Reproductive health financing in Kenya: An analysis of national commitments, donor assistance, and the resources tracking process

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Abstract

Understanding the flow of resources to reproductive health is essential for an effective repositioning of this key health component at the country level. This paper gives a comprehensive picture of what is happening in Kenya in terms of resources allocation for reproductive health and challenges faced in the resource tracking process. Data are drawn from the Kenyan budget estimates, the reproductive health accounts, and the Resource Flows Project data base. Overall, the findings show that reproductive health receives little attention within the government budgets despite their contribution to the MDGs. The private sector is a big financier of the services and household spending is very high. Donor assistance to Kenya has increased over the years, but the percentage of funds devoted to reproductive health is lower than it was in 2005. The paper recommends an increase in budget for reproductive health in order to achieve the MDGs in Kenya. Safety nets for the poor are also needed to reduce the burden of spending by households. The paper also recommends generation of more comprehensive reproductive health accounts data on a regular basis.

Keywords: reproductive health, financing, reproductive health accounts, Kenya.

Background

In September 2000, the countries of the world adopted the Millennium Declaration, setting out eight Millennium Development Goals (MDGs), which they pledged to achieve by 2015. It has been widely acknowledged that these goals can only be reached if there are significant improvements in reproductive health, especially in the poorest developing countries. Most
families in this part of the world still have more children than they want. Women especially suffer from the lack of means to control their fertility, \(^1\) and many die young from causes related to maternal health. \(^2\)

It is acknowledged that the sub-Saharan African countries have made the fewest strides especially as regards to the MDG5 target of reducing the maternal mortality ratio by three-quarters and achieve universal access to reproductive health by 2015. Statistics for the Sub-Saharan African region indicate that the maternal mortality ratio declined from an average of 870 per 100,000 live births in 1990 to 640 per 100,000 births in 2008,\(^2\) translating to a reduction by only 26% which is still far off the MDG target. Huge improvements remain to be made for achieving a universal access to antenatal care and family planning. The proportion of deliveries attended by skilled health personnel in the region slightly increased but remains low at 46% in 2009. \(^2\) The unmet need for contraceptives remains high at 25% in 2008. \(^2\)

During the ICPD+15 review meeting in Addis Ababa, Ethiopia in 2009, over 70% of countries in sub-Saharan Africa indicated that they received insufficient external financial resources mobilized to successfully implement their population programmes, in particular those needed to achieve the MDG 5 on maternal mortality and universal access to reproductive health. \(^3\) In addition a similar proportion of countries faced the challenge of inadequate government funding. About 68% of countries also indicated that they had difficulties in mobilizing other domestic resources (both government and private resources). In line with these challenges, a number of recommendations highlighted in the final report \(^3\) included:

- Increase technical and financial commitment of governments and development partners for the implementation of the MDGs and ICPD Programme of Action;
• Encourage the private sector to provide support for population and reproductive health programmes;

• Build institutional and human capacities for enhanced resource mobilization and contract negotiation skills within government agencies;

• Put in place national strategies, including partnership and coordination mechanisms, for better interaction between governments and all stakeholders, including NGOs and civil society for internal and external resource mobilization and monitoring of resource use, in support of population and reproductive health issues.

In light of the particular attention for reproductive health financing as a vital component for better reproductive health outcomes, it is important for governments and donors to have accurate health financing information which compare the funding needs with the allocation of resources (domestic and external), actual expenditure as well as projected availability of resources (domestic and external). The available information should respond to critical questions relating to the match between policy priorities and actual expenditures, the predictability of funding for different reproductive health components as well as the availability of funds across the different levels of the health system. Reproductive health account (RHA) is one tool that is used to generate this information. Generally conducted in tandem with the national health account (NHA), the reproductive health account is an additional, more detailed report of spending levels and patterns specific to reproductive health. [4] The reproductive health account is a comprehensive and consistent way to evaluate reproductive health expenditure data to help guide the allocation of limited resources among various needs. [5-7] Reproductive health accounts results can be used in various ways to inform reproductive health policy and programming. Only 22 countries in sub-Saharan Africa have successfully completed at least one round of national health account, and very few countries such as Kenya, Malawi, Rwanda, Namibia, Ethiopia
and Uganda, have generated reproductive health subaccounts.

This paper focuses on the Kenyan case. It first gives an overview of the reproductive health challenges as regards to the MDG5 and the policy framework related to reproductive health in Kenya. It then highlights the financial commitments (both by the government and donors) and expenditures to improve the maternal and child health and to reach a universal access to reproductive health services. The challenges facing reproductive health account estimation are also presented. Three main sources of data are used: the Kenyan budget estimates, the Kenyan national health accounts for 2005/6 and 2008/9 and the UNFPA Financial Resource Flows database. This analysis is part of the UNFPA endeavour to strengthen the resource tracking process and countries’ accountability to donors and civil society in sub-Saharan Africa through the Resource Flows Project. It is expected that this paper will stimulate critical thinking about resources allocation for maternal health and other reproductive health activities in Kenya, both by the national government and the donors. It is also expected that the recommendations for improving construction of reproductive health account provided in the paper serve as a basis to support the Kenyan government as well as other sub-Saharan African countries’ governments in their efforts to track the resources going to reproductive health in general.

About Kenya

Kenya is located in the eastern part of Africa and covers a total area of 582,646 square kilometres. Its population was estimated at about 39 million in 2009 with a current population growth rate of about 3%. The country is classified among low human development countries and among the countries with huge within-country differences in multidimensional poverty.

Table 1 presents data on selected development and health indicators of Kenya. Kenya is better off than many countries in
sub-Saharan Africa in terms of health indicators such as under-five mortality rate and infant mortality rate. [9-12] The resources available for the health system, including physicians, nurses and midwives and hospital beds are however low. As regards to health financing, Kenya spends less than the average of sub-Saharan African countries for health. On the other hand, donor assistance and out-of-pocket expenditure for health are generally high.

Table 1. Kenya: Selected health and development indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
<th>Sub-Saharan Africa average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross national income (GNI) per capita, 2010 ($)†</td>
<td>1,628</td>
<td>2,050</td>
</tr>
<tr>
<td>Income Gini coefficient, 2000-2010†</td>
<td>47.7</td>
<td>-</td>
</tr>
<tr>
<td>Human Development Index (HDI), 2010†</td>
<td>0.470</td>
<td>0.389</td>
</tr>
<tr>
<td>Population below income poverty line (PPP $1.25 a day), 2000-2008 (%)†</td>
<td>19.7</td>
<td>-</td>
</tr>
<tr>
<td>Life expectancy at birth, 2009 (years)</td>
<td>60</td>
<td>54</td>
</tr>
<tr>
<td>Under-five mortality rate, 2009 (per 1000 live births)†</td>
<td>84</td>
<td>127</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births), 2009†</td>
<td>55</td>
<td>80</td>
</tr>
<tr>
<td>Total fertility rate per woman aged 15-49, 2010-2015*</td>
<td>4.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Maternal mortality ratio per 1000,000 live births (1999-2008/9)§</td>
<td>488</td>
<td>-</td>
</tr>
<tr>
<td>Prevalence of HIV among adults aged 15-19 years (%)§</td>
<td>6.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Total expenditure on health as % of gross domestic product, 2000/2008§</td>
<td>4.2/4.2</td>
<td>5.5/6.0</td>
</tr>
<tr>
<td>General government expenditure on health as % of total government expenditure, 2000/2008§</td>
<td>9.1/5.8</td>
<td>8.2/9.6</td>
</tr>
<tr>
<td>External resources for health as % of total expenditure on health, 2000/2008§</td>
<td>8.8/26.8</td>
<td>6.6/9.5</td>
</tr>
<tr>
<td>Out-of-pocket expenditure as % of private expenditure on health, 2000-2008§</td>
<td>80.1/77.2</td>
<td>57.3/60.9</td>
</tr>
<tr>
<td>Physician per 10,000 population, 2000-2010†</td>
<td>1.4</td>
<td>2.3</td>
</tr>
<tr>
<td>Nursing and midwifery personnel per 10,000 population, 2000-2010§</td>
<td>11.8</td>
<td>10.9</td>
</tr>
<tr>
<td>Hospital beds per 10,000 population, 2000-2009†</td>
<td>14</td>
<td>19</td>
</tr>
</tbody>
</table>

Reproductive health challenges in Kenya

In the Kenya context, reproductive and child health care are generally combined, particularly in the motherhood context. The package of reproductive health services in Kenya includes the following components:

- Family planning services: All programs, goods and services intended to empower women to control the number and spacing of children, and all counselling, health education and information in support of the same;

- Maternal health services: This include all programs aiming to provide antenatal and postnatal care to mothers, including provision of dietary supplements for malnourished pregnant and lactating mothers;

- Childbirth services: Services to provide medical care for women delivering and giving birth;

- Infant care: All services intended to promote and improve the health and development of infants, including baby health care, growth monitoring and growth promotion, and provision of dietary supplements such as micronutrients;

- Child health services: All services for children, including immunization; and

- Other reproductive health services for women: These include all clinical services intending to enable women to safely exercise their reproductive health functions.

The contraceptive prevalence (any method) among married women is estimated at 46% in 2008/9 in Kenya, with quite important urban-rural differences (53% among urban women and 43% among rural women).\(^9\) Differences in contraceptive prevalence are also striking while considering the wealth quintile (from 20% among women in the lowest quintile to 57% among those in the fourth quintile).\(^9\) Besides, the use of long-term
methods such as intra-uterine device and implants is still negligible (around 2%).[9]

Adequate maternity services and the availability of skilled personnel to attend to complications during birth or caused by unsafe/induced abortion still constitute serious challenges in Kenya. While majority of pregnant women use antenatal care, less than 50% of women deliver with the assistance of skilled medical personnel. [9] The number of women dying as a result of complications during pregnancy and childbirth has decreased from 590 per 100,000 live births for the ten-year period prior to the 1998 KDHS [13] to 414 for the ten-year period before the 2003 KDHS. [14] The ratio has subsequently increased and has remained unacceptably high at 488 maternal deaths per 100,000 live births in 2008/9 [9], far away from the 2015 target of 147.

**Policy framework related to reproductive health in Kenya**

Population development is identified since 1994 in Kenyan health policies as a priority strategy for achieving balanced socioeconomic development, including family planning, adolescent health and well-being of the entire family.[15] The goals include a reduced fertility rate, increased proportion of health facilities providing integrated reproductive health services and better access and use of family planning services.

In response to Programme of Action of ICPD (1994), a national reproductive health strategy was adopted in 1997[16] with two objectives specifically related to maternal health and universal access to reproductive health services: reduce maternal mortality to 170 by 2010 and increase professionally attended deliveries to 90%. The main elements of the strategy include improving facility capacity at all levels to manage pregnancy related complications, unsafe abortion and newborn care and establishing a functioning referral system. The strategy was revised in 2009 with the adoption of the national reproductive health strategy 2009-2015.
The need for revision was to address several issues and challenges not factored in the 1997 strategy and to provide clear guidance and alignment with implementation of the first National Reproductive Health Policy which was launched in 2007.

Other key initiatives undertaken by the government of Kenya to accelerate the reduction of maternal mortality towards the achievement of the MDGs include the development and implementation of a Maternal and Newborn Health (MNH) Road Map 2010-2015. Launched in August 2010, the National MNH Road Map identifies limited national commitment of resources for maternal and newborn health as one of the major reasons of the slow progress in attainment of the MNH targets. For the implementation of the road map, it is estimated that the total additional cost for providing reproductive health services over the period is Kshs. 2 billion (about 24 millions of US$) in 2009/10, rising to Kshs. 3 billion (about 36 millions of US$) in 2010/11 and reaching Kshs. 4.1 billion (about 49 millions of US$) in the 2011/12 years. The costs are expected to start reducing thereafter.

The resources tracking process in Kenya

Kenya has undertaken four rounds of NHA (1994/5, 2001/2, 2005/6, and 2009/10). Reproductive health sub-accounts were estimated as part of the general health accounts during the 2005/6 and 2009/10 exercise. The process involves stakeholders in the health sector, especially those who constitute the Health Care Financing Task Force and those engaged in the Sector-Wide Approach (SWAp) process for an efficient use of the results. The national health account for the fiscal year 2005/06 was funded by the USAID/Kenya mission and government of Kenya whereas the one for the year 2009/10 was funded by the government of Kenya, the USAID/Kenya, the World Health Organization, and the World Bank.
The results from the NHA in Kenya are used to inform the preparation of the National Health Sector Strategic Plan (NHSSP) and to mobilise more funds for the health sector. The specific results from the reproductive health accounts give key expenditure information for national policymakers, donors, and other stakeholders, and guide their strategic planning in the area of reproductive health care.

The first policy objective of the reproductive health account exercise in Kenya is to measure the following indicators related to reproductive health:

- **The Total Health Expenditure on Reproductive Health** ($\text{THE}_{RH}$), which aggregates reproductive health expenditure from public sources i.e. government expenditure on reproductive health (GERH) and private outlays on reproductive health;

- **The Public/Government Expenditure on RH** ($\text{GE}_{RH}$), which is made up of tax-funded reproductive health expenditure and Parastatal expenditures on reproductive health;

- **Donors expenditures on reproductive health**, which aggregates reproductive health expenditures from the rest of the world or external sources;

- **The Social Security Expenditure on RH** ($\text{SSE}_{RH}$), which is the proportion of total premium paid by employees and employers for compulsory schemes of health (medical) care and medical goods channelled to reproductive health care for a sizeable group of population. This is the expenditure on reproductive health by National Hospital Insurance Fund (NHIF);

- **The MoH-ERH (Ministry of Health Expenditures on Reproductive Health)**, which is expenditure on reproductive health development channelled through the Ministry of Health or other public agencies;
• The Private Health Insurance Expenditure (PHIE), which represents the total of premiums collected from employers, households or sometimes other agents to prepay reproductive related medical and paramedical benefits, including the operating costs of these schemes; and

• Out-of-Pocket Expenditure (OOP), which is direct outlays of households including gratuities and payments in-kind made to reproductive health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the enhancement of the reproductive health status of individuals or population groups.

The second policy objective is to articulate the distribution of reproductive health expenditures by use. The third policy objective is to analyze efficiency, equity, and sustainability issues associated with the health care financing and expenditures patterns.

Key findings from the Kenyan reproductive health accounts

This section presents the key findings from the reproductive health accounts in Kenya and compared the results from the fiscal year 2005/06 to those from the fiscal year 2009/10.

About the reproductive health funding sources: The findings indicate that the Total Health Expenditure on Reproductive Health (THE\textsubscript{RH}) increased from Kshs 12.9 billion (170.4 millions of US$) in 2005/06 to Kshs 17 billion (225.2 million of US$) in 2009/10. The public sector contributed 34% of the THE\textsubscript{RH} in 2005/06 and 40% in 2009/10. The private sector (mostly households’ out-of-pocket) is a big financier of reproductive health services in Kenya and contributed 41% of the total expenditures in 2005/06 and 30% in 2009/10. Donors contributed 24% and 22% of the total reproductive health
spending in 2005/06 and 2009/10 respectively.

Consumers bear a disproportionate share when it comes to reproductive health and family planning expenditures in Kenya. In 2005/06, households contributed 38% of the THE\textsubscript{RH}. This dropped however to 29% in 2009/10 but remains very high. As a percent of total out of pocket expenditure on general health, households spend 14% on reproductive health services in 2009/10 as opposed to 10% in 2005/6. Out-of-pocket spending by consumers, especially the poor, has important implications for policy initiatives at reducing poverty and inequities in health access in Kenya.

**About the reproductive health financing agents:** Overall, 46.7% of the reproductive health financial resources passed through the public entities, specifically, the Ministry of Public Health and sanitation and the Ministry of Medical Services in 2009/10 as compared to 45.7% in 2005/06. Households, through out-of-pocket spending, controlled 19.3% in 2009/10 down from 26.3% in 2005/06. Private insurance controlled 9.3% in 2005/06 and 13% in 2009/10, NGOs 1.6% in 2005/06 and 9.4% in 2009/10 while the National Hospital Insurance Fund controlled 6.2% in 2005/06 8.8% in 2009/10.

**About the distribution of reproductive health expenditure by activities:** The Kenya NHA of 2005/06 and 2009/10 do not give estimates of expenditure by broad components of reproductive health care, but the broad estimate are broken down into curative (inpatient and outpatient), preventive (prenatal and postnatal, family planning service delivery) and rehabilitative elements. The findings indicate that outpatient curative care consumed the largest share of total health expenditure on reproductive health, at 41% in 2009/10 up from 25% reported in 2005/06. Inpatient curative care that includes deliveries and sterilizations, as well as other services that could not be disaggregated accounted for 30% of the total health expenditure on reproductive health in 2009/10 down from 62% in 2005/06.
Spending on family planning commodities: The reproductive health account estimations for 2005/06 and 2009/10 underestimate the resources going to family planning commodities mainly because they rely on distributional factors/ratios to apportion expenditures on reproductive health by activities. However, it is worth noting that when the two periods are considered, the resources going to family planning commodities increased in absolute terms from Kshs 13 million to 171 million. The contraceptive prevalence has indeed increased (by at least four percentage points) during the period to justify this huge increase in spending. USAID estimates indicate that Kenya will need to spend approximately Kshs 672 million (about 8.3 million of US$) on family planning commodities and direct personnel costs to provide care at the government facilities for all methods by 2015.¹⁹

Spending by health insurance: Coverage of health insurance in Kenya is limited both in terms of the numbers covered and the resources controlled by the insurance sector – National Hospital Insurance Fund (NHIF) and private health insurance. In 2005/06, private health insurance controlled 9.3% of the total expenditures on RH compared to 12.5% in 2009/10. NHIF controlled 6.2% of total RH resources in 2005/06 as opposed to 8.8% in 2009/10. In total, health insurance accounted for 21.3% of resources mobilized for reproductive health in 2009/10, up from 15.5% in 2005/06.

Key findings on national commitments for maternal health

Kenya’s maternal health (this includes neonatal and child health in the Kenyan context) sector has received little attention as far as budget allocation is concern despite its contribution to achieving the MDGs. As shown in Table 2, maternal health accounts for less than 5% of the total health budget and this
percentage has fluctuated over the years from 2.69% in 2009/10 to 4.74% in 2011/12. The projections for 2013/14 indicate a lower percentage of 2.26%.

Table 2. Budget and projections for maternal, newborn and child health in Kenya (in Kshs)

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent</td>
<td>105,493,057</td>
<td>107,029,760</td>
<td>122,373,037</td>
<td>124,880,551</td>
<td>141,458,570</td>
</tr>
<tr>
<td>Development</td>
<td>1,107,841,937</td>
<td>1,115,095,000</td>
<td>2,234,515,740</td>
<td>1,148,550,000</td>
<td>1,148,550,000</td>
</tr>
<tr>
<td>Total</td>
<td>1,213,334,994</td>
<td>1,222,124,760</td>
<td>3,456,888,777</td>
<td>1,273,430,551</td>
<td>1,290,008,570</td>
</tr>
<tr>
<td>Total health budget</td>
<td>47,721,023,650</td>
<td>51,273,627,351</td>
<td>49,715,126,230</td>
<td>54,123,112,000</td>
<td>57,134,244,000</td>
</tr>
<tr>
<td>MNCH as % of total health budget</td>
<td>2.69 (About 15.3 millions of US$)*</td>
<td>2.56 (About 15.6 millions of US$)*</td>
<td>4.74 (About 28.1 millions of US$)*</td>
<td>2.35 (About 15.1 millions of US$)*</td>
<td>2.26 (About 15.4 millions of US$)*</td>
</tr>
</tbody>
</table>

Source: Kenyan budget estimates; * USD amount based on our own calculation with an exchange rate of 84 Kshs for 1 US$.

Notes: The recurrent budget is built upon estimates numbers and is use to cushion the government in case revenues come in low. It includes revenue from taxes or loans and is used to cover operational costs such as salaries, utilities and maintenance.

The development budget comprises funding assigned for development purposes and includes funds from the development partners.

The development budget and projections include external resources that go through the Kenya budget system (on-budget).

As mentioned earlier, the government of Kenya indicated that 49 millions of US$ would be needed in 2011 for the implementation of the Maternal and New born Health Road Map. [18] Although it is indicated that the costs will be reducing thereafter, the current numbers in the budget projections will be likely enough to cover only half of the costs. This means that, unless a strong commitment is made to increase the budget going for reproductive health in general (and maternal and child health services in particular), a cost-sharing policy will be the most likely way to bridge the gap between the national budgets and the
level of resources needed to fund reproductive health activities. A cost-sharing policy set at 10/20 was implemented by the Kenyan government in 2004; with services at public health facilities free for all citizens, except for a minimum registration fee of Kshs 10 (about 0.12 US$) or Kshs 30 (about 0.23 US$). [20-21]. A reality check shows indeed that the total funds from cost-sharing are disproportionally higher than the government contribution for reproductive health services in various health districts [20]. This situation has huge implications for the financial burden of reproductive health expenditures on households, especially in a context of increased poverty.

**Trends in donor assistance to Kenya**

Kenya is one of the countries in sub-Saharan Africa that receive constant and important funding for health sector from various donors [22-23]—including several like-minded European donors [23]—Kenya is also one of the 68 priority countries in the Countdown to 2015 Initiative.[24]

This study made use of the UNFPA Financial Resource Flows data base (see Appendix 1 for detailed description) to examine the size and structure of donor funding for reproductive health activities to Kenya over the years. The UNFPA Resources Flows Project uses the ICPD costed-population package categories for collecting annual data on donors’ funding. These categories include: family planning, basic reproductive health services, prevention and treatment of STIs and HIV/AIDS, and basic research (see Appendix 2 for detailed description). Information about the funding level from donors for these four categories of activities has been collected by the UNFPA Resource Flow Projects since 1996. We limited our analysis to data collected from 2005 to 2010 since comparative information about the Kenya budget for reproductive health activities is available only for 2005/06 and 2009/10.
The figures gathered in Table 4 show that there has been a continuous increase in donor assistance for the four categories over the years, from 168.5 millions of US$ in 2005 to 445.4 millions of US$ in 2010. This amount includes assistance from developed countries, the United Nations System, foundations, NGOs, and development banks grants. However, the figures gathered in Table 4 indicate that most of the funding from donors and the increments are for supporting HIV/AIDS projects (i.e. prevention, mass media and in-school education, promotion of voluntary abstinence and responsible sexual behavior and expanded distribution of condoms). Donor assistance to Kenya specifically for basic reproductive health activities (i.e. information and routine services for prenatal, delivery and postnatal care, education and communication about reproductive health including HIV/AIDS) has fluctuated between 11.1 millions of US$ and 29.1 millions of US$ over the period. In absolute dollar amounts, donor assistance for basic reproductive health activities is increasing (from 17.1 millions of US$ in 2005 to 29.1 millions of US$ in 2010) but the percentage of donor assistance devoted to basic reproductive health activities in 2010 (6.5%) is lower than it was in 2005 (10.1%).

Table 4. Donor assistance to Kenya by ICPD category, 2005-2010 (Millions of US$)

<table>
<thead>
<tr>
<th>ICPD category/Financial year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td>15.901</td>
<td>2.184</td>
<td>0.501</td>
<td>9.103</td>
<td>11.272</td>
<td>14.657</td>
</tr>
<tr>
<td>Reproductive health</td>
<td>17.087</td>
<td>11.105</td>
<td>17.489</td>
<td>16.117</td>
<td>27.086</td>
<td>29.122</td>
</tr>
<tr>
<td>STD/HIV/AIDS</td>
<td>133.755</td>
<td>155.067</td>
<td>220.791</td>
<td>322.175</td>
<td>379.460</td>
<td>394.311</td>
</tr>
<tr>
<td>Research, data and policy analysis</td>
<td>1.779</td>
<td>1.088</td>
<td>0.434</td>
<td>0.638</td>
<td>6.906</td>
<td>7.408</td>
</tr>
<tr>
<td>Total</td>
<td>168.523</td>
<td>169.443</td>
<td>239.215</td>
<td>348.033</td>
<td>424.724</td>
<td>445.498</td>
</tr>
</tbody>
</table>

Source: the UNFPA/NIDI Financial Resource Flows data base

Table 4 also indicates that donor assistance to Kenya for family planning services in particular (i.e. including contraceptive commodities and service delivery, education and communication
among others) has been drastically reduced between 2005 and 2007, from 15.9 millions of US$ in 2005 to 0.5 millions of US$ in 2007. This declining trend has been observed in most sub-Saharan African countries for the reason that family planning had dropped down from the list of international development during the period.\[26\] Donor assistance for family planning has nevertheless increased since 2008 and the figures indicate a total amount of 14.5 millions of US$ in 2010.

**Major challenges facing reproductive health account estimation in Kenya and the way forward**

In spite of the extensive work undertaken by the national health account team, using international standards for health accounts, the reproductive health account process in Kenya suffers from three major challenges. The first major challenge is the fact that the budget for reproductive health activities cannot be broken down by service element, i.e. by family planning, maternal health services, childbirth services and infant care, child health services and management of other reproductive health problems. For future reproductive health expenditure analysis and to ensure a possible breakdown of reproductive health expenditure, this paper recommends a costing study at health facilities level as part of the reproductive health accounts. In this way, resources spent on reproductive health from the financing agents will be broken down into the reproductive health constituents using proportions generated from the costing study. Another way of attempting to break down the reproductive health expenditure at the national level is to take advantage of key informants (expert opinion) managing the reproductive health resources at the national level – department of reproductive health in the Kenyan case – to generate proportions of budget attributed to the different constituents.

The second major challenge facing reproductive health account estimation in Kenya is the lack of comprehensive data to estimate out-of-pocket spending on reproductive health. There is
increasing evidence that out-of-pocket expenses (OOPE) act as a financial barrier to essential health care, are a source of impoverishment, ill health and can exacerbate inequity.\textsuperscript{27,28} They may force households to reduce expenditure on other essential items such as food and rely on risky coping strategies. This applies particularly to catastrophic expenditures, i.e. expenditures that represent a significant proportion of the household budget. Out-of-pocket expenses have proved to be one of the components with least reliability in most health accounts.\textsuperscript{29} It is also recognized that out-of-pocket expenses are the largest or second-largest source of health care financing in developing countries on one hand, and the largest source of error estimates of national health spending on the other hand.\textsuperscript{29} Guidance is thus required to promote best practice in the identification of the available data sources. The available data for estimating the role of households were not sufficient enough to estimate the out-of-pocket spending on reproductive health in the Kenyan reproductive health accounts. The team ended up using distributive variables like utilization statistics and unit costs to derive some estimates of the out-of-pocket spending which was either highly underestimated or over estimated. A special Household Health Expenditure and Utilization Survey (HHEUS) targeting reproductive health services will therefore be required in future to estimate a robust out-of-pocket spending on reproductive health in Kenya.

Lastly, the third major challenge is the lack of information on spending on reproductive health by beneficiaries, rendering impossible to generate a Benefit Incidence Analysis that shows who benefit from reproductive health spending. The benefit incidence analysis is a tool that investigates the extent to which the financial benefits of public spending on social services accrue to different population groups (e.g. the poor, adolescents, older women and men).\textsuperscript{30,31} Benefit incidence analyses have long been used in the public finance field, to determine who benefits from public spending on specific programmes. The socio-economic status and health status of beneficiaries are of
particular importance in the analysis of reproductive health expenditures. The vulnerability status is an important concept as far as reproductive health accounts are concerned. Vulnerable groups include women or couples with unmet need, i.e. women or couples who want to limit or space childbearing but have no access to the means to do so, and adolescents. The breakdown of reproductive health spending by beneficiaries groups is one of the most challenging health accounts activity. It requires reliable health status data and population that can be linked to reproductive health expenditures. In the 2005/06 and 2009/10 Kenyan reproductive health accounts, these were not generated due to lack of reliable data on utilization of reproductive health services. However, for the general health, an analysis of who benefited from expenditures on general health was undertaken as household utilization on general health services using data from the Household Health Expenditure and Utilization Survey of 2007. To generate the reproductive health spending by beneficiary, the utilization statistics on reproductive health services need to be generated alongside the reproductive health account estimations.

**Discussion and recommendations**

Maternal and child health remain a major public health challenge facing Kenya. Maternal mortality has remained high and is estimated to be at 488 maternal deaths per 100,000 births in 2009/10, far from the MDG target of 147 maternal deaths per 100,000 births. Kenya is also far from reaching the MDG target of universal access to reproductive health. Less than 50% of women deliver with the assistance of skilled medical personnel, and the unmet need for family planning remains high at 30% among young people ages 15-24.

Many reproductive health priorities, such as improving service quality and client satisfaction, educating consumers, and providing more choices, are consistent with health sector reforms in Kenya. However, in terms of increasing resources for
reproductive health, not much has been achieved. As regards to funding on health in general, Kenya is doing poorly when compared to its neighbours or the sub-Saharan Africa average.\textsuperscript{[20,32]} Kenya is a signatory of the Abuja Declaration pledging to increase African governments’ funding for health to at least 15%, but the commitment remains to be met.\textsuperscript{[33]} The Kenyan government’s health expenditure as a percentage of total government expenditure has significantly declined from 8.6% in 2001-2002 to 4.6% in 2010-2011.\textsuperscript{[32]} The trend differs from other East African countries, such as Tanzania, Uganda and Ethiopia, who comparatively spend more on health as a percentage of government expenditure.\textsuperscript{[32]}

Kenya spent a total of 225.2 millions of US$ for reproductive health services in 2009/10\textsuperscript{[25]}, suggesting that a lot of effort have to be made by the government to mobilise domestic resources to fund the much-needed programs or to advocate for more funds from donors. As regard to family planning services in particular, substantial investments (about 8.3 million of US$) are needed by 2015 for providing commodities and cover personnel costs at the government facilities. Kenya must capitalize upon the growing momentum\textsuperscript{[34]} around family planning issues to firmly establish voluntary family planning programs as accepted, expected, and routine elements of national health care systems.

The reduction of out-of-pocket spending on reproductive health services should also be a key policy goal in Kenya. Households are contributing a substantial amount of resources through out-of-pocket spending (29% in 2009/10\textsuperscript{[25]}) to the overall financing of reproductive health. Data from the 2008-09 Kenya Demographic and Health Survey indicate that households still list cost as a leading barrier to their use of essential services.\textsuperscript{[9]} Various initiatives are being undertaken by the government of Kenya to reduce both per capita out-of-pocket spending by households as well as the share of total health funding contributed by households. These include cost-sharing policies and programs such as the Health Sector Services Fund, the output-based approach and the Joint Programme of Work and Funding. These
initiatives aim in particular to enhance the access to health financial resources by the poor and vulnerable. Recent evaluations of the output-based approach in Kenya indicated for instance that the uptake for skilled attendance during delivery (including normal delivery and caesarean section), as measured by redeemed vouchers increased to a high of 77% of vouchers redeemed. Such initiatives should be carried on with further investments to harness out-of-pocket spending into more efficient uses such as health insurance. This requires a strong commitment from both development partners and the government to increase and strengthen spending on reproductive health services.

Finally, the study recommends generation of more comprehensive reproductive health accounts data on a regular basis in Kenya. Improvements in reproductive health services require significant resource commitments as well as efficient and effective use of those resources. Decision-makers at national levels need to know whether their country has adequate resources to achieve the reproductive health goals. They also need to be accountable to donors, civil society and the United Nations. African governments often lack the technical instruments needed to plan for adequate budgets. Kenya has succeeded with other few countries in sub-Saharan Africa to complete rounds of national health accounts that include reproductive health subaccounts. This task could be achieved by all sub-Saharan countries with the adequate technical and financial support from both governments and development partners. This study recognizes that data related to resources going to reproductive health at the country level in Kenya are available, but the quality needs to be improved. The reproductive health account estimation process in Kenya suffers from a lack of data on expenditures by service element. The available data are also not sufficient enough to estimate households out-of-pocket spending. Furthermore, information on spending on reproductive health by beneficiaries is missing rendering impossible to generate a benefit incidence analysis that shows
who benefits from reproductive health spending. This study recommends a number of key activities to be carried on to develop a more complete picture of reproductive health account in Kenya and other sub-Saharan African countries. These include: 1) undertaking a costing of reproductive health services study at the facility/provider level, 2) undertaking household health expenditure and utilization surveys targeting reproductive health services to estimate robust information on out-of-pocket spending, and 3) expand NHA teams to include representatives of key NGOs and development partners.

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7. USAID, Using reproductive health subaccounts to advocate for increased resources for family planning, and Health Systems 20/20 Project, "National Health Accounts Subaccounts: Tracking Health Expenditures to Meet the Millennium Development Goals, Project Brief, 2009.

8. Information accessible online at:
<http://www.who.int/nha/country/en/>


33. In April 2001, African Union countries meeting in Abuja, Nigeria, pledged to increase government funding for health to at least 15%, and urged donor countries to scale up support. Detailed information is available at http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf

34. Recent meetings including the International Family Planning Conference in 2009 in Kampala, in 2011 in Dakar, and in 2012 in London attracted large audiences from around the world uniting global leaders around new funding commitments.
Appendix 1: About the UNFPA/NIDI Financial Resource Flows data base

The UNFPA/NIDI project on ‘Financial Resource Flows for Population Activities’ (RF) aims at monitoring expenditures and future commitments for population programmes at the country level, the term “population activities” referring to projects, programmes and activities in the following categories: a) Family planning services; b) Basic reproductive/maternal health services; and c) Basic research, data and population and development policy analysis.

The Resource Flows (RF) project's primary instrument to monitor global financial flows is the annual mail survey. In addition to the mail survey, 15 country case studies were conducted between 1997 and 2002. These studies helped to institutionalize domestic data collection and acquire a better understanding of national systems of financing population and AIDS activities. Since its inception, the RF project has evolved according to the needs of UNFPA and to the challenges faced in collecting accurate, reliable and timely data. In response to needs for more timely data, the RF project produces estimates and projections of resource flows to population and AIDS activities since 2003. Data collection is also strengthened by thematic studies on the use of Reproductive Health Accounts, the allocation of
population and AIDS funds in Sector-Wide Approaches (SWAps), and the estimation of private sector expenditures, including household expenses, and lower administrative level expenditures. For further information about the project and data collection see the resource flows website, http://www.resourceflows.org.

Data collection for donors started in 1996 and the sample for the 2010 survey included 125 organizations, including 24 DAC donor countries, 9 UN agencies, 28 foundations, 58 NGOs, 3 universities and research institutes, and 3 development banks. Data on population assistance are gathered with the use of a detailed questionnaire sent to major players in the field of population and AIDS, who’s funding accounts for the majority of funding for population assistance. These include donor countries that are part of the OECD/DAC and the European Union, multilateral organizations and agencies, major private foundations and other international NGOs and development banks that provide substantial population assistance. Most information for donor countries is obtained from the OECD/DAC database.

Data collection for the Domestic Survey started in 1996 and since 2008 the sample includes 171 developing countries and countries in transition. Data on domestic resources are collected via an annual survey sent by e-mail to UNFPA Country Offices for further distribution to government departments and national NGOs. A separate questionnaire for national consultants asks for information on the national budget, future commitments and the private sector. In addition, the consultant is requested to write a report on the data collection process, which provides more information on coverage, quality of data, and problems facing during follow-up and response. Data collected are based on: 1) primary sources; 2) actual expenditures (not commitments); 3) restricted to public sector (government and NGOs); and 4) include project level information to avoid double counting.

Questionnaires for governments are for distribution to those
departments that are involved in population activities, for example, Ministries of Health, Population, Education, or Central Statistical Offices, government-run research centres or universities. Questionnaires for national NGOs are for distribution to national non-governmental, not-for-profit organizations involved in population activities that are responsible for more than about one percent of the total funds for population activities in the country. This means that national foundations, research centres, etc can also fill out the NGO questionnaire.

There are separate questionnaires for donors and for developing countries and countries in transition. Depending on the questionnaire, the requested information includes the sources and flow of funds, type of projects/programmes, future commitments and self-generated income. Data are in principle confidential and the property of UNFPA. The donor questionnaires distinguish between primary donors (i.e. OECD/DAC members and international foundations of independent means), intermediate donors (i.e. multilateral organizations and international NGOs) and development banks (i.e. The World Bank Group and the three regional development banks).

The Domestic Survey takes place in selected countries in Asia, Pacific and Middle East, Latin America and the Caribbean and in all countries in sub-Saharan Africa. Kenya has 11 rounds of successful surveys so that can allow analyzing the trends of financial assistance from development partners as well as the trends in domestic resource mobilization for reproductive health issues.

Appendix 2: Population Activities Covered by the Programme of Action of ICPD

For a full description of the Programme of Action (UN-ICPD,
1995), see: http://www.unfpa.org/icpd/icpd_poa.htm. The so-called ‘costed population package’ covers according the Programme of Action:

“Basic reproductive health, including family-planning services, involving support for necessary training, supplies, infrastructure and management systems, especially at the primary health-care level, would include the following major components, which should be integrated into basic national programmes for population and reproductive health:

• In the family-planning services component - contraceptive commodities and service delivery; capacity-building for information, education and communication regarding family planning and population and development issues; national capacity-building through support for training; infrastructure development and upgrading of facilities; policy development and programme evaluation; management information systems; basic service statistics; and focused efforts to ensure good quality care;

• In the basic reproductive health services component - information and routine services for prenatal, normal and safe delivery and post-natal care; abortion (as specified in paragraph 8.25, PoA); information, education and communication about reproductive health, including sexually transmitted diseases, human sexuality and responsible parenthood, and against harmful practices; adequate counselling; diagnosis and treatment for sexually transmitted diseases and other reproductive tract infections, as feasible; prevention of infertility and appropriate treatment, where feasible; and referrals, education and counselling services for sexually transmitted diseases, including HIV/AIDS, and for pregnancy and delivery complications;

• In the sexually transmitted diseases/HIV/AIDS prevention programme component - mass media and in-school education programmes, promotion of voluntary abstinence and responsible
sexual behaviour and expanded distribution of condoms;

• In the basic research, data and population and development policy analysis component - national capacity-building through support for demographic as well as programme-related data collection and analysis, research, policy development and training.”