A n in-depth analysis of the Kenya Service Provision Assessment (KSPA) in 1999 revealed that health workers inappropriately cited contraindications and suggested medical examinations and tests that were not necessary before prescribing contraceptives. Half the providers incorrectly identified medical diseases and 36 percent incorrectly identified breast conditions as reasons they would not prescribe the pill. Most providers were inclined to do a test or exam that was not required before prescribing the pill. More than half cited unnecessary pelvic exams.

"Lack of adequate knowledge on contraindications and which exams and tests are necessary may represent a barrier to contraceptive access," said Dr. Richard Muga, Director of the National Council for Population and Development (NCPD). "We need to ensure that women are not being excluded from receiving the family planning method of their choice because of a medical condition that is perceived as a contraindication or because she cannot afford an inappropriate examination or test."

The findings were part of a larger study that examined factors that affect the use of reproductive health care services in Kenya. Designed to help guide health sector reform, the study was conducted by the Ministry of Health and the NCPD, Ministry of Planning and National Development, with funding from USAID. The KSPA was conceptualized to monitor and evaluate the supply side of service provision that cannot be captured using the Kenya Demographic Health Survey (KDHS). The objective of the assessment is to identify the strengths and weaknesses of health care and provide appropriate recommendations.

Plans are underway to conduct the 2004 KSPA to supplement the findings of the KDHS 2003 survey. The study is expected to provide baseline indicators for evaluating and monitoring the attainment of the Millennium Development Goals (MDGs) and the Economic Recovery Strategy goals. The study will also provide baseline indicators for the proposed sector wide Health Sector Strategic Plan (2005-2010) and other projects initiated in 2004 and 2005.

Other key findings include family planning training and knowledge, antenatal care services, quality of care, and client satisfaction.

Family Planning Training
Seventy eight percent of family planning service providers received family planning as part of their training in 2003.
Welcome to the inaugural issue of Kenpop News, the population newsletter. As population issues are central to the development agenda, we expect this newsletter to serve as a market place for the exchange of information between and among stakeholders in population and development.

The launch of Kenpop News supports the utilisation of NCPD’s goal of strengthening the voice of stakeholders in seeking support for population programmes.

Through Kenpop News, NCPD provides programme implementers, researchers, policy makers, development partners and ordinary Kenyans a platform through which they can address the common challenges that affect Kenya’s general welfare and development. The newsletter aims to strengthen co-ordination, implementation and support a broad range of population activities. In addition, it will serve to prioritise and address continuing and emerging issues highlighted by all players across sectors.

NCPD appreciates and recognizes all friends and partners who continue to support this initiative. We look forward to a strengthened partnership and continued collaboration. I trust that together, we will achieve our objectives of providing the needed information and quality services to enable Kenyans to live healthy and productive lives.

From the Editorial Suite

As we mark the 10th anniversary of the ICPD conference, Kenya has made notable progress in its population policies and in addressing problems. Kenpop News has captured these and other views and perspectives from the key stakeholders and also presents views from the grassroots through the eyes of the District Population Officers. Human interest angles presented by partners add spice and a lighthearted element to otherwise serious matters.

The KDHS 2003 Highlights form the theme for this first edition. We invite you to enjoy the content as you become informed and request your feedback so that we make Kenpop News your population magazine that addresses the questions and concerns, and burning issues wherever you are.

We welcome your feedback through ncpd@skyweb.co.ke

Editors
Kenya’s Population Policies

The development of population policies in Kenya encouraged the creation of communication and advocacy programmes on population and capacity building of health workers to promote the programmes

The first population policy in Kenya was the implicit policy that began in the early fifties under the auspices of the Family Planning Association of Kenya (FPAK). FPAK provided family planning services to Europeans, Asians, and a few “informed” black Kenyans. FPAK remains the largest NGO in the population field in Kenya to date.

Since independence, Kenya has had three explicit population policies: the National Family Planning Programme of 1967; the Population Policy Guidelines of 1984; and the National Population Policy for Sustainable Development (NPPSD) of 2000.

A close examination of the nature, scope and features of these policies reveals that they follow the following sequence of events: The pre-Bucharest World Population Conference of 1974; the Mexico Population Conference of 1984; and The Post-International Population Conference for Population and Development (ICPD) Cairo conference of 1994.

The 1967 population policy laid emphasis on family planning to address population and development issues through recognition that the country’s population growth rate was outstripping the economic growth rate. The implementation of the policy was entrusted to the Ministry of Health but studies showed that its implementation left a lot to be desired due to poor infrastructure at the ministry. The subsequent population policies are advanced generics of the policy and they are implemented through a multi-sectoral and multi-dimensional approach through collaboration with NGOs, the private sector, donor partners, and communities.

Implementing and Effectiveness of Kenya’s Population Policies

Between 1967 and 1979, Kenya witnessed a dramatic increase in fertility and reduction in infant and child mortality. From 1980 to 1989 the country witnessed signs of fertility decline, with further decline documented from 1990 to 1998.

Until the provisional findings of the 2003 Kenya Demographics and Health Survey (KDHS) highlighted that some of the survey indicators, such as fertility and mortality, were reversing, Kenya had already entered a demographic transition. The fertility transition can be traced as far back as 1982. The demographic transition at this phase (1982) can be attributed to good performance in the implementation of the country’s population programme.

Policy achievement can be hinged on the adoption of the national population policy in 1967 and the subsequent reviews that address emerging issues. Some derivative policies have also been developed addressing selected thematic areas such as the youth and the elderly. Programme achievements of the population policy are: a notable decline in population growth rate; increase in life expectancy; increase in contraceptive prevalence; a decline in the ideal family size among married women; and the establishment and implementation of the District Population and Development Programme.

Challenges

Throughout the implementation of the population policies, there has been very limited involvement of men in the family planning programme. Other challenges include limited funding, duplication of roles by NGOs, inconsistent commitment to family planning by opinion leaders despite political goodwill, and regional disparities in fertility and mortality levels and family planning trends as highlighted by the 2003 KDHS.

Other notable challenges include the high level of adolescent fertility, high prevalence of sexually transmitted diseases including HIV/AIDS, diversification of the economy to accommodate an increasing labour force, and the concern on quality of reproductive health services including family planning.

Lessons learnt

Implementation of the population programme has taught policy makers several things. Policy makers learnt that population is more than a medical concern as had been perceived during the 1967 to 1980 period and it demands a multidimensional integrated approach through involvement of the public, commitment of resources, and political goodwill and commitment to support the programme. A population policy should be comprehensive and consistent and its implementation should promote development of appropriate institutional infrastructure. Another lesson is that a population policy should have precise and realistic expectations from the target publics taking into consideration demographic, social, economic, political and cultural environments.

By Michael Mbayah, Policy Division, NCPD
New ARH&D Policy

The Minister for Planning and National Development, Prof. Anyang’ Nyongo’, recently launched a policy document on Adolescent Reproductive Health and Development (ARH&D). This is the product of a lengthy participatory process that involved many organisations and people including the adolescents themselves. The policy re-asserts that young people form a critical resource for today and the core of our future development, hence their health is a worthwhile investment for future growth and development.

The policy demonstrates the progress Kenya is making towards the implementation of the 1994 International Conference on Population and Development (ICPD) Plan of Action, which made a paradigm shift towards young people and their development. The policy recognises that gender considerations are fundamental to adolescents and youth health. It highlights the role adolescents can play in promoting their own health and development. It also reaffirms the role of parents, communities, education institutions, and religious organisations in assisting young people to develop positive norms, attitudes and values.

Successful implementation of this policy will be based on strategies that include advocacy programmes, behaviour change communications, provision of reproductive health services, research, capacity building, networking among partners, and monitoring and evaluation. The implementation framework will be multisectoral, spearheaded by the Ministry of Health and the NCPD.

USAID, through the POLICY Project and the Population Council, recently funded a workshop for organisations involved in ARH&D so that they could make their contributions towards the implementation of the policy.

At the workshop, the director of NCPD, Dr. Richard Muga, said that the government was willing to borrow ideas from NGO and private sector programmes so as to successfully implement a new National Health Plan.

“NGOs and other partner organisations should step up advocacy campaigns so that the Ministry of Health can be allocated more funds by the government and donor agencies for purchase of contraceptives,” Dr. Muga added while noting the low contraceptive practice among the youth as highlighted by the 2003 KDHS.

By Mr. Karugu Ngatia, Senior Assistant Director, and head of Programmes Division, NCPD

Criteria of Youth Friendly Services

The Ministry of Health (MOH) is working on the criteria for a youth friendly health facility. Below are some of the key highlights.

The facility should be manned by staff with skills in Adolescent Reproductive Health (ARH) and oriented on ARH. The facility should also aim to attract young people seeking information by providing youth friendly services such as videos, and recreation facilities. The clinic closing and opening times must accommodate the youth.

The health facility must also be accessible, highly visible and affordable to the youth. The provider/patient ratio should be such that it reduces waiting time without rushing through the counselling sessions. The facility should also have a feedback process for collecting views from the youth on the facility.

Basic reproductive health information themes should be designed to guide the health educators during service provision. The health educators should note the important topics for the youth such as STI/HIV/AIDS, family planning, sexual abuse, nutrition, alcohol and drug abuse, abortion, pregnancy, female circumcision, early marriage, and gender issues. The facility should also provide youth friendly IEC materials. The clinic should establish a referral system for complicated cases needing specialized attention. Service providers should provide confidentiality for the youth. A record of all services provided at the facility should be well documented for reference.

In order to strengthen the RH messages and services, the facility should establish a peer education programme. Youth should be encouraged to form youth groups e.g. establish abstaining clubs. Skill training activities should be encouraged. These include computer training, areas for income generation activities, tailoring, carpentry, outdoor games and tournaments, recording of radio programmes, puppetry, drama festivals, parent education programmes and production of IEC materials.

In conclusion, the facility should have attributes that attract youth, provide comfortable and appropriate setting for them, meet the needs of young people and are able to retain youth clientele for follow up, repeat visits and provide linkages in the community and with specialized services.

By Dr. Pamela Godia, Dept. of Reproductive Health, MOH
Partners in Population and Development (Partners) is an inter-governmental alliance of 19 developing countries which are, Bangladesh, Mali, Mexico, Nigeria, Yemen, Indonesia, Jordan, Pakistan and Thailand. Others are Kenya, Tunisia, China, Colombia, India, Uganda, Egypt, the Gambia and Zimbabwe. The alliance was established during the International Conference on Population and Development (ICPD) held in Cairo in 1994.

The main role of Partners is to expand and improve South-South collaboration in the field of Family Planning and Reproductive Health (RH) and also to strengthen institutional capacity to member countries to undertake south-south exchange activities.

The key issues addressed by the coalition are: the appropriate integration of reproductive health programmes into family planning initiatives; ensuring adequate allocation of resources for securing availability of essential RH services and products; addressing adolescent sexual and reproductive health; significantly slashing maternal morbidity and mortality to ensure safe motherhood; and effective prevention and treatment of STIs and HIV/AIDS.

The partnership has had several achievements. South to South documentation tools and methodologies have been devised and through these fifteen successful outcomes of interventions in RH in Africa have been documented for sharing experiences. A database of South to South Experts (SSEPs) and South to South Technical Advisory Services (STAS) consultants have been established and are continually updated on the Partners website.

In 2003, China signed agreements with Egypt and Kenya for policy level exchange visits and trading of condoms. The Chinese through the State Family Planning of China donated contraceptives and medical equipment to Kenya in the spirit of South to South collaboration.

Kenya, Uganda and Tanzania merged efforts in designing and implementing Reproductive Health programs since 1997 when they established the East African Reproductive Health Network (EARHN).

Way Forward

As a way forward Kenya needs to identify capacities which must be strengthened so that it is able to be effectively involved in South-South collaboration in the area of Reproductive Health, Family Planning and HIV/AIDS. One way to achieve this is to establish training facilities or training courses for people from other countries who wish to learn the relevant skills available within the country, documentation and dissemination of best practices, replication of good practices and up-scaling of quality Reproductive programs.

Kenya should also promote and facilitate South to South Collaboration as an alternative approach to sustainable development. It should also seek to demonstrate that South to South exchange is cost-effective, efficient and sustainable.

The South to South collaboration has yielded numerous benefits. Lead actors gain invaluable skills, knowledge and experience through the systematic transfer of their top experts across diverse regions and cultures. Through the sharing, countries forego the need for the costly process of trial and error. Evidence strongly suggests that South to South collaborations have yielded gains that far outweigh resources invested into the initiative. This proves the overall cost-effective nature of this broad collaborative effort. This is despite the myriad of challenges such as multiple languages, high taxation, lack of universal access to technology, co-ordination of experts and pressure from arduous commitments.

By Charles Oisebe, Partners Country Coordinator, Kenya
Successful use of Media to Advocate for Behaviour Change

The media is often faulted for its negativity - breach of personal rights - but the fact is that media can be harnessed to help bring about change in society.

The general role of the mass media is to inform, entertain, educate the public and advocate for change in society. Investigative journalism can expose ills in society, and explore options for behaviour change.

As a media training institution, the Kenya Institute of Mass Communication (KIMC) adopted a multi-media approach to initiate the Population Education Promotion Project (PEPP). The project was started with technical assistance from the Japanese International Co-operation (JICA) and through various media such as flannel graphs, folk media festivals, video shows and print materials, the programme advocated for behaviour change, and use of health care facilities in its target areas.

Several successes attributed to PEPP educational activities in the model areas were documented.

In Vihiga district, the number of women who gave birth at home but with the assistance of Traditional Birth Attendants (TBAs) rose significantly between 1992 and 1998. At the time, this was a good indicator. The rise was attributed to the combined effect of capacity building of TBAs through seminars at health centres, micro teaching classes for women and empowerment of TBAs through support of their activities.

The number of children immunized with the BCG and OPVI vaccines within two weeks after birth increased. A study done in Enzaro Jiko village found that there was a drop in infant mortality which was attributed to the increase in uptake of immunization services.

Health centre staff in Enzaro Jiko observed a decrease in intestinal parasite patients. The same area also had no deaths reported due to cholera in February and March 1998, while 58 people died from cholera in the neighbouring Jepkoyai locality. This was due to the construction of Enziro Jiko’s protected spring water sources, a public health campaign in schools and a change in people’s behaviour on their sourcing of water and how they process and store their water.

The project also helped improve the health status, family planning practice and fertility trends within the communities where it was initiated. This was possible because all the materials produced were based on the results of a needs assessment carried out in the model districts.

Uptake of health services in the model communities significantly went up due to improvement in health and family planning service delivery, the behaviour change communication activities carried out through various media and promotion of community development.

The main lesson from the initiative was that for the success of such a programme it is important to get cooperation from the community, effectively sell the idea of sacrifice and commitment and appreciate that media can play an important role to this end.

By Godfrey Kareithi, KIMC

Tips for working with the Media

It is rare that media reports or radio talk shows result in the changing of social behaviour of an entire community. They rather stimulate the discussion of issues that will eventually result in the change of behaviour, such as an increase in condom use, or attendance at VCT centres. Kenyan radio programmes, if presented professionally, work tremendously well in spreading health messages, particularly those that relate to sexual health.

There are three important points to remember when producing programmes:

1. You have to broadcast the issues you are addressing on a programme with the right listeners.

Issues about adolescent reproductive health have to be broadcast on programmes with adolescent listeners, by Godfrey Kareithi, KIMC.

Cont’d on Pg. 7

Kenya’s Minister for Information, Hon. Raphael Tuju browses the Web as the USAID Country Director Dr. Kier Toh looks on during the opening of the Internews Media Resource Centre
It was memorable and surprising to many people when the TV advertisement starring President Mwai Kibaki championing the campaign for behaviour change in regards to HIV/AIDS was first aired on our TV screens. This was the beginning of the Pamoja Tuangamize Ukimwi National HIV/AIDS communication campaign.

The launch marked a turn in the history of behaviour change communication campaigns in Kenya. The unique design and utilisation of key opinion leaders in a social marketing campaign opened a new frontier for influencing behaviour in a simple but convincing manner. A comprehensive planning period in which communication needs, information gaps, and communication channels were identified preceded the campaign.

This was the first phase of the national campaign. It lasted ten weeks on the main media while communication resources continue to be distributed in the country to support community activities in the war against HIV and AIDS.

A phase two campaign will be developed after the National AIDS Control Council (NACC) evaluates the impact of the phase one campaign. The phase two campaign is expected to set the programme agenda for more targeted interventions and will aim to strengthen existing partnership between NACC and organisations implementing behaviour change communication interventions.

Working with the Media from Pg. 6

who will be interested in listening to such issues. For instance: If you would like to broadcast or sponsor a programme on condom use for adolescents, you would have to choose a youth station for this.

You would also have to choose an appropriate time for your programme to be broadcast and do a lot of research before you decide on a programme. For instance:

You would have to choose a time that teenagers could listen to the radio. Choosing a time between 8am and 3pm, when they’re at school would defy your purpose.

2. You have to understand what format works for a specific programme.

The content and format of a programme are directly related to its impact. Merely having had all the issues that you believe are important to mention on air does not mean that your programme will have ANY impact. You have to make sure that those facts are presented in such a way that an adolescent will understand them. For example: If you talk about ways to prevent HIV infection, you have to have an appropriate person to demonstrate this. Only having an expert in the studio, will not work. You’ll need an HIV-positive teenager as well. The teenager’s experience is what adolescents will relate to.

An expert must be aware that technical language and NGO terms such as sero-conversion, ARV or OVC are not understood by journalists or adolescents. If you talk in such terms, your story will not have an impact.

3. You have to understand what journalism training and organising press conferences involve.

Training workshops: NGO workshops that provide journalists with information on desired issues, RARELY WORK. In Kenya, the journalists’ biggest problem is that they do not have the skills to use this information. They need journalistic skills that equip them to use the information you have shared with them. The information alone does not help. They need scriptwriting and interviewing skills.

Press Conferences: It is important that NGO’s understand what is newsworthy and what is not. NGO’s often get upset because journalists don’t attend media conferences or that their stories don’t get broadcast or published. Mostly, this is as a result of a poor understanding of newsworthiness. Many NGO’s think the opening of an office, a workshop, or the launch of a new project is in itself newsworthy. IT’S NOT! You have to find a news angle that will attract journalists. If your project or workshop is for instance about OVC issues, find an angle such as the discrimination against HIV-positive children in school to present to journalists.

Mia Molan is the Resident Advisor of Internews Network. Internews is funded by USAID and trains and supports Kenyan radio journalist in HIV/AIDS reporting. mia@internews.org
Kenya’s Statistics


Growth rate. Increased from 3.3 % in the 1948 - 1962 period to 3.9% in the 1966 -1979 and declined to 2.8% during the 1989 - 1999 period.

Rural / Urban Distribution. In the 1999 census, 23,300,100 people reported to be residing in rural Kenya and 5,361,000 in urban areas with Nairobi having a population of over two million. The Rift Valley had the highest population of 6,982,000 while North Eastern had the lowest of 962,000.

Most densely populated Province. Is Western Province with 456 persons per sq. kilometre while the least densely populated province is North Eastern with eight persons per sq. kilometre.

Life expectancy at birth. Has declined from 58 years to 54 years for males during the years preceding 1999 period and 61 years to 57 years for females during the same period. The highest life expectancy at birth was recorded in Central Province at 60 years for males and 68 years for females while Nyanza province recorded the lowest at 42 years for males and 48 years for females.

Adolescent childbearing. Is rampant yet the risk of dying at this age is four times higher than women older than 20 years. Adolescents account for 12% of births in Kenya. Across the provinces; Nyanza recorded the highest of 15% while North Eastern had the lowest of 8% adolescent births.

The primary school enrolment ratio for Kenya is 103 males to 99.8 females. The difference in ratios is more pronounced in Nyanza province with 121 males to 115 females.

Population living below poverty line. Increased due to poor economic performance from 52% in 1997 to 56% in 2002 with the proportion of the economically productive population being only 28% and dependency ratio of 113 per 1000 in the year 2000.

The Working woman. Sixty one percent (61%) of the total women who work are not paid compared to 39% of their male counterparts. This trend is recorded in all the provinces.

By Vane Lumumba, Research Division, NCPD

Knowledge of FP Services

Contd from pg. 1

basic medical training, while only 55 percent received in-service training. In a sign of dramatic improvement over the last decade, nearly all of the health care workers (96 percent) who graduated from basic training in 1995 or later, covered family planning as part of the training, compared to only 62 percent in 1990.

Family planning knowledge

On average, health workers providing family planning services asked four out of 11 standard questions considered essential for a new family planning client. Over half of providers failed to inform the client about multiple methods, one-third did not explain how to use the contraceptive prescribed and 28 percent did not mention the side effects.

In the 2003 Kenya Demographic and Health Survey (KDHS), the Contraceptive Prevalence Rate (CPR) remained constant at 39 percent of married women who were using any method of family planning. This plateau is in sharp contrast with previous trends since the early 1980s when a steady increase in family planning use among married women had been documented (see highlights of KDHS 2003 pp. ii-iii).

In his presentation of the KDHS 2003 findings, the Minister for Planning Hon. Prof. Anyang’ Nyongo’ said that the stagnating CPR could be attributed to contraceptive stock-outs in the previous years leading to drop-out by users. In addition, funding initially targeting family planning programmes may have been diverted to fighting HIV/AIDS. It is therefore important to look at the cost, availability, and the system for delivery of family planning services. The KSPA survey is expected to shed more light on this scenario.

Antenatal Care (ANC) services

Use of antenatal care is high, but not timely or frequent. Ninety two percent of the women used ANC services at least once during pregnancy. However, according to the MOH guidelines, women should visit ANC clinics in the first trimester of pregnancy, and thereafter – four or more times. Early and timely visits promote essential screening of high-risk mothers and emergency preparedness. The study revealed that only 14 percent of women visit in the first trimester and only six in ten women attend ANC services four or more times as is recommended.

Women receiving antenatal care from a health professional rose from 78 percent in 1989 to 95 percent in 1993, then dropped to 90 percent in 2003. In addition, the proportion of women who seek medical assistance during delivery declined from 50 percent in 1993 to 42 percent in 2003.

Availability and quality of service

Basic essential obstetric care (BEOC) should be available at all health facilities that provide delivery services. Of the sampled maternal health facilities providing delivery services, over half (55 percent) did not provide all the elements of basic obstetric care services. While delivery sets (equipment) were available in 80 percent of these facilities, only 62 percent of the delivery sets were complete.

Client Satisfaction

More than half of ANC service clients interviewed (57 percent) expressed a high level of satisfaction in general. However, only 24 percent believed that they were treated “very well.” Women who were older, over 25 years of age, more educated, and from a high social economic status were more likely to have a high client satisfaction with services. Lower levels of client satisfaction were found in the Coast Province, 42 percent; Eastern Province at 38 percent, and Nyanza, 19 percent. Ninety four percent of clients responded positively that the health workers were easy to understand, about 80 percent felt the information would be kept confidential, and about three-quarters were satisfied that the waiting time was reasonable.

By Dr. Paul Kizito, Senior Assistant Director
Policy Division, NCPD and Mr. George Kichamu,
Senior Assistant Director, IEC Division NCPD

contd from pg. 1
The Department of Reproductive Health (DRH) of the Ministry of Health provides most of the reproductive health services in Kenya. Dr. Josephine Kibaru, head of DRH, gives some useful insights on implications of the KDHS findings in Kenya.

Q. What should be our main source of concern from the KDHS 2003 findings?
A. Most of the indices have fallen. There is a rise in the Total Fertility Rate (TFR) and mothers are not using the delivery services that are in place. Many resources have been used over the years to provide these services but we still have these negative indices. There is need to go to the communities and find out why mothers are not using these facilities.

What is the MOH/DRH doing to ensure contraceptive availability and minimise stock outs?
The main reason for stock outs is donor dependability. Donors procure most of the contraceptives used by Kenyans. The government is trying to improve donor co-ordination in many ways, one of which was the development of the ‘Contraceptive Commodities Procurement Plan 2003-2006’ to help the Government plan in advance to meet this challenge.

The MOH is lobbying the Government for increased funding for contraceptive procurement. If the MOH has the funds, it can procure the contraceptives locally in case of a stock out. The MOH would like the District Health Management Team (DHMT) to give contraceptive distribution the same priority they give to vaccines and essential medicines.

Has the government identified sources of increased budgetary allocation to meet the rising need for family planning services?
The Abuja Declaration recommended that government should allocate 15 percent of its total revenue to the MOH. Currently, the government gives around 9 percent. The MOH is thus lobbying for increased budgetary allocation.

What kind of support would you hope for from donors and NGOs to meet the health needs of our country?
Donors need to invest in personnel training as part of helping us meet Kenya’s health needs. Donors also need to support NGO projects through the country’s health budget so that the effect of the projects can be felt countrywide or can easily be accessed for national up scaling in future. NGO funding should be through the budget so that they can respond to the country’s health priorities and they can help support the Government strategies.

For the first time the KDHS covered the Northern frontier Districts. What policies will the Government develop to ensure that people in these regions have equal access to health services?
The northern frontier receives the same budgetary allocation as any other districts or provinces in Kenya. But due to the nomadic lifestyle of people in that part of the country, static health points do not work. The only way to meet their health needs is through use of outreach services. The Government could support the outreach services currently provided by NGOs in the region so as to meet this challenge.

So as to deliver services to the region effectively, the MOH also needs to build on community partnerships. The residents are very conservative hence there is a need to find out what is acceptable to them before embarking on projects in the area. Many mothers and babies die during delivery due to the use of Traditional Birth Attendants (TBAs) and when an emergency occurs, mothers cannot be taken to the health centre on time because it is far away and transport is also a hassle.

Adolescents form an important component of the population. How do you propose to serve their special needs?
The DRH is also working on developing guidelines for youth friendly services and together with the NCPD and partners in reproductive health look forward to implementing activities in ARH&D soon.

Key indicators from KDHS 2003

- Condom use in Kenya is still low. Men are more likely (17%) than women (5%) to use a condom during sexual encounters.
- HIV/AIDS prevalence in Kenya is 6.7%. Women were more likely (9%) than men (5%) to be HIV positive.
- Level of education proved to be a factor in uptake of health services.
- Mosquito net use is low in the general population (14%).
- Under five mortality increased from 96 per 1000 (1993), 65 per 1000 (1998) to 114 per 1000 (2003) live births. This implies that one in every nine children in Kenya died before their fifth birthday.
- Vaccination coverage declined from 79% (1993), 65% (1998) to 52% (2003) KDHS.
- Female Circumcision. Thirty four percent of women in Kenya are circumcised (Somali 97%, Kisi 96% and Maasai 94%).
- Total Fertility Rate (TFR), number of children per woman, went up slightly from 4.7 in 1998 to 4.9 in 2003.
- Gender Violence data was collected for the first time. Forty four percent of married/divorced or separated women aged 15 to 49 had been either physically or sexually abused by their partner.
- HIV Status is not known by many Kenyans. Only 13% of Kenyan women and 14% men know their HIV status.
- Medically assisted delivery has fallen from 50% births in 1989 to 42% in 2003 KDHS.
Key Findings of the KDHS 2003 Survey

By George Kichamu

The Central Bureau of Statistics (CBS) together with other stakeholders carried out the 2003 Kenya Demographic and Health Survey (KDHS) from mid-April to mid-September 2003 using a national representative sample of almost 9,000 households. All women aged between 15–49 years and all men 15–54 years in a sub-sample of one-half of the households were eligible to be individually interviewed.

“Most of the indicators in the health sector have continued to deteriorate implying that all stakeholders in the sector should re-evaluate their programmes.”

The KDHS survey provides up to date data on child survival, contraceptive use, maternal care, child mortality and other key health topics. HIV/AIDS and gender violence were new components in the 2003 KDHS that also covered North Eastern Province for the first time.

The KDHS findings provide useful insight for policy makers and programme managers as the survey evaluates programmes, measures their effects and improves the design of health programmes. It assists policy makers develop strategies for efficient provision of Reproductive Health and Family Planning services in Kenya. The DHS surveys are continually improved to address questions policy makers and programme managers ask and offer important guidance for future provision and access to health care. In this article, we examine the preliminary findings of the 2003 KDHS, the final report of the findings will be ready for dissemination and distribution by June 2004.

HIV/AIDS

HIV/AIDS is one of the most serious public health challenges facing Kenya today. The 2003 KDHS for the first time included a survey on knowledge and prevalence of HIV/AIDS. Awareness of HIV/AIDS was high with 86 percent of women and 92 percent of men surveyed believing that there is a way to avoid the virus causing HIV/AIDS. Nairobi province had the highest awareness that HIV/AIDS can be prevented at 94 percent, while North Eastern province had the lowest with only 30 percent of women and 44 percent of men believing that AIDS can be avoided.

HIV/AIDS Prevalence in Kenya is now estimated at 6.7 percent among men and women aged 15 to 49 years. The survey found that 4.5 percent of the men tested were HIV positive compared to 8.7 percent of the women tested. The proportion of HIV positive persons was found to be lowest in the 15 to 19 age groups at 2 percent and highest in the 35 to 39 years age group at 10 percent for both sexes.

The survey found that only 13 percent of the respondents has ever been tested and know their HIV status. Thirteen percent of women and 14 percent of men are presumed to know their HIV status or at least knew it at a certain point.

Fertility

Fertility data was collected by asking every woman in the survey for a history of her births. In the period 1989 to 1998**, Kenya experienced a 30 percent decline in total fertility rate (TFR) from 6.7 children per woman in 1989 to 4.7 children per woman in 1998**. However, the 2003 KDHS showed a slight increase in TFR to 4.9 children per woman. The apparent increase may be attributed to the constant proportion of women using contraceptives in the period 1998 to 2003**. The TFR in rural areas (5.6 births) is higher than in urban areas (3.3 births).

Family Planning

Female respondents were asked to mention methods of family planning by which a couple can delay pregnancy and whether the lady had ever used it. The Contraceptive Prevalence Rate (CPR) plateaued at 39 percent of married women who were using any method of family planning. The plateau is in sharp contrast with previous trends since the early 1980s when a steady increase in family planning use among married women had been documented. Modern methods (31 percent) are more commonly used than traditional methods (8 percent).

Urban women (47 percent) are more likely than rural women (36 percent) to use contraceptives. Contraceptive use also increases dramatically with the level of education. More than three quarters of women with higher education are more likely to use any method compared to just over half of the women with incomplete secondary education and only 12 percent of those who never attended school. Married women

Contraceptive Use Among Currently Married Women, Kenya 1978-2003 (excluding northern districts)

![Contraceptive Use Among Currently Married Women, Kenya 1978-2003](image)
A drop in most of the indices is linked to the rise in poverty

in Central province have the highest contraceptive prevalence rate (67 percent), followed by Nairobi (52 percent). The lowest level of family planning use is in North Eastern province with less than one percent.

Fertility Preferences

Women were asked questions about whether and when they would like to have another child. Twenty-nine percent of all the currently married women would like to wait for two or more years before the next birth while 48 percent do not want to have another child or are sterilised. The vast majority of currently married women without a child (79 percent) would like to have a child soon. Women show greater interest in controlling their births once they have a child. The proportion of women wanting no more children or are sterilised rises from 9 percent among women with one living child to 79 percent of women with six or more living children.

Maternity Care

Mothers who had given birth in the five years preceding the survey were asked a number of questions about maternity and child health care. Mothers were asked whether they received antenatal care during pregnancy, and whether they received tetanus toxoid injections and/or iron supplements while pregnant.

Almost nine in ten mothers reported seeing a health professional at least once for antenatal care for their most recent birth. Coverage is slightly higher in urban areas than rural areas (93 percent and 87 percent respectively) and the proportion is lower in North Eastern province (25 percent) compared with a range of 87 to 95 percent in all the other provinces. Data showed that 67 percent of women with no education received antenatal care from a health professional compared to 88 percent of women with primary education and 99 percent of women with higher education.

Antenatal care from a health professional rose between 1989 (78 percent) and 1993** (95 percent) KDHS and then experienced a decline thereafter (92 percent in 1998 and 90 percent in 2003**). In addition, the proportion of women who seek medical assistance during delivery declined from 50 percent in 1993 to 42 percent in 2003**. More mothers and babies are at risk of dying during childbirth due to this drop in use of medical assistance during delivery.

Child Health and Nutrition

In the last decade, infant mortality rate has risen by 26 percent from 62 per 1000 live births in 1993 to 78 in 2003**. Under 5 mortality rose by 19 percent from 96 per 1000 live births in 1993 to 114 per 1000 in 2003**.

The increase in childhood mortality rates depicts deterioration in quality of life in the last decade. It may also be due to declining immunization rates of children under five years. The 2003 KDHS indicated that only 52 percent of children aged 12 to 23 months are fully immunized. This is a significant decline from 65 percent in 1998 and 79 percent in 1993**. This implies that more children are at risk of dying from preventable diseases like measles, polio, and tuberculosis.

Ownership and use of Insecticide Treated Mosquito Nets

Data was collected on the ownership and use of mosquito nets per household. Questions were also asked on the treatment of the nets with insecticides. More than 20 percent of the households reported at least one mosquito net but only 6 percent of these households have an insecticide treated net. Ownership and use of mosquito nets is highest in malaria endemic areas of Nairobi (37 percent), Coast (33 percent), Nyanza (31 percent) and Western provinces (19 percent).

Domestic Violence

For the first time, the 2003 KDHS surveyed the extent of gender violence. The results showed that 44 percent of women have ever been physically or sexually violated by their husbands or partners, while 29 percent of women indicated that they were victims of physical and sexual violence one year preceding the survey. Rural women were more likely to be victims of violence than their urban counterparts. In addition, women from Western (67 percent) and Nyanza (56 percent) provinces appear to have a higher risk of violence than women in other provinces.

Female Circumcision

“...There is need to have more programmes and policies that would reduce the incidence of domestic violence and female genital cutting (FGC) in the society.” Hon. Anyang’ Nyongo’

The data shows that 34 percent of women in Kenya are circumcised, which is a decline from 38 percent in the 1998 KDHS**. The percentage of women circumcised varies with age. Older women and those in rural areas are more likely to be circumcised than younger women and those living in urban areas.

Genital cutting is highest in North Eastern province (99 percent) and least in Western province (5 percent). The Somali (97 percent), Kisii (96 percent) and Maasai (94 percent) ethnic groups reported the highest rate of female circumcision while the Luo (0.7 percent) and the Luhyia (0.9 percent) had the lowest. The survey also revealed that the majority of Muslim women (54 percent) are circumcised compared to about one-third or more of the non-Muslim women.

**So as to make the data comparable, the percentage in most instances excludes data for the northern districts, which were surveyed for the first time in the 2003 KDHS.
A Three Point Turn by David Kinyua

The Kenya Demographic and Health Survey (KDHS 2003) confirmed fears within the population and reproductive health community that most of the key indicators had actually reversed. For a country that had earned international praise for achieving a low total fertility rate (TFR) of 4.7 percent in 1999 from a high of 8 percent a decade earlier to record a TFR of 5.0 percent is a reason for much concern. Fortunately, these concerns are being addressed.

Kenya was the first sub-Saharan African country to adopt an official national family planning policy. The main objective of the policy was to reduce the population growth rate, which was considered to be too high for the achievement of the country’s development objectives. Substantial achievements were made in policy and programme implementation over the years, especially in the campaigns to encourage Kenyans to adhere to a small family norm. This explains the decline in family size, TFR and subsequently reduction in birth rate. Now that this trend is reversing, there is need for urgent action. Is a three-point-turn in our strategies possible?

The first point is to ask ourselves how we treat population dynamics in development planning? We have merely been breaking down the population structure with little effort to highlight and address the challenges of population on the overall development in the country. Our first turn then will be to advocate for our planners to appreciate that changes in population and health programme. For instance, we can advocate for increased contraceptive uptake using participatory methods while providing factual information. We shall inform families, educate schools, and ask peers to educate each other and enlist religious organizations in our campaigns. We could train youth, men and women on life skills and, when possible, provide-friendly reproductive health services.

For the third turn – Communication - we will examine the cumulative, rather than discrete effects of communication. We shall be asking, for example; “If you are not aware, why don’t you know; and if you know, why don’t you act on the basis of that knowledge?” A full understanding of the underlying determinants of behaviour, is the basis of relevant messages and programmes aimed at influencing change.

Let us get started now!
At the International Conference on Population and Development (ICPD) held in Cairo in 1994, Kenya was among 179 countries that committed to advance reproductive health services and women’s rights and to make basic reproductive health services available to all by 2015. In 1999, Kenya was again among countries that ratified the Millennium Development Goals (MDGs) that committed the international community to an ambitious goal that would see the world reduce the number of persons living in absolute poverty by half by 2015. To do this, world leaders set specific targets for life expectancy, education, housing, gender equality, openness of trade, and environmental protection.

The five-year review of the implementation of the ICPD Programme of Action (PoA) in 1999 showed that progress was being made. Policies had been developed in most countries to address highlighted issues and governments were pushing the RH agenda. There is now a critical shift in focus in population policies and programmes from a primary concern towards achieving a country’s demographic targets through family planning programmes to an emphasis in improving the quality of life through promotion of human rights and provision of sexual and reproductive health services.

The review also revealed that much greater action was still needed in certain areas and by consensus it was adopted by the general assembly. The Key Actions validated the comprehensive approach to population and development articulated in the Programme of Action, affirmed the ICPD goals, and provided a set of benchmarks for achieving them.

The ICPD Programme of Action calls for increased access to healthcare for women

United Nations Population Fund (UNPFA) together with governments have conducted a survey of achievements made so far towards achieving this goals. Several activities are planned for 2004 to review implementation of the ICPD PoA.

UNFPA has conducted a field inquiry on national experiences among all countries and a report will be released during the annual session of the UNDP/UNFPA executive board on June 21 2004. The emphasis is on lessons learnt and on exchange of experiences at the regional level. Countries can identify how they can assist each other in a south-south co-operative spirit.

At the Global Round Table, the coalition will launch a report card and supplementary materials aimed at assessing country performance and ICPD commitments. The Round Table programme will have a strong emphasis on assessing the progress made toward achievement of ICPD and to help determine what action is needed to realize the goals by 2015.
The District Population Office was established to help the NCPD headquarters co-ordinate population and reproductive health activities at the district level. A District Population Officer (DPO) represents the NCPD at district meetings and contributes to issues related to population and reproductive health. The DPO also reports on ongoing activities and accomplishments to the headquarters.

An important task DPOs undertake is the dissemination of information on population and reproductive health to district stakeholders. The DPO is also a member of the District Development Committee (DDC) and makes contributions and recommendations during the preparation of district development and other strategic plans for the district. As feedback from DPO's provides important evidence-based information for the NCPD policy and monitoring and evaluation process, Kenpop News will be highlighting population issues from the DPO's.

Kakamega with Peter Nyakwara

Several organisations are currently implementing youth sexual reproductive health activities in Kakamega district and western province as a whole. The most notable are PATH-Kenya, the MOH/GTZ reproductive health programme, Uzima Foundation, Family Planning Association of Kenya (FPAK), World of youth and children, and the Kabras jua kali association among others. With the formulation of the ARH&D policy, many more organisations are likely to initiate programmes targeting young people and those undertaking youth related activities will refocus their activities in line with the policy and emerging issues.

Kisii and Gucha with Stephen Ndili

Nyanza province as a whole has a major problem with malaria. Several malaria control activities have been undertaken to deal with this. In Kisii and Gucha districts, Merlin, a local NGO, has been supporting malaria control activities since 1999. Merlin has helped in capacity building of health workers and health centres in the district to deal with malaria more effectively and has also helped the Ministry of Health, Ministry of Education and NCPD in training shopkeepers, teachers and pupils on malaria. Through cost sharing, Merlin has managed to make the project self-sustaining.

Kirinyaga with Peter Reriani

The poor performance of the coffee sector in recent years is one of the major reasons for the rise in poverty in Kirinyaga district. Poverty is visible in the lack of land for farming, poor housing, unemployment, lack of money to pay school fees and medical bills and, lastly, most people cannot afford a daily meal.

Domestic conflicts and drunkenness are the major social problems brought about by poverty. Land is the main bone of contention. In coffee farming areas, the issue of progressive sub-division has reduced land size to uneconomical small sizes. In the marginal area of Mwea division, farmers at the extensive rice scheme believe they can make better use of their land if they were allocated title deeds for the land they occupy.

Marketing of produce is a problem for both coffee and rice farmers. Coffee farmers blame their poverty on non-payment for their produce. Rice farmers have large stocks of unsold rice, while the government allows for importation of rice.

Kisumu with Alex Juma

Preliminary results of the Kenya Demographic and Health Survey 2003 rank Nyanza province as one of the leading Provinces in incidences of violence against women. Against this scenario, a number of programmes have been launched with the ultimate goal of reducing or eliminating all forms of violence in the community. Some of these include the dissemination of the Children’s Act and Gender Sensitisation at all levels and sectors.

Fida Kenya, with support from the 5th UNFPA Country Programme, has launched an in-school programme to deal with this practice. The objectives of the programme are to promote gender sensitisation in schools; identify traditional practices that affect child development; and to develop an Action Plan to deal with these harmful practices. The programme has helped increase the enrolment and school retention rate of the girl child in the district and has also led to the improvement in education performance of the girl child in National examinations. Peer education has also been introduced in some secondary schools while guidance and counselling has successfully been integrated in many schools to deal with cases of indiscipline, thus replacing corporal punishment.

Siaya and Bondo Districts with Samo Otieno

School attendance in Siaya and Bondo Districts is very low. The school drop out rate in both primary and secondary schools is very high. Poverty is the main reason for drop out from secondary schools since most students are not able to raise money for school fees and many girls drop out of school due to pregnancy. This has led to a high illiteracy level, which is visible in the reduced lateral development, increased insecurity, and a reduced participation in population development activities.
Three Young Girls Search for Love

By Catherine Ndii, DPO Mombasa

The heart rending true story of three sisters, Lena, Sarah, and Shauri (not their real names) who were brought up in love and respect comes to mind when I think of the suffering children encounter at the hands of adults. These three girls knew no violence until their parents died of HIV/AIDS.

Lena, sixteen years old, went to live with an uncle in an urban area. He raped her and she ran away. Her whereabouts are unknown. Sarah, fourteen years old, went to live with another uncle in a rural area. He raped her repeatedly and she too ran away. She is still on the run. Twelve year old Shauri lives with another uncle who has denied her education and she is currently the housemaid in his house. This is not news to most Kenyans since the appalling injustice directed at children by society today.

The reality is that most children are confronted with the same agony in these multicultural communities in the province living in diverse circumstances. The DPPO is challenged to understand the different myths and beliefs each community holds on health issues so as to adequately deal with the overall needs of the population.

The youth have been targeted all over the country in HIV/AIDS activities. In Nakuru, the Catholic Diocese initiated behaviour change, peer counselling and reproductive health education for the youth through a programme titled ‘an enlightened youth is a responsible citizen’. The programme uses a Christian belief model that states that behaviour is a function of belief and as such one should be motivated to act according to faith. Among the unique aspects of the peer counselling programme is the ‘virginity club’ started by the youth themselves that encourages the youth to declare their virginity and their willingness to abstain at all cost.

The Luo cultural norms contribute to the high rate of HIV/AIDS in Migori. Traditional attitudes and values have affected men’s sexual behaviour. Having multiple sexual partners among men is seen to be ‘macho’, hence, promiscuity is rampant. Wife inheritance and polygamy complicate matters further.

Children’s Rights

The Nyeri District Population and Family Planning (DPFP) committee met in March 2004 to discuss the implications of the KDHS findings and pinpoint areas that could be remedied. The District Development Committee (DDC) also deliberated on the findings. The DPFP Committee felt that it was necessary for the findings to be analysed down to the divisional level where most of the development activities are implemented.

The committee appreciated the fact that Nyeri district reported one of the highest percentages in uptake of family planning methods in the country (67 percent); however, they also noted that there was a need to enhance condom use, which was particularly low in the district.

Another cause for concern was the decline in uptake of immunisation services in Central province as a whole and Nyeri district. The number of fully immunised children declined from 92 percent in 1993 to 74 percent in 2003 in Central Province.

Rural urban migration has led to inadequate housing and the overburdening of education and health facilities in Nairobi. Another major challenge is the presence of multicultural communities in the province living in diverse circumstances. The DPO is challenged to understand the different myths and beliefs each community holds on health issues so as to adequately deal with the overall needs of the population.

There is need for information education and communication activities to increase awareness in the communities on child welfare issues. There is also need to enforce the rights of the child. Kenya’s population development agenda should place child welfare issues on high priority so as to complement existing programmes that try to deal with child exploitation.
Re-introducing the IUCD in Kenya

Although the contraceptive prevalence rate has tripled since 1984, the number of women using the Intra Uterine Contraceptive Device (IUCD) has decreased from 31 per cent in 1984 to 8 per cent in 2003. Despite its proven safety, effectiveness, acceptability and low cost it has become invisible among the available method mix for family planning over the past 15 years.

The Ministry of Health, with assistance from Family Health International (FHI), has launched an initiative aimed at popularising IUCD use. Through a well-planned process the MoH has undertaken consensus-building activities among partner organisations working in RH that are aimed at generating support for the re-introduction of the IUCD in the country.

Saving Women’s LIVES

The National Council for Population Development (NCPD) embraces the population policy in Kenya. It draws its mandate from the Session Paper No. 1 of 2000, which incorporated principles from the Programme of Action that was adopted at the Cairo International Conference on Population and Development (ICPD) in 1994. The policy emphasizes that “abortion will not be used as a method of family planning in Kenya and every attempt will be made to eliminate the need for abortion through reliable information, counselling and services. Women who have had an abortion will have access to quality services for management of complications arising from abortion. Post abortion counselling, education and family planning services will also be offered.”

The NCPD advocates the view that one way of preventing mistimed or unwanted pregnancy is to promote family planning services, including counselling on natural methods and access to a full range of modern contraceptives. This will enable women to avoid resorting to abortion as the only option. Family planning saves lives and can significantly reduce the number of unsafe, illegal abortions. However in the recent past, the NCPD is concerned that women could not access contraceptives due to shortages.

According to the latest Kenya Demographic and Health Survey of 2003, there is a large number of women who want to space or limit the number of children, but are not practising family planning. Moreover, the survey shows that the number of family planning users has stagnated over the last five years at 39 percent, with only a small increase over the last decade. During the same period, the number of children per woman has increased from 4.7 to 5.0. This is in stark contrast to the dramatic successes in family planning that Kenya experienced in the 1980s and early 1990s. The NCPD is currently involved in promoting dialogue to increase access to contraceptives and to reinforce family planning programmes.

The NCPD embraces and promotes the WHO strategy on safe motherhood, the ‘Making Pregnancy Safer’ initiative. The WHO strategy is designed to significantly reduce the number of unsafe abortions.

The various advocacy and consensus building activities are to cultivate ownership among the various groups who include programme managers, professional associations, service providers, researchers, trainers, funding agencies and clients of the project. A task force was established from this group to develop a strategy for the IUCD re-introduction.

Through the MoH AMKENI Project, a USAID-supported service delivery project, the initiative will build the capacity for IUCD use and distribution. The MoH’s Decentralised Reproductive Health Training and Supervision teams are implementing this objective. The programme will utilise the AMKENI Project’s behaviour change communication strategy to generate demand for the IUCD through various media tools and channels.

Partners in the project are already collecting data to help in monitoring and evaluating the progress. The information collected will help in refining and improving the programmes implementation strategy.

For more information contact FHI’s Research and Practice initiative at rtop@fhi.org or FHI Nairobi at iucdbriefs@fhi.or.ke
Marie Stopes Kenya

Marie Stopes Kenya is an NGO that provides reproductive health care to all people of reproductive age across Kenya. Established in 1986, Marie Stopes Kenya is affiliated to Marie Stopes International and runs 15 clinics and four maternity nursing homes across the country.

The nursing homes are located in four provinces - Coast, Nairobi, Nyanza and Central Provinces. Further to these clinics and nursing homes, Marie Stopes provides community outreach services in all provinces except North Eastern.

The organisation with assistance from partners offers affordable healthcare helping mothers deliver their babies and providing contraception advice and options to families across the country. The organisation plays an important role in the provision of reproductive health services in Kenya.

Baba Ndure’s experience

I used to pass through Eastleigh First Avenue every morning while going to work. On the street, I used to see a board boldly written Marie Stopes as I passed by. I never bothered to find out what Marie Stopes was.

One day, I was seated at home when my wife started experiencing labour pains. She was eight months pregnant, it was late at night, and I did not know what to do. At that point a Somali neighbour entered my house. With all that was going on I almost ignored him but as we talked I explained my predicament to him.

“How could you be suffering and a clean health facility is right next to your house?” he asked me unbelievably. I told him I did not know what he was talking about. He pointed at the Marie Stopes Clinic and I told him I thought it was just a normal business opened up by another entrepreneur.

“I do not want to hear that topic Mtoto ukimslapu Jua hujamhelpu Maisha ataflopu Kwani atakosahopu Mwishowe huwa ni sumu For your stomach will swell You will think it s hell And that will be the market tale Abstain is not in vain Abstain escape the pain Abstain its full of gain.”

By Margaret Warratha, Marie Stopes

Titbits

Baba Ndure’s experience

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I took my wife to the clinic and we were very well received. After a month, she delivered a beautiful baby girl and I named her ‘Bahati’. I was so thankful since the hospital was very clean, the health providers were kind and they all knew their work. Should I have a patient, I would not hesitate to refer him or her to Marie Stopes.

By Margaret Warratha, Marie Stopes
Gender Mainstreaming Activities

In the past decade, the Government has been active in mainstreaming gender issues into the national agenda. The Ministry of Gender, Sports, Culture and Social Services in collaboration with various organisations, has initiated a gender equity, equality and women’s empowerment programme that focuses on mainstreaming gender issues nationally so as to enable the implementation of the Governments Economic Recovery Programme for Employment and Wealth Creation from a gender perspective. Through this approach the Ministry of Gender will promote gender equality and the political, social and economic advancement of women.

The Government is a signatory of several international conventions and treaties on gender equality. These include the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the African Charter on Human and People’s Rights among others. Kenya also participated in the negotiation of the Vienna Declaration on Human Rights and the Beijing Declaration and Platform for Action in 1995. Institutional support is essential to strengthening organisations that promote gender issues. The government provides this kind of institutional support through the Ministry of Gender services and also through the enactment of the National Commission on Gender and Development in 2003. The Government has also established Units of Gender Issues (UGIs) in all key government ministries and department, NGOs, the District Women Development Committees and the National Facilitation Initiative for the implementation of the Beijing Platform for Action and the Women Groups.

The recent enactment of the National Commission on Gender and Development Act in 2003 will facilitate the setting up of the commission which will be autonomously mandated to coordinate all gender mainstreaming activities and advice the government on all aspects of gender and development.

The Gender Division through the UGIs and District Gender Focal Points will ensure gender mainstreaming in all sectors at all levels. Gender mainstreaming is also secured and monitored through gender training and support to all project staff.

By Juliet Kola, Women’s Bureau, Ministry of Gender, Sports, Culture and Social Services

Kenya to Receive US$9.5m for Population and Health Programmes

The Government of Kenya and the United Nations Population Fund (UNFPA) have signed an agreement to support population and health programmes as contained in the Country Programme Action Plan (CPAP) document 2004-2008. This country programme will be the sixth (6CP) by the UNFPA to Kenya.

The goal of the 6CP is to contribute to the improvement of the quality of life of the people of Kenya by supporting population and health policies and programmes. The country programme is to adopt a rights-based approach programme in order to empower males, females and adolescents, particularly girls to exercise their sexual and reproductive rights.

Programme partners identified to work with UNFPA in the implementation of the CPAP (2004-2008) will include a variety of stakeholders. These will include UN agencies, Government Ministries, NGOs, CBOs, faith-based organisations, national specialised training and research organisations and bilateral/multilateral development partners. The partnership will largely be at programme intervention level except for NGOs, CBOs and Government Departments, which will also receive direct financial support from UNFPA. The programme will be nationally executed under the overall co-ordination of the Ministry of Planning and National Development.

In addition to the US$9.5M committed for the 6CP UNFPA will seek to mobilise an additional US$2.5 Million from other sources, subject to donor interest to meet financial requirements for the realisation of the CPAP. UNFPA and the Government of Kenya will conduct annual programme review meetings, which will help determine continuation of the partnerships on the basis of satisfactory delivery of results.

By Karugu Ngatia (Senior Assistant Director), Head of Programmes Division, NCPD and Samuel Ogola, District Population Officer, Baringo and Nakuru

FPAK incorporates maternity services and ARVs into its programmes

Recently, the Family Planning Association of Kenya (FPAK) integrated maternity and outpatient services into its reproductive health services in all twelve of its clinics across the country.

Maternity services are available at Nairobi West and Eldoret Family Care Centres and will later on be expanded to other facilities. FPAK pioneered the family planning and population movement in Kenya in 1962, before the Government embraced the idea.

FPAK currently implements four HIV/AIDS interventions in different parts of the country. FPAK trains service providers on use of antiretrovirals (ARVs) and on the management of opportunistic infections. Four doctors, five nurses and two clinical officers have already been trained in this area.

The Association started targeting youth with RH information and services as early as 1977. Today, FPAK has five youth centres in Mombasa, Nairobi, Nakuru, Eldoret and Kisumu. Using the peer educator approach, the youth centres design and implement initiatives in adolescent sexual health and reproductive health services and information including VCT. FPAK is affiliated to the International Planned Parenthood Federation (IPPF).
through an initiative of the Ministry of Health, and with financial assistance from USAID through the POLICY Project, the above course will be launched at the United States International University - Africa (USIU-A) on 7th June 2004 and will run for two months up to August 6th 2004.

The focus of the course is to assist hospital managers to develop an understanding of the importance of linking planning and budgeting; learning how to identify the required resources in preparing a budget; how to estimate the cost of services; developing tools and techniques for preparing a budget and appreciating government planning and financial policies and procedures. The goal of the course is to strengthen the participants’ knowledge and leadership skills necessary for effective management of health care delivery in the country.

The course targets hospital management teams which are made up of the chair persons, the nursing officers in charge, hospital administrators, pharmacists, and medical records officers, supplies officers, and laboratory technologists, medical officers of health, medical superintendents and health board members. As the course gets rooted, those in similar ranks from the civil society, including private sector will also be considered to attend.

The short course is going to be institutionalized at the USIU-A and is designed to:

1. Be an interactive 8-week course conducted twice a year at the University;
2. Promote a modular structure and format to allow participants to integrate their learning with realities of work environments; and

For more details about the course, contact: The POLICY Project, Health Care Finance and Policy Division at policy@policy.or.ke OR the Ministry of Health - the Department of Policy Planning and Development and Division of Health Care Financing (Afya House, Nairobi)
Male Pill on the way?

The prospect of a male contraceptive pill is on the horizon according to scientists at the Institute of Primate Research (IPR) in Nairobi who are at an advanced stage of its development.

Dr. Pius Adoyo, is the head of reproductive health at IPR, and has been conducting research on the male pill in Japan over the past ten months, has identified sperm protein components that are instrumental to this breakthrough. His study is one alongside others by immunologists in Australia and in two United States universities, seeking to develop a new male immunocontraceptive.

What is an immunocontraceptive?
Immunocontraception is the use of the body’s immune defence mechanisms to provide protection against unplanned pregnancy. There are different research studies worldwide being carried out on immunocontraceptives, some focusing on the sperm and others on the female egg.

Developing an immunocontraceptive requires insertion of a gene for a specific protein in the genome of the desired molecule in a way that results in the production of the correct protein and sufficient accumulation of foreign protein for stimulation of immune response. IPR is working on developing a male immunocontraceptive that attacks a part of the sperm-production process.

Breakthrough

Last year, Dr. Adoyo, through support from the Japanese government, was able to further his research using Recombinant DNA technology (molecular biology). Although he transported some baboon sperm components to Japan to carry out further tests on his findings, for the first time he had access to human sperm for the research. His research work in Kenya is restricted to use of apes, mice and rabbits.

He took some components from the top of the human sperm and similar components from baboon sperm. He injected three rabbits with baboon sperm components, three rabbits with human sperm components and three rabbits with water as a control to his study. He observed the rabbits for three months and noted interesting new developments.

“I discovered that some baboon sperm components were similar to human sperm components which meant they could have been evolutionarily conserved,” Adoyo says, "I also identified three sperm proteins that have not been identified or documented by any scientist in the world before. The three proteins immobilise sperm when interfered with and are potential molecules for immunocontraceptive vaccine development.”

Another significant discovery was the fact that rabbits injected with baboon sperm components were able to build immune response to the target antigen in three days while it took rabbits injected with the human sperm antigen around a week to do so. The immunity levels generated by the baboon sperm samples were also much higher than those generated by human sperm samples. He is in the process of publishing his findings.

The IPR is currently looking for funding to further this research as the institute feels the study has made a major stride in the right direction.

Advantages and limitations

"Because men do not experience menstrual periods, they would not experience menstrual problems associated with the birth control pill in women,” he says.

Since vaccines are not necessarily administered through injections, the immunocontraceptive could be developed and taken orally as a pill and its dosage and administration could also be varied. Scientists have cited the fact that the injection could be given once every three months as an advantage instead of taking the pill everyday.

Designing an immunocontraceptive has proved to be difficult mainly because unlike disease prevention vaccines whose effects aim at long-term (mostly lifelong) immunization, immunocontraceptives aim for a highly effective immunization against human cells or molecules which should be reversible after a specified period of time. Other noted disadvantages are the delay between administration and attainment of effective immunity and the individual variation in immune responses and therefore in the level and duration of effectiveness. It is also noteworthy that an immunocontraceptive cannot act as a barrier to sexually transmitted infections.

Several research issues have yet to be conclusively addressed. No progress has been made toward final product development and before they can be universally sanctioned, their safety has to be ascertained.

There is an ongoing socio-political debate on the subject. Opponents to immunocontraceptive research have noted the unknown health risks of the method. Judith Richter and Susan Sexton in an article ‘the politics of contraceptive research’ say:

"Apart from potential auto immune diseases induced by cross reactions, an immunocontraceptive might also cause allergies or immune complex diseases that might interfere with or exerceberate existing immune disturbances, a risk of any vaccination.”

In global surveys on the male contraceptive pill, women have expressed apprehension on trusting a man to take the pill everyday.