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THE EQUITY FRAMEWORK:

Influencing Policy and Financing Reforms to Increase Family Planning Access for the Poor in Kenya



APRIL 2010

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On the Cover (left to right): 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.

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

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. It is clear that countries that have achieved high levels of family planning and reproductive health (FP/RH) services use have done so by reducing inequalities in service access (Health Policy Initiative, 2007). Kenya must ensure that FP services are appropriately designed for and reach the poorest groups.

The USAID | Health Policy Initiative, Task Order 1, and its predecessor, the POLICY Project, have supported FP/RH policy and advocacy in Kenya for more than a decade. In 2007, the Health Policy Initiative 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) data analysis, (2) dialogue, and (3) informing decisions. This report presents findings from the analysis in Kenya:

Poverty Analysis. The Health Policy Initiative reviewed existing literature on determinants of poverty and poverty mapping to understand access issues and geographic distribution of poverty in Kenya. The project 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 based on Kenya Demographic and Health Surveys (KDHS) from 1993, 1998, and 2003 reveal that (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. From the findings, 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 appropriate strategies to address those barriers. 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 among participants 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 in communities (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* (MOH, 2007), which provides guidance for the delivery of high-quality RH services throughout the country.

Financing Analysis. Kenya has implemented various demand- and supply-side financing mechanisms that seek 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 a pilot of an Output-Based Approach (voucher scheme). There have been problems with implementation: several studies concluded that (1) the cost-sharing policy 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. An assessment of the Output-Based Approach shows an increase by the poor in use of deliveries and FP services, but some difficulties have arisen in program implementation. The private sector market has grown slowly in Kenya due to the availability and lower cost of services in the public sector. The country still needs to design a healthcare financing strategy to ensure financing 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 analyses and engender commitment on potential equity goals and strategies to include in the national RH strategy. Next, the project disseminated key findings at the provincial level (Kisumu, Nyanza, and Mombasa, Coast) and community level (Kisumu, Siaya, and Homa Bay, Nyanza) 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 design of the new *National RH Strategy* (MOPHS and MOMS, 2009). As a result, 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, which is 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 and one that must be followed up with implementation, resources, and monitoring mechanisms.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
AMREF	African Medical and Research Foundation
CBD	community-based distribution
CBS	Central Bureau of Statistics
CHW	community health worker
CPR	contraceptive prevalence rate
DHS	Demographic and Health Survey
DRH	Division of Reproductive Health
FGD	focus group discussion
FHOK	Family Health Options Kenya
FP	family planning
FPAK	Family Planning Association of Kenya
HIV	human immunodeficiency virus
KDHS	Kenya Demographic and Health Survey
KIHBS	Kenya Integrated Household Budget Survey
KNBS	Kenya National Bureau of Statistics
Ksh	Kenyan shillings
KSPA	Kenya Service Provision Survey
ICPD	International Conference on Population and Development
IEC	information, education, and communication
ILO	International Labor Organization
ITAP	Innovations in Family Planning Services II Technical Assistance Project
IUD	intrauterine device
MDG	Millennium Development Goal
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NCAPD	National Coordinating Agency for Population and Development
NCPD	National Council for Population and Development
NGO	nongovernmental organization
NHIF	National Health Insurance Fund
OBA	Output-Based Approach
PRSP	Poverty Reduction Strategy Paper
RH	reproductive health
RH-ICC	Reproductive Health Interagency Coordinating Committee
SES	socioeconomic status
TB	tuberculosis
TFR	total fertility rate
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
W&E	waiver and exemption
WHO	World Health Organization

I. INTRODUCTION

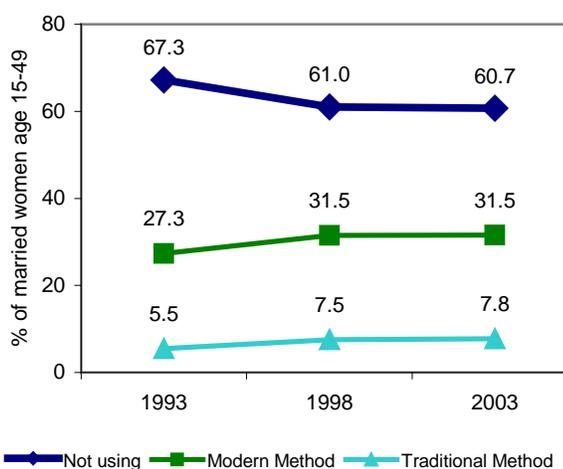
Kenya's estimated population of 39 million is growing at about 2.7 percent per year.¹ In the 1960s, Kenya was among the countries with the highest total fertility and population growth rates in the world. Yet, over the span of a generation, the country's total fertility rate (TFR) declined from 8.1 children per woman in 1977 to 4.7 children per woman by 1998 (CBS, 1980; and NCPD et al., 1999). This dramatic decline is due, in part, to a strong family planning (FP) program and increased acceptability and use of contraceptives among Kenya's citizens. The contraceptive prevalence rate (CPR) for all methods increased from single digits in the 1970s to 39 percent by 1998,

according to the Kenya Demographic and Health Survey (KDHS) (see NCPD et al., 1993 and 1999; and CBS et al., 2003). However, recent trends—including continued high TFR, high unmet need for family planning, and stagnant CPR—are cause for concern. The 2003 KDHS² found that TFR (4.9) and CPR had hit a plateau (see Figure 1), while about 1 in 4 married women of reproductive age continued to have an unmet need for family planning.

The country has also experienced a declining economy and the persistence of people living in poverty. According to the 2006 Kenya Integrated Household Budget Survey (KIHBS), nearly half of the population lives below the poverty line (46%), meaning that they do not have enough income to meet basic food needs (KNBS, 2006). Recent estimates suggest that about 40 percent of Kenya's population lives on less than US\$2 per day and 20 percent lives in extreme poverty on less than US\$1.25 per day (UNDP, 2009). According to the Human Development Index, which considers various indicators to determine well-being (including life expectancy, education, and standard of living), Kenya ranks 147 out of 182 countries overall (UNDP, 2009).

With the high inequalities in income distribution, the country's new blueprint for development, *Vision 2030*, aims to establish a socially just and equitable society without extreme poverty. However, continued high fertility and rapid population growth will pose challenges for Kenya's socioeconomic development—both at the national and household levels. Increasing access to family planning can contribute to slower population growth—and, ultimately, less burden on strained social services, the economy, and natural resources—as well as improved maternal and child health (see Box 1). At the household level, increased FP use, especially among the poor, could have far-reaching implications beyond improved reproductive, maternal, and child health. Reducing family size increases the household resources (e.g., time, money, food) available for investment in each child, thus helping families to create a path out of poverty and enhance quality of life. Thus, public health, human rights, and poverty alleviation

Figure 1. Contraceptive Prevalence by Type of Method in Kenya, 1993–2003 (KDHS)



¹ Population Reference Bureau Datafinder. Available at http://www.prb.org/Datafinder/Geography/Summary.aspx?region=39®ion_type=2 [accessed December 29, 2009].

² KDHS 2008 data were not available when the analyses presented in this report were conducted.

concerns all point to a need to better meet the family planning and reproductive health (FP/RH) needs of the poor in Kenya.

Rationale for the Activity

While trends vary by country, one point is clear: countries that have achieved high levels of FP/RH service use have done so by reducing inequalities in service access (Health Policy Initiative, 2007). Similarly, Kenya cannot expect to halt stagnation in its TFR and CPR without taking active steps to ensure that FP services are appropriately designed for and reach the poorest groups.

The USAID | Health Policy Initiative, Task Order 1, and its predecessor, the POLICY Project, have supported FP/RH policy and advocacy responses in Kenya for more than a decade. These efforts have focused on building policy and advocacy capacity within the country (among government and civil society partners); analyzing and formulating national policies; and linking policies to implementation plans and resources. Beginning in mid-2007, the Health Policy Initiative collaborated with in-country partners, including the Health Financing Task Force and Division of Reproductive Health (DRH) in the Ministry of Health (MOH),³ to carry out a multifaceted pro-poor approach specifically designed to improve access to FP/RH services for the poor. The ministry, with the project's technical assistance, formed a Working Group on Poverty and Access in June 2007 to provide recommendations on how to include the income poor and vulnerable groups into healthcare financing strategies, especially for FP/RH programs. As part of this effort, the project supported three major components:

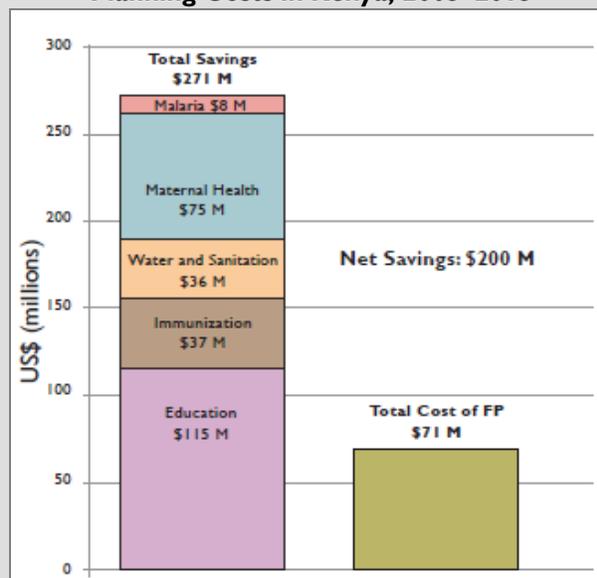
- Conducting desk reviews and secondary data analyses—supplemented with limited data collection through focus group discussions (FGDs) and interviews—to understand policy, operational, and financial issues affecting access to FP/RH services among the poor.
- Collaborating with in-country partners to convene meetings and disseminate information related to pro-poor policies and engage the poor in policy dialogue and advocacy.
- Working with partners, under the leadership of the government, to create appropriate policy strategies to improve access among the poor.

³ Following the 2008 elections, the Kenyan government divided the Ministry of Health into two ministries, the Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS). Activities presented in this report occurred before and after this bifurcation. For ease of use, the abbreviation MOH is used to refer to the single ministry (pre-election) and combined ministries (post-election), unless otherwise noted.

Box 1. Kenya Benefits from Increased FP Access

The Health Policy Initiative's analysis of the contribution of family planning to the Millennium Development Goals (MDGs) shows that satisfying unmet FP need in Kenya would avert 14,040 maternal deaths and 434,306 child deaths by the MDG target date of 2015. Moreover, FP use helps to reduce the size of the population in need of various social services. Thus, as shown in Figure 2, the cost savings in providing services to meet five of the MDGs outweigh the additional costs of family planning by a factor of almost 4 to 1.

Figure 2. Social Sector Cost Savings and Family Planning Costs in Kenya, 2005–2015



Source: Health Policy Initiative, 2006.

Conceptual Approach

Despite a desire to meet the needs of the poor, many government policymakers and other stakeholders struggle to plan and implement programs that reach them. Recognizing that even well-intentioned program efforts do not always reach their intended beneficiaries, the Health Policy Initiative designed the EQUITY Framework to provide stakeholders with practical guidance for ensuring that the voices of the poor are actively engaged in policymaking and that pro-poor strategies are incorporated throughout the *policy-to-action* continuum. Figure 3 presents the EQUITY Framework, which is based on the project's prior experiences and international best practices for pro-poor strategies.

Figure 3. The EQUITY Framework



EQUITY Framework

Engaging and empowering the poor. The poor should be empowered to become involved in program decisions that affect their healthcare needs. They are best able to speak to the challenges they face and to provide insights to design appropriate solutions. Thus, the poor have an important role to play in problem identification, advocacy, planning, and monitoring. In some cases, countries have also involved the poor as program implementers, training them to raise awareness, offer referrals, and provide certain services to others in their communities (Zosa-Feranil et al., 2009).

Quantifying the level of inequality in healthcare access and health status. Getting FP/RH needs of the poor on the national policy agenda first requires an understanding of the magnitude and urgency of the issue. Market segmentation analyses based on DHS data and poverty mapping can reveal the level of inequality and help to pinpoint areas of greatest need. In particular, it is important to recognize that the poor are not a homogenous group. It is not enough to equate poverty with rural areas and relative wealth with urban areas, as even within these areas, there are segments of the urban and rural poor that are in greatest need of services.

Understanding the barriers to service access and use. After determining the extent of inequalities, policymakers must understand the root causes of inequalities in health status and service access. Barriers to equitable service access and use are often rooted in a variety of sources, including policy, resource, operational, and sociocultural issues. Understanding these diverse issues will enable policymakers and program managers to design policy and programmatic strategies that are more responsive to the needs of the poor.

Integrating equity goals into policies, plans, and strategies. Too often, countries aspire to enhance health equity and alleviate poverty, yet fail to articulate clear equity-based goals and strategies. Integration of equity and FP issues requires a two-pronged approach: (1) incorporating equity goals, pro-poor strategies, and equity-based monitoring and evaluation indicators in national FP/RH policies and plans; and (2) including family planning as a component of national poverty alleviation and development programs and agendas. To make this happen, specific policies, goals, strategies, resources, and monitoring mechanisms are needed.

Targeting resources and efforts to reach the poor. While overall improvements in healthcare systems are desirable in most developing countries, experience has shown that health interventions will not reach the poorest groups without appropriate planning, targeting, and oversight (Gwatkin, 2004). Care must be taken to first identify the poor, understand their needs, and assess their barriers to increased service access and use. Building on this evidence, governments should integrate pro-poor approaches and formulate targeted, pro-poor policies and strategies as the foundation of appropriate programs. “Targeting” directs scarce resources to those most in need (POLICY Project, 2003). A “pro-poor” approach means that healthcare costs are based on the client’s ability to pay; the poor and nearly poor are protected from financial calamity due to a severe illness; and steps are taken to improve equitable access—in terms of quality, affordability, and the geographic distribution of services (Bennett and Gilson, 2001).

Yielding public-private partnerships for equity. Meeting the FP/RH needs of the poor requires that countries make the best use of all the available public, private, donor, and nongovernmental organization (NGO) resources. A “total market approach” takes advantage of resources in the public, private, and NGO sectors to ensure that the government and/or subsidized NGOs and private sector services cater to the needs of the poor, while clients who can afford to pay for services seek FP options in the commercial sector.

Policy Approach

This report describes how the Health Policy Initiative and partners applied the EQUITY Framework in Kenya. The framework’s components are dynamic, can overlap, and do not necessarily follow a linear process. Thus, the project carried out a Policy Approach with three major elements that each contributed to achieving equity: (1) data analysis, (2) dialogue, and (3) informing decisions. In close collaboration with the Working Group on Poverty and Access, Health Financing Task Force, DRH, and stakeholders at the decentralized level, the project followed a systematic process of analyzing data to assess barriers to access, organizing dialogue between the poor and key decisionmakers, and designing a strategic response for reaching the poor (see Figure 4).

Data analysis

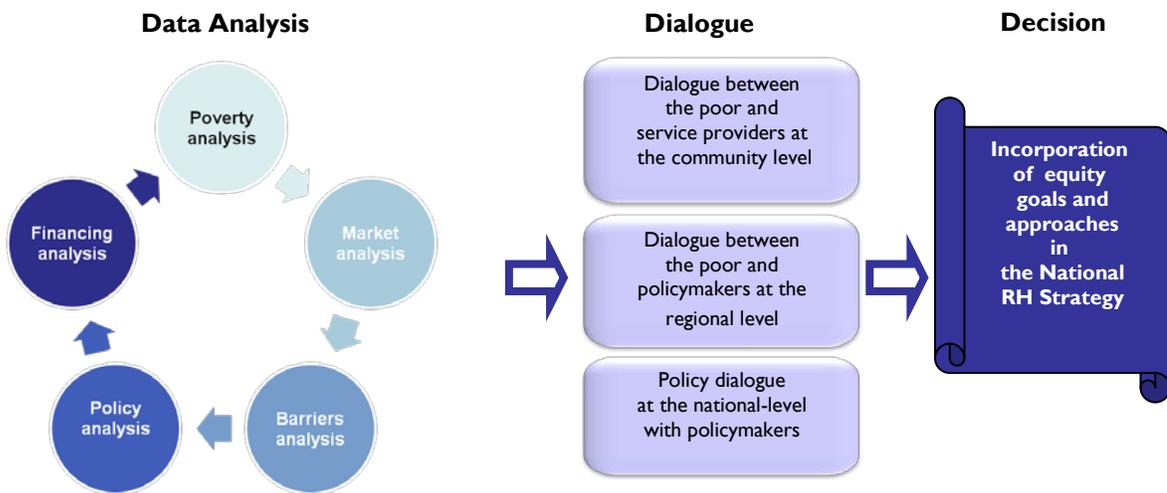
Data analysis involved five different assessments:

- *Poverty analysis:* The project reviewed existing literature on determinants of poverty and poverty mapping to understand access issues and geographic distribution of poverty (see Section 2). The project also reviewed mechanisms for engaging the poor in problem identification, policy formulation, policy implementation, and policy monitoring.
- *Market analysis:* The project conducted market analyses using the 2003 KDHS data to understand FP use, unmet need, source mix, and method mix among different socioeconomic quintiles (see Section 3). The project also explored differentials by quintiles in rural and urban areas.
- *Barriers analysis:* The project augmented the secondary data analysis with FGDs and exit interviews with poor women and men and interviews with service providers to collect information on (1) reasons of low/non-use of family planning; (2) operational, financial, and cultural barriers that affect access to FP services; and (3) level of awareness and opinions about

different financing mechanisms (see Section 4). The FGDs and interviews were conducted in Nyanza Province.

- **Policy analysis:** The project analyzed Kenya’s FP policy environment to determine the primary forces behind successes achieved from 1970–1990 and the stalling of progress from 1990 to date (see Section 5). This review considered FP/RH policies, *Vision 2030* and other national development plans, and operational policies that have facilitated or hindered the availability of FP services for the poor.
- **Financing analysis:** The project reviewed existing supply- and demand-side financing mechanisms—such as voucher schemes, waivers and exemptions, and the hospital-based National Health Insurance Fund reimbursement—to understand the adequacy of existing financing mechanisms in ensuring access to and affordability of FP services among the poor (see Section 6).

Figure 4. Policy Approach



Dialogue

The Health Policy Initiative and in-country partners organized dialogue at national, regional, and community levels (see Section 7 and Annex 1). The first national dialogue event, in December 2008, provided an opportunity to share preliminary findings of the five assessments and engender commitment on potential equity goals and strategies to include in the national RH strategy. Next, the project disseminated key findings at the provincial level (Kisumu, Nyanza, and Mombasa, Coast) and community level (Kisumu, Siaya, and Homa Bay, Nyanza) to gather reactions from local health authorities, program implementers, service providers, and members of poor communities. During these sessions, the poor interacted directly with service providers and decisionmakers to discuss the challenges they face in accessing and using FP services and pose potential solutions. The project organized a second national-level meeting in July 2009 to bring feedback from these deliberations to national decisionmakers.

Design a strategic response and inform decisions

The evidence-based dialogue and advocacy described above are part and parcel of the project’s policy work in Kenya and, specifically, informed design of the *National RH Strategy, 2009–2015* (MOPHS and MOMS, 2009). The Health Policy Initiative has been engaged in concerted policy dialogue and advocacy with various stakeholders to place FP/RH and equity issues high on Kenya’s agenda. These efforts aim to integrate pro-poor strategies into FP/RH policies, as well as include FP programs in national poverty alleviation plans to support the attainment of objectives in *Vision 2030*.

The project employed several approaches, including

- Fostering leadership and participation across sectors, groups, and levels;
- Helping diverse audiences achieve consensus;
- Using compelling evidence, such as the RAPID Model⁴ and the assessments summarized in this report, for advocacy and decisionmaking; and
- Designing action policies and operational guidelines to facilitate implementation (see Box 2).

In particular, the project provided technical assistance to DRH, the Health Financing Task Force, Working Group on Poverty and Access, provincial RH coordinators, National Coordinating Agency for Population and Development (NCAPD), RH Interagency Coordination Committee (RH-ICC), and special technical working groups—on the *National RH Policy* and *National RH Strategy*. The aim was to (1) design strategies and actively engage the poor to identify problems related to accessing FP services and (2) explore solutions responsive to the needs of the poor. As a result, for the first time ever, the *National RH Strategy* includes quantifiable equity objectives, indicators, and specific strategies for reaching the poor equity goals and objectives (see Section 7). Integrating equity goals into Kenya's national strategy is a positive step forward and one that must be followed up with implementation, resource, and monitoring mechanisms.

Box 2. Policy Highlights in Kenya

The Health Policy Initiative and its predecessor, the POLICY Project, contributed to the following:

- *National Condom Policy & Strategy, 2001–2005*
- *Costed Contraceptive Commodities Security Procurement Plan, 2003–2006*
- *Costed National Health Sector Strategic Plan, 2005–2010 (NHSSP II)*
- *Costed National Plan of Action on Adolescent RH & Development, 2005–2015*
- *Guidelines for Pricing FP Services and Commodities in Public Sector Health Facilities (2005)*
- *National RH Policy (2007)*
- *National RH Strategy (2009)*
- *National RH/HIV Integration Strategy (2009)*

⁴ RAPID is a computer model that analyzes the impact of rapid population growth on different sectors—including health, education, the environment, and economy—and highlights the benefits of slowing population growth, in part, through increased access to family planning.

Equity Objectives, Indicators, and Pro-poor Interventions in Kenya's National Reproductive Health Strategy

Equity Objectives:

- Address the special RH needs of the poor, hard-to-reach, and other vulnerable populations
- Reduce unmet need for family planning, unplanned births as well as socioeconomic disparities in contraceptive prevalence rate

Equity Indicator:

- CPR among the poor increased by 20 percentage points from 12% by 2015

Pro-poor interventions:

- Carry out an assessment of RH needs and service availability for hard-to-reach populations
- Support research that seeks to understand social and cultural determinants of non-use and unmet need for family planning among various social and economic groups to advocate for and promote evidence-based interventions
- Advocate for strategies to reduce inequities in access to reproductive healthcare
- Review/update policies and regulatory mechanisms in order to ensure that they facilitate universal and equitable access to FP education, information, and services
- Design strategies for improving equity in access to reproductive healthcare for hard-to-reach populations; these may include establishment of innovative outreach services compatible with their lifestyles and use of e-health technologies
- Use participatory approaches to work with communities, public and private sector institutions, and nongovernmental organizations to overcome barriers and promote appropriate use of available services
- Support community-based distribution to overcome social and geographic barriers to family planning particularly in rural and remote areas
- Mobilize civil society to advocate for family planning in disadvantaged communities
- Shift resources from relatively well served areas to areas of extreme poverty (poverty mapping) like North Eastern Province, Nyanza Province, and the dry (and poor) northern parts of the country. Similarly, shift resources to arid areas and to areas with pastoralist populations and to urban slums in major cities.

II. POVERTY ANALYSIS

Engage the poor | Quantify inequalities | Understand barriers | Integrate equity | Target resources | Yield partnerships

As a starting point, the Health Policy Initiative sought to better understand the nature of poverty in Kenya, which is essential for identifying the poor, understanding the barriers they face, and engaging them in policy dialogue. Thus, the project carried out a poverty mapping exercise and reviewed the literature to outline key determinants of poverty in Kenya. Importantly, the project also involved the poor to define what poverty means to them and used this definition as the working definition of poverty throughout the project's activities.

Definition of Poverty

As Zosa-Feranil et al. (2009) explain, poverty is a multidimensional concept that has evolved over time. Traditional measures of poverty have relied on quantitative measures, such as food/calorie intake or income level. For example, the 2005/06 KIHBS estimated the absolute poverty line at Ksh. 1,239 shillings per month for rural areas and Ksh. 2,648 per month for urban areas. According to the 2006 KIHBS, nearly half of the population lives below the poverty line (46%), meaning that they do not have enough income to meet basic food needs. Similarly, the government *Poverty Reduction Strategy Paper* (PRSP) (Ministry of Finance and Planning, 2001) defines poverty as the inadequacy of income needs and the lack of access to productive assets, social infrastructure, and markets.

While important, quantitative measures do not fully capture the impact of poverty on the lives of the poor. In addition to traditional measures of poverty (e.g., income, assets, nutrition, educational attainment), definitions have expanded to include issues such as voicelessness, isolation, and vulnerability (Zosa-Feranil et al., 2009). Two broad trends in international development thinking support greater engagement of the poor—on the one hand, there is increased emphasis on human rights, democratic principles, and participatory approaches, and, on the other hand, there is a search for solutions to help poverty-reduction and health programs achieve results. International reviews have attributed persistent poverty, in part, to a failure to effectively involve the poor in programs intended to reach them. Reducing poverty, therefore, requires engaging the poor to overcome the voicelessness and isolation they experience. Doing so is beneficial for both programs and people. The poor are best able to speak to the challenges they face and to provide insights to design appropriate responses. Engagement promotes dialogue and honest feedback, transparency, accountability, and shared ownership of initiatives. Moreover, engagement in itself is empowering for the poor and can help build their life skills and reduce isolation.

Kenya has carried out participatory poverty assessments—though a key limitation is that the assessments were seen as more of an information-gathering exercise and not as a mechanism for the poor to engage with the government (Mukui, 2005). As a first step, the poor should be involved in defining what poverty means to them. Thus, in Nyanza Province, the Health Policy Initiative organized FGDs (see Section 4) in which participants were asked to define what poverty means in their communities. The quote from a participant in Kisumu highlights the nature of poverty and its impact on families in Kenya. Going a step further, the project involved the poor in dialogue with community and provincial leaders (see Section 7 and Annex 1).

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.

FGD Participant, Kisumu, Kenya

Poverty Mapping in Kenya

Table 1 shows the distribution of absolute poverty levels by region and district in Kenya, based on 2006 data and political divisions. The geographical pattern is one of lower poverty levels in the center of the country, near the nation's capital of Nairobi, and higher levels of poverty in the surrounding areas and outer rim of the country. All provinces, except for Central Province, have districts in which 50 percent or more of the population lives in poverty. Even in the more urbanized Central Province, district-wise poverty levels range from 22–46 percent.

To carry out the FGDs and interviews for this activity, the project and in-country partners selected Nyanza Province, which has a high poverty level as well as low contraceptive use and high unmet need (see Section 3). The project also organized community dialogue and dissemination forums in the Nyanza and Coast provinces.

Table 1. Distribution of Absolute Poverty Levels (%) By Province and District, 2005/06

Poverty Level (%)	11–30		31–50		51–70		70+	
Central Province	Kiambu Kirinyaga Muran'ga	22 25 29	Nyeri Maragwa Thika Nyandarua	31 31 35 46				
Coast Province			Lamu	33	Taita Taveta Kilifi	57 68	Kwale Malindi Tana River	75 76 77
Eastern	Meru central Meru north	23 30	Meru South Embu Tharaka Mbeere	31 37 49 50	Machakos Mwingi Kitui Makueni Moyale	59 62 64 64 67	Isiolo Marsabit	71 92
North Eastern			Garissa	50			Wajir Mandera	84 89
Nyanza	Bondo	25	Siaya Rachuonyo Migori Homa Bay Kisii North Nyando Kisumu	40 40 43 45 47 48 49	Kisii Central Suba Kuria Gucha	51 52 61 67		
Rift valley	Kajiado Narok	12 27	Buret Nakuru Kericho Keiyo Nandi Laikipia	33 38 41 46 47 49	Trans Nzoia Uasin Gichu Koibatek Trans Mara Bomet Baringo Marakwet West Pokot	50 50 51 52 59 61 67 69	Samburu Turkana	73 95
Western			Vihiga Lugari Bungoma	40 46 50	Butere/mumias Kakamega Mt Elgon Teso Busia	51 53 58 59 69		

Source: KNBS, 2006.

Determinants of Poverty

Efforts to enhance access to FP services for the poor must consider the factors that contribute to poverty in the country. Some of the key determinants of poverty in Kenya include the following:

- Income distribution in the country is highly skewed toward the wealthiest. According to the 2001 PRSP, about 80 percent of the country's national income goes to the top 20 percent of the population (Ministry of Finance and Planning, 2001). The skewed distribution of national income and regional inequalities (urban/rural) work against government efforts to reduce poverty and promote the overall growth of the country.
- Unemployment is another contributor to poverty in the country. Due to the small size of the economy (reflected in the lack of Gross Domestic Product growth in real terms), fewer jobs have been created in both the formal and the informal sectors. In 2007, the total wage employment in the formal sector was 1.9 million compared with 7.5 million in the informal sector (CBS, 2008). Lack of employment results in lack of income to meet basic needs such as food, shelter, clothing, education, and medical services.
- Poverty reports—such as the 1997 Welfare Monitoring Survey (CBS, 2000), 2001 PRSP (Ministry of Finance and Planning, 2001), and 2006 KIHBS—indicate that, in both rural and urban populations, poverty increases as the household size and age of the head of household increases. An increasing family size requires additional expenditure at the household level when the income may not be increasing to match needs. In addition, as the head of household ages, he/she may become less involved in wage earning, leading to a decline in household income.
- HIV and AIDS have emerged as determinants of poverty in Kenya (Bollinger et al., 1999) and, indeed, in sub-Saharan Africa. Loss of productive members of the labor force, a rise in children orphaned by AIDS, and increasing costs of healthcare take a toll on household and community resources. Some families are forced to sell their land to pay these expenses. The situation is often worsened by deteriorating economic conditions that make it difficult for women to access health and social services.
- Environmental issues are a key concern in Kenya, as environmental degradation is “both a cause and consequence of poverty” (Suda, 2000, p. 91). Poverty and high population growth can strain the environment through increased resource use and unsustainable agricultural practices. Further, as many people in poor communities rely on agricultural work for their food and livelihoods, the poor are especially vulnerable to natural disasters, drought, and environmental degradation.
- Poor governance, human rights abuses, weak legal systems, and corruption increase poverty both directly and indirectly (Manda et al., 2001). Corruption directs resources to those with wealth and power. Building good governance in the management of national resources is a pre-cursor to sustainability and success of poverty eradication efforts.
- The Kenyan government has undertaken participatory poverty assessments that reveal the feminization of poverty due to “lack of property rights ..., discrimination at the household level in access to education, and the devastating effects of HIV/AIDS” (Mukui 2005, p. 7). Gender inequalities limit women's and girls' access to opportunities and education, as well as ownership and control over productive assets such as land. In addition, women also lack access to credit facilities due to lack of collateral for loans.
- Another dimension of poverty is disabilities. People with disabilities are often socially marginalized and neglected. They have been denied access to public utilities, good healthcare (including FP/RH services), basic education, inheritance rights, and vital information leading to lack of employment and security. People with disabilities also lack strong representation in many

decisionmaking bodies in Kenya, hence, policies, programs, and financing mechanisms often fail to meet their health, education, and social support needs.

Opportunities for Engaging the Poor

Based on project experience and a review relevant literature, the Health Policy Initiative developed a framework for how the poor have and can be engaged in various stages of the FP policy process (for more, see Zosa-Feranil et al., 2009).

- During the *problem identification* process, for example, the poor can be consulted through FGDs or exit interviews to understand a specific development problem or its underlying causes, as well as to identify barriers the poor face in accessing services.
- During the *policy formulation stage*, when policy options are identified and assessed and action and financial plans are developed, the poor can be engaged through FGDs or community-level forums. Planning committees can also meet with representatives of the poor and, in some instances, planning committees have included members representing poor communities.
- During *policy implementation*—which involves many steps, including allocating resources, identifying and removing operational barriers, and mobilizing for action—the poor can be engaged by identifying community workers and volunteers from among poor communities to provide services and outreach to their peers.
- During *policy monitoring and evaluation*, the poor can be involved in citizen monitoring committees, client exit interviews to assess the quality of services they received, community forums, and other mechanisms.

To integrate equity goals, issues, and strategies in Kenya, the Health Policy Initiative and in-country stakeholders engaged the poor in problem identification (see Section 4) and regional and community dialogue meetings (see Section 7 and Annex 1). Recommendations on strategies to engage the poor are also included in the new *National RH Strategy* (see Section 7).

Summary

Poverty and family planning are inter-linked. To the poor, non-availability of FP/RH services is strongly correlated with a heavy health burden, large economic loss, and unacceptable inequality in income and in economic opportunities. Having many children can lead to less resources (e.g., money, time, food) to invest in each child, resulting in poor nutrition, ill health, and limited educational opportunities and, ultimately, tying this group to the poverty trap. To break this cycle, it is essential to understand the barriers the poor face in accessing FP/RH services. Poverty is also increasingly understood to be a multidimensional concept—one that includes not only quantitative measures of poverty (e.g., income, calorie intake, or asset indicators) but also issues of voicelessness, isolation, and vulnerability. Decisions affecting the poor should be made *with* the poor, not *for* the poor. Thus, a key component of the EQUITY Framework is engaging and empowering the poor. Rather than being a “step,” engagement should be integrated across all efforts to design, implement, and monitor health policies for the poor.

III. MARKET ANALYSIS

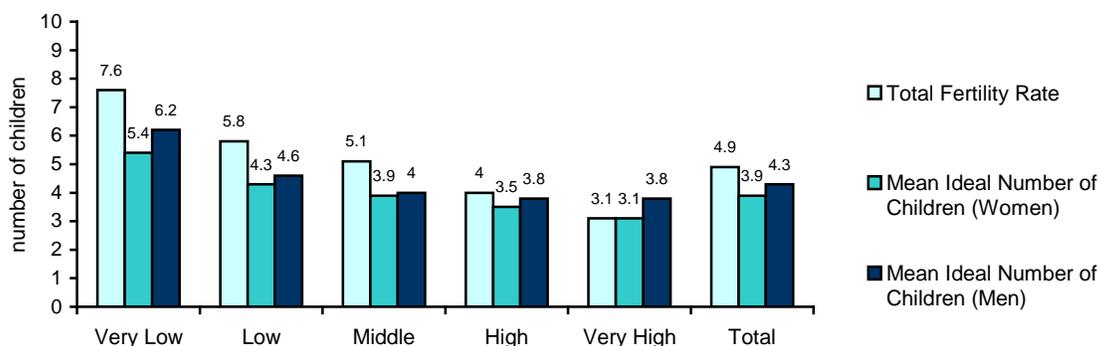
Getting the FP/RH needs of the poor on the national policy agenda requires an understanding of the magnitude and urgency of the issue. Using data from the 1993, 1998, and 2003 KDHS, the project analyzed the consumer and provider markets using the standard of living index created by Macro International. The project also created a disaggregated standard of living index for urban and rural areas based on the household’s living conditions and ownership of assets. Note that, based on the standard of living index, most residents in Nairobi and other urban areas are classified as being in the high or very high socioeconomic status (SES) groups. This classification is because people in urban areas tend to have greater household amenities, as compared with rural inhabitants. However, such measures do not adequately identify the urban poor and slum dwellers, who may have certain assets but still live in poor conditions and lack access to health services. Thus, the project carried out the disaggregated quintile analysis for rural and urban areas that considers level of inequality within urban and rural SES quintiles. Key findings from analyses using this method and data from the KDHS are presented in this section.

Key Findings

Poor Women Are Least Likely to Achieve Their Desired Fertility

Women in the very low SES group have a TFR that is more than twice that of women in the very high SES group (7.6 vs. 3.1) (see Figure 5). Women from the lowest SES group also experience the largest difference between their total fertility and preferred fertility (+2.2). In contrast, women from the very high and high SES groups have achieved or nearly achieved their mean ideal number of children. Men across all quintiles prefer a higher mean ideal number of children than women; however, the largest difference in preference is seen in the very low SES group.

Figure 5. Modern CPR among Married Women (15–49) by SES Quintiles in Kenya, 1993–2003 (KDHS)



Modern CPR is Lowest among the Poorest Women

The high TFR among the poorest groups is due, in part, to limited use of family planning by these groups. Overall, modern CPR in Kenya is 32 percent (2003 KDHS). Women from the lowest SES groups are the least likely to use modern contraceptive methods, and, from 1993–2003, Kenya made no progress in closing the gap in FP use between the low and high SES groups (see Figure 6). In 2003, only 12 percent of women from the very low SES group used a modern FP method, while 45 percent of women from the very high SES group did the same. Socioeconomic status affects access to and use of services, as there is an 8–14 percentage point increase in modern CPR for each increase in quintile status.

Unmet Need for Family Planning is Highest among the Poor

Unmet need refers to the proportion of married women of reproductive age who do not want any more children or want to wait two or more years to have a child but are not using contraception. Reaching women with unmet need is often viewed as a good place to start in terms of program efforts to expand FP access and increase CPR, because this is a group that has expressed a desire to space or limit future pregnancies and may be more receptive to FP use than other non-users. In Kenya, women in the very low, low, and middle SES groups have the highest level of unmet need for family planning (see Figure 7). In fact, total unmet FP need among women in the very low (33%) and low (30%) SES groups is nearly double the unmet need found among the very high (17%) and high (17%) SES groups.

Another way to look at the potential market for family planning is to examine women's responses to questions regarding intention to use family planning in the future. According to the 2003 KDHS, there is a large percentage of all women ages 15–49 who intend to use family planning (23.0%).

Intention to use is highest among the very low (28.4%) and low (26.7%) SES groups. Yet, while low SES groups have the highest unmet FP need and intention to use family planning, women from these groups also have the highest desire to have children in the near future, suggesting a need to better reach poor families with information, education, and communication (IEC) to promote a small family norm.

Wealthier Women Use a Wider Variety of Methods

People from lower SES groups use less variety of FP methods (see Table 2). Women who use family planning from the lowest SES groups show a preference for injectables and abstinence. Among the highest SES groups, women use injectables, oral contraceptives, and abstinence, as well as longer term methods such as intrauterine devices (IUDs), implants, and sterilization. Condom use is low across all groups.

While it is not possible to make conclusions about supply from these data alone, potential strategies for reaching lower SES groups could include expanding access to methods (e.g., through community-based distribution) and increasing access to a wider variety of methods to better meet the diverse needs of women from lower SES groups.

Figure 6. Modern CPR among Married Women (15–49) by SES Quintiles in Kenya, 1993–2003 (KDHS)

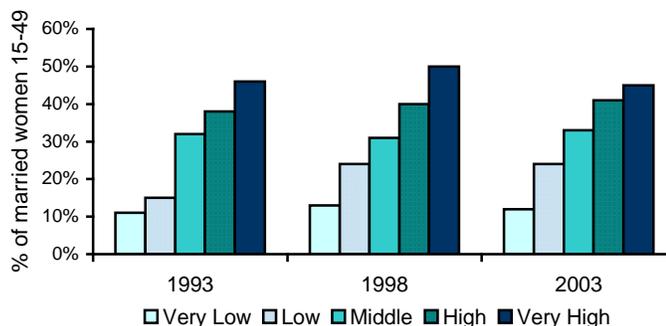


Figure 7. Unmet FP Need among Married Women (15–49) by SES Quintiles in Kenya, 2003 (KDHS)

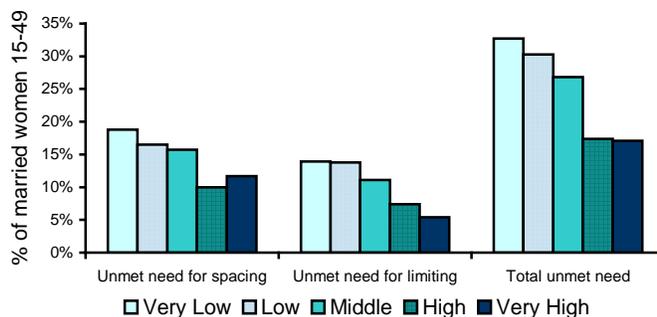


Table 2. Family Planning Method Mix (Modern and Traditional Methods) among Married Women (ages 15–49) by Socioeconomic Status, 2003 (KDHS)

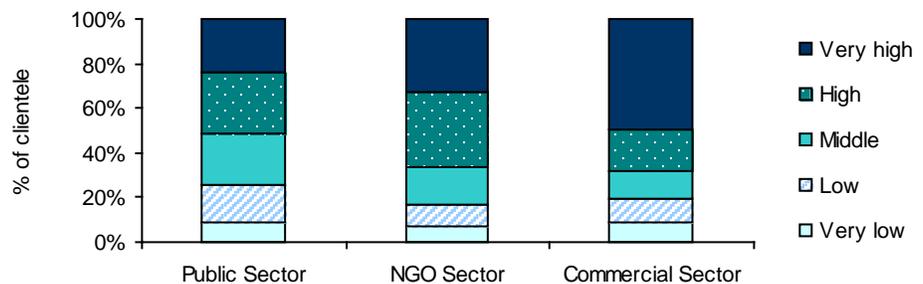
Method	Very Low	Low	Middle	High	Very High	Total
Injectable	40.0	39.2	42.3	32.4	33.7	36.5
Oral Contraceptive	12.1	16.7	18.4	20.1	22.2	19.2
Abstinence (periodic)	27.5	19.2	16.0	14.6	12.2	16.0
Sterilization (female)	7.3	10.7	11.5	13.9	9.6	11.1
IUD	1.2	2.5	3.3	6.6	10.7	6.1
Implant (Norplant)	1.7	2.1	2.8	5.4	6.0	4.2
Condom	3.8	4.5	1.4	2.1	4.2	3.1
Other Traditional Method	2.2	2.2	3.1	2.4	1.3	2.1
Withdrawal	4.2	2.9	1.2	2.1	0.2	1.6
Female Condom	0.0	0.0	0.0	0.3	0.0	0.1
<i>Total</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>
<i>N</i>	<i>169</i>	<i>305</i>	<i>384</i>	<i>490</i>	<i>587</i>	<i>1,934</i>

Many FP Clients Served by the Public Sector Are Not Poor

Typically, public sector services are intended to reach the groups who are most in need and are unable to afford services elsewhere. In Kenya, the public health sector provides the majority of FP planning services (53%). Other providers include the commercial sector (e.g., private hospitals, pharmacies/chemists, and shops) (35%) and NGOs, religiously-affiliated clinics, mobile clinics, and community-based distributors (11%). A look at the socioeconomic status of FP clients of the different providers shows that the very low and low SES groups represent a small proportion of the clientele in all sectors (see Figure 8).

Most alarming, however, is the fact that the very low (9%) and low (17%) SES groups account for only about one-fourth of the clients served by Kenya’s public sector, which, ideally, should cater to the needs of the poor. In practice, more than half of the public sector’s clients are from the high (27%) or very high (24%) SES groups.

**Figure 8. Clientele By Sector and SES Group, 2003
KDHS**

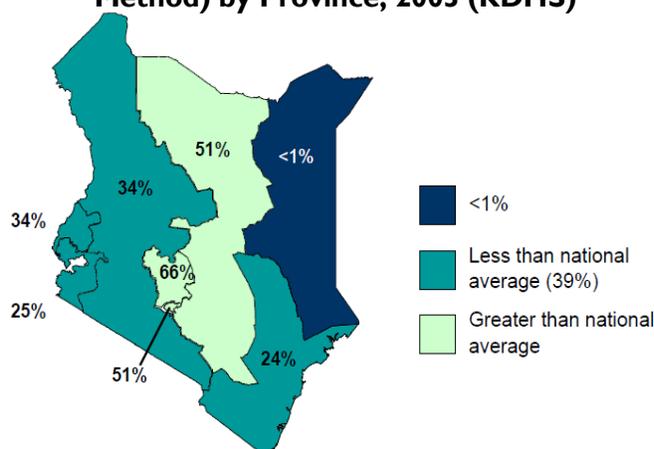


Looking at source of contraceptive methods, 68 percent of the lowest SES group receives contraceptives from the public sector, yet so do 56 percent of the high and 38 percent of the very high SES groups. About 1 in 5 (20.3%) clients from the very low SES group seeks contraceptives through the commercial sector, compared with about half (51.0%) of the very high SES group.

CPR Varies by Region and Area of Residence

The need to focus FP resources to reach the poor is clear. However, “the poor” are not a homogenous group. Differences in FP use can be seen across and within provinces, urban/rural areas, and SES groups. Figure 9 and Table 3 illustrate the disparities in contraceptive use across Kenya’s provinces. Use of any contraceptive method is highest in the middle of the country, in Central Province (66%), Nairobi (51%), and Eastern Province (51%). CPR for any method is slightly lower than the national average in the Rift Valley (34%) and Western provinces (34%). Nyanza (25%) and the Coast (24%) have low CPRs for any methods, while FP use is nearly non-existent in North Eastern Province (<1). In North Eastern Province, the arid, difficult terrain, mobile nature of nomadic communities, and dearth of health services (both stationary facilities and mobile clinics) all contribute to a lack of FP use.

Figure 9. Contraceptive Prevalence Rate (Any Method) by Province, 2003 (KDHS)



As shown in Table 3, rural populations (27%) have a higher unmet need for family planning than urban populations (17%). By province, unmet need is highest in the outer rim of the country, in Nyanza (35%), Western (32%), Rift Valley (28%), and Coast (25%) provinces. Moreover, while hardly any women in North Eastern Province are using family planning, about 1 in 10 women report having unmet need. Thus, Kenya will likely be better able to reduce total fertility by focusing FP resources, program efforts, and information, education, and communication campaigns on these areas with lower CPR and high unmet need.

Table 3. Current FP Use and Unmet Need among Married Women (age 15–49) by Province, 2003 (KDHS)

	National			Province							
	Total	Urban	Rural	Nairobi	Central	Coast	Eastern	Nyanza	Rift Valley	Western	North Eastern
Current Use											
Any method (%)	39	48	37	51	66	24	51	25	34	34	<1
Modern methods (%)	32	40	29	44	58	19	38	21	25	27	<1
Traditional methods (%)	8	8	8	6	9	5	12	4	10	7	0

Unmet Need											
Total unmet need (%)	25	17	27	16	11	25	22	35	28	32	10
For spacing (%)	14	11	15	13	6	16	11	21	16	19	9
For limiting (%)	10	6	11	4	5	9	11	14	12	13	1

However, even in provinces with relatively high levels of contraceptive use, there may be underserved populations, especially the urban and rural poor. Figure 10 presents modern CPR among different SES groups by their area of residence. This analysis shows that the high and very high SES groups in both urban and rural areas have a modern CPR that is higher than the national average (which is 32%). It is the urban and rural poor, comprising the low and very low SES groups, that are less likely to use FP services. Similarly, the urban and rural poor have the highest unmet need for family planning (see Figure 11). Unmet FP need among the very low and low SES groups in urban and rural areas ranges from about 20–35 percent among married women age 15–49.

Figure 10. Modern FP Use by Socioeconomic Status and Urban/Rural Residence, 2003 (KDHS)

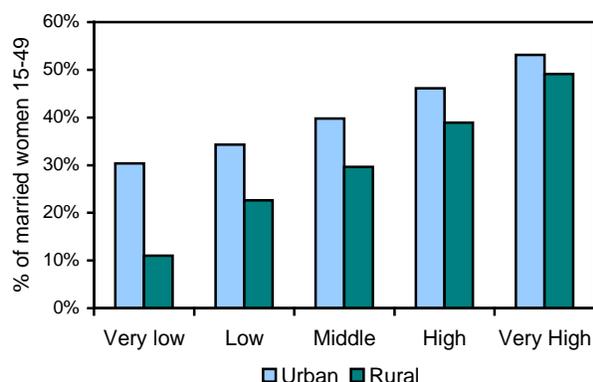
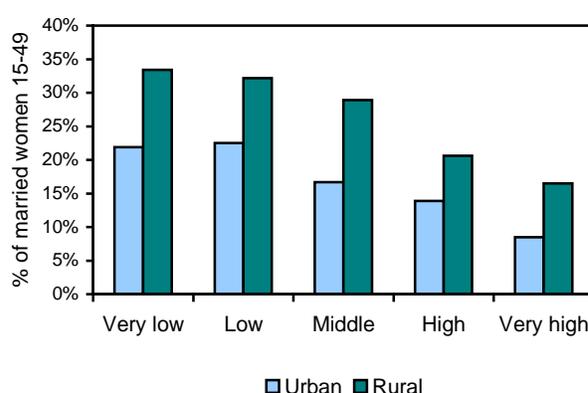


Figure 11. Unmet FP Need by Socioeconomic Status and Urban/Rural Residence, 2003 (KDHS)



Summary

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. Poor women have higher fertility and are least likely to achieve their desired fertility. They have the highest unmet need for family planning and highest intention to use family planning in the future. The women in the highest SES groups are well on their way toward achieving CPRs observed in middle-income countries, while the prevalence among low SES women remains very low. Poor women and their families need to be reached with FP information, services, and affordable options. Too often, however, public sector resources are being used by high and very high SES groups. Family planning programs are also failing to serve hard-to-reach regions and populations, such as arid areas in the North Eastern Province and urban slum dwellers. As explored in the next sections, barriers to FP access and use among the poor are varied and must be addressed through appropriate, tailored responses.

IV. BARRIERS ANALYSIS

Engage the poor | Quantify inequalities | Understand barriers | Integrate equity | Target resources | Yield partnerships

The data in the previous section make clear that Kenya’s poor are less likely to use FP services and also have the highest unmet need for family planning when compared to other groups. Further, they are less likely to benefit from the subsidized health services intended to meet their needs. Understanding the barriers the poor face in accessing services is essential for designing appropriate strategies to increase FP service access and use (see Figure 12). In response, the Health Policy Initiative sought to involve the poor in identifying barriers to FP access and use through FGDs, which were followed by further community dissemination and discussion of findings (see Section 7 and Annex 1).

To begin to understand barriers to FP service access, the project reviewed the 2003 KDHS and 2004 Kenya Service Provision Assessment (KSPA), which provide information on barriers to FP use, such as reasons for discontinuation, reasons for not intending to use family planning in the future, service/method availability, and service quality (NCAPD et al., 2005).

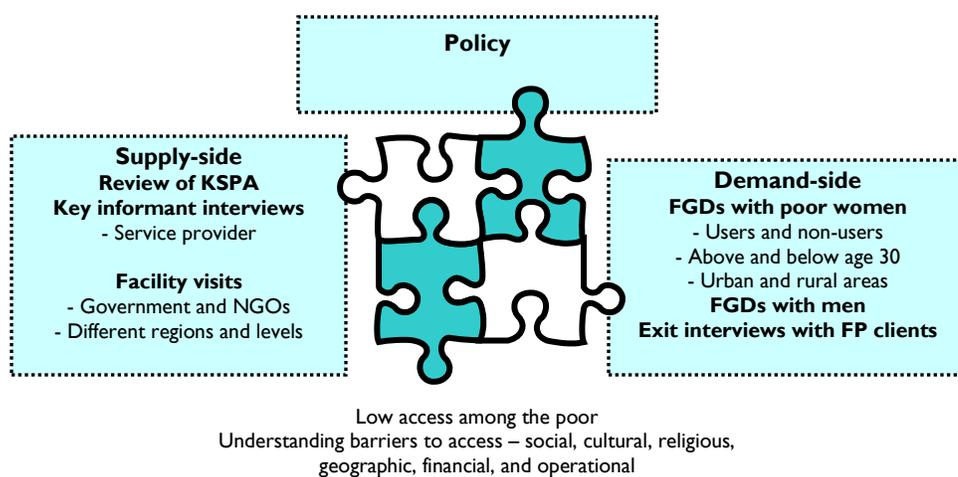
To complement this information and further explore the barriers faced specifically by the poor, in mid-2008, the project conducted a rapid assessment that sought to understand the issues behind low FP access by the poor in both urban and rural areas. The assessment focused on Nyanza Province, chosen due to its poverty level, low CPR, and high unmet FP need. In selected districts, the project conducted 33 FGDs (involving 10–15 participants each) with members of urban and rural poor populations. Participants included women under age 30, both FP users and non-users; women over age 30, both users and non-users; and men. The project also interviewed 23 FP service providers, and conducted short exit interviews with 154 clients to gather information on fees for services. Selected sites included Dienya Health Center, the Family Health Options Kenya (FHOK) Clinic in Kisumu, Kisumu District Hospital, Kombewa District Hospital, Lumumba Health Center, Marie Stopes, Maseno Mission Hospital, Migori District Hospital, and Nyanza Province General Hospital.

Key Findings

Misinformation and Misconceptions About Family Planning

Many of the focus group participants knew at least one method of family planning, and many recognized the benefits of family planning, especially for the health of women and children. Notwithstanding, many participants only knew about certain methods and were unaware of other methods, such as female condoms and implants. Despite a high awareness of some FP methods, the FGD participants and FP

Figure 12. Understanding Barriers to Access



providers noted common misconceptions about the use of family planning. These myths and misconceptions typically related to potential side effects, such as pain, infertility, or birth defects. In some cases, such beliefs were based on personal experiences but most often were based on reports from relatives or community members.

People say that users can deliver babies with two heads, and some report continuous headaches and backaches which make a woman unable to work, such as plowing the land, working in the shamba. This is the reason why I have not used, because I have to do a lot of hard work to feed my children. (Female, rural Nyanza)

I do not wish to use contraceptives because of the side effects my sister experienced. (Female, non-user, Kombewa)

Most women fear IUDs. They think it will hurt or the man will detect it or it is painful when inserted. But when we explained and some accepted to use it, they had a different experience, and their interactions with other fellow women made more to come for similar services. (Nurse, Kisumu)

Limited Male Involvement

In general, there is limited communication about family planning between spouses. Women in urban areas who use contraceptives said they do so because they were motivated by friends or nurses, not by their husbands. Moreover, spousal opposition was one of the key barriers mentioned in all the discussions. According to female and male discussants, men oppose FP use because they think women will become promiscuous, men want to have sons, or they believe having more children will ultimately add to the wealth of the family. Women who use family planning might also be seen as challenging men's authority.

The men do not like the idea of family planning because they think that when we go to the clinic, we go to hide so that we may be promiscuous. (Female, urban Nyanza)

When a woman unilaterally decides to use contraceptives without informing me, it means she is undermining my authority. (Male, urban Nyanza)

Many [men] are influenced by the peers who do not understand the need for family planning. They think that when their wives use contraceptives, they will no longer be able to have children. Some tend to think that having many children will enable them to become wealthy. Some people want to have children of both sexes, particularly when they only have girls. (FP provider, Nyanza)

Sociocultural and Religious Barriers

The preferences for large families and for sons are deeply held beliefs among members of the community, not only among men. For some men, there is a competition within the community to have larger families as this is believed to be a sign of strength and virility of the man and also of the family's wealth, as well as a guarantee that the family lineage will continue. Women report that mothers-in law support the belief that wives are meant to bear children for their sons. Women also said that having many children, especially sons, is a way to ensure their position or authority within the family and to keep their husbands from taking on additional wives.

When you have children, a man can no longer threaten you. (Female, rural Nyanza)

Many discussants mentioned religion as a barrier, a fact supported by the 2003 KDHS, in which 28 percent of the poorest women said that religious opposition is the main reason for non-use of family planning. Both Christian and Muslim discussants said that their religions prohibit FP use.

It is prohibited in Islam, so I cannot support it. (Male, urban Nyanza)

God forbids the use of contraception. It is like killing or a form of abortion. (Older female, rural Nyanza)

In some cases, discussants said that religious leaders are coming out in support of family planning and using references to religious teachings to support this view. For example, religious beliefs recognize that food comes from God, but that availability of food has limits. Thus, Christians are encouraged to use wisdom in their reproduction. Similarly, in Islam, it is desirable to have only the number of children for which one is able to care.

Costs and Frequent Stockouts

Costs for services include travel costs, lost wages or lost time for non-wage earners, costs for child care, and fees for services. The distances to health facilities are particularly prohibitive to residents of rural areas.

Because to go to the health post is so far, we don't have money to go. Women also do not have time to go. (Female, rural Nyanza)

Costs are burdensome for poor women because of frequent stockouts of commodities. Women reported frustration at having to pay travel costs, lose wages, plead with neighbors to watch their children, and/or take time away from their daily chores, only to reach the facility and learn that the FP commodities or other needed supplies are unavailable. Some poor women reported usually having only one day in a week (normally, on market days) to access FP services; and, should there be a stockout, the chances that they will come back is very slim.

However, distance and travel costs were not a barrier for all discussants, as some reported choosing to go farther to receive the services they want or to protect their confidentiality and avoid being seen by members of their own community.

Some of the providers have loose mouths. You go to the center to get services and the next day you hear people discussing about you in the market. (Young female, user, rural Nyanza)

Participants in the FGDs also reported having to pay fees for services. According to Kenyan government policy, FP services in government facilities are to be provided for free, as are government-supplied FP commodities distributed by private and NGO providers. However, clients might have to pay registration costs, fees for medical tests, and, in some cases, fees for commodities and other hidden fees, which are not uniform across providers or even within the same facility. Most public health facilities reported that oral pills are free but that Norplant, IUDs, and injectables incur costs.

Similarly, client exit interviews revealed that the public, faith-based, and NGO facilities all charge for FP methods and commodities. Out of the 154 clients interviewed, 94 (61%) had paid for the FP services, including 76 people who had accessed government facilities, which are supposed to offer free services. Of those who had to pay for services, 43 percent paid Ksh. 50 or below, 26 percent paid Ksh. 60–100, and 32 percent paid more than Ksh. 100.⁵

Provider Behavior

Some discussants reported poor provider-client interactions, including limited counseling on available FP options and side effects and condescending or unfriendly language. Providers also reported being

⁵ Percentages add up to more than 100 percent due to rounding.

overwhelmed by staff shortages and heavy workloads. In such cases, a provider noted, it is easier to provide the method the client asks than to initiate a full counseling session. Even so, discussants in urban areas mentioned generally having good provider-client interactions.

Summary

The FGDs, provider interviews, and client exit interviews identified key barriers such as misinformation and misconceptions, lack of constructive male engagement, sociocultural and religious beliefs, hidden costs for services, frequent stockouts, and provider bias and inadequate quality of care. These barriers suggest a need to adopt both demand-side strategies—to alleviate fears and misconceptions and encourage demand for family planning—and supply-side strategies—that increase the availability, affordability, and quality of services. Moreover, the government should take steps to improve the targeting and implementation of strategies, such as the fee waivers and exemptions, to reach the poor as intended.

V. POLICY ANALYSIS

Engage the poor | Quantify inequalities | Understand barriers | **Integrate equity** | Target resources | Yield partnerships

International and national frameworks the world over call for alleviating poverty, in general, and meeting the health needs of the poor, specifically. Yet, the lack of clear-cut, pro-poor policies and strategies may lead to the 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 conducted a desk review of policies and related documents and studies. Highlights from the review are summarized below.

1967–1978: Launch of the National FP Program

In 1967, Kenya adopted its first national population policy and launched the national FP program. The government sought to integrate family planning into national and subnational programs by creating maternal and child health/family planning units. FP activities were initiated mainly in areas that had adequate health services; thus, the approach was facility based and depended on clients going to fixed service delivery points (ILO, 1972). The MOH was the lead FP service provider (Oucho and Ayiemba, 1989), supplemented by the Family Planning Association of Kenya (FPAK).⁶ Development plans called attention to the high population growth rate (1966–70 plan) and issues such as high unemployment, diminishing levels of domestic savings, and pressure on social services (1974–78 plan). External funding supported a slow but steady increase in the number of facilities providing family planning. However, by the mid-1970s, donors had come to consider President Kenyatta's backing for population control and family planning to be weak (Krystall et al., 1975; Ajayi and Kekevole, 1997).

1979–1989: Innovative Service Delivery Models

The 1979–83 National Development Plan emphasized the importance of creating attitudes that favor reduction in the average size of families through IEC activities, expanded access in rural areas, and increased recruitment and training of rural family health field educators (Ajayi and Kekovole, 1998). President Moi, who came to power in 1978, began to make public statements about the importance of population control for the nation and of family planning for couples. Donor funding increased, leading to the establishment of more service delivery points and more public education. By the mid-1980s, more than 100 organizations in Nairobi alone were engaged in population activities (Krystall and Schneller, 1987). The government formulated integrated population policy guidelines in 1984, which accorded fertility reduction utmost priority. The FP program was also enhanced and integrated in the District Focus for Rural Development Strategy. Further, family planning was promoted through mass media, particularly radio. Despite these initiatives, FP provision was still dependent on clinics and physicians.

The repeal of the Nurses, Midwives, and Health Visitors Act of 1983—which covered the training, registration, enrollment, and licensing of nurses—and other subsequent laws and regulations during this period (e.g., on the procurement, manufacture, sale advertisement, and use of contraceptives) gradually increased the availability of contraceptive methods, both through clinics and community-based distribution (CBD) programs. With time, Kenya came to be regarded as having the greatest diversity in CBD programs and activities of any country in the world (Phillips et al, 1999). The majority of CBD activities proliferated with the support of the National Council for Population and Development (NCPD)⁷ with USAID funding. CBD programs did not operate from a standardized centrally-planned initiative, but

⁶ FPAK is now Family Health Options Kenya.

⁷ NCPD is now the National Coordinating Agency for Population and Development.

rather in diverse private- and public-sector organizations. For example, some agencies ensured coverage by canvassing, while others used community depots and others by distribution through village women's groups. CBD workers could be volunteers, compensated volunteers, or paid personnel. Volunteer CBD workers were an important source of contraceptives because they were not only physically but also socially close to their clients and perceived as members of the community (Chege and Askew, 1997). This relationship enabled them to address women's need for reassurance more successfully than the paramedical staff in clinic settings could and helped reduce the social distance between the provider and client (Rutenberg and Watkins, 1997). The use of traditional health practitioners such as CBD agents is credited with significantly increasing CPR (AMREF and the Population Council, 1993).

1990–1998: A New Paradigm, Yet Fewer Resources

In part in response to the 1994 International Conference on Population and Development (ICPD) in Cairo, Kenya's *National RH Strategy, 1997–2010* (MOH, 1996) placed greater emphasis on improving service quality, meeting clients' needs and desires, and supporting reproductive rights in laws and policies. These expanded mandates were further outlined in the 1997 revision of the "Family Planning Policy Guidelines and Standards for Service Providers" (MOH, 1997), which were originally produced in 1991 (MOH, 1991). Yet, despite a more holistic paradigm, the major factor during this period was the lack of funding for FP programs. The government, following health sector reforms and structural adjustment programs in the early 1990s, adopted user fees to sustain its health programs, particularly at the subnational levels. The reaction of most CBD agencies to the reduced donor funding, apart from sharply reducing the scale of activities, has been to attempt to promote service fees and income-generating activities for CBD workers to sustain motivation and reduce drop-out rates (Karanja et al., 2005). Although income generation was a popular initiative, these efforts have been difficult to sustain and tended to divert CBD workers from their core business of supplying contraceptives. Additionally, service fees were unpopular with many CBD workers, particularly those accustomed to receiving honoraria (Ferguson, 2001).

1998–2005: A Stagnating Response

Following the ICPD, the Kenyan government prepared and adopted the *Sessional Paper Number 1 of 2000 on the National Population Policy for Sustainable Development* (Republic of Kenya, 2001). The policy acknowledged the continued unmet need for family planning; the need for quality services; and the continued rural–urban differentials in fertility, mortality, and knowledge and use of contraceptives. For the first time, the population policy contained the issue of inequalities in access and use of reproductive health services. However, this period was marked by the continued decline in funding by donors for meeting Kenya's FP needs. The decline has been attributed, in part, to increased support for HIV activities by both the government and donors; changes in donor priorities and donor fatigue; failure of the government to put FP/RH on its agenda and provide an adequate budget for it; and competition for the available scarce resources within the health sector (Aloo-Obunga, 2003). Reduced funding for family planning contributed to the collapse of services provided by the NGOs; as a result, the major source of family planning became facility-based and commercial outlets. The major evidence for this comes from the rapidly changing method mix, which shifted away from pills toward clinic-provided methods, particularly the injectable even among the poorest (NCPD 1993, 1998). The 2003 KDHS and the 2004 KSPA results sounded an alarm to the position of the FP environment, as increases in the CPR and declines in the TFR stalled.

2005–Present: Seizing Opportunities

During the mid-2000s, FP champions within the government and civil society played an important role in beginning to expand the policy space through advocacy activities. For example, the POLICY Project and its successor, the Health Policy Initiative, worked to strengthen the advocacy capacity of the DRH, Kenya

Parliamentary Network on Population and Development (founded in 2004), NCAPD, and civil society groups, such as Women Challenged to Challenge, an organization that promotes the health needs, including reproductive health, of women with disabilities. Advocacy by POLICY and in-country partners contributed to achieving the first budget line for FP/RH in the national budget, making it possible for advocates trained by the Health Policy Initiative to advocate for increased FP/RH funding. As a result of this sustained engagement, the amount allocated through this budget line rose from Ksh. 200 million in 2005 to Ksh. 500 million in 2009.

Until recently, Kenya also did not have a national RH policy to provide a framework for the implementation of a comprehensive RH program. In 2004, the MOH and the RH-ICC—a multisectoral coordinating body under the DRH—asked POLICY and, subsequently, the Health Policy Initiative to lead the preparation of a national policy on reproductive health. POLICY began helping the MOH draft the *National RH Policy* in 2004. The Health Policy Initiative later provided technical and financial assistance to finalize the policy and facilitate its adoption. In October 2007, the MOH approved and adopted the country's first *National RH Policy*, which was launched officially in July 2008. With the theme “Enhancing the Reproductive Health Status for All Kenyans,” the policy provides a framework for delivery of high-quality RH services throughout the country. Key emphases include creation of sustained demand for family planning, contraceptive commodities security, constructive involvement of men in FP programs, promotion of community and private sector participation in provision and financing of services to expand access, and strengthening of the RH service delivery system at all levels.

Summary

Key challenges have been the limited resources for family planning, in general, and lack of clear articulation of how to finance FP services for the poor, in particular. Kenya's initial FP program strategy made no specific mention of the poor and, though Kenya has been touted to have had a strong FP program, there have been large inequalities in the placement of services. While in the 1980s–90s, the NGOs played a greater role in the expansion of services, the arid Northern part of Kenya remained underserved. CBD programs, while in operation, mainly targeted poor women in the rural areas, largely omitting the urban poor. Some efforts can be said to have focused on the poor, in accordance with the public sector's mandate to serve people whose access to preventive and curative health services depends on subsidies and assistance. For example, the government policy is that no user fees be charged on contraceptive commodities even if the services are sought in the private for-profit delivery points. Nevertheless, the 2004 KSPA revealed that a number of service providers still charged some fees, although they reported that these fees cover the cost of consultation. Moreover, the First Medium Term Plan (2008–2012) (Republic of Kenya, 2008) of *Vision 2030* has not made any provision for FP/RH programs despite national socioeconomic development hinging on poverty reduction, elimination of social inequalities, and reduction in high population growth.

VI. FINANCING ANALYSIS

Engage the poor | Quantify inequalities | Understand barriers | Integrate equity | **Target resources** | **Yield partnerships**

Resources and program efforts often fail to reach those in greatest need. International experience has shown that the poor have worse health outcomes than the better-off; they use health services less; and government health expenditures tend to benefit the better-off more than the poorest groups (Marmot, 2007). For example:

- According to DHS data in 24 countries (2001–2004), the poorest groups constitute less than half of the public sector FP service clientele.
- A study of seven African countries found that government healthcare expenditures were 2.5 times more likely to benefit the wealthiest quintile than the poorest quintile (Castro-Leal et al., 2000).
- An analysis of 47 countries revealed that inequalities in access to FP and maternal healthcare services were highest in countries with low and moderate service use levels—pointing to the need to simultaneously expand services *and* promote equity (Health Policy Initiative, 2007).

While overall improvements in healthcare systems are desirable in most developing countries, experience has shown that health interventions will not reach the poorest groups without appropriate planning, targeting, and oversight (Gwatkin, 2004). Specific steps must be taken to first identify the poor, understand their needs, and assess the barriers to service use that prevent the poor from seeking and obtaining services. Governments should integrate pro-poor approaches and formulate targeted, pro-poor policies and plans as the foundation of appropriate programs. “Targeting” directs scarce resources to those most in need (POLICY, 2003). A “pro-poor” approach means that mechanisms are in place so that healthcare costs are based on the client’s ability to pay; the poor and nearly poor are protected from financial calamity due to a severe illness; and measures are taken to improve equitable access—both in terms of quality and the geographic distribution of services (Bennett and Gilson, 2001).

Kenya faces similar challenges to ensuring that health interventions reach the poorest groups. In a parallel activity, the Health Policy Initiative investigated how budgetary planning and resource allocation functions under decentralization affect equity in resource allocation for FP and RH (Briscombe et al, 2010). The research found that the allocation of health sector financial resources remains highly centralized and opaque, and allocation decisions are made based primarily on previous years’ budget allocations rather than on health needs indicators. Equitable or fair resource allocation can only be accomplished by considering variation in needs across geographic and economic groups. The Health Policy Initiative’s research revealed that the allocation of health sector funds in Kenya has not accounted for differences in health status, service access, or provision costs across regions, provinces, and districts.

This section provides an analysis of the extent to which current programs create financing mechanisms that enhance or constrain FP/RH access for poor and vulnerable groups. It is based on a review of the literature and project experience in Kenya. Although the national poverty level is about 46 percent (KIHBS 2006), the poor constitute only 26 percent of public health sector FP clientele. However, Kenya has implemented a number of demand- and supply-side financing mechanisms that seek to increase access to FP/RH services among the poor. These include cost-sharing programs, waivers and exemptions, a National Health Insurance Fund, and a pilot Output-Based Approach. A brief discussion of the private sector explores the potential of Kenya’s private sector in responding to increased demand for FP services.

Cost-sharing Program

The combined effects of the increasing demand for health services and the declining amount of real public resources led many governments in the developing world to explore various health financing alternatives. Faced with a significant decline during the 1980s in its real per capita expenditures, the Kenyan government implemented Structural Adjustment Programs, including the introduction of cost sharing in the health and education sectors. The MOH initiated the cost-sharing program in December 1989 as part of a comprehensive health financing strategy that also included social insurance, efficiency measures, and private sector development. The ministry adopted the cost-sharing program in public health facilities to (1) mobilize additional resources to supplement non-wage recurrent spending; (2) reduce unnecessary use of services; (3) enhance efficiency in the operation of the referral system; (4) pool revenues to subsidize those unable to pay; and (5) introduce competition in the sector to catalyze quality (Collins et al., 1996).

Implementation problems at early stages of the cost-sharing program led to the suspension, in September 1990, of the outpatient registration fee, the major revenue source at the time (Collins et al., 1996). In 1991, the MOH initiated a program of management improvement and gradual re-introduction of an outpatient fee that was re-named as a “treatment” fee. The new program was carried out in phases, beginning at the national and provincial levels and proceeding to the local level. In contrast to the significant fall in revenue experienced over the period of the initial program, the later management improvements and fee adjustments resulted in steady increases in revenues.

The benefits of the cost-sharing program in terms of revenue collection must be weighed against concerns that user fees may not be affordable and, thus, could deny the poor and other vulnerable groups access to health services at public health facilities. Studies on user charges have shown that the poor are relatively more sensitive to price increases than wealthier groups (Gertler and Van der Gaag, 1990; Mbugua, 1993). According to Gertler and Hammer (1997), public sector fee increases reduce access more in rural areas, where there are fewer private alternatives. Several studies conducted in Kenya to assess the impact of user fees on utilization of healthcare services suggest that the cost-sharing policy worsened the existing inequalities in access to health services by preventing vulnerable groups from seeking appropriate healthcare (Quick and Musau, 1994; Mwabu and Wang’ombe, 1995; Huber, 1993). One study found that the 1989 outpatient registration fee led to an average reduction in use of 27 percent at provincial hospitals, 45 percent at district hospitals, and 33 percent at health centers (Mwabu and Wang’ombe, 1995). The 1996 Kenya Participatory Poverty Assessment found that user fees made visits to the government facilities prohibitively costly as the poor were required to make payments to reach the registration table, instead of being granted waivers. User fees, if not appropriately targeted to those who can afford to pay, exclude the poor from accessing healthcare services (Owino and Were, 1998).

Waivers and Exemptions

The government introduced waivers and exemptions (W&E) as a safety net for the poor and other vulnerable groups who could not afford the charges levied at public health facilities. At the onset, exemptions were intended to be automatic and apply to certain categories of patients or population groups. Exemptions were initially provided for children (0–5 years); health conditions such as sexually transmitted infections, including HIV, tuberculosis (TB), and leprosy; psychiatry; prisoners and those under police custody; traffic accident victims; civil servants; and destitute and patients from charitable institutions (Collins et al., 1996). With time, in terms of patients covered, the exemption list was narrowed down to about four categories: children under 5; TB patients; prisoners; and referrals from charitable institutions (Owino and Were, 1998). Waivers were intended for the low-income poor—to be granted on the basis of financial needs criteria. These assessment criteria for the low-income poor were largely determined at the community or facility level.

Implementation of W&E is characterized by a number of difficulties (see Box 3). At the local level, lack of awareness and information on the system led to weak commitment and limited implementation by staff. Due to inadequate involvement of all stakeholders in the system's formulation and limited advocacy or training regarding the importance of W&E, commitment to and understanding of the objectives of the policy change by facility staff were lacking (Owino and Were, 1998). For example, one study found that, less than half of providers were aware that antenatal care services were exempt from user fees for all clients (Sharma et al., 2005). Clients also had limited knowledge of available programs. One study (Quick and Musau, 1994) found that only 27 percent and 16 percent of the outpatients at the district hospitals and provincial hospitals, respectively, reported being aware of the W&E system. At the national level, leaders were not aware of measures set up to protect the poor and, thus, lacked political will to ensure accountability for implementing the programs.

Box 3. Stakeholder Perspectives on the W&E System

In 2007, the Health Policy Initiative, in collaboration with the MOH and Health Financing Task Force, organized a forum to deliberate on poverty and access to healthcare services in Kenya. Participants at the forum (including the Central Bureau of Statistics, NCAPD, Ministry of Finance, National Health Insurance Fund, development partners, researchers, representatives from the civil society) raised the following issues related to the administration of W&E in public health facilities:

- Difficulties in identifying the poor people that should be targeted for services, owing to varied definitions of poverty across communities
- Lack of community involvement in identification of the poor, rendering the system prone to abuse and manipulation by the politically connected at the expense of the poor
- Lack of community awareness of the existence of W&E and services available for the poor and vulnerable
- Lack of support and negative attitudes by the providers, which hinder consistent implementation of the system
- Cumbersome, costly administrative procedures that hinder implementation of the W&E system

National Health Insurance Fund

In 1966, an act of Parliament established the National Health Insurance Fund (NHIF) to create a compulsory hospital insurance fund to which employed persons earning Ksh.1,000 (~\$12) or more per month would make contributions and out of which benefits toward the healthcare expenses of the contributors and their dependants would be paid; this scheme does not cover the poorest populations. Over time, a series of amendments to the original act have been passed to accommodate changing healthcare needs of the Kenyan population, employment trends, and restructuring in the health sector. For example, in 1972, the government incorporated voluntary membership and, in 1990, introduced contribution on a graduated scale of income. In 1998, the old act was repealed and in its place the NHIF Act of 1998 was created with several new provisions. This piece of legislation currently governs the fund's operations, making it more efficient and responsive to the healthcare needs of Kenyans. It also transformed NHIF into a state corporation, de-linking it from the MOH, where it was formerly a government department.

The NHIF Act is intended to make provisions for inpatient and outpatient benefits. However, the current fund only provides for inpatient coverage and is undertaking actuarial studies to determine the feasibility of outpatient coverage for its members. Under the inpatient scheme, NHIF pays benefits to accredited hospitals and health providers on behalf of its members and their declared beneficiaries (spouses and children) who are admitted to accredited hospitals. Benefits payable cover part of hospitalization daily expenses incurred at approved daily rebate(s) that range from Ksh. 400 (~\$5) to Ksh. 2,000 (~\$25).

The fund is mandated, under the new Act, to invest funds in programs aimed at improving the quality of healthcare in the country. Both public and private hospitals are intended beneficiaries. The strategy on NHIF reimbursements is based on the rationale that user fees promote exclusion of the poor in access to health services and, hence, the fund aims to address this problem by trying to protect the poor and increase their access to high-quality health services. The current system of cost sharing in the health sector is based on the assumption that the majority of people can *afford* to pay medical care at the *point* and *time* of treatment. There are two major problems with this assumption. First, it is not realistic to assume that people can afford to pay at the time of treatment in a country where about 46 percent of the population lives below the poverty line (2006 KIHBS). Second, the cost-sharing system discourages people (the poor included) who can contribute to health insurance before illness occurs from making such contributions.

Although NHIF reimbursements to hospitals have provided a new source of funds directed toward the improvement of the quality of services in public hospitals, there are concerns that the poor have not benefited as intended. A survey by the MOH revealed that hospitals were the providers of choice for all the population segments seeking inpatient care. However, individuals in the highest quintile of the population have higher levels of use of both government and private hospitals (80% and 16% of the admissions in this group, respectively). Among individuals in the poorest quintile, the utilization rate of government and private hospitals were lower (49% and 7% of admissions in this group, respectively). Lower use of public hospitals by the poor, despite the lower fees, suggests this situation might be due to various reasons that include inability of households to pay (MOH, 2003). This pattern reveals a need to develop a health financing strategy that ensures the poor have access to healthcare services.

The government is currently considering policy options (e.g., social insurance approach, National Health Service approach) to establish universal coverage of the population with a basic package of health services to minimize barriers to access (MOPHS and MOMS, 2009).

Output-Based Approach

The Output-Based Approach (OBA) is a joint venture between the Government of Kenya and the Federal Republic of Germany through KfW Bank. The OBA project aims to increase access to high-quality FP/RH services through a voucher system for economically disadvantaged women. Under this system, accredited service providers are reimbursed for services that are rendered and meet the pre-determined agreement on service quality. The approach is being piloted in three rural districts (Kisumu, Kitui, and Kimbu) and two urban slums in Nairobi (Korogocho and Viwandani). It targets about 121,600 women in rural areas and 19,000 women in urban slums.

OBA provides vouchers for three types of services: safe motherhood services, FP services, and services for survivors of gender-based violence. The vouchers are distributed by more than 70 nongovernmental, community, and faith-based organizations operating in the project areas. Eligible clients purchase a voucher for the desired service at a subsidized cost: Ksh. 200 for the safe motherhood voucher and Ksh. 100 for the FP voucher. The FP voucher can cover initial and method-specific counseling, as well as provision of the method of choice. The voucher for gender-based violence services is free. The project's design ensures that only the poor and average-income populations are eligible for the vouchers. Determination of eligibility was facilitated by a poverty-grading tool developed to identify the poor and vulnerable groups. The tool is simple enough for use at the community level, and each site defines its own poverty indicators. It grades clients on the following attributes: quality of housing, access to healthcare services, access to water sources and sanitation, cooking fuel, amount of daily income, number of meals per day, security factors, garbage disposal, and rent/land ownership.

OBA has been successful in increasing deliveries by skilled birth attendants among the poor and low income groups. Moreover, vouchers dignify the poor by providing them with better choices and promoting competition between service providers to enhance the quality of services. The uptake of FP services has been low, as family planning (at Ksh. 100 for the FP voucher) is still relatively costly for the poor. The current charges for maternal and FP services are unaffordable for the poorest segment.

The United Nations Children's Fund (UNICEF) is implementing a similar model for maternal and neonatal health services in three districts of North Eastern Province (Wajir, Mandera, and Garrisa) (UNICEF, 2007). Under this model, vouchers are provided to pregnant women to improve maternal and neonatal outcomes by reducing morbidity and mortality. The project is designed to encourage skilled deliveries in health centers and dispensaries, as well as facilitate prompt referrals in cases of complications.

The Private Sector and NGOs

One challenge for development of the private sector market in Kenya has been the availability and lower cost of public sector FP services. Between 1984 and 1989, the private sector grew by only 1 percent compared with over 14 percent growth in the public sector (Janowitz et al., 1999). However, the results of the 2003 KDHS indicate that the contribution of public sources for commodities declined from 68 percent in 1993 to 58 percent in 1998 to 53 percent in 2003. The contribution of private sources increased from 25 percent in 1993 to 33 percent in 1998 to 41 percent in 2003. The public sector is still by far the most important provider for family planning, but these services often serve the high and very high SES groups (as discussed in Section 3). The NGO sector offers an alternative source of FP services for middle and high SES groups in many countries, yet the major NGO source in Kenya seems to serve primarily high and very high SES clients (Borda et al., 2005)—similar to that of the commercial sector. The commercial sector is growing to be an important provider for all SES groups, especially the higher SES groups (Borda et al., 2005). There has been a steady increase in the commercial sector's role in providing some FP commodities, especially oral contraceptive pills and condoms. The recent growth of commercial/"paid" sources of non-prescription contraceptives has been dramatic and has not yet been captured by existing FP literature (Karanja et al., 2005). A healthcare financing strategy could potentially be designed to create incentives for the private sector to continue to augment its role in responding to FP service needs for different SES groups, including the poor.

Summary

The EQUITY Framework recognizes that when resources are limited and there are underserved groups in the population, the role of the public sector should be to target subsidies for FP services and products to those with the greatest need—that is, to groups with high fertility, low contraceptive use, and high unmet need who, in the absence of government assistance, would be unable to obtain and use family planning. Gertler and Hammer (1997) outlined four types of targeting mechanisms through which the government can maximize healthcare outcomes and re-distribute subsidies toward the poor: (1) individual price discrimination based on means testing (verification of income levels); (2) geographical targeting that allocates resources to facilities closer to where the poor live; (3) differential pricing by level of service and self-selection (so that different levels of service are priced for different segments of the population); and (4) indicator targeting in which insurance status can be used as an indicator of ability to pay.

The reality in Kenya is that the government and its partners continue to disproportionately devote resources to relatively wealthier populations rather than to those who are poor or hard to reach. It is necessary to target resources to reach areas of extreme poverty, such as provinces in the outer band of the country and the dry (and poor) northern region. Similarly, there is a need to allocate resources to areas with pastoralist populations and to the urban slums in major cities. The country should also design a

healthcare financing strategy to ensure financing for the poor as well as strengthen and monitor the implementation of existing W&E policies. Finally, the country must foster a “total market approach” that takes advantage of resources in the public, private, and NGO sectors to ensure that the government and/or subsidized NGOs and private sector services cater to the needs of the poor, while clients who can afford to pay for services seek family planning options in the commercial sector. The public sector by itself cannot and should not be expected to fill the FP financing and service delivery gap. Indeed, each sector—public, private, NGO, social marketing—has an important role to play.

VII. INFORMING POLICY DIALOGUE AND DESIGNING A STRATEGIC RESPONSE

Engage the poor | Quantify inequalities | Understand barriers | Integrate equity | Target resources | Yield partnerships

In collaboration with the DRH, Health Financing Task Force, and Working Group on Poverty and Access, the Health Policy Initiative shared the findings of the poverty, market, barriers, policy, and financing analyses to inform policy dialogue. These efforts aimed to promote evidence-based decisionmaking, engage the poor in policy dialogue, and integrate equity goals and strategies into the new *National RH Strategy*. Advocacy by the project and in-country partners for equitable strategies was an ongoing process. This section reviews some of the key policy dialogue events and impact on the national strategy.

Policy Dialogue

As noted in Section 5, Kenya adopted its first-ever *National RH Policy* in 2007/08, which was formulated with technical assistance from the Health Policy Initiative. The new policy, recognition of the importance of reproductive health in *Vision 2030*, and international commitments such as the MDGs all reinforced the need for a new RH strategic plan. The Health Policy Initiative has been engaged in concerted policy dialogue and advocacy with various stakeholders to place FP/RH and equity issues high on Kenya's development agenda. The project employed several approaches, including

- Fostering leadership and participation across sectors, groups, and levels;
- Helping diverse audiences achieve consensus;
- Using compelling evidence, such as the RAPID Model (NCAPD, 2010) and assessments summarized in this report, for advocacy and decisionmaking; and
- Designing action plans and operational guidelines to facilitate implementation.

Further, the project supported the DRH, Health Care Financing Task Force, Working Group on Poverty and Access, provincial RH coordinators, NCAPD, RH-ICC, and special technical working groups—on the *National RH Policy* and *National RH Strategy*—to actively engage the poor in identifying problems related to access to FP services and in exploring potential solutions responsive to the needs of the poor.

National Level

Jointly with the MOH, the Health Policy Initiative facilitated a workshop that focused on pro-poor strategies, resource allocation, and FP costing in Nairobi on December 3–4, 2008. The project shared the initial findings from the five assessments, including the Nyanza FGDs, and experiences of other countries in designing and implementing pro-poor strategies. About 30 participants from key organizations—such as NCAPD, FHOK, GTZ, World Health Organization (WHO), Population Council, and Pathfinder International—attended the workshop. The workshop provided an opportunity to share priority barriers to access among the poor and promote dialogue with policymakers on generating policy options to address the barriers. Key issues discussed included lack of male involvement, lack of culturally appropriate information and FP services at the community level, low access and use among the urban poor, regional disparities in FP services, and the high costs to the poor for accessing FP services (e.g., long waiting time, user fees, transportation costs). Potential strategies recommended included integrating equity-based goals, strategies, and monitoring into the new *National RH Strategy*; conducting advocacy with parliamentarians to increase resource mobilization for the poor; targeting approaches to underserved regions and urban slums; promoting representation of the poor in various planning and program committees; and implementing FP programs in alignment with the national poverty alleviation efforts.

On June 18, 2009—following the provincial and community dissemination meetings (described below)—the Health Policy Initiative supported the Division of Health Care Financing and DRH to organize a second high-level policy seminar in Nairobi. The project shared the complete findings from the various equity-related analyses contained in this report, feedback from the communities, and an assessment of resource allocation in Kenya (Briscombe et al., 2010). The goals of the seminar were to discuss the findings of the project’s policy- and financing-related studies and obtain stakeholders’ recommendations and inputs.

Provincial Level

The Health Policy Initiative organized provincial-level meetings in December 2008 in Kisumu, Nyanza Province, and July 2009 in Mombasa, Coast Province, to share study findings with implementers and community members in the regions. These meetings brought together regional health officials and policymakers, FP service providers, and members of the poor and their representatives. Participants

included MOH officials, RH coordinators, provincial hospital staff, community representatives, NCAPD representatives, and Marie Stopes and other service providers. Moreover, poor community members interacted with policymakers and providers and shared what they felt about family planning and service access. The workshops concluded with the participants suggesting ways in which the poor could better access FP services and information (see Box 4).

Box 4. Recommendations from the Provinces

- Promoting FP component within the community health strategy
- Developing and implementing guidelines for male engagement
 - Involve religious leaders and local chiefs
 - Make FP clinics male friendly
 - Promote couple counseling for family planning, antenatal care, and postnatal care

Community Level

Following the provincial dissemination and discussion, the project disseminated findings at the community level to the rural and urban poor in the Kisumu (Kaloleni slum), Siaya, and Homa Bay districts in Nyanza Province. Among those participating in the meetings were poor women (both users and non-users of FP), men, government officials religious leaders, health service providers, and community health workers. Through these forums, the poor shared their views toward FP use and ways to improve service access. As summarized in Annex 1, the community meetings provided an opportunity to disseminate the findings; explore reactions from community members; and promote dialogue among the poor, their representatives, providers, and local religious and community leaders.

To raise awareness of family planning in communities, participants recommended the following:

- Involve both men and women in FP programs
- Mobilize churches, mosques, and community elders for FP promotional activities, including activities to reach men
- Carry out health education at the community level through community health workers (CHWs) with the help of the provincial administration
- Re-train CHWs, because the knowledge they have is often outdated and much has changed since their last training
- Conduct community outreach activities so as to reach the poor in their homes
- Adapt the approaches used for HIV and AIDS to discuss and create awareness about family planning
- Perform FP skits to help spread the word about the importance of using family planning
- Organize additional forums where women, men, and the provincial administration can discuss key issues and concerns

To improve FP uptake and service quality, participants recommended the following:

- Re-energize the CBD program and inform the community about FP availability at the community level
- Provide free access for FP services, with no user fees charged for the poor
- Design FP strategies to involve and reach people with disabilities
- Provide proper nutritional support as a means of encouraging FP use and helping to ward off side effects
- Bring health facilities closer to the people, especially the poor—for example, by establishing FP clinics in poor neighborhoods to help them save on transport costs
- Improve FP commodity supply at the health facilities
- Make more longer-term methods available at all facilities
- Improve relationships between the service providers and community members, and encourage service providers to give detailed information about the FP method chosen by the client

The project shared the community feedback with national stakeholders at the July 2009 meeting in Nairobi. To further promote dialogue, the Health Policy Initiative also produced a video documentation of the activity to show how the project and in-country stakeholders engaged the local communities, regional stakeholders, and the poor in FP/RH policy advocacy and dialogue (see Box 5).

Box 5. Video Documentation



In 2009, the Health Policy Initiative produced the video, “Kenya: Improving Equitable Access to Family Planning.” The 17-minute video presents data on family planning use in Kenya, with an emphasis on equity issues. It also includes interviews with project staff, in-country stakeholders, and participants in the community dissemination and dialogue meetings. The video is available via the Health Policy Initiative’s website at: <http://www.healthpolicyinitiative.com/index.cfm?id=videos>.

Incorporating Equity into the National RH Strategy

The analyses summarized in this report and the national, regional, and community-level dissemination meetings infused equity concerns into the collaborative process of developing the *National RH Strategy*—to which many individuals and organizations contributed under the leadership of the multisectoral RH Strategy Task Force. This approach helped to effectively engage the poor in policy dialogue and generated ideas about policy options to better target services and resources to the poor. As a result of the Health Policy Initiative’s technical support to the government—especially the Working Group on Poverty and Access and the special working group on the national strategy—the *National RH Strategy*, for the first time ever, includes quantifiable equity objectives and specific strategies for reaching the poor. Based on health needs, historical trends, and consideration for what could reasonably be achieved with stepped up efforts over the next five years, the government outlined the following equity-related objectives, indicators, and interventions:

Equity objectives:

- Address the special RH needs of the poor, hard-to-reach, and other vulnerable populations
- Reduce unmet need for family planning, unplanned births, and socioeconomic disparities in contraceptive prevalence rate

Equity indicator:

Increasing equitable access to reproductive health services

- CPR among the poor increased by 20 percentage points from 12% by 2015

Pro-poor interventions:

- Carry out an assessment of RH needs and service availability for hard-to-reach populations
- Support research that seeks to understand social and cultural determinants of non-use and unmet need for family planning among various social and economic groups to advocate for and promote evidence-based interventions
- Advocate for strategies to reduce inequities in access to reproductive healthcare
- Review/update policies and regulatory mechanisms in order to ensure that they facilitate universal and equitable access to FP education, information, and services
- Design strategies for improving equity in access to reproductive healthcare for hard-to-reach populations; these may include establishment of innovative outreach services compatible with their lifestyles and use of e-health technologies
- Use participatory approaches to work with communities, public and private sector institutions, and nongovernmental organizations to overcome barriers and promote appropriate use of available services
- Support community-based distribution to overcome social and geographic barriers to family planning particularly in rural and remote areas
- Mobilize civil society to advocate for family planning in disadvantaged communities
- Shift resources from relatively well served areas to areas of extreme poverty (poverty mapping) like North Eastern Province, Nyanza Province, and the dry (and poor) northern parts of the country. Similarly, shift resources to arid areas and to areas with pastoralist populations and to urban slums in major cities.

These goals link well with the Social Pillar component of *Vision 2030*, which is intended to address social equity and poverty reduction issues and promote poverty-reduction programs as part of the country's development agenda. In July 2009, national stakeholders, including the RH-ICC and provincial-level MOH personnel, endorsed the *National RH Strategy*. The Principal Secretaries of the health ministries (MOPHS and MOMS) subsequently approved the strategy, which was officially launched on April 22, 2010, in Nairobi. Integrating equity goals and interventions into Kenya's national strategy is a positive step forward and one that must be followed up with implementation, resources, and monitoring mechanisms.

VIII. CONCLUSION

Policy challenges and opportunities vary depending on the policy environment of a particular country. Before policy reforms can occur, policymakers must recognize that a problem or potential problem exists and must understand the implications of the problem for program effectiveness. In Kenya, the Health Policy Initiative and partners followed a systematic, evidence-based, country-driven process to develop a strategic response for addressing key barriers to FP access among the poor. This process was guided by the project's EQUITY Framework. The project organized policy dialogue and planning meetings to bring stakeholders together and reach a consensus on taking action to improve access among the poor and to define and debate the merits of emerging strategies. The in-country counterparts, including the poor, were fully involved in the process and provided insights on the broader context of health, development, and policy reforms. Policy dialogue helped build consensus, ownership, and commitment within the MOH and, more broadly, within national and regional partners.

Engaging and empowering the poor. To actively engage the poor in the policy process, the project and partners adopted a phased approach, including

- Creating the Working Group on Poverty and Access to oversee the process and provide recommendations on how to include the income poor and vulnerable groups into healthcare financing strategies;
- Engaging the poor through focus groups in Nyanza Province to define poverty and identify barriers to FP access, reasons for non-use, and potential solutions;
- Disseminating findings and encouraging dialogue between the poor and provincial and local leaders and service providers in the Nyanza and Coast provinces; and
- Collaborating with national stakeholders and decisionmakers to ensure that the deliberations contributed to the formulation of the *National RH Strategy* and subsequent DRH annual operational plans.

Quantifying the level of inequality in healthcare access and health status. The market analyses revealed that poor women in Kenya have higher fertility and are least likely to achieve their desired fertility. They have the highest unmet need for family planning and highest intention to use family planning in the future. Family planning programs are also failing to serve the poor and hard-to-reach regions and populations, such as arid areas in North Eastern Province and urban slum dwellers.

Understanding the barriers to service access and use. Involving the target population in identifying the barriers to seeking and receiving healthcare and how to resolve those barriers ensured that the solutions would ultimately address their needs. The FGDs, provider interviews, and exit interviews identified key barriers such as misinformation and misconceptions, lack of constructive male engagement, sociocultural and religious beliefs, hidden costs for services, frequent stockouts, and provider bias and inadequate quality of care.

Integrating equity goals into policies, plans, and strategies. Multiple policy and financing interventions are needed to meet the needs of different segments of the poor population and would be sustainable in the long run. The project supported two-pronged policy interventions that (1) incorporated equity goals, pro-poor strategies, and equity-based monitoring and evaluation indicators in the *National RH Strategy*; and (2) linked the family planning to poverty alleviation and development programs and agendas as outlined in *Vision 2030*. As a result, the *National RH Strategy* calls for addressing the special RH needs of the poor, hard-to-reach, and other vulnerable populations and includes a specific, time-bound indicator, which is to increase modern contraceptive use among the poor by 20 percentage points by 2015 (up from 12% in 2003).

Targeting resources and efforts to reach the poor. The poor in Kenya account for only about one-fourth of the clients of public health facilities. And, the reality is that the government and partners continue to disproportionately devote resources to accessible populations rather than those who are poor or hard to reach. Possible recommendations include (1) implementation of a targeted approach to improve access to family planning in selected regions and urban poverty pockets, (2) development of a comprehensive health financing strategy to ensure financing for the poor, and (3) support for stronger implementation and monitoring of existing programs, such as W&E policies (see Box 6).

Box 6. Targeting Efforts and Resources: Proposed Interventions

- Design targeted interventions for poverty pockets, slums, and other underserved regions
- Design and implement interventions for target groups (e.g., urban poor, men, people with disabilities)
- Ensure equitable allocation of resources

Yielding public-private partnerships for equity.

Kenya's public sector by itself cannot and, indeed, should not be expected to, fill the FP financing and service delivery gap. Indeed, each sector—public, private, NGO, social marketing—has an important role to play. The country should foster a “total market approach” that takes advantage of all sectors to ensure that the government and/or subsidized NGOs and private sector services cater to the needs of the poor, while clients who can afford to pay for services seek FP options in the commercial sector. To help put the *National RH Strategy* into practice, there is a need to design selected public-private partnership models and policies (e.g., accreditation, payment structures) in priority areas, targeted to meet the needs of the rural and urban poor. The Health Policy Initiative, in September 2009, facilitated a south-to-south exchange to share lessons learned from the USAID-funded private sector project in India⁸ with stakeholders in Kenya and members of the East, Central, and Southern Africa Health Community through face-to-face meetings and presentations. Contracting out non-clinical services and social franchising are potential interventions for Kenya. The country should also explore innovative models with NGOs—such as community-based distribution, which worked well in Kenya in the past—to reach underserved populations.

For the poor, lack of access to family planning and continued high fertility can mean fewer resources (e.g., money, time, food) for each child, leading to poor nutrition, ill health, and limited educational opportunities—ultimately trapping this group in a poverty cycle. For the society, continued rapid population growth will hamper Kenya's ability to meet the needs of its citizens and attain its health and development goals, such as those contained in the *Vision 2030* and MDGs. Integrating equity goals into Kenya's *National RH Strategy* is a positive step forward. A range of policy and financing initiatives should be implemented to ensure that the poor have equitable access to FP/RH services. No single strategy or program will expand access for all the poor and vulnerable groups in Kenya, underscoring the need to address poverty and equity from multiple angles, as demonstrated in the EQUITY Framework. Doing so will not only benefit the poor but also the society as a whole.

⁸ The USAID-funded Innovations in Family Planning Services II Technical Assistance Project (ITAP) implemented by Futures Group.

ANNEX I. COMMUNITY DIALOGUE MEETINGS

This annex summarizes issues raised during the community dialogue forums in Kisumu (Kaloleni Slum), Siaya, and Homa Bay. Recommendations emerging from the discussions are presented in Section 7.

Kisumu (Kaloleni Urban Slum) Community Dissemination and Dialogue

The participants in the community dissemination meeting in Kaloleni included CHWs, women, men, a Christian leader, and Muslim leaders. In reacting to the FGD findings, participants said that they have heard about side effects of FP use such as excessive bleeding and high blood pressure. Some women also attributed not having their menstrual flow and developing asthma as a result of FP use. For some women, the expenses involved in seeking FP services discouraged them. These expenses included charges for medical tests and transport costs. Some men confessed to not approving of family planning because they wanted more children. According to men, most women would rather seek FP services without informing them, resulting in mistrust within couples. They concurred that their faith did not approve of FP use and that use of condoms was not encouraged in communities, especially with wives.

Muslim religious leaders denied that religion was against FP use. In fact, for them, religion provides guidance to ensure that mothers and their children remain healthy. They did note, however, that the religion does not encourage use of modern methods, such as pills and injectables. According to Muslim leaders, it is desirable that one has the children that one can take care of; Islam advocates for healthy feeding of infants and encourages breastfeeding for at least two years. These measures encourage birth spacing and good health for the mother and child before the next conception. Islam also stresses the agreement between a man and his wife to find a way to ensure the health of the mother is maintained even after child birth. Traditionally, safe days and breastfeeding would be used to promote birth spacing. Similarly, the Christian leader said that in the book of proverbs, Christians are advised to use wisdom in their reproduction. In this case, it is up to the couple to decide which method they want to use; however, it would be ideal if they did not use a method that has side effects.

Participants noted that dissemination of FP information to the community had largely targeted women and totally left out men who are the primary decisionmakers in the homes. For the urban poor, there are many competing needs for the limited resources; and, as a result, family planning is not viewed as urgent. CBD workers are no longer supported to provide FP services at the community level and, thus, people do not always have access to FP commodities, which hinders uptake among non-users and leads to discontinuation among users. Participants living with HIV reported experiencing stigmatizing behavior from providers at FP access points, and, therefore, they avoided the clinics. Some of the HIV-positive women reported that with tuberculosis (TB), they could not use family planning, even though they would like to, as it might interfere with the TB treatment.

Siaya District Community Dissemination and Dialogue

Uranga and Boro Rural Poor

Participants in this meeting included about 20 people, including women, service providers at health facilities, CHWs, and men. Research findings were shared with the participants, who gave the following reasons to explain why they do not use family planning:

- Side effects including heavy bleeding or no menstrual cycle
- Male opposition
- Cultural issues and opposition from the Catholic Church and some traditional religious groups

For others, lack of enough food discouraged FP use, as some participants believed that they need to eat well to use FP services, as they are advised about the importance of proper nutrition when seeking antiretroviral treatment for HIV. Participants attributed male opposition to lack of exposure to other cultures and ways of life. Some reported that when women use family planning without their partners' knowledge, it serves to anger the men and, therefore, the men feel that they should act to show who is in control. Some participants argued for traditional FP methods, such as the safe days method and breastfeeding, which they said are acceptable to some churches.

According to participants, women who use family planning are stigmatized and regarded as prostitutes, and other community women are discouraged from associating with them. CBD workers also face challenges at the community level when they talk about family planning. They are often insulted, and some men even become violent when CBD workers are found talking to their wives. Women who use FP also complained of inadequate advice by service providers. One respondent reported being informed by the service provider that she would not become pregnant even without a method because the effects of the previous dose had not worn off. Also, the facility was out of supply of her preferred method. The woman did not receive the injectable method, did not seek an alternative, and ended up becoming pregnant. Thus, community members said, service providers do not inform clients about alternative methods, especially long-term methods such as Norplant and IUDs.

Health service providers at the meeting informed the participants that they wish to educate clients on other methods, but they are faced with severe staff shortages and heavy demands on their time for other services that are equally important and need attention. One provider reported being expected to provide services throughout the health center. In such cases, it is easier to give the method the client is asking for than it is to provide counseling on other methods. One nurse informed the participants that they should request to be told about other methods available and the side effects associated with them, as well as be informed to come back to the facility should they experience adverse effects of the FP method received. Some participants reported not going back to the facility once they experienced side effects.

Ugunja

A total of 35 participants took part in the Ugunja meeting, including women, men, and service provider at the community and facility levels. A number of women were eager to know more about family planning. In response to a question about low/non-use, the participants offered these reasons:

- Side effects and medical complications, such as back pains, loss of sexual desire, ulcers, abdominal pains, and itchiness in the lower reproductive tract.
- Most FP information comes from peers and friends, which may be distorted.
- FP use involves fees that the community members cannot afford.
- Geographical location of health facilities is not conducive for the rural poor; the health facilities are far away and family planning is not considered an emergency issue to warrant the journey.
- Nurses do not give enough support or advice in preparing clients for the FP methods given.
- Cultural norms encourage large families and male-child preference.
- Family planning is perceived to encourage promiscuity among women.
- FP use encourages polygamy with men wanting more children.
- Male opposition.
- Women are not open about what they want; as a result, men wait for the women to take the lead, but they do not and, thus, FP issues are not discussed by most couples.

Homa Bay District Community Dissemination and Dialogue

A total of 38 participants attended the dissemination and dialogue meeting in Homa Bay. Participants included poor women, men, and service providers at the community and facility levels. The community

understanding of family planning involved a description of spacing and determining the number of children a couple one would like to have. Participants were aware of different methods of family planning, and men at the meeting were able to identify different options available, even mentioning vasectomy.

Participants narrated various experiences with family planning:

My wife asked me if she could use an FP method but I refused, because a friend had a girlfriend who became pregnant in school and she delivered and was later put on an FP method so she could not conceive again in school. After school, they got married and have been unable to have a baby since! So I cannot allow my wife to use. (Male participant)

I have been sterilized, [by tubal ligation], and I have not experienced any side effects except during the recovery period where you are prone to fungal infections. I believe there should be more education on family planning. (Female participant)

Parents are the cause of most problems experienced today. This is because they take their school-going children for FP injections to prevent them from becoming pregnant. They do this through use of “quacks” or through some nurses who are only ready to receive money from such parents. (Service provider)

My husband was urged to marry another woman because I was not bearing enough children; they accused me of using family planning. I am regarded as an outcast in the community because I have only three children. (Female participant)

Sometimes you go to the clinic and have been on the injectable. You expect another shot, only to be told they are out of supply. The nurse will advise you not to worry since you can be safe even up to three months, is this true? (Female participant)

*Family planning does not just mean that you space births, but also that you have a good life and that will be determined by the overall number of children that you have. Family planning for our community needs very deep understanding, one needs to understand how it will help. I know my peers who have six, seven children and they do not understand anything about family planning. As discussed by one agriculturalist, one person needs seven bags of maize in a year. If you have seven children, you will need 7*7 bags of maize. Our gardens cannot even produce that much, so that means you will be underfeeding your family. So family planning encourages development. (Male participant)*

In response to some of these narrations, the nurse advised the women that, if their supply was not available at the clinic, they should buy it through a different vendor and take it to the clinic to be administered. However, the participants were not happy with this response, as it entailed additional expenses for FP use. The nurse confessed that they lacked a variety of FP methods locally, because there are few staff who have the know-how to administer the methods, especially long-term methods.

With regard to cultural barriers to FP use, participants encouraged women to speak to their husbands about family planning and not to tire even if they refuse, because chances are they will eventually understand the need for it. Men were also urged to allow their wives to seek FP services. In addition, those at the meeting were encouraged to discuss with their peers what they had learned about family planning to promote increased use of family planning.

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