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Achieving EQUITY for the Poor in Kenya:
Understanding the Level of Inequalities and Barriers to Family Planning Services

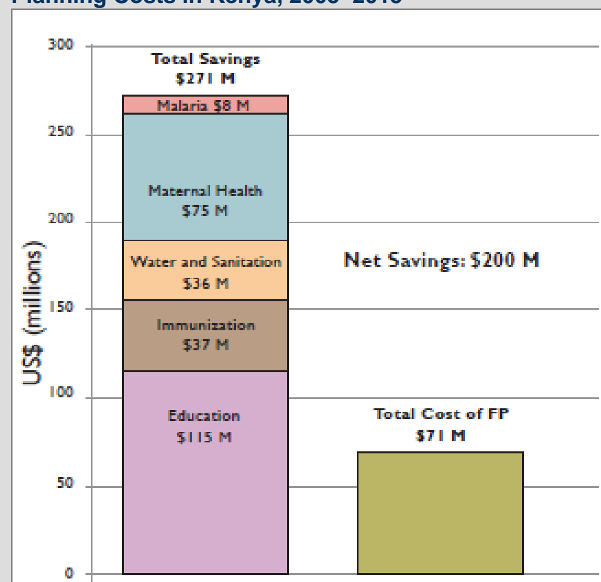
While trends vary by country, one point is clear: Countries that have achieved high levels of family planning and reproductive health (FP/RH) service use have done so by reducing inequalities in service access.[1] Given the sometimes large gaps in service use between the poorest and wealthiest populations, strategies to reach the poor can help countries expand overall FP/RH service access—ultimately leading to slower population growth, less burden on strained social services and natural resources, and improved maternal and child health (see Box 1). Reducing inequalities in service use could have far-reaching implications beyond improved reproductive health by helping families to create a path out of poverty and enhance quality of life.

To design effective FP/RH policies and strategies for reaching the poor in Kenya, it is essential to understand their needs and challenges. In response, the USAID | Health Policy Initiative, Task Order 1, carried out various analyses (including market segmentation, focus groups, and policy and financing reviews) to quantify the level of inequality in FP/RH service access, identify the barriers the poor face in seeking services, and explore where services are needed most. The complete findings will be published in a forthcoming report. This brief presents the preliminary findings to inform policy dialogue and discussion.

BOX 1 | Kenya Benefits from Increased FP Access

An analysis of the contribution of family planning to the Millennium Development Goals (MDGs) shows that satisfying unmet FP need in Kenya would avert 14,040 maternal deaths and 434,306 child deaths by the MDG target date of 2015. Moreover, FP use helps to reduce the size of the population in need of services. Thus, as shown in Figure 1, the cost savings in providing services to meet five of the MDGs outweigh the additional costs of family planning by a factor of almost 4 to 1.

Figure 1. Social Sector Cost Savings and Family Planning Costs in Kenya, 2005–2015



Source: Health Policy Initiative, Task Order 1. 2006. "Achieving the MDGs: The Contribution of Family Planning—Kenya." Washington, DC: Futures Group International.

What is the Current Level of Contraceptive Use in Kenya?

Kenya's strong national FP program contributed to a significant increase in the contraceptive prevalence rate (CPR) from 7 percent (modern and traditional methods) in the 1970s to 39 percent by 1998. The increasing CPR helped contribute to a decline in the country's total fertility rate (TFR), from an average of 8.1 children per woman in the late 1970s to 4.7 by 1998. However, both CPR (39%) and TFR (4.8) remained nearly constant from 1998–2003.[2]

The percentage of women using modern FP methods also has not increased over the last five years for which published data are available. According to the Kenya Demographic and Health Survey (KDHS), in 1993, 27 percent of married women age 15–49 were

using a modern method (e.g., oral pills, condoms, intrauterine devices [IUDs], injectables, implants, sterilization). CPR for modern methods increased to about 32 percent in 1998 and remained at this level through 2003. The percentage of women not using any method decreased from 67 percent in 1993 to 61 percent in 1998, leveling off at just under 61 percent in 2003 (see Figure 2).

The recent stagnation in contraceptive use and total fertility fuels continued rapid population growth, making it difficult for Kenya to achieve its national socioeconomic development goals.

What Is the Level of Inequality in FP/RH Service Use?

Defining who “the poor” are is a challenge. Simply looking at indicators such as the national poverty line is inadequate when trying to determine how to ensure that resources get to those *most* in need because, in many developing countries, a large proportion of the population lives below the poverty line. Recognizing this, a quintile analysis is typically used. One approach, popularized by the World Bank and Macro International, involves dividing the population into five equal groups based on an assessment of socioeconomic status (SES) according to a standard of living index. This approach recognizes that factors other than income, such as assets and household amenities, contribute to the SES of families. Analyses using this method and data from the KDHS are presented below.

Poor Women Lack Access to Family Planning. Women from the lowest SES groups are the least likely to use modern contraceptive methods, and, from 1993–2003, Kenya made no progress in closing the gap in FP use between the low and high SES groups (see Figure 3). In 2003, only 12 percent of women from the very low SES group used a modern FP method while 45 percent of women from the very high SES group did the same. Socioeconomic status affects access to and use of services, as there is an 8–14 percentage point increase in modern contraceptive prevalence use for each increase in quintile status.

Unmet Need for Family Planning is Highest among the Poor. Unmet need refers to the proportion of married women of reproductive age who want to

Figure 2. Contraceptive Prevalence by Type of Method in Kenya, 1993–2003 (KDHS)

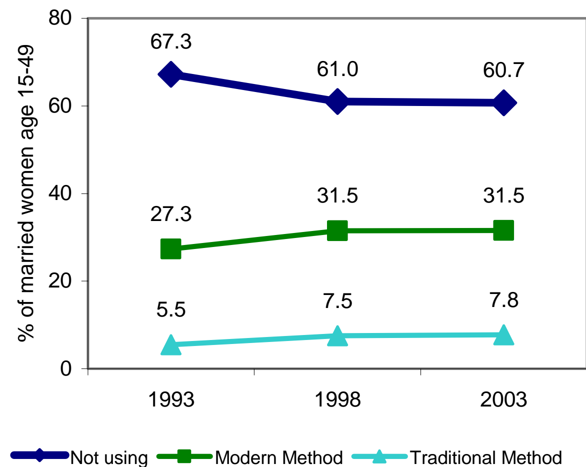


Figure 3. Modern CPR by Socioeconomic Status in Kenya, 1993–2003 (KDHS)

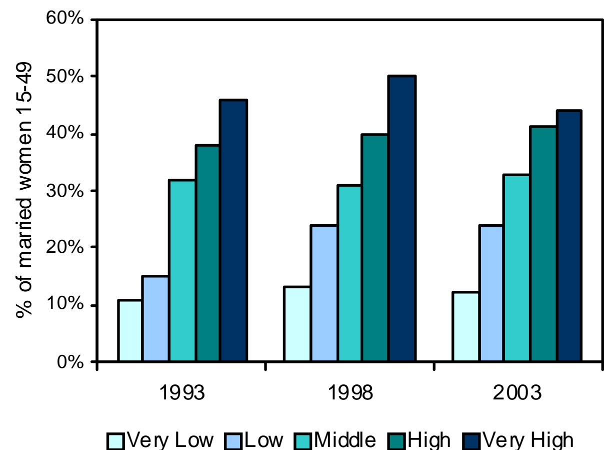
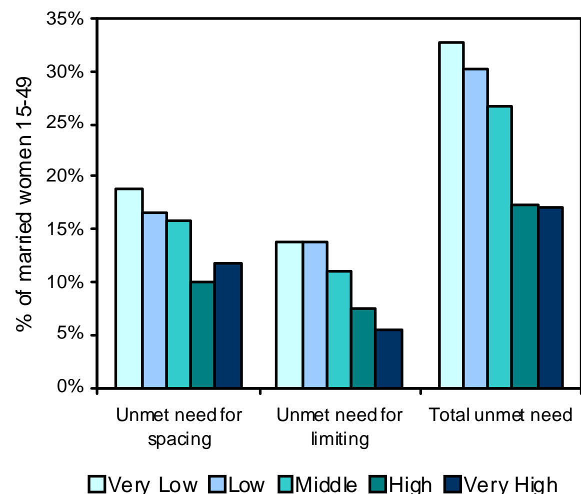


Figure 4. Unmet FP Need by Socioeconomic Status in Kenya, 2003 (KDHS)



wait two or more years to have a child, but are not using contraception. Reaching women with unmet need is often viewed as the "low hanging fruit" in terms of expanding FP access and increasing CPR, because this is a group that has already expressed a desire to space or limit future pregnancies and may be more receptive to FP use than other non-users.

In Kenya, women in the very low, low, and middle SES groups have the highest level of unmet need for family planning (see Figure 4). In fact, total unmet FP need among women in the very low (33%) and low (30%) SES groups is nearly double the unmet need found among the very high (17%) and high (17%) SES groups.

Many of the FP Clients Served by the Public Sector are Not Poor. Typically, public sector services are intended to reach the groups who are most in need and are unable to afford services elsewhere. In Kenya, the public health sector provides the majority of FP planning services (53%). Other providers include the commercial sector (e.g., private hospitals, pharmacies/chemists, and shops) (35%) and NGOs, religiously-affiliated clinics, mobile clinics, and community-based distributors (11%). A look at the socioeconomic status of FP clients of the different providers shows that the very low and low SES groups represent a small proportion of the clientele in all sectors (see Figures 5a–c). Most alarming, however, is the fact that these groups account for only about one-fourth (26%) of the clients served by Kenya's public sector, which, ideally, should cater to the needs of the poor. In practice, about half of the public sector's clients are from the high (27%) or very high (24%) SES groups.

Socioeconomic Status Affects Reproductive and Maternal Health. Inequalities between the poorest and wealthiest groups are also evident in other reproductive and maternal health indicators (see Table 1). Among women in the very low SES group, nearly half will marry by age 18 (45%) and two-thirds (66%) will give birth before they reach 20 years of age. In contrast, about 8 in 10 women in the very high SES group have a delayed marriage (age 18 or older) and 7 in 10 have a delayed first birth (age 20 or older). Women in the lowest SES group are also least likely to seek antenatal care (42%), have institutional deliveries (17%), or enjoy healthy birth spacing (35%). These factors affect the health of women and their children.

Figure 5. Socioeconomic Status of FP Clientele by Sector in Kenya, 2003 (KDHS)

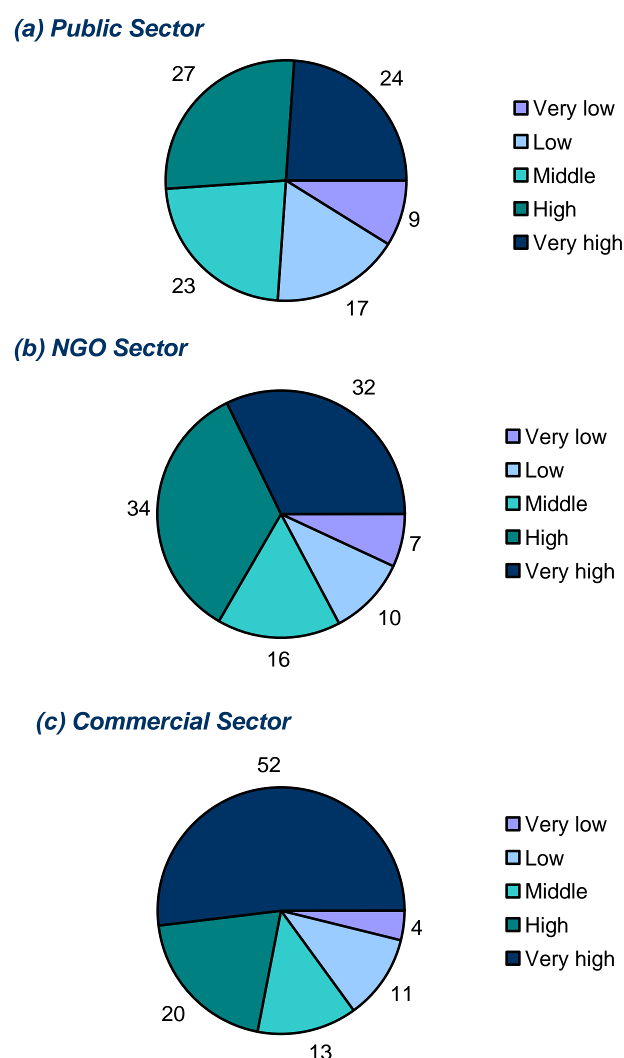


Table 1. Reproductive/Maternal Health Indicators by Socioeconomic Status in Kenya, 2003 (KDHS)

	Very Low	Low	Middle	High	Very High
Antenatal care	42	46	53	59	70
Institutional delivery	17	33	39	55	77
Delayed marriage (at age 18 or older)	55	72	68	80	83
Delayed childbearing (first birth at age 20 or older)	33	43	44	59	69
Birth spacing (36 months or longer)	35	43	45	48	54

Women seeking maternal and child health services at a hospital in Kisumu. Photo by Eric Ajwang.

What Keeps the Poor from Accessing FP Services?

The data above make clear that the poor are less likely to use FP services and also have the highest unmet need for family planning when compared to other groups. Further, they are less likely to benefit from the health services intended to meet their needs.

To better understand the barriers faced by the poor, the Health Policy Initiative conducted 33 focus group discussions with members of urban and rural poor populations in Nyanza and Coast Provinces in Kenya. Participants included women under age 30, both FP users and non-users; women over age 30, both users and non-users; and men. The project also interviewed 23 FP providers and conducted short exit interviews with 380 clients at selected sites. Barriers emerging from the preliminary analysis are summarized below.

Misinformation and Misconceptions

Many of the focus group discussants knew at least one method of family planning, and many recognized the benefits of family planning, especially for the health of women and children. Notwithstanding, many participants only knew about certain methods and were unaware of other methods, such as female condoms and implants. Despite a high awareness of some FP methods, discussants held misconceptions about the use of family planning. These myths and misconceptions typically related to potential side effects, such as pain, infertility, or birth defects. In some cases, such beliefs were based on personal experiences, but most often were based on reports from relatives or community members.

> *People say that users can deliver babies with two heads, and some report continuous headaches and backaches which make a woman unable to work, such as plowing the land... This is the reason why I have not used, because I have to do a lot of hard work to feed my children. (Female discussant, rural poor, Nyanza)*

Male Involvement

In general, there is limited communication about family planning between spouses. In urban areas, women who use contraceptives said they do so because they were motivated by friends or nurses, not by their husbands. Moreover, spousal opposition was one of the key barriers mentioned in all the discussions. According to female and male discussants, men oppose FP use because they think women will become promiscuous, men want to have sons, or they believe having more children will ultimately add to the wealth of the family. Women who use family planning might also be seen as challenging men's authority.

> *The men do not like the idea of family planning because they think that when we go to the clinic, we go to hide so that we may be promiscuous. (Female discussant, urban poor, Nyanza)*

> *When a woman unilaterally decides to use contraceptives without informing me, it means she is undermining my authority. (Male discussant, urban poor, Nyanza)*

Sociocultural and Religious Barriers

The preferences for large families and for sons are deeply held beliefs among members of the community, not only among men. For some men, there is a competition within the community to have larger families as this is believed to be a sign of strength and virility of the man and also of the family's wealth, as well as a guarantee that the family lineage will continue. Women report that mothers-in law support the belief that wives are meant to bear children for their sons. Women also said that having many children, especially sons, is a way to ensure their position or authority within the family and to keep their husbands from taking on additional wives.

When you have children, a man can no longer threaten you. (Female discussant, rural poor, Nyanza)

Many discussants mentioned religion as a barrier, a fact supported by the 2003 KDHS, in which 28 percent of the poorest women said that religious opposition is the main reason for non-use of family planning. Both Christian and Muslim discussants said that their religions prohibit FP use.

It is prohibited in Islam, so I cannot support it. (Male discussant, urban poor, Nyanza)

God forbids the use of contraception. It is like killing or a form of abortion. (Older female discussant, rural poor, Nyanza)

In some cases, discussants said that religious leaders are coming out in support of family planning and used references to religious teachings to support this view. For example, religious beliefs recognize that food is from God, but that it has limits. Thus, Christians are encouraged to use wisdom in their reproduction. Similarly, in Islam, it is desirous to have only the number of children that one is able to care for.

Costs and Frequent Stockouts

Costs for services include travel costs, lost wages or lost time for non-wage earners, costs for child care, and fees for services. The distances to health facilities are particularly prohibitive to residents of rural areas.

Because to go to the health post is so far, we don't have money to go. Women also do not have time to go. (Female discussant, rural poor, Coast)

Costs are particularly burdensome for poor women because of frequent stockouts of commodities. Women reported frustration at having to pay travel costs, lose wages, plead with neighbors to watch their children, and/or take time away from their daily chores, only to reach the facility and learn that the FP commodities or other needed supplies are not available.

However, distance and travel costs were not a barrier for all discussants, as some reported choosing to go farther to receive the services they want or to protect their confidentiality and avoid being seen by members of their own community.

Respondents also reported having to pay fees for services. According to Kenyan government policy, FP services in government facilities are to be provided for free, as are government-supplied FP commodities distributed by private and NGO providers. However, clients might have to pay registration costs, fees for medical tests, and, in some cases, fees for commodities and other hidden fees, which are not uniform across providers or even within the same facility. Most public health facilities reported that oral pills are free, but that Norplant (e.g., Kshs500), IUDs (e.g., Kshs200), and injectables (e.g., Kshs50) incur costs.

Provider Behavior

Some discussants reported poor provider-client interactions, including limited counseling on available FP options and side effects as well as condescending or unfriendly language. Providers also reported being overwhelmed by staff shortages and heavy workloads. In such cases, a provider noted, it is easier to provide the method the client asks than to initiate a full counseling session. Even so, discussants in urban areas mentioned generally having good provider-client interactions.

Where is the Need Greatest?

The need to focus FP resources to reach the poor is clear. However, "the poor" are not a homogenous group. Differences in FP use can be seen across and within provinces, urban/rural areas, and SES groups.

Figure 6. Contraceptive Prevalence Rate (Any Method) by Province (KDHS, 2003)

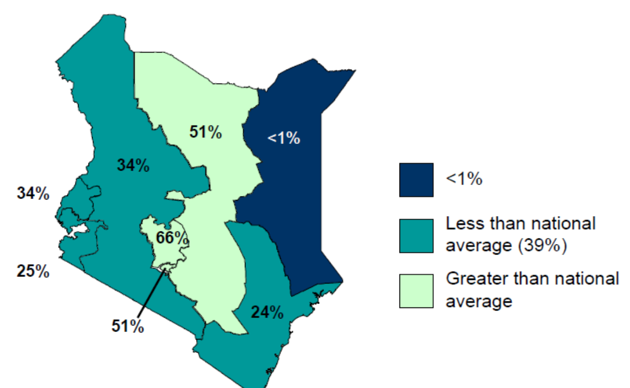


Table 2. Current FP Use and Unmet Need among Married Women (age 15–49) by Province, 2003 (KDHS)

	National			Province							
	Total	Urban	Rural	Nairobi	Central	Coast	Eastern	Nyanza	Rift Valley	Western	North Eastern
Current Use											
Any method (%)	39	48	37	51	66	24	51	25	34	34	<1
Modern methods (%)	32	40	29	44	58	19	38	21	25	27	<1
Traditional methods (%)	8	8	8	6	9	5	12	4	10	7	0
Unmet Need											
Total unmet need (%)	25	17	27	16	11	25	22	35	28	32	10
For spacing (%)	14	11	15	13	6	16	11	21	16	19	9
For limiting (%)	10	6	11	4	5	9	11	14	12	13	1

Figure 6 and Table 2 illustrate the disparities in contraceptive use across Kenya's provinces. Use of any contraceptive method is highest in the middle of the country, in Central Province (66%), Nairobi (51%), and Eastern Province (51%). CPR for any method is slightly lower than the national average in the Rift Valley (34%) and Western Provinces (34%). Nyanza (25%) and the Coast (24%) have low CPRs for any methods, while FP use is nearly non-existent in North Eastern Province (<1).

As shown in Table 2, rural populations (27%) have a higher unmet need for family planning than urban populations (17%). By province, unmet need is highest in the outer rim of the country, in Nyanza (35%), Western (32%), Rift Valley (28%), and Coast (25%) Provinces. Moreover, while hardly any women in North Eastern Province are using family planning, about 1 in 10 women report having unmet need. Thus, Kenya will likely be better able to reduce total fertility by focusing FP resources and program efforts on these areas with lower CPR and high unmet need.

However, even in provinces with relatively high levels of contraceptive use, there may be underserved populations, especially the urban and rural poor. Figure 7 presents modern CPR among different SES groups by their area of residence. This analysis shows that the high and very SES groups in both urban and rural areas have a modern CPR that is higher than the national average (which is 32%). It is the urban and rural poor, comprising the low and very low SES groups, that are less likely to use FP services. Similarly, the urban and rural poor have the highest unmet need for family planning (see Figure 8). Unmet FP need among the very low and low SES groups in urban and rural areas ranges from about 20–35 percent among married women age 15–49.

Figure 7. Modern FP Use by Socioeconomic Status and Urban/Rural Residence, 2003 (KDHS)

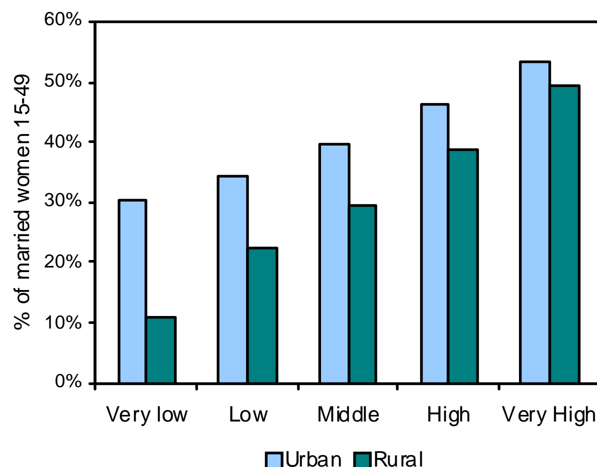
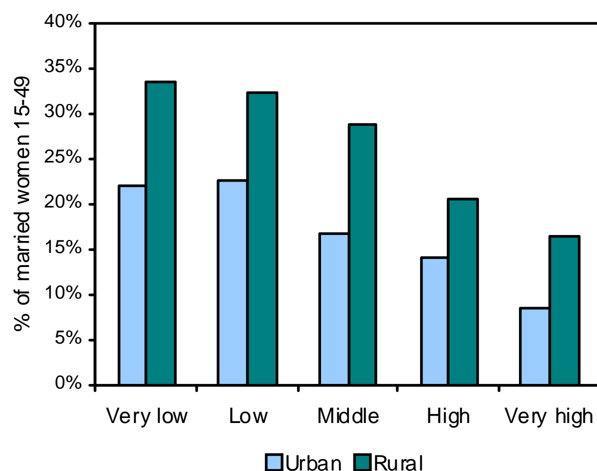


Figure 8. Unmet FP Need by Socioeconomic Status and Urban/Rural Residence, 2003 (KDHS)



Discussion: The EQUITY Approach

While overall improvements in healthcare systems are desirable in most developing countries, experience has shown that health interventions will not reach the poorest groups without appropriate planning, targeting, and oversight.[3] Care must be taken to identify the poor, understand their needs, and assess their barriers to increased service access and use. Building on this evidence, governments should formulate targeted, pro-poor policies as the foundation of appropriate, responsive programs. "Targeting" directs scarce resources to those most in need.[4] A "pro-poor" approach means that healthcare costs are based on the client's ability to pay; the poor and nearly poor are protected from financial calamity due to a severe illness; and steps are taken to improve equitable access—both in terms of quality and the geographic distribution of services.[5]

The Health Policy Initiative has designed the **EQUITY Approach** to ensure that health policies meet the needs of the poor. The approach calls for:

Engaging and empowering the poor—The poor should be empowered to become involved in the decisions that affect their healthcare needs. They are best able to speak to the challenges they face and to provide insights to design appropriate solutions. Thus, the poor have an important role to play in problem identification, advocacy, planning, and monitoring. In Kenya, the Health Policy Initiative involved the poor in problem identification through focus group discussions. The project has also worked with in-country partners to organize policy dialogue between the poor and their representatives and regional stakeholders in Nyanza Province. Further dissemination of findings from the focus group discussions has taken place at the community level in Kisumu, Homa Bay, and Siaya Districts. Through these forums, the poor shared their views toward FP use and ways to improve service access.

Quantifying the level of inequality in healthcare access and health status—Getting the FP/RH needs of the poor on the national policy agenda first requires an understanding of the magnitude and urgency of the issue. Market segmentation analyses based on DHS data and poverty mapping can reveal the level of inequality and help to pinpoint areas of greatest need. In particular, it is important to recognize that the poor are not a homogenous group. It is not enough to equate poverty with rural areas and relative wealth with urban areas, as even within these areas, there are segments of the urban and rural poor that are in greatest need of services. The preliminary analysis of inequalities in FP use presented in this brief shows that the lowest SES groups are least likely to use family planning and also have the highest unmet FP need.

Understanding the barriers to service access and use—Once the level of inequality is known, policymakers must have an understanding of why the inequalities exist. The focus group discussions summarized in this preliminary brief have identified key barriers such as misinformation and misconceptions, lack of constructive male engagement, sociocultural and religious beliefs, hidden costs for services, and inadequate quality of care. These discussion findings can complement existing data from the DHS to further explore reasons for non-use of family planning.

Integrating equity goals into policies, plans, and strategies—Several countries, including Kenya, aspire to alleviate poverty. To make this happen, specific policies, goals, strategies, resources, and monitoring mechanisms are needed. In Kenya, the Health Policy Initiative has provided technical support to the government and in-country partners to draft the new National Reproductive Health Strategy. The strategy calls for increasing "equitable access to reproductive health services" and includes specific, time-bound goals to: (1) reduce unmet FP need among the poor by 20 percent by 2015; and (2) increase modern CPR among the poor by 20 percentage points by 2015 (up from 12% in 2003).

Targeting resources and efforts to reach the poor—Integrating equity goals into the national strategy is a positive step forward, and one that must be followed up with implementation and monitoring mechanisms. The need of the hour is to target resources to reach areas of extreme poverty, such as North Eastern and Nyanza Provinces, and the dry (and poor) northern parts of the country. Similarly, there is a need to allocate resources to areas with pastoralist populations and to the urban slums in major cities. The country should also design a health financing strategy to ensure financing for the poor as well as strengthen and monitor the implementation of existing fee exemption policies.

Yielding public-private partnerships for equity—Meeting the FP/RH needs of the poor

requires that countries make the best use of all the available public, private, donor, and NGO resources. As discussed above, the poor in Kenya account for only about one-fourth of the clients of public health facilities. Strategies are needed to ensure that subsidized services (through the government or NGOs) reach the poorest populations and that the private sector serves clients that are more able to pay for services. The country should strengthen public-private partnerships with the commercial sector, and explore innovative models with NGOs—such as community-based distribution, which worked well in Kenya in the past—to reach underserved populations.

Community discussions on family planning use among the poor in Siaya District. Photo by Eric Ajwang.

Conclusion

For the poor, lack of access to family planning and continued high fertility can mean fewer resources (e.g., money, time, attention) for each child, leading to poor nutrition, ill health, and limited educational opportunities—ultimately trapping this group in a poverty cycle. For the society, continued rapid population growth will hamper Kenya's ability to meet the needs of its citizens and attain its health and development goals, such as those contained in the Vision 2030 and MDGs. A range of policy and financing initiatives should be implemented to ensure that the poor have equitable access to FP/RH services.[6] No one strategy or program will expand access for all the poor and vulnerable groups in Kenya, underscoring the need to address poverty and equity from multiple angles. Doing so will not only benefit the poor, but also the society as a whole.

FOR MORE INFORMATION

Health Policy Initiative, Task Order 1
Futures Group International
The Chancery Building, 3rd Floor
Valley Road, PO Box 3170
Nairobi, Kenya 00100
Tel: 254.20.2723951 / 254.20.2723952
Web: http://www.healthpolicyinitiative.com

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ENDNOTES

[1] Health Policy Initiative, Task Order 1. 2007. *Inequalities in the Use of Family Planning and Reproductive Health Services: Implications for Policies and Programs*. Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.

[2] Based on the 1977/78 Kenya Fertility Survey (KFS), and the 1989, 1993, 1998, and 2003 Kenya Demographic and Health Surveys (KDHS).

[3] Gwatkin, D.R. 2004. "Are Free Government Health Services the Best Way to Reach the Poor?" *Health, Nutrition, and Population (HNP) Discussion Paper*. Washington, DC: World Bank.

[4] POLICY Project. 2003. "Targeting: A Key Element of National Contraceptive Security Planning." *Policy Issues in Planning and Finance No. 3*. Washington, DC, Futures Group International, POLICY Project.

[5] Bennett, S. and L. Gilson. 2001. *Health Financing: Designing and Implementing Pro-poor Policies*. London: Department for International Development (DFID) Health Systems Resource Center.

[6] Health Policy Initiative, Task Order 1. 2007. "Approaches That Work: Health Equity." Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.