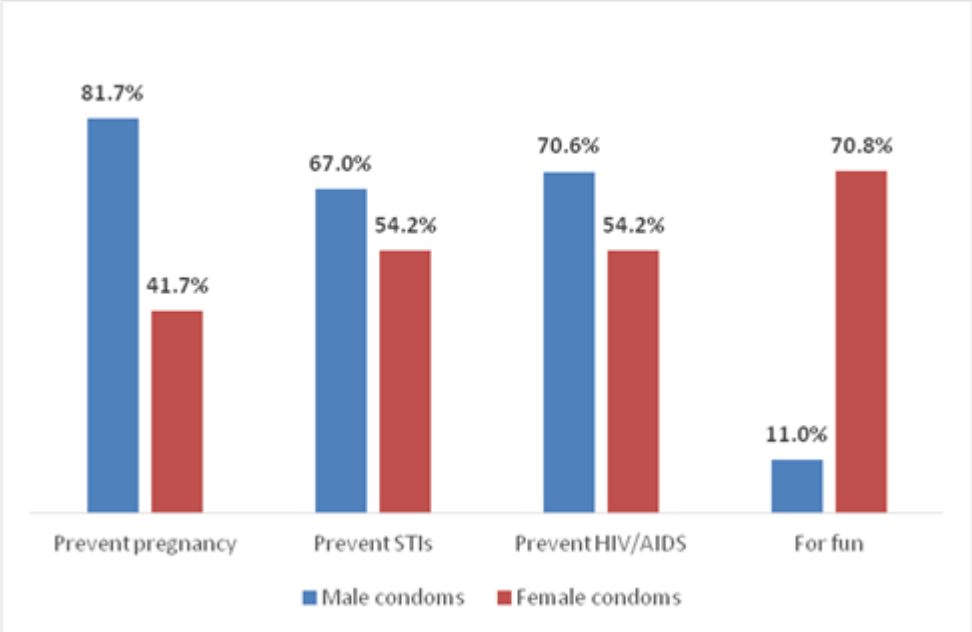

FIGURE 2: REASONS FOR CONDOM USE

Access to condoms

The most common places where people got male condoms from were pharmacies (59.5%), supermarkets/shops (44.1%), and health facilities (18%). The most cited response under "others" was "condom dispenser" (table 7). Concerning female condoms, community-based, non-governmental organizations (50%, n=12) and pharmacies/chemists (33.3%, n=8) were the most frequent places. Five respondents mentioned that they got FCs from supermarket/shops (20.8%) and another 5 got them from friends (20.8%).

Usual source of condoms	Male condoms (n=111)	Female condoms (n=24)
Pharmacy/chemist	59.5% (66)	33.3% (8)
Supermarket/Shop	44.1% (49)	20.8% (5)
Health facility	18.0% (20)	16.7 (4)
Entertainment joints/spots	13.5% (15)	8.3% (2)
Community-based organization / NGOs	9.0% (10)	50.0% (12)
Friend / relative	7.2% (8)	20.8% (5)
Other	4.5% (5)	0% (0)
Street hawker	1.8% (2)	0% (0)

TABLE 7: USUAL SOURCE OF CONDOMS

WILLINGNESS TO PAY FOR CONDOMS

To determine willingness to pay, respondents were first asked if they had ever purchased or paid for condoms. Most of them (n=91, 71.7%) had paid for male condoms at the median unit price of 23 KSH (US$ 0.22). Eleven out of 24 consumers who had ever used FCs reported that they paid for them (46%), and the median price was 200 KSH (US$ 1.90) per piece.

Based on a starter price of 20 KSH (MC) and 200 KSH (FC), the consumers were asked to express their willingness to pay based on hypothetical price increases of 5%, 10% and 20%, including the highest price they were ready to pay. The majority (n=100, 78.7%) were ready to pay 5% more for male condoms, and this number slightly decreased in case of 20% increment (73.2%). The highest price the consumers were ready to pay for MCs ranged from 3 to 300 KSH per unit and the median price was 50 KSH (US$ 0.48), which is about 2.5 times higher than the current market price of 20 KSH (US$ 0.19).

Overall 22.8% (n=29) were ready to pay for female condoms if the price increased by 5%, and the number of consumers decreased proportionally with the price increase. Only 18.1% (n=23) expressed willingness to pay if the price increased by 20%. The responses for the highest price that the participants were willing to pay for FCs ranged from 10 to 1,000 KSH with a median price of 150 KSH (US$ 1.45), which is lower than the current market price of 200 KSH.

Although women are less willing to pay for male condoms in case of price increases, the average highest price given by women was slightly higher than by men. However, no statistically significant difference was identified between gender groups in terms of the highest price they were ready to pay. The analysis did not identify any correlation between willingness to pay the highest price for male and female condoms and the monthly expenditures, as well as between the highest price and the number of items in the household.

There was no statistically significant difference between age groups and gender in terms of the highest price they were ready to pay for condoms.

Increment level	Male condoms		Female condoms	
	Price	%	Price	%
5% increment in starter price	21 KSH	78.7 (n=100)	210 KSH	22.8 (n=29)
10% increment in starter price	22 KSH	77.2 (n=98)	220 KSH	22.0 (n=28)
20% increment in starter price	24 KSH	73.2 (n=93)	240 KSH	18.1 (n=23)

TABLE 8: WTP FOR CONDOMS

Determinants for WTP for male condoms

To identify the key factors influencing WTP for male condoms, the consumers were asked about factors that would influence their decisions. The most frequently quoted enablers were motivation to prevent STIs, HIV/AIDS and pregnancy with 72.6% and 67.3% respectively. About 19.5% of consumers mentioned experiment as an enabling factor, while difficulty in obtaining of MCs from public sector was cited by 7.1% of consumers.

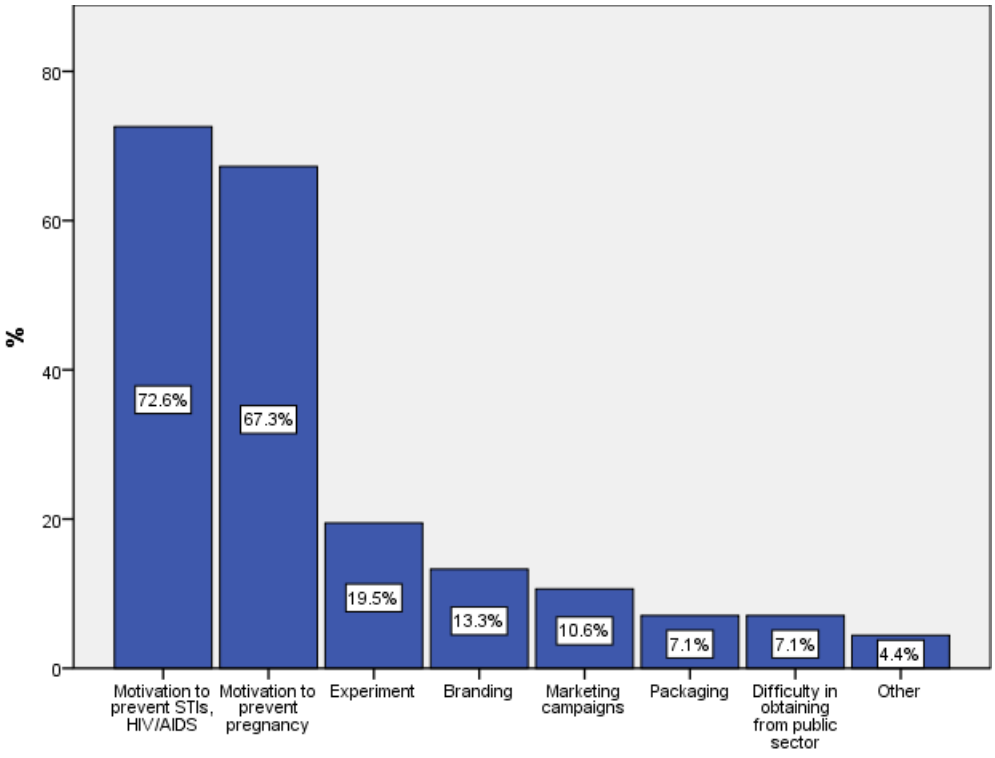

FIGURE 4: DETERMINANTS OF WTP FOR MALE CONDOMS (ENABLERS)

Among barriers, the consumers emphasized trust to partner (54.8%), use of other family planning methods (37.4%), and unwillingness of partner to use condom (30.4%). High price was mentioned by 16.5% of participants.

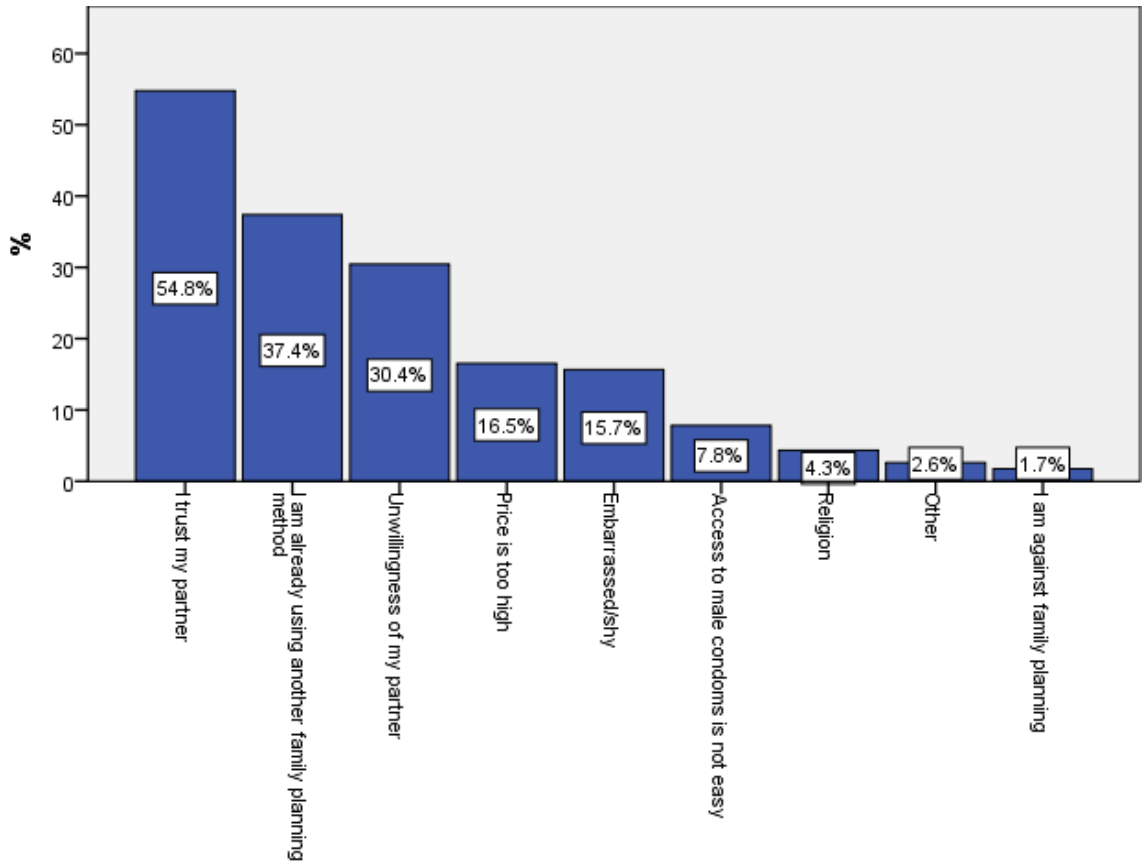

FIGURE 5: DETERMINANTS OF WTP FOR MALE CONDOMS (BARRIERS)

Determinants for WTP for female condoms

Similar to male condoms, the most frequently cited factors were prevention of STIs and HIV/AIDS (51.1%) and prevention of pregnancy (42.2%). Like in case of male condoms, experiment was the third enabler but for female condoms it was mentioned more often (35.6% vs. 19.5%).

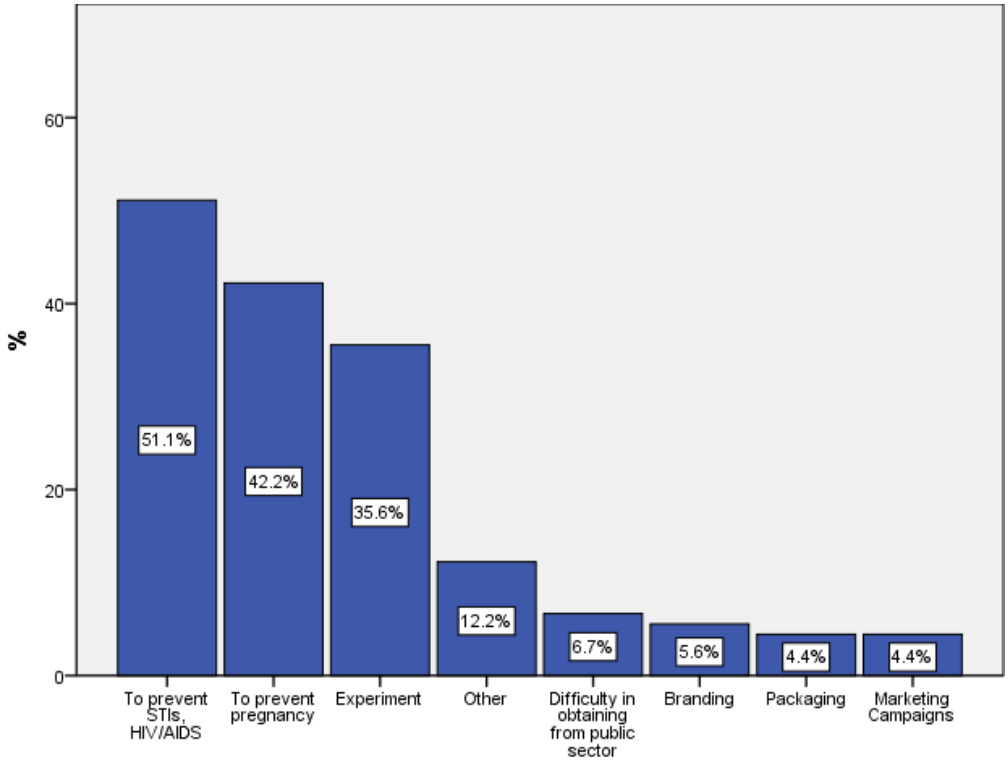

FIGURE 6: DETERMINANTS OF WTP FOR FEMALE CONDOMS (ENABLERS)

When it comes to barriers, more than the third of the respondents mentioned access to FCs and use of another FP method as influencing factors, with 38.4% and 34.8% respectively. High price, trust towards partner and partner's unwillingness to use condoms were cited with equal frequency, amounting to 31.3%.

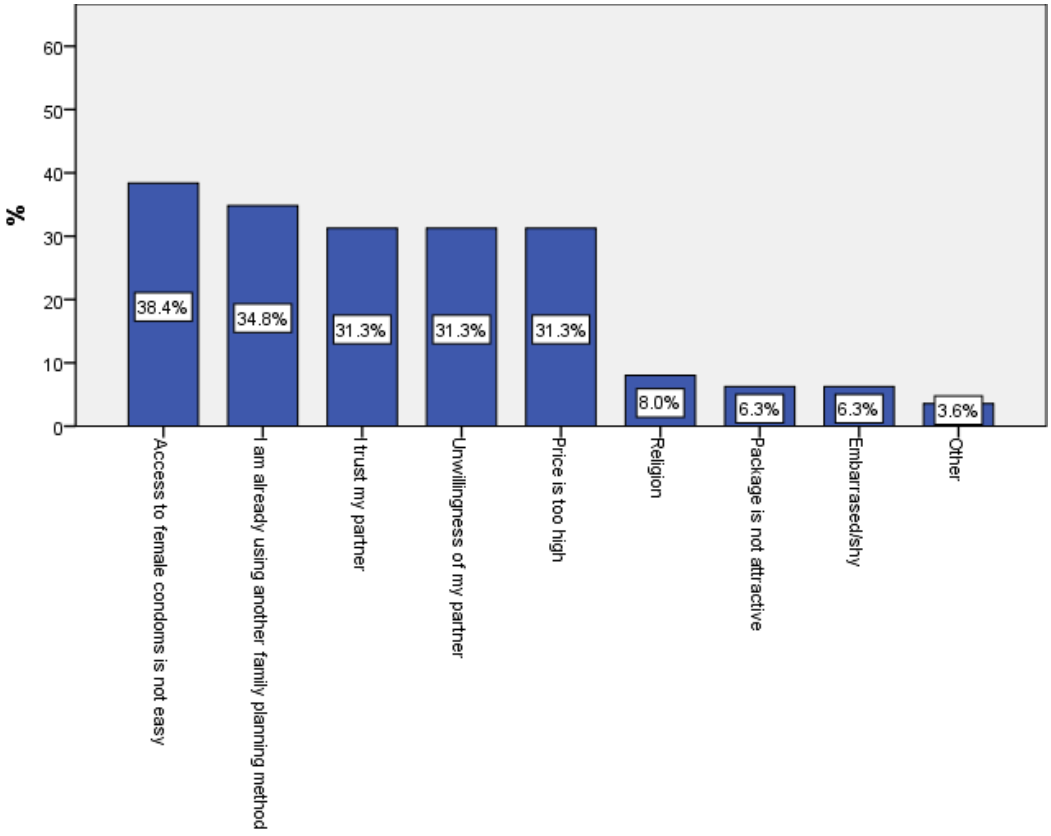

FIGURE 7: DETERMINANTS OF WTP FOR FEMALE CONDOMS (BARRIERS)

WILLINGNESS TO PAY FOR ADDITIONAL LUBRICANTS

The consumers were asked about use of additional lubricants along with male and female condoms, as well as willingness to pay separately for lubricants. In total 9.4% (n=12) of consumers used additional lubricants along with MCs and 3.9% (n=5) with FCs. However only 11 of them (8.6%) were willing to pay separately for additional lubricants.

Seven providers out of 9 indicated that their customers bought personal lubricants separately from condoms.

PROVIDERS' PERSPECTIVE ON WILLINGNESS TO PAY

WTP for condoms

During the interviews, the providers were asked to give their perception on the customers' motivation and WTP for condoms. According to providers, customers used condoms to prevent pregnancy, STIs and HIV/AIDS. In 22% of cases providers said that people mainly use male condoms for fun (Fig. 8).

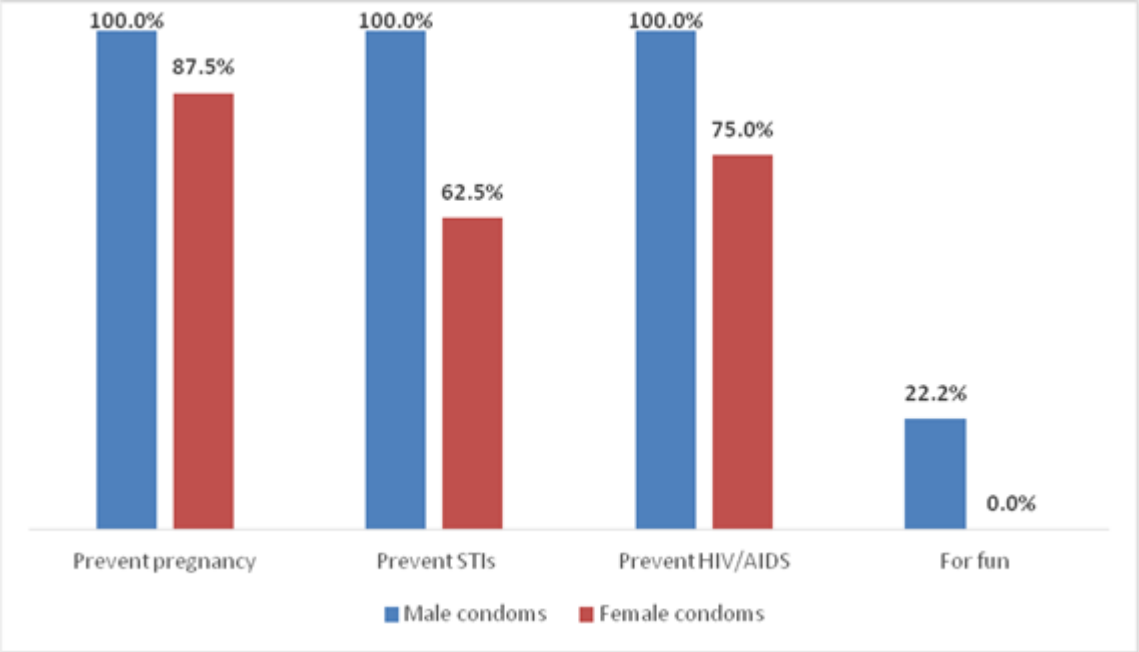

FIGURE 8: REASONS FOR USE OF CONDOMS FROM PROVIDERS PERCEPTIVE

Concerning willingness to pay, most providers (88.9%) said that clients would pay for male condoms in case of 20% price increment (24 KSH), and according to them, the median highest price per pack was 17 KSH (US$ 0.16), which was slightly below the current market price of 20 KSH, while the highest price reported by consumers was 2.5 times higher (50 KSH).

Furthermore, all providers stated that customers would not pay for female condoms more than the starting price, and according to them, the median highest price for one female condom was 100 KSH (US$ 0.95), which is lower than the median highest price cited by consumers (150 KSH) and below the current market price (200 KSH).

Determinants for WTP for male condoms

According to the providers, factors influencing consumers' willingness to pay for male condoms were motivation to prevent pregnancy (100%), prevent STIs, HIV/AIDS (100%), experiment (77.8%) and marketing campaigns (55.6%). It was stated that branding (22%), packaging (22%), and difficulty to obtain male condoms from the public sector (22%) were some other factors likely to influence their decisions (Fig. 9).

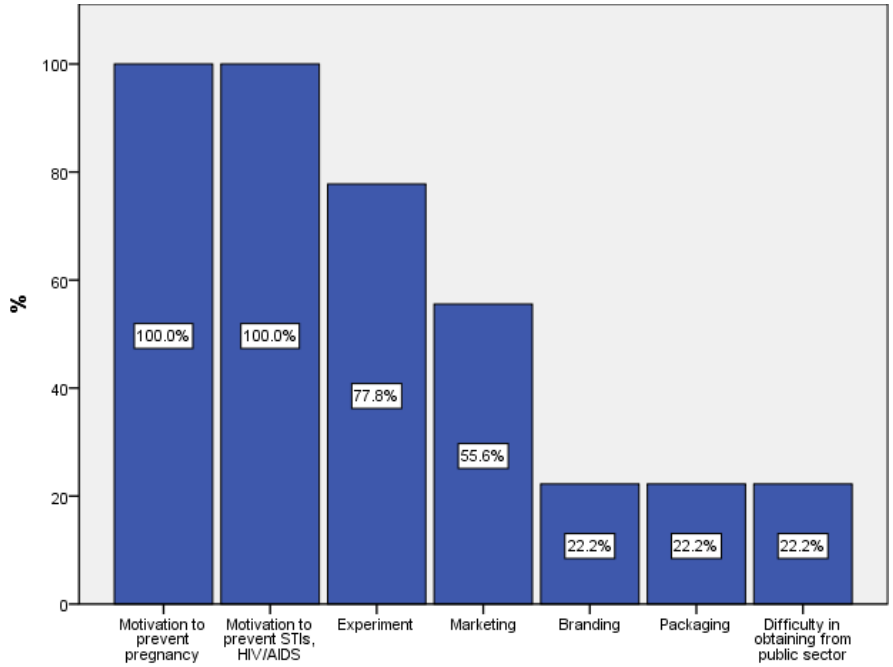

FIGURE 9: DETERMINANTS OF WTP FOR MALE CONDOMS, THE ENABLERS ACCORDING TO PROVIDERS

In comparison, the consumers mentioned experiment in 20% of cases while it was cited by 78% of providers. In contract with providers, consumers did not consider marketing campaigns a persuading factor (10.6%).

Among the possible barriers, the most cited ones were partner's unwillingness to use condoms (100%), high price (44.4%) and religion (44.4%).

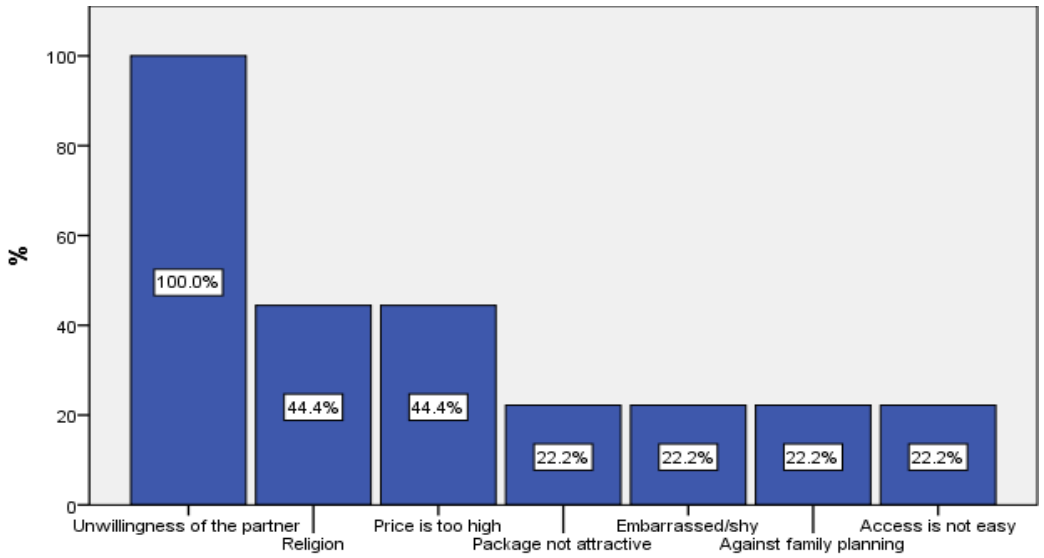

FIGURE 10: DETERMINANTS OF WTP FOR MALE CONDOMS, THE BARRIERS ACCORDING TO PROVIDERS

In the consumers' survey, partner's unwillingness to use condoms was mentioned by 30% of participants and high price was cited by only 16.5% of them. The consumers did not give high importance to religion and this factor was mentioned in only 4% of cases.

Determinants for WTP for female condoms

The providers were asked to cite determinants influencing customers' willingness to pay for female condoms. Among enablers the most frequently cited factors were motivation to prevent STIs and HIV/AIDS (88.9%), motivation to prevent pregnancy (77.8%), and marketing campaigns (55.6%). Similar to male condoms, branding (11%), packaging (11%), and difficulty to obtain female condoms from the public sector (22%) were not considered as significant enabling factors for customers' WTP.

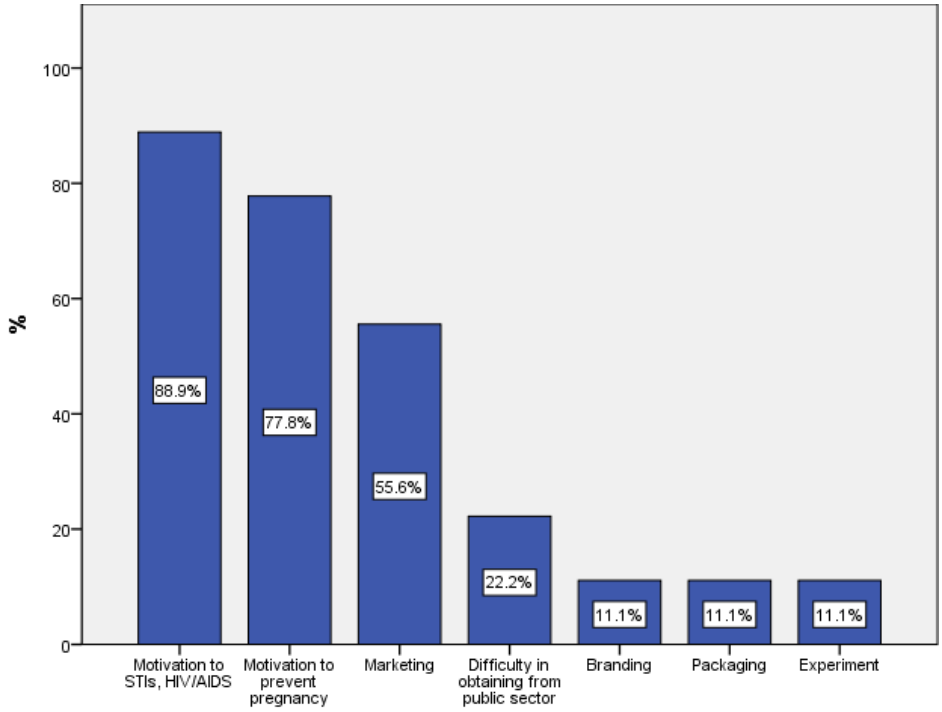

FIGURE 11: DETERMINANTS OF WTP FOR FEMALE CONDOMS, THE ENABLERS ACCORDING TO PROVIDERS

The barriers mentioned by providers were high price (88.9%), partner's unwillingness to use condoms (44.4%), and religion (44.4%). Problematic access and use of other family planning methods were equally mentioned by 33% of providers (Fig. 12).

Analysis of consumers' answers showed no correlation between religion and WTP for male and female condoms.

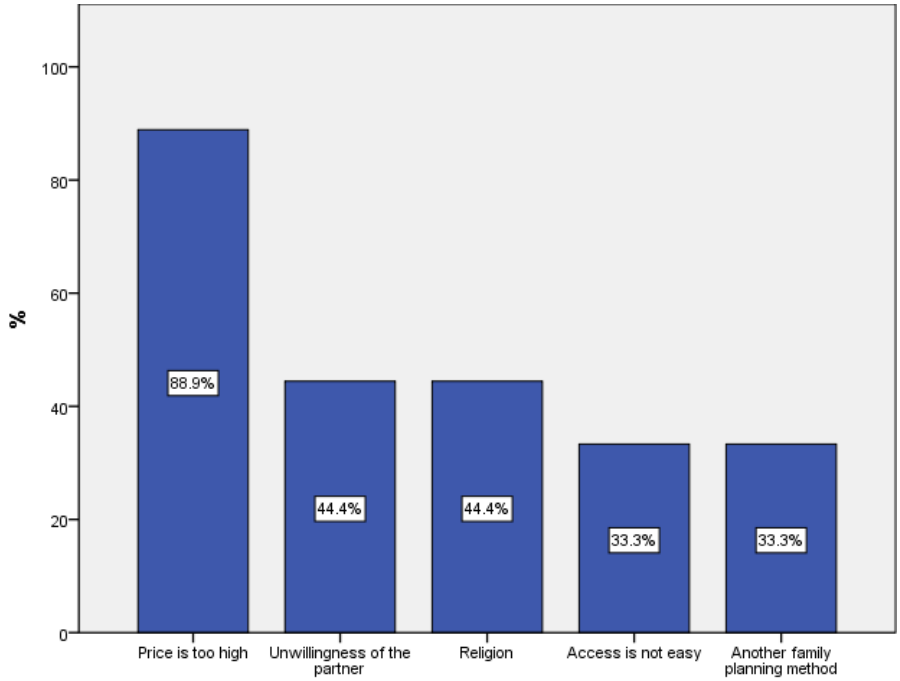

FIGURE 12: DETERMINANTS OF WTP FOR FEMALE CONDOMS, THE BARRIERS ACCORDING TO PROVIDERS

STAKEHOLDERS' PERSEPCTIVE ON CHALLENGES AND OPPORTUNITIES

The main challenges in ensuring access and availability is inadequate supply of condoms in the public sector with frequent stock-outs, especially with female condoms. With an average consumption of 12 million per month, the allocated funding is insufficient to meet the high demand. Per RH Interchange[5], UNFPA supplied 320,000 units of female condoms and 53 million units of male condoms in 2016. Given the reliance on imported condoms and lack of local manufacturers, lead time are long causing delays in supply. When it comes to female condoms, the number of WHO prequalified products is limited. There are opportunities to strengthen supply chain management of condoms in the public sector by improving the inventory reporting system, increasing warehouse capacity and distribution lead times.

The private sector can play a role in enhancing access to condoms, especially for the middle and high-income population. Thus, governments can adopt a total market approach (TMA) strategy to reduce the burden on the public sector. To create an enabling environment for private sector engagement, tax system should be made more favourable. Besides local manufacturing of condoms, public-private partnership in the distribution of condoms should be explored and encouraged. Another mechanism for enhancing access would be to increase the number of distribution and service delivery points. To stimulate the private sector, data on estimated demand and potential market size is important. The current LMIS only captures public sector data while there are no records of consumption from the private sector. Thus, bringing private sector on board would allow visibility on the consumption trend.

Overall the condom promotion among youth can be further boosted. Specific attention must be given towards increasing awareness on female condoms and reducing stigmatisation with its use. Currently female condom use is associated with sex workers.

[5] https://www.unfpaprocurement.org/rhi-home

CHAPTER 4: DISCUSSION

CONDOM ACCESS

Condoms in Kenya are mainly available through the public sector under donor funding through UNFPA and the Global Fund. The procurement of condoms in country is centralised and monitoring is done through logistics management information system, however it does not provide visibility on the supply of condoms or stock at facility level. Accessibility to condoms can be improved by improving inventory management and close collaboration of all organizations involved in supply and distribution of condoms in the country.

Male condoms are widely accessible in pharmacies and supermarkets/shops whereas female condoms are mainly available through NGOs and CBOs. The finding that more than half of the respondents get their male condoms from private pharmacies is consistent with the results of the DHS 2014. Similarly, for female condoms, around 33% of those interviewed obtain them from private outlets. This suggests that there is potential for these products in the commercial market especially among certain population segments such as students, urban dwellers and those with stable income.

During key informant interviews, stakeholders agreed that engagement of private sector in the market has the potential to improve access to condoms and to bridge the gap created by the reduced donors' commitments. Local production might contribute to sustainable supply and have a positive impact on pricing policy.

CONDOM UTILISATION

Not surprisingly male condom use was found to be higher than that of female condoms. It is encouraging to note that around 37% of the consumers reported to have used male condoms every time. In case of female condoms, the percentage is very low with 0.8%. Low female condom use may be attributed to poor knowledge and awareness, behavioural factors and inefficient supply and distribution mechanisms leading to stock-outs at different levels. The primary reasons behind condom (male and female) use are motivation to prevent HIV, STI and pregnancy. The free distribution of condoms among most at risk population (e.g. sex workers, MSM) may have contributed to creating negative perceptions about condoms and thus educational campaigns would be crucial in addressing such myths.

Based feedback received from the providers, the sale of female condoms was very low which may explain the fact that they only stocked one brand. On the contrary, a variety of male condom brands were stocked and sold from these retail outlets. While sales were good, further efforts on marketing (branding, packaging) and addressing demand-side barriers such as partner consent and religious beliefs are likely to improve uptake and thus utilisation.

Service providers believe that the price of female condoms will be the primary deterrent factor for willingness to pay followed by unwillingness of the partner and religious beliefs. Whereas the consumers feel that difficulty in getting them from service delivery points is one of the major barrier. This presents an opportunity for expanding access points and should be carefully considered especially for reaching specific population segments like students. Since stakeholders interviewed also confirmed this as a priority, follow-up work is needed to draw up more concrete strategies and plans.

WILLINGNESS TO PAY

Although it was not possible to determine any correlation between willingness to pay for condoms and socio-economic status of the interviewees, the results show that consumers are more willing to pay for male condoms than for female condoms. According to consumers, the highest price they are willing to pay for male condoms is 2.5 times higher than the market price. In contrast, the highest price for female condoms the consumers are willing to pay is below the current market price. Their opinion was confirmed by providers who noted that people would be more willing to purchase male condoms than female condoms.

Very similar factors influenced WTP for both male and female condoms, such as use of other family planning method, trust and unwillingness of partner. These factors are critical to enhance overall uptake and utilisation of condoms irrespective of the sector and therefore emphasizes the need for continued focus on condom promotion and awareness. Specifically, for female condom, both providers and consumers stated that price and access would be among the key determinants. It appears that difficulty in obtaining FCs in the public sector is driving consumers (or at least the existing users) to the private sector. This finding is critical in developing strategies for engaging the private sector. Although branding, packaging and marketing were not highlighted as drivers in this study, these will, no doubt, require equal attention to attract and retain condom users and out of pocket payers.

The different price points for condom pricing in the commercial market need to be further tested and determined, considering the study limitations (sample size and location) and extrapolation to the general population.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

The findings from this study suggest that there is a potential for expanding the private sector market for condoms in Kenya. Consumers in urban areas are generally willing to pay for condoms, driven by their motivation to prevent HIV/AIDs and pregnancy. As confirmed by both consumers and providers, the demand and as such the willingness to pay is much more for male condoms than female condoms. There is a need for closer collaboration between different market segments to address the existing needs for condoms.

Access can be improved by strengthening the inventory system in the public sector to track inventory levels and prevent stock outs and overstocking whilst allowing a better visibility of the demand. Given the decrease in donor funding, private sector can play an important role in improving access, and opportunities such as public-private partnerships and local condom production should be explored.

It will be important to give specific focus to raising awareness on female condoms not only to boost demand but also to influence willingness to pay. Since the use of FC for fun or experiment has been noted in this study, this should be given due consideration when developing appropriate branding strategies.

Further market research and study on willingness to pay for condoms across the country including rural areas are needed to obtain a comprehensive view of the market and to investigate the potential for engagement of the private commercial sector.

REFERENCES

1. http://data.worldbank.org/indicator/SP.POP.TOTL?locations=KE
2. http://www.oxfordbusinessgroup.com/news/kenya%E2%80%99s-retail-sector-ranks-second-most-formalised-africa
3. https://www.dhsprogram.com/pubs/pdf/SR227/SR227.pdf
4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676051/
5. https://www.unfpaprocurement.org/rhi-home

ANNEXES

ANNEX A: LIST OF STAKEHOLDERS

NASCOP – National AIDS & STI Control Program

NASCOP is a division within the Ministry of Health and is mainly involved with technical co-ordination of HIV and AIDS programmes in Kenya. NASCOP contributes to the bulk of the implementation of the Kenya National HIV and AIDS Strategic Plan III (KNASP III).

Contacts: http://www.nascop.or.ke/

KEBS – Kenya Bureau of Standard

Kenya Bureau of Standards (KEBS) is a statutory body established under the Standards Act (CAP 496) of the laws of Kenya. KEBS is committed to providing Standardization and Conformity Assessment services that consistently meet its customers' requirements.

Contacts: https://www.kebs.org/

PPB – Pharmacy and Poisons Board

The Pharmacy and Poisons Board is the Drug Regulatory Authority established under the Pharmacy and Poisons Act, Chapter 244 of the Laws of Kenya. The Board regulates the Practice of Pharmacy and the Manufacture and Trade in drugs and poisons.

Contacts: http://pharmacyboardkenya.org/

KEMSA – Kenya Medical Supplies Authority

Kenya Medical Supplies Authority (KEMSA) is a state corporation under the Ministry of Health established under the KEMSA Act 2013. KEMSA will provide reliable, affordable and quality health products and supply chain solutions to improve healthcare in Kenya and beyond.

Contacts: http://www.kemsa.co.ke/

UNFPA

Contacts: http://kenya.unfpa.org/

ANNEX B: DATA COLLECTION TOOLS

FORM A

Willingness to pay for male and female condoms
Questionnaire for consumer survey

Section A

No	Question	Response	Skip
1.	Age group	☐ 18 – 24 years ☐ 25 – 29 years ☐ 30 – 34 years ☐ > 35 years	
2.	Gender	☐ Male ☐ Female ☐ Other	
3.	Education	☐ None ☐ Primary ☐ Secondary ☐ College ☐ University ☐ Other ……	
4.	Marital status	☐ Single ☐ Married ☐ In a relationship	
5.	Religion	☐ Protestant ☐ Catholic ☐ Evangelical ☐ Hindu ☐ Muslim ☐ Other ……	

Section B

No	Question	Response	Skip
6.	Occupation	☐ Not working ☐ Government service ☐ Employee Corporate organisation ☐ Employee Small Business Enterprise ☐ Self-employed ☐ Student ☐ Other……	
7.	Partner's occupation	☐ Not working ☐ Government service ☐ Employee Corporate organisation ☐ Employee Small business Enterprise ☐ Self-employed ☐ Student ☐ Other……..	
8.	I, who is/are your financial provider(s)?	☐ Self ☐ Partner ☐ Both ☐ Parents ☐ Higher Education Loans Board(HELB)_Student loans ☐ Other ……	
9.	How much do you spend in a week?	☐ Less than Kshs 500 ☐ Kshs 500-2000 ☐ Kshs 2000-5000 ☐ Kshs 5000-7000 ☐ Kshs 7,000-10,000 ☐ Above Kshs 10,000 ☐ Do not know ☐ Not applicable	
10.	How much do you spend in a month?	☐ less than Kshs 5000 ☐ Kshs 5000-20000 ☐ Kshs 20,000-70,000 ☐ Kshs 70,000-120,000 ☐ above Kshs 120,000 ☐ Do not know ☐ Not applicable	
11.	How much do you spend on entertainment (dates, going out, watching movies etc) per month?	☐ Less than Ksh 1000 ☐ Kshs 1000-3000 ☐ Kshs 3000-5000 ☐ Kshs 5000-10000 ☐ Above Kshs 10,000	
12.	Does your household have: (tick all that applies)	☐ Electricity ☐ Piped/running water ☐ Television ☐ Refrigerator ☐ Vehicle ☐ Smart phone	

Section C

No	Question	Response	Skip
13.	Have you or your partner ever used a male condom?	☐ Yes ☐ No	If not, skip to Q16
14.	Was it during the last 3 months?	☐ Yes ☐ No	
15.	For what reason did you or your partner use male condom in the past? (tick as many boxes)	☐ Prevent pregnancy ☐ Prevent sexually transmitted infections (e.g. gonorrhoea) ☐ Prevent HIV/AIDS ☐ For fun ☐ Other ……	
16.	How often do you or your partner use a male condom?	☐ Never ☐ Sometimes (less than 5 times/week) ☐ Often (more than 5 times/week) ☐ Always ☐ Other ……	
17.	The last time you or your partner used a male condom, where did you or your partner get it from?	☐ Supermarket/shop ☐ Pharmacy/chemist ☐ Health facility ☐ Street hawker ☐ Friend ☐ Community-based organisation/NGOs ☐ Entertainment joints/spots ☐ Other…… ☐ Do not know	
18.	Where do you or your partner normally get your male condoms from?	☐ Supermarket/shop ☐ Pharmacy/chemist ☐ Health facility ☐ Street hawker ☐ Friend ☐ Community-based organisation/NGOs ☐ Entertainment joints/spots ☐ Other…… ☐ Do not know	
19.	Did you or your partner pay for the male condom?	☐ Yes ☐ No	If not, skip to Q 22
20.	How much did you or your partner pay for a packet of male condom?	☐ …… (KS)	
21.	How many condoms were in that packet?	☐ ……	
22.	The current market price of a packet of male condom is about 60 KSh. If the price increased to KSh 72 would you or your partner continue to pay for these condoms	☐ Yes ☐ No	
23.	If the price per piece increased to KSh 66 would you or your partner continue to pay for these condoms?	☐ Yes ☐ No	
24.	If the price per piece increased to KSh 63 would you or your partner continue to pay for these condoms?	☐ Yes ☐ No	
25.	What is the highest price you or your partner would pay for a packet of condom?	☐ …… (KS)	

26.	Do you or your partner use additional lubricants along with the male condom?	☐ Yes ☐ No	If no, skip to Q 29
27.	If yes, would you or your partner be willing to pay for additional lubricants separately?	☐ Yes ☐ No (state reason why)----------	
28.	Why would you or your partner buy male condoms? (tick as many boxes)	☐ Motivation to prevent pregnancy ☐ Motivation to prevent STIs, HIV/AIDS ☐ Marketing campaigns ☐ I like the Packaging ☐ Branding (I like or am familiar with the name) ☐ Experiment (try new flavours, studded etc) ☐ Difficulty in obtaining from public sector ☐ Other ……..	
29.	Why would you or your partner NOT buy male condom? (tick as many boxes)	☐ I am already using another family planning method ☐ I trust my partner ☐ Unwillingness of my partner ☐ Price is too high ☐ Access to male condoms is not easy ☐ Package is not attractive ☐ Embarrassed/shy ☐ Religion ☐ I am against family planning ☐ Other……..	

Section D

No	Question	Response	Skip
30.	Have you or your partner ever used a female condom?	☐ Yes ☐ No	If no, skip to Q33
31.	Was it during the last 3 months?	☐ Yes ☐ No	
32.	For what reason did you or your partner use a female condom in the past? (tick as many boxes)	☐ Prevent pregnancy ☐ Prevent sexually transmitted infections (e.g. gonorrhoea) ☐ Prevent HIV/AIDS ☐ For fun ☐ Other ……..	
33.	How often do you or your partner use a Female condom?	☐ Never ☐ Sometimes (less than 5 times/week) ☐ Often (more than 5 times/week) ☐ Always ☐ Other ……..	
34.	The last time you or your partner used a female condom, where did you get it from?	☐ Supermarket/shop ☐ Pharmacy/chemist ☐ Health facility ☐ Street hawker ☐ Community-based organisation/NGOs ☐ Entertainment joints/spots ☐ Friend ☐ Other…….. ☐ Do not know	
35.	Where do you or your partner normally get your female condoms from?	☐ Supermarket/shop ☐ Pharmacy/chemist ☐ Health facility ☐ Street hawker ☐ Community-based organisation/NGOs ☐ Entertainment joints/spots ☐ Friend ☐ Other…….. ☐ Do not know	
36.	Did you or your partner pay for the female condom?	☐ Yes ☐ No	If not, skip to Q 39
37.	How much did you or your partner pay for one female condom?	☐ …….. (KS)	
38.	The current market price for one female condom is about 200 KS. If the price per piece increased to KS 240 would you or your partner continue to pay for these condoms?	☐ Yes ☐ No	
39.	If the price per piece increased to KS 220 would you or your partner continue to pay for these condoms?	☐ Yes ☐ No	
40.	If the price per piece increased to KS 210 would you or your partner continue to pay for these condoms?	☐ Yes ☐ No	
41.	What is the highest price you or your partner would pay for one female condom?	☐ …….. (KS)	
42.	Do you or your partner use additional lubricants along with the female condom?	☐ Yes ☐ No	If no, skip to Q 45

43.	If yes, would you or your partner be willing to pay for additional lubricants separately?	☐ Yes ☐ No (state reason why)----------	
44.	Why would you or your partner buy a female condom? (tick as many boxes)	☐ to prevent pregnancy ☐ to prevent STIs, HIV/AIDS ☐ I like the Packaging ☐ Branding (I like or am familiar with the name) ☐ Experiment ☐ Marketing campaigns ☐ Difficulty in obtaining from public sector ☐ Other …….. ☐	
45.	Why would you or your partner not buy a Female condom? (tick as many boxes)	☐ I am already using another family planning method ☐ I trust my partner ☐ Unwillingness of my partner ☐ Price is too high ☐ Access to female condoms is not easy ☐ Package is not attractive ☐ Embarrassed/shy ☐ Religion ☐ I am against family planning ☐ Other……..	

FORM B

Willingness to pay for male and female condoms
Questionnaire for providers (Pharmacists in private commercial sector)

Section A: General Information

No	Question	Response	Skip
1.	Type of facility	☐ Wholesaler ☐ Distributor ☐ Retail pharmacy	
2.	Respondent	☐ Pharmacist in-charge ☐ Pharmacy manager ☐ Other, specify: ……	
3.	Years of business (number of years the company/business has been operating)	☐ <1 year ☐ 1 – 3 years ☐ 3 – 5 years ☐ > 5 years	
4.	Location	City: …… District: …… Region/County: ……	

Section B: Scope of business

No	Question	Response		Skip
5.	Type of medicines and health products sold	☐ Medicines ☐ Hormonal contraceptives ☐ Condoms, male ☐ Condoms, female ☐ Personal lubricants ☐ Medical devices ☐ Other……		
6.	Main source of products (tick all that applies)	☐ International manufacturers ☐ Local manufacturers ☐ International wholesalers ☐ Local wholesalers ☐ I don't know ☐ Other……		
7.	What is your usual source of male condoms?	☐ International manufacturers ☐ Local manufacturers ☐ International wholesalers ☐ Local wholesalers ☐ Non-Governmental Organization ☐ I don't know ☐ Other……		
8.	What is your usual source of female condoms	☐ International manufacturers ☐ Local manufacturers ☐ International wholesalers ☐ Local wholesalers ☐ Non-Governmental Organisation (NGO) ☐ I don't know ☐ Other……		
9.	How many different brands of male condoms do you sell?	☐ 1 ☐ 2 ☐ 3 ☐ 4 or more		
10.	Specify the most commonly sold brands of male condoms & selling their prices (up to 3)			
	Brand name	**Approximate number sold per month**	**Price (KS)/piece**	
11.	How many different brands of female condoms do you sell?	☐ 1 ☐ 2 ☐ 3 ☐ 4 or more		
12.	Specify the most commonly sold brands of female condoms & selling their prices (up to 3)			
	Brand name	**Approximate number sold per month**	**Price (KS)/piece**	
13.	What % mark-up do you currently apply on male condoms?			
14.	What % mark-up do you currently apply on female condoms?			

15.	What is your annual/monthly turnover in terms of condom sales:	☐ ……(KS/annually) OR ☐ ……(KS/monthly)	

Section C

No	Question	Response	Skip
16.	In your opinion, for which of the following reasons do your customers use male condoms?	☐ Prevent pregnancy ☐ Prevent sexually transmitted infections (e.g. gonorrhoea) ☐ Prevent HIV/AIDS ☐ Fun ☐ Other …….. ☐ Do not know	
17.	The current market price of a packet of male condom is about 60 KSh. If the price increased to KSh 72 would you or your partner continue to pay for these condoms	☐ Yes ☐ No ☐ Do not know	
18.	If the price per piece increased to KSh 78 would you or your partner continue to pay for these condoms	☐ Yes ☐ No ☐ Do not know	
19.	If the price per piece increased to KSh 81 would you or your partner continue to pay for these condoms?	☐ Yes ☐ No ☐ Do not know	
20.	In your opinion, what is the highest price a customer would pay for a pack of condoms	☐ …….. (KS)	
21.	Do you have customers asking to buy personal lubricants separately when buying condoms?	☐ Yes ☐ No	
22.	In your opinion, what would be the main reasons for consumer's willingness to pay for male condom? (tick as many boxes)	☐ Motivation to prevent pregnancy ☐ Motivation to prevent STIs, HIV/AIDS ☐ Marketing campaigns ☐ Packaging ☐ Branding ☐ Experiment (try different flavours, studded etc) ☐ Difficulty in obtaining from public sector ☐ Other ……..	
23.	In your opinion, for what reasons would theynot be willing to pay for male condom? (tick as many boxes)	☐ They are already using another family planning method ☐ Unwillingness of the partner ☐ Price is too high ☐ Access to male condoms is not easy ☐ Package is not attractive ☐ Embarrassed/shy ☐ Religion ☐ I am against family planning ☐ Other……..	

Section D

No	Question	Response	Skip
24.	In your opinion, for which of the following reasons do your customers use female condoms? (tick as many boxes)	☐ Prevent pregnancy ☐ Prevent sexually transmitted infections (e.g. gonorrhoea) ☐ Prevent HIV/AIDS ☐ Fun ☐ Other …… ☐ Do not know	
25.	The current market price of one female condom is about KS 200. If the price per piece increased to KS 240 would your consumers continue to pay for these condoms?	☐ Yes ☐ No ☐ Do not know	
26.	If the price per piece increased to KS 220 would your consumers continue to pay for these condoms?	☐ Yes ☐ No ☐ Do not know	
27.	If the price per piece increased to KS 210 would your consumers continue to pay for these condoms?	☐ Yes ☐ No ☐ Do not know	
28.	In your opinion, what is the highest price they would pay for one female condom?	☐ …… (KS)	
29.	In your opinion, what would be the main reasons for consumer's willingness to pay for female condom? (tick as many boxes)	☐ Motivation to prevent pregnancy ☐ Motivation to prevent STIs, HIV/AIDS ☐ Marketing campaigns ☐ I like the Packaging ☐ Branding (I like or am familiar with the name) ☐ Experiment (try new flavours, studded etc) ☐ Difficulty in obtaining from public sector ☐ Other ……	
30.	In your opinion, for what reasons would they not be willing to pay for female condom? (tick as many boxes)	☐ They are already using another family planning method ☐ Unwillingness of the partner ☐ Price is too high ☐ Access to female condoms is not easy ☐ Package is not attractive ☐ Embarrassed/shy ☐ Religion ☐ I am against family planning ☐ Other……	

FORM C

Questionnaire on Condom Supply Chain (PUBLIC SECTOR)

(Adapted and modified from WHO/HAI methodology and WHO indicators for monitoring country pharmaceutical situation)

COUNTRY:	**ORGANISATION:**
NAME OF RESPONDENT:	**DESIGNATION:**
NAME OF DATA COLLECTOR:	**DATE:**

Note: in all cases, information must be obtained for both male and female condoms.

1. NATIONAL MEDICINES (DRUG) POLICY (NMP)		**Remarks or Explanations**
Name & position of the principal respondent: Click here to enter text.		
1.1 Is there a National Medicines Policy (NMP)?	☐Yes ☐ No *If no, skip to question 1.4*	
1.2 Has the NMP been endorsed or adopted by the government?	☐ Yes ☐ No *If yes, which year* Click here to enter a date.	
1.3 Is there a NMP implementation plan that outlines the activities, responsibilities, budget and timeline?	☐ Yes ☐ No	
1.4 Is there a national Essential Medicines List (EML)?	☐ Yes ☐ No *If yes, how often is it updated?* Click here to enter a date.	
1.5 Are condoms included in the EML?	☐ Yes, both male and female condoms ☐ Yes, only male condoms ☐ Yes, only female condoms ☐ No	
2. REGULATION		
Name & position of the principal respondent: Click here to enter text.		
2.1 Is there an existing national regulatory authority (NRA)?	☐ Yes ☐ No *If no, skip to question 2.4*	
2.2 Is the NRA:	Tick one: ☐ part of MoH ☐ semi-autonomous ☐ autonomous	
2.3 What are the functions of NRA?	Tick all relevant boxes: ☐ marketing authorisation/registration ☐ import control ☐ licensing ☐ inspection ☐ quality control ☐ pharmacovigilance ☐ medicines advertising/promotion ☐ price regulation	
Marketing authorisation/ registration		
2.4 Is there a law requiring registration of condoms on the market?	☐ Yes ☐ No	
2.5 Is there any mechanism for exception or waiver of registration?	☐ Yes ☐ No	

2.6 Is there a mechanism for recognition of registration done by other countries?	☐ Yes ☐ No *If yes, please explain:* Click here to enter text.	
2.7 Is the criteria for assessing applications for registration made publicly available?	☐ Yes ☐ No	
2.8 Is there any mechanism to use the information from WHO/UNFPA prequalification programme?	☐ Yes ☐ No *If yes, please explain:* Click here to enter text.	
2.9 Number of condom brands registered in the country	Total number (male condoms): Total number (female condoms):	
2.10 Registration fee – per application	Amount in local currency:	
2.11 Retention fee (if applicable)	Amount in local currency:	
2.12 Time line for assessment of registration applications	Months	
Licensing		
2.13 Is there a law requiring licensing of the following:	*If yes, how many*	
Local manufacturers of condoms	☐ Yes ☐ No Number:	
Wholesalers / distributors of condoms	☐ Yes ☐ No Number:	
Private pharmacies selling condoms	☐ Yes ☐ No Number:	
2.14 Which other outlets or service delivery points are allowed to distribute/sell condoms?	☐ any supermarket or shop ☐ community-based organisations ☐ community health workers ☐ street hawkers ☐ Others: ……	
Quality control		
2.15 Is there a national laboratory for quality testing of condoms?	☐ Yes ☐ No *If yes, what is it called?* Click here to enter text.	
2.16 Are samples sent for testing to a laboratory outside the country?	☐ Yes ☐ No *If yes, give the name & location:* Click here to enter text.	
2.17 For which of the following purposes is testing done:		
Medicines registration	☐ Yes ☐ No	
Public procurement	☐ Yes ☐ No	
Post-marketing surveillance	☐ Yes ☐ No	
2.18 How many samples were tested in the past 12 months?	Number:	
2.19 What is number of samples tested in the past 12 months that failed to meet quality standards?	Number:	
2.20 What action is taken when condoms fail to meet quality standards?	Explain: Click here to enter text.	
3. FINANCING		
Name & position of the principal respondent: Click here to enter text.		
3.1 What is the total *annual* expenditure on condoms?	(local currency/USD): millions Year: Click here to enter a date.	including both government and private

3.2 What is the total Government (public sector) expenditure on condoms *annually*?	Male condom: (local currency): millions Year: Click here to enter a date. Female condom: (local currency): millions Year: Click here to enter a date.	government allotment, donor contributions, and all funds channelled through government
3.3 What is the private expenditure condoms annually?	(local currency): millions Year Click here to enter a date.	
3.4 Under the public health system, are condoms provided free to the people?	☐ Yes ☐ No If no, specify what fees are charged.	
3.5 Is there policy covering condom prices in		
Public sector	☐ Yes ☐ No	
Private sector	☐ Yes ☐ No	
3.6 If yes, which of the following exist:		
Maximum wholesale mark-up	☐ Yes ☐ No	
Maximum retail mark-up	☐ Yes ☐ No	
Duty on imported products	☐ Yes ☐ No	
3.7 Are there any provisions for tax exemptions or waivers for condoms?	☐ Yes ☐ No	
3.8 Is there a system for regulating or monitoring condom prices for consumers?	☐ Yes ☐ No If yes, describe briefly the system in place: Click here to enter text.	
5 PROCUREMENT		
Name & position of principal respondent: Click here to enter text.		
5.1 Is the procurement of condoms for the public sector centralised (or pooled at the national level)?	☐ Yes ☐ No	
5.2 Who is responsible for the public sector medicines procurement?	Tick one: ☐ Ministry of Health ☐ UNFPA ☐ Other donors, specify: …….. ☐ NGO ☐ Private institution contracted by the government ☐ Individual health institutions ☐ Other: ……	
5.3 How often is the tender for public sector procurement floated?	☐ every two years ☐ annually ☐ every six months ☐ as and when required	
5.4 What is the type of tender process used?	☐ national competitive tender ☐ international competitive tender ☐ limited (closed) bidding ☐ direct purchasing	
Quality monitoring		
5.5 What kind of quality-related documents are requested from manufacturers/suppliers at the time of delivery?		

5.6 What is the minimum shelf-life requirement for condoms upon delivery in the country?	☐ months OR ☐ % of total shelf life upon delivery in the country	
5.7 Is there a mechanism for supplier performance monitoring?	☐ Yes ☐ No	If Yes, please explain: Click here to enter text.
5.8 Is a pre-shipment inspection of condoms requested at the time of procurement?	☐ Yes ☐ No	If Yes, please explain: Click here to enter text.
5.9 Is there a procedure for recording complaints about product quality at all levels?	☐ Yes ☐ No	If Yes, please explain: Click here to enter text.
5.10 Is there a procedure for product recalls in the event of known or suspected defective products in the distribution channel?	☐ Yes ☐ No	If yes, please explain: Click here to enter text.
5.11 Are visual quality inspection of products conducted at all levels?	☐ Yes ☐ No	
5.12 Is there a procedure for disposal or expired or quality failed products?	☐ Yes ☐ No	
Additional comments:		
Warehouse & Distribution		
5.13 Is there a central warehouse for storage of condoms:	☐ Yes ☐ No	If yes, give the name and location: Click here to enter text.
5.14 Are there regional or district warehouses for storage of condoms:	☐ Yes ☐ No	If yes, explain the role of this warehouses in distribution: Click here to enter text.
5.15 What system of distribution is followed for condoms:	☐ push ☐ pull	Describe briefly:
5.16 How often is distribution of condoms done from the central to district level:	☐ annually ☐ six monthly ☐ quarterly ☐ monthly ☐ as and when required	
5.17 How often is distribution of condoms done from the district to lower levels:	☐ annually ☐ six monthly ☐ quarterly ☐ monthly ☐ as and when required	
Inventory management		

5.18 Is there a logistics management information system (LMIS), either paper-based or computerised?	☐ Yes ☐ No *If No, skip to question 5.21*	If yes, briefly describe the system including if it is functional at all levels:
5.19 Is the LMIS capture information on condoms?	☐ Yes ☐ No	
5.20 Does the LMIS allow central medical store to monitor stock status of all public health facilities?	☐ Yes ☐ No	
5.21 Does the central medical store regularly receive stock status reports from all public health facilities?	☐ Yes ☐ No	If Yes, describe the information captured in the report: Click here to enter text.
5.22 Is a physical inventory of health products (including condoms) conducted at all levels?	☐ Yes ☐ No If yes, specify how often: ☐ annually ☐ six monthly ☐ quarterly ☐ monthly	
5.23 Do facilities record quantities of expired condoms for the past year:	☐ Yes ☐ No If yes, specify at which levels?	
5.24 What are some of the major supply chain challenges that the public sector is facing in terms of condom access and availability?		
5.25 What challenges do you face in sourcing male and female condoms for your market?		
5.26 Describe the funding (national government & donor) trend for condom procurement for the past five years? What changes are expected in the coming years?		
5.27 How do you see the role of private sector in improving uptake and access to condoms in Kenya?		
5.28 What can the government do to enhance private sector involvement in condom distribution and supply?		
Additional comments: Click here to enter text.		