Policy Brief

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Characterization of Reproductive Health Services Provision in Thika District, Kenya

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Context, problem and issues investigated

The achievement of the ideal state of reproductive health (RH) is suboptimal in the developing world and especially the Sub-Saharan (SSA) region because of the problems engulfing the delivery systems. Impact of effective provision of reproductive health (RH) services can be manifested in health improvements in the population that needs the services. Available information suggests major deficiencies in performance indicators of various components of reproductive health. In this regard, Kenya is not an exception as far as achievements in RH indicators are concerned.

In Kenya, the total fertility rate (TFR) stood at 4.9 children per woman in 2006 and this had remained almost constant since 1995, while the contraceptive prevalence rate (CPR) has stalled at 39% since 1998. However, preliminary findings from the KDHS-2008 indicate that CPR has risen to 46% and TFR declined to 4.6 children in 2009, although unmet need in family planning (FP) remains high. Nationwide, only 40% of women give birth in a health care facility with maternal mortality standing at 414 maternal deaths per 100,000 live births. Maternal morbidity and mortality jeopardizes the health of the unborn and newborns. (HIV/AIDS remains a major health problem and developmental challenge in Kenya, consuming substantial resources. Some 6.7% Kenyans are HIV infected and each year there are 140,000 adults AIDS deaths and 86,000 new infections. According to KDHS-2003 38% of Kenyan women are circumcised, a reflection of inabilities to exercise RH rights by some women. Reproductive health needs and rights of adolescents have received relatively little attention to date. In Kenya, 10,000 to 15,000 secondary school girls drop out of school annually due to unplanned pregnancies.

The trends in RH indicators, together with under-achievements in other RH areas are worrying and raise pertinent questions about efficiency and effectiveness of

provision of RHS in Kenya. It is envisaged that good indicators on RH areas relate to how provision is organized, managed and delivered. Favourable indicators on RH care impact positively on economic growth and poverty reduction. Bloom and Canning (2000) discuss how health improvements can lead to income growth through higher productivity, education, investments in physical capital and gains from the demographic dividend. The broad objective of this study is to characterize RH provision, organization and management in Thika district, to gain insights into delivery modes that enhance RH service use and uptake.

RH service provision issues revolve around service providers, service delivery organizational forms whether vertical or integrated, management systems whether decentralized or centrally controlled and the choice delivery modes between community based, social marketing and facility based. Ideally, choice of organizational form, management system and delivery mode for the provision of RH services should be driven by the quest for efficiency.

Arguments for and against various reproductive health service provision models abound. Recent policy movement has targeted choices of organizational forms, management systems, and delivery models that emphasize integration and decentralization, on grounds of maximizing on the economies of scale and cost effectiveness. However, evidence to demonstrate the performance and extent of achievement of various RH provision models is scanty. In addition, there is no systematic assessment and characterization of the nature of existing provision models in Kenya. This study generates evidence from the Kenyan system to document the extent of achievement of innovations in RH service delivery through characterization of RH delivery models.

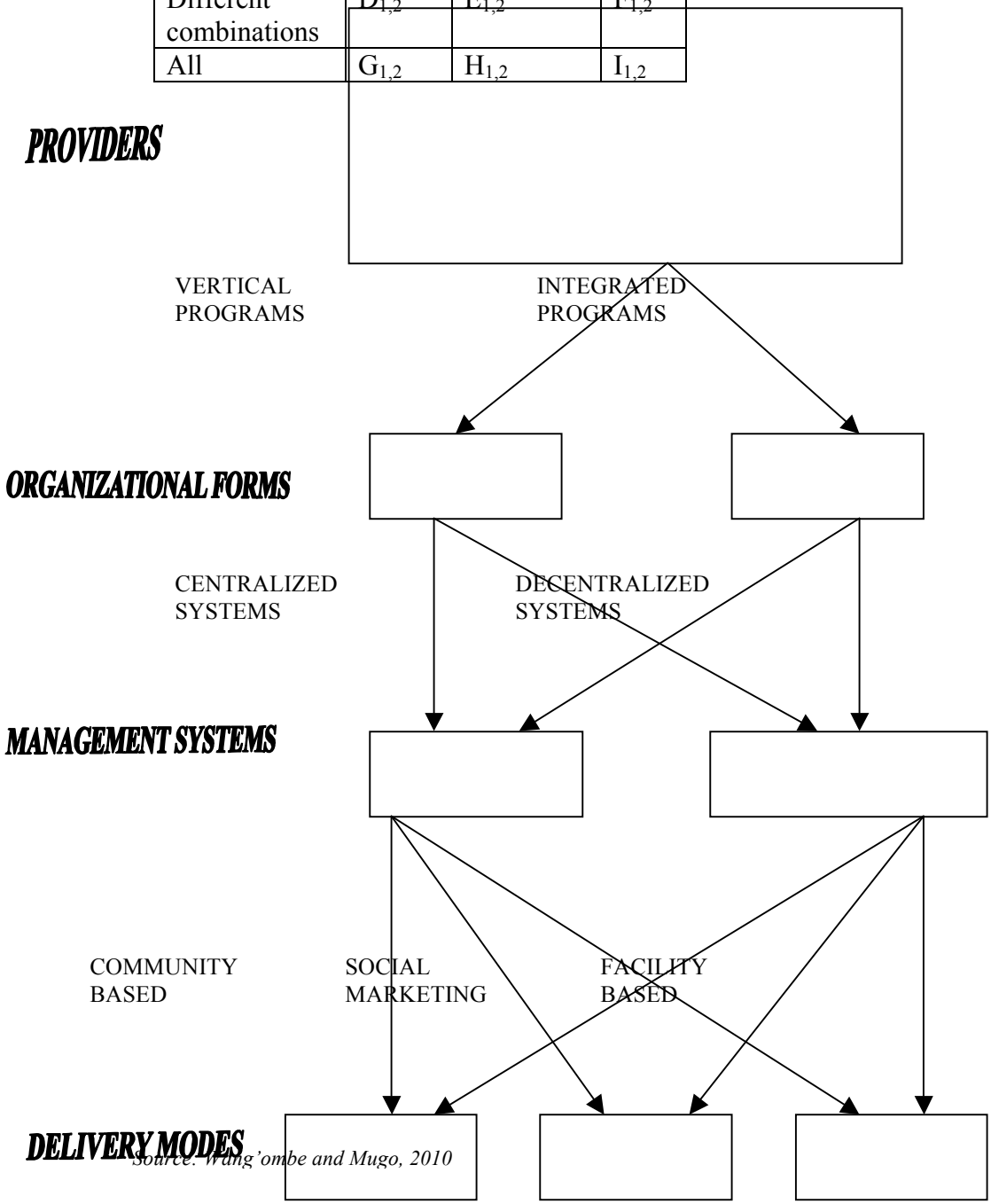
Methods of analysis

This study used survey data collected from Thika district, Central Kenya to generate evidence from the Kenyan system to document the extent of achievement of innovations in RH service delivery through characterization of RH service provision in terms of provider types and services, delivery modes, organization and management. Thika district is one of the seven districts in Central Province of Kenya. The district has 101 static health facilities with diverse ownership including the government of Kenya (GOK, 40.5%), mission or faith-based (FBO, 16.8%) and private-for-profit (PFP) 42.6%). District specific reproductive health data are scanty as the Province is the lowest level of analysis in the KDHS. Kiambu County, the proxy for Thika district, was the best performing in contraceptive usage in the last two KDHS of 1998 and 2003, recording nearly a 10% increase in CPR while the national average stagnated. Choice of Thika district provides the possibility of encountering different FP provision models. It would also provide explanation for both the success and failure for RH provision since it is located in the best performing province in terms of CPR and fertility rate reduction in Kenya.

Characterization methodology for the RH delivery system relied on the model in Figure 1 borrowed from Wang'ombe and Mugo (2010). It provides a scheme for characterization of RH service delivery beginning from the classification of providers as either providing individual services or groups of services individually or as a group, through organizational forms, management systems and delivery modes. Questionnaires were administered to selected facility and program managers to elicit information on provider types and services, organizational forms and management systems. The RHS provision model in Thika district was explored to determine which of the four social services provision scenarios outlined in Mwabu et al. (2001) were operational. The study also explored which of the three main types of service delivery modes namely community-based, social-marketing and facility or clinic-based existed in Thika district. In addition, a questionnaire was used to establish the provider types and delivery modes as well as the range of reproductive health services provided, by different providers.

SERVICES	PROVIDERS		
Single	$A_{1,2}$	$B_{1,2}$	$C_{1,2}$
Different combinations	$D_{1,2}$	$E_{1,2}$	$F_{1,2}$
All	$G_{1,2}$	$H_{1,2}$	$I_{1,2}$

Figure 1: REPRODUCTIVE HEALTH SERVICES PROVISION MODELS



Source: Wang'ombe and Mugo, 2010

Organizational forms of the RHS providers identified in Thika district were assessed to ascertain their extent of being vertical or integrated based on eight selected organizational aspects that were deemed relevant for RH services delivery. These included planning and budgeting, internal organization, staff roles and responsibilities, training, supervision, logistics and vehicles, management information systems and monitoring, and client services. Each provider type was subjected to an overall rating on a scale of one to 10, where one indicated strictly vertical and 10 strictly integrated.

The RHS delivery management system was characterized either as centralized or decentralized based on six selected management functional areas deemed relevant to RH delivery. These are reproductive health services delivery, financial resources, human resources, RH supplies, infrastructure and RH information systems. Each management functional area was disaggregated into several components and each assessed to ascertain which of the four management levels has the power, authority and responsibility to make decisions regarding the component. The four management levels are national, provincial, district and facility (or their equivalents for NGO programs). It is worth noting that decision-making can be at several management levels simultaneously. The expectation is that different management function areas and/or components thereof can exhibit various levels of centralization or decentralization depending on which management levels have decision-making power in respect of the component.

The study was based on a sample of 25 (24.8%) health facilities selected for characterization of reproductive health provision models. Ideally, random samples with or without stratification allow for generalization of findings. However, considerations for random sampling were rendered complex by the character of classifications of the units of study. Health facilities are classified as GOK or Non-governmental Organization (NGO), rural or urban, by levels of complexity of service and population coverage and there is wide variation in NGO category. In order to cater for representation of all these characteristics, sampling of facilities to characterize reproductive health provision models was purposive but representative, based on these classifications.

Frequency and percentage distributions were computed to establish the distribution of provider types in Thika district. In terms of RH service provision, further analysis included stratification by provider type and facility levels to establish provision scenarios existing in Thika district.

Key findings

Three types of providers namely GOK, PFP and FBO provided RHS in the district. They all provide both similar and different components of RHS to the same population. For example oral contraceptives, condoms and injectables were provided by all (except

catholic-run FBO) while the intra-uterine devices (IUD) and implants were not provided to the same extent by all. Male and female sterilization was also not available in FBO and only some GOK and PFP facilities provided the service on special arrangement. Childcare was widely available across all providers. Other components of RHS were also exhibited a provision model where different providers gave the same and different services to the same population. We observed that the provision situation in Thika district is such that there is a tendency for different providers to concentrate on particular FP methods e.g. GOK provider seems to favour oral contraceptives in contrast to IUDs for PFP. The RH demand conditions in Thika therefore creates a situation that enables co-provision by the three providers, more in a complementary rather than competing existence.

Thika district is well placed to provide most of the eleven components of RH services as set out in Cairo 1994. In particular, maternal and childcare services are available widely across providers. Some areas however require further attention. These include encouragement of provision of long-term FP methods such as sterilization, implants as well as emergency contraception especially considering that abortion is illegal. Counseling for elimination of harmful practices against women is poorly developed and appears to be passive with facilities responding as need arises. This aspect needs to be integrated into routine RH education to strengthen women's rights in their reproductive health choices. In addition, provision of youth friendly RH services and post exposure prophylaxis (PEP) for HIV needs to be stepped up especially in GOK program considering that the beneficiaries of these services are vulnerable groups such as women and youth who cannot afford PFP or FBO options.

Organization of RH provision shows a high level of integration, where some aspects like staff roles and responsibilities, supervision and client services were more integrated while others like ordering and training were less integrated. However, the general view of program and facility managers was that organization of RHS delivery is highly integrated. We conclude that aspirations of Cairo 1994 and National Reproductive Health Strategy 1997-2010 of Kenya have been largely achieved considering that no fully vertical programs exist in Thika.

We found that there is substantial decentralization in most of the six management functions considered. The most decentralized areas were in RH service delivery, financial resources and supplies, with moderate decentralization in infrastructure. Management of information systems and human resources are still centralized to a large extent. The type of decentralization seemed to differ across the three providers. The GOK program tended towards de-concentration in that the district health system is required to seek approval from the national level in making a number of decisions. A number of FBO providers also require approval from higher levels e.g. archdiocese while others do not. This reflects a mixture of de-concentration and delegation depending on faith base. The PFP program has the

highest level of decentralization; devolution. This was not an unusual result considering that most providers under the PFP programme are individual owners.

In a nutshell, how does the provision model in Thika district fit in with Wang'ombe and Mugo (2007)? RHS provision is characterized by both public and private providers, providing different combinations of RH services. This classifies RH provision in Thika as $E_{1,2}$ (Figure 1). Although the services are provided to different population groups such as women of reproductive health age, mothers and children, youth and adolescents there is no targeting as all receive available services from their provider of choice. Organization of RH service provision is highly integrated within providers, though full integration is yet to be realized. Similarly, though management systems differ slightly across the different providers, they can be categorized as exhibiting fairly high levels of decentralization to the district health systems. The PFP and FBO however exhibit higher levels of autonomy in majority of aspects of various management functions. RH provision in Thika district relies mainly on facility based mode of delivery. Community based and social marketing modes of delivery were not found to exist in Thika.

Policy recommendations

Thika district lies in the best performing province in terms of most RH indicators. We anticipated that it would offer an opportunity to understand potential provision models that enhance improved RH. We suggest that integrated organizational forms coupled with decentralized management systems augurs well for RHS provision and may contribute to RH improvement. While opportunities exist towards realization of full integration and highest levels of decentralization in organization and management of RHS, the policy of integration of service provision and decentralization of management should continue to be pursued, with a view to achieving full integration and devolved decentralization in all aspects of organization and management of RH service delivery.

Success and improved uptake of RHS, especially FP services has been attributed to community-based mode of delivery in several countries (Askew and Khan 1990; Bertrand and Brown, 1992; Routh and Khuda, 2000). That community-based and social marketing modes of delivery of RHS are no longer in operation in Thika district could be a pointer to unrealized and lost potential in uptake and achievement of higher level of RH status not just in Thika district but for Kenya, where these delivery modes are no longer in use largely due to funding issues. This study calls for re-introduction of community-based distribution of RHS to mitigate declines in RH status of the population while striving to reach disadvantaged populations.

Our findings suggest complementary roles in the provision of RHS, with three providers for both similar and different components of RHS to the same population.

In addition, findings indicate that while the provision situation in Thika district is such that different providers tend to concentrate on particular FP methods, the RH demand conditions in Thika creates a situation that enables co-provision by the three providers. In Kenya, the private sector plays a major role in health services provision and this is reflected in RHS provision in Thika. This situation raises issues of accessibility to RH services especially amongst the poor populations. This study recommends that the role of GOK in RHS provision be stepped up. Services such as provision of long-term FP methods counseling for elimination of harmful practices against women, provision of youth friendly RH services and PEP for HIV should increasingly be provided by GOK, considering that the beneficiaries of these services are vulnerable groups such as women and youth who cannot afford PFP or FBO options.