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Family Planning: a key ingredient for a healthier and more productive population

"Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care."
Government of Kenya, 2010

Introduction

The Kenyan constitution states that "Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care" (GoK, 2010). Through the Universal Health Coverage Programme under the president's "Big 4 Agenda", the health sector has made a deliberate effort to realise these constitutional provisions by developing policies and directing investments to ensure everyone can access quality, equitable and efficient sexual and reproductive health services.

Family planning is key to achieving universal health coverage and the Government of Kenya is committed to delivering on the promise of the 2030 Agenda for Sustainable Development including target 3.7; to ensure universal access to sexual and reproductive health services, including family planning, information and education. This requires renewed focus in lobbying for and mobilizing resources needed and addressing any funding gaps in achieving universal access to family planning.

In Kenya, unmet need for family planning is 16.9%, meaning that 16.9% of married women of reproductive age who do not want to get pregnant are not using any method of contraception (Track20, 2019). The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior. When women are denied access, for whatever reason, they face a much greater risk of unplanned and unsafe pregnancies. There is a need, therefore, to mobilize communities to adopt behavior and practices that promote healthy maternal, newborn and child health and to seek health care in good time. The current low-utilization of family planning services in the county makes achievement of the health intentions difficult.

Another compelling reason to invest in family planning alongside other investments in human capital is the potential to reap a demographic dividend. This is the accelerated economic growth that may result from a decline in mortality and fertility and the subsequent change in the age structure of the population. With fewer births each year, a county's young dependent population grows smaller in relation to the working-age population (World Bank, 2019). In order to attain the demographic dividend, the programmes that are geared towards fertility rate reduction are essential and need to be embraced. These include increasing commitment to and investment in voluntary family planning in order to reduce family size.

Why invest in family planning?

The benefits of investing in family planning are many and extend far beyond the health sector. While we know that increasing access to family planning supports the achievement of critical health outcomes such as reducing maternal mortality by reducing unintended pregnancies, there is considerable evidence to show that these investments also contribute to wider societal goals such as educational attainment, empowerment and economic growth, among others (HIPS, 2019).

This policy brief makes the case why Garissa county government should urgently address the financing gap in family planning in order to reap these rewards for the benefit of its citizens and the generations to come.

Benefits of investing in family planning

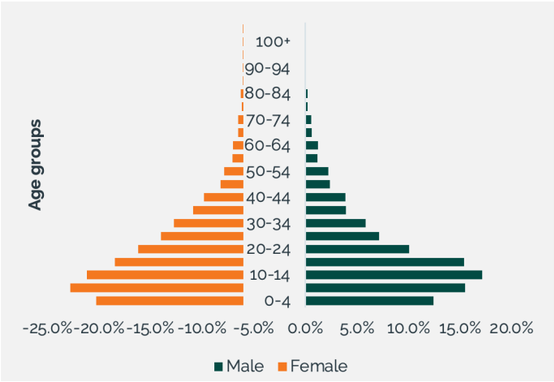
Evidence has shown that family planning:

- is a "best buy" for scarce government resources. It is relatively inexpensive and the return on investment is very high: every additional $1 invested in meeting the unmet need for contraceptives saves $2.20 in pregnancy related care (Guttmacher, 2017).
- helps women and families prevent unintended pregnancies and unwanted births thus contributing a reduction in maternal and child deaths (see figure 4 below).
- helps to lower burden of rapid population growth thereby reducing pressure on the environment and natural resources, thus making progress towards a sustainable human population and addressing environmental concerns such as global warming.
- leads to increases in household savings and helps families to increase investment in individual children - children in smaller families are better educated.
- empowers women by enabling them to plan the size and determine timing of their families.

County Profile

Garissa County has a total population of 841,353 (Male 458,975 Female 382,344, intersex 34). The annual population growth rate in Garissa County is 3.9%. The population age group distribution in the county is varied as follows: under one year 2.5%, under-fives 13.4%, under fifteens 42.1% and women of reproductive age (15-49 years) 22.4 %. The population projections indicate that the county has a high young population (0-15 years), representing a dependency ratio of 90% which means that for every working age person they have one additional number of dependent. This very high dependency ratio, which is significantly higher than the national ratio of 71%, means that the economically active population face a high burden to support children and older persons who are often economically dependent (World Bank, 2019).

Figure 1: Garissa Population Pyramid, 2019



Women of reproductive age (WRA, 15-49) in Garissa County make up about 22.4% of the county's total population. The fertility rate, on the other hand, is high at 6.1% compared with the national fertility rate of 3.9%. The county has a very low contraceptive acceptance rate which stands at 6% per cent compared to the national average of 58% for all methods. Modern contraceptive use is 5.5% compared to the national figure of 53.2%. The county has a high maternal mortality ratio of 646 per 100,000 live births, far above the national rate of 362, and urgently needs to put in place strategic interventions to save more maternal lives (MoH, 2018).

Table 1: Summary Statistics

Category	Garissa	Kenya
Total population	841,353	47,564,296
Male	458,975	23,548,056
Female	382,344	24,014,716
Intersex	34	1,524
Growth rate	3.9%	2.2%
Total fertility rate	6.1%	3.9%
Average household size	5.9	3.9
Contraceptive prevalence rate	6.0%	58.0%
Modern contraceptive use	5.5%	53.0%
Full immunization coverage	80%	68%
Unmet need for modern family planning method	29.9%	18.0%
Women of reproductive age (15-49)	22.4%	25.4%
Maternal mortality rate (per 100,000)	646	362
Neonatal mortality rate (per 1,000)	19.5	22
Infant mortality rate (per 10,000)	33.3	39
Under 5 mortality rate (per 1,000)	43.9	52

A facility assessment undertaken as part of this work gave a number of reasons for low uptake of family planning in the county including the paternal hierarchy as main decision makers; cultural stigma against family planning; lack of male involvement in reproductive health; and lack of knowledge about modern family planning methods.

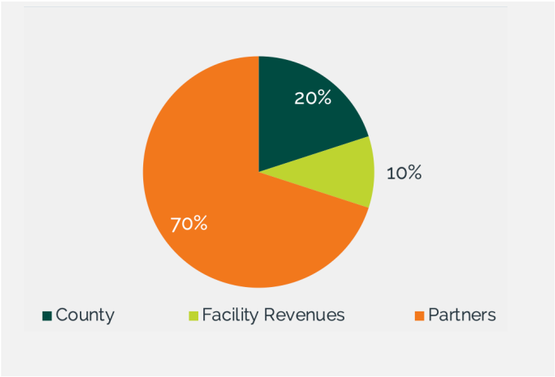
Facility family planning service assessment findings

Facility interviews were conducted to determine the effect of limited FP budgeting has on service delivery especially on commodity availability, human resources, availability of technical support through supportive supervision by the County and Sub-County Health Management Teams (CHMT/SCHMT) and related activities.

The facility assessment was used to establish the status in FP commodities availability and regularity of commodities supply. 33 % of the health facilities assessed faced high levels of regular stock-outs of the regularly supplied contraceptives, whereas 54 % did not face stock-out problems in the 6 months prior to the analysis.

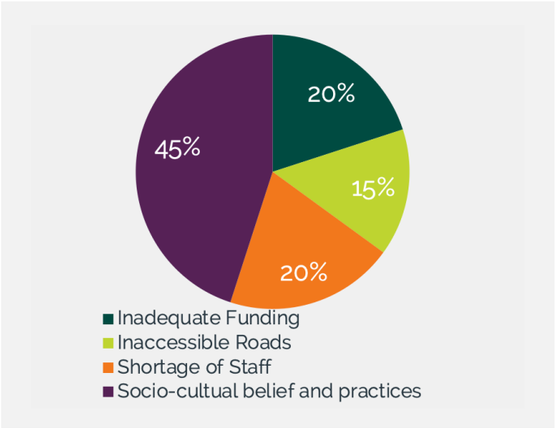
Facility outreach heavily relies on financial support from partners and county government at 70 % and 20 % respectively. In areas that do receive support, the assessment points to a need for better harmonization of the support in order to achieve more gains. Outreaches providing family planning services have been mostly being piggybacked on the other service areas like HIV/AIDs outreaches due to financial and other logistical challenges.

Figure 2: Source of funds for facility outreach support



Inadequate funding and social-cultural belief are some of the major challenge facilities face in running the community outreach programme as shown in figure 4.

Figure 3: Challenges facing community outreach program



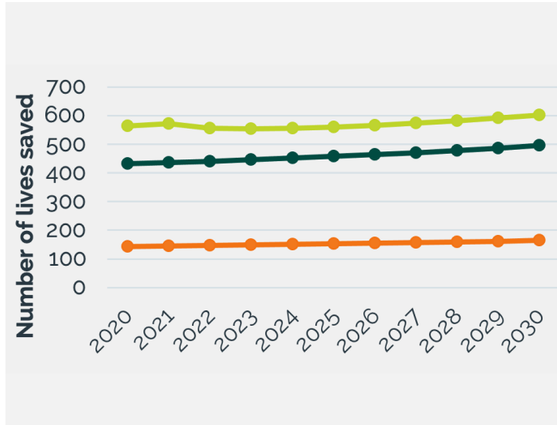
Investment case methodology

The Spectrum demographic modeling tool was used to estimate the costs and associated health, demographic and economic impacts of reducing unmet need for family planning. Baseline data was obtained from Kenya Housing Population Census report; Demographic and Health Surveys; Kenya Household Health Utilization and Expenditure Survey Report; County Economic Reports; County Integrated Development Plans; as well as the Costed Implementation Plans for FP (Bongaarts, 1978).

Investment case findings

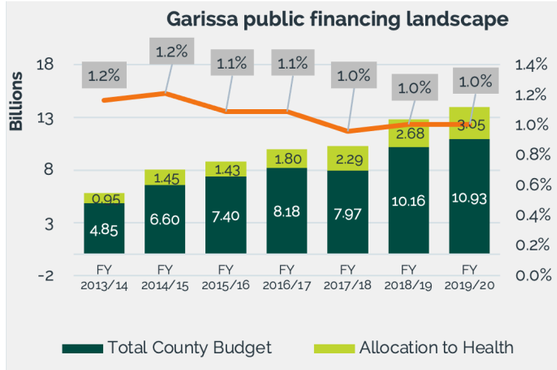
The outputs from the model were used to quantify the amount of resources the county was likely to save in the short or long-term and to estimate the lives that could potentially be saved by meeting the family planning needs of the county. From the model, a total of 1,677 mothers and 10,328 children (aged 0-59 months) lives would be saved by the year 2030, by investing a total of KSh 7.6 billion (or an average of KSh 692 million per year), as shown by figure 4.

Figure 4: Maternal and Child Lives Saved, 2020-2030



The budget allocation to family planning, under the Reproductive Health Programme, at the county level demonstrates the strong political will to increase public investment as well as the commitment to improve coverage of sexual and reproductive health and family planning services. Budget analysis shows that the county has been allocating between 20 % and 29 % of the county allocation to health since 2013/14, out of which about 1 % allocated for Family Planning.

Figure 4: Trends in Allocation to health and Family Planning, 2013/14 – 2019/20



The modelling shows that Garissa County Government, together with its partners, should direct a significant amount of resources to family planning in order to gain the social and economic benefits. An investment of KSh 7.6 billion is required to be invested in family planning in the 11 years (2020- 2030), most of which (46%) are intervention costs as shown in Figure 5 and Table 2. In order to reap these benefits, a significant amount will be required to be invested in health system building blocks including human resource, health products and technology and service delivery.

Figure 5: Total FP investment need, 2020-2030 (KES)

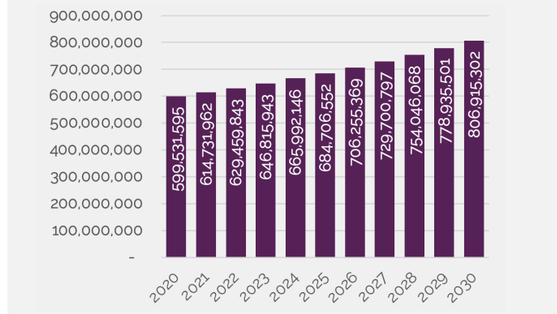


Table 2 provides a breakdown of the total resources needed to be channeled towards supporting the county in the effective delivery of quality family planning services that meets the contraceptive needs of women and girls in the county. It includes a breakdown of potential efficiency savings that range from KSh 89 million in 2020 to high of KSh 119 million in 2030 and wastage costs ranging from 5 million in 2020 and 6 million in 2030.

The potential resources saved from addressing inefficiencies and wastages provide a clear avenue for the county government to realize value for money in utilizing available resources and maintaining a family planning budget line as per the county Family Planning Costed Implementation Plan.

Table 2: Total costs, all delivery channels combined, KSh Millions

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total
Intervention costs	276.4	283.4	290.3	298.4	307.3	316.0	326.1	337.0	348.3	359.9	373.0	**3,516.2**
Program costs	41.5	42.5	43.5	44.8	46.1	47.4	48.9	50.5	52.2	54.0	55.9	**527.4**
Wastage costs	5.0	5.1	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.9	6.0	**59.9**
Logistics costs	16.0	16.2	16.4	16.7	17.0	17.3	17.6	18.0	18.4	18.7	19.1	**191.6**
Infrastructure investment costs	-	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.9	1.1	1.2	**5.9**
Other health system costs	172.2	176.6	180.9	185.9	191.5	196.9	203.1	209.9	217.0	224.2	232.4	**2,190.6**
Inefficiencies	88.5	90.8	93.0	95.6	98.4	101.2	104.4	107.8	111.4	115.1	119.3	**1,125.5**
Total	**599.5**	**614.7**	**629.5**	**646.8**	**666.0**	**684.7**	**706.3**	**729.7**	**754.0**	**778.9**	**806.9**	**7,617.1**

Policy recommendations

Based on the evidence presented in this brief, Garissa County Government needs to do the following;

Invest in family planning particularly at the county level

- The County governments should create budget line items for family planning and contraceptive commodities and ensure there is adequate funding each financial year. Funding provided for FP should be allocated as required. There should also be improvement in quality of, and access to services, with appropriate method mix.

Enhance-based advocacy and policy dialogue for FP prioritisation

- Strengthen targeted advocacy to influence decision makers to create a specific budget line for family planning to enable the county government to raise the required funding of 7.6 billion in the next 11 years through the county budget and enable the county government to track progress against commitments.
- Further promote male involvement and sensitization to address gender inequalities that can impact family planning decisions especially among patriarchal societies.
- Involvement and sensitization of religious scholars to address the myths and misconceptions about family planning
- Developing appropriate key messages targeting the communities on behavior messages

Incentivise and encourage multi-sectoral engagement and commitment

- Encourage investments in family planning to be made alongside other investments in education and employment opportunities in order to reap the demographic dividend thus supporting the National Demographic Dividend Vision through smart policies and smart investments, where family planning plays an important role in achieving Vision 2030
- Encourage development programmes and projects to contribute to family planning in the county by enhancing coordination, partnership, monitoring and evaluation to effectively track family planning activities implemented by multiple stakeholders.

Program recommendation

Capacity development for effective prioritisation of FP Programming

- Ensure the priorities outlined in the Family Planning Costed Implementation Plans are factored in county budgets to sustain FP program implementation in order for the county to reap a range of health benefits (such as maternal and child lives saved) as well as wider societal and economic benefits.
- Enhance supply chain management of county and sub-county pharmacists to prepare timely forecasting and quantification plans, preparing and implementing commodity redistribution plans to avoid stock-outs at facility level.

Lower the burden of out-of-pocket spending on reproductive health and child health:

- Financial barriers are a major reason why many people do not access health services, including family planning. As outlined in the Costed Implementation Plan, the national government must ensure that family planning is fully covered in the National Health Insurance Fund (NHIF).
- The county government must support the enrolment of more women under the NHIF to access affordable and quality health services including FP.

Need to scale up investment in high-impact preventive interventions to address missed opportunities and integrate FP services (HIPS, 2019)

- Although there has been an increment in budget allocation to health, funding to FP program has flattened at 1% and the knowledge, attitude, and practice of family planning is low in the county due to lack of education, few resources, and poverty as compared to developed counties. Investing in high-impact interventions will help to expand the programme to reach underserved groups and regions.

Strengthen community efforts to promote maternal, neonatal, and child health/demand creation

- There is a need to mobilize communities to adopt behaviour and practices that promote healthy maternal, new-born and child health and to seek health care in good time. Current low-usage of health services is making the successful achievement of health intentions difficult.

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