

Kenya's Programmatic Response to the Utilization of Family Planning services: Which Way to Go?

Timothy Chrispinus Okech (PhD)

Chandaria School of Business United States International University- Africa

Abstract—The Kenya government in collaboration with other stakeholders (including donors, NGOs, CBOs and private sector health providers amongst others) involved in family planning services have over the years continued to initiate various programmatic responses towards uptake of family planning services. These initiatives have been aimed at increasing contraceptive prevalence rate (CPR), reduction in both total fertility rate (TFR) and unmet need for family planning services. In this article, an attempt was made to review the existing policies and strategies that have been mooted over time and how they have impacted on TFR, CPR and unmet needs. Despite the initiative, surmount evidence has been deduced showing that TFR and unmet need still remains high while CPR is estimated to very low. This clearly shows that there could be certain responses that may have not been considered in enhancing the concerted efforts in the country. In this regard, various suggestions have been proposed to enhance utilization of family planning services as a bold step towards the reduction of both TFR and unmet need, while at the same time increase CPR. Among the suggestions include political and leadership commitment in the provision of sustainable resources in addressing family planning services; initiate tailor made initiatives in promoting family planning education and activities at all levels including household, community and levels. Other recommendations include enhancement of the activities of community based distributors and community health workers, as well facilitation in the formation of lobby groups to enhance attitude and cultural change, awareness creation and counselling, and development and dissemination of IEC materials need to be accorded priority.

Keywords—Family Planning Services, Contraceptives Prevalence Rate, Unmet Need and Total Fertility Rate

I. INTRODUCTION

Developing economies world-wide are characterized by rapid population growth rate partly attributed to high fertility and birth rates, steady declines in death rates, low contraceptive prevalence rate (CPR) and high but declining mortality rate (Oyedokun, 2007). Sub-Saharan Africa (SSA) countries with population growth rate of about 2.8 percent is considered as one of the highest in the world compared to the rest of the world (USAID/HPI, 2007). This has continued to exert pressure on the number of people in need of social services including health, among other public goods, which in turn require large amount of financial and human resources. This is likely to be an impediment towards the realization of some of the Millennium Development Goals (MDGs) like reduction of child mortality, improvement of maternal health, and combating HIV/AIDS, malaria and other diseases (Health Policy Initiative, 2007). To address these, issues, countries have focused their attention on birth control measures, especially the use of family planning services.

Tremendous efforts have been advanced in the development of safer and more effective family planning products especially contraceptives and in the provision of affordable and accessible services worldwide have. Yet, millions of individuals and couples around the world are unable to plan their families as they wish. It is estimated that over 120 million couples do not use contraceptives despite their desire to space or limit their childbearing (HPI, 2007). Further, the reduction of global poverty has become an overreaching priority for the international community as contained within the MDGs (USAID/HPI, 2007). While there are many interventions that can help reduce poverty and improve the lives of the poor, increasing access to contraceptives serves people's basic right to reproductive health as a cost-effective approach with far-reaching dividends (Policy Project, 2003).

Satisfying the family planning needs of the poor - who often live in rural areas and in marginalized urban areas (who mostly live in slums) and tend to have less access to health services, higher birth rates, and higher unmet need-promotes equity, helps address the multidimensional nature of poverty, and recognizes the long-term societal changes needed to sustain economic growth at the household and national levels (USAID/HPI, 2007). In addition, lowering total fertility rate through voluntary means such as increasing knowledge about

family planning and access to contraceptive supplies, in the long run, stimulates economic growth at the societal level and has substantive benefits for individuals and families (HPI, 2007).

1.2 Importance of Family Planning

Addressing family planning issues confers benefits not only at household level but also at community and society levels. For instance, Moreland and Talbird (2006) showed that satisfying unmet family planning needs in Kenya could avert 14,040 maternal deaths and 434,306 child deaths by the MDG target date of 2015. In USAID/HPI (2007), it was noted that the cost savings in providing services to meet MDGs outweigh the additional costs of family planning by a factor of almost 4 to 1. Specifically, the social sector cost savings and family planning costs in Kenya for 2005-2015 are estimated at \$271 millions, with maternal health taking \$75 million, while water and sanitation, immunization and education each taking \$36 million, \$37 million and \$115 million, respectively. This compares with the total cost of family planning estimated at \$71million, which implies that total savings will be \$200 million (Moreland and Talbird, 2006; USAID/HPI, 2007). Promotion of family planning in countries with high birth rates has the potential of reducing poverty and hunger, while at the same time averting 32 percent of all maternal deaths and nearly 10 percent of child mortality. This would contribute substantially to women's empowerment, achievement of universal primary schooling and long-term environmental sustainability (Cleland *et al.*, 2006).

Increased access to family planning services could slow down population growth rate, which in the process could reduce the costs of meeting MDGs in terms of universal primary education, which is influenced by the number of children in need of education (Moreland and Talbird, 2006). The cumulative cost savings to the education sector from satisfying unmet need is estimated at \$114.7 million by 2015 (UNFPA, 2005; Moreland and Talbird, 2006). Given that the effects of family planning are not immediate, long-term benefits would even be larger if the timeline were extended past 2015 (Moreland, 2006). This, according to Moreland (2006), will also facilitate realization of MDGs and Vision 2030 objectives in terms of immunization, clean water provision and sanitation, maternal health and malaria targets. Hawkins *et al.* (1995) observed that family planning services offer various economic benefits to the household, country and the world at large. First, family planning permits individuals to influence the timing and the number of births, which is likely to save lives of children. Secondly, by reducing unwanted pregnancies, family planning service can reduce injury, illness and death associated with child birth, abortions and sexually transmitted infections (STIs) including HIV/AIDS.

Further, family planning contributes to reduction in population growth, poverty reduction and preservation of the environment as well as demand for public goods and services (Shane, 1997; Cincotta and Engelman, 1997). Other substantial economic benefits could include demographic bonus or dividends. Demographic bonus exists when there is a shrinking share of the population consisting of dependent children at the same time as a greater share consisting of working-age adults. When this occurs, David *et al.* (2002) notes it boosts productivity and allows added savings and consequently investments. This "bonus" is not inevitable and depends on other policy variables, including economic opportunity, education and commitment to public health (David *et al.*, 2002). David *et al.* further noted that family planning helps to reduce the number of high-risk pregnancies that result in high levels of maternal and child illness and death. High population growth is associated with high illiteracy rates and low education level that make it difficult to implement government programmes, given their budgetary implications (Wawire, 2006).

In a World Bank report of 2003, it was observed that the use of family planning services is an important issue for a developing country like Kenya. This is due to the benefits gained in terms of development through reductions in fertility levels. Furthermore, the uptake of family planning widened choices available to people, particularly women, by allowing individuals and society more opportunities for social and economic development. Singh *et al.* (2004) revealed that a high fertility rate (which in many cases is attributed to low contraceptive prevalence rate) impedes economic growth. Countries with high "population pressure" or with rapidly growing populations may not be able to meet the large education, labour, health, and infrastructure-related demands of the population (Singh *et al.*, 2004). In Leisinger *et al.* (2002) it was noted that population growth affects the environment and raises concerns about food security, safe drinking water and availability of arable land. Similarly, reducing fertility could help alleviate poverty and stimulate economic growth. For instance, reducing the birth rate by 5 births per 1,000 during the 1980s would have reduced the average national incidence of poverty from 18.9 percent in the mid-1980s to 12.6 percent in the mid-1990s (Eastwood and Lipton (2001).

Merrick (2002) forecasted that declining birth rates contribute positively towards improvements in dependency ratio, with an increasing number of productive adults relative to the number of young and elderly dependents. This, Merrick (2002) contended, would be realized only if countries responded with appropriate family planning policies and the resources that would have been required to meet the needs of a larger number of dependents. According to USAID/HPI (2007), family planning can slow population growth and reduce demographic pressure, which can in turn help countries to lift themselves out of poverty. Reduced population sizes mean a decreased burden on national expenditures for education, health and other social services, as well

as less strain on the environment and natural resources. This further contributes directly to reduced infant and maternal mortality and morbidity. In a conference organized by NCPDA in 2010, it was observed that Kenya's population was growing by more than 1,000,000 people yearly, presenting a key barrier to the country's development efforts. It was contended that "these numbers portend great challenges in development planning" and in achieving Kenya's Vision 2030 goals.

2.0 Policy and Programmatic Responses Towards Family Planning in Kenya

Over the years, family planning programmes in Kenya have continued to receive overwhelming support from the Government of Kenya as well as other stakeholders including donors, NGOs, private sector providers, amongst others. This has been mainly due to its endeavour to reduce high population growth rate. The concern by the Government of Kenya about high population growth rate can be traced to 1962 when the census showed that Kenya's population was growing at 3.3 percent per annum (Republic of Kenya, 1994). Upon gaining independent, the government recognized the importance of family planning and formally accepted population planning and family planning as part of the National Planning Strategies as reiterated in Sessional Paper No. 1 of 1965 (Republic of Kenya, 1965). In the policy document, the government committed itself by spelling out the importance of managing population levels through the use of family planning services as immediate steps towards family planning education. This was to be achieved through the use of available local and national government facilities and personnel (Republic of Kenya, 1965).

As a bold step towards implanting its commitment, the government established various programs with the intent of promoting family planning among households. This was a sector wide initiative that was to involve various government ministries including Ministries of Health, Economic Planning, Finance, Education, Information and Broadcasting, and Labour and Social Services including Community Development. The cooperation and collaboration among the ministries and other stakeholders was through formation of the National Family Planning Council (NFPC). With the recognition of the need to reduce the population growth rate, the Government launched the National Family Planning Programme (NFPP) in 1967, based on the recommendations from a study by Population Council Advisory Mission. The programme was integrated with maternal child health (MCH), with the Ministry of Health (MOH) taking the responsibility for its implementation. Due to lack of an effective infrastructure and lack of trained personnel in family planning, the MOH relied greatly on private organizations and NGOs to carry out the services that were encompassed within the programme (Republic of Kenya, 1984; 1996a).

The 1969 census however, revealed that fertility rate was still very high in the country making the government to renew its commitment to reduction of population growth. As a result, the government led stakeholders in drawing up a five-year family planning programme for the period 1975-1979, whose objectives were: establishment of National Family Welfare Centre (NFWC); and establishment of 400 MCH/FP daily-service clinics and 17 mobile teams. Other objectives were provision of in-service courses for nurses in family planning; and intensification of information and education activities through 817 trained family health field educators (Republic of Kenya, 1984). In the Sessional Paper No. 4 of 1984, it was revealed that the five-year family planning programme had resulted in significant progress in information and education activities, although the family planning component had limited success in reducing population growth rate since the growth had increased to about 3.8 percent in 1979.

The limited success of the family planning component was due to lack of manpower, ineffective information, education and communication strategy, and more emphasis on child-care. Other factors contributing to these were lack of promotion of family planning by health staff, and lack of coordination of family planning activities. In order to address these weaknesses, the Government established the National Council for Population and Development (NCPD) in 1982. The Council was mandated to formulate population policies and strategies, and to coordinate population oriented activities aimed at reducing Kenya's population growth rate. The bulk of the terms of reference of the NCPD revolved around family planning activities. For instance, the NCPD responsibilities included determining priorities in family planning and population development activities, advising the Government of the scope and direction of all family planning activities, promoting public understanding and acceptance of family planning and a small family size, among others (Republic of Kenya, 1984, 1996a).

In the Kenya Health Policy Framework (KHPF) of 1994, the Government identified population development as a priority strategy for achieving balanced socio economic development. In the report, reproductive health components were identified as one of key strategies. Specifically, the Government prioritised reduction in fertility rate as well as increase in the proportion of health facilities providing integrated reproductive health services including family planning (FP) services as key priority in population development. In 1996, the Government launched Sessional Paper No. 1 of 1996 on *National Population Policy for Sustainable Development*, building on the guidelines of the Sessional Paper No.4 of 1984. The paper widened the scope of population policy by integrating the Programme of Action of the International Conference on Population and

Development of 1994. The paper also recognized population challenges as unmet need for family planning, increasing the quality of family planning services, and high level of adolescent fertility among other challenges. The policy paper, however, indicated that there are constraints in the effort to address these challenges. Among the constraints identified were insufficient funding, inconsistent commitment to family planning by some opinion leaders, and limited involvement of males in family planning, among others (Republic of Kenya, 1996a). In the paper, the Government committed itself to increase availability, acceptability and affordability of quality family planning services. In provision of family planning services, the Ministry of Health takes the responsibility for the coordination and implementation of family planning programmes (Republic of Kenya, 1996a). To ensure quality provision of these services, the government developed guidelines and standards for family planning service providers in 1991. The guidelines were not only developed to assist family planning providers in educating clients, but also to determine and provide the best method for clients' needs and to instruct the clients in the use of method and follow-up (Republic of Kenya, 1991). The guidelines were however reviewed in 1997 and consequently incorporated in the Reproductive Health/Family Planning Policy Guidelines and Standards for Service Providers (Republic of Kenya, 2007). In the document, provision of quality and sustainable family planning services was identified as the main goal that would help to reduce the unmet needs for family planning.

In response to the Programme of Action of the United Nations International Conference on Population and Development (ICPD) of 1994 and the Sessional Paper No. 1 of 1996, the MOH launched the National Reproductive Health Strategy for the period 1997-2010 in 1996. The strategy addressed issues such as promotion of the concept of reproductive health, family planning unmet needs, safe motherhood, adolescent and youth health, management of sexually transmitted infections (STIs) including HIV/AIDS, among others (Republic of Kenya, 1996a). In the strategy, the goal of family planning provision was to make available quality and sustainable family planning services to all who need them, in order to reduce the unmet needs for family planning.

The objectives were to increase access to family planning services from 60 percent of health care facilities to 90 percent by the year 2010 in addition to enhanced quality of the services. Others were to effect a well-researched and coordinated system of information, education and communication (IEC). These objectives were to be realized through conducting need assessments; mobilizing resources from government, NGOs and the private sector in order to facilitate extension of services to under-served and hard-to-reach communities and individuals. Others included ensuring uninterrupted supply of both contraceptives and expendable supplies; developing and sustaining client-oriented services through training of service providers in different aspects of service provision; conducting research to inform development of messages for target audience; and consolidating the management information systems in one system (Republic of Kenya, 1996a).

The National Reproductive Health Strategy was operationalised through the Implementation Plan for National Reproductive Health Strategy for the period 1999-2003 and National Health Sector Strategic Plan I for the period 1999-2004. The main objective of family planning component of the reproductive health, in the two strategic documents was increased utilization of family planning services in the country. Within this context, the MOH expected to increase access to family planning services from the then current 60 percent of healthcare facilities (in 1999) to 75 percent by the year 2004 (Republic of Kenya, 1998, 1999b). The increased utilization was envisaged to be achieved through social mobilization, expanding family planning services to the under-served and hard to reach areas, increasing participation of other stakeholders (NGOs and the private sector) in expanding supply delivery points (SDPs), mobilizing available resources for expansion of SDPs, development and dissemination of appropriate IEC materials and messages, development of a reliable system to ensure regular availability of contraceptive supplies, procurement and distribution equipment and supplies. The other activities included, conducting training and updating skills of service providers, ensuring regular maintenance of family planning equipment and instruments, strengthening the capacity for family planning services by NGOs, religious organizations and private sector, and recruiting and train more community-based distributors among others (Republic of Kenya, 1998, 1999b).

As part of its commitment in addressing population growth, the Government in the National Health Sector Strategic Plan II (NHSSP-II) of 2005-2010 specified the Kenya Essential Health Package (KEPH). Under this arrangement, a wide range of population growth issues was addressed. These ranged from maternal health infections, nutritional deficiencies, family planning and child spacing. The Government further reiterated its commitment in containing population growth in the Vision 2030 through various interventions including provision of family planning services (Republic of Kenya, 2007b).

In light of these worrying trends, the NCAPD organized a National Leaders' Conference on Population and Development towards the end of 2010 with the sole purpose of repositioning family planning programs and address broader population issues in Kenya. The conference brought together policy makers, donor agency representatives, and international experts in population and development. The conference sessions were structured around a core set of fourteen sub-themes. These themes ranged from health to education to science

and technology, and sessions were focused on re-framing population within the context of achieving development goals of Vision 2030 and the Millennium Development Goals. This is further an indication that despite the policy and strategic initiatives, population growth through use of family planning services still has some gaps that merit attention.

3.0 Situational Analysis

As one of the first countries in Africa to develop a Population Policy and establish a Family Planning Programme as the main policy lever to reduce the population growth rate, Kenya has been well placed to initiate a fertility transition through government-led actions (Koome *et al.*, 2005; Ian *et al.*, 2009). In the 1980s and 1990s, Kenya achieved a rapid fertility decline, because of the official commitment of the government, substantial funding and technical support from a range of bilateral and multilateral development partners. Indeed, when the results of the 1993 Demographic Health Survey (DHS) were released, Kenya's success in achieving a phenomenal decline in fertility was lauded globally, and many national and international observers felt that social norms in favour of small families and increased use of contraception were now well established and irreversible (Ian *et al.*, 2009).

Over the decade starting from the mid-1990s, the national family planning programme was substantially reduced following the withdrawal of funding from donors, and a reduction of government funding. As a result, the large-scale community-based distribution (CBD) programmes that allowed low-cost contraceptive information and services to reach rural and peri-urban communities declined drastically. At the same time, the nationwide information education and communication (IEC) campaigns advocating for small families and the use of contraception collapsed. Both of these components had been introduced as demand creation strategies for family planning services. The drastic reduction in investment in these strategies at this time reflected the false perception that the demand for family planning was sufficiently well established in the general population, and that the programme's focus should consequently have shifted to addressing the resulting unmet need (Crinchton, 2008).

Several other factors also influenced funding of the family planning programmes. Some of these relate to policy and programmatic decisions concerning the family planning effort in the 1990s. The International Conference on Population and Development (ICPD) in 1994 affirmed the importance of providing family planning within a rights-based framework and as part of a comprehensive set of services to meet individual reproductive health needs that would also address broader development concerns (Westoff and Cross, 2006). While this undoubtedly broadened the range and quality of reproductive health services provided in Kenya, the energies and resources expended on re-aligning policies, programmes and services almost certainly diluted the attention being paid to basic family planning services.

Long-standing donor investment in family planning in Kenya had been seen to produce a major fertility decline, and many donors either re-directed their investments into a broader range of maternal child health (MCH) related services. Others included emerging priorities such as HIV/AIDS, or in basket funding to the government to support a range of social investments (Ian *et al.*, 2009). According to Crinchton (2008), in the 1990s, the Kenyan economy was also characterized by declining growth in the Gross Domestic Product (GDP) and increases in the population living below the poverty line. At the same time, political tensions increased significantly following the introduction of a multiparty political system in the 1992 elections. Further, the donor community reduced funding for Kenya's programmes including family planning services, due to Kenya's poor macroeconomic policies. These factors attracted the attention of politicians as well as other influential leaders and indeed the general population. In the end, the family planning "success story" soon became yesterday's news, and attention to population issues in general and fertility decline in particular gradually waned. The political turbulence of the 1990s also facilitated a rise in public advocacy against family planning from conservative religious leaders and "pro-life" groups. As a result, many politicians became more cautious in making any public statements about reproductive health generally and family planning in particular. There was evidence of a decline in international and national support for the family planning programme since the mid to the late 1990s, which mirrors the decrease in overall official assistance to Kenya. This was estimated to have dropped from a high of above \$1 billion in the late 1980s to under \$400 million by 2000 (Crinchton, 2008). The timing of this decrease also parallels the stall in fertility decline, although the magnitude of the effect of this decrease in development assistance is yet to be fully evaluated.

An increase followed by a decrease in institutional commitment to family planning programmes appears also to have affected the stall, with the timing of these changes in commitment and corresponding programmes effort. This closely mirrored the decline and then stagnation in the fertility rate (Ian *et al.*, 2009). On the realization that HIV and AIDS were reaching pandemic proportions, the government of Kenya diverted national and international attention and resources into fighting the epidemic. Not only did this reduce the funding allocated for family planning services, but it also reduced the levels of national and international technical expertise available, and importantly, took well-trained health personnel and support systems away from reproductive health to work in the newly created HIV/AIDS programmes.

The 1998 DHS showed a four-percentage point increase in contraceptive prevalence rate from 26 percent to 30 percent, while total fertility rate (TFR) declined substantially over the same period from 5.4 to 4.7 (Republic of Kenya, 2003). These findings reinforced the impression that the fertility transition in Kenya was well and truly established, and that the strategies that were being implemented and levels of funding available for both creating and supplying demand were appropriate for the country at this stage of fertility transition. Consequently, the results of the 2003 DHS came as a shock to national and international observers and a flurry of activities ensued to try to “reposition” both family planning and population as key issues worthy of attention and investment. The government, for example replaced the NCPD with a National Coordinating Agency for Population and Development (NCAPD), and the Millennium Development Goals provided a platform for the role of population growth in sustainable development to be revisited and addressed.

Additionally, many development partners have sought ways to increase their investments in support of family planning services, but their gradual disengagement over the previous decade has meant that it has been difficult to make convincing arguments to increase allocations for family planning in the face of other development challenges such as transportation, infrastructure, HIV/AIDS and education. Studies have however, shown that, paradoxically, it is the wealthier groups who benefit from government healthcare spending, not the poor. Moreover, the poor may not be aware of policies designed to help increase access to reproductive healthcare services in general and family planning services in particular, such as user fee exemption schemes for the poor, or they may be subject to informal fees charged by providers Sharma *et al.* (2005a) and Sharma *et al.* (2005b). This is an indication that the government and other stakeholders need to re-consider their policies in terms of dissemination of information relating to family planning as well as the monitoring mechanisms.

4.0 Trends in the Provision and Demand for Family Planning Services

4.1 Trends in the Provision of the Services

Family planning services were first made available in Kenya in the 1950s by private doctors, albeit modestly, and by the Family Planning Association of Kenya (FPAK) (now called Family Health Options of Kenya (FHOK) from 1962. The Ministry of Health started providing a range of family planning services in 1967 through the network of MCH/FP Clinics. Community-based distribution programmes were introduced in 1982 but had collapsed by the late 1990s. Marie Stopes International (MSI) started offering services in 1985 through static clinics and diverse outreach strategies (Republic of Kenya, 1984). Long-acting and permanent methods (LAPMs) were strengthened in the late 1980s to mid-1990s, while social marketing of condoms and pills began in the 1990s. This clearly demonstrates an increased diversity of sources of family planning services, and the decreasing role of the public sector.

In 1993, sixty-eight percent of women obtained their contraceptives from public health facilities, while in 2003 only 58 percent obtained from the same facilities. The remaining, as shown in 2003 Demographic Health Survey (DHS), obtained their contraceptives from private clinics, and were supported by FHOK and MSI. Within the public health facilities, hospitals became much less important sources of contraceptive information and services. Also, the availability of clinical family planning services declined as skilled clinical providers have either left the field or focused their practice on more lucrative clinical services (Crichton, 2008). A sustained increase in the use of family planning until 1998 was a major factor in the fertility transition, providing women and couples with the means to help them plan pregnancies. From 1998 to 2003, contraceptive use among married women did not increase, remaining at 39 percent. This plateauing was also found for contraceptive prevalence among all women at 30 percent (Westoff and Blanc, 2006). While on the one hand family planning use stalled between 1998 and 2003, for married women with primary education, use, on the other hand, decreased from 23 percent to 16 percent for those with no education but increased from 52 percent to 62 percent for those with at least secondary education (KDHS, 2003).

Rapid urbanization in Kenya has led to an increasing focus of attention on family planning trends among urban dwellers. On a positive note, contraceptive use among married urban women (48 percent) was estimated to be higher than among rural women (37 percent) (USAID/HPI, 2007; Republic of Kenya, 2008). However, this aggregate figure masks tremendous variations within urban dwellers, with use of any method ranging from 60 percent among the highly educated to 14 percent among those with no education. A similar distribution in prevalence was found across wealth quintiles ranging from 48 to 13 percent (Republic of Kenya, 2008). Those with no education and the lowest level of wealth are likely to live primarily in the urban slums, highlighting the urgent need for family planning programmes that can reach this highly disadvantaged population.

The KDHS of 2008 reported that access to family planning varies with the level of income, education levels and wealth. The report notes that low level of income had contributed to low use of family planning services. It is estimated that about 60 percent of women with at least secondary education use a contraceptive method, compared to 40 percent and 14 percent of women with primary education and no education, respectively (Republic of Kenya, 2008). In terms of the level of income, only 43 percent of low- income earners

were using contraceptives as compared to 53 percent for high-income earners. Further, it was revealed in the KDHS of 2008 that slightly less than half of currently married women (46 percent) were using contraception.

In the report, it was reported that modern methods of contraception were the most commonly used at 39 percent compared to traditional methods at 6 percent). Of the modern methods, injectables were the most widely used, while periodic abstinence was the most popular traditional method. Further, contraceptive prevalence rate was at the peak among married women aged between 30 and 34 years and lowest among those aged between 15 and 19 years. In terms of residence, the report revealed that fifty three percent of urban women were using contraceptives, compared with forty three percent of their rural counterparts (Republic of Kenya, 2008). The report further notes that contraceptive prevalence increased with increase in level of education. Specifically, sixty percent of married women with at least some secondary education use a contraceptive method, compared to just 40 percent of women with primary incomplete education and only 14 percent of those who never attended school. The above statistics could be a representative of the women in slums who are not only expected to have low levels of education or no education at all but also with similar characteristics of rural residents.

4.2 Unmet need and Demand for Family Planning Services

Trends in the effectiveness of the family planning programme in reducing unwanted pregnancy was partly demonstrated in terms of unmet needs in a report by Kenya's Ministry of Health. For instance, between 1993 and 1998, total unmet need decreased substantially from 36 to 24 percent, with similar decreases for both spacing and limiting (Republic of Kenya, 2003). Between 1998 and 2003, however, total unmet need actually increased by one percentage point. This levelling off was fairly uniform across all sub-populations. The only exceptions over this time period were Coast Province with a five-percentage point decrease in unmet needs, and Nyanza Province with a nine-percentage point increase. This highlights the diversity with which the family planning programme was evolving across the country (Republic of Kenya, 2003).

Overall, total demand for family planning (that is all women with a met or unmet need) was about 66 percent of all women within the reproductive age. However, the proportion of women with satisfied demand was much higher among unmarried women (83 percent) than married women (63 percent). Indeed, only three percent of unmarried women, compared with 25 percent of married women, had an unmet need for family planning, indicating the need to prioritize increased attention to reaching married women (USAID/HPI, 2007; Republic of Kenya, 2008; and Ian *et al.*, 2009). According to Ian *et al.* (2009), unmet need is also higher among women younger than 35 years living in rural areas, and with the lowest wealth quintiles. Moreover, although demand for family planning was only 10 percent in North Eastern Province, satisfied demand was incredibly low at 1.6 percent, indicating that the province was to be considered a priority for addressing both wanted and unwanted fertility. Conversely, total demand for family planning was 80 percent in Central Province, and 86 percent of this demand was satisfied, with unmet need at only 11 percent. As may be expected, given the density of service outlets, urban areas (17 percent) had much lower levels of unmet need than rural areas (27 percent), and levels of satisfied demand were much higher (74 percent against 60 percent).

Interestingly, the highest levels of unmet need in urban areas (25 percent) were from among those who had completed primary education and were in the second and middle wealth quintiles, higher than the poorest and those with no education estimated at between 15 and 20 percent. This probably reflects the higher demand for family planning among these groups. This suggests that family planning activities in urban areas needed to be differentiated between those targeting the poorest and least educated for whom demand creation is still required, and those targeting the emerging middle class whose access to the services seems to be a bigger priority. In the UNFPA State of the World Population Report of 2004, it was reported that poorer women have children at younger ages, while wealth-based health inequities are greater for safe motherhood, adolescent fertility and contraceptive use. The report observed that poor women have more children throughout their lives than wealthier women, while poor countries have a heightened risk of maternal, infant, and child death and illness. Lastly, poor women in all the countries face higher risks than others and the use of family planning, particularly of modern methods, is higher in richer segments than poor segments of society (UNFPA, 2004). These differences are influenced by several factors, including obstacles in accessing services by the poor, which include costs for services and transportation, less accessible service locations, attitude about use of contraceptives and limited information about service options.

5.0 Conclusion and Way Forward

5.1 Conclusion

The review clearly show that the Kenyan government in collaboration with stakeholders have initiated concerted efforts to facilitate the use of family planning services as a step towards reducing total fertility rate (TFR) and unmet need for family planning as well as increasing contraceptive prevalence rate (CPR) [Republic of Kenya, 2003b; Republic of Kenya, 2007b; Republic of Kenya, 2008; and Ian *et al.*, 2009]. Despite these policy measures, total fertility rate still remains high at 4.6 percent, while CPR for all methods is at 46 percent.

On the other hand, the unmet needs for family planning services average at 24 percent (Republic of Kenya, 2007a; Republic of Kenya, 2009; Ian *et al.*, 2009). This is an indication that either the policies are not implemented as expected or that these policy pronouncement are too general and that they rarely trickle down to the intended population especially those within the reproductive age.

The high TFR together with low CPR, unmet needs for family planning services, low death rate (estimated at 14.02 deaths per 1,000 women), high birth rate (estimated at 39.73 births per 1,000 population) and low infant mortality (estimated at 59.26 per 1000 live births) [Republic of Kenya, 2009] will continue to contribute towards high population growth which has various macroeconomic effects to the economy. For instance, standards of living may continue to worsen when the rate of population growth continue to exceed the economic growth rate. At the household level, the high TFR will continue contributing towards depletion of productive resources in the society, rising cost of living, ill health, poor nutrition and limited educational opportunities, ultimately trapping women in a poverty cycle.

Utilization of family planning services has been the concern of not only the government but also other stakeholders including researchers. In this review, it has been established that despite the programmatic policy response towards utilization of family planning services, contraceptive prevalence rate remain very low while unmet need and total fertility rate is still high. In Okech *et al* (2011) various demographic, socio-economic and facility factors account for these. These according to Okech *et al* include partner's approval, religion, knowledge of family planning services, friendliness of family planning staff, quality of family planning services, proximity to family planning facility and income of the woman (see also GoK, 2012). Although Kenya is one of the pioneer countries in Africa to initiate a family planning (FP) program and its success has been extensively acknowledged, there still exist key challenges to improving faming planning statistics.

Recent reports show that key challenges to improving family planning statistics enumerated in the government's *National Reproductive Health Policy* of 2007 remain valid today (USAID, 2010, GoK, 2012). These include wide regional and socio-economic disparities in CPR; lack of security for contraceptive commodities; lack of sustained demand creation for family planning services; relatively low community and private sector participation in family planning service provision and low involvement of males; method mix that does not permit wide method choice and cost-effectiveness; inadequate family planning training for service providers; and low level of integration of family planning with HIV/AIDS services. Similarly, high rates of unmet need is attributed largely due to inadequate service provision, exacerbated by periodic stock-outs of contraceptives in some area, and poor access, especially among the poor and other socially disadvantaged groups (USAID, 2010). Particular challenges exist in increasing access to and utilization of family planning services by the poor, and hard to reach and vulnerable groups, including adolescents, orphans and vulnerable children, pastoralists, persons with disabilities, migrant and displaced populations, among others.

5.2 Way Forward

In order to enhance the uptake of family planning services as a bold step towards meeting the challenges envisaged in the Kenya's Vision 2030 and the realization of the MDGs, various recommendations are suggested. First, Political commitment and obligations by the government is critical to spearhead the sustainability in the provision of resources and enabling program environment required in overcoming both supply and demand side barriers (such as security of commodities, quality of the services, inadequate personnel, involvement of male persons, among others) to family planning services is necessary. These will go along way in reviving family planning education at both household and community level that targets every body in the society. This could be undertaken through print and mass media, chiefs' *barazas*, market places as well as newsletters and posters. Reviving and supporting the activities of community based distributors (CBDs) at community level need to be accorded the necessary priority to facilitate distributions of contraceptives and commodities. These initiatives need to be augmented by supporting family planning outreach activities by community health workers. This is expected to contribute positively towards enhancing awareness of family planning services and the benefits and side effects.

Secondly, the government in collaboration with development partners involved in the provision of family planning services need to enhance large scale training of service providers in quality care, client follow up, communication skills, counselling, referral and feedback and provision of a wide choice of family planning methods. With these considerations in place, there is likelihood of enhanced client confidence and commodity mix, which is expected to attract more users while at the same time encouraging further usage on those currently using them. However, for this programme to be effective, donor support is critical. Thirdly, creation of advocacy groups at community levels needs to be accorded necessary priority. This will not only articulate the rights of the clients, in this case the woman who seeks family planning services, but will lead to cultural change towards family planning services and encourage the uptake of family planning services. In the end, this is expected to contribute positively towards a reduction in the total fertility rate as well as decline in population

growth rate. As noted in Okech *et al* (2011), religious background of households and cultural practices do affect the women's use of family planning services negatively especially those in the slums.

Key stakeholders including the government, NGOs, CBOs, private health providers involved in propagating family planning need to initiate and promote targeting programmes for the uptake of family planning services instead of the blanket and general policy initiatives in place as reviewed. Programs that aim at increasing the proportion of women using family planning are likely to be more effective in increasing the uptake of family planning services thereby reducing unmet needs and total fertility rate while at the same time increase contraceptive prevalence rate in the country.

It also worthy while noting that only reviewed literature on programmatic responses towards family planning services, it is therefore necessary that an empirical analysis is conducted using the necessary scientific rigour and, where possible, disaggregate the population in terms of low income, middle income and high income to clearly determine the significant factors contributing to low utilization of family planning services in order to inform the policy process. Additionally, it will be necessary for a mapping survey to examine which stakeholder is doing what as a bold step towards encouraging sector-wide approach (SWA) towards the provision of family planning services. Similarly, it will be important for a study to be conducted that compares unmet needs to the contraceptive prevalence rate and total fertility rate in Kenya.

REFERENCES

- [1]. Abdullah K. H. (1997), A Hierarchical Model of Contraceptive use in Urban and Rural Bangladesh, *Contraception*, Vol. 55, No. 2:91-96.
- [2]. Abiodun, O.M., and Balogun, O.R. (2009), Sexual Activity and Contraceptive Use among Young Female Students of Tertiary Educational Institutions in Ilorin, Nigeria, *Contraception*, Vol. 79, No. 2:146-9.
- [3]. Africa Union (2006), Special Session of the Conference of African Union Ministers of Health Maputo, Mozambique, 18 – 22 September 2006, The Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health Rights, 2007-2010.
- [4]. African Population and Health Research Centre (2001), *Contraceptive Use Dynamics In Kenya Further Analysis of Demographic And Health Survey (DHS) Data*, Maryland: Macro International Inc Calverton.
- [5]. Ajayi, A and Kekovole, J. (1998). "Kenya's Population Policy: From Apathy to Effectiveness," in Anrudh Jain (ed.), *Do Population Policies Matter? Fertility and Politics in Egypt, India, Kenya, and Mexico*, New York: Population Council.
- [6]. Bertrand, J. T., Hardee K., Magnani, R.J., and Angle, M.A. (1995). "Access, Quality of Care and Medical Barriers in Family Planning Programs", *International Family Planning Perspectives*, Vol. 21, No. 2: 64-694.
- [7]. Blacker, J., (2000). *Kenya's Fertility Transition: How Long Will it GO?* London: Centre for Population Studies.
- [8]. Bulatao, R. A., Palmore, J.A., and Ward, S.E. (1989). *Choosing a Contraceptive: Method Choice in Asia and the United States*. London: Westview Press, Inc.
- [9]. Caldwell J.C and Caldwell, C.P. (1987). The Cultural Context of High Fertility in Sub-Saharan Africa, *Population Development Review*, Vol. 13, No. 3: 409-437.
- [10]. Caldwell J. C and Caldwell, P.C. (2002). Family Planning Programs in the Twenty-First Century *Studies in Family Planning*, Vol. 33, No. 1: 76-86.
- [11]. Chamberlain, G. (1994). *Quintile Regression, Censoring, and the Structure of Wages*, in C. Sims and J.J. Laffont (eds.), *Proceedings of the Sixth World Congress of Econometrics Society* (Barcelona, Spain), New York: Cambridge University Press.
- [12]. Chimere-Dan, O. (1996). Contraceptive Prevalence in Rural South Africa. *International Family Planning Perspective*, Vol. 2, No. 22: 4-9.
- [13]. Cleland, J., S. Bernstein, A. Ezech, A. Faundes, A. Glasier, J.(2006). "Family Planning: The Unfinished Agenda", *The Lancet*, Vol. 368: 1810-1827
- [14]. Clement, S. and Nyovani, S. (2004). Who Is Being Served Least by Family Planning Providers? A Study of Modern Contraceptive Use in Ghana, Tanzania and Zimbabwe, *African Journal of Reproductive Health*, Vol. 8, No. 2: 124-136.
- [15]. Crichton, J., (2008). "Changing Fortunes: Analysis of Fluctuating Policy Space for Family Planning in Kenya", *Health Policy and Planning*, Vol. 23, No. 5: 339-350.
- [16]. Curtis S.L. and Neitzel, K(1996). *Contraceptive Knowledge, Use and Sources, Demographic and Health Surveys Comparative Studies No. 19*. Calverton: Macro International Inc
- [17]. David B., David C., and Jaypee S. (2002). *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change*, New York: Rand.
- [18]. Davidson, R., (1989). Psychosocial Aspects of Contraceptive Method Choice, in Bulatao, R. A.; J. A. Palmore and S. E. Ward (Eds.), *Choosing a Contraceptive: Method Choice in Asia and the United States*. London: West View Press.
- [19]. Feyisetan, B. and Ainsworth, A. (1996). Contraceptive Use and the Quality, Price, and Availability of Family Planning in Nigeria, *The World Bank Economic Review*, Vol. 10 No. 1: 159-187.
- [20]. Feyisetan, B. J. and Bamiwuye, S. (1998). Postpartum Counselling and Contraceptive Use in Nigeria, *Ife Social Sciences Review*, Vol. 15, No. 1: 30-41.
- [21]. Gertler, P. and Van der Gaag, J. (1990). *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries*. Baltimore: The Johns Hopkins University Press.
- [22]. Health Policy Initiatives (2007). *Inequalities in the Use of Family Planning and Reproductive Health Services: Implications for Policies and Programs*, Washington DC: Futures Group International.
- [23]. Ian A., Alex E., Bongaarts J.T. (2009). *Kenya's Fertility Transition, Determinants and Implications for Policy Programmes*, Nairobi: Population Council.
- [24]. Ipas (2004). *A National Assessment of the Magnitude and Complications of Unsafe Abortion in Kenya*, North Carolina: Ipas.
- [25]. Karanja J., Njoroge, P. and Orero, S. (2005), *Impact of Trends in Community Based Family Planning On Contraceptive Prevalence Rate*, Working Paper No. 8, Nairobi: National Coordinating Agency for Population and Development.
- [26]. Karirah-Gitau, S. (1999). *Housing, Environment and Poverty Management in Eastern Africa A Case of Slum Settlements in Nairobi, Kenya – A Final Report A Shelter Afrique Research Project funded by IDRC*, Nairobi.

- [27]. Korir J. and Mwabu, G. (2004). Improving Access to Family Planning Services in Public Health Facilities by Underserved Populations in Kenya, A report prepared for POLICY Project, Nairobi.
- [28]. Korir J., Obonyo, B. and Aloo-Obunga, C. (2004). Assessment of Formal and Informal User Fees paid by Maternal Health Services in Kenya, A report prepared for POLICY Project, Nairobi.
- [29]. Kyalo, M.M. (1996). Determinants of Contraceptive Non-use in Kenya. Unpublished MA Thesis, University of Nairobi.
- [30]. Magadi, M., Zulu, E., Ezeh, A., and Curtis, S. (2001). *Contraceptive Use Dynamics in Kenya: Further Analysis of Demographic and Health Survey Data*, Maryland: Calverton.
- [31]. Moreland, S. (2006). *Egypt's Population Program: Assessing 25 Years of Family Planning*. Washington,DC: Constella Futures, POLICY Project.
- [32]. Moreland, S. and Talbird, S. (2006). *Achieving the Millennium Development Goals: The Contribution of Fulfilling the Unmet Need for Family Planning*. Washington, DC: Constella Futures, POLICY Project.
- [33]. Muia, E., E. Charlotte, Moses, L., Baya, E., Joyce, O. and Eigabeth, W. (2000). What do Family Planning Clients and University Students in Nairobi, Kenya, Know and Think about Emergency, *African Journal of Reproductive Health*, Vol. 4, No. 1: 77-87.
- [34]. Mwabu, G.M. (1984). A model of Household Choice Among Medical Treatment Alternatives in Rural Kenya, Ph.D Dissertation, Boston University.
- [35]. Mwabu, G., Wangombe, J. and Nganda, B. (2003). The Demand for Medical Care in Kenya, *African Development Review*, Vol. 15. No 2-3: 439-453.
- [36]. Mwabu, G. (2008). *The Demand for Health Care*, in: Heggenhougen, K., Ed., *Encyclopaedia of Public Health*, Amsterdam: Elsevier Science.
- [37]. Mwabu, G. (2009). The Production of Child Health in Kenya: A Structural Model of Birth Weight. *Journal of African Economies*, Vol. 18. No. 2: 212-260.
- [38]. Nganda, B., (2003). The Safe Motherhood Programme in Kenya: Unit Costing Study. A Report Prepared for POLICY Project, Nairobi.
- [39]. Ngau, P (1995). Informal Settlements in Nairobi. A Baseline Survey of Slums and Squatter Settlements: An Inventory of NGOs and CBOs activities, Nairobi.
- [40]. Njogu, W. (1991). Trends and Determinants of Contraceptive Use in Kenya, *Demography*, Vol. 28, No. 1 PP 83-99.
- [41]. Obonyo B., Otieno, F. and Muga, R. (2005). *Effect of Infant and Child Mortality on Fertility in Kenya*, Working Paper No. 2, Nairobi, National Coordinating Agency for Population and Development.
- [42]. Omondi-Odhiambo (1999). *Fertility Change, Family Planning and the Impact of CBD in Siaya District, Kenya*. A Study Report for Ministry of Health/ GTZ reproductive Health Project, Kenya.
- [43]. Oliver R. (1995). Contraceptive use in Ghana. The Role of Service Availability, Quality and Price. Living Standards Measurement Study, *World Bank Working Paper* No. 111. Washington DC.
- [44]. Oyedokun A. O., (2007), Determinants of Contraceptive Usage: Lessons from Women in Osun State, Nigeria, *Journal of Humanities and Social Science*, Vol.1, Issue 2.
- [45]. POLICY Project (2003). *Targeting: A Key Element of National Contraceptive Security Planning: Policy Issues in Planning and Finance* No. 3 Washington DC: Futures Group International.
- [46]. POLICY Project (2005). *Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit*. Washington, DC: Futures Group.
- [47]. Republic of Kenya (1981). *Kenya Fertility Survey 1977-1978. World Fertility Survey Programme*, Nairobi: Government Printers.
- [48]. Republic of Kenya (1984). *Kenya Contraceptive Prevalence Survey 1984*, Nairobi: Government Printer.
- [49]. Republic of Kenya (1994). *Health Policy Framework 1994-2010*, Nairobi: Government Printer.
- [50]. Republic of Kenya (1996a). *National Reproductive Health Strategy: 1997-2010*, Nairobi: Government Printer.
- [51]. Republic of Kenya (1996b). *Sessional Paper No. 1 1996 on National Population Policy for Sustainable*, Nairobi: Government Printer.
- [52]. Republic of Kenya (1997). *Reproductive Health/ Family Planning Policy Guidelines and Standards for Service Providers*, Nairobi: Government Printer.
- [53]. Republic of Kenya (1998). *Implementation Plan for National Reproductive Health Strategy 1999-2003*, Nairobi: Government Printer.
- [54]. Republic of Kenya (1999a). *Kenya Demographic and Health Survey 1998*, Nairobi: Government Printer.
- [55]. Republic of Kenya (1999b). *The National Health Sector Strategic Plan: 1999-2004*, Nairobi: Government Printer.
- [56]. Republic of Kenya (2000). *Family Planning Financial Analysis and Projections for 1995 to 2020 for Kenya*, Nairobi: Government Printer
- [57]. Republic of Kenya (2001). *National Condom Policy and Strategy: 2001-2005*, Nairobi: Government Printer.
- [58]. Republic of Kenya (2002). *Facility Improvement Fund-Supervision Manual*, Nairobi: Government Printer.
- [59]. Republic of Kenya (1996). *National Reproductive Health Strategy, 1997 – 2010*, Nairobi: Government Printer.
- [60]. Republic of Kenya (1997). *National Reproductive Health Strategy (NRHS) 1997-2010*, Nairobi: Government Printer.
- [61]. Republic of Kenya (2001). *National Condom Policy and Strategy*, Nairobi: Government Printer.
- [62]. Republic of Kenya (2003a). *Adolescent Reproductive Health and Development Policy*, Nairobi: Government Printer.
- [63]. Republic of Kenya (2003b). *Demographic Health Survey of 2003*, Nairobi: Government Printer.
- [64]. Republic of Kenya (2003c). *Economic Recovery Strategy for Employment and Wealth Creation (2003-2007)*, Nairobi: Government Printer.
- [65]. Republic of Kenya, (2003d). *Contraceptive Commodities Procurement Plan, 2003-2006*, Nairobi: Government Printer.
- [66]. Republic of Kenya (2005). *Family Planning Guidelines for Service Providers*, Nairobi: Government Printer.
- [67]. Republic of Kenya (2005). *Health Sector Strategic Plan II, 2005-2010*, Nairobi: Government Printer.
- [68]. Republic of Kenya (2007a). *National Reproductive Health Policy*, Nairobi, Government Printer.
- [69]. Republic of Kenya (2007b). *Kenya Vision 2030 The Popular Version*, Nairobi: Government Printer.
- [70]. Republic of Kenya (2009). *Demographic Health Survey of 2008*, Nairobi, Government Printer.
- [71]. Sharma, S., Smith, S. Sonneveldt, E. Pine, M., Dayaratmaya, V., and Sanders, R. (2005b). *Formal and Informal Fees for Maternal Health Care Services in Five Countries: Policies, Practices, and Perspectives*, Washington, DC: Constella Futures.
- [72]. Singh, S., Darroch, J., Vlassof, M., and Nadeau, J. (2004). *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care*. New York: UNFPA.
- [73]. Smit, J. Gray, A., McFadyen, L., and K. Zuma (2001). *Counting the Costs: Comparing Depot Medroxy-Progesterone Acetate and Norethisterone Oenanthane Utilization Patterns in South Africa*, Capetown: BMC Health Serim.

- [74]. Smit J., McFadyen, L., Beksinska M. de Pinho, H., Morroni, C., Mqhayi, M., Parekh, A., and Zuma, K. (2001). Emergency Contraception in South Africa: Knowledge, Attitudes, and Use among Public Sector Primary Healthcare Clients. *Contraception* Vol. 64, No. 6: 333-7.
- [75]. Stephenson, R., Baschieri, A., Clements, S., Hennick, M., and Madise, N. (2007). Contextual Influences on modern contraceptive Use in Sub-Saharan Africa, *American Journal of Public Health*, Vol. 97, No. 7:1233-1240.
- [76]. USAID/HPI (2007). *Achieving Equity for the Poor in Kenya: Understanding Level of Inequities and Barriers to Family Planning Services*, Washington D.C: USAID.
- [77]. United Nations Population Fund (UNFPA) (1994). *Achieving ICPD Goals- Reproductive Health Commodity Requirements, 2000-2015*. New York: UNFPA.
- [78]. United Nations Population Fund. (2004). *State of World Population Report 2004—The Cairo Consensus at 10: Population, Reproductive Health, and the Global Effort to End Poverty*. New York: UNFPA.
- [79]. United Nations Population Fund (2005). *Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health and Rights*. New York: UNFPA.
- [80]. Wawire, N.H.W. (2006). Determinants of Tax Revenue in Kenya, Unpublished PhD Thesis, Kenyatta University, Nairobi.
- [81]. Westoff C and Cross, A. (2006). *The Stall in the Fertility Transition in Kenya*, DHS Analytical Studies No. 9, Maryland: ORC Macro
- [82]. World Bank (1984). *Family Planning Service World Development Report*, Chapter 7, Oxford: Oxford University Press.
- [83]. World Bank (1993). *World Development Report 1993: Investing in Health*, New York: Oxford University Press.
- [84]. World Bank (2003). *World Development Report 2004: Making Services Work for Poor People*, Washington, DC: World Bank.
- [85]. World Health Organization (2005). *World Health Report 2005*, Geneva: World Health Organization.
- [86]. World Facility Survey (1977). *Kenya Fertility Survey*, Office of Population Research, Princeton, NJ: Princeton University.