



Setting New Goals for Family Planning in Kenya

Building on Decades of Progress in Contraceptive Use

September 2017



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ABBREVIATIONS

CPR	contraceptive prevalence rate
FP	family planning
FP2020	Family Planning 2020
ICFP	International Conference on Family Planning
ICPD	International Conference on Population and Development
KDHS	Kenya Demographic and Health Survey
mCPR	modern contraceptive prevalence rate
MOH	Ministry of Health
NCPD	National Council for Population and Development
PMA2020	Performance Monitoring and Accountability 2020
RH	reproductive health
RMHSU	Reproductive and Maternal Health Services Unit
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

This report describes the development of new goals for modern contraceptive prevalence for Kenya. It explains the rationale for revising the family planning (FP) goal that Kenya set in 2012 (Kenya National Council for Population and Development, 2012), by looking at Kenya's situation in the context of the global, historical landscape.

The Government of Kenya identifies FP as a pillar of the improvement of the health status of women and their families, as documented in the Kenya Development Plan Vision 2030, the National Reproductive Health Policy (2007), and the Kenya Health Sector Strategic Plan (2013-2018).

According to the 2014 Kenya Demographic and Health Survey (KDHS)—the most recent—FP uptake among married women improved, from 39 percent in 2008–2009 to 53 percent in 2014 (Kenya National Bureau of Statistics [KNBS], et al., 2015). With this tremendous growth in Kenya's modern contraceptive prevalence rate (mCPR), the country surpassed its 2015 target of 52 percent. Moreover, given the trend in growth of the mCPR, Kenya is likely to achieve its 2020 target of 58 percent by 2018. (In recognition of this achievement, the Kenya Ministry of Health [MOH] received the global Excellence in Leadership for Family Planning Award at the International Conference for Family Planning, Nusa Dua, Indonesia, in 2016.)

The government realized that new family planning targets were needed to reflect Kenya's progress and sustain the momentum of growth in modern FP uptake. Thus, in February 2016, the Reproductive and Maternal Health Services Unit (RMHSU) of the MOH and the National Council for Population and Development (NCPD), began a series of meetings with partners, organized as thematic working groups. These working groups were charged with developing a roadmap to position FP as an engine of development that would reap demographic dividends in Kenya¹ and contribute to the country's reproductive health strategy.

The roadmap is informed by projections in the mCPR for 2020, 2030, and 2050. Data from the 2014 KDHS formed the baseline for county estimates. The proposed mCPRs for 2020 (58%), 2030 (66%), and 2050 (70%) will be applied in advocacy for increased political commitment, demand creation, and support for county-level planning; in FP commodity forecasting and quantification; and in revision of other pivotal documents such as the population policy, reproductive health (RH) policy, health policy, and costed FP implementation plans.

¹ "The demographic dividend is the accelerated economic growth that may result from a decline in a country's birth and death rates and the subsequent change in the age structure of the population. With fewer births each year, a country's young dependent population declines in relation to the working-age population. With fewer people to support, a country has a window of opportunity for rapid economic growth if the right social and economic policies are developed and investments made."

Source: Population Reference Bureau (2012). Retrieved from <http://www.prb.org/Publications/Articles/2012/demographic-dividend-factsheet.aspx>

INTRODUCTION

Kenya's Family Planning Program

Since its independence in 1963, the Government of Kenya has adopted policies, strategies, and programs to manage population to promote the country's socioeconomic development. In 1967, Kenya was the first country in sub-Saharan Africa to establish a National Family Planning Program; over the years since, the government has expanded this program and articulated guidance and policies to support it. The goal of the government's most recent policy—the National Population Policy for Sustainable Development (Kenya National Council for Population and Development [NCPD], 2012)—is for Kenya to attain a high quality of life by managing population growth to a level that the country's resources can sustain. This policy constitutes a framework that is intended to guide national population programs and activities for the next two decades. The policy considers national and international emerging and continuing population concerns. It also responds to Kenya's development agenda, as set forth in the Kenya Vision 2030 blueprint (Government of Kenya, 2007).

The Government of Kenya has created an enabling policy environment for the implementation of population-related programs and projects, by implementing Kenya Vision 2030 and establishing the NCPD to address and coordinate population and development issues. The government continues to collaborate closely with development partners, nongovernmental organizations, community-based organizations, faith-based organizations, the private sector, and others in the population and development sector that have been proactive in supporting FP, RH, maternal and child health, and HIV and AIDS programs. Kenya Vision 2030, the National Reproductive Health Policy (2007), and the Kenya Health Sector Strategic Plan (2013–2018) identify FP as a pillar in the development and improvement of the health status of women and their families (Ministry of Health, 2012).

Kenya's FP program has made impressive achievements. From 1984 to 1998, the contraceptive prevalence rate (CPR) more than doubled, from 17 percent to 39 percent (NCPD, et al., 1999). After remaining level for some time, the CPR increased again, to 46 percent, in 2008–2009 (KNBS, et al., 2010). According to the most recent (2014) statistics, 58 percent of currently married women and 65 percent of sexually active unmarried women are using an FP method (KNBS, et al., 2015). More currently married women use modern FP methods (53%) than traditional methods (5%)—an increase from 39 percent in 2008–2009. The percentage of sexually active unmarried women using modern methods is even higher, at 61 percent. Injectables are the most widely used modern method (26%), followed by implants (10%) and the pill (8%). With these increases in modern contraceptive use from 2008–2009 to 2014 there has been a decrease in fertility rates, from 4.6 to 3.9 children per woman (KNBS, et al., 2010; KNBS, et al., 2015). Regional disparities exist, however, with some counties reporting a CPR as low as 2 percent and others reporting a CPR as high as 76 percent. The adolescent pregnancy rate is also high: 96 per 1,000 births (KNBS, et al., 2015).

Improvements in unmet need for FP have been inconsistent, as well. Unmet need is the number or percentage of women expressing a desire to space births for at least two years or limit the number of births, and thus do not want to become pregnant but are not using contraception (MEASURE Evaluation, 2011). Unmet need for contraception increased between 2003 (24.5%) and 2008–2009 (25.6%), but it decreased to 18 percent (9% for spacing and 8% for limiting) as of 2014 (Kenya Central Bureau of Statistics, et al., 2004; KNBS, et al., 2010; KNBS, et al., 2015). The highest unmet need for FP

is found in Nyanza (32%) and Rift Valley (31%) provinces. The provinces with lowest unmet need are North Eastern (15%) and Central (16%). The country's large unmet need has been attributed to inadequate service provision, poor access to FP commodities, and lack of support for contraceptive security because of overdependence on donor funding (Ministry of Public Health and Sanitation and Ministry of Medical Services, 2009).

Kenya's Commitments to Family Planning 2020: 2012–2020

In July 2012, Kenya made a commitment at the London Summit on Family Planning to protect individual rights to good-quality RH care, including FP information, services, and supplies, as stated in the Constitution. Family Planning 2020 (FP2020) is an international partnership that emerged from the London summit; Kenya is one of FP2020's 69 focus countries, and as such, its mCPR is tracked, as an indicator of the country's fulfilment of its commitment.

Kenya's budgetary allocation for FP grew from US\$2.5 million in 2005–2006 to US\$6.6 million in 2012–2013. However, there was no budgetary allocation for FP during the period of constitutional change and devolution from central to county governments; from 2013 to 2014 to 2016 to 2017, the government allocated only US\$500,000 for FP. The national government is working closely with NCPD and development partners to secure increased financing for FP commodities and services. To increase access to FP services among the poor and hard-to-reach segments of the population, the government made deliberate commitments to scale up long acting and reversible methods through a national strategy that rallied partners and counties, brought financing and technical expertise; advocacy efforts by NCPD with policy makers including parliamentarians; communication through various media such as national and community radio; social marketing through private sector networks and FBOs; the introduction of a community health strategy in 2012 and integration of FP with the HIV services. The government also established more than 70 youth empowerment centers, with a target of having one in each constituency to provide "one-stop shop" for youth-friendly information, including FP (Country Commitments: Kenya, 2014).

In recognition of these efforts in providing FP services, Kenya received the global Excellence in Leadership for Family Planning Award at the International Conference on Family Planning (ICFP), held in Nusa Dua, Indonesia, in 2016.

It was noted during a post-ICFP meeting that Kenya had surpassed the 2015 goal, and with current growth of the modern contraceptive prevalence rate (mCPR), Kenya was on course to achieve the 2020 target (58%) by 2018, well in advance. In other words, the actual growth in mCPR was more rapid than projections, including those of the 2012 Population Policy for National Development. It became apparent that the goal needed to be revised upward.

To sustain the momentum for growth in modern FP uptake, in February 2016, the government, through the MOH's RMHSU and the NCPD, convened a meeting of partners to deliberate strategies so that, going forward, FP would be increasingly viewed from a development lens and resonate with national and county resource allocation.

In April 2016, FP2020 organized a regional focal point workshop for anglophone Africa, in Kampala, Uganda, which was attended by a Kenyan team led by the focal points MOH, NCPD, the Department for International Development (United Kingdom), the United States Agency for International Development

(USAID), and the United Nations Population Fund (UNFPA). During the two-day meeting, government and donor focal points; technical experts; FP2020's core convening organizations, including UNFPA and USAID; and members of FP2020's secretariat developed action plans to accelerate progress in the focus countries, emphasizing areas that are key to fulfilling FP2020 commitments. Table 1 summarizes Kenya's action plan.

Table 1. Action items from the anglophone Africa regional focal point workshop, April 2016

Action items for the secretariat and partners		
Action	Persons responsible	Timeline
Participate by phone in meeting with the Kenya National Bureau of Statistics to discuss and secure their endorsement for updating the mCPR goal.	MOH and NCPD will schedule the meeting; Jason Bremer asked to join by phone.	By May 31, 2016
Convene conference call with John Stover, Jason Bremer, et al. to discuss the modelling approach and analyses needed to revise the goal.	NCPD with Secretariat (Jason Bremer)	By June 30, 2016
Continue to support increased visibility of Track20 work and data in-country.*	Secretariat (Jason Bremer)	Ongoing
Continue to clarify the role of new FP2020 regional managers and how Kenya country focal points should engage with them.	Secretariat	Ongoing

*Track20 is a tool that Avenir Health developed for the 69 FP2020 focus countries to collect and report FP data: <http://www.track20.org/>

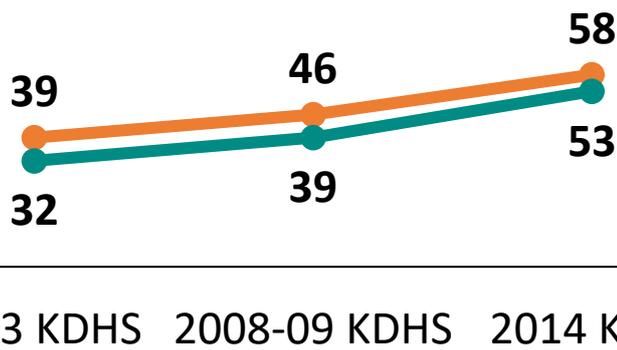
Revising the Kenya Family Planning Goal

The Need to Revise Kenya's FP Goal

Around the time of release of the 2014 KDHS, in mid-2015, development partners had perceived the need to review the FP targets for the country and counties.

Nationally aggregated KDHS data for 2003–2014 showed progressive use of contraceptives by women of reproductive age (see Figure 1).

Figure 1. Trends in the use of contraceptives among women of reproductive age* (2003–



*The figure shows the percentages of currently married women ages 15–49 using any contraceptive method and any modern contraceptive method.

However, county-specific estimates of key FP indicators were needed. As the 2010 Constitution of Kenya devolved management of the health docket to county governments, it became necessary for the national government to ensure policy support for counties to manage the county health docket, including FP.

Results of the 2014 KDHS indicated significant variances in mCPR among the counties, from 2 percent to more than 70 percent (see Figure 2).

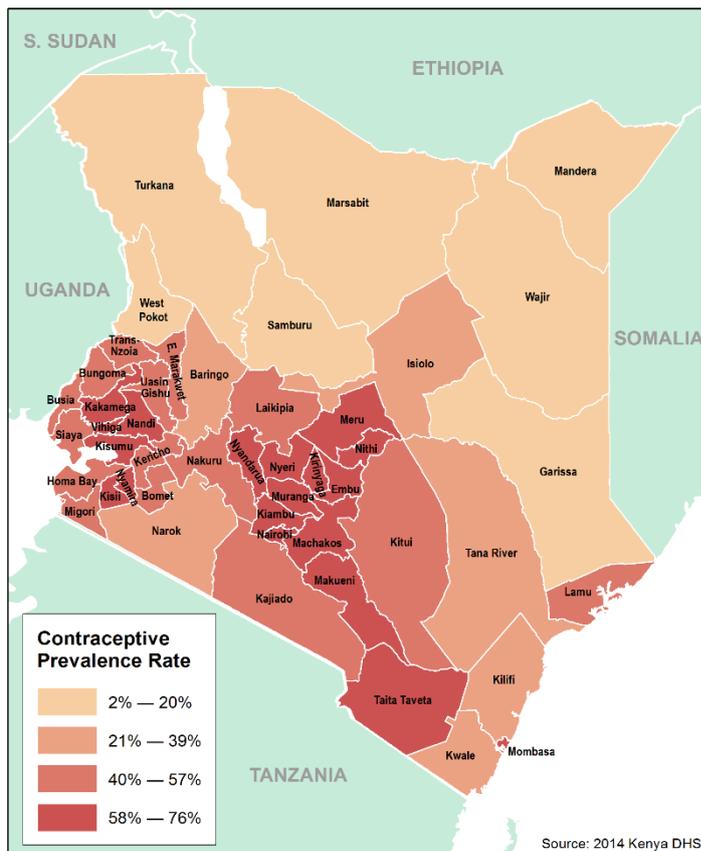


Figure 2. County differentials in the use of modern contraceptives (2014 KDHS)

Setting the Agenda and Establishing Thematic Working Groups

As the RMHSU, NCPD, and stakeholders continued to meet, they decided to create a roadmap for FP. They would work through existing thematic groups, strengthening their linkages. Where necessary, they would form new groups. These groups would report to National Family Planning Technical Working Group, which was in already in place. Their tasks were to identify pressing issues compromising FP uptake in their thematic areas (see Table 2); review data from KDHS surveys, Performance Monitoring and Accountability 2020 (PMA2020), Track20, RMHSU annual reports, and other sources to inform decisions; identify strategies to be implemented; and document their work.

Table 2. Thematic groups' tasks and composition

Thematic group	Tasks	Partners
Advocacy and Policy	<ul style="list-style-type: none"> Implement a standard approach/process to engage leaders in budgeting and planning at the national and county levels for sustainability and high-quality service delivery Provide technical assistance to the Council of Governors in policy and budgeting Implement media engagement 	NCPD, USAID, and Health Commodities and Services Management, Population Reference Bureau
FP Commodity Security	<ul style="list-style-type: none"> Apply existing terms of reference to ensure an uninterrupted supply of contraceptives to the population in need 	
Service Delivery	<ul style="list-style-type: none"> Build on past experiences and highlight successful cost-effective strategies for specific counties Ensure integration of FP in other health services Plan pre-service and in-service training of healthcare workers on skills for bilateral tubal ligation; explore task shifting Involve Kenya Obstetrical and Gynaecological Society and private facilities; ensure the quality of counseling skills, especially for pharmacists; and address the issue of inequity among the counties Identify bottlenecks to offering high-quality FP services in the public and private sectors, and provide possible solutions 	Jhpiego, Population Services Kenya
Youth and Behavior Change Communications	<ul style="list-style-type: none"> Work with youth in fragile settings such as slums, youth at risk of gender-based violence, young married girls, and uneducated youth, and develop a group of young leaders/advocates Identify public- and private-sector bottlenecks and possible solutions to offering high-quality adolescent and youth-friendly services 	Population Services Kenya, Deutsche Stiftung Weltbevölkerung, and Jhpiego
Northern Arid Lands	<ul style="list-style-type: none"> Identify bottlenecks to offering high-quality FP services in these regions, and provide socioculturally acceptable solutions Address the inequality and high unmet need in these counties Find unique approaches for the prevailing religious, gender, and nomadic-cultural circumstances to address the need for an FP voice/champion on the health of women and children and the population strain on resources 	UNFPA, Save the Children, and the African Medical and Research Foundation
Public-Private Sector Partnerships	<ul style="list-style-type: none"> Identify strategies that will improve the partnerships at all levels and reduce unmet demand among specific populations 	

Thematic group	Tasks	Partners
Measurement, Data, and Knowledge Management	<ul style="list-style-type: none"> Facilitate stakeholder review and consensus on priority indicators for Kenya (guided by the 2013–2017 Kenya Health Sector Strategic Plan, Vision 2030 targets per the Health Sector Handbook, and global commitments [e.g., FP2020 indicators]) Consolidate evidence for the national policy at the subnational level Build a core team at the national level to support the subnational levels and conduct further analysis by county (e.g., 2014 KDHS, DHIS 2 services statistics, PMA2020 surveys) Establish criteria for setting FP goals in consultation with stakeholders Document the goal-setting process 	Population Council, FHI 360, MEASURE Evaluation PIMA, Track20, PMA2020, Marie Stopes Kenya, University of Nairobi, Management Sciences for Health/Health Commodities and Services Management, and USAID Kenya/East Africa Family Health Team

The MOH RMHSU and NCPD provided leadership for the thematic groups, steering the process of developing key FP priorities and coordinating with the National Family Planning Technical Working Group.

SELECTING A MODEL

After the Measurement, Data, and Knowledge Management Group agreed to the terms of reference, the RMHSU organized meetings to draft a work plan and initiate a review followed by a goal-setting process.

Key Considerations in the Revision of Kenya's FP goal

1. **What level of growth is realistic? How much further does Kenya want to push achievements in FP goals? Is there a global benchmark measure for FP?**
2. **The 2013–2017 Kenya Health Sector Strategic Plan sets a target of 80 percent CPR by 2017. This target would essentially set Kenya at below replacement-level fertility.**
 - Demographers estimate that CPR grows by about 2 percent annually, based on historical trends. Kenya's FP2020 costed implementation plan for 2012–2016 reflects that thinking, because the target through 2015 was to increase CPR by 2 percentage points per year. Group consensus was that this amount of increase is achievable and sustainable.
 - Data from the 2014 KDHS indicate that this amount of growth was occurring at the national level between 2008 and 2014 (at least among married women), although earlier periods saw lower rates of increase (2003 through 2008–2009 saw CPR increasing at 1.13 percent per year).
 - An evaluation study by Paul Schultz in Matlab, India, demonstrated that an increase in CPR of 10 percent to 15 percent resulted in a decrease in fertility by one child (Schultz, T.P. (2001).
 - Most countries achieve a maximum CPR of between 65 percent and 70 percent. This is not necessarily equivalent to a total fertility rate (TFR) at replacement level, because methods can mainly be used for spacing.
 - However, in Kenya, it appears that the ideal family size is very close to the TFR. In such cases, the group explored the possibility of looking at the recent rate of decline in TFR and base current targets: TFR declined from 4.9 in 2003 to 3.9 in 2014 (by one child per woman in 11 years, which is a reduction of about 0.1 child per woman per year).
3. **Work with relevant institutions to determine population estimates as a basis for goal setting.**
 - Population estimates determine county revenue allocation, and therefore this needs to be approached tactfully. The group discerned a need for consensus across stakeholder constituencies (county governors, national policy and programs, and development partners) to ensure that the updated goal is understood and accepted.
4. **Build county scenarios.**
 - Looking at specific criteria for clustering counties by TFR or CPR, the group considered the option of grouping counties either by current CPR or by recent changes (percentage growth in CPR). Additional questions arose from this option:
 - o What further growth do we want to see in counties with a high mCPR (e.g., Kirinyaga, at 76%)?
 - o Should the group segment counties further, by mCPR, TFR, unmet need, or consistent supply of FP commodities?

- o What are the peculiar behaviors of population segments, especially those with low mCPR?

5. Incorporate data on contraceptive commodities.

- Data on the management of contraceptive commodities were noted to be a critical factor in setting goals; therefore, the group reviewed these data and linked FP service delivery statistics to them.

6. Consider adolescents and youth.

- Are data available for those ages 10–19?
- Registration of births is low, and thus it is difficult to determine the exact number of births to adolescents and youth. The Civil Registration Department estimates that 18 percent of births are to adolescents. The results of the PMA2020 survey in 2015 estimated the adolescent birth rate at 96 per 1,000 births (or 1 in 10 births) (PMA2020 and ICRH, 2015).

7. Consider the availability of data for goal revision.

- Kenya has a significant amount of historical data on FP, fertility, and related maternal and child health measures. KDHS provides estimates on contraceptive use, unmet need and method mix, demand for FP, and desire for more children. The 2014 KDHS would provide estimates at the county level.
- Data collected before 2003 excluded the North Eastern region and several northern districts in the Eastern and Rift Valley provinces. Modelling would need to be done to fill the gaps in data.

Modelling with Family Planning Goals and Impact Now Models

With these considerations in mind, the group’s first step was a rapid assessment of data and methods available globally for FP goal setting. Reference was made to the process, leading to the 2012 London Summit, where the FP2020 goal of “120 by 2020” was set. Developing the FP2020 goal was acknowledged to have been challenging, because of the lack of several data elements in the 69 focus countries. Kenya had better availability of current and historical data to facilitate modelling toward a new goal. The task would be to identify a “best fit” model for the present need. The team discussed whether to set one country goal from which to determine counties’ contributions or to determine county-specific goals and aggregate nationally. They agreed to start with a national goal, working downward to counties and helping them figure out how to contribute to the national goal, so the selected model needed to address that need.

The Impact Now model by Marie Stopes and Avenir Health’s Family Planning Goals model were considered at the start of the process. Both were tested, by running analyses using the requisite data inputs. Ultimately, a decision was made that neither model would be appropriate. The Family Planning Goals model was designed to set interventions rather than national goals; was evolving, and had been used only once, in Senegal; and assumed a homogenous population, which would also be a problem, given the immense variation within Kenya counties. Impact Now was dropped, because it essentially is a program management tool, without functionality for national goal setting. A recommendation was made to seek alternative models to meet the Measurement, Data, and Knowledge Management Group’s requirements.

Modelling with Spectrum

It became apparent that the best fit for setting new goals for Kenya would be Spectrum, which had been used in 2010–2011 to arrive at reductions on the TFR from 4.6 (in 2009) to a replacement-level TFR of 2.1 by 2050, and to increase life expectancy from 57 years (in 2009) to 72 years (by 2050) for the 2012 Population Policy for National Development.

Features of the Spectrum Model

Spectrum is a suite of policy models. One of them, FamPlan, suited the team’s need, because it is designed for setting realistic goals and projecting the FP requirements needed to reach national goals (Avenir Health, 2016). It can also be used to plan the expansion of services required to meet program objectives and to evaluate alternative methods of achieving goals. The system uses assumptions about the proximate determinants of fertility and the characteristics of the FP program (method mix, source mix, and discontinuation rates) to calculate the cost and the number of users and acceptors of different methods by source.

Table 3 lists the data required to effectively use the Spectrum model.

Table 3. Data requirements for modelling with Spectrum

Data element	Source
Population data Women of reproductive age Births	2015 United Nations World Population Prospects for national totals 2009 Census
mCPR and method mix	2014 KDHS
Other demographic and fertility data; total fertility, age-specific fertility rate Percentage married, ideal number of children, percentage births unwanted	2014 KDHS
Postabortion and postpartum FP	2014 KDHS—calculated from data set, regional World Health Organization/Guttmacher data on abortion and postabortion care
Public-sector facilities (total number, percentage offering FP)	DHIS 2 for counties (number reporting FP services/total number), 2010 Kenya Service Provision Assessment
Community health workers	DHIS 2
Mobile clinical outreach	Marie Stopes Kenya
Social franchise outlets	Social Franchising Compendium (includes the HealthStore Foundation, Marie Stopes Kenya's Amua Franchise, Population Services Kenya's Tunza, and Kisumu Medical and Education Trust Huduma Poa
Stockouts	PMA2020 (considering DHIS 2)

Upon agreement to use this model, however, a challenge was that Kenya did not have a Spectrum specialist at the time. USAID/Kenya and East Africa reached out to Avenir Health, the model’s designer, to obtain technical assistance, because the organization had assisted with a review in 2010 of the previous goals. John Stover, a senior analyst and modeller at Avenir Health, agreed to help the team remotely in the preparatory phase and to be present for the final steps.

RMHSU hosted the working group for a series of conference calls with Professor Stover to provide an overview of the model, establish the data requirements, and agree to a timeline and dissemination plan.

Steps and Outcome of Spectrum Modelling

The following considerations were taken into account.

Historical Growth Rates of mCPR

Establishing the historical growth rate entails assessing the annual change in mCPR over time to inform projections for the new mCPR goal. Table 4 shows that the annual change in Kenya varied, from 0.9 in 1978–1984 to 2.5 in 2008–2014.

Table 4. Historical growth rates of mCPR in Kenya, 1978–2014

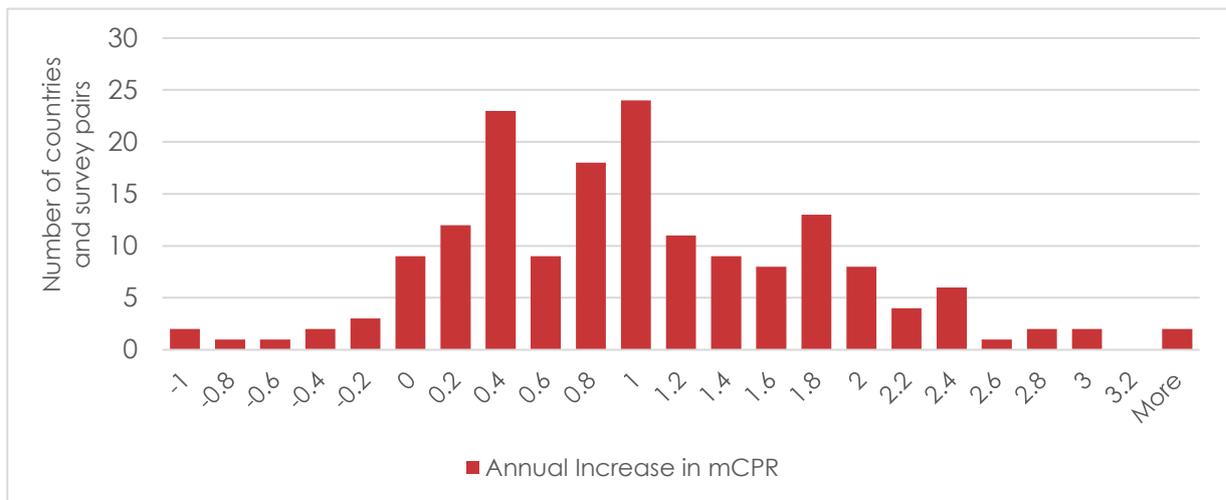
Survey period	mCPR	Annual change
1978–1984	4.4–9.7	0.9
1984–1989	9.7–17.9	1.6
1989–1993	17.9–27.3	2.4
1993–1998	27.3–31.5	0.8
1980–2003	31.5–31.5	0.0
2003–2008	31.5–39.4	1.4
2008–2014	39.4–53.2	2.5
1989–2014	17.9–53.2	1.4

Source: Kenya Fertility Survey and the Kenya Demographic and Health Surveys

mCPR Projections from the International Experience

To come up with a picture of international growth in mCPR, the team chose countries with at least two DHS surveys to generate a histogram for 170 survey pairs across 57 countries between 1989 and 2014 that met this criterion. In this example, 25 countries had a median annual growth rate of 0.8. In the case of sub-Saharan Africa, where Kenya is located, the median growth rate was 0.7. Kenya had experienced both rapid and slow growth rates, but its average exceeded the international average. At intermediate levels, growth was higher; at low and high levels, the growth rate was slower. Figure 3 illustrates this growth rate.

Figure 3. Annual change in mCPR as measured by DHS across 57 countries and 170 survey pairs conducted between 1989 and 2014

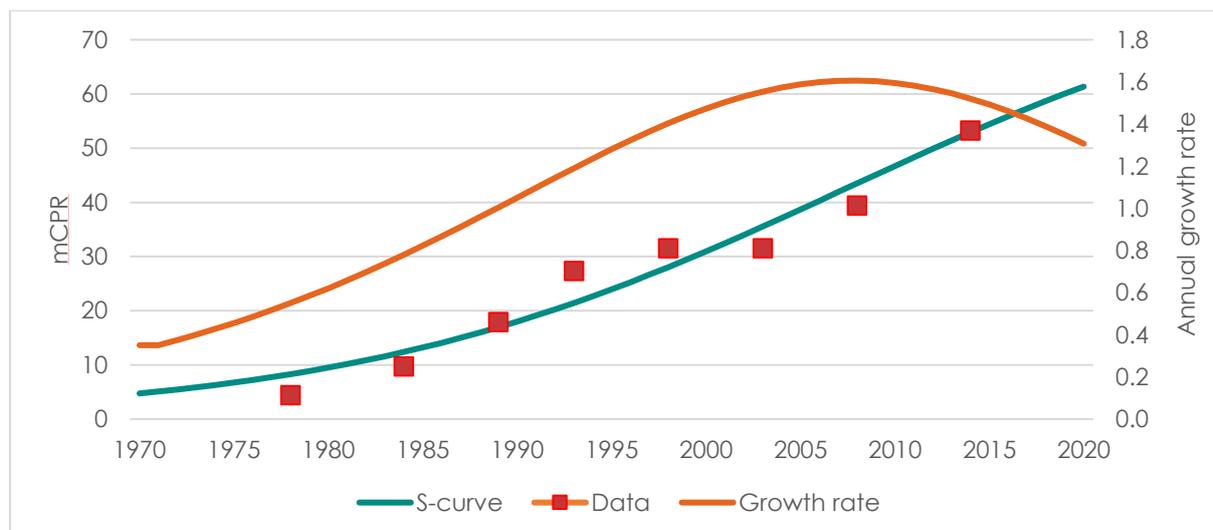


Source: Kenya Demographic and Health Surveys of 47 countries

Analysis of mCPR Projections through the Family Planning Estimation Tool

Projections for mCPR can also be made using data from surveys such as KDHS. Because most surveys are not conducted annually, annual estimates are impossible. Although statistics on services can be used to provide annual data, most such data are incomplete. The model works by fitting a curve on historical data to determine the long-term trend, which shows variations over time. In the case of Kenya, the available data indicate that Kenya has experienced a steady growth in mCPR, and the country is now entering a period where CPR is high and the growth rate is not expected to increase significantly. This approach is plausible, because it uses more sources of available data to make the projections. Figure 4 illustrates Kenya’s CPR growth rate from 1970 with projections to 2020.

Figure 4. mCPR projections for Kenya using the family planning estimation tool





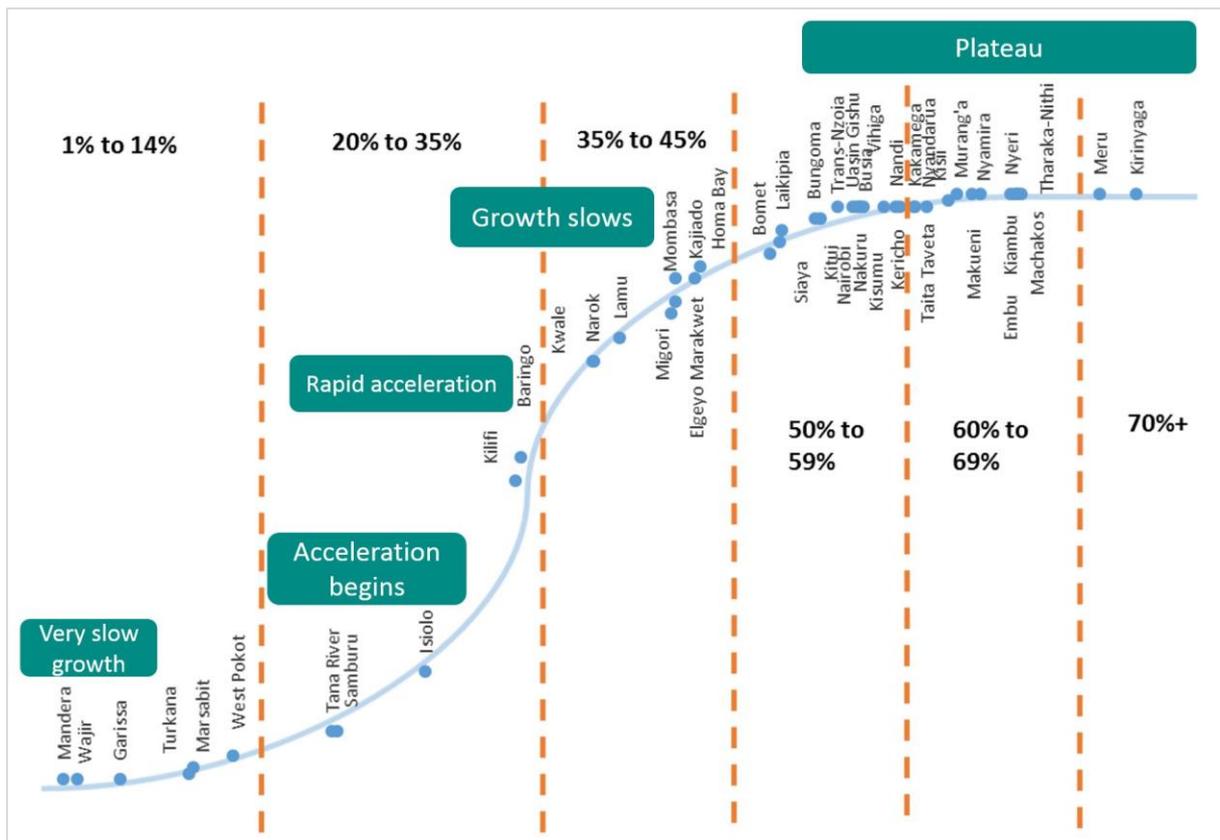
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mCPR Projections from County CPR Patterns

The 2014 KDHS showed large variations in mCPR across counties. As Figure 5 shows, when mCPR data from the counties were plotted, an S-curve distribution emerged, indicating that just a few counties were at a level where they would experience high growth rates, and others would experience low growth rates. The weighted average annual growth rate was 0.68. Because most counties were entering high CPR, using this simulation would result in a CPR of 56.9 in 2020, which means that Kenya would fall short of the current 2030 goal.

Kenya is the first of FP2020 focus countries to map mCPR for its administrative units on a chart, and utilizing it to advocate with county management to develop strategies to increase mCPR. This good practice has been shared with FP 2020 and development partners as a to be adopted by other countries.

Figure 5. Differentials in county mCPR



Source: KNBS, et al., 2015

Family Planning Goals Model

The team used the Family Planning Goals model (Track20, 2017) to determine a mix of interventions, creating scenarios that would be needed to achieve the new mCPR goal set using Spectrum. The model provides information on what must be done to achieve a desired level of mCPR. Alternatively, the model is used to determine the level of mCPR that would be achieved when interventions are scaled up to the maximum level. The model enables an in-depth understanding of the relationships among mCPR, TFR, other proximate determinants of fertility, and the volume of services required by a given FP method to reach the goals. This model can set goals for unmet need, achieving a target TFR (such as desired TFR or replacement-level TFR), achieving a target mCPR, meeting the global goal for demand satisfied by reaching 75 percent of demand satisfied with modern methods by 2030, and addressing funding constraints by estimating the funding likely to be available in the future from all sources.

Proximate Determinants of Fertility Model

The Proximate Determinants of Fertility model indicated that TFR is a function of the number of births a woman has during her lifetime if there was nothing acting to restrict her fertility versus the factors acting to restrict it, such as marriage, postpartum susceptibility, and abortion (Bongaarts & Potter, 1983). Variables are the proportion of women who are married or in union, the duration of the period after a birth when a woman cannot become pregnant again (known as postpartum insusceptibility), the total abortion rate, sterility, and the use of contraception. In the case of Kenya, the Proximate Determinants of Fertility model took into consideration data from the 2014 KDHS to arrive at the indicators shown in Table 6.

Table 5. Proximate determinants of fertility, Kenya

Proximate determinant	2014 value
Proportion married or in union	59.7%
Postpartum insusceptibility	8.6 months
Total abortion rate (estimated)	0.94
Proportion infecund	1.9%
mCPR	53.2%
Traditional CPR	4.8%
TFR	3.9
Total fecundity	23.75

Source: KNBS, et al., 2015

Summary of the Approaches to Goal Setting

The approaches to goal setting led to a consensus on goals for 2020 and 2030. It was evident that Kenya had transitioned from a TFR of 8.1 in the late 1960s to 3.9 in 2014—a clear indicator that growth in mCPR was possible with the support of many players, including the government and development partners. Kenya’s population dynamics and challenges would require unique county-specific interventions, described as follows:

- Kenya was on track to attaining the target of 58 percent mCPR by 2020.
- The country had achieved growth rates of between zero and 2.4, while the global median growth rate was between 0.7 and 0.8. Increasing mCPR for Kenya from 53.2 percent to 70 percent by 2030 would require an annual growth rate of 1.05 percentage points per year, which was above the global growth rate.
- The resulting S-curve from projections showed a rapid increase in mCPR that then levelled off.
- A 1-percentage point increase in mCPR implied about a 4 percent increase in the number of modern FP users, which would in turn require a growth rate in services of 4 percent to keep up with this rapid growth.

Based on this information, it was important to ask whether there would be a benefit to not changing the goal. The existing policy goals were 70 percent mCPR by 2030 and 75 percent by 2050. Achieving the 70 percent goal for mCPR by 2030 would mean that Kenya would reach the replacement-level fertility growth rate (2.1) by that year.

Choice of Metric

The final choice of metric was informed by the need to track indicators and to report to the global FP2020 movement. FP2020 has 17 indicators, and the additional priority indicators from the 2014 KDHS included service delivery statistics and commodity management indicators. Commodity management was a critical factor in setting targets; therefore, the link between supply and consumption remained critical. Some key questions that would inform mCPR were how to reconcile the commodities supplied to the counties versus the reported mCPR. It was also important to define indicators that were actionable at the national and county levels. To track progress on adolescent and youth-related indicators, it was important to assess the availability of data for 10- to 19-year-olds. Another challenge was the incomplete data on registration of births from facilities and at the community level. Although civil registration estimates indicated that adolescents accounted for about 18 percent of births, PMA2020 estimated that adolescents accounted for 96 of 1,000 births, which translates to 1 in 10 births.

According to international data, the median annual growth of mCPR was 0.8 percent worldwide, while sub-Saharan Africa experienced a median growth rate of 0.7 percent. Statistics indicated that at high levels of mCPR, the annual increase became much lower than in previous years. In the case of Kenya, to achieve 70 percent mCPR by 2030, the annual increase would need to be 1.04 percentage points. The available county data showed that most of the counties (28) had an mCPR of more than 50 percent; most counties with an mCPR below 50 percent had smaller populations.

Making Projections for 2020, 2030, and 2050

Because the Measurement, Data, and Knowledge Management Group established a pattern for mCPR for Kenya, classified the counties by variations in mCPR (most counties had high mCPR), and established a baseline for 2016, the next step entailed using the available data to make projections for 2020 and 2030. The projections for 2020, 2030, and 2050 were based on mCPR reported in the 2014 KDHS.

The guiding point for the development of the new goals was the high level of county mCPR (above 60%), which meant that the annual rate of increase would become much lower than in previous years. Therefore, to achieve 70 percent mCPR by 2030, the annual increase would be approximately 1.04 percentage points.

The county mCPR data informed the decision to revise the goal downward for 2030 and 2050. The modeler ran further analyses, given the reality presented by the county differentials.

RMHSU and NCPD co-hosted a meeting in September 2016 to present the revised goals. Table 7 shows the team’s consensus on new FP goals appropriate for Kenya.

Table 6. mCPR projections for Kenya in 2020, 2030, and 2050

	2015	2020	2030	2050
Current goals (Population Policy for National Development)	52 Actual 53.2+ (assuming increase since KDHS 2014)	58	70	75
Proposed new goals	N/A	58	66	70

DISSEMINATION OF THE REVISED GOALS AND NEXT STEPS

Once the new goals were determined, the question became how to disseminate them and to whom.

It was clear from the outset that the revised goals would be used for advocacy and to increase political commitment; create demand; and support of county-level planning, FP commodity forecasting and quantification, and revision of other key documents such as population and RH policies. Translating the revised goal into policy and strategy is key to invigorating progress in FP in Kenya. It will be the mandate of MOH and the Ministry of Devolution and Planning to steer revision of the National Population Policy to reflect the new goals, adoption of the goal into the Mid Term Expenditure plan 2016-19 and subsequent reflection in revised RH Policy and Strategy, County Integrated Strategic Plans and the Kenya Health Strategic Plan.

The Measurement, Data, and Knowledge Management Group would also support counties in the dissemination and use of the county-level goals, as well as define interventions to achieve the revised goals. A national team representing all of the thematic working groups would hold regional county meetings or make visits to provide technical support for dissemination of county goals and the action planning process. The national team would provide policy direction and capacity building for teams in the counties, by taking them through all of the processes involved in goal setting. The national team would also visit each county to help it arrive at the most cost-effective interventions to reach the goals. The revision of the two-year supply plan for FP commodities was proposed, as well as the need to clearly define advocacy messages for the new goals.

The thematic working groups did not engage with counties when they revised the FP goals, and methods are needed to encourage the counties' buy-in of the goals and the actions required to achieve the goals. Immediate next steps are to brief policymakers on the process and the revised FP goals, and disseminate the goals to development and implementing partners as well as county stakeholders. In addition, the revisions should be incorporated in relevant government policy documents and implementation plans.

LESSONS LEARNED

The Measurement, Data, and Knowledge Management Group faced a major challenge because it lacked expertise in the various modelling approaches, and had to seek external assistance. The group's work needs to cascade beyond the national nucleus to counties and thereby address the dearth of local expertise to conduct similar processes in the 47 counties.

County involvement in the revision of the FP goal would have been desirable. Such involvement would have substantially increased the time taken; however, the investment in building county capacity would have been a worthy investment for future exercises. In addition, county involvement would have made the goal more relevant to the county health management teams.

The ultimate intention is that with a revised FP goal, Kenya can enter another era of excellence, mobilizing the necessary resources and expertise to achieve equitable FP outcomes for the population and strengthening the systems to monitor progress.

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