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FP/RH Access for the Poor in Kenya: EQUITY Framework Encourages Policy and Financing Reforms

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This brief summarizes the report, *The EQUITY Framework: Influencing Policy and Financing Reforms to Increase Family Planning Access for the Poor in Kenya* (2010) prepared by the USAID | Health Policy Initiative, Task Order 1.



(From top): Women seek maternal and child healthcare services at a hospital in Kisumu. Community discussions on family planning use among the poor in Siaya District. Community dissemination meeting of the findings from the focus group discussions. Photo Credit: Eric Ajwang.

Kenya has made significant progress in increasing contraceptive prevalence and acceptance for family planning since the 1960s, when it had one of the highest total fertility and population growth rates in the world. However, recent trends—including the continued high total fertility rate (TFR), high unmet need for family planning, and stagnant contraceptive prevalence rate (CPR)—are cause for concern. Countries that have achieved high levels of family planning and reproductive health (FP/RH) services use have often done so by reducing inequalities in service access. Similarly, Kenya must ensure that FP services are designed for and reach the poorest groups.

From 2007–2009, the USAID | Health Policy Initiative, Task Order 1, collaborated with in-country partners, including the Health Financing Task Force and Division of Reproductive Health (DRH), to carry out a multifaceted activity designed to improve access to FP/RH services for the poor. The activity included three major components: researching policy, operational, and financial issues affecting access to services among the poor; engaging the poor in policy dialogue and advocacy; and collaborating with partners, under the leadership of the government, to create appropriate FP/RH policy strategies to improve access among the poor. This work drew on the Health Policy Initiative's EQUITY Framework and Policy Approach. The EQUITY Framework involves

- Engaging and empowering the poor;
- Quantifying the level of inequalities in healthcare access and health status;
- Understanding the barriers to service access and use;
- Integrating equity goals into policies, plans, and strategies;
- Targeting resources and efforts to reach the poor; and
- Yielding public-private partnerships for equity.

Because the components of the framework are dynamic, can overlap, and do not necessarily follow a linear process, the project implemented a Policy Approach with three major elements that contributed to achieving equity: (1) analysis, (2) dialogue, and (3) informed decisions.

ANALYSIS

Poverty analysis. The Health Policy Initiative reviewed the literature on poverty determinants and poverty mapping to understand access issues and geographic distribution of poverty in Kenya. The project also engaged the poor, through focus group discussions in Nyanza Province, to define what poverty means for them. One participant explained that “*Poverty is hunger; inability to feed children; uncertainty about the next meal; inability to access healthcare; lack of alternative opportunities for survival; absence of shelter and clothing; powerlessness and disinheritance from ancestral land.*”

Market analysis. The market analyses using 1993, 1998, and 2003 Kenya Demographic and Health Survey (KDHS) data quantified the level of inequalities: (1) poor women are least likely to achieve their desired fertility; (2) modern contraceptive use is lowest among the poorest women; (3) unmet FP need is highest among the poor; (4) wealthier women use a wider variety of FP methods; (5) many FP clients served by the public health sector are not from the poorest groups; and (6) the CPR varies by region and area of residence. It is clear that Kenya's stagnating TFR and CPR are due, in large part, to a failure to meet the needs of the poor in both urban and rural areas.

Barriers analysis. Understanding the barriers the poor face in accessing services is essential for designing responsive strategies. The Health Policy Initiative involved the poor in identifying the barriers to FP access and use through focus group discussions and exit interviews, as well as community dissemination and discussions of findings. Key barriers identified included (1) a lack of information about different methods and misconceptions about family planning; (2) limited male involvement in communication about family planning and spousal opposition; (3) sociocultural preferences for large families and for sons as deeply held beliefs (not only among men); (4) perception of religious beliefs as a barrier; (5) high costs for services, including travel costs, lost wages, lost time, costs for child care, and fees for services; (6) frequent stockouts of commodities; and (7) negative provider behavior.

Policy analysis. A lack of pro-poor policies and strategies may lead to continued inequalities in access to health services, including family planning and reproductive health. To understand the history and current status of Kenya's FP/RH policy environment, the Health Policy Initiative reviewed policies and related documents and studies from the past four decades. Although there was considerable progress in earlier years, from the mid-1990s to 2005, there was a decline in funding and support for family planning, as government and donors shifted to support for HIV activities and other development priorities. During the mid-2000s, FP champions within the government and civil society played an important role in expanding attention to FP/RH issues through concerted advocacy. In 2007, Kenya adopted its first-ever *National RH Policy*, which provides guidance for the delivery of high-quality RH services throughout the country.

Financing analysis. Kenya has implemented various financing mechanisms that aim to increase access to FP/RH services among the poor. These mechanisms include cost-sharing; waivers and exemptions (W&E); the

National Health Insurance Fund; and the pilot Output-Based Approach (voucher scheme). Challenges with implementation include (1) the cost-sharing policy has worsened existing inequalities in access to health services by preventing vulnerable groups from seeking affordable healthcare; (2) the W&E system has had limited impact due to lack of awareness of the system; and (3) the National Health Insurance Fund does not adequately address the needs of the poor. The Output-Based Approach increased institutional deliveries among the poor, but FP services remain costly. The private sector market has grown slowly in Kenya due to the availability and lower cost of services in the public sector. Moreover, the country needs to design an overall healthcare financing strategy to ensure financing for services for the poor.

DIALOGUE

The Health Policy Initiative and in-country partners organized dialogue at national, regional, and community levels. The first national dialogue event, in December 2008, provided an opportunity to share the preliminary findings of the five equity-related analyses and engender commitment on potential equity goals and strategies to include in the national RH strategy. Next, the project disseminated findings at the provincial level (Nyanza and Coast) and community level (Kisumu, Siaya, and Homa Bay) to gather reactions from local health authorities, program implementers, service providers, and members of poor communities. The project organized a second national-level meeting in July 2009 to share this feedback with national decisionmakers.

INFORMED DECISIONS

The equity-related analyses and policy dialogue at the national, provincial, and community levels informed the drafting and design of the new *National RH Strategy*, launched in April 2010. The strategy includes quantifiable, equity objectives and strategies for the first time ever. Specifically, it calls for addressing the special RH needs of the poor, hard-to-reach, and other vulnerable populations and includes a time-bound indicator: to increase modern CPR among the poor by 20 percentage points by 2015 (up from 12% in 2003). It also outlines pro-poor strategies, such as reviewing policies to ensure they facilitate equitable access to FP services and shifting resources to areas of extreme poverty. Integrating equity goals and pro-poor interventions into Kenya's national strategy is a positive step forward that must be followed up with implementation, resources, and monitoring mechanisms.