FAMILY PLANNING SPENDING ASSESSMENT IN KENYA

FY 2014/15 – 2015/16

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List of Acronyms and Abbreviations

AMREF	African Medical and Research Foundation
BMGF	Bill & Melinda Gates Foundation.
CPR	Contraceptive Prevalence Rate.
DfID	Department for International Development
DRH	Division of Reproductive Health
FBO	Faith-based Organization
FHI	Family Health International
FHOK	Family Health Options of Kenya
FP	Family planning
GDP	Gross Domestic Product
GOK	Government of Kenya
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KEMSA	Kenya Medical Supplies Authority
KfW	Kreditanstalt für Wiederaufbau
KIHBS	Kenya Integrated Household Budget Survey
KSh	Kenya Shillings
mCPR	Modern Contraceptive Prevalence Rate
NASA	National HIV/AIDS Spending Assessment
NCPD	National Council for Population and Development
NGOs	Non-government Organizations
OECD	Organization for Economic Co-operation and Development
PATH	Program for Appropriate Technology in Health
PS Kenya	Population Services Kenya
PSI	Population Services International
ROK	Republic of Kenya
TFR	Total Fertility Rate
TCI	The Challenge Initiative
UNFPA	United Nations Population Fund
URHI	Urban Reproductive Health Initiative
USAID	United States Agency for International Development

Executive Summary

Kenya family planning (FP) program has in recent years recorded impressive gains, with the contraceptive prevalence rate improving from 46 percent in 2009 to 58 percent in 2014. These achievements notwithstanding, the unmet need for family planning stands at 18 per cent nationally, which calls for continued financing of FP among other factors. In Kenya, financing of FP interventions and other activities originate from several sources that include development partners (donors), government – national and county and private sector including households through out of pocket spending.

The specific objectives of the FP Spending Assessment were to determine the total expenditures on FP in 2014/15 and 2015/16 from different sources including, determining the FP expenditures by different spending categories, and establish who are the providers of FP services and analyze spending by each provider ownership and type. There were four basic questions that were answered by the assessment including who pays for FP services at the county level, who manages the FP funds and up to what level, who provides FP services, and what FP services were provided.

All the three set of entities involved in FP financing and service provision were included in the sample of entities used to collect data from. The financing sources included National Government, County Government, USAID, UNFPA, KfW, DfID, Bill & Melinda Gates Foundation. The financing agents considered Kenya Medical Supplies Authority, NCPD, Planning Division at the Ministry of Health, Marie Stopes, The African Medical and Research Foundation, JHPIEGO, Family Health International, Pathfinder, PATH, Population Council, IntraHealth, Clinton Foundation, Family Health Options of Kenya, Palladium and Population Services Kenya (PS Kenya). In addition, counties sampled were The Challenge Initiative (TCI) called Tupange Pamoja in Kenya of Kericho, Migori, Mombasa, Nairobi, Uasin Gishu and Non-TCI counties of Nyeri, Kakamega, Kajiado, Nyamira, Makueni. Data collection exercise involved both top-down and bottom-up approaches. The top-down approach was implemented first, collecting data from financing sources as well financing agents. Additional data were sought from OECD database on the FP expenditure in Kenya. In terms of the bottom-up approach, the data were collected data from service providers at the counties. The data were collected from both public and private health facilities.

The results showed that total FP spending was KSh 6,413 million (US$ 73 million) in 2014/15 and KSh 6,813 million (US$ 70 million) in 2015/16. These results, however, did not include out-of-pocket expenditure for FP. FP expenditure was about 2 percent of total health expenditure. As percentage of GDP, FP expenditure stood at 0.11 percent 2014/15 and declined slightly to 0.10 percent in 2015/16. United States Government accounted for the largest share of total FP expenditure, contributing about 28.2 percent followed by county governments (27.9%), Government of United Kingdom (16.5%), UNFPA (11.1%) and BMGF (7.1%) in 2014/15. In 2015/16, there was a general decline in percentage contribution of the major sources of financing FP except for the Government of United Kingdom. This notwithstanding, in 2015/16, the major sources were still United States Government (27.2%), county governments (26.3%), and Government of United Kingdom (18.9%).

International NGOs and foundations were the main financing agents in the provision of FP services in the country. County health departments came second accounting for slightly over 28 percent of the total FP spending in 2014/15 and about 27 percent in 2015/16. KEMSA, through financing of FP commodities, managed for the third largest share of the expenditure

taking about 15 percent of the total expenditure. Marie Scopes, AMREF and national NGOs were also key entities in channeling funds for FP activities and services.

In terms of FP service providers, county health facilities consumed for the highest expenditure on FP services. Overall, the public health facilities accounted for about 43.6 percent of the total expenditure on FP. In more disaggregated analysis, the share of spending on FP activities by international NGOs (excluding JHPIEGO and Marie Stopes) was 21.6 percent followed by public dispensaries (19.6%), public health centres (18.6%), Marie Stopes (10.9%), JHPEIGO (5.9%), public hospitals (5.4%) National NGOs (5.0%) and AMREF (3.8%). In terms of FP services, provision of implants accounted for the highest amount and percentage of the total FP expenditure, taking 23 percent in 2014/15 and 20 percent in 2015/16. This was followed by provision of injectables at 16.6 percent in 2014/15 and 17.3 percent in 2015/16. In both financial years, human resources for FP services took the largest amount of expenditure, followed by administrative expenses and expenditure on implants and related consumables. Other recurrent expenditure included expenses for meetings and workshops and injectables.

The FP expenditure was allocated to the counties using different criteria. For the financing sources and financing agents that did not disaggregate the data, county mCPR and adjusted for actual users of FP services were used to allocate FP spending appropriately. For instance, for USAID supported agents and implementers, their FP spending was allocated to counties of focus. The expenditure on FP commodities from KEMSA was already given by counties and that was taken as given. The indirect expenditure by County Governments was estimated per country as explained in the methodology.

Conclusion

It can be concluded that financing of FP services is heavily depended on international funds and this is not sustainable. Another conclusion is that FP spending assessment approach provides useful information for understanding total expenditures and the components and it can be Can be replicated in other countries

In addition, this study has made a unique contribution of tracking financial flow for FP in Kenya and thus keeping the reproductive health agenda alive by highlighting resources flows for FP. The findings in this study will help the national government, county governments, donor agencies and NGOs working in reproductive health access financial resource flows for FP which is critical in raising awareness on the need for resource mobilization to address the unmet FP needs.

To enable more effective and timely advocacy for resources—in addition to tracking the funding commitments and spending the study team has mapped the various processes to show how the funds flow from source of financing to financing agents and then to service provider. This is expected to enable stakeholders to get a better understanding of the financing process for FP in Kenya. In addition, the tracking exercise can potentially help other countries

understand their financing situation, track funding flows, and effectively advocate for resources. In addition, the methodology used can be used with other tools to complete a broader analysis of total supply chain costs, funding levels, and advocacy needs for family planning programs or the wider health sector.

Recommendations

1 The national and county governments should continue exploring new health financing strategies as well as consider increasing investments and public spending on for FP. At the same time, the private sector should take a more active role considering that donor support is unsustainable in the long term. Leverage on the private sector resources to expands PF commodity and services availability. This could be done by embracing Public Private Partnerships.

2 Given the importance of household expenditure on reproductive health, it will be critical in future to analyze total household spending on FP and on which specific components of FP

3 Replicating this approach in other countries to inform countries on spending and also inform international monitoring of FP spending at global level.

4 Although the assessment showed that county governments were contributing to spending on FP services, there was no one county with direct budget allocation for FP. County health department should therefore introduce and fund a line item on FP goods and services. This will ensure county governments support through direct financing the FP.

5 Inclusion of FP services as part of the benefit package of NHIF/proposed SHI to increase access and financing of FP services.

6 Ensure political commitment at both national and county level to leverage additional funding for FP.

7 Employ financial resource tracking of FP services to inform policy, planning and budgeting of FP commodities. Financial tracking of FP services can also inform alternative financing approaches.

8 Explore the possibility of incorporating family planning into the conditional cash transfer (CCT) program to increase access to family planning services.

INTRODUCTION

1.1 Country Context

Kenya is one of the countries in the East Africa, and it has a total surface area of 581,309 km^2. It borders Tanzania to the south, Uganda to the west, South Sudan to the northwest, Ethiopia to the north and Somalia to the northeast. Kenya's population was about 46 million in 2016, making it the seventh most populated country in Africa[1]. Kenya's population is rapidly growing, and it is projected that it could increase to 85 million by 2050. Kenya's population is predominantly young mostly rural, with only 24% of Kenyans living in urban settlements. However, the country is experiencing rapid urbanization.

In the last three years, the country has experienced sustained but modest economic growth. According to Kenya National Bureau of Statistics, the gross domestic product (GDP) grew by 5.3 per cent in 2014, 5.7 per cent in 2015 and 5.8 per cent in 2016. In absolute terms, GDP at market prices was KSh 5,402,410 million, KSh 6,260,646 million, KSh 7, 158, 69 million in 2014, 2015 and 2016, respectively. According to the World Bank, the GDP at current US dollars was US$ 1.4 billion in 2014, US$ 63.4 billion in 2015 and US$ 70.53 billion in 2016. GDP per capita income was US$ 1335 in 2014, US$ 1377 in 2015 and US$ 1,455 in 2016. The purchasing power parity (PPP) GDP per capita, based on international dollars was 2,900 in 2014, 3,019 in 2015 and 3,156 in 2016. The growing per capita income took the country to lower middle-income status in 2014. The implications of this would be increased capacity of the economy to generate revenue for national government, which may increase domestic financing of services including health services in generally and family planning (FP) services.

The poverty head count ratio is estimated at 45.6 per cent based on the Kenya Integrated Household Budget Survey (KIHBS) 2005/06, indicating that about 46 percent of Kenyans live below absolute poverty line. The poverty varies between rural and urban areas, with 49.1 per cent of rural population and 33.7 percent of urban population living in absolute poverty. The country is currently processing data for KIHBS 2015/16, which will give current poverty level in the country. Kenya, like most Sub-Saharan Africa, have low human development index. According to World Human Development Reports of 2015 and 2016, Kenya's human development index (HDI) was 0.548 in 2014 and 0.555 in 2015.

[1] Kenya National Bureau of Statistics, Economic Survey 2017

1.2 Overview of FP In Kenya

Kenya FP program has had impressive achievements, with the contraceptive prevalence rate (CPR) standing at 46 percent in 2009 and 58 percent in 2014. These achievements notwithstanding, the unmet need for family planning stands at 18 per cent nationally, though there are disparities across counties. The large unmet need is attributed to inadequate service provision and poor access to FP commodities, and lack of support for contraceptive security due to over-dependence on donor funding. Besides, contraceptive use is suppressed by low male involvement in family planning and high unmet need for family planning and, poor access to family planning services (Republic of Kenya, 2011).

The dividends of the increasing CPR have been a decline in total fertility rate (TFR) over the years, to stand at 3.9 in 2014. Figure 1.1 and Figure 1.2 provide trends in CPR and unmet need for FP, respectively, over the years.

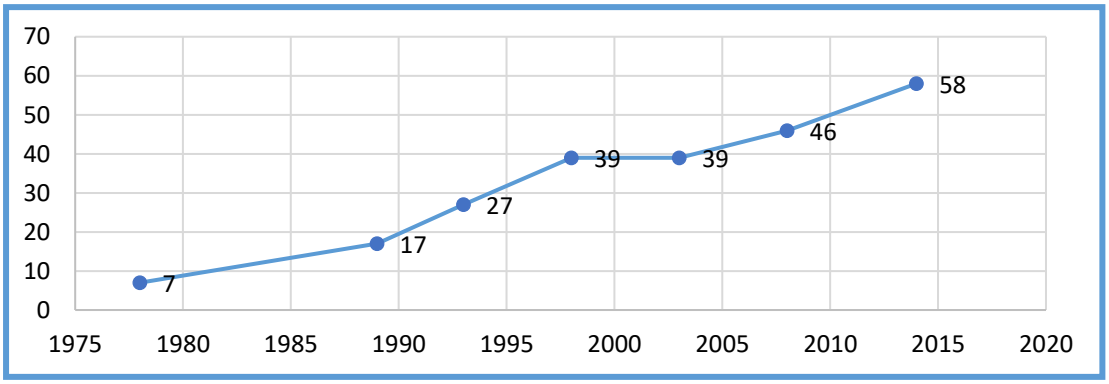

Figure 1.1: Trend in overall CPR

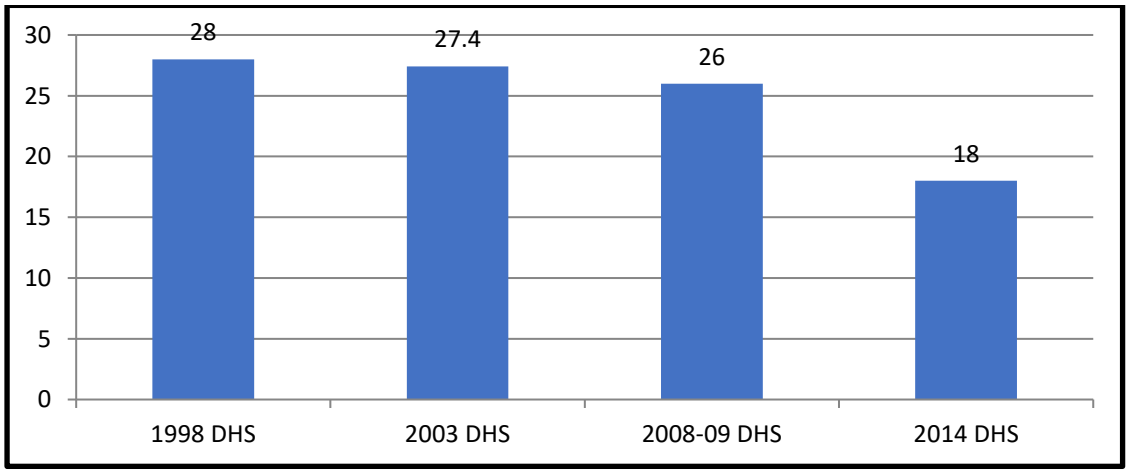

Figure 1.2: Trend in unmet need for FP

1.3 Context for the Assessment

Track20 is a Gates Foundation funded project to track progress in FP towards the goals of FP2020. One of its activities is to track FP expenditures. The tracking borrowed heavily from UNAIDS National HIV and AIDS Spending Assessment (NASA). NASA is a standard comprehensive and systematic methodology used internationally to determine the flow of resources for HIV and AIDS. Tracking of FP expenditure considered resource flow of both financial and non-financial resources from their origin to the end point of service delivery, among the different institutions involved. Tracking was done from financing sources whether public, private or foreign and among the different providers of services. In summary, the tracking sought p to answer the following questions:

- Who pays for FP in the county?
- Who manages the funds and up to what level?
- Who provides the FP services?
- What FP services were provided?

In general, FP tracking was aimed at obtaining the overall picture of the total spending on FP and FP services provided in the country and in the counties by the various stakeholders. The specific objectives of the FP Spending Assessment were to determine the total expenditures on FP in Financial Years (FY) 2014/15 and 2015/16 from different sources including, determining the FP expenditures ~~on~~ different spending categories, and establish who are the providers of FP services and analyze spending by each provider type.

The results of the study provide estimates of expenditures on FP from government (national and county) essential to: i) inform global monitoring of spending on FP, especially government contribution can be used in estimating county government contribution for Tupange Pamoja (TCI), ii) inform the resource gap analysis at national and county level by comparing available resources and resource needs based on the strategic and operational plans; iii) provide financial information that will inform policy dialogue, iv) help in planning and budgeting at the County level in order to strengthen the case for family planning within the County and National development agenda ; v) be used to advocate for increased funding for FP resources in counties, and vii) be used to monitor progress of polices in place by assessing whether expenditure is per priority areas.

METHODOLOGY

2.1 Overall Scope of the Exercise

This scope of this study was the government financial years 2014/15 and 2015/16. In Kenya, government financial year begins on 1st July and ends on 30th June the following year. However, other sources of FP resources used different years, mainly calendar year, running from January to December. To harmonize the financial years, attempts were made to estimate expenditure based on the government financial year. Finally, FP expenditure by households in terms of out-of-pocket was not included.

2.2 Classifications used to build the FP spending Accounts

This study adopted NASA classifications, but customized them to FP spending tracking. Following the NASA classifications, FP spending assessments classifies three sets of entities in the flow of funds for FP as financing sources, financial agents and service providers.

i. Financing Sources: Financing sources are defined as entities which ultimately bear the expenses of financing FP services and related activities.
ii. Financial Agents: Financial agents are defined as entities which pass funds from financing sources to other financial agents or service providers in order to pay for the provision FP services. They determine how funds are allocated to finance the different FP services.
iii. Service providers: Providers are defined as entities that produce and provide health care goods and services as they relate to FP.

In addition to the three entities, the other classifications consist of family planning service categories and categorization of budgetary items in the production of FP services. Table 2.1 through Table 2.5 summarize the classification.

Table 2.1: Classification used for financing sources

FS: Financing sources		Where funding originates from.
FS.01	Public funds	This is further broken into National Government, regional government, County Government.
FS.02	Private funds	Include households, private for-profit and not-for-profit organizations.
FS.03	International funds	Include wide range of entities such as bilateral, multilateral, foundations such BMGF, and international private organizations.

Table 2.2: Classification used for financing agents

FA: Financing agents		Channels for funding.
FA.01	Public sector	Includes ministries and departments at national and regional government, state corporations
FA.02	Private sector	Include households, private insurance firms, private employers, for-profit and not-for-profit organizations, national NGOs.
FA.03	International purchasing organizations	Include wide range of entities such as bilateral, multilateral, foundations such BMGF, and international NGOs.

Table 2.3: Classification used for FP service providers

PS: FP service providers		Actors engaged in the production and delivery of Services.
PS.01	Public sector providers	Providers that are integrated in government. This would also include government agencies (such as Ministries, hospitals, schools, etc.)
PS.02	Private sector providers	Not-for-profit and for-profit organizations including private health facilities and national NGOs.
PS.03	Bilateral and multilateral entities – in country offices	Bilateral and multilateral agencies.
PS.04	Rest-of-the world providers	Other international organizations such foundations.

Table 2.4: Classification used for FP services

FPSC: FP service categories		Activities or programs to that result in effective provision of FP to those who need them.
FPSC.01	Family planning services	Further classified into provision of different FP methods, demand creation activities among others.
FPSC.02	Program management and administration	Program expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. These include planning and administration, monitoring and evaluation (M&E), operation research, supply systems support among others.
FPSC.03	Human resources	This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the FP. Cost of human resources for provision of FP methods is already covered under the FP services and was excluded from human resource classification. Training and capacity building is the main category under this classification.
FPSC.04	Enabling environment	Mainly advocacy and institutional development expenditure
FPSC	FP related research	Classified into different types of research excluding operational research.

Table 2.5: Classification used for FP services

FPPF: FP factors of production		They consist of budgetary items in terms of recurrent and capital expenditure.
FPPF.01	Recurrent expenditure	Further classified into budget items such salaries, FP commodities, IEC, materials, administrative expenses such utilities, transport and travel expenses, meeting and workshops expenses etc. Provision of different FP methods, demand creation activities among others.
FPPF.02	Capital expenditure	The main categories of the classification features are buildings, capital equipment, and capital transfers. These categories may include major renovation and reconstruction or enlargement of existing fixed assets, as these interventions can improve and extend the previously expected service life of the asset.

2.3 FP Spending Assessment Approach

The FP spending assessment borrows heavily from National HIV/AIDS Spending Assessment (NASA) approach. In this adapted methodology, the resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to support the provision of family planning services in a country. The tool tracks actual expenditure from public, private and international sources for all FP related interventions, services and activities. By adapting the NASA methodology, this assessment follows the national health accounts framework and principles. It applies standard accounting methods to reconstruct all transactions in a given country, 'following the money' from the funding sources to agents and providers and services provided.

The FP assessment, therefore, follows a system of expenditure tracking that involves the systematic capturing of the flow of resources by different financial sources to FP service providers, through diverse mechanisms of transaction. A transaction comprises of all the elements of the financial flow, the transfer of resources from a financial source to a financing agent or service provider, which spends the money in different budgetary items to produce FP services for population in need of FP.

FP spending assessment applies either or both top-down and bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from financing sources down to the financing agents and FP service providers. On the other hand, the bottom-up approach tracks expenditures from service providers' expenditure records, and facility level records, then following up to the financing agents and eventually the financing sources.

Given that the service providers, especially the health facilities lack data on actual expenditures on FP, costing techniques can then be used to estimate actual expenditure based on internationally accepted costing methods and standards used measure past actual expenditure. Ingredient and step-down costing is used for direct and shared expenditure for FP, whilst shared costs are allocated on the most appropriate utilization factor. As part of its methodology, the FP assessment employs double entry tables or matrices to represent the origin and destination of resources, avoiding double-accounting of the expenditures by reconstructing the resources flows for every transaction from funding source to service provider, rather than just adding up the expenditures of every agent that commits resources to FP activities.

2.4 Sampling

To facilitate the sampling process, a listing frame of key financing sources and financing agents in provision of FP services in Kenya, was developed by the team from Kenya National Council for Population and Development (NCPD). The key financing sources considered were the National Government, the County Government, USAID, UNFPA, KfW, DfID, Bill & Melinda Gates Foundation. In addition to the financing sources, a representative sample of financing agents was selected purposively based on the volume of funds managed by the agent[2]. These included Kenya Medical Supplies Authority (KEMSA), NCPD, Planning Division at the Ministry of Health, Marie Stopes, The African Medical and Research Foundation (AMREF), JHPIEGO, Family Health International (FHI 360), Pathfinder, PATH, Population Council, IntraHealth, Clinton Foundation, Family Health Options of Kenya (FHOK), Palladium and Population Services Kenya (PS Kenya).

Furthermore, a sample of counties was also selected, covering all regions in the country. These were Tupange Challenge Initiative (TCI) counties of Kericho, Migori, Mombasa, Nairobi, Uasin Gishu and Non-TCI counties of Nyeri, Kakamega, Kajiado, Nyamira, Makueni. In these counties, at least 10 service providers were sampled in each county with associate of County Reproductive Health Teams. Additionally, county finance departments in the 10 counties were included in the sample.

2.5 Data Collection

Data collection exercise involved both top-down and bottom-up approaches. The top-down approach was implemented first, collecting data from financing sources as well financing agents. NCPD provided logistic support for data collection by providing introduction letters to team that undertaking data collection. NCPD submitted the letters as well following with phone call to the selected sources and agents. The standard questionnaires were used to collect data from the financing sources and financing agents. However, not all of them were able to fill the forms but they provided financial data based on their report formats.

KEMSA provided disaggregated data on expenditure on FP commodities by sources of funds, county, health facility or service providers, facility ownership. The sources funds FP commodities were UNFPA, USAID, KfW, and Government of Kenya. Additionally, UNFPA

[2] Note that some of the financing agents are also sources of funds as well as providers of services.

and KfW provided data on their contribution for FP commodity procurement as well other FP related activities in the country. The KEMSA data did not show DfID contribution but DfID provided its expenditure for FP in the public health facilities. The financial agents that provided data were JHPIEGO, Marie Stopes, NCPD, AMREF, FHI 360, Pathfinder, PATH, Population Council, IntraHealth, Clinton Foundation, FHOK, Palladium and PS Kenya.

Additional data were sought from OECD database on the FP expenditure in Kenya. These were used to triangulate support from USAID to FP in the country. The OECD data also contained disbursement from DfID and UNFPA. However, the data provided directly by DfID and UNFPA were used only, excluding the amount indicated under OECD for these two sources. The OECD FP expenditure data for USAID for the financing agents that did not provide was used to estimate amounts used for FP. In case where the funds were meant for both FP and population activities, the funds were allocated at about 20%, based on the FP workload within MCH/FP services in the country. Lastly, in the top-down approach, data on county health expenditure for the two years were obtained from the National Treasury.

In terms of the bottom-up approach, the data collecting team visited the counties and collected data from service providers using standardized tools. The data were collected from both public and private health facilities (mainly not for-profit). The data collected induced workload statistics for FP services and all other service, staff utilization FP in specific and where relevant staff utilization for MCH/FP in general. The expenditure data on FP at the facility level were not generally available since the services are integrated. This necessitated the use of costing methods to estimate amount spent for FP at that level. Similarly, expenditure on FP specific activities by the country government was not available for the same reason as well the fact most counties do not have FP specific line item.

2.6 Data Analysis

Data entry and analysis were facilitated by use of Excel Spreadsheet. The data were entered by identifying the expenditure by a given FP service provider, and tracing back to a financing agent and one financing source at a time. This was done to ensure no double counting. One entry in one row in Excel comprised a financing source, a financing agent, a service provider, FP service categories, and FP production factors. Indirect contribution of the county government and private sector health care providers were estimated using costing approaches as explained in the sections that follow.

2.7.1. Estimation of Indirect County Government Expenditure

The new constitutional dispensation has resulted in creation of regional level governments called county governments. In the devolution, services such as health care services and social services have been transferred from Central government to the County governments. County Governments make significant contribution to the FP provision through human resources and health infrastructure. County Governments pay for the health personnel and other recurrent inputs especially overhead costs in the provision of health services in generally, and FP services in particular. Additionally, the Governments provide space and equipment in the provision of FP- related health services. Indirect contribution by the County Governments was estimated for the period under the study. In the estimation, costing analysis was carried out to determine the actual expenditure incurred by counties for health services during the period of expenditure tracking.

County expenditure from National Treasury was disaggregated into personnel emolument, drugs, non-pharmaceuticals, laboratory and x-ray regents and materials, operations and maintenance, and training. The total expenditure, excluding drugs, were added together to obtain the amount that would be allocated to FP services in the counties. This amount was allocated to FP services in each county using the percentage of FP workload in total workload in the county. The workload data in each county was obtained from the Kenya DHIS-2. In order to compute the percentage of FP service in utilization in the total workload, all workloads were converted in outpatient visits equivalent. In the conversion, one inpatient-day or one bed-day was assumed to be equal to 4 outpatient visits. The rule of thumb from literature is from 3 to 4 visits for a bed-day. In Kenya, the Dynamic Costing Model, used even higher intensity ratio of one bed-day for 4.6 outpatient visits. All the bed-days encompassing inpatient and maternity services were converted into outpatient visits and were added to all outpatients visits to obtain total workload equivalent. The FP percentage was then obtained by dividing total FP visits by total workload equivalent visits. This was done for every county for the two years (see Appendix A for details). The county health expenditure, excluding drugs, was multiplied by FP percentage to get an estimate of County Government FP expenditure in each of the financial years.

2.7.2. Estimating Private Sector FP Spending

Primary data were collected from private health facilities proving FP services in the sampled counties. The data provided by these facilities were on workload and staff utilization for FP

services. Given data limitation, a different cost approach was used. In the approach, the average number of full-time employee (FTE) in FP service, at different level of facilities, was estimated based on the sample data collected. In addition, the number of not-for-profit facilities and number of for-profit facilities were obtained using KEMSA data on commodity distribution. The FTE multiplied by average gross gave the average cost of human resource for FP service at a given level of facility. The total cost of human resource for the sector was obtained by multiplying cost of human resource at facility by the total number of facilities in the country.

FP EXEPNDITURE FINDINGS

3.1 Financing of FP in Kenya

In Kenya, financing of FP interventions and activities are undertaken by different stakeholders. The stakeholders consist of sources of funds, financing agents, and the providers of FP services. Figure 1.3 presents diagrammatic view of the flows of funds for FP.

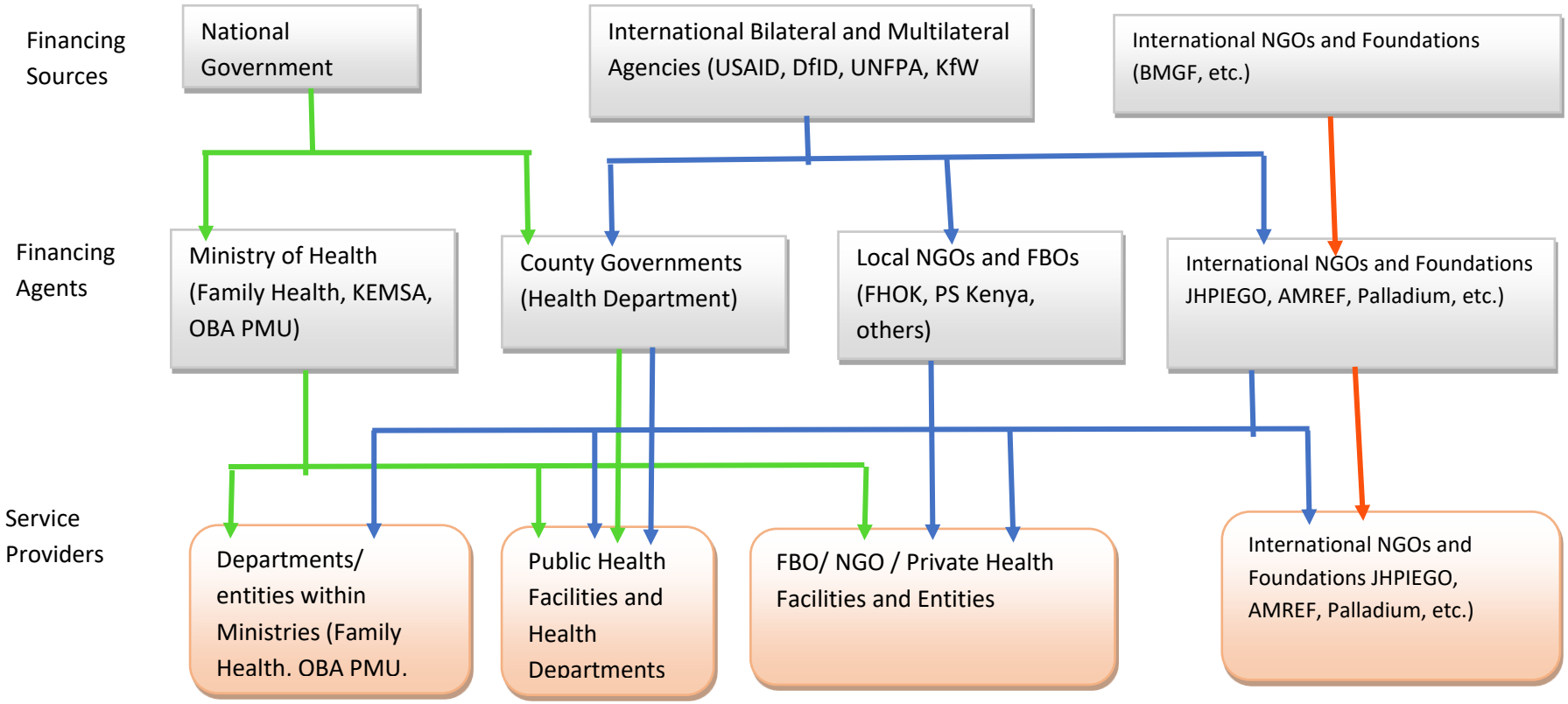

Figure 1.3: Flow of resources for family planning services

3.2 Total Expenditure on FP in Kenya

The estimated total expenditure for FP services in Kenya for the two financial is presented in Figure 3.1.

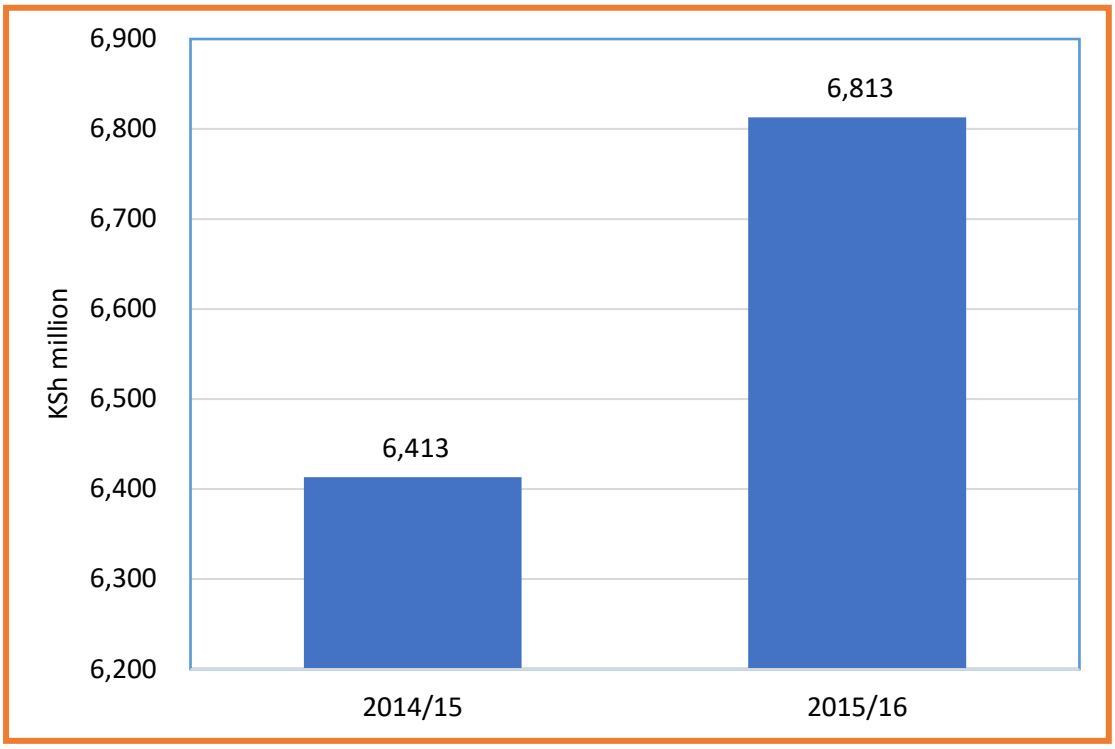

Figure 3.1: Estimated total FP spending

Figure 3.1 shows that total spending in the local currency increased from KSh 6,413 million in 2014/15 to KSh 6,813 million in 2015/16. In terms of the US dollars, the amount of expenditure decreased slightly from about US$ 73 million[3] in 2014/15 to KSh US$ 70 million in 2015/16. It should be noted that the expenditure in each of the years excluded out-of-pocket expenditure for FP services, which in Kenya make up a small percentage of the financing of FP services. Table 3.1 shows some summary statistics for comparison.

[3] Exchange rate of KSh 87.62 per US$ in 2014/15 and KSh 97.56 per US$ in 2015/16.

Table 3.1: FP spending, health expenditure and gross domestic product

	2014-2015	2015-2016
Total expenditure on FP (KSh million)	6,413	6,813
Population (million)	43.6	44.8
Per capita FP spending (KSh)	147	152
Per capita FP spending (US$)	1.68	1.56
Total Health Expenditure (KSh million)	308,000	345,747
Total Health Expenditure (US$ million)	2,743	3,476
Per capita health expenditure (KSh)	7,064	7,822
Per capita health expenditure US$)	80	79
FP spending as % of total health expenditure	2.1%	2.0%
Gross domestic product (GDP) (KSh million)	5,831,528	6,709,671
GDP per capita (KSh)	133,751	149,769
FP spending as % of GDP	0.11%	0.10%

The total health expenditure reported in Table 3.1 was estimated using the results from NHA 2012/13 and provisional results from NHA 2015/16. In 2012/13, the total health expenditure was KSh 234 billion (US$ 2,743 million) and KSh 345 billion (US$ 3,416 million) in 2015/16. The estimated total health expenditure for 2014/15 was computed using linear interpolation of the amounts for 2012/13 and 2015/16. As shown in Table 3.1, FP expenditure was about 2 percent of total health expenditure. As percentage of GDP, FP expenditure stood at 0.11 percent 2014/15 and declined slightly to 0.10 percent in 2015/16.

3.3 FP Expenditure by Financing Sources

There are several financing sources for FP in the country. Table 3.2 and Figure 3.2 show the results of FP spending analyzed by key financing sources.

Table 3.2: Expenditure by financing sources

	2014/15		**2015/16**	
Financing sources	**KSh million**	**US$ million**	**KSh million**	**US$ million**
BMGF	458	5.23	318	3.26
County Governments	1,787	20.39	1,793	18.38
FBO health facilities	14	0.16	15	0.15
National Government	106	1.21	21	0.22
KfW	29	0.33	523	5.36
Private health facilities	51	0.58	51	0.53
UNFPA	711	8.12	338	3.46
United Kingdom	1,059	12.08	1,285	13.17
United States	1,807	20.62	1,852	18.98
Others	391	4.47	617	6.33
Total	**6,413**	**73**	**6,813**	**70**

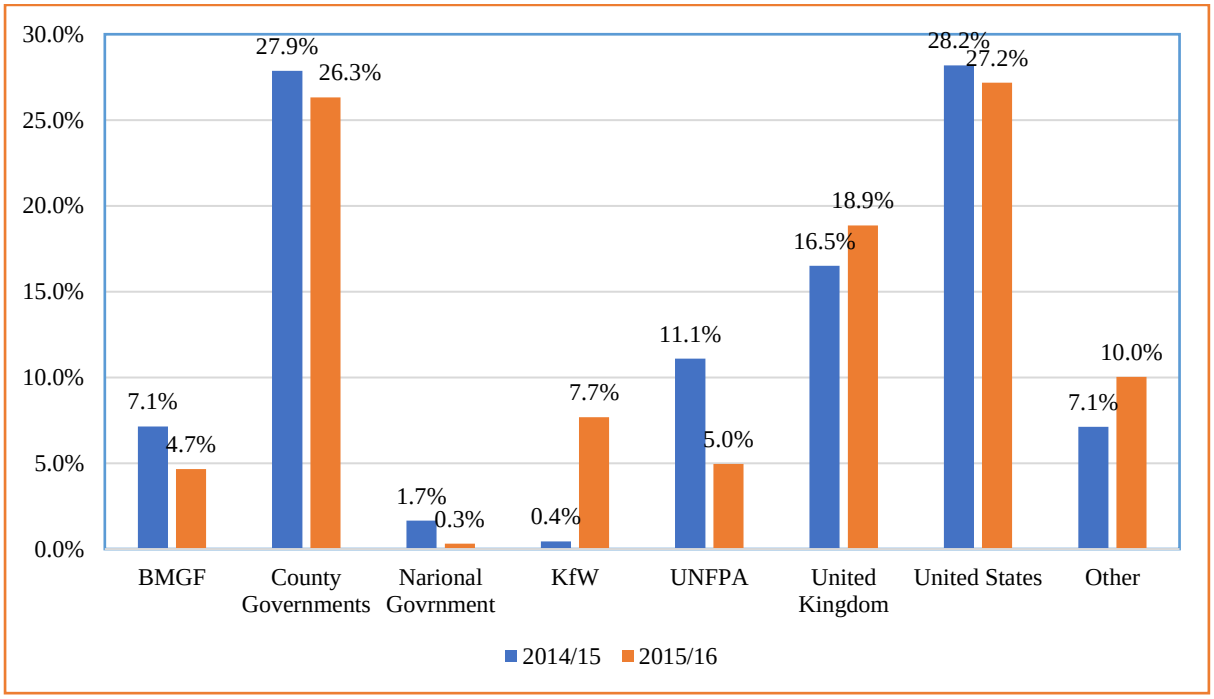

Figure 3.2: Spending by financing sources

Table 3.2 and Figure 3.2 show that United States Government accounted for the largest contribution to total FP expenditure. In 2014/15, it contributed 28.2 percent followed by county governments (27.9%), Government of United Kingdom (16.5%), UNFPA (11.1%) and BMGF (7.1%). In 2015/16, there was a general decline in percentage contribution of the major sources except for the Government of United Kingdom and others combined. Further, in 2015/16, the major sources were United States Government (27.2%) county governments (26.3%), and Government of United Kingdom (18.9%).

3.4 FP Expenditure by Financing Agents

Financing agents refer to entities that manage and use the funds for payment or purchase of FP services, FP commodities and other FP related activities. The financing agents also decide the type of activity fund. Table 3.3 and Table 3.4 show the results of FP spending by financing agents.

Table 3.3: FP Expenditure by financing agents

	2014/15		2015/16	
Financing agents	**KSh million**	**US$ million**	**KSh million**	**US$ million**
AMREF	272	3.11	231	2.37
County Health Department	1,822	20.80	1,847	18.94
Donors[4]	111	1.27	143	1.47
International NGOs and Foundations	2,142	24.44	2,148	22.02
KEMSA	991	11.30	1,012	10.37
Marie Stopes Kenya	599	6.84	840	8.62
MOH	62	0.71	45.40	0.465
National NGOs	238	2.71	359	3.68
NCPD	31	0.36	26	0.27
Private sector	100	1.15	41	0.42
UNFPA	19	0.22	92	0.95
Others	25	0.29	28	0.28
Total	**6,413**	**73**	**6,813**	**70**

Table 3.4: Relative shares of FP by financing agents

Financing agents	**2014/15**	**2015/16**
AMREF	4.2%	3.4%
County Health Department	28.4%	27.1%
Donors	1.7%	2.1%
International NGOs and Foundations	33.4%	31.5%
KEMSA	15.4%	14.9%
Marie Stopes Kenya	9.3%	12.3%
MOH	1.0%	0.666%
National NGOs	3.7%	5.3%
NCPD	0.5%	0.4%
Private sector	1.6%	0.6%
UNFPA	0.3%	1.4%
Others	0.4%	0.4%
Total	**100%**	**100%**

The tables show that international NGOs and foundations are the main financing agents in the provision of FP services in the country. However, their share has been declining over time, from about 33.4 percent in 2014/15 to 31.5 percent in 2015/16. On the other hand, county health departments came second accounting for slightly over 28 percent of the total FP spending in 2014/15 and about 27 percent in 2015/16. KEMSA, through financing of FP commodities, accounted for the third largest share of the expenditure taking about 15 percent

[4] These are for those who acted as agents for own spending directly.

of the total expenditure. Marie Scopes, AMREF and national NGOs are also key entities in channeling funds for FP activities and services.

3.5 FP Expenditure by Service Providers

Service Providers are entities that engage directly in the production, provision and delivery of FP services against a payment for their contribution. FP services and interventions are provided by a number of providers including public entities, private for profit and non-profit domestic organizations and international entities. Table 3.5 and Figure 3.3 provide broad picture of the main providers of FP services during the two years under consideration.

Table 3.5: FP Expenditure by service providers

	2014/15		2015/16	
FP Providers	KSh million	US$ million	KSh million	US$ million
AMREF	272	3.11	231	2.37
County Health Department	117	1.33	136	1.4
Departments within MOH	62	0.71	45	0.47
FBO/ NGO Dispensaries	26	0.3	34	0.34
FBO/ NGO Health Centers	8.5	0.1	11	0.11
FBO/ NGO Hospitals	0.6	0.01	1.0	0.01
International NGOs and Foundations	1486	16.96	1,368	14.03
JHPIEGO	357	4.08	426	4.37
Marie Stopes Kenya	599	6.84	840	8.62
National NGOs	273	3.11	384	3.94
Private Dispensaries	49	0.56	49	0.5
Private Hospitals	7.68	0.09	4.1	0.04
Public County Hospitals (level 4)	329	3.76	384	3.93
Public County Hospitals (level 5)	90	1.03	100	1.02
Public Dispensaries	1,309	14.93	1,288	13.21
Public Health Centers	1,188	13.56	1,272	13.04
Referral Hospitals (level 6)	-	-	0.61	0.01
Others	238	2.72	238	2.44
Total	**6,413**	**73**	**6,813**	**70**

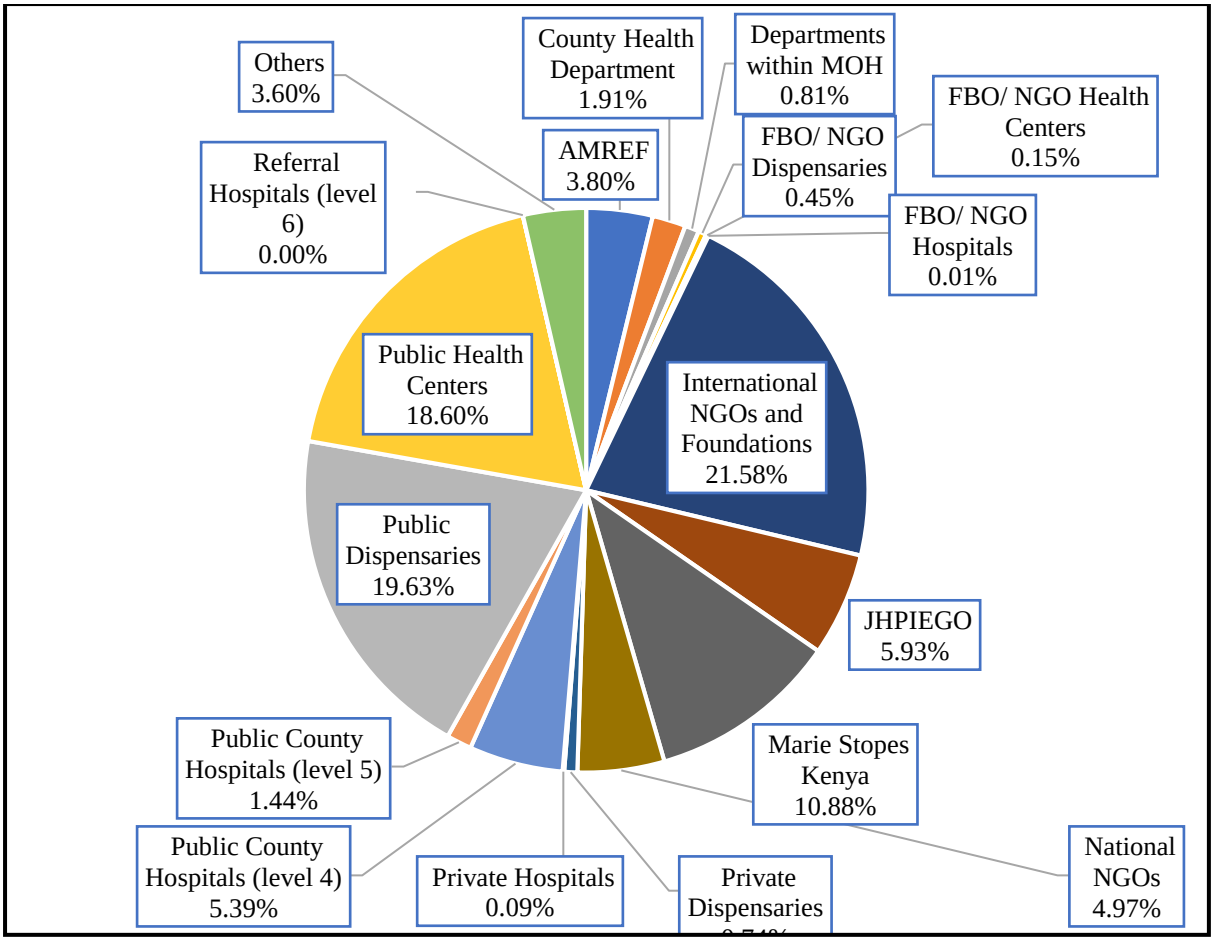

Figure 3.3: Percentage of expenditure by service providers

Table 3.5 and Figure 3.3 show the county health facilities accounted for the highest expenditure on FP services. Overall, the public health facilities accounted for about 43.6 percent of the expenditure. In more disaggregated analysis, the share of spending on FP activities by international NGOs was 21.6 percent followed by public dispensaries (19.6%), public health centres (18.6%), Marie Stopes (10.9%), JHPEIGO (5.9%), public hospitals (5.4%) National NGOs (5.0%) and AMREF (3.8%).

3.6 Expenditure by FP Services

The expenditure in the provision of any FP method in this section consisted of FP commodity, consumables, staff, and operating and maintenance expenses. It is not only the cost of the commodity. Table 3.6 and Table 3.7 show FP spending on FP service according to detailed classifications that were developed.

Table 3.6: FP spending by type of service or activity - 2014/15

Services/ activities	KSh million	US$ million	Percent
Provision of male condoms for FP	237	2.71	3.7%
Provision of female condoms for FP	0.08	0.00	0.0%
Provision of pills	255	2.91	4.0%
Provision of injectables	1,065	12.15	16.6%
Provision of IUD	103	1.17	1.6%
Provision of implants	1,488	16.98	23.2%
Provision of standard days method service	24	0.28	0.4%
Contraceptives not disaggregated	183	2.09	2.9%
FP services not disaggregated by type	305	3.48	4.7%
Information, education and communication	243	2.77	3.8%
Planning, coordination, and management	919	10.49	14.3%
Monitoring and evaluation	219	2.50	3.4%
Operations research	143	1.63	2.2%
Drug supply systems	105	1.20	1.6%
Upgrading and provision FP medical equipment	13	0.15	0.2%
Training and capacity building	876	9.99	13.7%
Advocacy	95	1.09	1.5%
FP-specific institutional development	88	1.00	1.4%
Voucher provision	52	0.60	0.8%
Total	**6,413**	**73**	**100%**

Table 3.7: FP spending by type of service or activity - 2015/16

Services/ activities	KSh million	US$ million	Percent
Provision of male condoms for FP	209	2.14	3.1%
Provision of female condoms for FP	0.09	0.00	0.0%
Provision of pills	255	2.61	3.7%
Provision of injectables	1,179	12.09	17.3%
Provision of IUD	242	2.48	3.6%
Provision of implants	1,382	14.17	20.3%
Provision of standard days method service	17	0.17	0.2%
Provision of contraceptives not disaggregated	120	1.23	1.8%
FP services not disaggregated by type	440	4.51	6.5%
Information, education and communication for FP	375	3.84	5.5%
Planning, coordination, and management	941	9.65	13.8%
Monitoring and evaluation	211	2.17	3.1%
Operations research	203	2.08	3.0%
Drug supply systems	120	1.23	1.8%
Training and capacity building	854	8.76	12.5%
Advocacy	181	1.86	2.7%
FP-specific institutional development	55	0.56	0.8%
Voucher provision	28	0.29	0.4%
Total	**6,813**	**70**	**100%**

The tables show that provision of implants accounted for the highest amount and percentage of the total FP expenditure, taking 23 percent in 2014/15 and 20 percent in 2015/16. This was followed by provision of injectables at 16.6 percent in 2014/15 and 17.3 percent in 2015/16. Other services with significant amount and percentage of expenditure include planning and management, and training and capacity building. Additional and more aggregated analysis is presented in Figure 3.4.

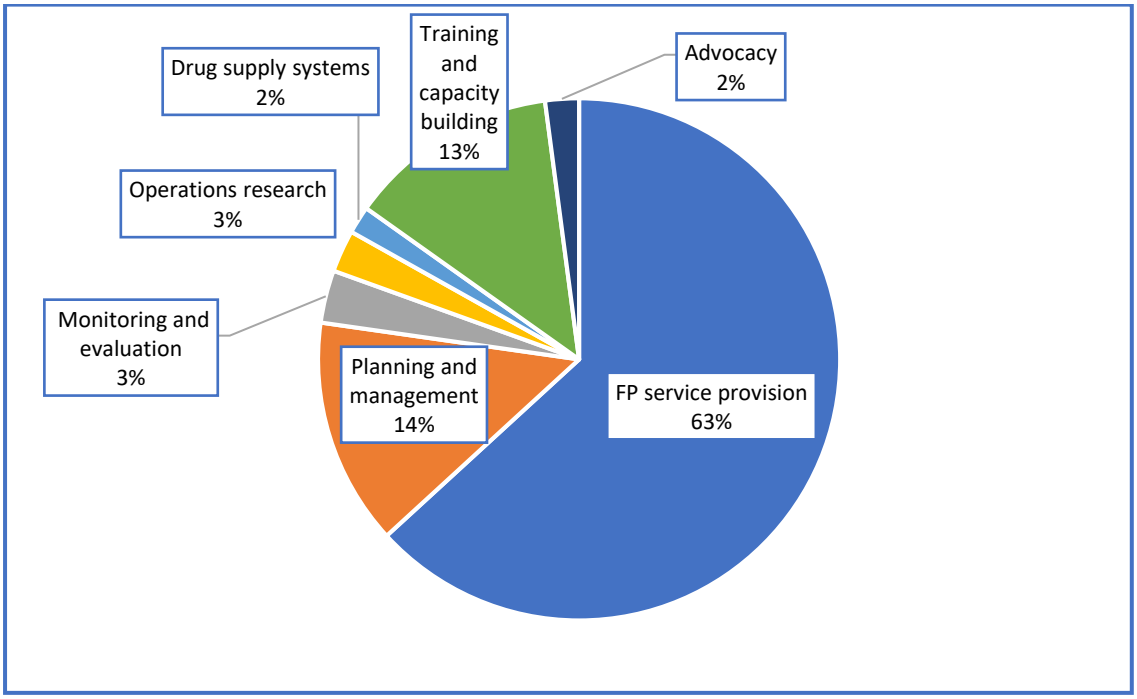

Figure 3.4: Percentage of expenditure by services 2014/15 – 2015/16

As shown in Figure 3.4, FP service provision accounted for 63 percent of the total expenditure over the entire period under consideration, followed planning and management (14%) and training and capacity building (13%).

3.7 Expenditure by Production Factors

This entailed classifying total FP spending by budget items but disaggregated by recurrent and capital categories. Table 3.8 shows expenditure for 2014/15 and Table 3.9 for FP spending in 2015/16.

Table 3.8: FP spending by type of service or activity - 2014/15

Type of service or activity	KSh million	US$ million	Percent
Female condoms for FP	0.08	0.001	0.00%
Male condoms for FP	89	1.01	1.38%
Pills	95	1.08	1.48%
Injectables	397	4.53	6.18%
IUD	84	0.95	1.30%
Implants	753	8.59	11.74%
Beads	8.96	0.1	0.14%
Contraceptives and consumables not disaggregated by type	184	2.1	2.87%
IEC	212	2.42	3.31%
Human resources	2,803	31.99	43.70%
Administration	833	9.51	12.99%
Consultancy	111	1.27	1.74%
Meetings and workshops	541	6.17	8.43%
Transportation and travel expenses	144	1.65	2.25%
Vouchers	52	0.6	0.82%
Capital	64	0.74	1.00%
Others	42	0.48	0.66%
Total	**6,413**	**73**	**100%**

Table 3.9: FP spending by type of service or activity - 2015/16

Type of service or activity	KSh million	US$ million	Percent
Female condoms for FP	0.09	0.00	0.001%
Male condoms for FP	60	0.61	0.88%
Pills	94	0.96	1.38%
Injectables	508	5.21	7.46%
IUD	224	2.30	3.29%
Implants	645	6.61	9.47%
Beads	1.48	0.02	0.02%
Contraceptives and consumables not disaggregated by type.	120	1.23	1.76%
IEC	319	3.27	4.69%
Human resources	2,884	29.56	42.33%
Administration	894	9.16	13.12%
Consultancy	175	1.79	2.57%
Meetings and workshops	587	6.02	8.62%
Transportation and travel expenses	151	1.55	2.22%
Vouchers	28	0.29	0.41%
Capital	25	0.25	0.36%
Others	97	1.00	1.43%
Total	**6,813**	**70**	**100%**

In both financial years, human resources for FP services took the largest amount of expenditure, followed by administrative expenses and expenditure on implants and related consumables. Other recurrent expenditure included expenses for meetings and workshops and injectables. Figure 3.5 shows that, over the period of two years, human resources accounted 43 of FP spending, followed by commodities (25%), administrative expenses (13%), and meetings and workshops (9%).

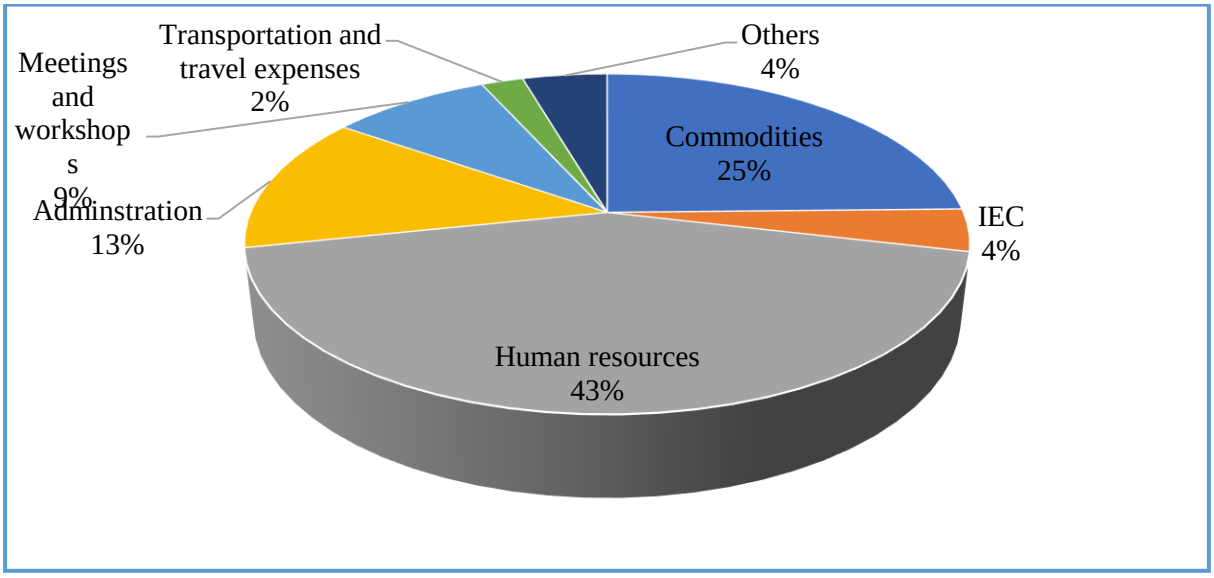

Figure 3.5: Percentage of expenditure by production factors 2014/15 – 2015/16

3.8 Expenditure by County and National Levels

The FP expenditure was allocated to the counties using different criteria. For some financing agents that provided data, most were to provide estimates of the amount spent at counties and at national level. These agents provided data correctly. For the financing sources and financing agents that did not disaggregate the data, county modern contraceptive prevalence rate (mCPR) and adjusted for actual users of FP services were used to allocate FP spending appropriately. For instance, for USAID supported agents and implementers, their FP spending was allocated to counties of focus. However, for Palladium (ESHE) and PS Kenya, their FP spending was allocated to all counties in the country based on FP users. The expenditure on FP commodities from KEMSA was already given by counties and that was taken as given. The indirect expenditure by County Governments was estimated per country as explained in the methodology. The results are shown in Table 3.10 and Table 3.11. Results show disproportionate expenditure for Nairobi County.

Table 3.10: FP spending by county and national levels - 2014/15

	FP commodities	County Government expenditure	Other expenditure from different sources	Total		Percent
				KSh	US$	
Baringo	12,935,476	29,478,869	350,425	42,764,770	488,072	0.67%
Bomet	24,399,910	14,212,093	16,035,158	54,647,162	623,685	0.85%
Bungoma	48,584,053	62,986,077	60,774,883	172,345,013	1,966,964	2.69%
Busia	23,864,115	38,854,986	16,793,688	79,512,788	907,475	1.24%
Elgeyo Marakwet	6,948,473	29,614,151	7,928,143	44,490,767	507,771	0.69%
Embu	20,878,088	34,762,755	15,161,679	70,802,522	808,065	1.10%
Garissa	9,799,595	9,099,695	34,100,919	53,000,208	604,888	0.83%
Homa Bay	29,985,030	36,620,428	8,530,967	75,136,425	857,528	1.17%
Isiolo	4,835,588	11,161,624	41,172,057	57,169,269	652,470	0.89%
Kajiado	10,743,963	5,467,241	24,151,325	40,362,530	460,655	0.63%
Kakamega	82,077,876	52,231,245	95,336,418	229,645,540	2,620,932	3.58%
Kericho	11,662,296	31,665,375	8,499,626	51,827,297	591,502	0.81%
Kiambu	36,982,937	54,702,830	83,750,959	175,436,726	2,002,249	2.74%
Kilifi	34,118,870	44,543,577	42,038,308	120,700,754	1,377,551	1.88%
Kirinyaga	9,896,172	7,627,849	15,127,626	32,651,648	372,651	0.51%
Kisii	19,216,207	51,082,962	43,027,948	113,327,116	1,293,396	1.77%
Kisumu	60,679,699	70,376,304	133,686,790	264,742,793	3,021,495	4.13%
Kitui	47,539,588	58,408,356	36,154,408	142,102,352	1,621,806	2.22%
Kwale	24,100,026	27,628,920	6,802,040	58,530,987	668,011	0.91%
Laikipia	11,467,711	1,515,803	455,377	13,438,891	153,377	0.21%
Lamu	1,901,171	12,376,866	1,605,083	15,883,119	181,273	0.25%
Machakos	23,269,868	58,024,552	99,663,285	180,957,705	2,065,260	2.82%
Makueni	28,936,381	53,129,466	18,701,457	100,767,304	1,150,052	1.57%

Mandera	2,722,871	7,461,950	48,668,045	58,852,867	671,684	0.92%
Marsabit	96,808	2,641,772	41,161,439	43,900,019	501,028	0.68%
Meru	50,364,686	60,782,245	37,304,441	148,451,372	1,694,267	2.31%
Migori	58,311,485	29,758,830	8,468,584	96,538,899	1,101,793	1.51%
Mombasa	14,937,849	46,956,178	90,088,517	151,982,544	1,734,568	2.37%
Muranga	22,723,518	36,336,460	40,973,376	100,033,354	1,141,675	1.56%
Nairobi	183,132,239	209,158,400	181,856,993	574,147,633	6,552,715	8.95%
Nakuru	69,789,562	81,645,136	123,615,261	275,049,959	3,139,130	4.29%
Nandi	44,267,391	40,544,170	54,994,829	139,806,390	1,595,602	2.18%
Narok	1,444,160	24,412,745	8,228,820	34,085,725	389,018	0.53%
Nyamira	38,182,204	57,620,824	8,261,185	104,064,213	1,187,679	1.62%
Nyandarua	26,704,463	27,139,407	14,020,141	67,864,012	774,528	1.06%
Nyeri	35,473,817	55,861,936	16,131,112	107,466,866	1,226,513	1.68%
Samburu	7,269,995	8,865,351	34,986,967	51,122,313	583,456	0.80%
Siaya	32,651,624	47,302,239	51,452,877	131,406,740	1,499,738	2.05%
Taita Taveta	4,930,749	36,229,255	5,213,071	46,373,075	529,253	0.72%
Tana River	9,200,781	3,882,045	34,132,938	47,215,765	538,871	0.74%
Tharaka Nithi	28,420,169	32,112,967	11,485,241	72,018,377	821,942	1.12%
Trans Nzoia	13,878,420	31,941,090	8,592,591	54,412,101	621,002	0.85%
Turkana	6,403,394	24,082,988	61,000,378	91,486,760	1,044,133	1.43%
Uasin Gishu	50,755,457	31,778,341	8,681,301	91,215,100	1,041,033	1.42%
Vihiga	9,850,784	21,140,107	14,058,171	45,049,062	514,142	0.70%
Wajir	10,469,599	7,141,738	41,643,674	59,255,011	676,274	0.92%
West Pokot	5,457,925	66,504,875	7,729,980	79,692,779	909,529	1.24%
National	-	-	1,551,437,972	1,551,437,972	17,706,474	24.19%
Total	1,312,263,046	1,786,873,073	3,314,036,476	6,413,172,595	73,193,177	100%

Table 3.10: FP spending by county and national levels - 2015/16

	FP commodities	County Government expenditure	Other expenditure from different sources	Total		Percent
				KSh	US$	
Baringo	36,028,501	29,677,133	2,197,554	67,903,188	696,065	1.00%
Bomet	16,099,906	15,263,510	20,967,772	52,331,188	536,439	0.77%
Bungoma	53,741,855	71,312,864	82,401,822	207,456,542	2,126,605	3.04%
Busia	24,678,904	31,715,541	22,820,735	79,215,181	812,022	1.16%
Elgeyo Marakwet	19,875,537	33,909,407	12,230,266	66,015,210	676,712	0.97%
Embu	16,010,843	57,147,441	33,465,961	106,624,244	1,092,989	1.56%
Garissa	4,164,000	9,237,294	29,172,851	42,574,145	436,421	0.62%
Homa Bay	48,660,254	32,556,520	14,496,747	95,713,520	981,144	1.40%
Isiolo	7,332,381	13,888,460	40,270,033	61,490,874	630,333	0.90%
Kajiado	11,581,812	39,790,967	33,841,765	85,214,544	873,521	1.25%
Kakamega	51,878,986	57,168,683	68,333,326	177,380,996	1,818,305	2.60%
Kericho	16,464,475	33,162,102	12,978,790	62,605,367	641,758	0.92%
Kiambu	48,280,930	69,697,742	120,815,956	238,794,628	2,447,846	3.50%
Kilifi	26,741,902	54,785,673	50,445,573	131,973,148	1,352,836	1.94%
Kirinyaga	12,412,698	39,410,905	33,261,471	85,085,075	872,194	1.25%
Kisii	42,754,759	63,373,792	60,943,094	167,071,645	1,712,625	2.45%
Kisumu	47,396,019	23,776,128	104,773,950	175,946,096	1,803,596	2.58%
Kitui	44,091,208	63,908,222	49,801,256	157,800,686	1,617,590	2.32%
Kwale	26,205,890	21,271,000	8,237,249	55,714,138	571,117	0.82%
Laikipia	7,527,854	3,175,571	1,063,741	11,767,167	120,623	0.17%
Lamu	3,024,224	16,080,262	1,528,968	20,633,454	211,510	0.30%
Machakos	46,495,570	59,226,225	88,532,422	194,254,217	1,991,270	2.85%

Makueni	52,140,874	55,176,739	23,646,398	130,964,011	1,342,492	1.92%
Mandera	853,106	6,236,689	50,614,642	57,704,437	591,519	0.85%
Marsabit	246,477	9,919,255	39,930,063	50,095,795	513,524	0.74%
Meru	30,562,285	96,397,517	59,415,792	186,375,594	1,910,507	2.74%
Migori	54,611,018	18,514,972	14,669,456	87,795,446	899,977	1.29%
Mombasa	14,550,211	52,933,493	55,597,168	123,080,872	1,261,683	1.81%
Muranga	11,254,477	41,148,514	67,589,117	119,992,107	1,230,020	1.76%
Nairobi	279,605,864	96,340,142	173,372,271	549,318,277	5,630,976	8.06%
Nakuru	45,486,659	77,511,643	166,786,597	289,784,899	2,970,540	4.25%
Nandi	26,483,526	38,164,108	76,253,613	140,901,248	1,444,357	2.07%
Narok	29,178,912	40,135,400	13,130,248	82,444,560	845,126	1.21%
Nyamira	13,918,940	73,302,413	12,485,477	99,706,829	1,022,079	1.46%
Nyandarua	17,010,205	35,304,834	32,157,671	84,472,710	865,917	1.24%
Nyeri	23,536,320	51,906,459	34,958,932	110,401,711	1,131,711	1.62%
Samburu	4,805,423	14,704,130	30,220,249	49,729,802	509,772	0.73%
Siaya	43,598,577	39,938,455	57,887,032	141,424,064	1,449,716	2.08%
Taita Taveta	13,065,450	47,035,501	5,753,419	65,854,370	675,063	0.97%
Tana River	4,969,781	9,866,220	29,260,256	44,096,257	452,024	0.65%
Tharaka Nithi	7,696,645	9,205,293	28,726,498	45,628,436	467,730	0.67%
Trans Nzoia	18,001,574	46,000,151	13,195,965	77,197,691	791,341	1.13%
Turkana	2,672,955	1,368,393	64,972,818	69,014,166	707,453	1.01%
Uasin Gishu	34,242,425	43,209,672	14,077,014	91,529,111	938,251	1.34%
Vihiga	12,367,466	19,906,715	19,014,904	51,289,085	525,756	0.75%
Wajir	6,203,529	8,641,584	39,979,971	54,825,085	562,003	0.80%
West Pokot	30,331,278	20,331,111	12,393,632	63,056,021	646,377	0.93%
National	-	-	1,602,846,632	1,602,846,632	16,430,531	23.53%
Total	1,388,842,486	1,792,734,844	3,631,517,138	6,813,094,468	69,839,969	100%

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 Summary and Conclusions

The results showed that total FP spending was KSh 6,413 million (US$ 73 million) in 2014/15 and KSh 6,813 million (US$ 70 million) in 2015/16. These results excluded out-of-pocket expenditure for FP services by individuals and households. FP expenditure was about 2 percent of total health expenditure. As percentage of GDP, FP expenditure stood at 0.11 percent in 2014/15 and declined slightly to 0.10 percent in 2015/16. United States Government accounted for the largest contribution to total FP expenditure, contributing 28.2 percent followed by the County Governments (27.9%), Government of United Kingdom (16.5%), UNFPA (11.1%) and BMGF (7.1%) in 2014/15. In 2015/16, there was a general decline in percentage contribution of the major sources except for the Government of United Kingdom. This notwithstanding, in 2015/16, the major sources were still United States Government (27.2%) county governments (26.3%), and Government of United Kingdom (18.9%).

International NGOs and foundations were the main financing agents in the provision of FP services in the country. County health departments came second accounting for slightly over 28 percent of the total FP spending in 2014/15 and about 27 percent in 2015/16. KEMSA, through financing of FP commodities, accounted for the third largest share of the expenditure taking about 15 percent of the total expenditure. Marie Scopes, AMREF and national NGOs are also key entities in channeling funds for FP activities and services.

In terms of FP service providers, county health facilities accounted for the highest expenditure on FP services. Overall, the public health facilities accounted for about 43.6 percent of the expenditure. In more disaggregated analysis, the share of spending on FP activities by international NGOs was 21.6 percent followed by public dispensaries (19.6%), public health centres (18.6%), Marie Stopes (10.9%), JHPEIGO (5.9%), public hospitals (5.4%) National NGOs (5.0%) and AMREF (3.8%). In terms of FP services, provision of implants accounted for the highest amount and percentage of the total FP expenditure, taking 23 percent in 2014/15 and 20 percent in 2015/16. This was followed by provision of injectables at 16.6 percent in 2014/15 and 17.3 percent in 2015/16. In both financial years, human resources for FP services took the largest amount of expenditure, followed by administrative expenses and expenditure on implants and related consumables. Other recurrent expenditure included expenses for meetings and workshops and injectables.

The FP expenditure was allocated to the counties using different criteria. For the financing sources and financing agents that did not disaggregate the data, county mCPR and adjusted for actual users of FP services were used to allocate FP spending appropriately. For instance, for USAID supported agents and implementers, their FP spending was allocated to counties of focus. However, for Palladium (ESHE) and PS Kenya, their FP spending was allocated to all counties in the country based on FP users. The expenditure on FP commodities from KEMSA was already given by counties and that was taken as given. The indirect expenditure by County Governments was estimated per country as explained in the methodology.

4.2 Conclusions

It can be concluded that financing of FP services is heavily depended on international funds and this is not sustainable. Another conclusion is that FP spending assessment approach provides useful information for understanding total expenditures and the components and it can be Can be replicated in other countries

In addition, this study has made a unique contribution of tracking financial flow for FP in Kenya and thus keeping the reproductive health agenda alive by highlighting resources flows for FP. The findings in this study will help the national government, county governments, donor agencies and NGOs working in reproductive health access financial resource flows for FP which is critical in raising awareness on the need for resource mobilization to address the unmet FP needs.

To enable more effective and timely advocacy for resources—in addition to tracking the funding commitments and spending the study team has mapped the various processes to show how the funds flow from source of financing to financing agents and then to service provider. This is expected to enable stakeholders to get a better understanding of the financing process for FP in Kenya. In addition, the tracking exercise can potentially help other countries understand their financing situation, track funding flows, and effectively advocate for resources. In addition, the methodology used can be used with other tools to complete a broader analysis of total supply chain costs, funding levels, and advocacy needs for family planning programs or the wider health sector.

4.3 Recommendations

1. The national and county governments should continue exploring new health financing strategies as well as consider increasing investments and public spending on for FP. At the same time, the private sector should take a more active role considering that donor support is unsustainable in the long term. Leverage on the private sector resources to expands PF commodity and services availability. This could be done by embracing Public Private Partnerships.
2. Given the importance of household expenditure on reproductive health, it will be critical in future to analyze total household spending on FP and on which specific components of FP
3. Replicating this approach in other countries to inform countries on spending and also inform international monitoring of FP spending at global level.
4. Although the assessment showed that county governments were contributing to spending on FP services, there was no one county with direct budget allocation for FP. County health department should therefore introduce and fund a line item on FP goods and services. This will ensure county governments support through direct financing the FP.
5. Inclusion of FP services as part of the benefit package of NHIF/proposed SHI to increase access and financing of FP services.
6. Ensure political commitment at both national and county level to leverage additional funding for FP.
7. Employ financial resource tracking of FP services to inform policy, planning and budgeting of FP commodities. Financial tracking of FP services can also inform alternative financing approaches.
8. Explore the possibility of incorporating family planning into the conditional cash transfer (CCT) program to increase access to family planning services.

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Appendix A: FP Allocation Percentage Per County

Table A1a: FP percentage 2014/15

	MCH	FP	OPD	Dental	Others	IPD	Maternity	Equivalent OP visits	Total workload	FP%
Baringo	144,430	38,445	877,910	5,827	49,855	69,967	11,715	245,046	1,361,513	2.80%
Bomet	193,840	74,956	1,498,869	3,126	81,912	33,599	16,886	151,455	2,004,158	3.70%
Bungoma	465,339	136,345	1,326,519	18,826	175,868	213,946	33,837	743,349	2,866,246	4.80%
Busia	292,834	75,865	876,381	9,289	97,375	127,555	16,853	433,224	1,784,968	4.30%
Elgeyo Marakwet	125,321	46,289	802,186	3,370	54,193	33,520	10,514	132,102	1,163,461	4.00%
Embu	206,631	76,868	1,311,185	5,770	123,488	80,963	12,316	279,837	2,003,779	3.80%
Garissa	132,494	11,111	557,771	5,069	22,147	52,117	10,887	189,012	917,604	1.20%
Homa Bay	281,556	81,455	1,135,536	2,231	97,150	102,448	20,769	369,651	1,967,579	4.10%
Isiolo	41,506	9,273	180,310	2,686	18,998	37,060	3,817	122,631	375,404	2.50%
Kajiado	181,385	42,575	687,186	5,006	54,610	56,285	9,771	198,168	1,168,930	3.60%
Kakamega	595,148	180,628	2,136,750	9,432	216,489	360,101	41,324	1,204,275	4,342,722	4.20%
Kericho	200,698	73,116	1,215,133	15,738	125,804	136,779	21,343	474,366	2,104,855	3.50%
Kiambu	430,148	98,903	2,275,862	27,935	174,822	268,512	48,930	952,326	3,959,996	2.50%
Kilifi	635,411	105,198	1,442,676	8,688	140,371	151,239	36,260	562,497	2,894,841	3.60%
Kirinyaga	198,501	73,109	1,000,756	5,410	99,626	95,052	10,862	317,742	1,695,144	4.30%
Kisii	352,740	100,255	1,715,821	17,097	130,908	229,408	35,309	794,151	3,110,972	3.20%
Kisumu	286,790	96,153	1,219,542	20,642	123,944	348,160	21,533	1,109,079	2,856,150	3.40%
Kitui	297,000	121,361	1,347,485	1,387	133,323	36,323	8,770	135,279	2,035,835	6.00%
Kwale	552,993	78,873	1,209,898	2,210	87,363	84,374	21,252	316,878	2,248,215	3.50%
Laikipia	113,956	39,749	551,835	6,253	59,294	97799	12988	332361	1,103,448	3.60%
Lamu	41,859	11,929	158,969	1,752	12,412	14400	2678	51234	278,155	4.30%

Table A1b: FP percentage 2014/15

	MCH	FP	OPD	Dental	Others	IPD	Maternity	Equivalent OP visits	Total workload	FP%
Machakos	347,273	125,801	1,413,781	14,956	164,562	157,171	21,264	535,305	2,601,678	4.80%
Makueni	408,970	113,547	1,529,459	15,947	139,412	106,938	17,880	374,454	2,581,789	4.40%
Mandera	66,521	6,085	398,938	660	8,581	866	8,258	27,372	508,157	1.20%
Marsabit	74,813	8,356	267,843	845	17,036	19,293	3,727	69,060	437,953	1.90%
Meru	262,640	118,954	1,207,386	14,444	164,793	191,554	33,969	676,569	2,444,786	4.90%
Migori	354,498	98,703	1,142,385	5,446	115,284	93,857	27,813	365,010	2,081,326	4.70%
Mombasa	269,055	55,459	597,470	23,294	99,750	182,892	23,521	619,239	1,664,267	3.30%
Muranga	291,281	106,457	1,712,169	18,939	153,435	78,869	16,393	285,786	2,568,067	4.10%
Nairobi	803,301	214,256	2,267,500	68,440	343,538	355,384	50,873	1,218,771	4,915,806	4.40%
Nakuru	493,831	135,059	2,259,807	31,672	213,401	357,937	43,737	1,205,022	4,338,792	3.10%
Nandi	187,164	98,696	1,129,894	5,318	105,640	42,133	11,917	162,150	1,688,862	5.80%
Narok	182,651	38,790	741,854	2,616	51,797	31,744	11,478	129,666	1,147,374	3.40%
Nyamira	156,153	67,917	660,501	1,101	72,606	53,844	14,245	204,267	1,162,545	5.80%
Nyandarua	160,641	53,290	843,441	5,288	66,091	21,571	7,803	88,122	1,216,873	4.40%
Nyeri	217,398	84,396	1,492,112	25,096	138,458	228,902	18,129	741,093	2,698,553	3.10%
Samburu	66,770	10,647	392,269	135	12,474	5,261	1,887	21,444	503,739	2.10%
Siaya	325,892	103,663	1,327,458	5,698	124,502	103,948	20,847	374,385	2,261,598	4.60%

Table A1c: FP percentage 2014/15

	MCH	FP	OPD	Dental	Others	IPD	Maternity	Equivalent OP visits	Total workload	FP%
Taita Taveta	143,172	52,483	543,470	8,334	58,368	55,256	8,723	191,937	997,764	5.30%
Tana river	51,863	9,663	229,302	512	10,818	4,989	2,662	22,953	325,111	3.00%
Tharaka Nithi	92,786	46,936	551,669	8,629	62,862	56,817	6,884	191,103	953,985	4.90%
Trans Nzoia	219,741	60,295	654,534	4,888	89,281	111,093	13,143	372,708	1,401,447	4.30%
Turkana	103,419	20,375	379,409	1,725	31,106	35,737	4,576	120,939	656,973	3.10%
Uasin Gishu	217,511	74,644	1,103,224	20,337	106,623	839	26,787	82,878	1,605,217	4.70%
Vihiga	180,600	38,762	701,959	4,338	41,812	27,614	10,543	114,471	1,081,942	3.60%
Wajir	90,886	6,492	436,880	895	6,523	881	8,549	28,290	569,966	1.10%
West Pokot	107,588	108,427	706,456	3,005	116,843	25,689	8,175	101,592	1,143,911	9.50%
Total	11,646,998	3,430,609	48,219,750	470,302	4,595,548	4,980,686	832,397	17,439,249	85,802,456	4.00%

Table A2a: FP percentage 2015/16

	MCH	FP	OPD	Dental	Others	IPD	Maternity	IP equivalent OP	Total workload	FP%
Baringo	135,019	32,344	903,098	6,042	43,970	69485	7433	230754	1,351,227	2.4%
Bomet	195,162	75,007	1,349,720	4,056	81,352	29729	10784	121539	1,826,836	4.1%
Bungoma	532,489	132,564	1,129,443	14,259	165,472	194618	27086	665112	2,639,339	5.0%
Busia	283,298	72,014	971,188	6,792	93,214	116937	12962	389697	1,816,203	4.0%
Elgeyo Marakwet	128,696	44,050	831,670	3,483	56,861	32770	5743	115539	1,180,299	3.7%
Embu	202,478	74,126	1,170,872	5,648	123,144	51121	8056	177531	1,753,799	4.2%
Garissa	121,376	9,557	505,532	4,881	22,403	64819	6749	214704	878,453	1.1%
Homa Bay	312,001	84,598	1,209,578	1,219	104,889	114003	21092	405285	2,117,570	4.0%
Isiolo	40,601	10,760	215,265	2,674	18,062	34824	2630	112362	399,724	2.7%
Kajiado	212,664	48,775	770,689	8,659	60,570	38775	7285	138180	1,239,537	3.9%
Kakamega	655,543	178,927	2,404,857	17,186	219,635	398782	182009	1742373	5,218,521	3.4%
Kericho	215,632	57,513	1,218,827	14,373	102,364	106065	12692	356271	1,964,980	2.9%
Kiambu	502,776	107,242	2,323,052	32,061	188,566	284412	37029	964323	4,118,020	2.6%
Kilifi	572,665	99,464	1,455,702	8,210	129,862	176348	23275	598869	2,864,772	3.5%
Kirinyaga	193,291	71,485	1,032,469	5,713	95,192	99470	6834	318912	1,717,062	4.2%
Kisii	349,376	112,122	1,547,703	14,308	136,961	173366	25501	596601	2,757,071	4.1%
Kisumu	319,507	94,824	1,256,716	23,935	124,417	415854	19113	1304901	3,124,300	3.0%

Table A2b: FP percentage 2015/16

Kitui	310,333	115,742	1,320,278	4,442	131,233	59467	5572	195117	2,077,145	5.6%
Kwale	450,380	63,363	1,364,210	2,576	70,987	92414	13401	317445	2,268,961	2.8%
Laikipia	151,157	42,803	661,823	8,094	68,277	127941	9958	413697	1,345,851	3.2%
Lamu	40,257	13,414	191,339	1,929	14,032	16383	4021	61212	322,183	4.2%
Machakos	635,254	123,795	2,098,750	12,926	163,779	224055	17488	724629	3,759,133	3.3%
Makueni	427,776	109,825	1,603,197	18,132	138,925	110295	12294	367767	2,665,622	4.1%
Mandera	72,353	4,837	403,206	1,059	5,643	498	6209	20121	507,219	1.0%
Marsabit	73,126	8,346	307,041	1,360	15,022	25304	2733	84111	489,006	1.7%
Meru	249,078	113,523	871,147	8,677	133,605	116877	12015	386676	1,762,706	6.4%
Migori	341,570	92,048	1,144,592	4,065	105,809	458196	17635	1427493	3,115,577	3.0%
Mombasa	303,563	47,453	685,169	21,116	93,375	160868	16079	530841	1,681,517	2.8%
Muranga	289,547	91,965	1,626,960	18,354	136,887	45774	11615	172167	2,335,880	3.9%
Nairobi	468,189	98,564	2,342,584	66,238	328,402	340317	23980	1092891	4,396,868	2.2%
Nakuru	501,802	129,413	2,073,635	39,589	199,464	358289	31995	1170852	4,114,755	3.1%
Nandi	158,412	72,298	949,398	7,413	83,977	29161	11167	120984	1,392,482	5.2%
Narok	171,217	43,233	652,394	3,232	52,828	18939	7425	79092	1,001,996	4.3%
Nyamira	163,243	86,390	657,376	1,068	92,192	47046	14182	183684	1,183,953	7.3%
Nyandarua	174,069	55,096	895,120	5,981	69,761	30519	5513	108096	1,308,123	4.2%

Table A2c: FP percentage 2015/16

Nyeri	202,968	76,693	1,422,180	15,038	117,111	164869	10275	525432	2,359,422	3.3%
Samburu	74,492	13,149	329,599	785	16,107	6579	2656	27705	461,837	2.8%
Siaya	325,085	88,921	1,305,297	7,938	110,506	82323	15295	292854	2,130,601	4.2%
Taita Taveta	149,011	51,339	532,686	8,156	58,076	32686	4906	112776	912,044	5.6%
Tana river	68,479	12,779	287,752	163	15,347	5827	1717	22632	407,152	3.1%
Tharaka Nithi	88,443	85,522	508,974	7,136	97,020	48712	3303	156045	943,140	9.1%
Trans Nzoia	181,423	65,425	642,898	6,187	95,821	97506	10019	322575	1,314,329	5.0%
Turkana	124,486	17,130	459,715	3,740	29,276	58503	3879	187146	821,493	2.1%
Uasin Gishu	253,749	83,677	1,131,318	24,611	116,460	58403	21940	241029	1,850,844	4.5%
Vihiga	184,138	33,460	691,544	4,412	37,687	16264	7081	70035	1,021,276	3.3%
Wajir	125,023	10,057	502,936	508	10,082	3335	8208	34629	683,235	1.5%
West Pokot	118,812	26,798	700,311	4,520	36,093	26260	6959	99657	986,191	2.7%
Total	11,850,009	3,182,430	48,659,810	482,944	4,410,718	5,264,988	735,793	18,002,343	86,588,254	3.7%

Appendix B: Questionnaires for data collection

Data collection tool for sources and agents

Objectives of the form: I. To identify the origin of the funds used or managed by the institution during the year under study. II. To identify the recipients of those funds.			
Indicate what currency will be used throughout the form with an "X":	**Local currency**	**US$ Exchange rate in Year of Assessment**	**Other (specify):**
Name of the Institution:			
1. Financial or Calendar Years:			
2. Person to Contact (Name and Title):			
3. Address:	**4. E-mail:**		
5. Phone:			

6. Type of institution: Select category of institution with an "X".	I. Public central government	
	II. Public regional government	
	III. Public local government	
	IV. Private-for-profit national	
	V. Private-for-profit international	
	VI. National NGO/CBO	
	VII. International NGO	
	VIII. Bilateral Agency	
	IX. Multilateral Agency	

7. Origin of the funds received: List the institutions that granted the funds spent on **Family Planning (FP)** during the year under study. Include own institution as a source where it is the case.	
Origin of the funds	Amount of funds received during the year
(Name of the Institution and Person to Contact)	
7.1 Institution:	
Contact:	
7.2 Institution:	
Contact:	
7.3 Institution:	
Contact:	

7.4 Institution:	
Contact:	
7.5 Institution:	
Contact:	
7.6 Institution	
Contact:	
TOTAL:	

8. Origin of non-financial resources:

List the institutions that granted non-financial resources (donations) for **Family Planning (FP)** during the year. Include own institution as a source.

Origin of the non-financial resources (Name of the Institution and Person to Contact)	Type of Resource received	Quantity Received	Monetary Value in Year of Assessment
8.1 Institution: Contact:			
8.2 Institution: Contact:			
8.3 Institution: Contact:			
8.4 Institution: Contact:			
8.5 Institution: Contact:			
8.6 Institution Contact:			
TOTAL:			

9. Destination of the funds:

I. List the institutions to which funds were transferred during the year under study.

II. Quantify the transferred funds.

III. Quantify the transferred funds *reported as spent* during the period under study. If no information is available regarding the amount spent, state "No Data" in the cell.

Destination of the funds (Name of the Institution and Person to Contact)	Funds transferred	Funds spent	Counties
9.1 Institution: Contact:			
9.2 Institution:			

Contact:			
9.3 Institution: Contact:			
9.4 Institution: Contact:			
9.5 Institution: Contact:			
9.6 Institution: Contact:			
TOTAL:			

10. Recipients of non-financial resources: List the institutions to which your agency donated non-financial resources for **Family Planning (FP)**, during the year under study.

Recipients of the non-financial resources (Name of the Institution and Person to Contact)	Type of Goods donated	Quantity Received	Monetary Value in Year Assessment
10.1 Institution: Contact:			
10.2 Institution: Contact:			
10.3 Institution: Contact:			
10.4 Institution: Contact:			
10.5 Institution: Contact:			
10.6 Institution: Contact:			
10.7 Institution: Contact:			
TOTAL:			

11. Consumption of the funds: If the institution consumed resources in producing services or goods, (i.e. administrative costs in managing the funds), complete a Providers form (Form # 3 and its annex) regarding those funds.

Data collection tool for FP service providers

Year of the expenditure estimate: _____			
Objectives of data collection from the Provider: I. To identify the origin of the funds spent by the provider in the year understudy. II. To identify in which FP Functions/ activities the funds were spent. III. To identify the FP Beneficiary Populations for each FP Function/ activity. IV. To identify the FP Production Factors for each Function/ activity.			
Indicate what currency will be used throughout the form with an "X":	**Local currency**	**US$ Exchange rate in Year of Assessment**	**Other (specify):** _____
Name of the Provider:			
1. Person to Contact (Name and Title):			
2. Address:		**3. E-mail:**	
4. Phone:	**5. Fax:**		
6. Type of institution: Select category of institution with an "X".	1. Public central government		
	2. Public regional government		
	3. Public local government		
	4. Private-for-profit national		
	5. Private-for-profit international		
	6. National NGO/CBO/CSO		
	7. International NGO/CSO		
	8. Bilateral Agency		
	9. Multilateral Agency		

NB. PLEASE PROVIDE ACTUAL EXPENDITURE REPORTS WHICH PROVIDE AS MUCH DETAIL AS POSSIBLE TO SUPPORT THE DATA REQUESTED HERE

SECTION A			
1. Please provide information on source of funds and non-financial commodities			
a. ORIGIN OF THE FUNDS RECEIVED			
List institutions that granted FUNDS spent during the financial year			
Name of Donor	**Contacts**		**Funds Received**
Source1			
Source2			
Source3			
Source4			
Source5			
Total			

b. ORIGIN OF NON-FINANCIAL RESOURCES

List institutions that granted *NON-FINANCIAL* used during the financial year

Name of the Institution	Contacts	Type of Resource received	Quantity Received	Purchase Value (or Estimated Monetary Value)
Total				

SECTION B

DESTINATION (USE) OF FUNDS

1. Please provide information on expenditure of funds received from the various sources

Expenditure of the Funds Received per Donor/Source				
Source 1		**Source1**		
List of Activities /Program ***(Please provide details of each Activity)***	**Amount Spent**	**Beneficiary Population/ Target Population**	**Expenditure Breakdown per Factor of Production/ Itemized expenditure**	**Amount Spent**
Activity 1:				-
				-
				-
				-
				-
				-
Total	**-**		***Total***	**-**
Activity 2:				-
				-

				-
				-
				-
				-
Total	**-**		***Total***	**-**
Activity 3:				-
				-
				-
				-
				-
				-
Total	**-**		***Total***	**-**

Expenditure of the Funds Received per Donor/Source

Source 2		**Source2**		
List of Activities /Program *(Please provide details of each Activity)*	**Amount Spent**	**Beneficiary Population/ Target Population**	**Expenditure Breakdown per Factor of Production/ Itemized expenditure**	**Amount Spent**
Activity 1:				-

				-
				-
				-
				-
				-
Total	**-**		***Total***	**-**
Activity 1:				-
				-
				-
				-
				-
				-
Total	**-**		***Total***	**-**
Activity 1:				-
				-
				-
				-

				-
				-
Total	**-**		***Total***	**-**
Expenditure of the Funds Received per Donor/Source				
Source 3		**Source3**		
List of Activities /Program *(Please provide details of each Activity)*	**Amount Spent**	**Beneficiary Population/ Target Population**	**Expenditure Breakdown per Factor of Production/ Itemized expenditure**	**Amount Spent**
Activity 1:				-
				-
				-
				-
				-
				-
Total	**-**		***Total***	**-**
Activity 2:				-
				-
				-

				-
				-
				-
Total	**-**		***Total***	**-**
Activity 3:				-
				-
				-
				-
				-
				-
Total	**-**		***Total***	**-**