Family Planning in Kenya:
A Review of National and District Policies and Budgets
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>AOP</td>
<td>Annual Operational Plans</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CS</td>
<td>Contraceptive Security</td>
</tr>
<tr>
<td>CSOs</td>
<td>Civil Society Organizations</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
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<tr>
<td>DRH</td>
<td>Department of Reproductive Health</td>
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<tr>
<td>DSW</td>
<td>Deutsche Stiftung Weltbevolkerung</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>FHOK</td>
<td>Family Health Options Kenya</td>
</tr>
<tr>
<td>FPOK</td>
<td>Family Planning Options Kenya</td>
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<tr>
<td>GDP</td>
<td>Growth Domestic Product</td>
</tr>
<tr>
<td>GoK</td>
<td>Government of Kenya</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and</td>
</tr>
<tr>
<td></td>
<td>Development</td>
</tr>
<tr>
<td>IEA</td>
<td>Institute of Economic Affairs</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
</tr>
<tr>
<td>KNBS</td>
<td>Kenya National Bureau of Statistics</td>
</tr>
<tr>
<td>KNCHR</td>
<td>Kenya National Commission for Human Rights</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoPHS</td>
<td>Ministry of Public Health and Sanitation</td>
</tr>
<tr>
<td>NCPD</td>
<td>National Council for Population and Development</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>NHSSP II</td>
<td>National Health Sector Strategic Plan II</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>RHR</td>
<td>Reproductive Health Rights</td>
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<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health Rights</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UPE</td>
<td>Universal Primary Education</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgements

DSW (Deutsche Stiftung Weltbevoelkerung) wishes to acknowledge the contribution and support of various organizations and individuals who made this study possible. We highly appreciate the contribution of members of staff from the Ministry of Health – Finance Department, Division of Reproductive Health (DRH) and the Kenya Medical Supplies Agency (KEMSA) for their help and willingness to share information. In particular we wish to acknowledge Ms. Gladys Someren, Family Planning Coordinator at DRH, Hon. Dr. Anisa Omar, County Executive for Health in Kilifi, Hon. Catherine Mukenyang, County Executive for Health in West Pokot, Josephine Kinyanjui of Health Rights Advocacy Forum (HERAF), John Kinyanjui of International Budget Partnership (IBP) and Karen Rono of Development Initiatives for their support in making this study possible.

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Finally, to all our colleagues who in one way or another supported the exercise, keep up with the good spirit.
Executive Summary

The Kenyan population increased by about one million each year between 2000 through 2010 and is now one of the highly populated countries in Africa at more than 40 million. The population grew at a faster rate than the economic indicators, threatening the reproductive and maternal newborn health gains realized in the past and posing a big obstacle in the achievement of Millennium Development Goals (MDGs) and Vision 2030. For Kenya to realize a more manageable population growth rate there is need to improve the Contraceptive Prevalence Rate (CPR) that currently stands at 45.5%. (Kenya Family Planning costed Implementation Plan 2012).

Unmet family planning needs in Kenya have been there since independence. A comparison of the 2003 KDHS report with that of 2009 indicates that the unmet need for FP increased from 24.5% (2003) to 25.6 (2009). These includes women expressing a desire to space births for at least two years or limit the number of births and hence necessitating women who do not want to become pregnant but are not using contraception (DHS 2012). This has been attributed to poor access to FP services especially at the community and facility level, sporadic insecurity of FP commodities and inadequate funding of FP programs.

This study seeks to understand the reasons behind the high unmet need for family planning in the country and particularly in Kilifi and West Pokot counties. The study reviewed policies and budgetary documents at national and county levels which showed that the high unmet need is attributed to inadequate service provision, poor access to FP commodities, lack of support for contraceptive security due to over-dependence on donor funding and suppressed use by low male involvement in family planning.

The research was conducted at three levels using both primary and secondary sources of data.

In the communities: The research used a bottom up approach where communities were questioned on their definition of unmet need, the challenges they face and their recommendations. Focus Group Discussions were held with women, men and young people in West Pokot and Kilifi which ranked those recommendations and identified two key advocacy priorities in each county. These recommendations also were the basis for formulating some of the research questions.

At county level: DSW then assessed health facilities in the communities which had hosted the FGDs to counter check the community members’ statements. District operations plans, county Budgets and work plans were assessed with those recommendations in mind, using standard analysis tools. Key informant interviews were held with county heads of health in Kilifi and West Pokot where the researchers met the county health executives, county steering teams and nurses at health facilities.

At national level: Interviews were held with key informants from Division of Reproductive Health, MOH Finance Department and the Kenya Medical Supplies Authority, NGOs and donors. Budget documents including Budget Estimates and Expenditure Reports for 2010/2011, 2011/2012 and 2012/ 2013 financial years were also analyzed.
Family Planning in Kenya:

**Key findings**

- Since independence, the Kenyan government has recognized that population management is key in realization of sustained socio-economic development. It is one of the countries in Africa that invested in Family Planning (FP) programming by developing a number of population policies, strategies and programmes to address population management challenges over time. Indeed Kenya has assented to global and regional agreements including ICPD, Maputo, Abuja and FP2020 protocols. However, it has done very little or nothing to institutionalize and implement them. This can best be exemplified in the Abuja declaration of allocating 15% towards health and the Maputo requirement that countries should allocate 15% of the health budget to RH. This is yet to be met, with Kenya allocating only 6% of the 2013/2014 budget to health.

- This study reviewed more than 10 Kenya policies underlining the importance of improving family planning efforts by investing more in FP programmes; however this has not happened with the family planning budget stagnating at around 600 million for the last 3 financial years. (HERAF 2012)

- Community perceptions from FGDs revealed that many women would like to plan their pregnancies but are not using any FP methods because the health facilities offering these methods are a long distance from their villages. Health facility assessments show that FP commodities in health facilities expire or are redistributed because of low utilization rates. The Kenya RH policy promotes community based distribution of FP to expand access to FP services and recently approved distribution of injectable contraceptives in marginalized areas (Reproductive Health Policy 2007). However, key informants with policy makers and programme implementers in RH/FP stated that the strategy is not working well. Reasons include the reluctance of nurses to implement the strategy as well as lack of resources to fund the community strategy including incentives to CHWs.

- FP efforts in Kenya are largely donor driven with data from OECD/DAC (http://www.oecd.org/dac/stats/idsonline.htm) showing that of all DAC donor support to Kenya, population policy and programmes received Kshs. 3.5 billion while the government invested Kshs. 600 million to the same.

- In Kenya the problems associated with unmet need for FP are as a result of very little investment in RH/FP by government. As we know, development problems are always mirrored to low budgetary investment and in the Kenyan FP case, it’s no difference.

- Family planning budgets are highly fragmented, with on and off budget sources, making it difficult to understand the aggregate efforts to alleviate the unmet need for FP. Budget fragmentation\(^1\) thus is a huge problem in the country. There is great need for a comprehensive budget analysis of both off budget, on budget and other forms of budgetary support to the RH/FP sectors.

- Human Resource towards health is way below the standard set by WHO where the nurse-patient ratio should be one nurse per 500 patients. The real situation is different. Though the government has initiated efforts to make sure that each constituency gets 30 extra community nurses and 10 community health workers; their bases of equality rather than equity will continue marginalizing the already left behind areas.

- Male Involvement in Family planning is very low; Data collected in Msumarini health center indicated that among the 20 women who came for FP services during the month of May 2013, only 2 were accompanied by their husbands, 10 left their cards at the health center while 2 asked for their cards to be written ante natal clinic. Men treat family planning efforts as a female only area of engagement and thus avoid it. This has been compounded by CSOs whose target on family planning matters rest on women and ignore men.
Key recommendations and conclusions

1. Increase Direct Government support to FP

The study found out that the government has been allocating about 600 million shillings to FP each year for the last three years. These resources are directly given to KEMSA for purchase of DEPO. Donors in Kenya support other contraceptives. There is great need for the government to take up the support for family planning through increased allocation as recommended in FP2020.

2. Domestication and Implementation of Treaty

The government assented and ratified the MDGs, FP2020, Maputo and Abuja protocols but their implementation is wanting. The government funds health with only 6% of its total budget while the recommended % is 15. There is need for the CSOs and communities to push the government to live to its promises and allocate more resources, particularly to the county governments where the services are provided.

3. Increase budget allocation and tracking

Monitoring and implementation of the costed plan by the government should be undertaken to ensure adherence to its plans and that monies planned for RH are not diverted to other areas. Support/advocating for a baseline study on segments of the population that has had the largest changes in CPR in the past five years (different age-groups, gender and counties) to create a clear intervention plan and to upscale the intervention strategies is required.

- Off Budget allocation should also be tracked to comprehensively ensure that all spending for health is accounted for.
- Ineffective spending as a result of late release of funds to the ministries and to the hospitals should be highlighted, followed up, exposed leading to increased efficiency in healthcare provision.

4. Increase Human Resource for health

The government continues to allocate resources to counties and constituencies towards HR for health on equality bases. The Economic stimulus package has very little flexibility for equity in increasing health care providers to the far to reach areas while supporting at the minimal the areas with ‘over subscription’ of health providers. The 2013/14 budget has allocated KES 3.1 billion and KES 522 million for recruitment of 30 community nurses and 10 community health workers, respectively, for each constituency to improve accessibility to health services. This will increase health workers in areas that already have more and will deny remote areas the required equity and affirmative action in development. This study urges the government to relook at this aspect and allocate health care providers per need bases. This should be in line with the WHO recommended of 1:1000 doctor per patient ratio and 01 to 500 nurse to patient ratio. (Kinflu Y, Dal Poz MR, Mercer H, Evans DB 2009 Mar;87(3):225–30.)

5. Improved access to information from government and donors

Kenya FP budget is mainly donor supported with the government only investing around 600 million. There is then a problem of budget fragmentation with no clear and documented budget figures for how much is invested in family planning by both donors on and off budget. There is need for comprehensive health budget analysis of off budget e.g. Constituency Development Fund (CDF) on budget and other forms of budgetary support to the RH/FP sectors. The

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2 On and off budget information is not shared to all and thus cannot be sure of how much investment was put to family planning.
Family Planning in Kenya:

information should be mainstreamed and readily available. The persistent lack of access to information on health budgets as a total has led to many people believing that the government has not achieved the 15% threshold for health. However, it may have reached there and the only problem is lack of information on other budgetary support given to the health sector including CDF, HSSF, and money for hiring of new nurses under the economic stimulus package has never been documented.

6. Improved policy environment and integration

Various Studies have shown that integrated RH and HIV services can improve health outcomes by improving access to health care, it is cost effective, and it increases financial sustainability. Indeed, the government has developed the minimum package for integrated FP and HIV services. Existing HIV programs can increase access to FP services for more than 200 million women worldwide if well integrated.

There is need for increased advocacy for integration of FP under HIV programmes. Policy push for NASCOP to incorporate family planning in their work would increase funding support to FP.

The government has invested 3.1 billion shillings to free maternal care (Financial Statement 2013/14); this is an opportunity for advocacy for integration of free maternal care to include family planning programmes, education and commodities to the mothers and their families.

7. Increased male Involvement in FP

Community education on the importance of male involvement in family planning and to lower the socio-cultural factors such as low involvement of women in decision-making, myths and misconceptions on FP and finally the conflicting messages from political and religious leaders which hinder family planning uptake should be undertaken. These are issues highlighted in government reports and also came out strongly during the FGDs in West Pokot and Kilifi.
Background and Introduction

Kenya’s population can be classified as “very young”, that is one in which at least two-thirds of the population is composed of people under age 30 years, and only 5 percent of the population is above 60 years. This is as a result of persistent high fertility in Kenya that has resulted in a relatively large and increasing youthful population. Further reduction of fertility and childhood mortality rates are critical if Kenya is to record a decline in population growth rate in the future.

Though Kenya was the first country in sub-Saharan Africa to establish a National Family Planning Programme in 1967, the initially family programme of mid-1990s up until the mid 1990s saw the average number of births per woman drop from about eight in the late 1970s to around five births per woman in the mid-1990s (KSPA 2010). It stalled in the 1990s due to inadequate investment in family planning, diversion of resources to HIV and AIDS and reduced commitment to family planning from leaders. While birthrate stagnated in the period 2003 to 2009, mortality drastically declined as measured by the Infant Mortality Rate (IMR) from 74 deaths per thousand live births in 2003 to 52 deaths per thousand live births in 2009. The average index of mortality measure, Crude Death Rate (CDR), declined to about 10 per 1,000 people in 2009.

The unmet need for family planning (FP) has been attributed to lack of adequate access to FP services at community and facility level, sporadic insecurity of FP commodities and inadequate funding of FP programs. According to the

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3 Population Policy for National Development Sessional Paper No.3 of 2013
4 Kenya service Provision assessment, 2010
2009 KDHS, the unmet need for FP increased from 24.5% (2003) to 25.6 (2009). These includes women expressing a desire to space births for at least two years or limit the number of births and hence necessitating the need for a spirited advocacy for increased funding.

The Government demonstrated its commitment to population and development programmes by creating an enabling policy environment for implementation of the programmes and projects. Providing good governance in the implementation of Kenya Vision 2030, supporting the National Council for Population and Development (NCPD) to address and coordinate population and development issues, and collaborating closely with development partners, NGOs, CBOs, FBOs, private sector and other key players in the population and development sector. The development partners have been active in supporting reproductive health, maternal and child health, and HIV/AIDS programmes.

The history of family planning policy and programmes in Kenya since 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>2004</td>
<td>NCPD became a semi-autonomous agency under the Ministry of Planning and Economic Development, the National Coordinating Agency for Population and Development (NCPD)</td>
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<tr>
<td>2005</td>
<td>The budget for 2005/6 presented to parliament and passed, allocating funds to family planning for the first time</td>
</tr>
<tr>
<td>2007</td>
<td>National Reproductive Health Policy published</td>
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Sources: Ajayi and Kekovole (1998); Blacker et al. (2005); Aloo-Obunga (2000); NCPD (2000).

The study looks at policies since 2004 as that is the year when the government set up a specific department/body to deal with population growth.
Research methodology

The research was conducted using both primary and secondary sources of data. Interview guides targeting government agencies (Division of Reproductive Health, MOH Finance Department and the Kenya Medical Supplies Authority), health facilities, NGOs and donors were developed and used to collect data through interviews and FGDs in West Pokot and Kilifi. Budget documents including Budget Estimates and Expenditure Reports for 2010/2011, 2011/2012 and 2012/2013 financial years were also analyzed and data collected manually interpreted.

This analysis adopted both qualitative and quantitative research techniques to gather information. Qualitative research method was applied to get in-depth information from Key informants who included the county heads of health in Kilifi and West Pokot while quantitative research was used to assess the health facilities using questioners.

To ensure reliability, validity, and adequacy, DSW adopted participatory methodologies and reviews a wide source of information, which was done systematically in undertaking the assignment. The respective implementers at both the county and national level were involved in the entire process.
Study Location

The research was carried out in Nairobi targeting the Ministry of Health (which has merged both Public Health and Sanitation (MoPHS) and Medical Services (MoMS), West Pokot and Kilifi County. It covered Murkijit health centre in West Pokot and Msumarini and Vipingo Centre in Kilifi County. Four focus group discussions in four locations in Kilifi Pokot was also conducted.

The study was conducted in two phases; Focus Group Discussion (FGDs) with four women groups, two youth groups and two male groups in Kilifi and West Pokot County respectively. FGDs aimed at assessing the community attitudes towards family planning, barriers of access and use of contraception.

This was followed by in-depth interviews with key stakeholders including county health directors to help in corroborating the information gathered at the FGDs; the Ministry of Health, and National council for population and development to identify factors that inhibit effective implementation of family planning policies. The study further analyzed budgets estimates, spoke to key staff at treasury to understand how funding is allocated to RH/FP at national and district.

Desk review of Policy was also carried out to assess the extent to which family planning and other reproductive health issues are prioritized in broad development and health policies and strategies; to understand key policy and programme priorities and policy implementation challenges and responses that are considered critical for the achievement of the objectives of the policies; and to assesses the extent to which key family planning issues identified by communities members are reflected in the policies.

Target Population

The target population was the general community members with similar education, socioeconomic status and experience with contraceptive use and included women of reproductive age, aged between 25 – 49 years; young people (male and female) aged 15-24 and men of reproductive age (25-49) in Kilifi and West Pokot County. County health care providers including nurses at the 4 facilities provided information for the study. Government officials from Ministry of Health (MoH) and county governments’ health dockets also formed part of the target population. Specifically, DSW focused on the Division of Reproductive Health - family planning department, Ministry of Health, Ministry of Finance and the Kenya Medical Supplies Authority, which supplies FP commodities, and general communities that use FP commodities. Donors and development partners were also targeted by the research.

Data Collection Tools

Data collection was done using five different questionnaires. The questionnaires had both open and closed questions and filled by key informants from the Division of Reproductive Health (DRH), the county directors of health, NGOs, Donors and CSOs working in reproductive health sector. A budget analysis data collection sheet was also developed looking at budget allocations towards RH/FP within the target counties and the Nation at large. The tool analyzed how much the donor and government have allocated towards the RH/FP nationally and in the counties.

Data Analysis

The study being highly qualitative, data was analyzed using themes and patterns. However, minimal data was collated and was entered into MS Excel for analysis, graph and table development.
Objective of the study

To establish the level of policy implementation and budget commitment at national and district/sub national level that address unmet needs of family planning

Specific objectives

- To assess how different policies related to RH prioritize Family Planning
- To establish the level of government and donor commitment in funding FP interventions at national and sub-national level
- To assess the level of implementation of RH/FP policies at district level
- To describe unmet need for FP according to community perspective at sub national level.

Research questions

1. How is FP prioritized in global, regional and national policies
2. What is the current level and funding trend for FP by government (central & district) and donors
3. What is the level of implementation of RH/FP related policies at district level
4. How do women, men and youth in communities conceptualize unmet need for FP
Family Planning in Kenya:

Kenya’s population is estimated at 42.7 million with a life expectancy of 57 years for men and 59 years for women and is expected to reach about 77 million by the year 2030 assuming there will be no change in population growth rate estimated at 2.9 percent per annum in 2009. Although the contraceptive prevalence rate is higher in urban than in rural areas, 23% of the total demand for family planning still remains unmet in urban areas of Kenya. This rapid population growth will require greater investments in basic social services and hence exerts pressure on the economic planning. Indeed, the government investment in family planning has been very low, therefore has continued straining the economy if the Kenyan population continues to grow in the same trend.

2008/9 Kenya Demographic and Health Survey as well as the preliminary reports on the 2009 Population and Housing Census, clearly indicate that Kenya is at the stage of demographic transition characterized by substantial decline in mortality and persistent relatively high fertility. Increasing family planning support in the country would be critical in achieving of the MDGs especially those specific to reducing poverty, hunger and maternal deaths.

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6 United Nations 2012
7 Kenya Bureau of Statistics
Past Achievements

The implementation of the measures stipulated in the past population and related policies and programmes contributed to achievements of demographic outcome provided in table 1:

Table 1: Trends of key indicators

<table>
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<th>Indicator</th>
<th>1984</th>
<th>2000</th>
<th>2010</th>
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<tr>
<td>Annual population growth rate (%)</td>
<td>3.3</td>
<td>2.8</td>
<td>2.9</td>
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<tr>
<td>Total fertility rate (per 1000 live births)</td>
<td>6.7</td>
<td>4.9</td>
<td>4.6</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>63</td>
<td>74</td>
<td>52</td>
</tr>
<tr>
<td>Child (under-5) mortality rate (per 1000 live births)</td>
<td>90</td>
<td>115</td>
<td>74</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (%)</td>
<td>17</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>Family planning knowledge (%)</td>
<td>81</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>Desired family size</td>
<td>5.8</td>
<td>4.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Life expectancy (years)</td>
<td>62</td>
<td>61</td>
<td>57</td>
</tr>
<tr>
<td>HIV prevalence (%)</td>
<td>-</td>
<td>6.7</td>
<td>6.3</td>
</tr>
</tbody>
</table>

**Policy analysis**

Kenya Policy environment has been favorable to health related issues. Indeed, Kenya is among the few countries that has assented to most of the world wide treaties. The 2010 Constitution guarantees the rights of an individual to the highest attainable standard of health, including reproductive health such as Family Planning services. The constitution also obligates the state to fulfill Sexual and Reproductive Health Rights (SRHR) ‘progressively’, depending on the available resources. This requires the state to demonstrate ‘measurable progress towards the full realization of the SRHR and to restrain from adopting ‘regressive measures’. The State is further obligated to fulfill those rights that require immediate realization such as freedom from discrimination and freedom to control one’s health and body\(^8\) (HERAF 2012).

Apart from the Constitution, Kenya also has a number of policies and strategies that seek to promote access to Family planning services, which include the National Reproductive Health Policy, 2007 to be implemented through the National Reproductive Health Strategy 2009-2015; the Adolescent Reproductive Health and Development Policy, 2003; the National Condom Policy and Strategy (2009-2014; the Contraceptive Policy and Strategy (2002-2006); the Contraceptive Commodities Procurement Plan (2003-2006); the Contraceptive Commodities Security Strategy (2007-2012); the National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya, August 2010\(^9\).

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\(^8\) The Kenyan Constitution, 2010

\(^9\) Realizing Sexual and Reproductive Health Rights in Kenya, KNCHR, 2012
Kenya’s vision for national development found in the vision 2030 aims at building Kenya into a globally competitive and prosperous middle income nation by the year 2030. Guided by the MDGs, the second pillar i.e. the social pillar commits to ensuring increased uptake of Reproductive Health services by poor and vulnerable women.

Despite all these efforts, Kenya has a contraceptive prevalence rate of 46% (KDHS, 2008-09) suggesting that the realization of Sexual and Reproductive Health Rights need more prioritization in resource allocation especially in the public sector to enhance access to quality FP services for all women. (HERAF 2012).

Although Kenya has worked hard to support FP programming and by extension help its population to space their children adequately for better growth and development, the population is estimated to grow by about one million per year, or 3,000 people every day, over the next 40 years to reach just under 100 million by 2050 and about 160 million by end of the century\(^{10}\).

It is against this background that this study seeks to analyze the different policies and treaties that Kenya has passed towards it Reproductive Health/Family Planning Sector, reviews them in its quest to establish baseline on Kenya’s policy status as regards to reproductive health and family planning.

**International Policy Frameworks**

**Family Planning 2020**

The Family Planning 2020 (FP2020) is a global partnership that supports the right of women and girls to decide freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

In Kenya, the mandate to implement FP2020 was given to the National Council of Population and Development; however there is no implementation plan for the same. Worth of note is that Kenya Government has committed to increase contraceptive prevalence rate from 46% to 56% by 2015. NCPD and DRH further committed to engage donors on Kenya’s commitment in accelerating access to FP, making the case that Kenya is ready. There is also need to revive the Advocacy Sub-committee on RH/FP Technical Working Group (TWG), under the leadership of NCPD to lead the advocacy efforts for additional family planning resources has been in limbo since the formation of the group in November 2012.

**The Millennium Development Goals**

Although Kenya’s has made positive strides towards the achievement of the Millennium Development goals, the country is still struggling with Indicators number 5b. Under the MDGs, issues dealing with SRHR were partially addressed in MDG 5, target 5b. However in the report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda “A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development” universal access to sexual reproductive health and rights is recognized as essential component to a healthy society. The report further recognizes the need to ensure access to SRHR for adolescent, which is all time low and leads to unplanned pregnancies and unsafe abortions caused by inaccessibility to modern methods of contraception.

\(^{10}\) The East African, June 22-23 : Outlook pg. 36
**International Conference on Population and Development (ICPD)**

In 1994, the ICPD called for the improvement of reproductive health as a global priority that all countries should place at the center of their development efforts. The United Nations Fourth World Conference on Women echoed this the following year. Participants at both conferences challenged countries and organizations to address gender imbalances and to respect the reproductive rights of women and men as necessary conditions for improving reproductive health (UNFPA 1994).

To this end, Kenya has customized the ICPD through the Population Policy for National Development Sessional Paper No. 3 of 2012, which succeeds Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development, which guided implementation of population programmes up to 2010. It recognizes and puts into consideration international and national emerging and continuing population concerns. The Policy is aimed at contributing to the realization of Kenya Vision 2030 aiming at attaining high quality of life for the people of Kenya by managing population growth to a level that can be sustained with the available resources. On family planning, the Sessional Paper provides an overall framework and proposes measures to be undertaken to address the critical population management issues. The Policy identifies rapid population growth and a youthful population structure as key issues that will pose challenges in the realization of Vision 2030. High fertility coupled with high unmet need for family planning over a long period of time, has contributed largely to the observed youthful population structure.

**Regional Policy Frameworks**

**Abuja Declaration**

In 2001, African governments committed to allocating at least 15% (domestic public sources of funding) of annual budgets to the improvement of the health sector. It further called upon donor countries to complement these resource mobilization efforts by fulfilling the yet to be met target of 0.7% of their Gross National product as Official Development Assistance to developing countries and cancelling Africa’s external debt in favor of increased investment in the social sector. Immediate action to use tax exemption and other incentives to reduce the prices of drugs and all other inputs to health care services for accelerated improvement of population health in Africa was also agreed upon (African Union 2001). (Govender V, McIntyre et al. 2008). This however is still a dream especially in Kenya where budgetary allocation to health has stagnated in the percentage share where the budget for 2010/11 and 2013/14 was at 6%. (GoK Financial Statement 2013/14)

**Maputo Protocol**

Kenya ratified the Maputo protocol in October 8th 2010 and it calls for the elimination of discrimination against women and declares each woman’s right to respect for her dignity. It requires member states to pass effective laws criminalizing violence against women (including sexual violence) and take steps to end cultural practices that encourage such violence. It also prohibits practices like Female Genital Mutilation that negatively affect women and requires the state to provide support and rehabilitation to those who have undergone such practices or forms of violence. The Maputo Plan of Action sought to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. (African Union 2006). It also calls for 15% investment of the health budget to Reproductive health.
National Policy Frameworks

National Reproductive Health Policy (2007)

Kenya’s Ministry of Health (MOH) formally approved and adopted the country’s first-ever National Reproductive Health Policy in October 2007 with the theme “Enhancing the Reproductive Health Status for All Kenyans”. It lays emphasis on reaching the underserved communities and those in greatest need as well as the most vulnerable. The policy articulates the need for an enhanced budgetary investment as well as monitoring of appropriations for reproductive health, standardization of services offered by reproductive healthcare providers while ensuring proper monitoring and evaluation of the quality of service that reproductive healthcare providers give is a key highlight in the policy.

National Family Planning Costed Implementation Plan (CIP)

The CIP strives to make quality FP services more accessible and equitable through

i. Informing policy dialogue, planning, and budgeting at the national, regional, and county (district) levels to strengthen the case for family planning within the national development agenda.

ii. Provide an opportunity for MOPHS, and the Government of Kenya, in general, to understand the budgetary needs for implementing the National FP program in an effective manner, which will achieve projected targets and make projections for the future FP needs of the country based on an increasing demand for services.

iii. Provide MOPHS/Division of Reproductive Health (DRH) with reliable source of financial information for the FP Program, act as a basis upon which the annual operation plan for FP will be based, and be a useful guide for contraceptive commodity planning to ensure sustained commodity security.

iv. Mobilize and sustain quality resources (human, financial, technical, commodities, and equipment) that are essential for achieving cost-effective and scaled-up family planning services.

v. Develop benchmarks that will be used by the Government and development partners to monitor and support the family planning program.

The CIP budget was costed at 10,786,012,00; 5,777,514,000; 4,952,008,000 and 5,115,542,000 for the financial years 2012/2013, 2013/2014, 2014/2015 and 2015/2016 respectively. However, this has not been achieved in the previous or the current budget due to lack of commitment and political leadership to further the population agenda.

Minimum Package for reproductive health and HIV integrated services

Integrating reproductive health and HIV/AIDS policies, programmes and services is essential for meeting global and national goals such as the vision 2030 and MDG 4, 5 and 6 (Minimum package for RH-HIV integration in Kenya, 2010). The national reproductive health and HIV/AIDS strategy (2009) lay down a framework for integration of RH and HIV services which is to provide more comprehensive, convenient, acceptable and cost effective RH and HIV/AIDS programmes. The strategy has outlined the framework for service delivery at the six Kenya Essential Package for Health (KEPH) levels11.

The Minimum Package seeks to provide guidance to implementers on the minimum requirements in terms of infrastructure, human resources, skills set, training material, equipment, commodities and supplies, and MdE that are necessary at any level of care for effective service provision.

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11 Community, dispensary, health centre, district hospital, provincial hospital and national/tertiary level.
The policy acknowledges that RH and HIV services have similar characteristics, target populations and desired outcomes. In low resource settings like Kenya, both services are typically offered through decentralized public health services with the intention of improving the quality of life of clients through informed decision making and meeting unmet needs for care.

The policy identifies 3 strategies for its implementation. On site i.e. one stop shop for RH-HIV integrated services; Off-site, i.e. clients access one type of RH-HIV integrated service and receive others outside the facility; mixed approach i.e. base service is provided wholly at facility but the other service is only initiated due to inadequacies of skills on the site. The 1st and the 3rd strategies are however lacking. National Family Planning Guidelines for Service Providers, (2010).

The guidelines cover strategies to improve access to high-quality family planning services, such as training and appropriate supervision of community health workers; adding community midwife to the categories of health workers who may provide family planning services; postpartum family planning packages, and including post abortion contraception. Other strategies include provision of services to people with disabilities and other special needs; integrating family planning with other reproductive health services, including HIV and AIDS services and screening for cancers of reproductive organs; new contraceptives; and male involvement in family planning. Though the government has made strides by adding community midwife to the categories of health workers who may provide family planning services more so injectables, they are not well trained to handle them. The communities are also resistant to receiving injectables from community mid-wife since they are perceived to be non-medics.

**Norms and Standards for Health Service Delivery, 2006**

This strategy sets out guidelines for service providers, both public and private, to follow when delivering health services to the communities. Norms and Standards for Health Service Delivery strategy is a rational framework to guide Kenya’s investment in health sector inputs across the country, and to ensure equity in availability of investments needed for the delivery of service to the Kenyan population.

The norms and standards are a presentation of the expected inputs that are needed to ensure the efficient and effective delivery of defined health services at the different levels of the health system.

One of their key focus is deployment of health service providers, the numbers and the services to be offered by the same. However, there are huge disparities in the distribution of health providers with some areas having more than other areas. A case in point is the disparity between Kiambu and West Pokot County, where a health center in Kiambu County has at least ten nurses, while west Pokot County has 19 unmanned health centers. (Kapenguria District report 2011) Key to note is that there is a directive to hire and deploy 30 nurses per constituency in each county who will deal with integrated health services provision. These health care providers are required to offer all health services including FP. Lack of enough personnel to deal with FP issues have made it impossible for women to access FP services in time and with the care it requires.

Deployment of health service providers needs to be decentralized and higher incentives given to people willing to go work in marginalized and far-flung areas. Increasing availability of service providers will, encourage communities to seek FP services from the nearby health centers.

However, there are no incentive standards set for those working in hard to reach areas and no retention plan in the same areas. For county governments to retain these health providers, they should build quarters for them and the national government to accredit their institution and offer more points for medics who serve in these areas.
A Review of National and District Policies and Budgets

Policy Study findings

From the policies analyzed, it is clear that the government has overall been supportive of the family planning sector by adopting to various policy and strategies which are aimed at ensuring that unmet family planning needs for women is addressed. Indeed, the study notes that the ministry of Health (MoH) is also keen in matters of reproductive health in by setting aside a programme for Family planning under the Department of Reproductive health. The ministry has also produced policies on reproductive health, family planning costed plans and integration of family planning and HIV strategies.

The study notes that for the country to achieve its family planning national goals as articulated in Vision 2030, the following areas need to be worked/improved on: 

- On MDGs, the government and relevant ministries have all the information but it’s clear that their prioritization on FP and RH needs is still low. Lobbying is key to ensure that the need for unmeet contraceptive is realized for Vision 2030 to be achieved.
- On FP2020, the thematic working group on FP needs to be re-convened if more resources would go towards family planning. Proper policy framework and commitment to the fulfillment of the policy is key in meeting the above goals. It’s the role of the CSOs and communities to push the government to allocate more resources, particularly to the county governments where the services are provided.
- Under Abuja and Maputo protocols, there is need to push the government to increase its budgetary allocation towards health, which is important in building a stronger society, and economy. There is also need to push the government to withdraw specific provisions in the VAT bill of 2013 placing VAT on contraceptives.
- Studies have shown that integrated RH and HIV services can improve health outcomes by improving access to health care, it is cost effective, and it increases financial sustainability. Existing HIV programs can increase access to FP services for more than 200 million women worldwide if well integrated. There is need for increased advocacy for integration of FP under HIV programmes through policy push for NASCOP to incorporate family planning in their work thus increasing funding support to FP.
- The Kenyan government only caters for FP commodities at an amount of 600 million per year and donors facilitate about 5 billion. The government has invested 3.1 billion shillings to free maternal care; this is an opportunity for advocacy for integration of free maternal care to include family planning programmes, education and commodities to the mothers and their families.
- Full integration of population concerns into development strategies has not been achieved. This will further be hindered by the creation of many devolved units in form of counties, which will be requiring more resources and awareness.
- CSOs and the government need to demystify the Maputo protocol by disseminating information on the different articles and how they relate to a woman’s health. Although strides in legislating policies against FGM have taken root in Kenya, implementation of Maputo protocol is not popular due to article 14 allowing abortion if the health of the mother is at risk thus the need for demystification.
- Kenyan government needs to fund the necessary policies it has formulated to improve RH/FP. The study found that Kenya has formulated good policies towards RH/FP though the implementation is hindered by budgetary allocation towards the same.
A closer look at the estimated resources required for FP per year reveals a lot of underfunding as highlighted in Table below.

Table 2: Estimated Resource Requirements by Thematic Area and Fiscal Year

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources</td>
<td>7,514,732,000</td>
<td>7,000,000,000</td>
<td>6,500,000,000</td>
<td>6,000,000,000</td>
</tr>
<tr>
<td>Commodity Security</td>
<td>1,157,826,000</td>
<td>1,200,000,000</td>
<td>1,250,000,000</td>
<td>1,300,000,000</td>
</tr>
<tr>
<td>Youth</td>
<td>1,500,000,000</td>
<td>1,400,000,000</td>
<td>1,300,000,000</td>
<td>1,200,000,000</td>
</tr>
<tr>
<td>Demand Creation</td>
<td>461,589,000</td>
<td>410,000,000</td>
<td>360,000,000</td>
<td>310,000,000</td>
</tr>
<tr>
<td>Integration &amp; Cross-</td>
<td>165,000,000</td>
<td>150,000,000</td>
<td>135,000,000</td>
<td>120,000,000</td>
</tr>
<tr>
<td>Cutting Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10,800,150,000</td>
<td>9,584,533,000</td>
<td>8,452,008,000</td>
<td>7,315,542,000</td>
</tr>
</tbody>
</table>

Source: National Family Planning Costed Implementation Plan (2010-2015), MoMS/MoPHS

The total amount needed to attain the goal of 56% CPR by 2015 is Kshs 26,652,233,000 i.e. approximately Kshs 26.7 Billion which can only be achieved if there is investment of resources and commitment towards the achievement of these plans. In the financial year 2012/13 the government allocated Kshs 68,668,478,564 to the two ministries of health making it a tall order to, allocate Kshs 10.8 billion to FP alone. The government needs to play a key role if the CIP objectives are to be met within the timelines proposed.

The Kenyan Budget 2013/14 highlighted the deficiency of human resource in the area of health. To this end, the government allocated KES 3.1 billion and KES 522 million for recruitment of 30 community nurses and 10 community health workers, respectively, for each constituency to improve accessibility to health services. This however is on equality precedence other than on equity where allocation should be per need and not just arbitrary. The study finds a huge discrepancy in adding nurses and health workers to some already overstaffed areas while giving the bare minimum to other areas (“Case of Gatundu verses Msumarini dispensaries”)

- Increased support to communities to change their mind set from the ‘white coat doctors’ to trained community workers. Communities have not been well trained or sensitized on the same and thus are afraid of allowing CHWs to administer the injectables in the far to reach areas.
- There is need to have a specific body to push for FP 2020, this will help in mitigating loss of benefits that can be accrued from having such a body to push the national agenda in the FP/RH issues.
- Focusing on RH needs for persons with disability and rural area population is an area that needs intervention by RH/FP players. Although the National Reproductive policy is in place, it has not benefited the common mwananchi as much as it was envisioned. Dissemination to lower levels is weak and uptake at the community level even lower. The rural youth and women who require these services most have not been targeted so as to benefit from improved health care.

Devolution and health care financing is also an opportunity to incorporate RH as an essential component in gender equity.

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This are areas identified by the ministry of health as having low accessibility by health providers
• On the comprehensive implementation plan for FP; Limited systematic use of population data in formulation, implementation, monitoring and evaluation of development plans and programmes; reduced commitment for reproductive health and population programs after the HIV/AIDS was declared a national disaster are some of the impediments towards CIP implementation. The government cites poverty levels, rapid population growth and population momentum as some of the social economic constraints they are facing.

• Integrating RH and HIV services will enable health care providers to address the comprehensive SRH needs of clients. The study notes that, FP is key, but greatly underutilized in HIV prevention strategy and they offer a critical entry point for most STIs.

• Community education on the importance of male involvement in family planning and to lower the socio-cultural factors such as low involvement of women in decision-making, myths and misconceptions on FP and finally the conflicting messages from political and religious leaders, which hinder family planning uptake, should be undertaken. These are issues highlighted in government reports and also came out strongly during the FGDs in West Pokot and Kilifi. There is also need for increased awareness/trainings on the policy to the communities, local hospitals and dispensaries on the importance of the Community Health Workers (CHWs) and TBAs what does it stand for in full for the successes of the RH policies in the country.

• Monitoring and implementation of the costed plan by the government should be undertaken to ensure adherence to its plans and that monies planned for RH are not diverted to other areas. Finally support/advocating for a baseline study on segments of the population which has had the largest changes in CPR in the past five years (age-groups, provinces, etc.) to create a clear intervention plan and to upscale the intervention strategies.

Other policy recommendations:

- Expand family planning services delivery points including community based distribution
- Promote male involvement and participation in family planning
- Ensure appropriate contraceptive method mix and commodity security in service delivery points
- Strengthen the integration of family planning, HIV/AIDS, reproductive health and other health services
- Intensify advocacy for increased budget allocation for population, reproductive health and family planning services
National budget analysis

Introduction

The Kenyan national budget has been growing with each year. Indeed, table 2 is a clear indication of that growth. Specific focus on national data indicates that Kenya GDP has been expanding and so has the national budget. NB: This study has analyzed the budget in its nominal figures and they are in millions.

Figure 1: National budget figures
Growth of national budget is a critical to expansion of service provision and also is an indicator of progress in provision of services. Indeed, Kenya has invested heavily in infrastructure including building hospitals and offering more health services through the bigger budget. Worth to note is that there is a significant support for the Kenyan national budget that is donor driven in both grants and loans, it is balanced in that there is no deficit on the total budget attained through local and external revenues; thus government is able to meet its budgetary needs.

It’s critical also to examine if the growth by itself is proportionate to the population increment. Kenya has a population of 43 million people and with a budget of 1.64 trillion shillings in 2013/14 budgets; it essentially means that the allocation per person in total budget is 39534.88 shillings.

This is essentially on total budget. However, a closer look of the development expenditure is more worrying with the government only investing 15939 shillings per year. This is highly an under investment in the population in the general budget and thus an increment of the same is required if Kenya is to meet its various targets and visions.

From the national budget, the study focused on the national health budget as highlighted below;

**Figure 2: National Health budget figures**

The health budget has grown from 41 billion in 2010/11 to 94 billion in 2013/14 budget as highlighted in the table above (2013/14 financial Statement). On the face of it, there has been an increase but looking at the percentage share of the total budget, the trend is worrying.

**Figure 3: Health budget percentage to National budget**
In 2010/11, the health budget percentage share of the national budget was 4%, which increased to 6% in 2011/12, and then fell to 5% in 2012/13 and then rose again to 6% in 2013/14 (2013/14 financial Statement). This means that the health budget in Kenya is around 6%, which is 9% less than 15% in the Abuja declaration.

The study looked at the recurrent verses development budget and noted that in the financial year 2013/14, the government has allocated 19 billion of the national health budget to recurrent expenditure and 15 billion to development representing a 55% allocation to recurrent expenditure.

It’s worth noting that Kenya has redistributed its governance structures and thus while initially we had two ministries dealing with health matters, i.e. Ministry of Medical Services and Ministry of public Health and Sanitation, now there is one joint ministry handling the two areas. Also worth noting is the fact that although the government has allocated 94 billion shilling to health, 60 billion has been devolved to the counties for the same function. The monies left to run national programmes including infrastructure for doctors, hiring of new health service providers, free maternity and FP is 34 billion shillings only. Out of the 34 billion shillings in the 2013/14 budget, KES 19.8 billion was allocated for recurrent expenditure while KES 14.9 billion went to development expenditure.

The study notes that there has been a gradual increase of health resource on per capita even as the population continues to increase. It’s worth noting that the World Health Organization (WHO) recommends a per capita health expenditure of US$44, approximately Kshs 3000, while in Kenya it is at 2185 (DI Resources for poverty eradication: A background paper October 2012). This is a positive indication in that even with population growth; there is more resource for every individual in the nation.

Graph 1: Per Capita Budget allocation

On reproductive health, Kenya invests money in two key sectors; Family Planning and Maternal Child Health (FP&MCH). The reproductive health docket has been singled out with Maternal, Child Health being allocated KES 3.8 billion for free access to maternal health. However, these monies will be given on a reimbursement of cost bases and thus facilities will be required to improve their onsite services if they are to benefit from the same.

A check on the nominal verses real figure of the national budget and the health budget indicate a steady increase in the figures.
GoK Funding for Reproductive Health in Kenya

In 2007, a more comprehensive national RH policy was launched whose goal 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; and improving responsiveness to the client needs. To operationalize the policy, the National Reproductive Health Strategy (NRHS, 1997-2010) was developed. It identified several priority areas namely; safe motherhood, maternal and neonatal health, family planning, adolescent/youth sexual and reproductive health and gender issues.

Despite having an enabling policy environment to promote universal access to reproductive health services, there still exists a disconnect between the policies and action, or rather policies and budget allocation which often leaves a gap that must be filled. The health sector in particular relies on several sources of funding: public (government), private firms, and donors as well as health insurance schemes. Unfortunately, limitations in implementing an overall healthcare financing strategy have hindered effective planning, budgeting and provision of health services especially FP services.

Family Planning Budget

Core Sources of Funding for FP Contraceptives

Of the total revenue collected from direct and indirect taxes, the government does allocate funds towards FP contraceptives. However, the government became a funding source for FP contraceptives since 2005/06. Previously, the sources of funding were solely development partners.

The sources of funding for FP contraceptives, while known, are not always reflected within the GOK budget. For example, while the amount of funds provided by KPW is explicitly stated in the government budget, the amount of funds provided by USAID is not reflected.

Also not reflected in the government budget is the amount of money UNFPA allocated towards the emergency consignment of DMPA. While UNFPA makes use of their own procurement system (in emergence and normal situations) and delivers the contraceptives to KEMSA for distribution, the funds which UNFPA has allocated for contraceptives procurement should still be known by relevant government officials for transparency and accountability. While the amount of money provided by government for FP contraceptives can be determined within budget documents, the exact amount of funds provided by development partners is unclear.

Budget Allocation Processes for FP Contraceptives

Kenya operates on a cash budget system and this has significant implications for the budgeting process in general. In gaining a deeper understanding of the budgeting process for FP contraceptives, what emerged is that in planning the budget, three consecutive planning phases are required. The first phase is informed by the needs of the country, whereas the second and third phases are informed by the reality of a cash budget.

First Phase

The Division of Reproductive Health (DRH) bears the responsibility for developing the FP contraceptives budget. The budget for FP contraceptives is informed by the national FP contraceptive needs. In determining the national FP contraceptive needs, DRH carries out forecasting and quantification using the population data as per the most recent KDHS as well as the Contraceptive Prevalence Rate (CPR) by method. These two data sets are fed into the Reality
Check Tool which calculates the required quantities by method as well as the required budget. DRH then submits the FP contraceptive budget to the Ministry of Public Health and Sanitation (MOPHS) for consolidation. MOPHS then submits the consolidated budgets to Ministry of Finance.

These budget preparation processes in which DRH and MOPHS engages are intensive. However, they occur in a context whereby neither the Ministry nor its Divisions have any knowledge as to the amount of funds which the MOF will finally allocate to the MOPHS, and in turn the allocation towards FP contraceptives. According to representatives within the Planning and Finance units of MOPHS, this budget preparation process thus becomes one whereby budgets that are developed represent ‘wish lists’, rather than realistic planning tools. The reality of what can be planned is thus only determined when MOF indicates the budget ceiling to the MOPHS.

Prior to being informed of the budget ceiling, MOPHS is required to defend their ‘wish list’ budget at a meeting convened by MOF. This meeting whereby the Ministry defends their budget occurs in the absence of any clear indication of the available resource envelop. However, based on ‘common practice’, the representatives of the Ministry are aware that almost always only about 40% of the submitted budget is allocated to the Ministry. It is therefore unsurprising that representatives from the DRH do not avail themselves at the MOPHS budget defense meeting, instead perceiving the process as a futile one. Their absence at these meetings does however create frustration among their colleagues, particularly as representatives of the Ministry’s Planning and Finance units are then required, in the absence of any detailed knowledge, to defend the budget of the DRH.

**Second Phase**

The final allocation of funds to MOPHS is based on available funds and it is at this point that MOPHS is informed of the resource envelope available for the Ministry. Guided by the resource envelope, MOPHS does an internal allocation to each of its Divisions, and it is a process wherein Divisions are not allowed any opportunity to negotiate with the Ministry.

Based on these allocations, each Division is then required to revise their budgets (and their plans) and submit these to MOPHS. MOPHS then once again consolidates the budgets and submits the revised Ministry budget to MOF. The MOF then consolidates all sector budgets into a national budget which is presented to Parliament in June, and when members of parliament vote for it, the budget books (Estimates of Recurrent and Development Expenditure) are printed. The printing of the budget books provide DRH with certainty that it will receive the allocations stipulated for FP contraceptives. However, there is no certainty as to when in the financial year the allocation will be made available.

**Third Phase**

A certainty that arises with the confirmation of the GOK amount allocated for FP contraceptives is that there will be insufficient resources available to respond to the FP contraceptive needs determined in Phase 1 of the planning process. For example, in the current fiscal year (2012/13), the national DMPA, POPs and ECP needs were about 11.7m vials, 2.2m cycles, and 127 thousand cycles respectively. However, the GOK budget allocation could only cater for about 4.3m vials of DMPA, 600,000 cycles of POPs and 64,000 cycles of ECP.

According to a DRH representative, support for addressing the resource gap for FP contraceptives is then solicited by way of a meeting, which DRH convenes with the FP Commodity Security Committee. This committee comprises FP partners and is chaired by the Director of Public Health and Sanitation. The meeting focuses on obtaining commitment from partners as to which specific FP method they will support in terms of quantities that will be procured and distribution thereof. This phase in the planning process is one whereby donor funds are relied upon to fill the gaps
A Review of National and District Policies and Budgets

left due to the portion of allocations from GOK. There is recognition within DRH that this reliance on donors in dealing with 13 HERAF - Research Report - 2013 (Improved quality, availability and accessibility of family planning services in Kenya – 2013)

FP contraceptive needs is not sustainable as support from donors can be withdrawn at any stage due to donor fatigue as well as changes in donor priorities. According to a DRH representative, the lack of sustainability of this approach must be considered especially because withdrawal of donor support will result in Kenya plummeting into a worse position whereby even less of the FP contraceptive needs can be met leading to CPR stagnation or decline.

The process of planning the budget is thus one of repetition with no clear indication that it will be improved upon, however, this is likely to change with new devolved system. Unfortunately, what becomes evident from this three phased planning process is that phase 1 is considered a required, yet largely futile exercise and phase 2 as well as phase 3 both represent restrictive parameters from which there are no opportunities for deviation. Furthermore, the reliance on donor funds, captured within phase 3 of the planning process, indicates that the nature of relationships with donors places Kenya in an extremely vulnerable position. These planning processes, whether futile or restrictive, appear to provide fertile ground wherein despondency and lack of interest in the prospect of achieving improved responses to FP contraceptive manifests. Hence, a complete devaluation of the budget as an effective planning tool for addressing the need for FP contraceptives.

**Family Planning Budget**

Kenya’s family planning budget has stagnated over the years, with the government committing to Kshs600 million per year but actual disbursement of 575 million every year for FP commodities, which has been the trend for the last 3 years.

**Table 2: Total National Budget for RH and FP Budgets (Nominal Value)**

<table>
<thead>
<tr>
<th>Item</th>
<th>FY2010/11</th>
<th>FY2011/12</th>
<th>FY2012/13</th>
<th>FY2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH Budget</td>
<td>679161260</td>
<td>679161260</td>
<td>679161260</td>
<td>3,700,000,000</td>
</tr>
<tr>
<td>FP Budget</td>
<td>527977500</td>
<td>527977500</td>
<td>527977500</td>
<td>600,000,000</td>
</tr>
</tbody>
</table>

Initially, the RH budget was at one percent of total health budget but it has increased to 4%. This is as a result of allocation of KES 3.8 billion for free access to maternal health, in line with the promise outlined in the Jubilee manifesto. However, while initially FP budget has been around 78% of total allocation to RH (this covers only development expenditure and not recurrent), it has dropped to a mere 16% this financial year with the government directing most of its resources to free maternal care. However, the nominal figure hasn’t reduced. This thus calls for an evaluation of how FP services are provided and increased advocacy to integration of services will be key.

The implications are a worsening situation in Kenya as the decrease in budgets for FP contraceptives occurs inversely to the growth of FP contraceptive needs. Further, three Kenya Demographic Health Surveys have indicated a rise in the unmet need for FP Contraceptives from 24%, 25% and 26% in 1998, 2003 and 2008-09 respectively. This rise has been attributed to lack of adequate access to FP services at community and facility level, frequent stock-outs for FP commodities and inadequate funding of FP programs. (HERAF 2013)
According to DRH representatives, the allocations for FP contraceptives when made available, an Authority to Incur Expenditure (AIE) is issued to KEMSA to facilitate the procurement process. The KEMSA representative as well as the expenditure information in the ‘Development Vote Book Status Report’ reflected that for the 2010/11 to 2012/13 financial years, the expenditure matched the allocations. As explained by KEMSA and DRH representatives, the expenditure and allocations on FP contraceptives will always balance as a result of the process. These officials explained that only once the MOPHS account reflects the amount stipulated in the budget for this line item, is KEMSA issued with the Authority to Incur Expenditure (AIE) together with the schedule of contraceptives to be procured. Once the AIE is issued, KEMSA is then able to initiate the procurement process and when the contraceptives are delivered by the supplier, DRH is informed and has to verify and authorize KEMSA to make payment to the supplier.

Official Development Assistance (ODA) for FP

European donors and particularly those under the DAC are the greatest supporters of FP in Kenya, which comes through the Official Development Assistance (ODA) channeled to governments and NGOs. It however supports population policy programmes and reproductive health and does not focus directly on family planning. There is need to have specific budget lines for family planning within the ODA sector support to have meaningful change even in government allocations.

As noted in the table below, donor support for population programmes has been increasing in Kenya from USD 299 million in 2008 to USD 445 million in 2011. This is not proportionate to government support which hasn’t increased in the said period.

<table>
<thead>
<tr>
<th>Dataset: Creditor Reporting System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient</td>
</tr>
<tr>
<td>Sector</td>
</tr>
<tr>
<td>Flow</td>
</tr>
<tr>
<td>Channel</td>
</tr>
<tr>
<td>Amount type</td>
</tr>
<tr>
<td>Flow type</td>
</tr>
<tr>
<td>Type of aid</td>
</tr>
<tr>
<td>Year</td>
</tr>
<tr>
<td>Donor</td>
</tr>
<tr>
<td>Amount</td>
</tr>
</tbody>
</table>

Data extracted on 12 Aug 2013 06:58 UTC (GMT) from OECD.Stat
Table 3: European Commitments verses Disbursement to Kenya

The Total Official Development Assistance (Commitments and disbursements) have for a long time been relatively equal. However, in average, the European donors give less the amount they commit to development in Kenya. In 2009, the donors’ commitment was 803 million while they only disbursed 459 million, approximately 57% of total commitments. This was the same case in 2010 but we have seen improvement in 2011 where they disbursed 94% of their commitments. Worth of note is that the Kenyan government had all along budgeted and planned for this amount and thus without it, planned development projects did not take off.

Table 4: European Donors Health commitments verses disbursements for Kenya

On health commitments, the situation has been similar although in 2008 – 2010 more disbursement that commitments came through with donors committing 81 million in 2010 and disbursing 86 million. This still affects government planning as they now have surplus in their coffers. However, in 2011 the trend went back to donors not meeting their obligation to health.
In table 3, we see the same inconsistencies with the donors on their support to the reproductive health in Kenya. 2008 was its worst with donors committing to give 75 million only to disburse 30 million. 2010 also was a bad year for investment in reproductive health as donors only gave 15% of their total commitment towards RH issues. This inconsistency jeopardizes government and CSO programmes and unlike other sectors, recovering the gains lost over one year is difficult.

Table 6: European donors’ commitments and disbursement to Family planning in Kenya

Initially, European donors would disburse a lot more than they committed in support for family planning. This went on until 2009 when the commitments to family planning fizzled and all the budget support directed towards population and RH. This lack of a clear budget line for family planning has affected government and CSO’s in planning towards implementation of the costed plans for FP.
County Budget Data

Introduction

Kenya has operated a centralized system of governance and by extension of budgetary allocation until 2013. This included the budget making cycle, which ran from October every year to late May of the next year. [http://international-albudget.org/kenya/]. In this structure, the National planning commission (NPC) with the ministry of finance reviewed the resources that were likely to be available to the government in the coming year. This was then forwarded to ministries to develop their own proposed expenditure in line with available resources. In June, the minister of finance would then present his annual financial statement in parliament, which was debated by members of parliament. This was merely a formality since parliament had no powers to amend the budget (they could however reject it in totality though this has never happened). The financial statement was then renamed the Appropriation bill and when passed it became an Act.

Deducing from the above, counties or districts as they were previously referred were not directly involved in budget input. However, they were involved in fragmented ways where the ministry of health would liaise with local District Medical Officer of Health (DMOH) asking for their operational plans. Nevertheless, this was a mere formality, as most districts would get the same allocation as the previous years. With the promulgation of the 2010 constitution and coming into effect of the county governments, Kenya has changed its budgetary structure and as noted, health services have been fully devolved.
Family Planning in Kenya:

County Budgets

In the previous years, funds to the districts were sent to the various ministry officials and the district accountant mandated to reconcile the information for the resources availed to the district. This was mainly reported through the annual operational plans for each district and sent to treasury.

Presented below are the total county budgets for West Pokot and Kilifi as obtained from the County principal officers of finance.

There were also direct allocations mainly from the ministry of Local governments through LATF funds and the CDF act resources. In Kilifi County which has 5 constituencies, the figures from CDF allocation are highlighted;

Table 7: Kilifi County CDF

<table>
<thead>
<tr>
<th>Kilifi County</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAHARI</td>
<td>87604827</td>
<td>105,357,760</td>
<td>130910701</td>
</tr>
<tr>
<td>KALOLENII</td>
<td>83533435</td>
<td>101,665,399</td>
<td>126,322,614</td>
</tr>
<tr>
<td>GANZE</td>
<td>71090789</td>
<td>85,365,010</td>
<td>106814531</td>
</tr>
<tr>
<td>MAUNDI</td>
<td>82856863</td>
<td>99,707,241</td>
<td>123899734</td>
</tr>
<tr>
<td>MAGARINI</td>
<td>72622607</td>
<td>87,754,103</td>
<td>109037541</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>397708521</strong></td>
<td><strong>480449513</strong></td>
<td><strong>596975121</strong></td>
</tr>
</tbody>
</table>

In West Pokot, the set-up is the same as highlighted in the table below.

Table 8: West Pokot County CDF

<table>
<thead>
<tr>
<th>West Pokot County</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kacheliba</td>
<td>69781117</td>
<td>84455374</td>
<td>104913905</td>
</tr>
<tr>
<td>Kapenguria</td>
<td>75521027</td>
<td>91139323</td>
<td>113243796</td>
</tr>
<tr>
<td>Sigor</td>
<td>75139371</td>
<td>90693567</td>
<td>112689928</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>220441515</strong></td>
<td><strong>266288264</strong></td>
<td><strong>330847629</strong></td>
</tr>
</tbody>
</table>
The study observes that West Pokot budget, while added the 400,000 that the county (previous districts were allocated in total) for the last 3 financial years totals to 220,841,515, 266,668,264 and 331,247,629 for the years 2010/11, 2011/12 and 2012/13 respectively while in Kilifi, while adding the 227044 shillings allocated to the districts cumulated to 397,935,565, 480,676,557 and 597,202,165.

In essence, the devolved funds have been a major boost to development expenditure in the counties since their inception. Indeed, a comparison between direct government allocation and the CDF indicate that CDF provides for about 95% of all development expenditure that goes direct to districts, this is however not captured in the county funds since it’s directly from treasury.

**New Budget Dispensation**

The new devolved system of governance has seen health being fully devolved to the counties. The Kenya government allocated 60 billion shillings with each county allocating at least 10% of its allocation to health.

Kilifi County has the biggest budget allocation of Kshs. 8,959,352,786 and allocated 934,277,491 to health. On the other hand West Pokot County has Kshs. 3,037,074,699.20 and allocated 708,382,978 shillings to health. This ideally means that while Kilifi has allocated only 10.43% of its total resources to health; West Pokot has invested 23.32%.

**Table 9: County, Health and RH/FP budgets in Kilifi and West Pokot counties**

<table>
<thead>
<tr>
<th>County</th>
<th>Total Budget</th>
<th>Health Budget</th>
<th>RH/FP Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Pokot</td>
<td>3,037,074,699.20</td>
<td>708,382,978</td>
<td>424,425,478</td>
</tr>
<tr>
<td>Kilifi</td>
<td>8,959,352,786</td>
<td>934,277,491</td>
<td>307,408,031</td>
</tr>
</tbody>
</table>

On resource distribution, Kilifi focused mainly on human resource and infrastructure for health, while West Pokot focused more on service delivery to its people with more monies going to immunization and general health provision. This is a clear indication on how the new budget dispensation has brought to the fore community participation and inclusion in Budget making process. The communities in West Pokot were in demand of more services since they currently have very few providers, while the Kilifi communities are more geared towards getting better equipped hospitals. This is reflected in the current budget.

**Table 10: percentage share of Health and RH to total County Budget**

<table>
<thead>
<tr>
<th>County</th>
<th>Total Budget</th>
<th>Health share to total Budget</th>
<th>RH/FP Budget share of Health Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Pokot</td>
<td>100%</td>
<td>23.32451613</td>
<td>59.9146918</td>
</tr>
<tr>
<td>Kilifi</td>
<td>100%</td>
<td>10.42795739</td>
<td>32.90328986</td>
</tr>
</tbody>
</table>

While Indicators like the ones in West Pokot may lead to satisfaction that there is a lot of budgetary support to RH/FP, it’s important to note that 406,382,978 shillings is allocated to wages and thus the only specific allocation to RH/FP service delivery is 16,718,500 shillings representing a mere 3.93% of total RH/FP budget. This is the same case with Kilifi where compensation for employees is 66% shillings.
Due to the new geo-political realignment in Kenya, this study undertook to review the county budgets according to per capita where in West Pokot, the total population is at 512,690 while in Kilifi County, and the total population is estimated at 1,109,735. The table below shows investment in health, population and the per capita allocations for the two areas.

### Table 11: Per capita allocation of Health Budget

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Health Budget</th>
<th>Per capita allocation of Health Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Pokot</td>
<td>512,690</td>
<td>708,382,978</td>
<td>1381.698449</td>
</tr>
<tr>
<td>Kilifi</td>
<td>1,109,735</td>
<td>934,277,491</td>
<td>841.8924257</td>
</tr>
</tbody>
</table>

The above figures are way below the government allocation of 2185 per person for health and the WHO recommended allocation of 3000 shillings per person, a clear indication that the national government health priorities are not being reflected in the counties.

On reproductive health, the study undertook similar per capita assessment of the two counties and while data from Kilifi is lacking, West Pokot can be used for generalization and the results are highlighted in the table below;

### Table 12: Per capita allocation of RH Budget

<table>
<thead>
<tr>
<th>County</th>
<th>Reproductive age Population</th>
<th>RH service delivery Budget</th>
<th>Per capita allocation of RH service delivery Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Pokot</td>
<td>43,249</td>
<td>16,718,500</td>
<td>387</td>
</tr>
</tbody>
</table>

From the table above, West Pokot County has allocated only 387 per person towards reproductive health needs. A quick assessment in the local Murkujit Health center indicates that this can only cater for pills which cost about 200 shillings for each cycle. Meaning that the county government has only catered for one month subscription of FP commodities and expect the remaining 11 months in the year to be catered for by either the patients or donors.

### Key findings and implications/emerging issues

- Kenya has a new governance structure with two levels of governments that is national and county. The implications of this roles redistribution make it virtually impossible to compare previous allocation of health with the current year. There is need to have a specific study on Kenya for the year 2014 and compare the 2014/2015 budget with the 2013/14 allocations to ensure that FP priorities are mainstreamed in the planning.

- Also due to increased requirement for public participation in budget making process; there is need to increase Euro-leverage project activities around civic education on budget making, tracking and monitoring by the citizenry.

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13 Defined as women of child bearing age (District health Information System for west pokot)
- Health care provision is one of the sectors that were devolved. The devolved areas include county health facilities and pharmacies, ambulance services, promotion of primary health care, licensing and control of undertakings that sell food to the public, refuse removal, refuse dumps and solid waste disposal. This by extension means that counties have the enormous role of distributing the little resources allocated to health to these sectors. A quick scan of the county plans indicates that FP is not among those sectors. It is critical to note that though the allocation for health has increased this year and much of it has been devolved; the money is not necessarily meant for development expenditure. The 60 billion devolved for health care provision includes recurrent expenditure and capita infrastructure investment and thus little will go to actual service provision. The implication is that in counties where family planning is not a priority, there will be little or no investment towards it.

- Family planning provision and management has been left at the national level. This essentially means that counties will continue relying on national plans if FP uptake is to be increased.

**Study Recommendations**

1. **Budget allocations should reflect commitments towards responding to contraceptive needs**
   With a streamlined budget process whereby realistic plans to address the contraceptive needs within Kenya are formulated, budget allocations and expenditure are more likely to reflect expressed commitments towards the provision and distribution of contraceptives. The budget allocations and expenditure from GOK as well as development partners will also more likely be aligned to implement a plan to overcome the contraceptive shortages and respond to the contraceptive needs within the country.

2. **Need for Streamlined budget process to enable planning for effective responses to contraceptive needs**
   If the budgeting process is streamlined, key role-players responsible for determining allocations and expenditure for contraceptives, will be better able to formulate more realistic plans to respond to contraceptive needs. A streamlined process will mean that planning of interventions are taken seriously, from the outset, key role-players will be expected to formulate realistic plans, which include overcoming the problem of insufficient provision and distribution of contraceptives.

3. **There is need for Effective and Responsive Procurement and distribution processes towards contraceptive needs**
   While a transparent and streamlined budget process will undoubtedly create the environment for the shortcomings of the procurement and distribution to be critically examined, it is still necessary to give attention to the urgency for improving procurement and distribution mechanisms for the provision of contraceptives. These processes need to be examined jointly by the GOK and development partners as a unified approach towards addressing contraceptive needs within Kenya is essential.

4. **Need for Transparency in budgeting for provision of contraceptive commodities**
   The GOK and development partners play a critical role in addressing contraceptive needs within the country. Conversely, in order to better monitor and improve upon the actions of government and development partners, transparency within budgeting in the provision of contraceptive is essential.

   Transparency of these allocations and expenditure will enable better tracking of how much is being contributed towards addressing the contraceptive needs in the country and how efficiently the funds and/or commodities are being used. Furthermore, with a transparent budgeting process insights will be provided into how the process of procuring and distributing contraceptives can be improved. For these actions to be realized and for GOK to have an improved chance of addressing the contraceptive needs within the country, there has to be political support and commitment.
County case studies

Health Facility and FDG findings

West Pokot

West Pokot County is located in the Rift Valley Province in the western parts of Kenya. It has a population of 512,690 people with a land size of 9164.7 sq. km and is divided into 4 sub counties and constituencies. It borders Turkana County to the East, Elgeyo - Marakwet County to the south, Trans Nzoia County to the West and Uganda to the North. It has 99 health facilities.

<table>
<thead>
<tr>
<th>Facility Classification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensaries</td>
<td>73</td>
</tr>
<tr>
<td>Medical centers</td>
<td>12</td>
</tr>
<tr>
<td>Health centers</td>
<td>8</td>
</tr>
<tr>
<td>Sub district Hospitals</td>
<td>1</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>

Due to its harsh mountainous terrain accessing of health care services is adversely affected thus posing critical challenges in the achievement of MDGs 4, 5 and 6.

The Ministry of health through its county health technocrats while developing the draft health budget had estimated the cost of running health care in the FY 2013/14 to be approximately 2.6 billion shillings. This was based on elaborate infrastructural developments and improvements, human resource for health expansion, restructured health services in the county and operationalization of sustainable community health services among others were identified as intervention areas in line with the expectation of the Constitution of Kenya 2010.

However, due to budgetary constraints, the Ministry of Health was allocated a budget ceiling of Kshs 708,382,978 about 26% of what was approximated and expected. This means that the MOH has enormous challenges in coming up with a lean budget reflecting on the ceiling advanced. Cognizant of this bare fact of a budget deficit of 1.9 billion shillings, the MOH is seeking to persuade health practitioners, partners, philanthropists and well-wishers to help plug the current deficit and take health service delivery to the desired levels.

The study carried out Focus Group Discussion with male, female and youth participants. The participants were identified from Key sectors that included Community health workers, women leaders, men leaders, and youth leaders. The study also identified a woman who had little or no information on FP to help the groups delve into the realities and come up with functional solutions to their problems.

In West Pokot, the study identified the ‘controls’ in 2 elderly women who are still holding to their traditions and one elderly man who were deemed to be anti FP. Women gave various definition of unmet family planning need which included lack of access to the FP services, cultural hindrances to FP usage and poor relations with the FP providers such that women shy away from going to the facilities for the same.
Kilifi County

Kilifi County is in the former Coast Province of Kenya. Its capital is Kilifi and its largest town is Malindi. The county has a population of 1,109,735 and covers an area of 12,245.90km sq. Kilifi County is located North and North East of Mombasa County on the coastal line bordering Tana River, Taita Taveta, Mombasa and Kwale Counties. Kilifi town lies on the Kilifi Creek, between Mombasa and Malindi.

Kilifi County has a mix of cultures. It is however home to Mijikenda’s nine communities. Malindi hosts most Italians, Arabs and Bajunis and other communities of Kenya are also found there. Tourists’ hotspots along the coast have Britons, Germans, Belgians and other western communities.

Due to it being a tourist hotspot, Kilifi County has a high School drop-out rates of as high as 26%, with early pregnancies and marriages being cited in the 2005-2012 Kilifi District Strategic Plan as a serious problem. Low retention in school, early and unwanted pregnancies and vulnerability to HIV/AIDS trap young adolescents—especially girls—in a cycle of poverty.

Child sexual abuse within the community and in schools in Kilifi is also rampant. The parental authority over children exhibited at home is extended to school and some teachers use this authority to sexually abuse children under their care. In Kilifi, the government Children’s District office reports that most of the defilement cases that they deal with involve girls of ages 12-16 years.

<table>
<thead>
<tr>
<th>Health outcomes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully-immunized pop &lt;1yr (%, 2010/11)</td>
<td>78</td>
</tr>
<tr>
<td>Malaria (as % of all 1st outpatient visits)</td>
<td>16.1</td>
</tr>
<tr>
<td>TB in every 10,000 people (2009/10)</td>
<td>30</td>
</tr>
<tr>
<td>HIV+ ante-natal care clients (%, 2010)</td>
<td>3.0</td>
</tr>
</tbody>
</table>
Family Planning in Kenya:

Focus Group Discussions (FGDs)

The study carried out Focus group discussion with male, female and youth participants. The participants were identified from Key sectors that included Community health workers, women leaders, men leaders, youth leaders. The study also identified general woman who had little or no information on FP to help the groups delve into the realities and come up with functional solutions to their problems. In Kilifi the study identified two religious leaders who were deemed to be anti FP.

Study FGD Findings

FP attitudes and awareness

Out of the 49 women interviewed during the FGDs in Kilifi and West Pokot, all of them knew of at least two methods of family planning but a majority (90%) within the group and the community preferred using Injectables. This was corroborated by a nurse at Msumarini Health Centre in Kilifi who reported that they do administer about 100 injectables per month; compared to 6% who are on long term pills while a negligible percentage uses emergency pills. The coil is very little known and thus its usage is not accounted for. The center also lacks the insertion as well as the extraction tools. According to a Nurse at the Msumarini Health center; *we even sometimes are forced to use the scapel to remove the nor-plants which is highly risky*. The usage of the mentioned methods is as a result of availability where injectables are freely accessible especially through monthly outreach by Marie Stopes in Kilifi. *Worthy of note is that in discussions with the youth in the two counties, 80% of them are aware of the emergency pill and mostly use it.*
Among the male respondents, their main method of contraceptive is condom use at 30% (Most men are aware of condoms but confessed that they will not use them at home as it’s a sign that you don’t trust your wife). Though they are aware of the existence of the long term method – vasectomy, it is not popular and most of them indicated that it is not a method they would uptake for reasons such as divorce (divorce is a common occurrence among the Pokot’s) and the need to sire more children. Also mentioned was that once a man undergoes vasectomy and its known by the public, other men within the society deemed him as a lesser man. On the other hand, women respondents indicated that men use condoms but outside their marriage i.e. with *mpango wa Kando*.

**Poverty and economy leading to Increase in FP uptake**

Kenya’s poverty levels stands at 44 to 46 per cent according to the World Bank 2012 estimate. This implies that, close to half of the Kenyan population lives below the poverty line. Most respondents in the FGDs indicated that their main reason for family planning uptake is to ensure that they remain above and are able to provide for their families with the soaring poverty levels. A male responded in West Pokot said *"The fact that I only have ten acres of land and five sons is worrying me a lot, what will they inherit? Will they manage to pass on land to their children? We don’t question what God gave us but I wish I had fewer sons, I would have been able to take them to school and give them a better future."*

The need to have a smaller family that one can provide for in health and education is a leading cause in the increased uptake of family planning. However in contrast, the provision of free maternity service, free primary and secondary education by government is having its toll on FP programs since the communities do not see the need to plan the families anymore.

**Causes of unmet Family Planning needs**

A better understanding of reasons/barriers faced by women in using family planning or intent to use is helpful in informing social policy intended to increase demand for family planning. In this regard, the FGDs in Kilifi and West Pokot also sought out to establish reason for the same. The following reasons were highlighted;

**Fertility-related issues and Desire to become pregnant**

Experiences within the communities on contraceptive use are that women take longer to get pregnant after using pills and Injectables. 45% of those interviewed indicated that they knew or had heard of someone who took long before giving birth. The fear of delayed childbirth has led to use of traditional family planning methods of withdrawal safe days of the cycles.

**Lack of Support by Men**

This has been singled out as one of the biggest hindrance to family planning uptake. A visit to Murkujit Health Center in West Pokot indicated that out of the 26 women who visited the center to seek antenatal family planning services, only two came with their husbands who are Community health workers and thus well informed about FP.

Incidentally according to the Clinical Officer at Vipingo health center in Kilifi, most men will accompany their wives when they come to give birth but not for family planning uptake/advice. In the Kilifi community, the child belongs to the man and this is seen as a direct benefit to them. Increased education and to be involved in Family Planning is key to increase in FP uptake among the sampled communities.

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14 *Mpangovakando* is a popular Swahili phrase for mistresses.
Inadequate information on FP methods or the source of a method

According to a female community health worker in West Pokot, “the attitude of the health service providers within our community is highly wanting; a woman will go to ask for advice on which family planning method to use and the person in charge of the hospital will just give you a list and ask you which one you want, no education on which suits me best, no hormonal scans and no one tells you of the side effects”. Overall, health providers were accused of not taking time to educate patients on the best methods for use.

The County West Pokot however refuted the claims saying the current crop of health providers were women friendly and were doing their best to educate them. She indicated that the problem was limited number of health providers serving a vast area. For example, in West Pokot County, out of the 56 health centers set up, only 19 have regular medical personnel in charge.

The current budget provision has developed an equality of nurses’ programme under the Economic Stimulus Package where they will be sending 30 nurses per constituency in the whole republic; this is though not informed by need or lack of personnel. If not checked, Gatundu health center in Kiambu County which has 23 nurses will receive an extra four nurses while Vipingo health center in Kilifi will only receive one. Furthermore, we are not sure if the nurse sent to Vipingo, a rural hardship area, will agree to render his/her services there or will prefer the many private health centers in the urban and more developed areas.

According to the Nurse at Msumarini dispensary, “There is huge deficit of health workers in our health stations. This is best exemplified in Kilifi where at Msumarini health center; there are only 2 nurses and a visiting clinical officer to serve a community of 6000 persons. There is a great need to push government to provide incentives for nurses and other medical officers to go to those areas.”

Health concerns

Many women indicated that there is a lot of fear of side effects arising from the use of FP such as continuous bleeding, low libido, stomach and back ache, giving birth to deformed children among others. Lack of access, cost and inconvenience were other reason cited for the low uptake. The aforementioned, is supported by data from KDHS (2010), stating that “nearly four women in ten (38%) said the main reasons they are not using or intending to use family planning are method related, especially fear of side effects (16%) and health-related concerns (15%)”. Source: 2008–2009 KEHS (KNBS and ICF Macro, 2010).

Traditional practices

In Kilifi, communities beliefs in witchcraft is high leading to parents aiming at having many children so that incase misfortune strikes; they will be left with a few children. Indeed, the popular saying in Mtswapa in Kilifi county is ‘pata watoto watano, mmoja ni wa mungu, mwingine wa mchawi na watatu ni wako’ (loosely translating to get five children, one belongs to God, the other one for witchdoctor and three are for the family)

Other reasons cited

• Religion, where respondents cited that God gave man the mandate to go procreate and fill the world
• Some of the respondents believed that family planning is a western thing imposed on Africans by the western countries
• The Study further found that older women, uneducated women, men and young women in the community are unlikely to take up family planning; young women were singled out as unique and their response was that they were not engaged in sexual behavior since they are not married
• It’s worth to note that most of this young women are aware of safe and unsafe days and use emergency pills after every sexual encounter which they deem unsafe.
Key Community Recommendations

Study/community recommendations from Kilifi and West Pokot County

- Issue One: Carry out sensitization activities targeting men who least support family planning. It was also suggested that CSOs should develop strategies or come up with programmes where men are the sole beneficiaries of FP training. The need for door to door outreaches was also recommended as a way of bringing togetherness and appreciation on the importance of FP to husbands/living in partners

- More research should be carried out on men family planning methods to help increase men’s uptake of Family Planning methods

- Conduct capacity building trainings on the different Family Planning methods highlighting the advantages and disadvantages of the methods.
Bibliography


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