Integrating Equity Goals and Approaches into Policies, Plans, and Agendas: 

*The Kenyan Example*

Presenter’s Name

Date

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Which Health Policies Are Pro-Poor?

ORDER № 503
12.28.2002
On improving outpatient obstetric-gynecological care
In Ukraine
Making Health Policies Pro-Poor ...
Policy Review

- Does the policy consider high-level poverty and/or low access to healthcare among the specific target group a priority?
- Does the policy include specific strategies to improve access to healthcare services?
- Does the policy include explicit objectives to reduce inequities in service use or health outcomes for the poor?
- How are objectives expressed?
  - Increase contraceptive prevalence among the poor
  - Reduce gaps between rural and urban areas
- To what extent does the policy consider level of poverty and inequities in allocating financial resources?
- Does the monitoring and evaluation plan include equity-based indicators?
Policy Formulation

1. Conduct poverty and equity analysis
2. Set equity goals
3. Identify and engage key stakeholders
4. Put inequity issues high on policy agenda
5. Develop equity-based M&E indicators
6. Design pro-poor strategies

Empower and Engage the Poor
Policy Implementation

- Develop an action plan
- Mobilize resources for the poor
- Allocate resources equitably
- Monitor progress using equity-based M&E indicators
- Establish accountability mechanisms: participatory monitoring
- Analyze unintended consequences and take actions to address evolving problems
Integrating Equity Goals and Approaches in the National RH Strategy in Kenya

Photo credits: Health Policy Initiative/Kenya (left and right) and ©iStockphoto.com/Britta Kasholm-Tengve (center).
### Basic Demographic and Socioeconomic Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population size</td>
<td>Approx 38M</td>
</tr>
<tr>
<td>Annual growth rate</td>
<td>2.9% p.a.</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td></td>
</tr>
<tr>
<td>- Males</td>
<td>54</td>
</tr>
<tr>
<td>- Females</td>
<td>59</td>
</tr>
<tr>
<td>Crude birthrate</td>
<td>41.3 per 1,000</td>
</tr>
<tr>
<td>Crude death rate</td>
<td>11.7 per 1,000</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (married women)</td>
<td></td>
</tr>
<tr>
<td>- Modern</td>
<td>32%</td>
</tr>
<tr>
<td>- Traditional</td>
<td>8%</td>
</tr>
<tr>
<td>Proportion below poverty</td>
<td>46%</td>
</tr>
<tr>
<td>Mean household size</td>
<td></td>
</tr>
<tr>
<td>- Poor</td>
<td>6.2</td>
</tr>
<tr>
<td>- Non Poor</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Source: DHS 2003 Kenya

Photo credit: UNICEF/C-79-53/Goodsmith
Engaging and Empowering the Poor

- Policy, program, and implementation decisions affecting the poor should be made with the poor, not for the poor

- **Poverty** is—hunger, inability to feed children, uncertainty about the next meal, inability to access healthcare, lack of alternative opportunities for survival, absence of shelter and clothing, powerlessness, and disinheritance from ancestral land.

  *Focus group discussion, Kisumu, Kenya*

Photo credit: Health Policy Initiative (HPI)/Kenya
Quantifying the Level of Inequality in Family Planning Use

- Quintile analysis
  - Urban
  - Rural
- Market segmentation analysis
  - Provider market
  - Consumer market
  - Provider-consumer interaction
  - Market trends

Evolution of Inequalities in Family Planning Use in Kenya

Source: DHS 2003 Kenya
## Level of Inequalities in Use of FP and MH Services

Reproductive Health Indicators by Socioeconomic Status in Kenya, 2003

<table>
<thead>
<tr>
<th>RH Indicators</th>
<th>Poorest</th>
<th>Lower Middle</th>
<th>Middle</th>
<th>Upper Middle</th>
<th>Wealthiest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning use (modern methods)</td>
<td>0.12</td>
<td>0.24</td>
<td>0.33</td>
<td>0.41</td>
<td>0.44</td>
</tr>
<tr>
<td>Unmet need for family planning</td>
<td>0.33</td>
<td>0.30</td>
<td>0.27</td>
<td>0.17</td>
<td>0.17</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>0.42</td>
<td>0.46</td>
<td>0.53</td>
<td>0.59</td>
<td>0.70</td>
</tr>
<tr>
<td>Institutional delivery</td>
<td>0.17</td>
<td>0.33</td>
<td>0.39</td>
<td>0.55</td>
<td>0.77</td>
</tr>
<tr>
<td>Delayed marriage (marriage at age 18 or older)</td>
<td>0.55</td>
<td>0.72</td>
<td>0.68</td>
<td>0.80</td>
<td>0.83</td>
</tr>
<tr>
<td>Delayed childbearing (first birth at age 20 or older)</td>
<td>0.33</td>
<td>0.43</td>
<td>0.44</td>
<td>0.59</td>
<td>0.69</td>
</tr>
<tr>
<td>Birth spacing (36 months or longer)</td>
<td>0.35</td>
<td>0.43</td>
<td>0.45</td>
<td>0.48</td>
<td>0.54</td>
</tr>
</tbody>
</table>

Understanding the Barriers to Access

Supply-Side
- Review of KSPA
- Key informant interviews
  - Service providers
  - Program officers and policymakers
- Facility visits
  - Government and NGOs
  - Different regions and levels

Demand-Side
- FGDs with poor women
  - Ages: <30 and >30
  - Provinces: Coast and Nyanza
  - Areas: urban and rural
- FGDs with men
  - Exit interviews with FP users

Policy
- Review of policies
- Review of development plans
- Review of financing mechanisms

Low access among the poor
Understanding barriers to access—social, cultural, religious, geographic, financial, and operational
Key Barriers

- Lack of male involvement
- Sociocultural and religious barriers
- Regional disparities in access and use of FP services
  - Urban and rural; different regions
- Frequent stockouts
- High costs of accessing FP services (long waiting time, transportation)
- Misinformation and misconceptions

Photo credit: Suneeta Sharma, Futures Group
Lack of Male Involvement: Husband’s Approval
Lowest among the Poorest Women

Distribution of Women by Whether Husband Approves of Family Planning

Source: DHS 2003 Kenya
Lack of Male Involvement: Spousal Opposition

Spousal Opposition: Focus Group Discussions

• “The men do not like the idea of family planning; they think that when we go to the clinic, we go to hide so that we may be promiscuous.”
  (female discussant, Kaloleni Kisumu)

• “When a woman unilaterally decides to use contraceptives without informing me, it means she is undermining my authority.”
  (male discussant, Kaloleni Kisumu)

• “Some of these problems are our own, making some of women take drugs secretly because we have not yet discussed.”
  (female user, Kaloleni Kisumu)
Lack of Male Involvement: Need for Male-friendly Services

- Healthcare system is not friendly to men
- Men “excluded” from FP service provision in the public sector
- However, several men acknowledged the benefits of FP
Sociocultural and Religious Barriers

Religious opposition is the main reason for non-use among 28% of the poorest women (DHS 2003)

- “It is prohibited in Islam (haraam) so I cannot support it.”
- “God forbids the use of contraception; it is like killing—form of an abortion.”

(respondent, Nyatike)
Cultural Factors

- “Our mothers complain they need grandchildren.”
  (male discussant, Kaloleni Kisumu)

- “When a man have 5 children who are girls, many of them think that the next might be their luck of having a boy.”
  (discussant, Nyatike)

- “The issue of FP is not just between man and his wife; some … men compete in having children so that they are not ‘beaten to it’ by their brothers or cousins. It is a matter of competition between co-wives, between brothers, and between communities so if you tell a man to stop having children or have fewer children, it is like lowering not only his ego but also of their lineage.”
  (elderly male discussant, Nyatike)

In this community, it is also believed that the females should remain virgins until they are married, but males should experiment and “test” their sexuality/virility via multiple partners.
Regional Disparities in Access and Use of Family Planning Services

Current use of any method by currently married women

- <1%<br>
- Less than national average (39%)<br>
- Greater than national average<br>

Source: DHS 2003 Kenya
Frequent Stockouts of Contraceptives

• High dependence on donors for contraceptive commodities, not a government priority

• Government budget line (500m) established only recently

• Systems failures adversely affect distribution to facilities and targeting

• Lack of community-based distributors

• April 30, 2009: Stockouts in most methods except condoms (3 mos.) and pills (6 mos.)
High Costs of Accessing FP Services

• 35% respondents report lost wages or time in seeking services (KSPA 2004)

• Regional variations exist
  ▪ Women in the Coast, Nyanza, and Eastern provinces are more than 4 times more likely to report some financial loss
Misinformation and Misconceptions

• “The stories people hear about contraceptives make people fear. We hear that women who use contraceptive give birth to children with birth defects—some with such big heads, funny limbs, etc.”

• “Women who use contraceptives often give birth to children with birth defects.”

• “Some of the women who use contraceptives often develop complications as a result of side effects.”
Incorporated Equity Goals and Approaches in the National Reproductive Health Strategy

Equity Goals and Objectives

- Increasing equitable access to reproductive health services
  - Unmet FP need among the poor reduced by 20% by 2015
  - Contraceptive prevalence rate among the poor increased by 20%—from 12%—by 2015
Strategies

• Mobilize civil society to advocate for FP in disadvantaged communities

• Develop mechanisms for engaging the poor or organizations representing the poor in problem identification, planning, and advocacy

• Develop culturally appropriate FP communication strategies for application at the community level

• Shift resources from well-served areas to extremely poor areas
  ▪ North Eastern Province, Nyanza, dry and poor North

• Shift resources to arid areas, pastoralist territories, and urban slums in major cities
Targeting Resources and Efforts to the Poor

• Design and implement targeted interventions for
  ▪ Under-served regions—rural areas and urban slums
  ▪ Under-served populations—males

• Ensure equitable allocation of resources

• Develop targeted health financing interventions
  ▪ To inform scale-up of the Output-based Approach (Vision 2030+)
  ▪ To inform the strategy to ensure pro-poor financing
  ▪ To strengthen implementation of fee exemption mechanisms

• Organize policy dialogue to select priority approaches and mobilize action
Yielding Public-Private Partnerships for Equity

Private sector participation—an untapped potential

- Develop public-private partnership (PPP) policy
- Promote delivery of integrated HIV/FP/RH/child health services
  - Leverage resources for FP
  - Promote greater collaboration between public and private sectors
- Develop and test PPP interventions
  - Contracting out to private providers
  - Soliciting donations from individuals
  - Encouraging business councils and workplace health services
Lessons Learned

• Conduct evidence-based advocacy and planning

• Engage the poor and key stakeholders in problem identification, planning, and implementation

• Ensure that strategies are sustainable, strengthen local capacity, and build on existing mechanisms/systems and current work being done to reach the poor

• Advocate for mobilizing, allocating, and targeting resources for the poor