



Policy Brief

No. 10 • April 2010

A publication of the National Coordinating Agency for Population & Development

Equalizing Access to Family Planning Can Reduce Poverty and Improve Health

Family planning – deciding whether and when to have children – generally entails the use of contraception to implement such plans. Research substantiates that there is a considerable “unmet need” for contraception among people who want to delay their next birth by at least two years or to stop having children but are not using a method of contraception.

Poverty Affects the Use of Family Planning

For those who cannot afford to meet their basic human needs for clean water, adequate food and nutrition, health care, education, clothing and shelter, contraception may be far down the list of priorities. This may be so even if family planning services are subsidized or free.

A comparison of the use of family planning services shows that globally, developed countries, which have lower levels of poverty than developing countries, have higher levels of family planning usage. Inequalities also exist within countries, including Kenya, according to household wealth.

Although the ability to plan one's family is a basic



human right, it is one that is not equally accessible to all. Poverty and skewed access to information and services play a role in the ability of individuals and couples to plan their families.

This policy brief analyses the interactions among these factors and recommends ways to improve universal and equitable access to family planning, regardless of income.

Family Planning Has Many Benefits

When the need for family planning is not met, women and families have more children than they intended, and populations grow more rapidly than economic and social development can keep pace with.

Improving and equalizing access to family planning can yield significant benefits for Kenya's future economic and social development – and for family wellbeing. Family planning has other advantages as well, as described below.



It Saves Lives

Researchers estimate that universal access to family planning services could save the lives of about 150,000 women worldwide each year (Singh et al., 2009).

Adequate spacing between births can also save the lives of infants and children. Increasing intervals between births to three years could prevent the deaths of 1.8 million children under five years of age each year (UNFPA, 2007).

Kenya's maternal mortality ratio is estimated to be about 488 deaths per 100,000 live births (KNBS and ICF Macro, 2010). Annually, about 14,700 Kenyan women and girls die as a result of pregnancy-related complications.

Additionally, between 294,000 and 441,000 women and girls suffer from disabilities caused by complications during pregnancy and childbirth. Most such deaths and disabilities can be prevented with cost-effective health care services, including family planning (Futures Group, 2002).

It's Cost-Effective

A global cost-benefit analysis found that spending an additional US\$3.6 billion to improve access to contraceptives for women in the poorest developing countries,

Birth intervals of less than 36 months (three years) are more common among poor women than among wealthy women. Shorter birth intervals translate into higher infant, child and maternal deaths and disabilities among poor women and children.

including Kenya, could prevent 53 million unintended pregnancies and nearly 25 million abortions.

This would translate into large health care savings (Singh et al., 2009). But enabling women and couples in poor countries to have smaller families has occurred only in the presence of comprehensive family planning programmes, which require strong government and often donor support.

Poverty and Inequality in Kenya

In 2009, the UNDP *Human Development Report* (HDR) ranked Kenya among the highly unequal countries in the world in terms of citizens' ability to access quality education, health care and the basic necessities that contribute to a decent life. Out of 182 countries, Kenya was ranked 147th.

Inequality in Kenya is considered to have been at its worst

level in 1999, when more than half the population lived below the poverty line.

In that year, Kenya was ranked among the ten most unequal countries in the world (SID, 2004). This was the culmination of a trend that

had worsened since the early 1970s.

In 2008, the Kenya National Bureau of Statistics (KNBS) found that the poverty levels in the country had declined. And despite its low ranking by the 2009 HDR, Kenya recorded a decline in the levels of inequality. These were indications that the welfare of Kenyans was improving.

These improvements at the national level hide many dispari-

Poor people are disadvantaged in terms of access to media messages on the benefits of family planning as well as in the utilization of family planning services.

ties within the country – between urban and rural areas, between geographical regions, and between different income groups.

Access to Family Planning Has Improved the Lives of Kenyans

One approach that has improved the welfare of the Kenyan population is the availability of family planning. Much has been achieved since 1967 when the Government began the national family planning programme. Today, the provision of family planning services has spread to many parts of the country, although there are still areas where distances to a service provider are great.

Between 1978 and 2009, the proportion of married women using contraception increased



from 7% to 46%, while the average number of births per woman decreased from 8 to 4.6 (KNBS and ICF Macro, 2010). This decline in fertility has lowered the country's population growth rate from 3.8% in 1979 to the current estimated level of 2.7% (World Bank, 2009).

Even though improvements have been made in the reduction of inequality, poverty and the

In Kenya, as in most developing countries of the world, the biggest threat to poverty reduction efforts is continued rapid population growth.

population growth rate, national goals are far from being achieved.

The National Population Policy for Sustainable Development aims to reach a population growth rate of 2.1% by the end of 2010. At the same time, the country's development blueprint, *Kenya Vision 2030*, envisions a poverty level that is below 10% by the year 2030 (GOK, 2007). This will be nearly impossible to achieve for a population that at the current growth rate will almost double in size by 2035.

Family Planning, Fertility, and Poverty

In Kenya, as in most developing countries of the world, the biggest threat to poverty reduction efforts is continued rapid population growth.

And like other countries with rates of population growth above 2% per year, Kenya is characterized by a youthful population, relatively large average family size and a high percentage of people living in poverty.

Children of the poor are likely to be less well-nourished and less well-educated than those from wealthier families. They also tend to be ill-prepared for employment and often remain poor when they grow up. Worse, stunting – physical and intellectual – as a result of prolonged childhood malnutrition is irreversible.

In the 1990s, Kenya's economic growth stagnated at an average annual rate of below 2%. Growth picked up from 2003 to 2007 and achieved a peak rate of 7% (KNBS, 2008a).



Despite this improvement, the rapid rate of population growth does not permit the spending of sufficient resources to meet the increasing demands of the growing population for water, food, education, housing and health care.

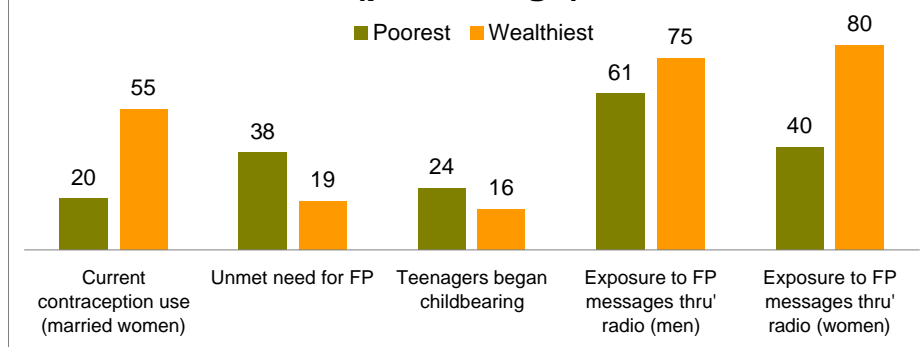
Family Planning Is a Powerful Tool for Combating Poverty

With a population growth rate of 2.7%, the country's population is expected to double in less than 30 years. Currently 47% of the population lives below the poverty line¹ (KNBS, 2008b). The rapid population growth is likely to increase the numbers, if not the percentage, living in poverty. Slower population growth would permit the expansion of employment and services to a greater percentage of people, spurring economic and social development.



¹The poverty line refers to the minimum expenditure per month required to meet a household's nutritional and basic non-food needs. The poverty line in Kenya was estimated at Ksh1,239 and Ksh2,648 for rural and urban households, respectively (CBS, 2005).

Figure 1: Family planning and childbearing differentials - 2008 (percentage)



Source: KDHS 2008/09 (KNBS and ICF Macro, 2010).



prevalence rate grew steadily from the onset of the programme in 1967 to 1998, it stalled at 39% from 1998 to 2003. Recent surveys show that it has now increased to 46% among currently married women, but use is much lower among poor women (CBS, 2003; KNBS and ICF Macro, 2010). For all these reasons, more efforts are needed in Kenya to help people achieve their desired family size through improved access to quality family planning knowledge and services, especially among the poor.

Poverty and Family Planning in Kenya

There are significant differences between income groups not only in the use of family planning, but also in related factors, such as exposure to family planning messages. Some of these differences are highlighted in figures 1–3 for the poorest and richest 20% (quintile) of the population (KNBS and ICF Macro, 2010).

The data in the figures suggest that there are serious income inequalities in terms of access to family planning information and services. Urgent and appropriate

actions are therefore needed to eliminate these inequalities.

The Poor Have Higher Unmet Need and Lower Use of Contraceptives

Figure 1 shows that in 2008, current contraceptive use was nearly three times higher among married women who are wealthy (55%) than among women who are poor (20%).

Unmet need for family planning among the poorest (38%) is twice that of the richest income group (19%). One-quarter of the teenagers in the poorest income group had already begun childbearing, compared with less than one-fifth of those in the richest income group.

Although about two-thirds of men who were in the lowest wealth quintile had heard a family planning message on the radio, this was low compared with the 75% in the highest wealth quintile who had heard such a message. Less than half of women in the lowest wealth quintile had heard a family planning message on radio, compared with 80% in the highest quintile.

These differences show that the poor are disadvantaged in terms of information about the benefits of family planning and

Family planning enables couples to have the number of children they intend to have and to space their births, thereby improving child health and survival and reducing maternal depletion caused by having too many or too closely spaced births. Parents are able to devote more resources to each child, thereby improving child nutrition, education levels and living standards. Family planning programmes enable women to enter the labour force and contribute to their family's income.

Although the contraceptive

Figure 2: Current use of modern contraception by wealth quintile - 2008 (percentage)



Source: KDHS 2008/09 (KNBS and ICF Macro, 2010).

contraceptive use to improve their wellbeing.

The Poor Are Less Able to Achieve Their Desired Family Size

Family sizes are also significantly different between the lowest and highest income groups. While the highest wealth quintile had a total fertility rate (TFR) of 2.8 children per woman in 2008, the lowest wealth quintile had a TFR of 7 children, more than twice as high as that of the wealthier women and well above the national average of 4.6 children per woman.

The number of children wanted by the poorest respondents was 5.3, in comparison with 2.5 children wanted by wealthy women. Poor women had 1.7 more children than they wanted, whereas wealthy women had 0.4 more children than desired.

The Government of Kenya has approved a comprehensive mix of contraceptive methods to be provided to the public (MOH, 2007a). Despite this, the Government acknowledges that one of the challenges for the provision of family planning is the lack of security for contraceptive commodities (MOH, 2007b).

All organizations involved in

the provision of contraceptives are required to ensure that there is an adequate method mix in addition to assuring that the contraceptives are accessible and affordable to all people in need of them. Figure 2 shows the modern family planning methods used by married women in the lowest and highest wealth quintiles.

Injectables were the method of contraception most often used among married women in both the highest and lowest wealth quintiles. Among the wealthiest women, the proportion using any modern method was much higher than that of poor women. Even the least expensive methods, i.e., oral pills and condoms, are utilized by less than 3% of the poorest women, compared with 12% of the wealthiest women.

The fact that the highest proportion of poor women use injectables (7%) may be an indication that the availability of inexpensive, long-acting methods

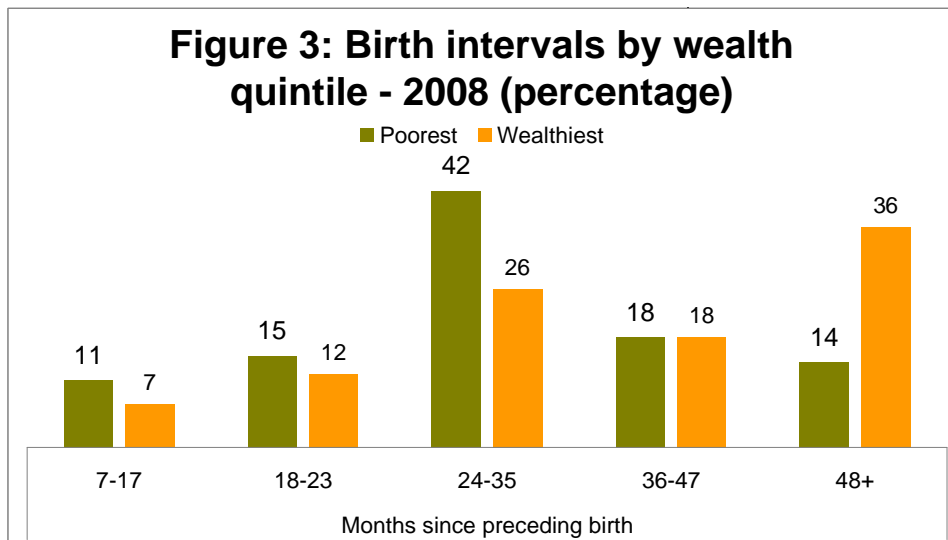
Parents who use family planning are able to devote more resources to each child, thereby improving child nutrition, education levels and living standards.



can increase contraceptive utilization among the poor.

The Poor Have Less Optimal Spacing between Births

The interval between a birth and the next pregnancy is an important factor in child survival and maternal health. Intervals of at least two years but not more than five years between a birth and the next pregnancy are associated with the healthiest pregnancy outcomes. Short birth-to-pregnancy intervals can lead to more stillbirths, miscarriages, infant and maternal deaths, and disabilities (USAID, 2007).



Source: KDHS 2008/09 (KNBS and ICF Macro, 2010).

Figure 3 compares the birth intervals between the poorest and wealthiest women. The largest proportion of poor women (42%) who had a second or higher order birth during the five years prior to the survey had an interval of 24–35 months between births, compared with the wealthiest women, of whom the largest proportion (36%) had an interval of 48 months or more.

In general, the chart shows that over two-thirds (68%) of the poorest women had a less than optimal birth interval of below three years (7–35 months), but over half of the wealthiest women have a more beneficial birth interval of three or more years. Given that more than a

third of poor women have an unmet need for family planning, the disparities in birth intervals between the two income groups can be significantly addressed by reducing the high unmet need for spacing and limiting births among the poor.

Implications of the Inequalities in Access to and Use of Family Planning

Efforts to reduce poverty and improve living standards depend on Kenya’s ability to curb the rapid rate of population growth. If the population growth rate were reduced from 2.7% to 2.1%, as is the goal of Kenya Vision 2030, the country would have more resources to invest in quality social services and job creation.

Existing inequalities in the use of family planning make it unlikely that efforts to reduce the growth rate and subsequently the poverty levels will be successful without simultaneous action to address these inequalities. Since the poor make up nearly half of the population in the country, a significant change in the welfare indicators can only be achieved by address-

ing the family planning needs of this large, under-served segment.

Programme Implications

The ability to plan one’s family is supported when there is a broad choice of contraceptive methods to suit the diverse needs of individuals of varying ages, abilities and circumstances.

In addition, comprehensive and high quality family planning services include counselling on method attributes and how to manage side effects, sexuality education, prevention and management of sexually transmitted infections, and infertility management. These elements are the most likely to be missing in services that are accessible to the poor.

The findings on inequality and poverty described above have two main programme implications. First, programmes need to focus on improving strategies for reaching the poor with information and services.

More efforts should be made to better understand the needs of the poor and the constraints that prevent them from using existing services. This information

Increased provision of family planning services and commodities that are free and accessible to the poor must go along with programmes to increase the public’s understanding and appreciation of the importance of family planning to their own individual well being and that of the nation as a whole.

Family planning programmes can help to reduce poverty by enabling women to enter the labour force and contribute to their family's income.

will help programmes reach the poor and effectively eliminate the existing inequalities.

Second, more emphasis is needed to raise awareness among the poor about the benefits of family planning. For example, the health benefits of spacing children at least two and preferably three years apart is not widely known.

Enhancing the public's understanding and appreciation of the role of family planning in the reduction of poverty and improvement of health and the standard of living must be accompanied by increased provision of family planning services and commodities that are free and accessible to the poor.

Recommended Policy Actions

At the policy level, the need to address existing inequalities in family planning and income levels has been recognized and documented, for example, in the National Reproductive Health Policy, National Contraceptive Commodities Security Strategy, Poverty Reduction Strategy Paper and Kenya Vision 2030.

While quite a number of activities have been implemented to reduce inequalities, more action is urgently needed. NCAPD therefore recommends that the Government of Kenya take the following actions:

- ◆ Increase government and donor resources for family planning to match the current

and anticipated future demand. This demand is driven both by the growing numbers of Kenyans of reproductive age and by the increasing proportion of women with an unmet need for contraception – and ideally by the success of awareness raising efforts.

- ◆ Expand the method mix of modern contraceptives provided by the Government and programme implementers to ensure that a range of family planning options is available to consumers. These contraceptive options should include those that are effective, easy to administer, long-acting and less costly.
- ◆ Improve access to family planning services among the poor, under-served, rural and hard-to-reach populations through outreach of information, education and services to these populations, and by training health workers to provide respectful, comprehensive services to the poor.
- ◆ Expand community-based distribution of contraceptives to the poor. The Community Strategy in the Government's

second National Health Sector Strategic Plan (NHSSP II) should emphasize the role of community health extension workers (CHEWs) in distributing contraceptives.

- ◆ Streamline the Government's contraceptive logistic system and supply chain to avoid the frequent stock-outs of contraceptive commodities that currently undermine the success of the programme. This will help meet the anticipated increase in demand for family planning services.
- ◆ Implement a national information, education and communication (IEC) campaign, to reaffirm the importance of family planning in national development, and to increase knowledge about the different contraceptive methods and the benefits of family planning for women's

Poor women are much less likely than wealthy women to use any major modern contraceptive method, indicating that poor women are less able to prevent unintended pregnancies.





and children's health, especially among the poor and those who are semi-literate.

These recommendations are in harmony with the National Reproductive Health Policy. The policy aims to increase the use of modern contraception as a way to help women and families promote and maintain good health, thereby contributing to the overall development of the country.

With these actions to reinvigorate Kenya's family planning programme and help all women and couples have the number of children they intend to have, regardless of income, Kenya

Enabling women and couples in poor countries to have smaller families has occurred only in the presence of comprehensive family planning programmes, which require strong government and often donor support.

can move forward into a new decade of reduced inequality and increased prosperity.

References

- CBS, MOH and ORC Macro. 2004. *Kenya Demographic and Health Survey, 2003*. Calverton, Maryland: Central Bureau of Statistics, Kenya Ministry of Health and ORC Macro International.
- CBS. 2005. *Geographic Dimensions of Well Being Poor in Kenya*. Central Bureau of Statistics, Nairobi, Kenya.
- Futures Group. 2002. *Maternal and Neonatal Programme Effort Index*. Glastonbury, USA.
- GOK, 2007. *Kenya Vision 2030 – A Globally Competitive and Prosperous Kenya*. Ministry of Planning and National Development and the National Economic and Social Council, Nairobi, Kenya.
- KNBS. 2008a. *Kenya Economic Survey 2008*. Kenya National Bureau of Statistics, Nairobi, Kenya.
- KNBS. 2008b. *Well Being in Kenya – A Socio-Economic Profile*. Kenya National Bureau of Statistics, Nairobi, Kenya.
- KNBS and ICF Macro. 2010. *Kenya Demographic and Health Survey 2008/09*. Calverton, Maryland: Kenya National Bureau of Statistics and ICF Macro.
- MOH. 2007a. *National Contraceptive Commodities Security Strategy*. Ministry of Health, Nairobi, Kenya.
- MOH. 2007b. *National Reproductive Health Policy*. Ministry of Health, Nairobi, Kenya.
- SID. 2004. *Pulling Apart – Facts and Figures on Inequality in Kenya*. Society for International Development, Nairobi, Kenya.
- Singh, Sushella, Jacqueline Darroch, Lori Ashford and Michael Vlassoff. 2009. *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. New York: Guttmacher Institute and UNFPA.
- UNDP. 2009. *Human Development Report: The Human Development Index – Going beyond Income*. United Nations Development Programme, New York, USA.
- UNFPA. 2007. *Family Planning and Poverty Reduction – Benefits for Families and Nations*. United Nations Population Fund, New York.
- USAID. 2007. *Healthy Timing and Spacing of Pregnancies*. Washington, D.C.: United States Agency for International Development.
- World Bank. 2009. *World Development Indicators, 2009*. Washington, D.C.: The World Bank.

NCAPD Policy Brief No. 10, Equalizing Access to Family Planning Can Reduce Poverty and Improve Health

Any part of this document may be freely reviewed, quoted, reproduced or translated in full or in part, provided the source is acknowledged. It may not be sold or used in conjunction with commercial purposes or for profit.

Production of this Policy Brief was made possible by the support of the United States Agency for International Development (USAID) through the Population Reference Bureau. The contents and opinions expressed herein are those of the authors.

© 2010, National Coordinating Agency for Population and Development

National Coordinating Agency for Population & Development

PO Box 48994 - GPO, Nairobi 00100, Kenya

Tel: 254-20-271-1600/01

Fax: 254-20-271-6508

www.ncapd-ke.org

NCAPD is a semi-autonomous government agency that formulates and promotes population policy and coordinates related activities for sustainable development in Kenya.