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FAMILY PLANNING IN KENYA
Program and Problems

by

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ABSTRACT

This paper gives first a brief outline of the development of family planning services in Kenya, including the development of official policy. It then describes the present population planning services under the headings: organization; operations; plans for the future; research and evaluation; private efforts; educational efforts; foreign assistance. The final section mentions the anticipated strengthening of the program by the introduction of the five-year family planning plan, and stresses the need for the development of suitable curricula on population education .

FAMILY PLANNING IN KENYA

BACKGROUND

The availability of modern contraceptives in Kenya dates back to early 1950's when the country was still a Colony of Britain. Usage was, however, restricted to the European and Asian communities in the country and available to only a few African middle class individuals. Modern techniques of contraception have been available in the past (pre-1966) through private practitioners. In the 1950's, through the assistance of the Pathfinder Fund, the first efforts to form a family planning organization began. In 1957, the Family Planning Association of Kenya (FPAK) was formed, and five years later in 1962, it became affiliated with the International Planned Parenthood Federation (IPPF) by which it is now largely financed. Although the early activities of FPAK were directed mainly to the urban populations they did demonstrate that a "demand" for such services existed. The functions played by FPAK in these early years was invaluable, and it was from this small beginning that the present National Family Planning Program has stemmed.

OFFICIAL CONCERN WITH POPULATION MATTERS

Official concern with population growth in Kenya has been recent, i.e. since 1966. Nevertheless, Kenya was the first sub-Saharan African country to adopt an official national family planning program. In 1965 the Kenya Government invited the Population Council to send a team of experts with the following aims:

- (1) To study the population problem in Kenya with a view to making recommendations on the ideal rate of growth.
- (2) To recommend a suitable program for effecting the ideal rate of growth.
- (3) To make recommendations on administration of the program.
- (4) To recommend procedures for obtaining funds and technical assistance for carrying out the program.

In mid 1965, the Population Council Advisory Mission studied data regarding Kenya, consulted with representatives of the Government and various official and private organizations, and toured the country visiting villages, Government offices, hospitals, and health facilities. Additional studies were made of schools and training centers in the country. The Advisory Missions'

report was based on the above explorations supported by knowledge regarding economic and demographic trends in other developing countries and by experience with technical assistance to other countries. The report was submitted to Kenya Government in late 1965, and after careful consideration the Government decided in early 1966 that it would "...pursue vigorously policies designed to reduce the rate of population growth through voluntary means..." A program was authorized to be undertaken in cooperation with the FPAK and was launched in 1967. Policy supervision and coordination are the responsibility of the Ministry of Health. In addition, the Ministry of Health is responsible for provision of clinical services for family planning while the Family Planning Association has the responsibility of motivating and recruiting family planning clientele.

As presently organized, the basic aim of the national family planning program is to make "family planning information, education and services available on request, through free clinics in all Government hospitals and health centers". The program is closely linked with the maternal and child health programs. The program specifically includes provision of assistance to couples with infertility problems. The Kenya Government agreed at the beginning of the national program that it would provide 25 per cent of the program costs, the remainder being shared among domestic and overseas organizations interested in assisting.

POPULATION POLICIES

Open opposition to the national family planning program has been negligible and sporadic. Where it has been present, it has usually stemmed from the political arena. While there has been no national leader of consequence who has openly opposed family planning (the opposite is true in fact; many national leaders have publicly supported family planning) those who have opposed population planning or limitation usually base their arguments on traditional attitudes: that large families are desirable; or that Kenya is by no means an overcrowded country if we consider population density alone. However, the fact that Kenya's 1969 population demonstrated an even higher rate of natural increase (3.3 per cent per annum) than was hitherto estimated (previously we estimated that the natural rate of increase was 3.0 per cent) has probably helped to prevent the National Family Planning Program from becoming a controversial issue.

There has been little or no religious opposition to the program. Many of the country's Roman Catholic Mission Hospitals offer family planning services, even though mainly to their non-Catholic clientele. The FPAK has secured the active cooperation of the Muslim leaders. The military supports family planning, and several clinics are located at military installations and bases.

Polygamy was widely practiced in Kenya in the past. It continues today but to a lesser degree. Therapeutic abortion is performed in Kenya only for strict medical indications. Because of the absence of reliable data, the extent to which illegal abortion is practised is not fully known, but based on the number of admissions for completion of abortions, it seems to be high and on the increase.

POPULATION PROGRAMS

Objectives: No specific target has been set in Kenya's program other than that of reducing the excessive rate of natural increase, estimated in December 1972 as 3.5 per cent per annum. To what level this reduction should be has not yet been stated. The Population Council Mission had been requested to make recommendations on the "ideal" rate of growth in Kenya. In the opinion of the Mission, since there was no single answer to this question, a meaningful target would be as low a mortality as possible and realistic and acceptable reduction in fertility. The belief was that the immediate objective of the national program should be to make the means of limiting the number of children, as well as assistance to infertile women desiring children, available to every family - in other words, to make every pregnancy the result of a voluntary choice. The resulting level of fertility would depend on many factors and is therefore difficult to predict, but it was felt that this might reduce fertility by as much as 5 percent in 10 to 15 years, a decrease that was considered to be no greater than desirable. Accordingly, a realistic target was to build up, within five years, a program structure that would introduce family planning at a rate that would achieve this reduction.

Type: Kenya's National Family Planning Program is a free service provided by Government personnel within Government facilities. As such, it is part of the National Health Service. The most widely used methods of contraception are the intrauterine device (IUD) and the pill. The injectable Defro Provera is gaining popularity but its use is restricted to women with a family of 5 and is available only in urban areas. Certain basic principles are adhered to:

- (1) The program is viewed as an integral part of - rather than as an alternative to - efforts towards social and economic development of the country.
- (2) The program is closely linked to maternal and child health services.
- (3) The program to reduce the birth rate is wholly voluntary, with full respect for the wishes, religious beliefs, and customs of individual parents.
- (4) The program places emphasis on spacing of births rather than on limitation of numbers.

ORGANISATION

Because the family planning program is considered to be part of the maternal and child health care, the Director of Medical Services (DMS), Ministry of Health, is responsible for the overall policy and planning of the National Program. He is the Chairman of the Family Planning Working Committee, the family planning advisory body. The committee is supposed to meet at monthly intervals to deal with matters of policy, plans and coordination of the Ministry's activities with those of other participating agencies. Its members consist of the Chairman, members of the Family Planning Section of the Ministry of Health, and representatives of the Ministry of Finance and Economic Planning, FPAK and IPPF. In addition, other officers of the Ministry of Health and representatives from other ministries are invited to attend when their expertise is required or when there is relevant information to be imparted to them.

The Family Planning Section of the Ministry of Health is responsible for the implementation and daily operation of the national program. Within the Ministry of Health the Section of Epidemiology and Medical Statistics had a dual role: collection and analysis of health statistics and evaluation of the National Family Planning Program. Because of shortage of staff in this Section, too often evaluation of family planning programs is neglected.

The Health Education Unit, a branch of the Ministry of Health, prepares material relating to various aspects of health and is specifically involved in the area of family planning. In this unit, there is a health educator and an audio-visual expert, who are charged with the responsibility for improving both the quality and quantity of the Unit's output. As is true of the Epidemiology Section, the Health Education Unit, while it devotes some time to matters relating to family planning, is undermanned and consequently produces very limited materials on family planning.

The warehouse, or medical store, has a separate family planning division employing only three full time workers. These individuals are responsible for storage and dispatch to clinics of all family planning equipment and supplies.

The rest of the staff consists of medical and paramedical personnel in Government service and those working for the Nairobi City Council, mission hospitals and local authorities. However, the ultimate responsibility or task for dispensing family planning services falls largely on Government personnel.

As previously mentioned, the role of the Family Planning Association of Kenya (FPAK) is that of education and motivation. The Association employs, at present, a cadre of only 50 field workers. Through lectures, person-to-person talks, and use of audio-visual aids, they introduce the people to the concept of family planning and supply them with information regarding existing Government clinics and their location and function. FPAK is also currently experimenting with the use of mass media, especially the radio and newspapers, and has commissioned a series of research studies by a local marketing research agency as well as by the University.

OPERATIONS

Facilities: Unlike many developing countries, which have had to create new and expensive organizational structures to provide family planning services to the public, Kenya is fortunate in having one of the best-developed medical systems in East and Central Africa through which family planning has been introduced.

Personnel: The greatest single internal constraint to ready advancement of the family planning program in Kenya lies in the shortage of medical and paramedical personnel. Since the program is part of the National Health Service, the dispensing of family planning services is the responsibility of Government medical and paramedical personnel but the number of medical and paramedical personnel in Government service is totally inadequate. As a result, personnel are already overburdened with existing health work and do not necessarily consider the addition of family planning service to be a high priority.

The shortage of doctors makes it impossible to place the burden of responsibility for actively running the family planning program on them. Subsequently, in October 1969, the Ministry of Health decided that Government personnel other than doctors would be allowed, after adequate training, to dispense family planning services, including the insertion of IUDs. This

measure greatly facilitated the introduction of family planning services, but shortages in paramedical personnel still make it impractical to implement family planning on a large scale as the demand for family planning services continues to increase every year.

Methods: Kenya's program is based on the free distribution of oral contraceptives and IUDs, both obtained free from the Swedish International Development Authority (SIDA). Other contraceptive methods are available though they are not as popular as the above two. There is little demand for condoms. Surgical sterilisation of the female by tubal ligation is usually performed only for medical indication and thus the number of such procedures is limited. Male sterilisation by vasectomy is performed even less frequently, as demand for such procedure is negligible. Certain conventional methods, particularly those used by the female, such as creams, jellies, diaphragms, and foaming tablets, seem to find their main use in the large urban centers. Even here, however, their use is not so wide-spread.

From late 1969, there has been an increased demand by both family planning clients and medical staff for the injectable forms of contraceptives - the Defro Provera. While injectables are available, they are generally restricted to those clients who have a family of five or more children. In the areas where they are available (usually in urban areas) the main indication for use is that of completed family: in other words, for limitation rather than for spacing of the family.

PLANS FOR FUTURE

Training: The main plan for the future revolves around organized family planning training for all Government medical and paramedical personnel. As the first step in the training programs that commenced in mid-1970, doctors and a few registered nurses have already been trained and more will continue to be trained. Since doctors constitute the smallest group of personnel and also happen to have the heaviest existing commitments, this group is being trained to take the role of supervisors and consultants. The function in running the clinics has fallen into the hands of registered nurses, medical assistants, and enrolled nurses. The last two categories are being trained in provincial capitals and, while most of them are still in schools, when trained, they will meet the immediate demands.

The long term plans call for introducing the subject of family planning into the curriculum of the medical school, schools of nursing, and institutions where medical assistants are trained. Arrangements are also made

for seminars on the general aspects of population growth and family planning to be given to such groups as social workers, community development workers, school teachers, teachers in training, public health nurses, and agriculturists. In short, the program calls for involving as many extension workers in family planning as possible.

RESEARCH AND EVALUATION

Personnel: Prior to the inception of the National Family Planning Programs several Knowledge, Attitudes and Practices (KAP) studies had been done. Further studies continue to be done mainly by the academic staff of the University and by others interested in the general subject. The research and evaluation section of the Ministry of Health is understaffed and not quite capable of mounting large scale research. Plans call for a strong unit which will mainly be concerned with research and evaluation in family planning.

Procedure for Evaluation: Up to now, within the Ministry of Health, program evaluation has been based on the clinic record card used by all Government family planning clinics and other clinics giving family planning services. While the card collects basic data on the client, e.g., physical examination and data for first visit and up to eighth revisit, it does not help in the measurement of how well the program is progressing; rather it measures how many people come to the clinic in any given day. Plans call for development of a technique which measures not only the number of people utilising family planning services but more importantly the effectiveness of the services provided throughout the country.

PRIVATE EFFORTS

Commercial Channels: Besides the FPAK which is now working hand in hand with the Government effort, other private efforts are being made to spread the family planning message. Since early 1972, the Population Services Inc. (PSI) from the University of North Carolina, has mounted a social marketing project in one of the heavily populated Districts of Kenya. The PSI deals mainly with condoms which are made available through local shops. While it is too early to assess the success of this project, tentative indications are that the demand for services is very high. If this is so, then in the future chances are that non-clinical methods will be distributed through private channels and thus make family planning services available to many more people throughout the country.

EDUCATIONAL EFFORTS

Besides the many, often ad hoc, lectures that are given to groups in the country, little has been done in terms of family planning, utilizing educational institutions such as schools. To this extent the youth of the country has been left out. (55% of the total population is under 20 years of age.) The reason for their being left out is understandable considering the history of the planned parenthood movement which has emphasized clinical methods and the provision of service to married couples.

To include this important group in discussions of population, KAP studies on youth and teachers are currently underway and preliminary indications are that youth know very little about reproduction or any aspect of population dynamics. Discussions are underway with the Ministry of Education to find the best way of introducing population education into schools.

For the out of school youth, FPAK and the World Assembly of Youth are trying to find ways of involving them through seminars, youth clubs and training institutions. The World Education Council is devising methods of involving the adult population by having special workshops. When all these approaches are fully refined and become operational, that will go a long way in educating the total population in population matters. It is in the area of education that international organizations such as UNESCO/WHO could be of greatest assistance by helping set up experimental projects and devising various approaches for differing groups.

FOREIGN ASSISTANCE

Many international organizations have shown keen interest in assisting with population/family planning matters in Kenya. The British Overseas Development Agency (ODM) has contributed office equipment and vehicles for a Section of Epidemiology and Medical Statistics. The Ford Foundation has provided grants to finance training and education as well as travel fellowships. The IPPF contributes financial support to FPAK and to the Family Welfare Center, where most training for doctors and nurses is held. The IPPF also provides mobile teams to give family planning services and training.

The Netherlands Government has contributed the services of two gynecologists, two nurse-midwives, one cytologist, one demographer and a statistician, plus some office equipment. The Norwegian Government has contributed clinical equipment for 50 family planning clinics.

The Population Council has provided a medical adviser and a demographer attached to the University of Nairobi. The Population Council also supports seminars on interrelations between population growth and economic development.

The Swedish International Development Agency has provided the services of an administrative adviser to the Ministry of Health, in addition to contraceptive supplies already mentioned above.

The United States Agency for International Development (AID) provides the assistance of a health education expert and an audio-visual expert, as well as supplies and basic equipment for the Health Education Unit. The FAO's Programme for Better Family Living (PBFL) has come on the scene since late 1971. It is currently training local leaders in matters affecting the family, including family planning.

Taking into account the "hidden" input of the Kenya Government, such as medical personnel, clinic facilities, etc, the foreign input exceeds local inputs by a considerable margin. The program is still in its crucial early stages of development with an ever-increasing demand, which has had to be financed immediately. Thus the heavy foreign input. At the time of writing, the World Bank is considering a new five-year family planning plan in which major changes are proposed. If the proposed plan is acceptable, it will have a budget of K£10.5 million.* When this five-year plan is finally approved, then the Kenya Government will have assumed major financial responsibility for population planning in the country.

SUMMARY

Factors facilitating efforts in family planning:

- (1) The formal adoption by Government of the National Family Planning Program - the first in sub-Saharan Africa.
- (2) The awareness of many individuals in the Government, particularly in the Ministry of Finance and Economic Planning of the need to decrease the growth rate of the population.

* 1 K£ = US \$ 2.80.

- (3) The ever-increasing demand for services even in the absence of large-scale advertising campaigns or use of mass media.
- (4) The gradual realization on the part of the population that, with increasing health and decreasing infant and maternal mortality, it is no longer necessary to bear as many infants as possible in order for one or two to survive to adulthood.
- (5) The existence of a network of medical facilities where family planning clinic sessions can be held.
- (6) The willingness of various international agencies to assist the program.

Factors limiting efforts in family planning:

- (1) The gross shortage and maldistribution of medical and paramedical personnel at all levels. This state of affairs is likely to show little improvement within the next several years.
- (2) The difficulty in releasing local Kenyan medical and paramedical personnel for training in family planning. (This will improve as the Government commits itself more and more to family planning.)
- (3) For personnel trained in family planning, heavy workloads and a system of "priorities" that makes it difficult to allocate time for the operation of family planning clinics.
- (4) Inability in the past to make use of mass media. This is now changing if not already changed.
- (5) Difficulty encountered in incorporating a new cadre into Government service - in this case, family planning extension workers.
- (6) The rather low level of input, both in terms of funds and of personnel, by the Ministry of Health. This is expected to change drastically when the five-year family planning plan comes into operation.
- (7) Various restrictions imposed by foreign donor agencies on the way in which funds may be spent within the program.

THE FUTURE

When the five-year family planning plan comes into operation, it is anticipated that the whole program will be strengthened. Various components of the program that hitherto have not been working well will hopefully be improved. Research and evaluation will be started to identify program needs and problems.

Perhaps the other most important area for the new plan will have to be in education. In school and out-of-school programs have to be developed and curriculum has to be improved so that the vast majority of the population who are now not affected by the program may become involved. In this area the help of experienced people will be needed.