

Country Analysis of Family Planning and HIV/AIDS: Kenya

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Executive Summary

This study was designed to document the extent to which Kenya has managed both its family planning/reproductive health (FP/RH) and HIV/AIDS programs in the context of the high HIV prevalence (14%) the country is experiencing. In order to gain further insights on the dynamics of the FP program (FPP) in the country, interviews were conducted with 16 key informants from relevant government ministries/departments, NGOs, collaborating agencies, and donors. Questions touched on specific issues of FP/RH and HIV/AIDS regarding funding levels, staffing/personnel issues, integration and role of nongovernmental organizations (NGOs) and the private sector in FP/RH and HIV/AIDS programs. The background information for the study was obtained from several policy documents and other related official documents such as strategic plans, relevant survey results/reports, development plans, and statistical abstracts.

Specifically, the study set out to achieve the following objectives:

- Document success or failure of countries experiencing high levels of HIV/AIDS in implementing FPPs
- Document lessons learned and make recommendations for the development and implementation of improved FP and HIV/AIDS programs
- Make cross-country comparisons about findings in terms of experiences with the FPP in the context of high HIV prevalence.

Highlights of the findings and subsequent recommendations of the study include the following:

1. There is an apparent deliberate shift toward the HIV/AIDS program at all levels (i.e., politically, officially and programmatically) at the expense of the FPP. Both programs, however, are extremely important for the development of the country and its population. More intensified advocacy is needed to put the FPP back prominently on the agenda of the Ministry of Health (MOH) and all other relevant players.
2. The National AIDS and STDs Control Program (NAS COP) and the Division of Reproductive Health—both of which are under the MOH—are not working as closely as they should to enhance the integration of HIV/AIDS and FP/RH. HIV/AIDS should become a more visible issue for the Division of Reproductive Health. This is especially true if the prevention of mother-to-child transmission (PMTCT) of HIV and related activities are to be enhanced through the MCH/FP outlets. The division, therefore, needs to take the lead in implementing an integrated approach of FP/RH and HIV/AIDS.
3. The current level of unmet need for family planning of 24 percent may be understated as this estimate from the 1998 Kenya Demographic and Health Survey (KDHS) only considers currently married women and does not include sexually active unmarried adolescents.
4. Improved and expanded management of sexually transmitted infections (STIs) has increasingly become an HIV/AIDS control strategy rather than an RH component, as was the case about 10 years ago. The Division of Reproductive Health should continue to keep the issue of STIs at the top of its agenda as an RH issue too.
5. Family planning has fallen off the agenda in some ways; however, the majority of Kenyans, including those who are HIV positive, need FP services. In addition, adolescents are continually

left out of the country's FPP. It is also recognized that family planning is important in HIV/AIDS prevention and control. There is therefore great need to bring back family planning.

6. The continued existence of the National Council for Population and Development (NCPD) is significant as an indicator of both political and official commitment and support for the FPP. The NCPD ought to take advantage of its position and strive to keep the FPP on top of the agenda. Everybody seems to be looking up to the MOH's Division of Reproductive Health to do this.
7. Sustaining and/or improving current levels of the total fertility rate (TFR) and contraceptive prevalence rate (CPR) will be difficult if donor support wanes. The government needs to put in place strategic measures to ensure sustainability of the FPP.
8. A study should be undertaken to determine the extent to which HIV/AIDS is affecting the operations and functions of the MOH.
9. There is a lot of skepticism concerning health sector reform, especially with regard to its implementation at the district level and its impact on the uptake of FP services, which have been hitherto free.

Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral
BCC	Behavior change and communication
CBD	Community-based distributor
CBS	Central Bureau of Statistics
CPR	Contraceptive prevalence rate
CYP	Couple-years of protection
DFID	Department for International Development
FP	Family planning
FPAK	Family Planning Association of Kenya
FPP	Family planning program
HIV	Human immuno-deficiency virus
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
INTRAH	Program for International Training in Health
KCPS	Kenya Contraceptive Prevalence Survey
KDHS	Kenya Demographic and Health Survey
KFS	Kenya Fertility Survey
MCH	Maternal and child health
MMR	Maternal mortality ratio
MOH	Ministry of Health
NACC	National AIDS Control Council
NCPD	National Council for Population and Development
NASCOP	National AIDS and STDs Control Program
NGO	Nongovernmental organization
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
RH	Reproductive health
SDP	Service delivery point
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TFR	Total fertility rate
UNFPA	United Nations Population Fund
VCT	Voluntary counseling and testing
WHO	World Health Organization

Introduction

High HIV/AIDS prevalence in Kenya means that the government must address both the health and socioeconomic implications of limited access to family planning and other RH services within the context of the HIV/AIDS epidemic. The health and social benefits of family planning make it a central component of RH programming for many reasons, including

1. Family planning helps clients attain their RH and family-building goals.
2. It prevents unwanted pregnancy.
3. It lowers infant and maternal mortality.
4. Family planning allows couples to be more productive members of society.
5. It helps HIV-positive women meet their RH needs by helping them avoid unwanted/unintended pregnancies.
6. At the family level, family planning empowers HIV-positive couples to freely decide on limiting subsequent births.
7. At the macro level, expanding the FPP helps reduce the burden on health services, which are already overwhelmed and unable to meet the needs of the current population.

This study was designed to document the extent to which Kenya has successfully managed both FP/RH and HIV/AIDS, in the context of high HIV prevalence (14%). In order to gain further insights on the dynamics of the FPP in the country, interviews were conducted with 16 key informants from relevant government ministries and departments, NGOs, cooperating agencies, and donors. Questions were asked touching on specific issues of FP/RH and HIV/AIDS with regard to funding levels, staffing/personnel issues, integration, and role of NGOs/private sector in FP/RH and HIV/AIDS programs in the country. Specifically, the study set out to achieve the following objectives:

- Document success or failure of countries experiencing high levels of HIV/AIDS in implementing FPP.
- Document lessons learned and make recommendations for the development and implementation of improved FP and HIV/AIDS programs.
- In conjunction with case studies being carried out in other countries, enable cross-country comparisons in terms of experiences with the FPP in the context of high HIV prevalence.

Background

In Kenya, as in many developing countries of the world, the organized FPP has made contraceptives more widely available and acceptable. The proliferation of service delivery points (SDPs) for family planning and a more intensive effort on information and education, both the result of a stronger implementation of the government's population policy during the 1980s and 1990s, provided the opportunity for women and couples to practice family planning more easily. At the same time, socioeconomic conditions, especially the real monetary cost of children, also played a crucial role in motivating the adoption of small family norms (Ferguson, 1991).

This scenario greatly contributed to Kenya's fertility decline from a high of 8.1 children per woman in the 1970s to 4.7 during 1995–1998 (KDHS, 1998). However, because of high population growth and the young age structure of Kenya's population—thousands more women enter reproductive age annually—necessitating the need for expanded and sustained FP services to raise (or even to maintain) the contraceptive prevalence rate (CPR) at 39 percent (in 1998) and reduce further (or even maintain) the

fertility rate. It is worth noting that the Kenya Demographic Health Surveys (KDHS) have also contributed greatly to confirming the socioeconomic determinants of FP use, such as education, age, and socioeconomic status.

Integrating broader RH services with family planning, and vice-versa, is potentially an efficient use of resources. It also benefits women by providing convenient and more comprehensive care. Similarly, FP and HIV/AIDS programs can be mutually reinforcing because increased condom use can prevent unwanted pregnancies as well as the spread of HIV.

Indeed, in Kenya's National Reproductive Health Strategy (1997–2010), the relationship between HIV/AIDS and adverse pregnancy outcomes and maternal health is fully acknowledged. That HIV/AIDS raises maternal mortality and morbidity and that pregnancy hastens progression of HIV to AIDS in HIV-positive women are also underscored in the document. It goes on to state:

Due to this mutual interaction and the fact that both conditions, i.e., pregnancy and HIV infection, affect or are found in the same segments of the population, contraceptives that prevent both pregnancy and STDs/HIV (e.g., condom) will take a central role in both family planning and STDs/HIV prevention programmes. (MOH, 1996)

Yet some key informants in this study seemed to see FPP and HIV/AIDS programs as parallel entities as illustrated with the following statement:

We have always been focused. Even no file exists here for HIV/AIDS. NASCOP holds that portfolio... On paper the inclusion of HIV/AIDS in the National RH Strategy looks visible... But there are no activities at the RH Division level. The programmes are run in a parallel manner... However, the fact that antenatal care (ANC) is the entry point for PMTCT has necessitated training in integration and this is currently going on... (Division of Reproductive Health)

Maternal Mortality in Kenya

While the goal of safe motherhood in the National RH Strategy is to reduce maternal mortality from 365/100,000 live births to 300/100,000 in 2000, to 230/100,000 in 2005, and 170/100,000 by 2010, estimates still put maternal mortality rates at a high of 650/100,000 (MOH, 1998a).¹ With an average of 4.7 births during her lifetime, a Kenyan woman, therefore, has a 1 in 36 lifetime risk of dying from maternal causes. Indeed, maternal deaths represent an estimated 27 percent of all deaths for women ages 15–49 (Kiragu, 2000). For every maternal death, it is estimated that an additional 30 women experience serious, even life-threatening, morbidity (Ashford, 2002). However, had fertility not declined significantly in the past quarter century in Kenya, thousands more women would be dying annually from maternity-related causes, and tens of thousands more would be experiencing serious maternal morbidity.

Women aged 15–49 represent about one-quarter (23%) of the country's total population of about 30 million (CBS, 2000b), which means that nearly 7 million Kenyan women are exposed to the risk of pregnancy and, therefore, the potential risk of maternal morbidity and mortality. The major obstetric causes of maternal mortality are hemorrhage, infection (sepsis), obstructed/prolonged labor, and complications from abortion. Other indirect causes are anemia and malaria during pregnancy. However,

¹ There are approximately one million births annually in Kenya. A maternal mortality ratio (MMR) of 650/100,000 live births would result in about 6,500 maternal deaths annually. A recent report on maternal mortality estimates that the number of maternal deaths annually in Kenya might be as high as 14,700. This is based on the World Health Organization's estimate of an MMR of 1,300 for Kenya (POLICY Project, 2002).

studies are beginning to show that there are a host of underlying causes of maternal mortality in Kenya. The most common causes of maternal mortality, as stated above, belie the more fundamental development problems that influence maternal mortality, such as the state of medical services, quality of care, and the facilities' abilities to respond to obstetric emergencies. Maternal deaths result primarily from delays in receiving emergency treatment at the critical moment when the women need attention most (Rogo et al., 2001). Strategies to address maternal mortality must, therefore, address the underlying factors that influence maternal mortality.

Contraceptive Prevalence, Unmet Need, and Unwanted Fertility

Kenya's CPR in 1998 was 39 percent (KDHS, 1998), up from 33 percent in 1993 (KDHS, 1993). There has been a steady rise in CPR from 7 percent in the late 1970s to 17 percent in 1984, 27 percent in 1989, 33 percent in 1993, and 39 percent in 1998. This steady rise has been attributed mainly to the country's fairly strong FPP, which has had a good balance of public and private sector involvement. There has also been a substantial shift in method mix from traditional and less effective methods to more effective modern methods. Kenya has also continued to experience a fertility transition from a high of 8.1 births per woman in the 1977/78 Kenya Fertility Survey (KFS) to 6.7 in the 1989 KDHS and to 4.7 children per woman in the 1998 KDHS, a decline of 42 percent between the late 1970s and the late 1990s. However, these achievements fall short of the government's set objectives as stipulated in its 1999 *National Population Policy for Sustainable Development*; by 2002, CPR would have reached 43 percent, 53 percent by 2005, and 62 percent for all methods by 2010. At the same time, TFR would drop from 5 children in 1995 to 4 in 2005 and 2.5 in 2010.

The FP goal, as stipulated in Kenya's *National Reproductive Health Strategy* (MOH, 1996), aspires to "make available quality and sustainable FP services to all who need them in order to reduce the unmet needs for family planning." However, a closer look at unmet need for family planning and unplanned/unwanted fertility reveals that there is still a lot more to be done to achieve this goal. The 1989, 1993, and 1998 KDHS have consistently shown that many women report wanting to delay or to limit future births; however, they are not using any FP method. These are the women with "unmet need" for family planning. Indeed, this need was almost 40 percent in 1989, 37 percent in 1993, and about 24 percent in 1998 among married women.² In the 1998 KDHS, 37 percent of births were also found to have been unintended. Moreover, the desired TFR of 3.5 was also significantly lower than the actual 4.7 births per woman (MOH, 2001b). Elimination of such births can only be achieved through the use of an FP method or abstinence. Indeed, Kenya's *FP/RH Policy Guidelines and Standards for Service Providers* states: "To meet this need, it is necessary to improve the quality of care in FP services, especially accessibility and availability" (MOH, 1997).

It is noted, however, that the above estimates are conservative, as they do not include sexually active unmarried adolescents. In the 1989 KDHS, 8.6 percent of females ages 15–19 were pregnant at the time of the survey, and 77 percent of the unmarried adolescent girls in this group did not desire the pregnancy. If this group were to be included in the estimates, the figures for unmet need and, therefore, potential demand for family planning would be much higher. In the 1993 and 1998 KDHS, 70 and 63 percent of currently married women had a need to use family planning, implying that in 1993 with a CPR of 33 percent, less than one-half of the need was met, whereas in 1998 about three-fifths (60%) of the need for family planning was met.

² Of all currently married women in 1998, 63 percent had a need for FP (the remainder did have a current need for contraception because they were pregnant or lactating or they wanted another birth within two years.) Of the 63 percent, 39 percent were using contraception and 24 percent were not, and therefore had an "unmet need" for FP. Of this 24 percent, 10 percent had a need for contraception for spacing and 14 percent had a need for preventing all future pregnancies (i.e., they did not want another birth at any time).

Among the 7 million women of reproductive age in Kenya, approximately 15 percent (1.1 million) become pregnant every year. Twenty percent of these pregnancies are estimated to be unwanted or unplanned (Kiragu, 2000). In 1989, 1993, and 1998, 21 percent, 17 percent, and 17 percent of females ages 15–19 were already mothers, whereas 4 percent in 1993 and 1998 were pregnant with their first child at the time of the survey. Assuming that the majority of the births and/or pregnancies in this age group are unwanted, this also points to higher levels of unmet need.

Unmet need for family planning also has implications for both maternal and under-five mortality levels. If all women who wished to delay or limit births used effective contraception, maternal mortality would drop an estimated 17–35 percent (Ashford, 1995). Reducing the proportion of high-risk pregnancies and births through family planning can also reduce infant and child mortality.

Major Sexually Transmitted Infections

The incidence of STIs is high and increasing in Kenya. The situation has worsened considerably with the emergence of the HIV/AIDS pandemic. The association between STIs, such as chlamydia, gonorrhea, and syphilis, and HIV infection is now well documented. Indeed, STI control is recognized as an effective means of reducing or slowing the spread of HIV. However, aside from understanding and appreciating the biological relationship between STIs and HIV transmission, monitoring trends in STIs can provide valuable information on sexual transmission of HIV as well as the impact of behavioral interventions, such as the promotion of condom use. Two comprehensive intervention programs in Nairobi have shown that treating STIs, promoting the use of condoms, and providing peer counseling can have important benefits. An intervention with sex workers in one area of Nairobi led to a reduction in the annual incidence of new HIV infections among the sex workers from 45 percent in the late 1980s to 10 percent in the 1990s. Large declines in the prevalence of STIs have also occurred (MOH, 1997).

Kenya's *FP/RH Policy Guidelines and Standards for Service Providers* states:

A major concern of all RH workers should be the rapid increase in the prevalence of STIs and HIV/AIDS. The only effective means of protection against these infections is safe sexual practices including abstinence and the use of barrier methods. For those at risk of STIs /HIV/AIDS, these guidelines stress the need to use barrier methods such as condoms in addition to any other method of family planning.” (MOH, 1997)

Facilities that offer STI-related services outside urban centers are limited; in 1998, it was estimated that only 30–35 percent of dispensaries and health centers were capable of offering diagnosis and treatment of common STDs. Available data show that, even though rates of STIs remain much higher in the high-risk groups and urban populations, infections are also quite prevalent among women in low-risk groups, such as those attending antenatal and FP clinics. Among such women in Nairobi (between 1986–1991), the rates of gonorrhea ranged from 3–10 percent; Chlamydia, 8–9 percent; and syphilis 1.9 percent. On the other hand, a rural area study reported prevalence of gonorrhea from 3–12 percent; chlamydia 1–13 percent, and syphilis 0–9 percent, which were higher than those reported for Nairobi (MOH, 1996). This may be a reflection of the limited facilities for treatment and inadequate knowledge about symptoms of the infections in the rural population.

A number of programs have been implemented around the country to improve the treatment of STIs. The MOH reports that more than 50,000 cases of STIs are being treated each month, representing a significant increase from just a few years ago when drug supplies to treat STIs were scarce (MOH, 2001a). Improved

and expanded management of STIs has therefore been adopted more as an HIV/AIDS control strategy than an RH component as would have been the case 10 years ago.

HIV/AIDS

Kenya is ranked among the 10 countries worldwide with the highest HIV/AIDS prevalence rates and fifth among countries with the greatest number of adults and children with HIV/AIDS (Ross et al., 1999). The majority of people affected are ages 15–49. On average, 200,000 new HIV cases are reported annually, and the country loses about 700 people per day due to AIDS. For more about HIV/AIDS in Kenya, see Box 1.

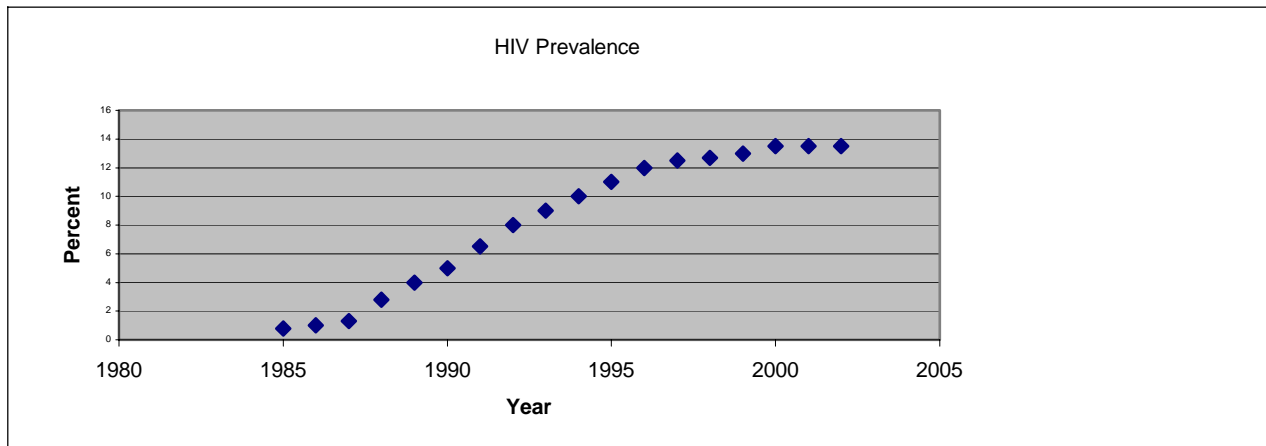
Box 1: HIV/AIDS in Kenya: Facts, Estimates, and Figures at a Glance

- HIV prevalence has risen from 0.8 percent (1985) to 13.5 percent (2001) (see Figure 1)
- About 2.5 million Kenyans are infected with HIV
- 1.5 million Kenyans have died of AIDS since 1984
- One of every eight adults in rural Kenya is infected
- One of every five adults in urban areas is infected
- 200,000 new HIV infections occur annually
- 200,000 develop AIDS every year
- 1,000,000 have been orphaned due to AIDS-related deaths of one or both parents
- There are 600–700 AIDS-related deaths per day
- 75 percent of infections are in rural areas among people ages 15–39
- Economic loss due to HIV/AIDS is estimated at US\$3 million per day
- Life expectancy at birth has declined from 60 years to less than 50 years

Source: MOH, 2001a

Figure 1 below shows the trend of HIV prevalence in Kenya:

Figure 1: HIV Prevalence, 1985–2002



Source: MOH, 2001

Thus, since AIDS was first reported 17 years ago in Kenya, HIV prevalence has increased dramatically. Although there are signs that the prevalence rate is stabilizing, it is doing so at a very high level.

In its Eighth Development Plan (1997–2001), the government of Kenya acknowledged the following:

The single most important health challenge that Kenya has faced in its post-independence history is the HIV/ AIDS pandemic... being the only known health problem that has the potential to reverse the significant gains made in life expectancy and infant mortality.... The HIV/AIDS pandemic is becoming much more than a health problem as it encompasses economic, social and cultural dimensions.

This sentiment was further reiterated when, in November 1999, the President of the Republic declared AIDS a national disaster, stating

AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence.... AIDS has reduced many families to the status of beggars...no family in Kenya remains untouched by the suffering and death caused by AIDS...the real solution of the spread of AIDS lies with each and everyone of us.

As in many sub-Saharan countries hit hard by HIV/AIDS, the consequences for both economic and social policy are severe. A growing number of children are becoming orphans while high rates of illness and death affect economic and agricultural production because deaths occur among the most economically active age groups.

The Eighth Development Plan (1997–2001) concluded, “From a fiscal standpoint, the pandemic threatens to tie up the entire MOH recurrent budget by 2000.” This view is echoed in the current Ninth National Development Plan (2002–2008):

The rapid increase in the number of HIV/AIDS infected people presents a major challenge to health services... Management of HIV/AIDS infections is too expensive. The drugs cost on average about Ksh. 700,000 per person per year... Virtually all aspects of development have experienced the severe impacts of HIV/AIDS at household, community and national levels. It has created shortage in manpower and also overstretched social services, especially the health services and the social security system...During the Plan period the prevention and control of the pandemic will be guided by a strategic plan that is already in place...

Abortion

The World Health Organization (WHO) estimates that illegal abortions are one of the leading causes of maternal mortality globally and may be responsible for as many as 150,000 deaths each year. Although abortion is illegal in Kenya, unless performed to save the life of a woman, it is still common and often occurs under unsafe conditions. About 20 percent or more of all pregnancies in Kenya are estimated to be unwanted or unplanned, all of which have the potential of ending in abortions. According to the 1989 population census, 25 percent of Kenya’s population is aged 10–19, constituting the fastest growing age group. Fertility in this age group was also found to be high with about 152 births per 1,000 women ages 15–19 in 1989 and 111 in 1998. Since expulsion from school is almost inevitable for girls who become pregnant, abortion remains a common solution for an unwanted pregnancy.

Kenya's current restrictive abortion law results in a large number of illegal abortions that typically take place in unhygienic and dangerous conditions. From 1995–1999, official statistics recorded about 105,500 abortions (CBS, 2001b), giving an annual average of about 21,000 abortions. However, these are official statistics, based on women who ended up in health facilities for management of complications of abortion. Thousands of abortions are unrecorded.

Of the estimated 75,000 abortions conducted to terminate the unplanned/ unwanted pregnancies, nearly 5 percent result in maternal deaths (Kiragu, 2000). Abortion is also a major cause of morbidity among women of reproductive age as indicated by the fact that 50–60 percent of beds in acute gynecological wards in Kenya's major hospitals are occupied by women with abortion-related complications (Rogo, 1996).

Breastfeeding

The 1993 KDHS found that almost all (97%) Kenyan children were breastfed for some period of time, which was generally not influenced by the sex of the child, mother's residence or education, or place of delivery or assistance at delivery. Overall, 54 percent of newborns were put to the breast within the first hour of birth and 84 percent within the first day. These figures were 58 and 86 percent, respectively, in the 1998 KDHS.

Levels of exclusive breastfeeding were, however, very low. Among infants aged less than two months of age, only 27 percent were being exclusively breastfed, and one-half (54%) in 1993 and three-quarter (75%) in 1998 were already receiving supplements. By age six to seven months, exclusive breastfeeding is almost nonexistent for Kenyan babies; 97 percent are receiving food supplements.

Findings

Status of the Family Planning Program and Trends

The proportion of women practicing contraception or family planning (i.e., CPR) in Kenya increased from 7 percent in 1977–1978 to 17 percent in 1984, 27 percent in 1989, 33 percent in 1993, and 39 percent in 1998 (1977–1978 KFS; 1984 Kenya Contraceptive Prevalence Survey (KCPS); 1989, 1993, and 1998 KDHS). At the same time, the TFR declined from 8.1 children (1977–1978) to 4.7 children per woman in 1998. Both the rise in CPR and decline in TFR were attributed mainly to the relatively strong FPP in the country. Apart from the socioeconomic considerations of raising large families, the main driving force behind this “success” story was largely the government's efforts to increase the number of SDPs for family planning together with a more intensified and focused information, education, and communication (IEC) strategy. The number of SDPs for family planning has increased from 1,600 in the 1980s to 1,700 in 1995, and 2,050 in 1998. Currently, of the 4,349 health facilities in Kenya, 2,482 (57%) are offering FP services.

In general terms, Kenya, the first African country to adopt an FPP (1967) and a National Population Policy (1984), has maintained an effective program within the MOH. However, the existence of the Family Planning Association of Kenya (FPAK) has also contributed to the country's ability to keep family planning on the agenda from as early as the 1960s. Indeed, FPAK has contributed greatly to the country's couple-years of protection (CYP), which peaked at an average of more than 100,000 CYP per year in the mid-1990s. During this period, FPAK adopted broad and aggressive implementation strategies that included widespread community-based distributor (CBD) coverage and outreach activities as well as countrywide coverage of static delivery sites (clinics). Due to limited resources, the association has had to

close a number of its clinics as well as reduce its CBD coverage in recent years, and this has seen a reduction of its CYP to an annual average of about 60,000 per year.

Creation of the NCPD in 1982 further reinforced the government's commitment to implementing a more focused and coordinated population policy from that time onwards, culminating in the development of the *National Population Policy* in 1984. The 1980s marked the peak for both government and donor support for Kenya's FPP—as a major component of the promulgated population policy.

Social marketing for condoms is also becoming a major strategy for enhancing condom use in Kenya, especially in this era of HIV/AIDS. Indeed, Kenya's HIV/AIDS strategic plan identified two principal goals for effectively reducing the spread of HIV, one of which is enhancing condom use for protection against the transmission of HIV and STIs. So pervasive is this need that the government has recently published its *Condom Policy and Strategy (2001–2005)* to ensure an adequate national supply of and access to condoms and drum up public education and advocacy to create demand for condom use (MOH, 2001b). It is acknowledged that 15 percent of condoms are provided through the social marketing strategy mounted mainly by Population Services International (PSI) for the *Trust* brand condoms. However, condom use for family planning is generally low. According to the 1998 KDHS, only 1.3 percent of currently married women (and 1.8 percent of all women) reported condom use. Even among sexually active unmarried women, condom use (8%) is third after injectables (12.2%) and pills (10.7%), although they are most used (11.3%) among those ages 15–19. Nearly one-half of unmarried men (47%) reported using condoms (vs. 8 percent of married men), but only 4 percent reported using the pill or injectables (vs. 21 percent of married men). The study goes on to acknowledge that “this may represent different reproductive and health (disease prevention) strategies related to marital status.”

Despite the apparent effective FPP in Kenya, the general feeling among those interviewed is that more still needs to be done. However, respondents also acknowledged that this may not be easy, given that increased attention of both the government and donors is directed to HIV/AIDS and HIV/AIDS-related issues in the country. Even the inclusion of FP/RH issues in the current national HIV/AIDS strategic plan was found wanting. One respondent observed:

The issue of STDs is adequately addressed in the said Strategic Plan simply because STDs is an HIV/AIDS issue but the inclusion of family planning in the same strategy is not visible.... There should be efforts to look at family planning and HIV/AIDS in the same context.... In the long run, ignoring both would have the same impacts... (Marie Stopes/Kenya)

Status of Political Support for Family Planning

With the advent of HIV/AIDS and the magnitude of its impacts on both the health and socioeconomic status of the country, since the mid-1990s, attention of the government and donors began to shift from the FPP to HIV/AIDS. HIV/AIDS began to be seen as a national disaster and a public health emergency. There are tell-tale signs that support for the FPP is either stagnant or declining altogether. This is illustrated by the views expressed by respondents in the following sections.

Existence of Political Support

When interviewed regarding the existence and/or level of support currently being accorded to the FPP, respondents expressed the following views:

- Family planning has fallen off the agenda.

- Support is still there but less than in the past.
- Support is there, but leaves out certain segments of the population such as adolescents, both married and unmarried.
- Support is there, but family planning is not always a very popular subject and politicians tend to shy away from unpopular subject matters/issues lest they lose the confidence of the electorate.
- Family planning is at times politicized; for example, factored into the country's ethnic equation to give the impression that family planning is being used to reduce the voting power of certain ethnic groups in the country.
- A great deal of focus is on HIV/AIDS, such that there are hardly any positive statements on family planning by political leaders any more.
- Support for the FPP was very strong in the 1970s; however, it has waned over the years, taking a nosedive in the 1990s and into the 21st century.

Few of the respondents felt that political support is still strong, and even then only when family planning is looked at as a component of reproductive health. The following sentiments expressed by the respondents go a long way in illustrating some of the above points:

...Family planning has fallen off the agenda, maybe because people are dying. But it was never in government's agenda anyway...because to keep it in the agenda, it is necessary for the government to know the amount of contraceptive requirements and determine funding levels from government and existing gaps, which can be funded by donors. As it is now it is a donor-driven programme with donors supplying the necessary contraceptives... (DFID)

It is there, as far as married adult couples are concerned but non-existent for the youth. My concern is adolescents who are lumped together—i.e., in-school and out-of-school youth. The legally married adolescents are also lumped together with the general married adult population...yet they need special attention. (INTRAH)

Very strong because the political will is there.... as reflected in the amount of resources, procurement for family planning commodities, establishment of structures such as NCPD and the RH Advisory Board... (NAS COP/MOH)

There is some element of political support though at times the FPP is politicized by thinking and saying that it is a way of reducing voting power of certain people. (FPAK)

Existence of Official Support

Respondents were asked if the official support or the rationale for the FPP had changed, given the high rate of HIV prevalence in the country. The following points illustrate what they thought:

- Support for family planning has not changed as demonstrated by the government's efforts to provide FP services despite the obvious constraints; encouragement to donors to procure FP commodities.
- Support is still there because a demand had been created which must be satisfied.
- Support is still there, especially for the broader reproductive health, but a lot depends on the management of the division/unit responsible for the national RH program, since it is obvious that reproductive health is now competing with HIV/AIDS for government attention as well as resources.
- Continued existence of NCPD is a sign of both political and official goodwill.

- Support is there, but the government needs to formulate policies that would ensure sustainability of the FPP achievements.
- Support is waning and donors should share part of the blame for this downward trend.

Again, the above points can be elaborated by the following quotes from a few of the respondents:

Donors are also to blame for the fall of family planning off the agenda. The donors don't seem to give the government the chance to also make a contribution on this...in terms of providing a budget line for FPP.

...The big question is: Where is the Ministry of Health in terms of sustaining the TFR levels or reducing it (even) further? We are not sure of any strategic direction to achieve this. (INTRAH)

There is political goodwill... e.g. the existence of NCPD... the government's efforts to encourage donors to procure family planning commodities. (Division of Reproductive Health)

It is still there but it is unfair to pinpoint family planning as (it is) a narrow component of reproductive health. Otherwise the broader reproductive health (issues and rights) still has quite a bit of support from the Ministry of Health. (NASCOP/MOH)

No changes. We still see training in FPP-related areas being supported by MOH. Donors are also allowed to procure family planning commodities by MOH. (Division of Reproductive Health)

"Still very strong since the Ministry of Health supports strongly the RH programme and HIV/AIDS. However, implementation depends on the head of the division or department under whose docket reproductive health falls. If the head is focused than support will surely come." (MOH)

Programmatic Support

Traditional FP NGOs are increasingly turning their attention to HIV/AIDS to attract funding. However, they say they are not doing this at the expense of family planning, but just as an add-on to their FP/RH-related programs. New NGOs that are establishing themselves as HIV/AIDS-focused are not incorporating family planning into their mandates and core activities. Donor funding is increasingly moving toward HIV/AIDS program.

Perceived Need for Family Planning vis-à-vis HIV/AIDS

Given the magnitude and impacts of HIV/AIDS, especially on mortality levels and socioeconomic development, is family planning still needed in Kenya? All the informants agreed that there is even a stronger need for family planning than ever before. The following are some of the reasons given for this perceived need for family planning in the country:

- There are high levels of unmet need for family planning.
- Eighty-five percent of the population ages 15–49 is HIV negative.
- HIV-positive couples need family planning to avoid becoming pregnant/having more children.
- Correct information on methods and other benefits of family planning must be provided.

- HIV/AIDS is not a contra-indication to family planning.
- Family planning is beneficial at the family level.
- Impacts of large populations are just as bad as those of HIV/AIDS—if left unchecked.
- Family planning is an important component of reproductive health.
- There is a felt need for family planning as evidenced by contraceptive use.
- Family planning is the entry point to PMTCT: “PMTCT starts with preventing the mother from becoming pregnant.”
- Family planning is a means of (gender) empowerment of women towards being in control of their health.
- Birth spacing for both maternal and child health is needed.
- Family planning is needed to slow population growth.
- Family planning is needed to bring up quality children.
- Family planning is needed to leave behind fewer orphans in case of AIDS deaths.
- Lower TFR means fewer AIDS orphans.

The following quotes from respondents illustrate the strong opinions held for the need for family planning even now:

This may be the time when we need family planning the most as well as accurate and the right information... (including)... benefits of protection against diseases...The time to promote condom (use) is here and now... (FPAK)

As far as I am concerned, the need for family planning is demonstrated by consumption (of contraceptives). So long as there's consumption, there is need; so why should we deny the women family planning? And for women who are HIV-positive, why deny them family planning? In any case,... the first step to PMTCT starts with preventing the mother from getting pregnant. (FPAK)

I have often been asked this question...even by very educated people, and I have often endeavored to answer it this way: that it is even more urgent to have effective FPP with the advent of HIV/AIDS for two main reasons ... Low TFR means fewer AIDS orphans and family planning among HIV+ women means avoiding having HIV+ babies/children...thus avoiding having to care for chronically sick children... (FPAK)

Families should still be planned and separately address causes of death—e.g., preventing the spread of HIV/AIDS and STIs instead of reducing family planning efforts. (INTRAH)

Funding Trends

Since independence in 1963, the government of Kenya has continued to design and implement policies aimed at improving the health status of the people. It has attempted to increase coverage of and access to health care services; to reduce morbidity, mortality, and fertility; to promote public health care; and to encourage participation of private and NGO sectors to play a greater role in the delivery of health services. This notwithstanding, Kenya's health system has overemphasized curative care—to the tune of more than 60 percent of the government's recurrent budget allocation for health. Preventive and promotive health services (where family planning falls) have therefore lagged behind.

There is an absence of reliable data on levels and trends in expenditures to support FP services through the years. However, the following points can be made:

1. Most informants think that government and international donor support for family planning has declined in recent years. Certainly, *overall* government funding for health services has declined dramatically in recent years.
2. Funds needed to support FP services will continue to increase for the foreseeable future. According to one study, estimated public sector expenditures for family planning (including support from international donors) were about \$24–25 million in 2000 and were projected to increase to between \$43 and \$56 million in 2020, due to continued growth in the reproductive age population and continued rise in the contraceptive prevalence rate (NCPD et al., 2000).

International donors have historically provided funds for procurement of all contraceptive commodities in Kenya. According to the Kenya MOH's new *Contraceptive Commodities Procurement Plan for 2003–2006* (February 2003), there are large shortfalls for financing procurement of contraceptive commodities for 2003–2006. These shortfalls are shown by method in Table 1.

Table 1: Contraceptive Commodity Shortfalls, 2003–2006

Method	Estimated Total Costs (US\$)	Current Funding Commitments (US\$)	Current Funding Shortfalls (US\$)
Male condoms	13,500,000	7,500,000	6,000,000
Injectables (Depo)	20,500,000	6,100,000	14,400,000
Low-dose pills	3,220,000	2,415,000	805,000
Progestin-only pills	515,700	405,000	110,700
IUCD	133,200	133,200	0
Implants (Jadelle)	4,860,000	405,000	4,455,000
Female condoms	612,000	360,000	252,000
Total	43,340,900	17,318,200	26,022,700

The table shows that only about 40 percent of the expected procurement costs for contraceptives required for the four years 2003–2006 are currently committed. This apparent reluctance of donors to provide funding at the levels required to meet Kenya's FP needs can be attributed to several factors:

- Increased support for in HIV/AIDS activities by both the government and donors
- Changes in donor priorities
- Donor fatigue
- Failure of the government to put family planning (and reproductive health) high on its agenda and provide a budget line for it
- Competition for the available scarce resources within the health sector

Staffing Trends and Issues

The government is the largest provider of healthcare, operating about 56 percent of all health facilities in the country and providing 60 percent of all healthcare services. The government also manages more than one-half of the hospitals, more than 75 percent of health centers, and 62 percent of the dispensaries. NGOs operate almost one-third of the hospitals and one-quarter of the dispensaries. The private sector operates almost 90 percent of the nursing and maternity homes, but relatively few hospitals. However, medical doctors make up only about 4 percent of total health personnel; clinical officers about 3 percent; and nurse/midwives, the majority in FP service providers, 31 percent. While only 16–19 percent of Kenya's population live in urban areas, more than one-half the health sector personnel (56%) work in urban areas.

There are indications that HIV/AIDS is affecting staff attrition rates due to either AIDS deaths or self-deployment by staff to HIV/AIDS-related work outside of government, which is motivated by higher salaries. As far as deaths of staff due to AIDS at the central level is concerned, interviews with MOH human resource officials revealed that there were a few deaths during 1996–1997; however, such an occurrence has become rare in recent years. At district/health facility levels, AIDS-related illnesses are quite common, which lead to high rates of absenteeism. The extent to which this is happening and affecting the operations and functions of the MOH is yet to be ascertained and documented. However, it was revealed that HIV/AIDS has had a negative impact on staff morale, especially health service providers, due to pressures of work and the heavy workload with very little positive results. This picture is aptly brought out in the following sentiments coming from two of the key respondents:

Yes, the workload is too much. Yet the staff feel like they are doing zero work... as people continue to die... it is as if all the things they learned at school (of medicine, of nursing) about treating and managing a patient has gone to waste... Yes, especially when there are no drugs and tools for managing patients... there is also the issue of increased workload.... (MOH)

And on the fear of being infected,

In the 80s yes, when staff at the clinics were worried about both infecting themselves and cross-infection (from patient to patient)... morale was quite low...(FPAK)

Quality of care has gone down due to fear of handling AIDS patients coupled with lack or shortage of adequate protective gear for staff who subsequently lose confidence in their ability to handle AIDS patients, continues yet another respondent. (MOH)

It is also becoming increasingly evident that health workers concentrate on preventive efforts rather than curative care of AIDS patients due to this lack of confidence.

Whether the MOH was redeploying increasing numbers of its staff from other programs to the HIV/AIDS program, it was established that such a policy for redeployment did not exist within the ministry. Instead, the government advocates for integration of services though this has been poorly implemented. At the same time, there are no HIV/AIDS-designated wards, laboratories, or clinics in the health facilities to warrant this kind of redeployment or even voluntary/elective shift by staff themselves from FP/RH or other units to HIV/AIDS. Furthermore, there is no classification or categorization of health personnel along those lines. Even though MCH/FP clinics are set aside in health facilities with specific staff designated to work in them, there are no official statistics at the central level to show this. Any such redeployment at the health facility is usually internal arrangements within the respective facilities' management to meet their health provision requirements at any given time. Such assignment of staff to work in certain units is also usually done on a rotational basis.

On whether the MOH was losing staff due to overseas recruitment, one respondent said:

Let's look at it as a national issue since (in recent years) we are losing very experienced nurses to overseas recruitment. Even retired nurses are leaving the country instead of taking up jobs even with local NGOs in Kenya...The entire health sector is losing experienced nurses to overseas market. (MOH)

In this scenario, the most affected cadres of health workers are the nurses—both those practicing and those teaching nursing. Doctors are also affected, even though this has occurred over several years. As the

official put it: "...But doctors have always been moving and in any case, the exodus among nurses is more felt than that of doctors."

Changing Roles of NGOs and Private Sector in the Family Planning Program

On the question whether focus for the hitherto traditional FP/RH NGOs has shifted to HIV/AIDS in recent years, with increasing concentration primarily on HIV/AIDS interventions, the response was generally affirmative, but with a rejoinder that this shift is happening at two levels:

- *Establishment of new NGOs:* Increasing numbers of NGOs are being established to work in HIV/AIDS-related programs without necessarily declaring their interest in or taking on the FPP as an add-on to their activities.
- *Integration:* NGOs that were traditionally or primarily FP organizations are also increasingly turning their attention to integrating HIV/AIDS into their FPPs. This integration is beginning to occur at the community level with IEC and behavior change communication (BCC) provision, and at the clinic level, where integration is expected to address the following components of HIV/AIDS:
 - PMTCT
 - Voluntary counseling and testing (VCT)
 - STI counseling and treatment
 - Treatment of opportunistic infections

Other components for integration include condom distribution at community and clinic levels, and home-based care, while the private sector continues to play a major role in ARV provision. However, some respondents were quick to express their skepticism about the issue of integration. One said:

I am skeptical. All the NGOs are saying they are integrating reproductive health and HIV/AIDS. I think this is all rhetoric for attracting money that is available for HIV/AIDS. There is no money in family planning. My thinking is that NGOs should concentrate on advocacy and creation of demand for services rather than provision of services.... I would rather have the Government improve its health services to meet that demand... (Marie Stopes/Kenya)

I don't know. But I think that they are now thinking the broader reproductive health, including HIV/AIDS. Of course there is the tendency to follow money...and there is money in HIV/AIDS. But I don't know if this (what the NGOs are doing) is additional or substitution.

On the other hand, others felt that this shift is occurring as a response to several factors/situations: the 1994 International Conference on Population and Development (ICPD), availability of funding in HIV/AIDS, and the government's call for integration.

However, the question remains whether this shift is making NGOs better or jeopardizing their work. In addition, has the communities' perception of NGOs as FP organizations changed as well?

Overall Perceptions

Kenya has done relatively well in terms of its FPP, although more still needs to be done. With the advent of HIV/AIDS, the FPP is being provided little support politically, officially, programmatically, and financially.

With family planning even more crucial now than ever, there is a need to drum up support for the FPP. Integration between FP/RH and HIV/AIDS needs to be strengthened, and the government organs responsible for both programs should show a commitment toward this. And with the emerging issues of HIV/AIDS, such as PMTCT and VCT, the RH strategy needs to be reviewed and revised to visibly and adequately address these issues as well.

There seem to be a lot of doubts and skepticism about health sector reform and what it entails, especially for the FPP. For example, “that there is the danger of introducing cost-sharing in family planning”... “A lot will depend on the health management at the district level”... “It is a question of disease versus family planning... We must look at it very carefully as the reform is for cost-sharing, yet family planning has traditionally been a free service in Kenya...”

Another respondent summed it up this way:

I am torn here because the concept and its application would indicate that things would be better since districts would be in charge and in control of generating financial resources and using the same. But the implementation at executive level which shifts from time to time is questionable...Decentralization is supposed to make things better, but are they better...In Uganda, decentralization worked very well until the president stopped cost-sharing...(World Bank)

Summary and Conclusion

The study findings have been based on the interviews conducted among about 16 key respondents who work in various capacities within the relevant government departments, NGOs/cooperating agencies, or donors and are fairly knowledgeable about the FP and HIV/AIDS programs in Kenya. The background information for the study was obtained from several policy documents and other related official documents such as strategic plans, relevant survey results/ reports, development plans, and statistical abstracts.

1. There is an apparent deliberate shift towards the HIV/AIDS program at all levels (i.e., politically, officially, and programmatically) at the expense of the FPP. Many respondents saw both programs as extremely important for the development of the country and its population. There is need for more intensified advocacy to put the FPP back prominently on the agenda of the government, MOH, donors, and all other relevant players.
2. NASCOP in the MOH and the Division of Reproductive Health are not working as closely as they should, to enhance the integration of HIV/AIDS and FP/RH. HIV/AIDS should become a more visible issue for the Division of Reproductive Health. Likewise, family planning should also become a more visible issue for NASCOP. This is especially true if PMTCT and related activities are to be enhanced through the MCH/FP outlets. The division, therefore, needs to take a leading role in the implementation of an integrated approach of reproductive health and HIV/AIDS.
3. The current level of unmet need for family planning of 24 percent may be an understatement, as this estimate from the 1998 KDHS does not include sexually active unmarried adolescents.
4. Improved and expanded management of STIs has increasingly become an HIV/AIDS control strategy rather than an RH component, as was the case some 10 or so years ago. The Division of

Reproductive Health should continue to keep the issue of STIs at the top of its agenda as an RH issue.

5. Family planning has fallen off the agenda in some ways; however, the majority of Kenyans, including those who are HIV positive, need FP services. And adolescents are continually left out of the country's FPP. It is also recognized that family planning is important in HIV/AIDS prevention and control. There is therefore great need to bring back family planning.
6. Apparently, the continued existence of NCPD is significant as an indicator for both political and official support for the FPP in the country. The NCPD ought to take advantage of its position and strive to keep the FPP on top of the agenda. Everybody seems to be looking up to the MOH department to do this.
7. Sustaining and/or improving current levels of TFR and CPR will be difficult if donor support wanes. The government needs to put in place strategic measures to ensure sustainability of the FPP through encouraging donors to include family planning in their support to Kenya and also support integrated programs, creation of a budget line for FP activities as well as introduction of fee for FP service.
8. A study needs to be undertaken to determine the extent to which HIV/AIDS is affecting the operations and functions of the MOH.
9. There is a lot of skepticism concerning health sector reforms, especially with regard to its implementation at the district level and its impact on the uptake of FP services, which have been hitherto free.

References

- Ashford, L. 1995. "New Perspectives in Population: Lessons Learned from Cairo." *Population Bulletin* 50(1).
- Ashford, L. 2002. "Hidden Suffering: Disabilities from Pregnancy and Childbirth in Less Developed Countries." *Population Reference Bureau* 2.
- Becker, S. 1999. "Measuring Unmet Need: Wives, Husbands, or Couples." *Family Planning Perspectives* 25(4): 172–180.
- Central Bureau of Statistics (CBS). 2001a. Economic Survey, 2001. Republic of Kenya.
- Central Bureau of Statistics (CBS). 2001b. Statistical Abstract, 2000. Republic of Kenya.
- Chege, J. and I. Askew. 1997. "An Assessment of Community-based FPP in Kenya." Population Council.
- Ferguson, A. 1991. "FP Adoption, Change, and Discontinuation: A Retrospective Study from Two Rural Areas of Kenya." MOH.
- Kiragu, J. 2000. "Abortion and Human Rights in sub-Saharan Africa." *Initiatives in RH Policy* 3(2).
- Kimuyu P., M. Wagacha, and O. Abagi (eds). 1999. *Kenya's Strategic Policies for the 21st Century: Macroeconomic and Sectoral Choices*. Institute for Policy Analysis and Research (IPAR).
- Ministry of Health (MOH). 1996. National Reproductive Health Strategy (1997–2010). Nairobi: MOH.
- Ministry of Health (MOH). 1997. FP/RH Policy Guidelines and Standards for Service Providers. Nairobi: MOH.
- Ministry of Health (MOH). 1998a. Implementation Plan for the National Reproductive Health Strategy: 1999–2003. MOH.
- Ministry of Health (MOH). 1998b. National Health Sector Strategic Plan: 1999–2004. Nairobi: MOH.
- Ministry of Health (MOH). 2001a. *AIDS in Kenya: Background, Projections, Impact, Interventions, and Policy*. 6th Edition. Nairobi: MOH and NACC.
- Ministry of Health (MOH). 2001b. Health Management Information System (HMIS): Report for 1996–1999. Nairobi: MOH.
- Ministry of Health (MOH). 2003. *Contraceptive Commodities Procurement Plan, 2003–2006*.
- Ministry of Finance and Planning. 1996. National Development Plan (1997–2001). Republic of Kenya.
- Ministry of Finance and Planning. 2002. National Development Plan (2002–2008). Republic of Kenya.
- National AIDS and STDs Control Programme (NAS COP)/Ministry of Health (MOH). 1998. "Report of the Second National HIV/AIDS/STD Conference: Lessons Learned." Nairobi: NAS COP/MOH.

National Council for Population and Development (NCPD). 1989. Kenya Demographic and Health Survey. Nairobi: Ministry of Finance and Planning.

National Council for Population and Development (NCPD). 1993. Kenya Demographic and Health Survey. Nairobi: Ministry of Finance and Planning.

National Council for Population and Development (NCPD). 1998. Kenya Demographic and Health Survey. Nairobi: Ministry of Finance and Planning.

National Council for Population and Development (NCPD), Ministry of Health (MOH), and the POLICY Project. 2000. *Family Planning Financial Analysis and Projections for 1995 to 2020*. NCPD, MOH, POLICY Project.

POLICY Project. 2002. *Maternal and Neonatal Program Effort Index: Kenya*.

Rogo, K. 1996. "Induced Abortion in sub-Saharan Africa." *African Journal of Fertility, Sexuality, and RH* 1(1).

Rogo, K., C. Albo-Obunga, C. Ombaka, M. Oguttu, S. Orero, C. Oyoo, and J. Odera. 2001 "Maternal Mortality in Kenya: The State of Health Facilities in a Rural District." *East African Medical Journal* 78(9).

Ross, J., J. Stover, and A. Willard. 1999. *Profiles for FP and Reproductive Health Programme: 116 Countries*. Glastonbury, CT: Futures Group International.