Changing fortunes: Analysis of fluctuating policy space for family planning in Kenya

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Key Messages

- Policy space for the issue of family planning in Kenya contracted during the late 1990s, and has since begun to expand, due to changing contextual factors and the actions of different individuals
- Proponents of family planning within two government ministries played an important role in expanding the policy space through both public and intra-government advocacy activities
- Policy space analysis can provide useful insights into the dynamics of routine policy and programme evolution and the challenge of sustaining support for issues after they have made it onto policy agenda

Abstract

Population policies often receive weak or fluctuating levels of commitment from national policy elites, leading to slow policy evolution and undermining implementation. This is true of Kenya, despite the government's early progress in committing to population and reproductive health policies and successful implementation during the 1980s. This key informant study on family planning policy in Kenya found that policy space contracted, and then began to expand, because of shifts in contextual factors, and because of the actions of different actors. Policy space contracted in the 1990s in the context of weakening prioritisation of family planning programmes in national and international policy agenda, with negative implications for sexual and reproductive rights and progress with reducing fertility rates. Champions of family planning within the Kenyan Government bureaucracy played an important role in expanding the policy space through both public and hidden advocacy activities. The case study demonstrates that policy space analysis can provide useful insights into the dynamics of routine policy and programme evolution and the challenge of sustaining support for issues after they have made it onto policy agenda.

Introduction

In many parts of the world, family planning policies tend to receive weak or fluctuating levels of commitment from national policy elites, leading to slow policy evolution and undermining implementation. This is true of Kenya, where the government made early progress in committing to population and reproductive policies, yet where prioritisation of the issue by policy elites and resource allocations have fluctuated, with negative implications for policy implementation (Chimbwete et al. 2003). In Kenya as elsewhere in

sub-Saharan Africa, the past decade has seen weakening prioritisation of family planning programmes in national and international policy agenda (Cleland et al, 2006), undermining sexual and reproductive rights and progress towards the millennium development goals.

The problem of sustaining political and bureaucratic commitment for the implementation and evolution of policies affects a variety of policy issues (Grindle and Thomas 1991; Buse et al 2003). Waning commitment can lead to stagnation in implementation, and can undermine the likelihood that political and bureaucratic actors create new policies and strategies to adapt to changing contexts, such as shifts in external funding trends. It is particularly important for reproductive health policies, which in Southern countries and elsewhere do not tend to be supported by strong, mobilised groups of users and have historically been controversial and perceived as driven by external actors (Ajayi and Kerkevole 1999; Chimbwete et al. 2003). Thomas and Grindle (1994) observe that the policy space for sustained commitment and implementation of population policies is constrained by the dispersed and long-term nature of their impacts, and the lack of mobilised support from users of family planning services. Over the past decade, this has been aggravated by weakening international prioritisation of population and family planning policies, with official development assistance for family planning declining and resources and attention being diverted to HIV and AIDS programmes (Cleland et al. 2006).

Yet despite this, the issue of changing policy space for existing policies has rarely been addressed in policy analysis, which tends to focus instead on how issues first make it onto the policy agenda and how policy reforms can be successfully implemented (Grindle and Thomas 1991). Analysis of implementation tends to combine assessments

of the resources and technical capacity available and the winners and losers of a policy, without adequate attention to how support for existing policies waxes and wanes once issues move from being perceived as urgent policy problems to 'politics-as-usual' by policymakers.

This key informant study addresses this gap by examining factors affecting the fluctuating level of prioritisation of family planning among Kenyan government policymakers. Based on 12 key informant semi-structured interviews carried out during 2006 and 2007 and a review of academic and official publications and reports, this paper examines shifting contextual factors and the role of actors in expanding or contracting policy space for sustained prioritisation of family planning. In particular, it examines strategies and actions taken by a range of actors to 'reposition' family planning in government policy and to ensure the incorporation of contraceptive commodities in the national government budget of 2005, for the first time in the country's history.

Walt and Gilson (1994) have highlighted the need for integrated analysis of processes of policymaking, the context in which they occur, and the actors involved. Generally applied to policy reform, the literature on agenda setting and decision making in policy processes involves analysis of factors that enable or prevent policymakers from carrying out policy reform. Policy makers can be thought of as operating within a 'policy space' which defines the degree of agency they have for reforming and implementing policy (Grindle and Thomas, 1991; Kingdon, 1984). According to Grindle and Thomas (1991), the size of a policy space is determined by a combination of contextual factors, the circumstances surrounding the policy process, and the political and bureaucratic acceptability of the policy's content.

Contextual factors can provide opportunities and barriers to reform, and include historical, social, cultural, political, economic and demographic factors and situational or focusing events, like epidemics, droughts or media coverage of issues (Grindle and Thomas, 1991; Buse et al., 2005). Policymakers are confronted with thousands of issues and have limited resources for dealing with them, and competition between policy areas (Shiffman 2007). International actors and international structural trends have a critical influence on national policy processes, with a multiplication of external actors and increased diversity and fragmentation in international health funding (Buse et al. 2000; Cerny 2002). These international factors have diverse and often contradictory influences, particularly in contexts of national government dependence on external funds, of shifting funding priorities, persistence in vertical programming, and aid conditionalities. The characteristics of policy elites are also important contextual factors, for example the values, level of expertise, experiences, and goals and loyalties of elites determine both the receptiveness of decision makers to policy changes, and their success in advocating for change. Political and policy entrepreneurs often play a central role in championing issues (Shiffman, 2007; Grindle and Thomas, 1991).

Another important determinant of policy space is the 'policy circumstances', or the extent to which a policy issue is perceived by policy elites to be a matter of crisis or 'politics-as-usual'. This affects the process of policy making, including perceptions of urgency, the level at which decisions are taken and the extent of risk taking (Grindle and Thomas 1991; Walt and Gilson 1994). Policy crises involve strong pressure on policymakers to act, high political stakes and can lead to radical shifts in the prioritisation of issues.

The political and bureaucratic acceptability of a policy's content are determined by characteristics such as the distribution of costs and benefits of the policy, its

administrative and technical content, the level of public participation it involves, the resources required for implementation and the length of time needed for its impacts to become visible (Grindle and Thomas 1991).

As well as contextual and circumstantial factors, advocacy strategies can be important for widening policy spaces. Shiffman asserts that the generation of policy prioritisation of an issue depends on a combination of factors including: clear indicators to show the extent of the problem, the existence of political entrepreneurs to champion the cause, the organisation of attention-generating focusing events and the availability of politically acceptable policy alternatives (Shiffman, 2007). Technical analyses, such as projections of population and economic growth, tend to be particularly important for convincing policy elites of the need for population policies and family planning services (Thomas and Grindle, 1994). Successful advocacy may require the 'framing' of contested or neglected issues in a way that legitimises them as an important issue for governments to address (Joachim, 2003; Schön and Rein 1991), appeals to prevailing social norms (Shiffman, 2007; and employs policy narratives, or stories that simplify issues and persuade others of their importance (Roe, 1991; Keeley, 2001).

This study aims to provide insights into the challenge of sustaining commitment to existing policies in shifting political, economic and international contexts. The Kenyan case has implications for advocates trying to influence policy on family planning and other neglected sexual and reproductive health issues.

Methods

The material for this case study is based on 12 semi-structured interviews and 2 unstructured discussions with high-level officials and programme staff from government ministries and agencies, international NGOs, national NGOs, a bilateral donor, and an academic with expertise in demography in Kenya[1]. Textual analysis of interview transcripts was carried out to gain insights into the experiences of the different individuals who played key roles in the policy process, and their perspectives on policy space for family planning in Kenya (Ulin et al. 2005). The notation I1, I2, IX is used in the results section as a code for the various key informants.

A review was carried out of official and academic publications and grey material on family planning policy in Kenya, reports of relevant meetings, and the theoretical literature on budget and policy processes, advocacy and framing, and the politics of government budgets.

Factual information provided by key informants was investigated using other sources including further interviews and written materials. Data from different key informant interviews sources were compared and triangulated with written resources to assess their validity and to mitigate the impact of biased or partial testimony from key informants who were closely involved in the events concerned. Where discrepancies and information gaps were found, further investigation through telephone interviews with key informants and grey literature investigations was carried out to resolve inconsistencies and omissions.

The policy analysis involved an investigation of factors affecting the policy space for reform using a framework developed by Grindle and Thomas (1991), augmented with insights provided by Walt and Gilson (1994).

Results

This section begins with an overview of the case study, examining trends in levels of prioritisation, resource allocations and implementation of family planning in Kenya from the late 1990s onwards. The remainder of the section examines each of the factors affecting the policy space for family planning, analysing the ways in which they helped to expand or contract policy space.

Box 1: The history of family planning policy and programmes in Kenya

1962	Family Planning Association of Kenya (FPAK) established
1967	Government of Kenya's first population policy, but FP services and IEC mainly provided by the private sector
1975	The government launched a 5 year Family Planning Programme
1982	The National Council for Population and Development was established in the Office of the Vice President.
1984	First National leader's Population Conference in Nairobi
1994	United Nations International Conference on Population and Development (ICPD), Cairo
1996	NCPD published its National Population Advocacy and Information Education and Communication (IEC) Strategy for Sustainable Development 1996-2010.
1997	National Reproductive Health Strategy published
2000	NCPD published the second Population Policy for Sustainable Development
2003	Kenya Demographic and Health Survey generates deteriorating indicators (published in 2004)
2004	NCPD became a semi-autonomous agency under the Ministry of Planning and Economic Development, the National Coordinating Agency for Population and Development (NCAPD)
2005	The budget for 2005/6 presented to parliament and passed, allocating Kenyan government funds to family planning for the first time

Sources: Ajayi and Kekovole, 1998; Blacker et al. 2005; Aloo-Obunga, 2000; NCPD 2000; Global Gag Rule Project 2006

Box 1 summarises Kenya's long history of family planning programmes. Although the first Population Policy was introduced in 1967, public family planning services did not begin in earnest in Kenya until the 1980s (Chimbwete et al 2003). Rates of fertility

decline in Kenya in the 1980s and early 1990s were impressive. Kenyan Demographic and Health Survey (KDHS) results had shown a steady decrease in the number of births per woman from 8.1 in the 1970s to 4.7 in 1995-1998. These successes were partly due to a rapid expansion of family planning services (Ajayi and Kekovole, 1999). During the 1980s and early 1990s, the Kenyan government demonstrated considerable commitment to family planning, through the development of national policies and guidelines, involvement of high-level politicians, the establishment of the National Council for Population and Development (NCPD) in the Office of the Vice President, and support for increased distribution of contraceptives through governmental and non-governmental health facilities, and extensive information, education and communication (IEC) campaigns (Blacker 2006; Ajayi and Kekovole, 1999). This was in the context of strong support for population policies by external actors, which played an important role in expanding the policy space for family planning. Donors were highly active in advocating for population programmes and donors covered the costs of all government and non-government family planning services and IEC campaigns.

During the late 1990s, this emphasis waned, and donor funding for family planning services and IEC declined, in the context of a shift in priorities to HIV and AIDS, donor fatigue, lack of active government commitment and competition for scarce available resources in the health sector (Aloo-Obunga 2003; NCPD 2003; I5, I13).

Combined with poor management of commodity procurement between the MoH and KEMSA (I13; I4), the unreliable and dwindling international funds were a cause of a considerable weakening of government and voluntary sector family planning services (I2, I7, I4). Some clinics suffered from commodity stock outs and lack of method choice, while others closed altogether (I2, I4, I7). The Kenya Service Provision Assessment

Survey of 2004 found that in the five years preceding the survey, the proportion of health facilities offering any method of family planning declined from 88 to 75 percent (NCAPD et al, 2005). In 1996, the NCAPD launched a National Population Advocacy and IEC strategy for Sustainable Development 1996-2010, but this strategy floundered when funding from UNFPA was withdrawn in 2000 (I5, I6, The Global Gag Rule Project, 2006).

The 2003 Demographic and Health Survey results revealed a stall in fertility decline at 4.8 in 2000-2003, and the rate actually rose for women who had not completed primary education (CBS et al., 2005; Westoff and Cross, 2006; Blacker et al., 2005). The 2003 KDHS revealed increases in unmet needs for contraception and high contraception discontinuation rates (Blacker et al., 2005). These trends caused concern among national and international actors about implications for the rate of population growth in Kenya. In 2004 UN predictions of Kenya's population by mid 2050 were revised from 48 to 70 million, based on these new figures (Cleland et al., 2006). Although various societal, economic and demographic factors may have contributed to the worsening fertility and contraceptive use trends, one important influence is likely to have been the weakening of FP service delivery in the context of declining emphasis on family planning in donor and government policy circles (Blacker et al., 2005; Westoff and Cross, 2006).

When preliminary results from the KDHS were circulated by the Central Bureau of Statistics (CBS, since renamed the Kenyan National Bureau of Statistics) in January 2004[2], the deteriorating trends were immediately noted, and the NCAPD carried out further analysis of the KDHS findings, with support from USAID (I12). A stakeholder's meeting of government departments and development partners was held in late 2004.

The KDHS data catalysed existing concern on the issue from government officials, civil society and donors, and an advocacy campaign was launched with the aim of 'repositioning family planning' as a multi-sectoral government priority[3]. A reproductive health working group, of government officials, NGOs and donors, chaired by the Ministry of Health, identified a specific goal to address donor dependency by ensuring the government allocated Ministry of Health resources to family planning for the first time. The NCAPD led public advocacy initiatives with parliamentarians, ministers and government finance officials in the Ministry of Health, Ministry of Planning and Ministry of Finance. Behind the scenes, officials within the Division of Reproductive Health in the Ministry of Health, using data provided by the NCAPD and CBS, advocated for the importance on family planning services for maternal and child health to budget officers in the Ministries of Health and Finance.

The NCAPD's campaign secured a high-level statement in support of family planning in the form of a cabinet memo and coverage of the issue in the press. In April 2005, the Ministry of Health presented the budget to the Ministry of Finance and made a case for the need for changes (I4; (I1). The Ministry of Health also had to justify and secure future family planning budget increases in cross-sector meetings as part of the Medium Term Expenditure Framework (MTEF) process (where budget officers from the different sectors debate the allocation of resources) (I4, I2). The budget was then formulated by the Ministry of Finance and presented to Parliament and passed in June 2005, allocating 200m Kenyan Shillings, or 2.62million US Dollars[4] to family planning commodities. Two workshops were held for parliamentarians during 2005, which successfully mobilised sympathetic politicians, leading to the establishment of a Parliamentary Network on Population and Development in 2006.

These developments represent an expansion in the policy space for family planning in Kenya, but there has not yet been a return to the favourable context of the 1980s and early 1990s. The budget line demonstrates a degree of governmental commitment to the issue, and is expected by MoH staff to improve sustainability by offsetting fluctuations in donor funding and supporting better coordination of the commodity procurement process. Through the budget process, awareness was raised among officials in the ministries of health, finance and other sectors. The Sector Working Group report on the health sector MTEF for 2006/7 to 2008/9 is an example of this, listing family planning in a list of priority 'pro-poor' health expenditures (Government of Kenya, 2006).

However, the size of the new family planning budget line remains modest. The government allocation for this line increased to 300 million Kenyan shillings, or 4.17 million US dollars, in the 2006/7 budget, but this is still only around one third of the cost of Kenya's public sector provision of family planning commodities (Ministry of Health 2003). Some NGO and donor key informants continue to question the extent to which senior politicians and government are officials are treating FP as a government priority (I8, I14, I15). Implementation of family planning programmes remains undermined by poor planning and logistics in both the MoH and KEMSA (I14, I15)[5]. Progress in integrating reproductive health with HIV and AIDS policy and programmes continues to be undermined by vertical international funding mechanisms (Druce 2006). At the time of writing, the Ministry of Health and other actors have yet to take decisive action to reverse the decline in public IEC services (I8, I14). Key informants from NCAPD, Ministry of Health and NGOs who were involved in the advocacy process in 2005 describe their efforts to 'reposition family planning' in the Kenyan government as ongoing (I2; I3; I6).

Factors affecting policy space

This case study reveals that policy space contracted, and then expanded, because of shifts in contextual factors, but also because of public and hidden efforts to reposition FP led by champions of family planning within the bureaucracy with the support of NGOs and donors. I now explore each of the sets of factors identified in the policy processes literature (Grindle and Thomas 1991; Walt and Gilson 1994), to assess which were important for expanding or contracting the policy space for family planning family planning prioritisation and inclusion in Kenya's 2005 budget. Table 1 summarises the impacts of the policy content of family planning and various circumstantial and contextual factors on policy space, comparing their impact on policy space during the second half of the 1990s with the years since 2000.

Policy content

As shown in Table 1, the policy content, or the administrative, technical and political characteristics of family planning policy, did not play a significant role in changing the policy space during the period examined in this case study. The characterstics of the policy do not generate strong vested interests in support for or opposition to the policy. The issue of family planning therefore tends to involve low political stakes for the Kenyan Government, with neither strong constituency of support or opposition to the issue from the electorate or the bureaucracy (I2; I6 I15; I16). The benefits of family planning services are felt by individuals, who are unlikely to mobilise in support of the issue. Impacts of population policies on development and economics are long-term and hard to measure. Organisations such as national reproductive health NGOs that had worked to

promote family planning during the 1990s are weak in terms of political influence and access to resources. There appears to be insufficient knowledge about how far family planning is accepted by individual Kenyans, but generally it is unlikely to meet strong opposition, although there are high levels of myth and suspicion about particular methods in some communities (Feldblum et al. 2001; I12; I15; 16). There had been some opposition from community leaders on pro-natalist grounds during the 1960s and 1970s (Chimbwete 2003). Two key informants argued that the belief that Kenya needs a high birthrate to replace those dying from AIDS is a popular view among communities and MPs use it to appeal to voters (I6, I2), but it was generally thought that such attitudes are no longer very influential in Kenyan politics (I2, I6, I7, I15).

Family planning policies are have relatively intense administrative requirements because of the need for continuous administrative resources to be allocated to procurement, storage and distribution of contraceptive commodities, and the technical skills required for effective service delivery.

Because of family planning policy's low political stakes and administrative intensity, support and opposition to the reprioritisation of family planning was focused within the bureaucracy, and was relatively uncontentious, focusing on the need to persude budget officials of the importance of the budget line (I1; I2; I4; I6). Apart from the scarcity of funds within the health sector, the 2005/6 budget allocation did not appear to meet with much overt opposition within the bureaucracy (I13).

Table 1: Factors affecting policy space for family planning in Kenya

	Mid-late 1990s **Policy space contracting**	**Early 2000s** **Policy space expanding**
1. Policy content	↓ Lack of mobilised support from users of FP services → Low political stakes → Concentration of costs and benefits in the bureaucracy	↓ Lack of mobilised support from users of FP services → Low political stakes → Concentration of costs and benefits in the bureaucracy
2. Circumstantial factors	↓ HIV and AIDS became a policy crisis, drawing attention and funding away from family planning	↑ HIV and AIDS policy is making a gradual transition from 'crisis' policy making to 'politics-as-usual'
3. Contextual factors		
Characteristics of policy elites	↓ A perception that fertility transition would progress automatically, without the need for constant government intervention	↑ Concern among policymakers about trends in fertility, FP services and contraceptive use. ↑ Effective champions of FP within the bureaucracy
Availability of policy evidence		↑ Availability of evidence of a decline in family planning
Political	↓ Prioritisation of HIV and AIDS ↓ Deprioritisation of FP ↓ Shortage of government resources allocated to health sector	↑ Sympathetic high-level politicians ↑ Increase in government resources for health sector ↑ New government increasing resources to the health sector
Bureaucratic	↓ Conservative and centralised budget processofficials ↓ Intra- and inter-sectoral competition for resources ↓ Prioritisation of HIV and AIDS and perceived trade-off with FP	↑ Mandate and influence of NCAPD ↑ Concern about weak FP service delivery within MoH ↓ Conservative budget officials ↓ Intra- and inter-sectoral competition for resources ↑ Introduction of the MTEF
International	↓ Vertical HIV & AIDS funding ↓ Prioritisation of HIV and AIDS	↑ Financial and technical support for FP advocacy from

	↓ Reduced donor funding for FP services and IEC	international NGOs and donors
National civil society	↑ Media sensitisation to issue of FP	↑ Technical support for FP advocacy from national NGOs ↑ History of media sensitisation to issue of FP
Social and cultural	↓ Religious opposition to condoms	↑ Religious opposition becoming less vocal

↓: Factors constraining Policy Space

↓: Factors expanding policy space

→: Factors affecting the policy space but not expanding or constraining it

Circumstantial factors

Table 1 demonstrates how shifts in the policy circumstances helped to create a more supportive environment for family planning. This involved both an increase in concern among policymakers about the issue, as well as policy space opening up because of a shift in perception of HIV and AIDS as a policy issue. Since the time of Kenya's first population policy in the 1960s, family planning has consistently been regarded by policy elites as an issue of 'business as usual' rather than a crisis issue. Government officials repeatedly stated that a difficulty for securing prioritisation of family planning in the Ministry of Health is that it is not considered to be an emergency, unlike other health issues such as epidemics (I6, I3, I4). During the 1990s, the policy space for family planning narrowed further, when HIV and AIDS was perceived as a crisis issue (Aloo-Obunga, 2003; NCPD 2003).

FP has become routine. It has been overrun by other activities like HIV/AIDS (I4)

This was exacerbated further by a perception that family planning and HIV and AIDS are competing issues that can be traded off against each other. This narrowed policy space for family planning by diverting resources away and undermining acknowledgement of the interdependence between the two services and the need for integrated policies and programmes.

There was the occasional minister who would priorities HIV over FP. (I2)

During the 1990s, the deprioritisation of family planning seems to have been reinforced by complacency among government officials and politicians about the positive trends in fertility and contraceptive use rates. There seems to have been a perception that the fertility transition would continue without the need for continuous government intervention, further undermining the sense of importance of family planning as a policy issue.

People did not realise what was happening when the decline in FP funding started. For a long time, FP had been doing very well. It was at the peak of its success when HIV/AIDS became a crisis issue. [The decline in government prioritisation of FP] was an involuntary decrease. (I5)

By 2003, HIV and AIDS was no longer seen as such an urgent crisis, enabling the reassertion of family planning as a priority, based on evidence from constraints in policy implementation and research evidence.

Contextual factors

Changes in the political, bureaucratic, national and international context had a major impact in widening the room for manoeuvre open to proponents of family planning within the bureaucracy. Table One demonstrates how, during the period examined in this case study, there were shifts in all these areas that either increased opportunities for family planning to be prioritised within government, or reduced the contextual constraints against this occurring.

Characteristics of policy elites

The attitudes of certain groups of policy elites played an important role in restricting the policy space for family planning during the late 1990s and early 2000s, necessitating advocacy campaigns to persuade the government to take action on the issue. As described above, some officials regarded HIV and AIDS and family planning as competing areas, and believed that HIV and AIDS should be prioritised as it was a more urgent issue. One key informant described budget officers in the Ministry of Health as being opposed to any display of creativity or decisions that are perceived as 'radical' (I6). Budget officials had to be convinced of the need to innovate by introducing government funding for an item that is already funded by donors:

> *Health indicators such as IMR and MMR are declining in Kenya. Our strategic plan 2005-2010 shows the need to reverse these trends. FP is important for reducing MMR. One third of IMR is neonatal mortality. Economists understood*

this. But there was a feeling that partners were already supporting adequately. So why put money to this not drugs or infrastructure? (I4)

The presence of champions of family planning in the Ministries of Planning and Health who were committed to promoting the issue was a major contextual factor enabling the expansion of the policy space. In 2003, a new Director of NCPD was appointed, who was charismatic and influential within government and with donors, enabling him to mobilise resources for family planning advocacy, and to sell the issue in high-level meetings (I9, I14). The head of the Division of Reproductive Health also played an important role in sensitively and effectively advocating for family planning as a national priority within the Ministry of Health (I13, I14).

Availability of policy evidence

The availability of data demonstrating the 'policy problem' was a catalyst for alerting policy entrepreneurs to the need to for family planning to be reprioritised. Key informants from the NCAPD, MoH, USAID and NGOs pointed to the importance of the 2003 KDHS data in identifying and persuading others about the importance of the issue.

The plateau [of contraceptive use and fertility rates] was a critical turning point. (I1)

The results showed clearly that unmet need for FP had not changed for over 10 years. Contraceptive prevalence was the same. The TFR was beginning to show an increase. These figures rang a bell. So we did further analysis. Our finding was that there was a shortage of commodities. […] We needed a broad program of high-level advocacy to lobby government, partners and donors' (I2).

Contrary to the previous quotation, those working on the issue in government had already expressed concern about declining prioritisation of family planning and decreasing donor funding before the KDHS was carried out (NCAPD 2003; Ministry of Health 2000). The publication of this data provided an opportunity and a resource for champions of family planning to use in their advocacy, which they did in a variety of fora, in public meetings with parliamentarians and in internal budget meetings within the Ministry of Health and during the MTEF process (I12; NCAPD 2005). The data provided a resource for proponents of family planning to employ in efforts to create a sense of urgency about family planning as a policy problem.

Figures on the correlation between the contraceptive prevalence rate (CPR) and MMR were also useful in persuading parliamentarians and bureaucrats of the importance fo the issue (I2), but reproductive health data appears to have been less widely used than fertility indicators.

Politics

The policy entrepreneurs received high level, yet passive political support, which may have been important in overcoming any bureaucratic opposition to mobilising resources for implementation. As indicated in table one, high level politicians, who have a direct decision-making role or indirect influence on the health budget, were sympathetic to reproductive health and population issues. The Minister of Health, Charity Ngilu, was considered to be sympathetic to reproductive health issues (I4; I6), but some key informants argued that she did not actively prioritise them (I14; I16). The current President Mwai Kibaki had demonstrated personal commitment to population policy

during the 1980s and 1990s (Ajayi and Kekovole, 1998; Chimbwete et al. 2003). During 2004, the creation of NCAPD with its new advocacy mandate through an act of parliament, and the issuing of a Cabinet Memorandum in support of family planning citing the deteriorating DHS indicators, both indicate a degree of high-level political sympathy for the issue.

This commitment continued in name even during the period of weakening commitment to family planning. The Government of Kenya continued to make commitments to family planning in its 1996 IEC strategy and the Population Policy for Sustainable Development of 2000, yet failed to take action in response to shifting donor trends, allowing implementation and policy evolution to stagnate (NCAPD 2003). Informants from outside the government were generally in agreement that while government commitment had increased, since a low point around 2000, it has not returned to the high levels of the 1970s (I8, I14, I15).

While most key informants did not see the change of government in 2002 as having a major impact on family planning, one senior budget official in the Ministry of Health argued that the new government's increased prioritisation of health means increasing allocations to the health sector (I13).

The level of support for family planning from parliamentarians appears to have been mixed. In the 1960s and 1970s, some Kenyan politicians avoided publicly articulating their support for family planning because the issue was not popular with the electorate (Aloo-Obunga, 2003; Chimbwete 2003). By the early 2000s, the issue seems to be treated more with indifference than outright opposition among the public and

parliamentarians, and some parliamentarians actively support the issue (I2; I6; I8; I14; I15; NCAPD 2006a).

Bureaucratic

Conservatism, lack of transparency and concentration of decision-making power in the budget process were factors constraining the policy space, preventing the government from allocating resources to FP until 2005. A case had to be made within the Ministry of Health on the importance of government funding for family planning, to overcome opposition due to competition for resources within the bureaucracy and because of conservatism in budget processes (I2; I4; I6).

> *The whole of the Ministry of Health must be willing. The Ministry is under-funded. Introducing a budget line is not an easy thing. We have to take money from elsewhere (I4).*

However, a factor that facilitated the acceptance of a government budget line for family planning was the receptivity of government economists to the importance of access to contraceptives for improving health indicators (I4; I12; I13). The institutional relationship between the Planning Unit of the Ministry of Health and the Ministry of Planning also facilitated the new budget line, as the head of the Planning Unit had been involved in the production of the 2003 KDHS, understood the importance of family planning, and was responsible for the initial drafting of the MoH budget (I12).

The experience of poor implementation within the Ministry of Health was an important factor creating concern about the issue within the ministry and triggering action to address it. In the Division of Reproductive Health and among NGO service providers, the

policy problem was identified because of stock outs of family planning commodities from health facilities, leading to a concern that family planning policy implementation was ineffective and action needed to be taken to improve service delivery.

> *'The Ministry of Health had a general feeling that FP implementation was not good enough.' (I3)*

Since its creation as an agency in 2004, the existence of NCAPD has been an important factor expanding the policy space for family planning prioritisation in Kenya. One key informant emphasised that the creation of NCAPD as an agency precipitated a considerable improvement in its effectiveness and policy influence. NCAPD is semi-autonomous, so has operational flexibility, while retaining strong links with the Ministry of Planning (I1; I7). It has a mandate to do high-level advocacy (I2; NCAPD 2005).

By contrast, the Division of Reproductive Health (DRH) does not have the mandate to advocate publicly for an increase in resources, so it needed other public champions (I2; I6 I14; Aloo-Obunga 2003). Key officials within the DRH were able to carry out internal advocacy to influence senior Ministry of Health officials, with technical support from NCAPD and NGOs such as Constella Futures, then known as the POLICY Project (I6, I14; Ministry of Health 2000).

The introduction of the Medium Term Expenditure Framework (MTEF) in 1999 (MoH, 2005) may have been a supporting factor for allocating increased government resources to family planning. Allocations for family planning in the 2006/7 were much easier to pass than in 2005, because the budget line was created, budget officials in the relevant ministries had been sensitized, a precedent had been set and the MTEF allowed for an increase in resources in this area (I1; I4; I7; I12; I13).

International

Population first made it onto Kenyan government agenda because of the influence of external actors, and even at the height of prioritisation of the issue during the 1980s and early 1990s, the government always relied on external resources to fund policy implementation (Ajayi and Kerkovole 1998; Chimbwete et al 2003) The family planning advocacy and budget process of 2005 took place in a complex context influenced by shifting donor priorities, funding mechanisms for development assistance, and multiple formal and informal partnerships between national and international organisations. As with the national government, many international donors shifted their priorities to HIV and AIDS during the 1990s, leading to declining foreign aid allocations for family planning (Aloo-Obunga 2003; NCPD 2003). The high external pressure that had influenced political elites to prioritise population and RH issues during the 1980s and early 1990s declined. There may also have been a decrease in donor commitment to family planning spending in itself, aside from the shift to HIV and AIDS. Some key informants described a situation of donor fatigue brought on by frustration with poor planning and lack of ownership for the issue in the Ministry of Health.

> *Donors got fed up with the lack of planning. DRH used to say, "we have a shortage of pills. UNFPA can give us an emergency drop". UNFPA would do this, but 6 months later they'd come back and ask for another bail out. (I14)*

Key informants stated that donor agencies consider IEC to be expensive and there is a lack of conviction in its importance and effectiveness (I6, I2). There appears to have

been complacency among donors as well as national actors about fertility transition, and a belief that it would happen naturally without the need for sustained interventions.

> *Implementation disappeared in the 1990s. There was an expectation that the transition would continue automatically. Resources were moved away (I1).*

> *Donors no longer wanted to support community-based distribution, questioning its impact. (I2).*

On the other hand, supportive international factors included the provision of financial and technical assistance for advocacy on family planning from donors such as USAID and of technical assistance to NCAPD-led advocacy initiatives from international NGOs such as Futures Group and the African Population and Health Research Center (I2; I14). A number of international NGOs and donors played active roles in a committee which provided costings and other analysis in order to develop a rationale for the new budget line. Since 2000, UNFPA has been funding improvements in the division of responsibility and coordination between MoH and NCAPD, which may have helped them to carry out joint advocacy for family planning (I5). USAID and Constella Futures have been supporting the Ministry of Health and to develop a policy on procurement (I6; I14). However, the continuing complexity of donor priorities and funding systems despite coordination initiatives may have undermined the ability of the Health Ministry as a whole to respond to the worsening of family planning use indicators or to improve coordination between SRH and HIV and AIDS programmes (Druce et al. 2006; I6). In this case, the role of individual 'policy entrepreneurs' was essential for ensuring that family planning was addressed in the budget process.

Government and donor key informants unsurprisingly differed as to where they put the blame for poor coordination and commodity stockouts, with a USAID official stating that

> *[…] there was a major problem when the Germans picked up the bulk of procurement but there was a 6 month gap between projects which the ministry had not picked up on, so there were almost commodity stockouts. The ministry did not understand the donor's cycle. (I14)*

A senior government official on the other hand, argued,

> *Donors have no idea of our procurement schedule. You would find lorries arriving at KEMSA without any storage space. (I13)*

National civil society

The key informants from government tended to downplay the contribution of civil society in the policy process, with one official arguing that, "Civil society plays a role but it is small. Family planning [policy] is really an area for governments, between different government agencies" (I1). However, NGOs such as FHOK and KAPAH did play a supportive role in promoting family planning by providing technical assistance to government advocacy strategies and activities as members of the reproductive health working group (I2; I5). A history of advocacy activities by reproductive health NGOs may have helped to create a supportive environment for family planning. Campaigns carried out by NGOs such as KAPAH during the 1990s to sensitise the media to accurate reproductive health reporting by NGOs campaigns (I5; I14) helped to secure media coverage of the advocacy workshops (I7).

Religious factors

Religious groups that oppose certain reproductive health services still have an influence on policy in Kenya, particularly in the areas of adolescent rights and condoms (I5; I6; I3; I4). However, overt religious opposition to condoms is now lower than it was in the 1980s and early 1990s, when there was hostility from a coalition of Roman Catholic and Muslim organisations. Two key informants described how religious groups had concerns about family planning, necessitating sensitisation by the government (I2) and civil society during the 1990s (I5). The 2000 Population Policy was a milestone because of the long consensus process of drafting the policy, with religious coalitions raising issues and several redrafts before it was adopted in parliament (I5). HIV and AIDS may also have helped to make opposition less vocal. One key informant argued that HIV/AIDS has led people to reconsider their opposition to family planning, especially the use of condoms.

> *'no one has not been affected by HIV/AIDS. Religious groups have decided to lay low and remain silent' (I5).*

In general, family planning is not considered by key informants to be a controversial issue, in comparison with many African countries in the region.

> *[In Kenya,] we don't really have opposition to family planning. It's so normal, it's not an issue. The Catholic Church is opposed to FP, but it's not proactively opposing FP, just condoms. FP is not being hindered by culture or religion in Kenya, but by lack of political will. (I15)*

Advocacy strategies

In addition to the shifting contextual factors, described above, advocacy activities led by bureaucrats, with support from political, international and civil society actors, helped to expand the policy space for family planning from 2003 onwards. Certain characteristics and strategies appear to have been effective in encouraging increased prioritisation of the issue, including combining public and intra-government advocacy, organising focusing events, and using a variety of policy narratives to 'reframe' family planning.

The advocacy process involved a range of actors, loosely coordinated through family planning and reproductive health committees chaired by the Ministry of Health, with membership including NCAPD, NGOs and donors. The aims were multifaceted. They included 'repositioning' family planning by raising its profile as a government development priority, by making it genuinely multi-sectoral, and enhancing integration with HIV and AIDS and other reproductive health issues such as maternal and child health (I1). It also involved countering traditional scepticism about family planning among those who try to marginalise it as a 'women's issue' by presenting it as non-radical and for the benefit of Kenyan society as a whole.

Agenda setting to incorporate family planning in the 2005 budget process involved two advocacy processes. The first was a public process to influence parliamentarians, senior bureaucrats and the wider public, led by NCAPD. The second involved internal government advocacy to influence the budget process within the Ministry of Health and between the Ministry of Health, the Ministry of Planning and the Ministry of Finance.

The public efforts centred on the budget process. In April and July 2005, two advocacy workshops were convened by NCAPD, with support from national and international NGOs and donors (NCAPD 2005; NCAPD 2006b). Presentations and speeches on the

importance of family planning and the deteriorating trends were delivered by NCAPD, the African Inter-Parliamentary Network on Reproductive Health and the Ministry of Health. These workshops targeted ministers, senior administrators and budget officials from the Ministries of Finance, Planning and Health, and parliamentarians (I3, I4, I7). The workshops were reported in the press, and key informants argue this public profile of the event helped to persuade key officials in the bureaucracy to accept and support the allocation of national resources to family planning (I1; I2; I6; I7; I14).

The exact role played by the parliamentarians is hard to pinpoint. Key informants involved in the work with parliamentarians argued that the ultimate aim of targeting MPs was to make them become active in the budget process, advocating for resources to go to FP (I6, I14), however, parliamentarian's direct impact on the budget is extremely small, limited only to simply passing or rejecting the whole budget (Gomez et al., 2004; IPAR, 2004; Mwenda and Gachocho, 2003). Overall, targeting the parliamentarians may have a more long-term effect through strengthening networks of support for reproductive health among politicians and paving the way for future work with parliamentarians, rather than directly affecting the budget line. The workshops supported the creation of two parliamentary networks on population and development (NCAPD 2006b). However, it is possible that the parliamentary workshops may have catalysed the budget line decision from the Ministry of Health, by putting senior officials in the ministry under scrutiny about their response to the deteriorating KDHS indicators. In this way, the workshops can be regarded as 'focusing events', which raised the profile of the issue, strengthened networks of sympathetic individuals, and mobilised action.

In the parallel, hidden advocacy process, officials within the Division of Reproductive Health (DRH) worked to influence the Ministry of Finance for the government to fund

family planning commodities (I1). NCAPD provided data and other support to the DRH in this process. A line of advocacy was necessary through government hierarchies, where officials in the Division of Reproductive Health took advantage of routine meetings to persuade Ministry of Health budget officials and senior administrators such as the Director of Medical Services (DMS) of the importance of adding family planning to the budget. In turn, these senior officials had to convey this message to the Ministry of Finance and during multi-sectoral planning meetings such as Medium Term Expenditure Framework (MTEF) meetings. In budget negotiations, they had to defend the line item to prevent it from being removed.

> *[The Division of Reproductive Health (DRH)] needs to be able to push the DMS [Director of Medical Services] who oversees the budget under the PS [Permanent Secretary] to make these decisions. There is a line of command from DRH to DMS to PS to the Ministry of Finance. If Kibaru [Head of the DRH] is not shouting enough to the DMS, the DMS will not be shouting to the PS, and so on.*

The decision to allocate government resources to family planning commodities was more of a process than a single decision point. It began when bureaucrats in NCPAD, DRH and the Ministry of Health Planning Unit variously identified the need for the budget line (I4; I1; I2; I7). The process encompassed ministerial budget meetings and the Medium Term Expenditure process and culminated in the acceptance of the budget by the Minister of Finance. The Planning office in the Ministry of Health started the process officially, tabling arguments to the Ministerial Budget Committee charged with formulating the budget. Budget decision makers, particularly the Director of Medical Services and the Permanent Secretary were presented with arguments about the need for the new budget line based on shortfalls in family planning funding from donors and the implications of declining KDHS indicators for health and development. In turn, the

Ministry of Health Budget Committee inserted the budget line into the ministerial budget and defended it to the cross-sector MTEF Secretariat in the Ministry of Finance. (I12; I13)

A wide range of policy narratives were employed by different actors in their bid to reframe family planning as an important issue for economic growth, development and health, that should be prioritised in public policymaking. The policy narratives used appear to have been diverse, differing between organisations and even between individuals within organisations. Particular individuals used various policy narratives, targeting different arguments to different audiences. Key informants explained how the head of the Division of Reproductive Health used 'government language' and internal advocacy within the MoH to make sure the issue did not seem radical or part of an external agenda (I7, I6). Some advocates appealed to nationalism, urging the government not to leave family planning for Kenyan citizens to donors (I2, I13). In meetings with parliamentarians during 2005 and 2006, arguments about the importance of family planning for economic and social development and poverty reduction were used (NCAPD 2005; NCAPD 2006a; NCAPD 2006b).

There were also attempts to transform attitudes among policy elites about the beneficiaries of family planning, highlighting their benefits for men, children, low-income families, and the nation at large, countering popular assumptions that family planning is a "women's issue". Some key informants for this study described the importance of presenting family planning as uncontroversial and in line with national Kenyan aspirations and prevailing gender norms. For example, one key informant in NCAPD who played a key role in advocating with parliamentarians presented the argument that by freeing women's time spent on raising children through improving access to

contraceptives, 'the husband can be taken care of' (I7). With a couple of notable exceptions, key informants did not mention reproductive health rights as one of the arguments for family planning services.

Arguments were made to counter a general perception among policymakers that sustained fertility transitions occur automatically due to socio-economic change, without requiring government intervention (I2; I6). One key informant stated that 'without continual family planning IEC, acceptance will decline' (I6). One informant argued that,

> *'There is a tendency for poor communities to continually reduce their acceptance of FP, especially if they feel threatened. FP is not readily accepted by the poor except if they receive information and community-based distribution. Hence the need for continuous IEC provision' (I2).*

Population and SRH narratives were adeptly combined by some key informants, for example in arguments that high quality family planning services based on choice of methods are essential for acceptance of family planning by the Kenyan public and for lowering total fertility rates.

Shortages in family planning commodities in clinics and poor quality of service delivery were blamed for causing discontinuation of contraceptive use and decreasing acceptance of contraceptive methods (I1, I2, I8).

> *'In the 1990s, there was unmet need for FP. Many women had unintended children. When they went to a facility, they did not find the contraceptive of their choice. They went away, meaning to come back another time, but did not […] When there are shortfalls in FP commodities, fertility goes up automatically' (I1).*

Discussion and conclusion

Studies using policy space analysis tend to focus on the questions of how new issues make it onto policy agenda and how policy reforms can be sustained and implemented (Grindle and Thomas 2001). Very few studies have acknowledged the dynamics of policy spaces in routine implementation of policies and programmes. This paper examines the challenge of sustaining commitment to existing policies in politics-as-usual circumstances. In Kenya, family planning policies have been in place for a long time and have been successfully implemented in past decades, particularly during the 1980s. The case study examined in this paper is therefore not so much about 'agenda setting' but about how support for existing policies waxes and wanes because of changes in policy circumstances and context, especially if policy implementation is dependent on external funds.

The case study approach brings certain limitations to this paper. In particular, it limits the potential for developing concrete assertions about causality in the policy process or for generalising about results. Despite these limitations, the paper provides lessons for policy space analysis, and the evidence from the Kenya case supports lessons on agenda setting and policy prioritisation from other contexts.

This study has shown how shifts in contextual factors and policy circumstances first contracted and then widened policy space for family planning in Kenya. Policy elites advocating for the issue of family planning took action that further widened the space within which they operate. During the mid- to late-1990s, policy space for family planning was contracting due to a deprioritisation of the issue among national and international actors, and the onset of a policy crisis around the issue of HIV and AIDS policy crisis, which shifted attention and donor funding away from family planning. Until 2005, the full

cost of family planning commodities in government programmes was met by donors and the Kenyan government was slow to react to or mitigate the effects of a sudden drop in external funding for commodities, with detrimental implications for service provision. The case study demonstrates that the literature on policy processes could benefit from investigating budget processes in more detail, because of their role in intra-government negotiation and advocacy for planning and prioritising policy issues.

It appeared that the deprioritisation had been involuntary rather than planned, based on a lack of ownership of the issue by the government, donor fatigue and complacency about the sustainability of the fertility transition among both national and international actors. This is an example of what Buse et al. (2005) describes as the common role of unplanned drift of policies in response to political pressures or opportunities or shifts in funds provided by global initiatives. The 'policy content' of family planning, involving intensive and sustained bureaucratic demands, dispersed benefits of family planning programmes and low political stakes, is a likely reason why population policies tend to evolve slowly and are often poorly implemented (Thomas and Grindle 1994). In Kenya, the actions of champions within the bureaucracy and intra-government advocacy therefore became important. The advocacy around family planning and the 2005 budget involved attempts to counter this tendency by securing political commitment and government resources for the issue and addressing complacency by feeding new evidence from the 2003 KDHS into policy. The public events with parliamentarians and the media and the attempts to foster awareness of RH issues in the public by NCPAD could be seen as an attempt to move the issue from the purely bureaucratic arena into the public domain.

From 2003 onwards, therefore, shifts in contextual factors created a certain amount of policy space, which was then widened by advocacy strategies to 'reposition family planning'. The introduction of the budget line for contraceptive commodities in 2003 was an important aspect of the expanding policy space. Although getting an existing program into a national budget is no guarantee of public allocation to FP in the long-term, it does demonstrate a national commitment (Shiffman 2006), and gives more chance for sustaining public FP programmes and addressing some of the logistical issues and fluctuations in levels of external funding.

Contextual factors which widened the policy space for government funding of family planning included the creation of NCAPD, the existence of bureaucratic champions of family planning, and financial and technical support from donors and international and national NGOs. Circumstantial factors that supported the process included the publication of clear indicators of the problem in the 2003 KDHS results, as well as the shift in perceptions about HIV and AIDS from crisis policymaking, to 'politics-as-usual'. In addition, advocacy strategies were effective in widening the space further through a combination of public and 'hidden' intra-government efforts to reframe family planning and present it as a priority issue that is in line with Kenyan health, development and economic goals and dominant gender norms, rather than being an external agenda. The case study reveals the important role government officials can play in sensitising colleagues within and between ministries to neglected SRH issues. In Kenya this was dependent on the existence of highly-motivated individuals in both the Ministry of Planning and the Ministry of Health, and the existence of the NCAPD, which had the independence and mandate to carry out advocacy on population-related issues. In accordance with Walt and Buse (2000), Buse et al., (2005) and Cerny (2002), both formal organisations and civil society in the international context played a vital role in

shaping the domestic policy process, first helping to contract, then to expand the policy space for family planning.

The case study supports Shiffman (2007)'s assertion of the importance of the availability of reliable indicators to demonstrate the policy problem and the organisation of focusing events. As predicted by Thomas and Grindle (1994), technical analyses of population problems played a central role in persuading policy elites of the need for reform. The availability of reliable data in the 2003 KDHS galvanised efforts to address this shift and were useful as advocacy tools for convincing budget and other officials of the need to reprioritise family planning.

Government officials and politicians who support family planning appear adept at selecting from the range of policy narratives and tailoring their arguments for different audiences. Advocate's use of arguments to reframe family planning as non-radical, promoting collective welfare and development and in tune with Kenyan development aims and prevailing gender norms can be seen as a strategy advocates use to 'Legitimis[e] initially contested women's issues' (Joachim, 2003). Advocates of family planning used policy narratives to reframe family planning, contesting the social meaning of the issue, establishing the existence of a policy 'problem' and legitimating certain courses of action by government (Schön and Rein, 1991).

Despite the expansion of policy space in recent years, very few of the key informants interviewed for this study were of the opinion that the issue has been restored to the level of government priority and implementation success it enjoyed during the 1980s.

Efforts to promote family planning as a priority in Kenya and to secure resources for implementation continue.

Endnotes

[1] The key informants were from the Ministry of Health (a senior budget officer [I13] and two officials in the Division of Reproductive Health [I3; I4]), the National Coordinating Agency for Population and Development (NCAPD) [I1; I2; I7] and the Central Bureau of Statistics (CBS) in the Ministry of Planning [I7], USAID [I14], Planned Parenthood Federation of America – International [I15; I16], Constella Futures [I6], Kenyan Association for the Promotion of Adolescent Health (KAPAH) [I5], and Marie Stopes International [I8]. Additional unstructured discussions were carried out with an international advisor to the Ministry of Health [I10] and a demographer with expertise on family planning in Kenya [I9].

[2] The KDHS 2003 results were published in 2004 but were discussed in meetings during late 2003 within the Ministry of Planning and with other stakeholders

[3] Although the specific agenda to use advocacy to 'reposition family planning' began to appear in government documents during 2005, the agenda appears to have its roots among actors in the then NCPD and supporting US agencies from before the KDHS figures emerged. A 2003 document that does not feature KDHS results cites the need for 'renewed high-profile public commitment by high-level leaders to reinvigorate FP in Kenya' (NCPD 2003).

[4] This figure is based on the conversion rate between Kenyan Shillings and US Dollars in June 2005

[5] At the time of writing, Ministry of Health data on contraceptive use trends has not yet shown any clear signs of improvements since the introduction of the new budget line in June 2005, although it may be too early to expect to see the impact [14].

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