Family Planning Spending Assessment in Kenya

FY 2016/17

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We are also indebted to the Track20 project (implemented by Avenir Health) for supporting this project with funds from the Bill and Melinda Gates Foundation.

List of Acronyms and Abbreviations

BMGF	Bill & Melinda Gates Foundation.
CPR	Contraceptive Prevalence Rate.
FP	Family planning
GDP	Gross Domestic Product
GOK	Government of Kenya
KEMSA	Kenya Medical Supplies Authority
KES	Kenya Shillings
KIHBS	Kenya Integrated Household Budget Survey
mCPR	Modern Contraceptive Prevalence Rate
NASA	National HIV/AIDS Spending Assessment
ROK	Republic of Kenya
TFR	Total Fertility Rate

Executive Summary

Background

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 throughout of pocket spending.

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 endpoint of service delivery, among the different institutions involved.

Purpose

The main purpose of this study was to provide information on Government spending on family planning for reporting on FP2020.

Methodology

The study was a cross-sectional study involving a survey for only financial year July 2016 to June 2017 and covering Government resources only. In the approach, the following was covered: Who pays for FP in the county? Who manages the funds and up to what level? Who provides the FP services? And What FP services were provided?

Data collection exercise involved both top-down. The top-down approach was implemented first, collecting data from financing sources as well as financing agents. Ministry of Health and National Treasury provided data on national government expenditure while KEMSA provided disaggregated data on expenditure on FP commodities by sources of funds, county, health facility or service providers, facility ownership. However, both levels of governments did not spend any money on FP commodities during the year under consideration. The data on county health expenditure for 2016/17 were obtained from the National Treasury.

Data entry and analysis were facilitated by the use of an 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 was estimated using costing approaches.

Results

The results showed that total government expenditure in 2016/17 was KES 1,802 million (US$ 17.49 million). In 2016/17, it contributed County Government contribution was 97.6 percent and National Government followed by Government contributed 2.4 percent. County government health departments were the main financing agents in the provision of FP services in the country. It was shown that the public dispensaries accounted for the highest expenditure on FP services at about 42 percent followed by public

health centres at 36 percent, level 4 county hospitals (10%), county health departments (5%), level 5 county hospitals (4.5%) and National Government (2.4%) in 2016/17

The provision of implants accounted for the highest amount and percentage of the total FP expenditure, taking 43 percent in 2016/17 followed by the provision of injectables (39%), pills (9%), programme management (7%) and IUCD (1%). The results further showed 90.4 percent of FP expenditure was on personnel costs while 4.6 percent and 3.3 percent were spent on administrative costs and maintenance costs respectively.

Conclusions

The results have shown that both levels of governments did not spend any amount on FP commodities, which implies the problem of sustainability of commodity supply in the country. The supply of the commodities relied 100% on donors. The National and County Governments should, as a matter of urgency, allocate funds for FP commodities

INTRODUCTION

1.1 Country Context

Kenya is one of the countries in 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 47 million in 2019, making it the seventh most populated country in Africa. 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. The Economic Survey of 2019 indicated that the country recorded an economic growth rate of 5.9 percent in 2016, 4.9 percent in 2017 and 6.3 percent in 2018 (KNBS, 2019). GDP per capita at current prices was given at KES 154,802 (US$ 1,559) in 2016, KES 174,791 (US$ 1,695) in 2017 and KES 186,296 (US$ 1,857) in 2018. GDP per capita at constant prices was KES 94,797 in 2016, KES 96,788 in 2017 and KES 100,310 in 2018 (Republic of Kenya, 2019).

The poverty headcount 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 the absolute poverty line. The poverty varies between rural and urban areas, with 49.1 per cent of the 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 the current poverty level in the country. Kenya, like most Sub-Saharan Africa, have a low human development index. According to the World Human Development Reports of 2015 and 2016, Kenya's human development index (HDI) was 0.548 in 2014 and 0.555 in 2015.

1.2 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.

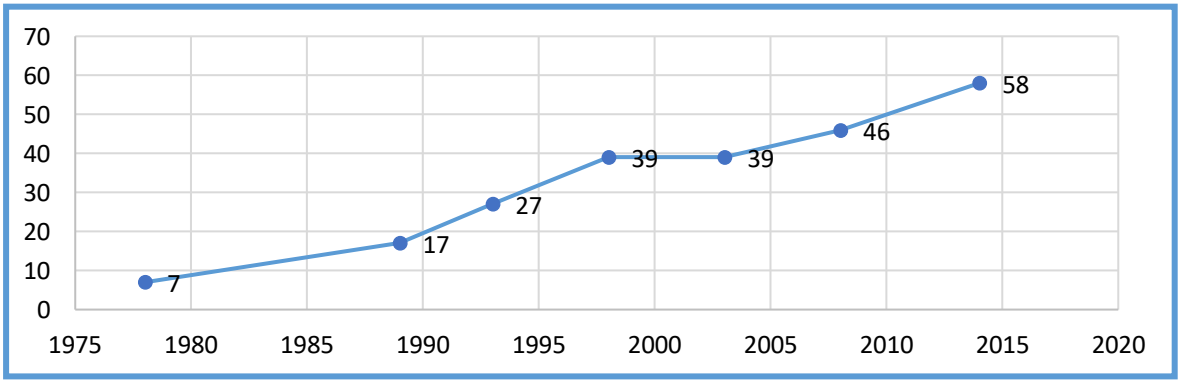

Figure 1.1: Trend in overall CPR

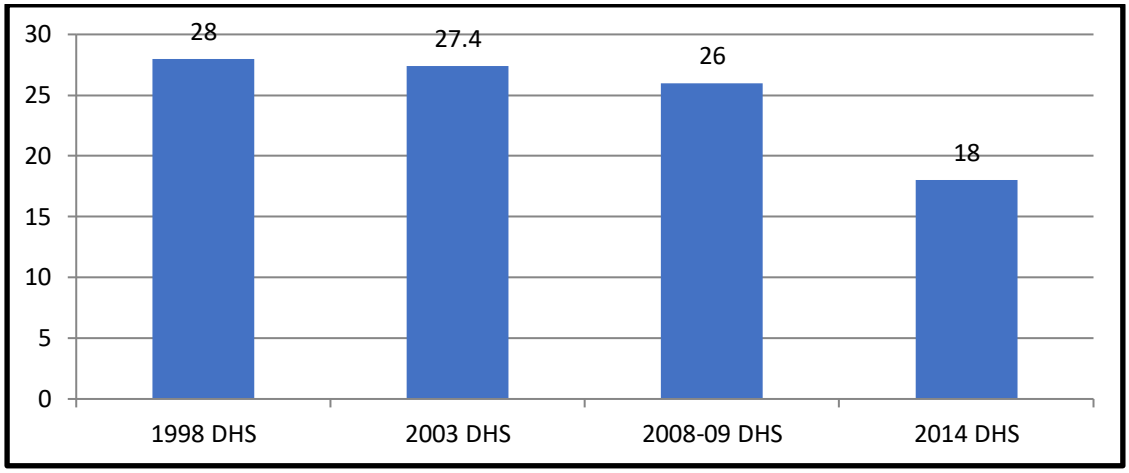

Figure 1.2: Trend in unmet need for FP

1.3 The 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 endpoint of service delivery, among the different institutions involved. Tracking was done from financing sources from National and County Governments only. In summary, the tracking sought 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 objective of the FP Spending Assessment was to determine the total expenditures on FP in Financial Year (FY) 2016/17 and 2015/16 by Government of Kenya, consisting the National level and County Level. The results of the study provide

METHODOLOGY

2.1 Overall Scope of the Exercise

This scope of this study was the government financial year 2016/17. In Kenya, the Government financial year begins on 1st July and ends on 30th June the following year. The other sources of FP funding in the country were excluded since the intention of the work was to cover only government expenditure on FP/

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, Table 2.2 and Table 2.3 summarize the classifications that were used.

Table 2.1: Classifications used for sources, agents and providers

FS: Financing sources		**Where funding originates from**
FS.01	Public funds	This is further broken into National Government, Regional Government, County Government.
FA: Financing agents		**Channels for funding.**
FA.01	Public sector	Includes ministries and departments at national and regional Government, state corporations
PS: FP service providers		**Actors engaged in the production and delivery of Services.**
PS.01	Public sector providers	Providers that are integrated with Government, including 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.

Table 2.2: Classification used for FP services

FPSC: FP service categories		Activities or programs that result in the effective provision of FP to those who need them.
FPSC.01	Family planning services	Further classified into the 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 the provision of FP methods is

FPSC: FP service categories		Activities or programs that result in the effective provision of FP to those who need them.
		already covered under the FP services and was excluded from human resource classification. Training and capacity building are the main categories 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 2.3: 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 as salaries, FP commodities, IEC, materials, administrative expenses such as utilities, transport and travel expenses, meeting and workshops expenses. 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 the National HIV/AIDS Spending Assessment (NASA) approach. In this adapted methodology, 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 the 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 the 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 on the ~~sources of funds~~ 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 to retrogressively measure past actual expenditure. Ingredient and step-down costing are 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 the funding source to the service provider, rather than just adding up the expenditures of every agent that commits resources to FP activities.

2.4 Data Collection

Data collection exercise involved both top-down. The top-down approach was implemented first, collecting data from financing sources as well as financing agents. Ministry of Health provided data on national government expenditure while KEMSA provided disaggregated data on expenditure on FP commodities by sources of funds, county, health facility or service providers, facility ownership. However, both levels of governments did not spend any money on FP commodities during the year under consideration. The data on county health expenditure for 2016/17 were obtained from the National Treasury.

2.5 Data Analysis

Data entry and analysis were facilitated by the use of an 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 was estimated using costing approaches, as explained in the sections that follow.

The new constitutional dispensation has resulted in the 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 a 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 general, 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 ~~of~~ expenditure, excluding drugs and laboratory and x-ray regents and materials, were added together to obtain the amount that was 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 outpatient 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.

FP EXPENDITURE RESULTS

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 3.1 presents a diagrammatic view of the flows of funds for FP.

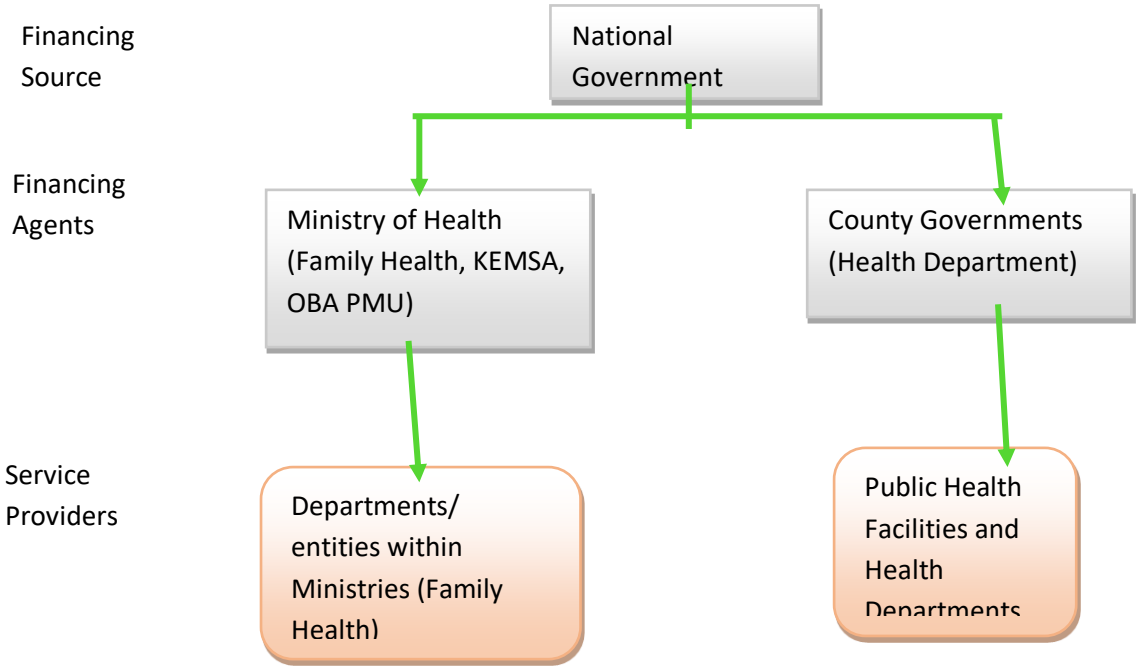

Figure 3.1: Flow of resources for family planning services

3.2 Total Government Expenditure on FP in Kenya

Health care financing is a critical element of the social and economic development of a country. An efficient health financing mechanism will enable the health sector to achieve important health sector goals in line with the Universal Health Coverage (UHC) agenda and the long-term goals as enshrined in the vision 2030 of ensuring access to quality and affordable health care for all.

Financing sources as are the institutions/ entities that contribute funds to finance the FP. Table 3.1 and Figure 3.2 show the results of FP spending analyzed by key financing sources.

Table 3.1: Expenditure by National and County Governments

Sources	KES million	US$ million
National Government	42.39	0.41
County Governments	1,759.16	17.08
Total	1,801.55	17.49

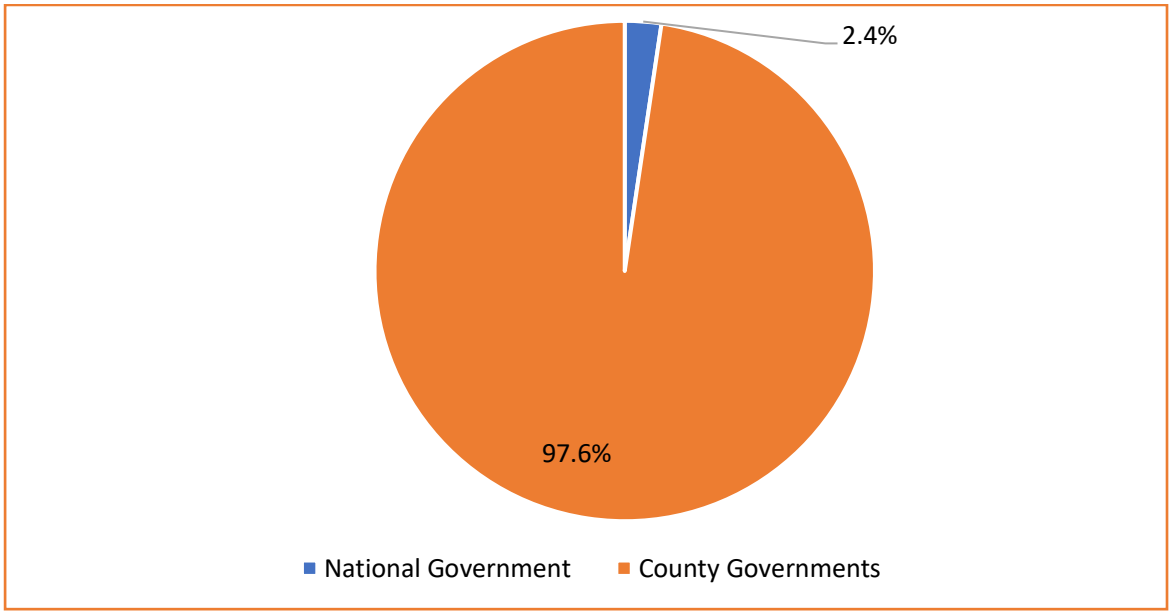

Figure 3.2: Spending by government sources

Table 3.1 shows total government expenditure in 2016/17 was KES 1,802 million (US$ 17.49 million). Figure 3.2 shows that the County Government accounted for the largest contribution to total FP expenditure. In 2016/17, it contributed County Government contribution was 97.6 percent and National Government followed by Government contributed 2.4 percent.

3.3 FP Expenditure by Financing Agents

Financing agents refer to institutional units/ entities that manage and use the funds for payment or purchase of FP services, FP commodities and other FP related activities. They assist in responding to questions on who manages the financing arrangements for raising revenue, pooling/managing resources, and purchasing services. The financing agents also decide the type of activity fund. Figure 3.3, Table 3.2 shows the results of FP spending by financing agents.

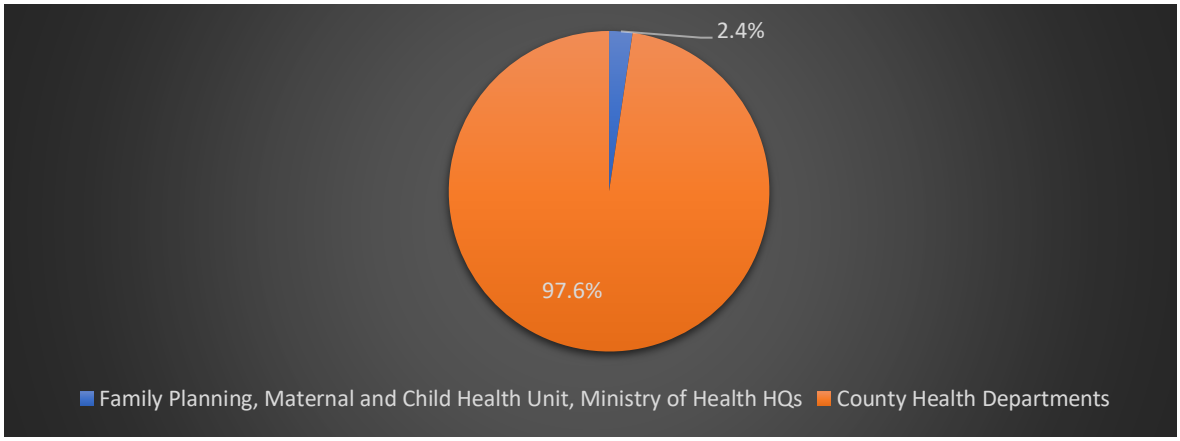

Figure 3.3: FP Expenditure by financing agents

Table 3.2: FP Expenditure by financing agents

Financing Agents	KES million	US$ million
Family Planning, Maternal and Child Health Unit, Ministry of Health HQs	42.39	0.41
County Health Departments	1,759.16	17.08
Total	**1,801.55**	**17.49**

Table 3.2 shows that county government health departments were the main financing agents in the provision of FP services in the country. The County health departments managed 98 percent of all FP expenditures in the public sector.

3.4 FP Expenditure by Service Providers

Service providers are entities that engage directly in the production, provision and delivery of FP services. Table 3.3, Table 3.4 and Figure 3.4 provide a broad picture of the main providers of FP services during the year under consideration in the public health sector.

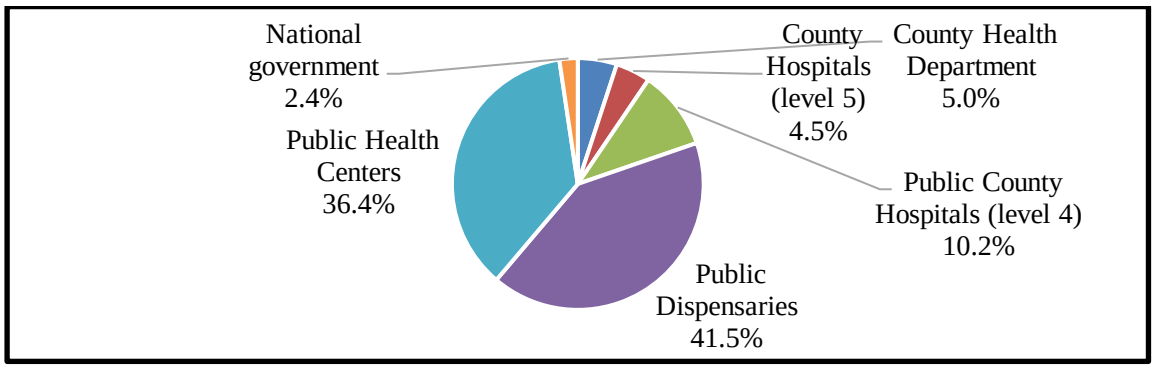

Figure 3.4: Percentage of expenditure by service providers 2016/17

Table 3.3 and Figure 3.3 show the public dispensaries accounted for the highest expenditure on FP services at about 42 percent followed by public health centres at 36 percent, level 4 county hospitals (10%), county health departments (5%), level 5 county hospitals (4.5%) and National Government (2.4%) in 2016/17.

Table 3.3: Family Planning Spending Categories by Service Provider (PS) (KES million)

	FPSC 1.6: Provision of pills	FPSC 1.7: Provision of injectables	FPSC 1.8: Provision of IUD	FPSC 1.9: Provision of implants	FPSC 1.23: Information, education and communication for FP	FPSC 2.1: Planning, coordination, and programme management	FPSC 3.2: Training and capacity building	Total
County Health Department	-	-	-	-	-	90.60	-	90.60
County Hospitals (level 5)	7.64	31.87	0.83	34.98	2.57	-	2.33	80.21
Public County Hospitals (level 4)	18.69	77.98	2.02	85.57	-	-	-	184.26
Public Dispensaries	75.80	316.25	8.19	347.01	-	-	-	747.24
Public Health Centres	66.59	277.82	7.19	304.85	-	-	-	656.45
National government	-	-	-	-	-	42.39	-	42.39
Total	**168.72**	**703.93**	**18.22**	**772.40**	**2.57**	**132.99**	**2.33**	**1,801.15**

Table 3.4: Family Planning Spending Categories by Service Provider (PS) (US$)

	FPSC 1.6: Provision of pills	FPSC 1.7: Provision of injectables	FPSC 1.8: Provision of IUD	FPSC 1.9: Provision of implants	FPSC 1.23: Information, education and communication for FP	FPSC 2.1: Planning, coordination, and programme management	FPSC 3.2: Training and capacity building	Total
County Health Department	-	-	-	-	-	879,656	-	879,696
County Hospitals (level 5)	74,173	309,465	8,011	339,565	24,959	-	22,609	778,782
Public County Hospitals (level 4)	181,463	757,096	19,598	830,736	-	-	-	1,788,894
Public Dispensaries	735,912	3,070,353	79,479	3,368,996	-	-	-	7,254,740
Public Health centres	646,503	2,697,324	69,823	2,959,683	-	-	-	6,373,333
National government	-	-	-	-	-	411,528	-	411,528
Total	**1,638,051**	**6,834,237**	**176,911**	**7,498,981**	**24,959**	**1,291,184**	**22,609**	**17,486,933**

3.5 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. Table 3.5 shows FP spending on FP service according to detailed classifications that were developed.

Table 3.5: FP spending by type of service or activity – 2016/17

	KES million	USD million	Percent
FPSC 1.6: Provision of pills	168.72	1.64	9.4%
FPSC 1.7: Provision of injectables	703.93	6.83	39.1%
FPSC 1.8: Provision of IUD	18.22	0.18	1.0%
FPSC 1.9: Provision of implants	772.40	7.50	42.9%
FPSC 1.23: Information, education and communication for FP	2.57	0.02	0.1%
FPSC 2.1: Planning, coordination, and programme management	132.99	1.29	7.4%
FPSC 3.2: Training and capacity building	2.33	0.02	0.1%
Total	1,801.15	17.49	100.0%

The table shows that provision of implants accounted for the highest amount and percentage of the total FP expenditure, taking 43 percent in 2016/17 followed by the provision of injectables at 39 percent, pills (9%), programme management (7%) and IUCD (1%).

3.6 Expenditure by Production Factors

This entailed classifying total FP spending by budget items but disaggregated by budget categories. As shown, 90.4 percent of FP expenditures were spent on personnel costs, while 4.6 percent and 3.3 percent were spent on administrative costs and maintenance costs respectively. Table 3.6 shows the expenditure for 2016/17.

Table 3.6: FP spending by production factors- 2016/17

FP Services	KES	US$	Percent
Condoms	0	0	0.0%
Pills	0	0	0.0%
IUCD	0	0	0.0%
Injectable	0	0	0.0%
Implants	0	0	0.0%
Transport and travel	24,530,737	238,162.49	1.4%
Personnel	1,628,893,869	15,814,503.58	90.4%
Administrative costs	83,157,702	807,356.33	4.6%
Training	2,328,741	22,609.13	0.1%
IEC	2,570,741	24,958.65	0.1%
Maintenance	59,672,321	579,342.92	3.3%
Total	**1,801,154,110**	**17,486,933.11**	**100.0%**

3.7 Conclusions

The results have shown that both levels of governments did not spend any amount on FP commodities, which implies the problem of sustainability of commodity supply in the country. The supply of the commodities relied 100% on donors. The National and County Governments should, as a matter of urgency, allocate funds for FP commodities

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