HERAF
Health Rights Advocacy Forum

TAKING HEALTH RIGHTS A NOTCH HIGHER

Family Planning Service Provision in Kenya

A Status Report on Government Investment towards Family Planning Contraceptives (2010/2011 - 2012/2013)

HERAF (Health Right Adovacy Forum)

Research Report 2013

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Mr. Edward Miano
Executive Director
Health Rights Advocacy Forum

LIST OF ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AOP	Annual Operational Plans
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Security
CSOs	Civil Society Organizations
DFID	Department for International Development
DFPA	Danish Family Planning Association
DHS	Demographic and Health Surveys
DRH	Department of Reproductive Health
DSW	Deutsche Stiftung Weltbevolkerung
FHI	Family Health International
FP	Family Planning
FPAK	Family Planning Association of Kenya
FPOK	Family Planning Options Kenya
GDP	Growth Domestic Product
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEA	Institute of Economic Affairs
KDHS	Kenya Demographic and Household Survey
KNBS	Kenya National Bureau of Statistics
KNCHR	Kenya National Commission for Human Rights
KSPA	Kenya Service Provision Assessment
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOH s	Ministry of Health
MoPHS	Ministry of Public Health and Sanitation
NCPD	National Council for Population and Development
NEML	National Essential Medicines List
NGOs	Non Governmental Organizations
NHSSP II	National Health Sector Strategic Plan II
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHR	Reproductive Health Rights
SDPs	Service Delivery Points
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNAIDS	United Nation on AIDS
UNFPA	United Nation Family Planning Association
UNFPA	United Nation for Population Development
UPE	Universal Primary Education
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The unmet need for family planning has been attributed to lack of adequate access to FP services at community and facility level, sporadic insecurity of FP commodities and inadequate funding of FP programs. According to Kenya Demographic Survey from 1998 – 2008/09, the unmet need for FP increased from 24% (1998), 25% (2003) to 26% (2008-09). One of the reasons attributed for this was women expressing a desire to space births for at least two years or limit the number of births and hence necessitating the need for a spirited advocacy for increased funding.

Specifically, the study set out to assess the amount of government funding allocated in 2010/2011, 2011/2012 to 2012/2013 financial year and funds spent under FP contraceptives from 2010/2011 to 2012/13 financial years in Kenya. The study also looked at factors influencing family planning contraceptives budget allocation and expenditure in Kenya.

The research utilized both Primary and secondary sources of data collection. For the primary sources, three questionnaires targeting three government agencies were filled through interviews while secondary sources included reviewing of key budget documents. The data collected was manually analyzed and interpreted.

Highlights of the findings of the study include the following:

1. To determine the national FP contraceptives needs, DRH uses the population data as per the most recent KDHS and Contraceptive Prevalence Rate (CPR) by method calculated using KDHS projections as well utilization data from the districts. Based on these needs the Division then embarks on a forecasting and quantification budgeting process to establish the national needs. However, the final budget is inadequate compared to the national demand for FP contraceptives.
2. Each department presents and defends its budget. However, what is finally reflected in the printed budget books bears no resemblance to what was submitted. Indeed the allocation trend over the last three years has remained the same and sole reason provided was budget ceiling.
3. Expenditure is based on printed budget books but depends on availability of liquid cash. All GOK allocation for contraceptives is used for procuring contraceptives, though 10% of the cost is also allocated for distribution of procured contraceptives.
4. Kenya Medical Supplies Authority (KEMSA) reported both pull and push systems are used in distribution. The pull system involves the health facilities making direct orders to KEMSA based on the consumption data at the facility level while the push System involves KEMSA as instructed by DRH distributing FP contraceptives to health facilities and district stores.

The government allocation is not sufficient to meet the public sector FP needs. There is therefore need for allocation of more funds from GOK. Though the budgeting process that leads to allocation and the actual expenditure is rigorous, its purpose is defeated by ceilings from MOF coupled with inadequate representation by heads of departments including Division of Reproductive Health (DRH) during budget defense meetings convened by MOF.

CHAPTER ONE: BACKGROUND

1.1 BACKGROUND

Over the last 50 years, Kenya has emerged as a leader in progress towards health and development goals, reducing child mortality, increasing school attendance among youth, lengthening life expectancy, and strengthening the economy. Kenya was an early leader in family planning in Africa, with a programme that was comprehensive, reached all communities, and had strong political leadership, from the 1960s up until the mid 1990s. As a result, the average number of births per woman dropped from about eight in the late 1970s to around five births per woman in the mid 1990s (KSPA 2010) . The programme stalled in the 1990s due to inadequate investment in family planning, diversion of resources to HIV and AIDS and reduced commitment to family planning from leaders.

As a result, in the past two decades the unmet need for family planning services has been on the rise at 24%, 25% and 26% in 1998, 2003 and 2008-09 respectively according to the Kenya Demographic Health Survey. By decreasing the unmet need, government will decrease unwanted pregnancies, which occur disproportionately among the poor and may have a significant impact on poverty status. Unwanted pregnancies often tend to be higher risk, particularly among women at the extremes of the fertile age spectrum. Unwanted pregnancy is strongly associated with maternal mortality through unsafe abortion and pregnancy complications involved with high-risk factors and other complications leading to maternal or newborn deaths.

The Kenyan family planning program traces its roots to the 1950s when a group of volunteers started what was to become the Family Planning Association of Kenya (FPAK). Nevertheless, it was not until 1967 that a national family planning program was launched. Under this plan, family planning was integrated into the maternal and child health division of the Ministry of Health. In 1984, the Government ratified a set of population policy guidelines to assist in the implementation of the program. Reflecting the 1994 International Conference on Population and Development (ICPD), these guidelines were further revised in the population policy for sustainable development, issued in 2000 (United-Nations 1994; Jain 1998; CBS et al. 2004).

While facing an annual population growth rate of three percent, the Government of Kenya (GoK) incorporation of FP into the country's overall development policy in 1965 led to Total Fertility Rate decline in mid - 1980. Correspondingly, the Contraceptive Prevalence Rate (CPR), which had grown by six percent in the early 1990s, stagnated at 39 percent among married women between 1998 and 2003. Contraceptive discontinuation rates increased from 33 percent of users in 1998 to 38 percent in 2003 and this was linked to problems in contraceptive supply and weaknesses in quality of care and continued high levels of poverty.

1.1.1 Family Planning Contraceptives Policy in Kenya

The 2010 Constitution guarantees the rights of an individual to the highest attainable standard of health, including reproductive health such as Family Planning services. The constitution also obligates the state to fulfill Sexual and Reproductive Health Rights (SRHR) 'progressively', depending on the available resources. This requires the state to demonstrate 'measurable progress towards the full realization of the SRHR and to restrain from adopting 'regressive measures'. The State is further obligated to fulfill those rights that require immediate realization such as freedom from discrimination and freedom to control one's health and body .

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

Kenya's vision for national development found in the vision 2030 aims at building Kenya into a globally competitive and prosperous middle income nation by the year 2030. Guided by the MDGs, the second pillar i.e. the social pillar commits to ensuring increased uptake of Reproductive Health services by poor and vulnerable women.

Despite all these efforts, Kenya only has a contraceptive prevalence rate of 46% (KDHS, 2008-09) suggesting that the

realization of Sexual and Reproductive Health Rights need more prioritization in resource allocation especially in the public sector to enhance access to quality FP services for all women.

1.1.2 GoK Funding for Reproductive Health in Kenya

In 2007, a more comprehensive national RH policy was launched whose goal is to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery; and improving responsiveness to the client needs'. To operationalize the policy, the National Reproductive Health Strategy (NRHS, 1997-2010) was developed. It identified several priority areas namely; safe motherhood, maternal and neonatal health, family planning, adolescent/youth sexual and reproductive health and gender issues.

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

1.1.3 The Impact of HIV and AIDS Pandemic

As the issues surrounding HIV/AIDS increased, many leaders and programmes, including international donors that had focused on reproductive health through family planning shifted their concern to HIV. As a result, the increase in the unmet need and more women forced to seek FP service from private entities was evidenced. Further, contraceptive use stalled, and the fertility level has remained the same for nearly ten years, at 4.6 (KDHS 2008-09) births per women today .

As a consequence of the decreased funding and shift in priorities, the community-based distribution programmes came to a halt. Many people who had relied on CBD workers for family planning information and supplies no longer knew where to turn for services. Another consequence was that information, outreach and advocacy about family planning were dramatically reduced. Efforts to counter myths and misconceptions about family planning were weakened, and misinformation increased (Pathfinder International, 2005).

1.1.4 Proposed Cost Implementation Plans for Family Planning Contraceptives

As part of interventions that will accelerate achievement of MDGs and Vision 2030, the Ministries of Health through the Division of Reproductive Health aimed to raise CPR by at least 2% every year for the next five years to reach 56% or more by the year 2016 . Towards this end, the Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS), in collaboration with development partners and other stakeholders developed the Costed Implementation Plan (CIP) for FP. The plan, informed by the National Reproductive Health Policy 2007, consists of interventions and activities required to achieve this increased CPR as well as the resources needed to support them are reflected in the National Family Planning Costed Implementation Plan (CIP).

Table 1: Estimated Resource Requirements by Thematic Area and Fiscal Year

Estimated Cost (KSh.)				
Thematic Area	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Human Resources	7,500,594,000	2,674,991,000	1,684,458,000	1,660,000,000
Commodity Security	1,157,826,000	1,286,703,000	1,469,863,000	1,662,453,000
Youth	1,500,154,000	1,434,403,000	1,419,213,000	1,419,967,000
Demand Creation	461,589,000	346,094,000	357,838,000	354,880,000
Integration & Cross-Cutting Issues	165,849,000	35,323,000	20,636,000	18,242,000
Total	**10,786,012,000**	**5,777,514,000**	**4,952,008,000**	**5,115,542,000**

(Source: National Family Planning Costed Implementation Plan (2012 -2016), (MOH)

With the total amount needed to attain the goal of 56% CPR by 2016 totaling up to is 26,652,233,000 Kshs i.e. approximately Kshs 26.7 Billion, Kenya needs to show its commitment towards the achievement of these plans which can only be through adequate investment. Comparing this amount to the total of Kshs 68,668,478,564 allocated to the 2 ministries of health in the 2012/13 financial year, allocating Kshs 10.8 Billion seems impossible. The government needs to play a key role if the CIP objectives are to be met within the timelines proposed.

1.2 PROBLEM STATEMENT

The unmet family planning is attributed to lack of adequate access to FP services at community and facility level, sporadic insecurity of FP commodities and inadequate funding of FP programs. These have contributed to slow increase in contraceptive prevalence rates, high infant and child mortality rates, high maternal deaths (an estimated 7,000 women die from pregnancy related causes annually), and a rapidly growing population and urbanizations rates.

Informed by these worrying trends, the Kenya government and stakeholders are repositioning family planning programs and addressing the county's broader population issues. Unfortunately, the country's budgetary allocation into RH programmes is insufficient. This is complicated further by logistical, and management challenges. Public sector facilities still experience occasional stock-outs of specific contraceptives, thereby negatively impacting on method of choice and leading to high discontinuation rates and low uptake of FP services.

Interventions seeking to advocate for higher allocations of the national budgets to FP services particularly on FP commodities as well as advocacy efforts towards effective and 100% utilization of the funds dedicated to FP commodities would lead Kenya to make progression to the attainment of MDG 5. The intervention will result in progression of realization of sexual and reproductive health rights in Kenya. Indeed in the year 2010, Kenya promulgated a new constitution that provides for the right to health care including reproductive health care (article 43(1) (a). This provides opportunities to assess and monitor the budgetary allocations aimed at ensuring family planning services are available and accessed by all.

The project will achieve this by conducting budget analysis in order to gather information that will be useful in advocating for increased budget and expenditure for FP commodities including contraceptives so as to address the frequent stock outs and therefore improve access to Family Planning services in Kenya.

The goal is to improve quality, availability and accessibility of family planning services in Kenya, through increased budget allocation and effective utilization of funds for family planning programmes in 2013/14 and 2014/15 financial years

1.3 OBJECTIVES OF THE RESEARCH

The research aimed at achieving the following objectives:

1. To assess the amount of government funding allocated to FP Contraceptives from 2010/2011 to 2012/2013 financial years in Kenya
2. To assess the amount of government funding spent on family planning Contraceptives in 2010/2011 and 2011/2013 financial years in Kenya
3. To determine the factors influencing family planning contraceptives budget expenditure in Kenya.

1.4 RESEARCH METHODOLOGY

The research was conducted using both primary and secondary sources of data. For the primary source, three questionnaires targeting three government agencies were developed and used to collect data through interviews. These institutions included the Division of Reproductive Health, MOH Finance Department and the Kenya Medical Supplies Authority. For the secondary sources, HERAF reviewed Budget documents including Budget Estimates and Expenditure Reports for 2010/2011, 2011/2012 and 2012/ 2013 financial years. The data collected was then manually analyzed and interpreted.

1.4.1 Location of the Research

The research was carried out in Nairobi, the capital city of Kenya. All government headquarters are situated in the Nairobi including the Ministry of Public Health and Sanitation (MoPHS) and Ministry of Medical Services (MoMS).

1.4.2 Target Population

The target population of the research included government officials from Ministry of Public Health and Sanitation (MoPHS) and Ministry of Medical Services (MoMS). Specifically, HERAF focused on the Division of Reproductive Health, MoPHS Finance Department and the Kenya Medical Supplies Authority.

1.4.3 Sampling

Due to the specifity of the information required (Budget allocation, Expenditure and factors influencing allocation and spending); HERAF sampled three government agencies working on FP contraceptives. These included Division of Reproductive Health (DRH) and MoPHS Finance Department focused on planning for budget allocation towards FP contraceptives and the Kenya Medical Supplies Authority focused on the procurement and distribution of FP contraceptives.

1.4.4 Data Collection Tools

Data collection was done using three different questionnaires with both open and closed questions and filled by key informants from the included Division of Reproductive Health (DRH) and MoPHS Finance Department and the Kenya Medical Supplies Authority

1.4.5 Data Analysis

The data collected was analyzed both manually and use of Ms Excel. Manual analysis applied to the qualitative data collected while the quantitative data was analyzed using the Ms Excel.

CHAPTER TWO: DATA ANALYSIS AND FINDINGS

2.1 AMOUNT OF GOVERNMENT FUNDING ALLOCATED TO FP CONTRACEPTIVES IN KENYA

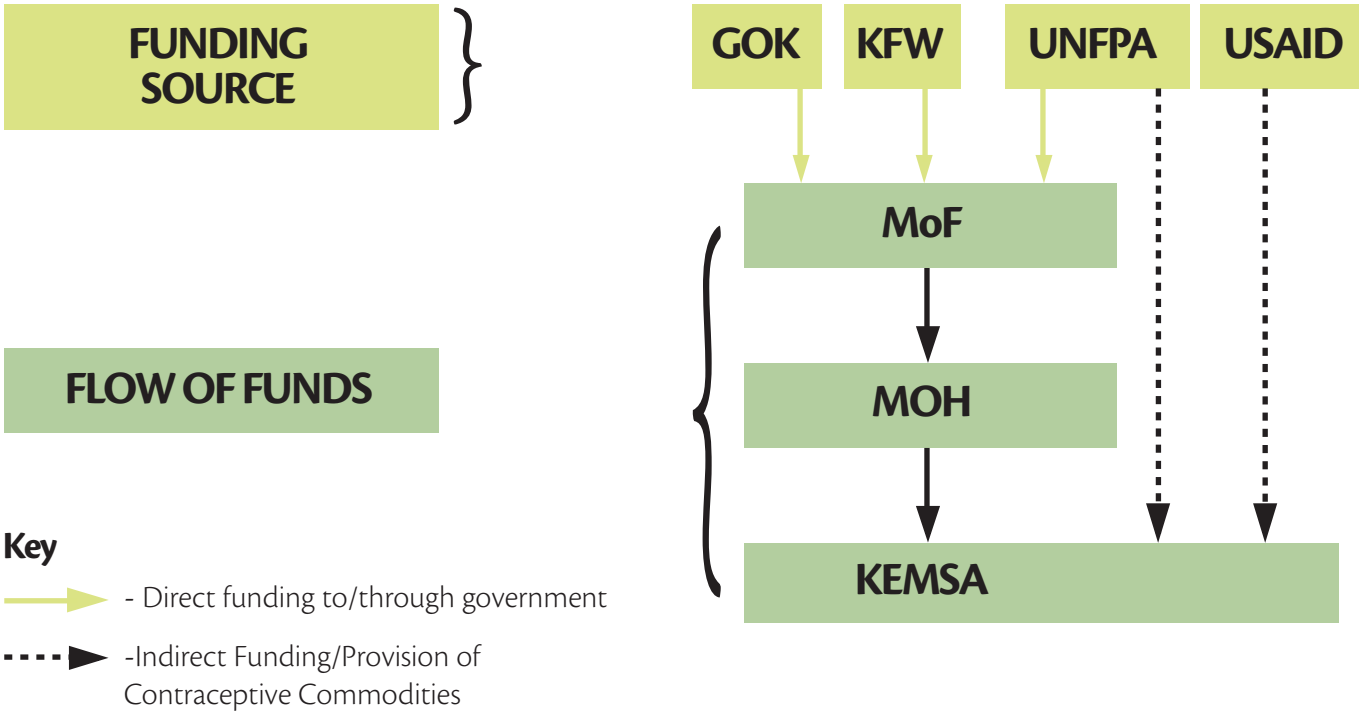
2.1.1 Core Sources of Funding for FP Contraceptives

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

The sources of funding for FP contraceptives, while known, are not always reflected within the GOK budget. For example, while the amount of funds provided by KFW is explicitly stated in the government budget, the amount of funds provided by USAID is not reflected. Also not reflected in the government budget is the amount of money UNFPA allocated towards the emergency consignment of DMPA. While UNFPA makes use of their own procurement system (in emergence and normal situations) and delivers the contraceptives to KEMSA for distribution, the funds which UNFPA has allocated for contraceptives procurement should still be known by relevant government officials for transparency and accountability.

While the amount of money provided by government for FP contraceptives can be determined within budget documents, the exact amount of funds provided by development partners is unclear.

Figure 1: Sources of funding and resource flow for FP commodities in Kenya



2.1.2 Budget Allocation Processes for FP Contraceptives

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

First Phase

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

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

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

Second Phase

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

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

Third Phase

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

According to a DRH representative, support for addressing the resource gap for FP contraceptives is then solicited by way of a meeting which DRH convenes with the FP Commodity Security Committee. This committee comprises FP partners and is chaired by the Director of Public Health and Sanitation. The meeting focuses on obtaining commitment from each partner as to which specific FP method they will support in terms of quantities that will be procured and distribution thereof. This phase in the planning process is one whereby donor funds are relied upon to fill the gaps left due to the portion of allocations from GOK. There is recognition within DRH that this reliance on donors in dealing with

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

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

2.1.3 Allocations towards Family Planning and MCH

The Ministry of Health budget comprises allocations for MOMS as well as MOPHS, with recurrent (allocations from government) and development budgets (on budget allocations from government and development partners) for each clearly specified. Family Planning and Maternal Child Health (FP&MCH) is a programme within the MOPHS budget. The trends observed in relation to the overall MOH budget, MOPHS budget as well as the FP&MCH budget is important as they provide insight into the extent to which FP contraceptives are prioritized.

Between 2010/11 and 2012/13, the Ministry of Health has received approximately 5% of the overall national budget. The failure to move closer towards allocating 15% of overall national budget towards health clearly indicates that Kenya is nowhere near to observing the Abuja Declaration to which it is a signatory.

Table 2: Proportion allocation towards Health and FP Contraceptives for 2010/11 to 2012/13 financial years

Item	2010/11	2011/12	2012/13
Total National Budget Shs Millions	827,258,760,027	946,156,096,073	1,195,170,902,180
Total National Health Budget Shs Millions	41,501,162,510	49,715,126,230	68,668,478,564
Percentage of MoH allocation from National Budget	5.0%	5.3%	5.7%
Family planning and maternal and Child health item 0009	575025000	575025000	575025000
Percentage of FP contraceptives allocation from MoH Budget	1.4%	1.2%	0.8%

(Source: Budget Estimates for FY 2010/11, 2011/12 and 2012/13)

Based on the budget estimates for 2010/11 until 2012/13, MOPHS consistently received the smallest portion of the overall Ministry of Health budget with drastic fluctuations in the proportion allocated namely, 42% in 2010/11, 26% in 2011/12 and 41% in 2012/13. While fluctuations are also observed in the proportion of the MOPHS budget allocated towards FP&MCH, the direction of these fluctuations are opposite to those noted in the proportion of the MOH budget allocated to MOPHS. In 2010/11, FP&MCH received 4% of the overall MOPHS budget, however, in 2011/12 the proportion allocated to FP&MCH increased to 7% and then in the current financial year the proportion decreased to 2% of the total MOPHS budget.

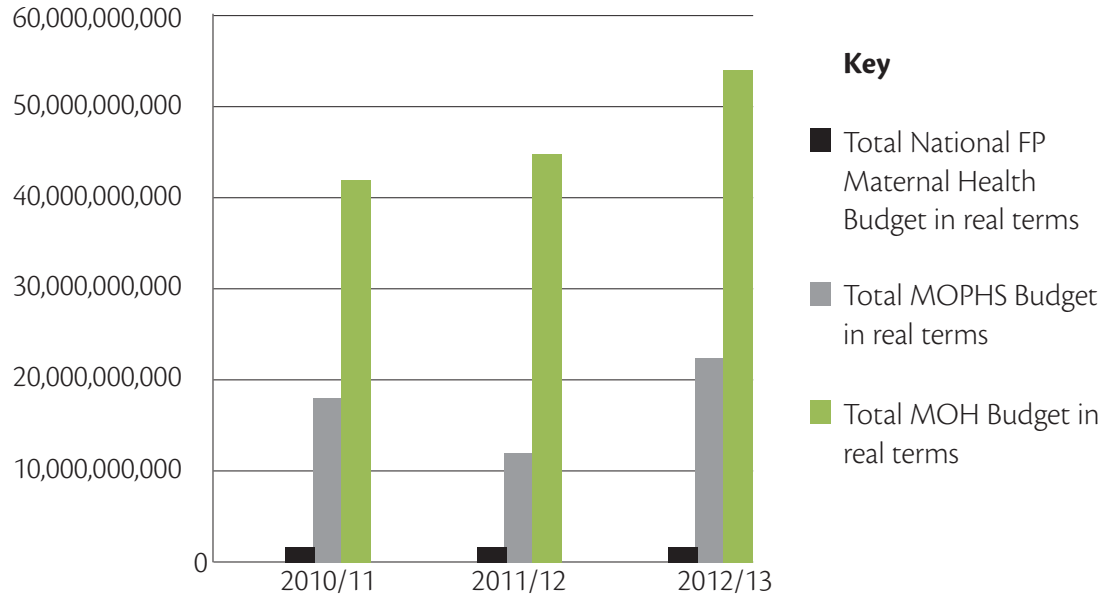
Table 3: Proportion of allocations towards MOPHS and FP&MCH for 2010/11 to 2012/13 financial years

	2010/11	2011/12	2012/13
MOPHS budget as proportion of overall Health budget	42%	26%	41%
FP&MCH budget as proporation of overall MOPHS	4%	7%	2%

(Source: Budget Estimates for FY 2010/11, 2011/12 and 2012/13)

As evident in figure 2, this declining growth rate occurs when during the same period, the real growth rate for both the MOPHS budget as well as the total National Health budget each reflect increases of 101% and 26% respectively. Indicating that even when there is opportunity to increase the budget for FP&MCH this does not occur.

Figure 2: Total budget allocations in real terms for National FP&MH, MOPHS and MOH over the 2010/11 to 2012/13 financial periods



Source: Budget estimates for 2010/2011, 2011/2012 and 2013 FY

From the above information, it is apparent that health continues to be insufficiently prioritized in resource allocation. While undoubtedly this is a concern, more worrying is that FP&MCH remains not only a low priority, but based on the current financial year, a declining priority.

2.2 Amount of Government Funding Spent on Family Planning Contraceptives in 2010/11 and 2011/12 Financial Years in Kenya

2.2.1 Family Planning Contraceptives Budget Line

Within the Estimates of Development Expenditure, the FP contraceptives budget line is coded '2211000 – Specialized Materials and Supplies' within the 'Family Planning and Maternal and Child Health item 0009' budget. To date, allocations for FP contraceptives has been at national level. According to the available budget information for 2010/11 to 2012/13 financial years, the allocations for FP contraceptives have remained constant, with Kshs 522 750 000.00 allocated towards procurement of contraceptives and Kshs 52 275 000 allocated towards distribution of FP contraceptives. The constancy of the allocation is a concern as not only does it reflect that prioritization of FP contraceptives has not improved, but furthermore that the amount allocated towards FP contraceptives has declined in real terms, reflecting real growth decreases of 12% from 2010/11 to 2011/12 and 9% from 2011/12 to 2012/13.

Table 4: Information obtained from 'Development Vote Book Status Report & DRH Representatives

Allocation in Nominal terms	**2010/11**	**2011/12**	**2012/13**
Procurement	522750000.00	522750000.00	522750000.00
Distribution	52275000.00	52275000.00	52275000.00
Total	**575025000.00**	**575025000.00**	**575025000.00**
Deflators	1	1.14	1.25
Allocation in Real Terms	**2010/11**	**2011/12**	**2012/13**
Procurement	522750000.00	458552631.58	415200000.00
Distribution	52275000.00	45855263.16	41820000.00
Total	**575025000.00**	**504407894.74**	**460020000.00**
Real growth Rate		-12%	-9%

(Source: Budget Estimates for FY 2010/11, 2011/12 and 2012/13)

The implications are a worsening situation in Kenya as the decrease in budgets for FP contraceptives occurs inversely to the growth of FP contraceptive needs. Further, three Kenya Demographic Health Surveys have indicated a rise in the unmet need for FP Contraceptives from 24%, 25% and 26% in 1998, 2003 and 2008-09 respectively. This rise has been attributed to lack of adequate access to FP services at community and facility level, frequent stock-outs for FP commodities and inadequate funding of FP programs.

According to DRH representatives, the allocations for FP contraceptives when made available, an Authority to Incur Expenditure (AIE) is issued to KEMSA to facilitate the procurement process. The KEMSA representative as well as the expenditure information in the 'Development Vote Book Status Report' reflected that for the 2010/11 to 2012/13 financial years, the expenditure matched the allocations. As explained by KEMSA and DRH representatives, the expenditure and allocations on FP contraceptives will always balance as a result of the process. These officials explained that only once the MOPHS account reflects the amount stipulated in the budget for this line item, is KEMSA issued with the Authority to Incur Expenditure (AIE) together with the schedule of contraceptives to be procured. Once the AIE is issued, KEMSA is then able to initiate the procurement process and when the contraceptives are delivered by the supplier, DRH is informed and has to verify and authorize KEMSA to make payment to the supplier.

2.2.2 Family Planning Commodities Procured and Procurement Commitments

Despite the uncertainties regarding the allocation and expenditure on FP contraceptives, an alarming reality is that with the declining allocations and expenditure, less FP contraceptives are being attained. This is evidenced by the reported amount of FP contraceptives procured for the 2012/13 and procurement commitments for the 2013/14 financial years as per the GAP Analysis. Table 5 and Table 6 pertains to GAP analysis for 2012/13 financial years, and Table 7 and Table 8 reveals GAP analysis for 2013/14 financial years. When comparing these tables, it is apparent that Kenyan Government commits significantly less towards the attainment of FP contraceptives in 2013/14 than in the previous financial year, and this occurs even when there are increasing requirements identified for a specific FP contraceptive. Questions do arise about the way in which requirements are being defined as in 2012/13, the commitment for male and female condoms did not meet the identified requirements, yet in 2013/14, although there were no commitments towards procurement of female and male condoms, the identified requirements for these FP commodities were significantly less than the previous financial year.

Table 5: FP commodities (excluding male & female condoms) - requirements, committed and GAP analysis 2012/13

Product	Unit price	2012/2013					
		REQUIREMENTS		COMMITTED		GAP	
			(Us Dollars)		(Us Dollars)		(Us Dollars)
		11,713,895	11,186,770	11,713,895	11,186,770		
POPs	0.310	2,195,325	680,551	606,411	187,987	1,588,914	492,563
COCs	0.210	5,341,680	1,121,753	5,341,680	1,121,753		
EC Pills	0.250	127,1814	31,732	64,528	16,100	62,653	15,632
Implants - Jadelle	8.500	185,300	1,575,050	135,300	1,150,050	50,000	425,000
Implants - Implanon	22.820	45,000	1,026,900	45,000	1,026,900		
IUCDs	0.540						
Cycle Beads	2.500	76,260	190,650	76,260	190,650		
Total Cost (US Dollars)			**15,813,405**		**14,880,210**		**933,195**

Source: KEMSA FP Gap Analysis Report for 2012/13

Table 6: Male and Female Condoms - requirements, committed and GAP analysis 2012/13

Product	Unit price	2012/2013					
		REQUIREMENTS		COMMITTED		GAP	
		Units	Cost (US dollars)	Units	Cost (US dollars)	Units	Cost (US dollars)
Male Condom	0.029	602, 586,982	17,595,540	175,070,000	5,112,044	427,516,982	12,483,496
Female condoms	0.720	4,825,726	3,474,523	805,000	579,600	4,020,726	2,894,923
Total Cost (Us Dollars)			**21,070,063**		**5,691,644**		**15,378,419**

Source: KEMSA FP Gap Analysis Report for 2012/13

Table 7: FP Commodities (excluding make and female condoms-requirements committed and GAP analysis 2013/14

Product	Unit price	2013/2014					
		REQUIREMENTS		COMMITTED		GAP	
		Units	Cost (US dollars)	Units	Cost (US dollars)	Units	Cost (US dollars)
DMPA	0.955	17,255,755	16,450,596	8,420,000	8,041,100	8,085,755	8,409,496
POPs	0.310	864,808	268,090			864,808	268,090
COCs	0.210	5,490,548	1,153,015			5,490,548	1,153,015
EC Pills	0.250	64,220	16,023			64,220	16,023
Implants - Jadelle	8.500	347,840	2,956,640	144,889	1,231,557	202,951	1,725,084
Implants - Implanon	22,.820	537,935	12,263,354	159,016	3,628,745	378,379	8,634,609
IUCDs	0.540						
Cycle Beads	2.500						
Total Cost (Us Dollars)			**33,107,718**		**12,901,402**		**20,206,317**

Source: KEMSA FP Gap Analysis Report for 2013/14

Table 8: Male and Female Condoms - requirements, committed and GAP analysis 2013/14

Product	Unit price	2013/2014					
		REQUIREMENTS		COMMITTED		GAP	
		Units	Cost (US dollars)	Units	Cost (US dollars)	Units	Cost (US dollars)
Male Condom	0.029	191,374,510	5,588,136			191,374,510	5,588,136
Female condoms	0.720	1,178,689	1,295,056			1,178,689	1,295,056
Total Cost (Us Dollars)			**6,883,192**				**6,883,192**

Source: KEMSA FP Gap Analysis Report for 2013/14

When comparing the information from the GAP analysis for 2012/13 to that obtained from KEMSA reports on FP commodities procured for that financial year, it is observed that even less units were obtained than those which were initially specified as 'committed' for procurement.

2.3 FACTORS INFLUENCING FAMILY PLANNING CONTRACEPTIVES EXPENDITURE

2.3.1 Expenditure of Family Planning Contraceptives Budget

The flow of funds for FP contraceptives with respect to the funding provided by the government is relatively clear. Government's funds for FP contraceptives are issued by the Ministry of Finance to the Central Bank. Every government Ministry has an account with the Central Bank of Kenya. Once funds are received into the account of the MOPHS as per the line item, then an Authority to Incur Expenditure (AIE) is issued to KEMSA together with the schedule of contraceptives to be procured.

While the flow of funds from government to KEMSA for procurement of FP contraceptives is clear in theory, the practice is complicated as a result of disbursement processes. Even though the financial year commences in June and concludes in July of the following year, the transfer of funds to KEMSA for procurement of FP contraceptives tends to occur late in the financial year. For example, KEMSA reportedly received funds for the 2012/13 financial year in February 2013 i.e. 7 months after the financial year commenced. This inevitably creates delays with respect to the procurement and distribution of FP contraceptives. According to KEMSA, the time period between when a tender for contraceptives is awarded and when the contraceptives are delivered to KEMSA is approximately 90 days (if the process is not interrupted through an appeal to a losing bidder). In light of the report that KEMSA received 2012/13 funds in February 2013, procured contraceptives are likely to only be delivered to KEMSA three months later i.e. in May 2012/13, thus hampering distribution.

2.3.2 Commodities Ordered and Commodities Received

This lack of correlation between contraceptive requirements, commitments and procurement is also evident with respect to the commodities ordered and that which is received. When looking at the patterns within two districts over the 2011/12 and 2012/13 financial years, it emerges that often the quantities of contraceptives ordered are significantly different to that which is received. For example, at Ndeere Health Centre (see Table 10), during the 2011/12 financial year, while the quantity of COC ordered was 20, the quantity received was 252. At Gobei Health Centre (see Table 11), differences in quantities ordered and quantities received for COC during the 2011/12 financial year are also observed. Furthermore, at these same facilities, over the 2011/12 and 2012/13 periods, it is noted that the quantities of Depo that is received tends, more often than not, to be lower than that which was ordered.

Table 9: NDEERE Health Centre 2011/12 and 2012/13 commodities ordered and received

	2011/2012			
Issue Date	**Product Name**	**uom**	**Qty odered**	**Qty issued**
25/10/2011	Depot Medroxyprogesterone Acetate Inj-150mg	KIT(100VIALS)	20	4
25/10/2011	IUCD COPPERT	PIECE	20	50
25/10/2011	Lev/ Ethinyl Tablets(Coc) – 15 Mcg/ 30 Mcg	3X21	20	252
25/10/2011	Levonorgesterel 75mg Implant with disposable trocar	SET	20	50
09/02/2012	Depot Medroxyprogesterone Acetate Inj – 150mg	KIT(100VIALS)	20	4
09/02/2012	IUCD COPPERT	PIECE	20	50
09/02/2012	Lev/ Ethinyl Tablets (Coc) – 15 Mcg/30 Mcg	3X21	20	252
09/02/2012	Levonorgestrel 75 mg Implant with disposable trocar	SET	20	50
21/06/2012	Lev/ Ethinyl Tablets (Coc) -15Mcg/30 Mcg	3X21	200	252
	2012/2013			
Issue date	Product name	uom	Qty ordered	Qty issued
30/09/2012	Levonorgestrel 75 mg Implant with disposable trocar	SET	10	20
31/12/2012	Depot Medroxyprogesterone Acetate Inj -150 mg	KIT(100VIALS)	5	4
21/03/2013	Depot Medroxyprogesterone Acetate Inj – 150mg	KIT(100VIALS)	10	2

Source: KEMSA Master Facility Code sheet for 2011/2012 and 2012/2013

Table 10: GOBEI Health Centre 2011/12 and 2012/13 commodities ordered and received

	2011/2012			
Issue Date	Product Name	uom	Qty odered	Qty issued
531022	Depot Medroxyprogesterone Acetate Inj – 150 mg	KIT(100VIALS)	8	2
531022	Lev/ Ethinyl Tablets (Coc) -15 Mcg/30 Mcg	3X21	8	100
539489	Lev/ Ethinyl Tablets (Coc) – 15 Mcg/ 30 Mcg	3X21	150	100
	2012/2013			
Issue Date	Product Name	uom	Qty ordered	Qty issued
03/10/2012	IUCD COPPERT	PIECE	50	50
13/10/2012	IUCD COPPERT	PIECE	50	50
31/12/2012	Depot Medroxyprogesterone Acetate Inj – 150mg	KIT(100VIALS)	1	4
31/12/2012	Levonorgestrel Tablets (Ec) – 750 Mcg	PACK OF 2s	20	20

Source: KEMSA Master Facility Code Sheet for 2011/2012 and 2012/2013

2.3.3 Distribution of FP Contraceptives

According to representatives within KEMSA and DRH, the distribution of contraceptives occurs through dual systems, namely a pull system and a push system. The pull system is one whereby the amount of commodities distributed is determined by the consumption data at the health facility as each health facility is responsible for making direct orders to KEMSA. The push system (one that is reportedly being phased out and currently limited to the South and North Rift regions) is one whereby a health facility received standard kits and quantities of FP commodities that are determined by DRH. KEMSA also uses the push system with respect to the distribution of FP commodities to district stores as guided by DRH.

According to representatives from KEMSA, DRH Coordinators and more recently the District Pharmacists quantify the district needs, submit the list to the DRH which then allocates which as well as what amount of FP commodities should go to each district and instructs KEMSA accordingly. The push system being applied with distribution to district stores was explained as a consequence of the need to rationalize orders and allocate FP commodities based on what is available. Representatives from within DRH emphasized that unless there are low stocks or FP methods are out of stock, the districts normally get what is ordered. Considering that the FP commodities being procured are insufficient to respond to the FP commodity requirements and are not necessarily aligned with the amounts to which the government commits to procuring, a norm within districts is thus that the FP commodities being ordered are not being received. Furthermore, when there are always insufficient FP commodities, DRH inevitably needs to rationalize the stock and allocate based on availability, therefore, in practice, it seems that the push system is the commonly utilized approach with respect to distribution of FP commodities.

In a context where the stocks for FP commodities are inadequate, the accuracy of the consumption data informing the rationalization process has been questioned with respect to whether or not figures are inflated resulting in the oversupply and expiry of certain FP commodities, and/or an inadequate mix of FP commodities creating stock-outs for some commodities and expiry of overstocked FP commodities.

CHAPTER 3: CONCLUSION AND RECOMMENDATIONS

3.1 Conclusion

The government of Kenya allocates funds towards FP contraceptives. On the other hand while the sources of funding for FP contraceptives from development partners are known they are not always reflected within the government's budget. Therefore it is evident that the amount of money provided by government towards FP contraceptives can be determined within budget documents, but the exact amount provided by development partners remains unclear.

The budget line for Family Planning is found within the 'Family Planning and Maternal and Child Health item 0009' budget in Ministry of Health Development Expenditure. The FP contraceptives budget line is coded '2211000 – Specialized Materials and Supplies'. Unfortunately, allocations into this budget line have remained constant, at Kshs 522 750 000.00 for procurement of contraceptives and Kshs 52 275 000 for distribution of FP contraceptives. The constancy of the allocation is a concern as not only does it reflect that prioritization of FP contraceptives has not improved, but also the fact that the amount allocated towards FP contraceptives has declined in real terms, reflecting real growth decreases of 12% from 2010/11 to 2011/12 and 9% from 2011/12 to 2012/13. This does not augur well for a country that should progressively realize the Family Planning needs of its population as less number of people in need access the commodities each year.

The practice of disbursing funds from Central Bank to the procurement agency KEMSA though clear in theory is complicated and takes longer than anticipated. As a result procurement of FP commodities is never done on time. Even though the financial year commences in June and concludes in July of the following year, the transfer of funds to KEMSA for procurement of FP contraceptives tends to occur late in the financial year. This inevitably creates delays with respect to the procurement and distribution of FP contraceptives which in normal circumstances the process should take about 90 days.

The quantities of contraceptives ordered are significantly different to that which is received at facility levels. In most instances facilities receive less than the amount that they have ordered an indication that health facilities are not able to meet the Family Planning needs of their population.

The provision of contraceptives plays a significant role in contributing towards improved contraceptive prevalence rates, reducing maternal mortality as well as being effective in dealing with rapid population growth. Considering this dire situation in Kenya, formulating plans and ensuring effective budgeting processes and mechanisms to translate the plans into actions are essential. While the government has expressed commitments by way of creating national legislative frameworks and ratifying international legislative agreements, there are glaring gaps with respect to the failure to allocate resources to enable required changes to occur.

It is therefore, necessary for the government to review the budgeting processes, allocations and expenditures as well as procurement and distribution mechanisms of the government and development partners in addressing the contraceptive needs within the country.

3.2 Recommendations

According to the study the following actions are recommended:

1. Budget allocations which reflect commitment towards responding to contraceptive needs

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

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

2. Procurement and distribution processes designed to implement effective responses to contraceptive needs

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

3. Transparency within budgeting for provision of contraceptive commodities

The GOK as well as development partners play a critical role in addressing contraceptive needs within the country. However, in order to better monitor and improve upon the actions of government and development partners, it is essential for there to be transparency within budgeting for the provision of contraceptive commodities.

Therefore, the value of all contributions (financial and commodities) towards provision of contraceptives should be reflected within the GOK budgets. Transparency of these allocations and expenditure will enable better tracking of how much is being contributed towards addressing the contraceptive needs in the country and how efficiently the funds and/or commodities are being used. Furthermore, with more transparent budgeting insight will be provided into how the process of procuring and distributing contraceptives can be improved.

For these actions to be realized and for GOK to have an improved chance of addressing the contraceptive needs within the country, there has to be political support and commitment.

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