Policy Brief

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Addressing Sexual Reproductive Health Challenges in Kenya: The Poverty Dimension

Good health is a pre-requisite to the socio-economic development of any country. Investments in reproductive health can lead to both economic and health benefits for individuals, families, and communities. In Kenya, efforts to reduce poverty have, to some extent, been hampered by poor reproductive health and inadequate health care services.

Currently, about half of Kenyans live below the poverty line, majority of the children are born without the assistance of a skilled health personnel, the proportion of unintended or mistimed pregnancies is high, HIV and AIDS continues to afflict a considerable proportion of the population, and the availability of maternal health care services is far from adequate. This policy brief examines the state of sexual reproductive health and poverty indicators in Kenya and recommends measures that should be taken to improve them.

Reproductive Health and Poverty, Where is the Link?

Globally, about one-third of the disease burden among women aged 15 to 49 years is from sexual and reproductive ill health.[1] In order to deal with this burden, individuals, families, and governments need to expend their resources. For many individuals and families in the developing countries, these expenses may be beyond their ability and may require them to sacrifice other needs. Unintended pregnancies in many cases lead to unsafe abortions that could in turn lead to ill health and death among women. Early childbearing and short intervals between births, in addition to potential adverse health effects, hampers the socio-economic development of women by denying them opportunities to education and higher incomes.[2]

Sexual reproductive health is the state of complete physical, mental, and social well-being in matters relating to the reproductive system and its functions and processes. Sexual and reproductive health services are mainly related to family planning, maternal health, and sexually transmitted infections.

A large family size affects household well-being through competition for scarce household resources that may lead to poor nutrition and health as well as low levels of education for family members. The overall effect of unplanned and frequent births is that

it leads to a rapid population increase. This in turn puts a lot of strain on the government as most of the resources have to be directed towards meeting the increasing demand for health care, housing, food, and education at the expense of economic development.

Family planning, which entails practicing appropriate spacing of births and avoiding unintended and early births, can contribute to the good health of the mother, proper care of children and the overall well-being of the family. This may in turn ensure a healthy and productive population as well as the availability of more resources for development at the household and national level.

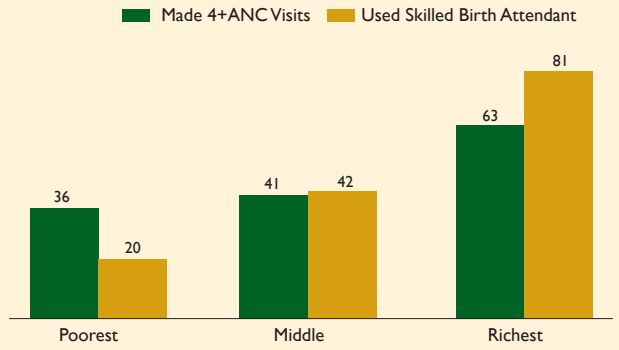
HIV infections contribute to ill health, poverty and in some cases death. In Kenya, HIV and AIDS have been identified as a major threat to public health.[3] The cost incurred in providing continuous care to a family member with AIDS usually puts great strain on family resources. Many children are therefore subjected to poverty following the death of their parents or guardians. Children who are orphaned by AIDS are often forced to leave school in order to fend for themselves.

Education has invariably been associated with improved household income as well as positive health outcomes. An educated population is well placed to meaningfully participate in productive economic activities that can contribute to poverty alleviation.[4,5,6] At the same time an informed public is able to understand and utilize health information appropriately thereby improving its health, including sexual and reproductive health.

Status of Reproductive Health, Education and Poverty

Antenatal Care (ANC) is an essential service that helps to ensure that women have a safe pregnancy and a good birth outcome. According to the 2008-09 Kenya Demographic and Health Survey (KDHS), on average about half of the pregnant women in Kenya make at least 4 ANC visits to a skilled health provider. However, according to Figure 1, only one-third of pregnant poor women make the recommended 4 ANC visits compared to two-thirds of the wealthiest pregnant women. The Figure further shows that at the time of delivery, only 1 out of 5 pregnant poor women get the services of a skilled provider during delivery compared to 4 in 5 among the wealthiest pregnant women. On average, 2 in every 5 pregnant

Figure 1: Utilization of skilled ANC and birth delivery services among women 15-49 years by wealth status (percent)



Source: *2008-09 Kenya Demographic and Health Survey*

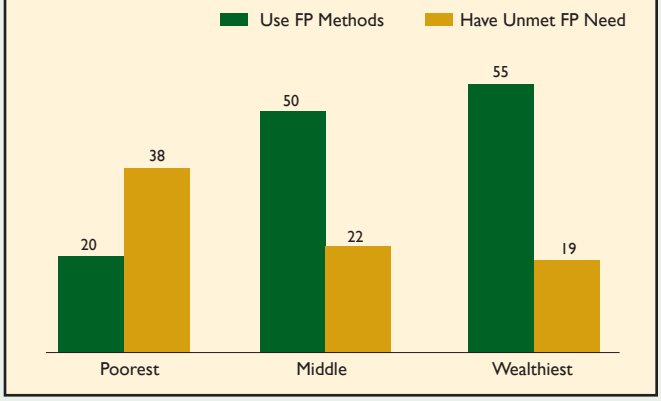
women in Kenya deliver with the help of a skilled service provider.

Access to health care services during pregnancy and delivery can help to avert serious health problems and death. However, from the 2010 Kenya Service Provision Assessment (KSPA), only one-third of the health facilities in Kenya provide delivery services. This situation is made worse by the fact that only 5 percent of the facilities offering delivery services are able to provide comprehensive emergency services for pregnant mothers which include blood transfusion and caesarian section services.

Kenya has made significant progress in increasing the proportion of married women who use family planning (FP) methods, but a lot still remains to be done. Although 4 in every 5 health facilities provides modern family planning services, the 2008-09 KDHS found that slightly less than half of the married women currently use FP methods. A comparison of the wealthiest and poorest women, as depicted in Figure 2, shows that 55 percent and 20 percent of these women use FP methods respectively.

The 2008-09 KDHS survey also found that about a quarter of married women were not using any FP method despite them having an intention to delay the next pregnancy or have no more children. This could partly explain why the proportion of unintended pregnancies in Kenya is high. Among the poorest women, the proportion that was found not to be using any FP method to either delay or prevent pregnancy was twice that of the wealthiest women as shown in Figure 2. Poor households often have larger family sizes due to lower family planning use. According to the 2006 Kenya Integrated Household and Budget Survey (KIHBS), on average 2 out of every 5 poor

Figure 2: Use of FP methods and unmet need for FP among women 15-49 years by wealth status (percent)

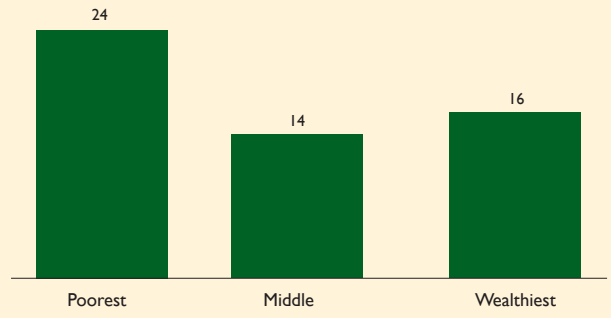


Source: *2008-09 Kenya Demographic and Health Survey*

households have at least seven or more members compared to about 1 in 5 of the non-poor households.

Early pregnancy, a major health risk among younger women, is much higher among the poorest women compared to wealthier women. As shown in Figure 3, the 2008-09 KDHS found that teenage pregnancy among the poorest female teenagers was 24 percent compared to 16 percent among wealthier ones.

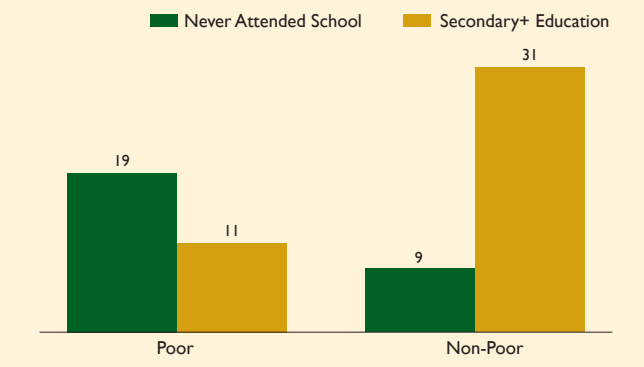
Figure 3: Prevalence of teenage pregnancy among women 15-19 years by wealth status (percent)



Source: *2008-09 Kenya Demographic and Health Survey*

In terms of education status, the 2006 KIHBS found that only 1 in every 10 poor persons had attained secondary or higher education compared to 3 in 10 among the non-poor as shown in Figure 4. The Figure also shows that the proportion of poor individuals who have never attended school was twice that of the non-poor. Among children aged 6 to 17 years who had left school, the main reason cited was lack of finances. This was the case with two-thirds of those who were supposed to be in primary school and a third of those who were supposed to be in secondary school.

Figure 4: Education status by wealth (percent)



Source: *2006 Kenya Integrated Household and Budget Survey*

Poverty in Kenya declined from above 50 percent in the 1990s to 46 percent according to the 2006 KIHBS. A comparison of the poor and non-poor shows a significant difference in the dependency ratio. Among the poor, there are 94 dependents for every 100 working age people, while among the non-poor there are 72 dependents for every 100 working age people.

Implications for Policy and Programmes

The findings of KDHS (2008-09) and KIHBS (2006) have shown that in general, low utilization of ANC services, low skilled birth attendance and low family planning methods use is associated with poverty. Early childbearing among teenage girls and lower education levels are also directly linked to poverty levels. These findings underscore the importance of having interventions that specifically target the SRH needs of the poor as well as address the high poverty levels in the country. Sexual reproductive health indicators for Kenya can only improve if the poor are specifically targeted both at policy and programme levels.

If the current trend in the utilization of sexual reproductive health services continues and the poverty levels remain high, then Kenya will maintain a population growth rate that cannot be sustained by the available resources. This will lead to many undesirable outcomes such as congestion in towns, pollution and destruction of the environment, high levels of crime, increase in poverty levels, and poor access to social services including education. In addition to this, improvements in maternal and child health will be difficult to attain hence more women and children will become ill, and in some cases die, due to poor sexual reproductive health. However, in order to avert the above consequences, the Government, development partners, and stakeholders need to take

decisive action to improve sexual reproductive health and reduce the poverty levels in the country. Without this kind of action, the development aspirations of Kenya will never be realized.

Policy and Programme Recommendations

In order to improve the sexual reproductive health outcomes for Kenya and alleviate poverty in the long run, the following actions are proposed at both policy and programme level:

- ***Scale up skilled attendance at both health facility and community levels:*** The Government, through the Ministries of Health, needs to urgently work at scaling up the proportion of facilities providing delivery services especially in the rural areas where access to these services is difficult. This can be done by strengthening the existing public health facilities to provide these services, and in areas with dire need, opening up new facilities. In order to enhance public-private partnerships, the Government should encourage and provide an enabling environment for the private sector to scale up delivery services. Over the next 5 years the proportion of facilities offering delivery services should be increased to 60 percent from the current 30 percent. Community midwifery initiatives should also be promoted to increase skilled attendance at the community level.
- ***Increase access to education at all levels***: The Ministries of Education need to increase access to education, especially for the poor and vulnerable populations, by identifying factors hindering enrollment, retention and completion of schooling. Over the next five years, the Ministries of Education should systematically work towards this end so as to decrease the proportion of people who have never attended school and those who are dropping out while at the same time increasing the proportion that have secondary and above level of education.
- ***Enhance communication on benefits of family planning***: The National Council for Population and Development in collaboration with other stakeholders need to continuously increase public awareness on the benefits of family planning and having small families through several media channels such as radio, television, newspapers and public meetings. Through these channels, especially radio and public meetings, majority of the poor will be reached. With increased public awareness, the uptake of family planning methods among currently married women is expected to increase to about 60 percent by 2020 from the current 46 percent. Over time, household sizes are expected to decrease in harmony with the targets of the population programme. In addition, the dangers and disadvantages of teenage pregnancies should be emphasized and spelt out through the public awareness activities. Availability of family planning supplies should be enhanced as outlined in the National Family Planning Costed Implementation Plan (2012-2016).
- ***Ensure diligent implementation of Vision 2030***: The Kenya Vision 2030 Delivery Secretariat should ensure that the 5-year plans for the vision are fully implemented between now and the year 2030. By making a close follow-up on the implementation, the aspirations of the vision to make Kenya a middle income country with a high quality of life for its citizens will be achieved.
- ***Improve linkages between communities and the health care system***: Implementation of the Community Health Strategy by the Ministry of Public Health and Sanitation needs to be accelerated over the next 5 years in order to improve the linkages between the communities and the health facilities. This will help to increase access to SRH services especially in the rural areas where majority of the poor live.

The above recommendations are in harmony with the aspirations of Kenya to create a society where all people can prosper and lead a quality life.

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

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