SECTION 4

FAMILY PLANNING AND POVERTY TRENDS IN SUB-SAHARAN AFRICA

Across SSA, countries have adopted the goal of poverty eradication through a range of commitments, such as Sustainable Development Goal 1 to "end poverty in all its forms everywhere" or the African Union's Agenda 2063 goal to achieve a high standard of living, quality of life, and well-being for all citizens through poverty reduction.[16] Combined, these powerful political and financial commitments should be accelerating poverty reduction, helping women and households rise upward in income and wealth.

The 2016 report made the case that wealth-based differentials in contraceptive use and fertility may limit economic opportunities for low-income households, making efforts to address access to family planning an important component of poverty reduction strategies. The report highlighted stark disparities in contraceptive use, childhood malnutrition, secondary education, and teenage pregnancy between the wealthiest and poorest segments of the population.

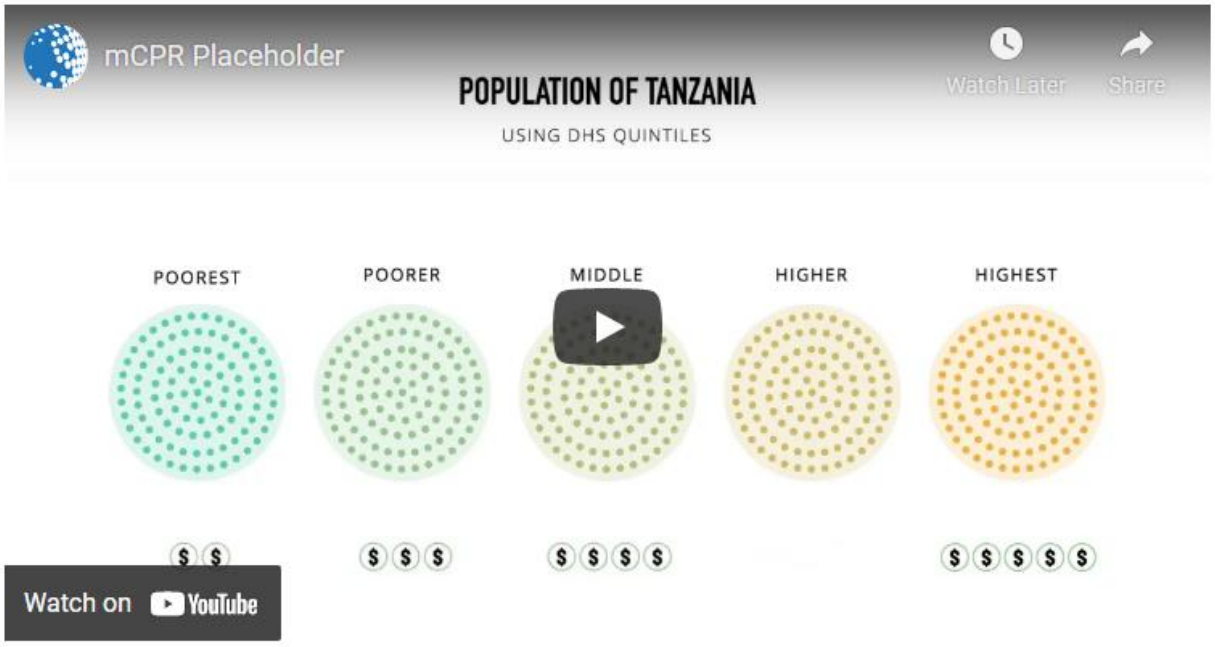
Our current report expands on the 2016 analysis to assess the extent to which family planning programs are reaching women in the poorest households in the most recent decade for which data are available. We examine a subset of 12 countries with available DHS data over an approximately 10-year period. Previous studies found that reproductive health equity between poor and rich households has improved over the past decade.[17] Many such findings rely on the DHS wealth index, which is country- and survey-specific—so using the same index to assess trends over time or between countries can lead to inaccurate comparisons.[18] A 2018 DHS report developed and applied a measure of absolute poverty to 31 FP2020 focus countries to generate comparable poverty groups within and across countries. It found substantial declines in absolute poverty across many low- and middle-income countries. However, this approach compares those who live below a metric of absolute poverty with those who do not, which does not allow us to capture broader changes in economic status over time.
To overcome this limitation, we recalculated wealth groups, standardizing the quintiles to enable comparison over time and across countries. We created five wealth categories, defined as:

- Very poor households.
- Poor households.
- Middle wealth households.
- Upper-middle wealth households.
- High wealth households.

We then analyzed the data to quantify the relative contributions of changes in women's economic status, compared with other factors, to increases in mCPR. If increases in mCPR are largely driven by factors other than economic status improvements, our analysis attributes the increase to the family planning program. This attribution of non-economic status improvements to the family planning program is a limitation of our analysis, as other factors (for example, education status) certainly contribute to increases in mCPR as well. However, changes in those factors are unlikely to account for all increases in mCPR not attributed to economic status improvements.

Using this approach, we find that increases in mCPR are being driven not just by improvements in women's economic status but also by family planning program efforts. In fact, increases in mCPR are often largest among women in the poorest households, suggesting family planning programs are reaching women regardless of their economic status

For a detailed explanation of the methods, check out our **methods explainer video**.



Many women and households moved out of the poorest wealth categories.

Tremendous gains were made in poverty reduction over the last decade, at least prior to the onset of the COVID-19 pandemic. The proportion of households in the very poorwealth category of our analysis—and, along with it, the proportion of women in the very poor wealth category—declined in all 12 countries (see **Table 4**). Countries including Kenya, Tanzania, and Zambia are among those who saw a decline of more than 20 percentage points in households in the very poor wealth category alone.

Table 4: Percentage-Point Change in the Proportion of Households Across Wealth Categories in Selected Countries

	Poorest	Poor	Middle Wealth	Moderately Wealthy	Wealthiest
DRC	↓ -0.93	↓ -3.10	↑ 0.07	↑ 3.74	↑ 0.22
Ethiopia	↓ -11.24	↓ -18.38	↑ 10.57	↑ 11.35	↑ 7.71
Kenya	↓ -26.05	↓ -6.47	↑ 7.52	↑ 11.00	↑ 14.00
Liberia	↓ -19.26	↓ -11.00	↑ 2.14	↑ 12.20	↑ 15.92
Malawi	↓ -13.83	↓ -14.01	↑ 3.73	↑ 11.83	↑ 12.27
Mali	↓ -27.01	↓ -13.81	↑ 7.96	↑ 18.19	↑ 14.67
Nigeria	↓ -15.74	↑ 1.28	↑ 5.38	↑ 3.30	↑ 5.79
Rwanda	↓ -20.24	↓ -25.22	↓ -0.95	↑ 25.60	↑ 20.81
Senegal	↓ -11.28	↓ -3.30	↑ 0.08	↑ 3.54	↑ 10.97
Tanzania	↓ -20.97	↓ -16.03	↑ 6.53	↑ 13.69	↑ 16.78
Uganda	↓ -20.74	↓ -18.96	↑ 5.54	↑ 14.64	↑ 19.52
Zambia	↓ -23.07	↓ -3.47	↑ 11.31	↑ 9.47	↑ 5.76

Source: Avenir Health analysis of Demographic and Health Surveys.

Increases in contraceptive use across wealth categories are largely a result of family planning program efforts.

In all 12 countries, mCPR increased among the very poor and poor households in our analysis; and in most cases, the largest increases in mCPR were in these categories (see **Table 5**). Rwanda experienced the highest increase in mCPR in the very poor households (35 percentage points) between its two surveys. Liberia saw more growth in very poor households than in any other wealth category. Mali and Senegal were exceptions: In both countries, the largest increases in mCPR were in the high wealth category.

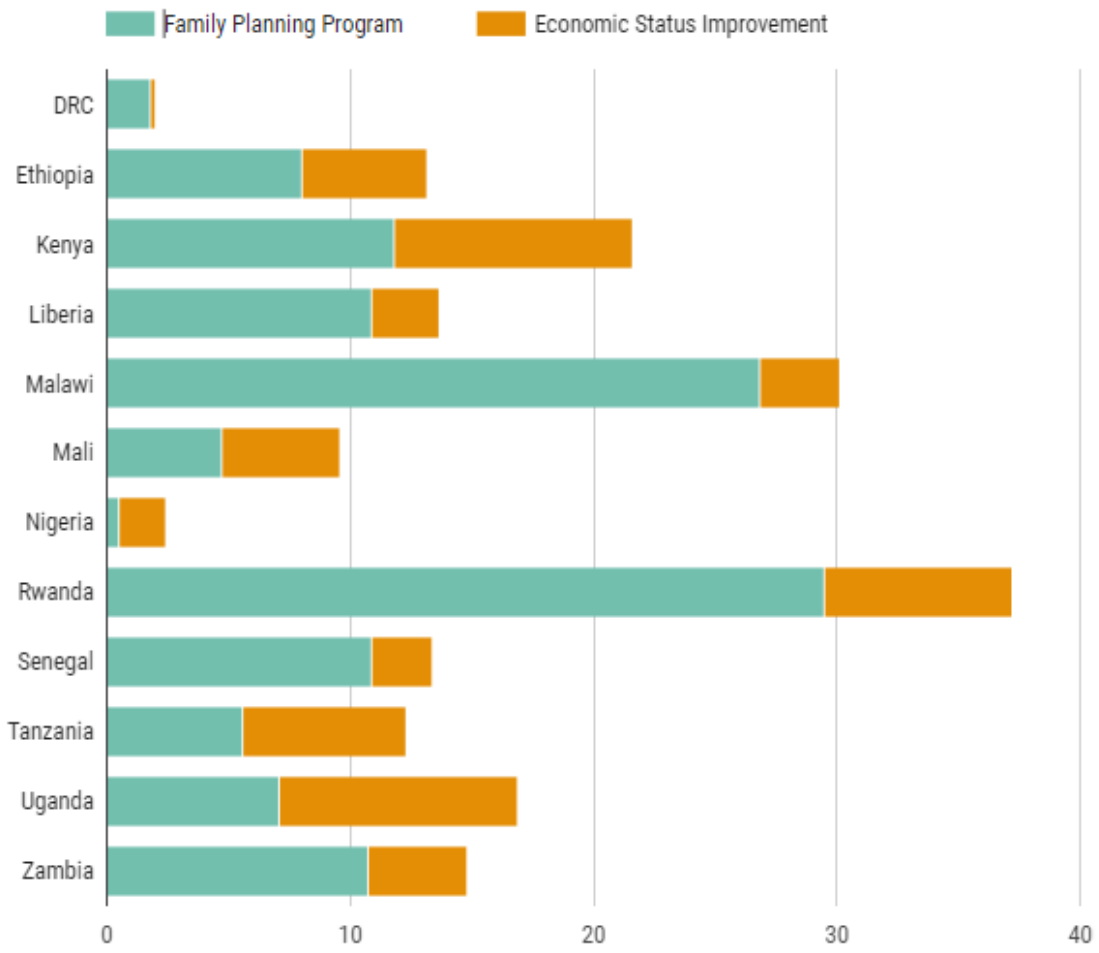
Table 5: Percentage-Point Change in mCPR in Each Wealth Category in Selected Countries

	Poorest	Poor	Middle Wealth	Moderately Wealthy	Wealthiest	Mean Use
DRC	↑ 0.9	↑ 3.0	↑ 1.2	↑ 2.0	↑ 2.1	↑ 2.0
Ethiopia	↑ 9.3	↑ 17.6	↑ 13.4	↑ 0.3	↓ -0.2	↑ 13.3
Kenya	↑ 13.0	↑ 22.0	↑ 16.4	↑ 8.6	↑ 2.8	↑ 21.6
Liberia	↑ 19.6	↑ 11.7	↑ 13.9	↑ 8.8	↑ 4.6	↑ 13.6
Malawi	↑ 30.6	↑ 31.3	↑ 27.5	↑ 29.9	↑ 17.8	↑ 30.0
Mali	↑ 1.5	↑ 4.7	↑ 6.1	↑ 4.8	↑ 4.2	↑ 9.5
Nigeria	↑ 0.5	↑ 1.6	↓ -0.4	↑ 0.7	↑ 0.2	↑ 2.5
Rwanda	↑ 35.4	↑ 37.0	↑ 36.2	↑ 33.9	↑ 15.2	↑ 37.2
Senegal	↑ 10.1	↑ 12.4	↑ 11.8	↑ 13.0	↑ 7.6	↑ 13.3
Tanzania	↑ 11.0	↑ 13.3	↑ 8.9	↑ 6.2	↓ -5.0	↑ 12.3
Uganda	↑ 13.9	↑ 15.0	↑ 11.0	↑ 5.8	↓ -1.6	↑ 17.0
Zambia	↑ 8.8	↑ 16.6	↑ 15.3	↑ 9.3	↓ -0.4	↑ 14.7

Notes: Data display the percentage-point change in mean modern contraceptive use between DHS for households in each wealth category.
Source: Avenir Health analysis of Demographic and Health Surveys.

In eight out of 12 countries (all except Mali, Nigeria, Tanzania, and Uganda), most growth in mCPR can be attributed to family planning programs. The family planning program accounted for the vast majority of mCPR gains in countries such as DRC, Malawi, Rwanda, and Senegal, as **Figure 15** illustrates.

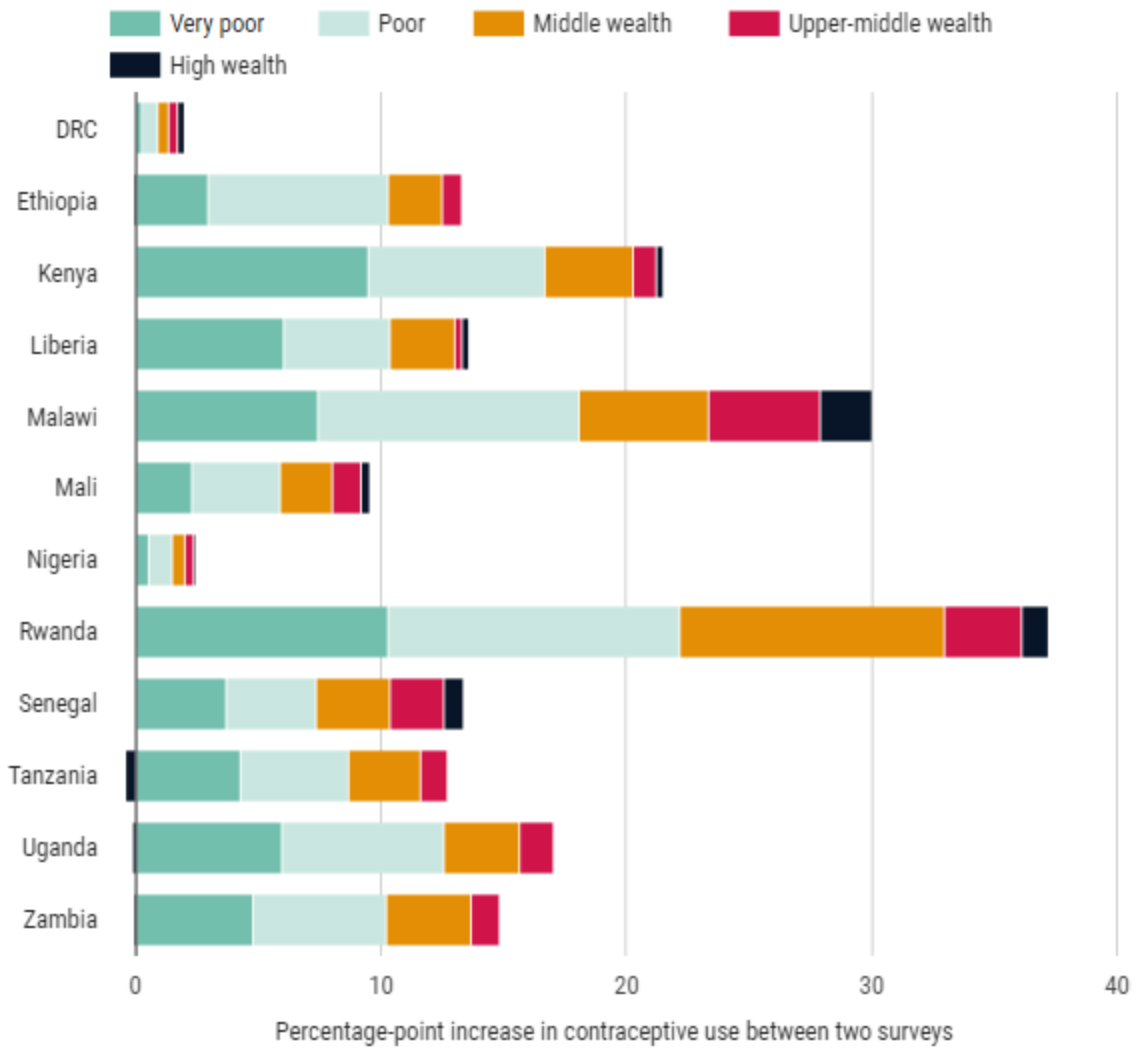
Figure 15: Percentage-Point Contribution of Family Planning Program and Household Economic Growth to mCPR Increases



Source: Avenir Health analysis of Demographic and Health Surveys.

In all 12 countries, women in the very poor and poor wealth categories drove the overall modern contraceptive use increase, as **Figure 16** shows. Women in very poor households contributed the most to mCPR growth in Kenya, Liberia, and Senegal. Such growth is a sign that, during the last decade, family planning programs have been effective at reaching women and households regardless of their economic status, and in fact uptake among women in the very poor household category is a key contributor to overall increases in mCPR.

Figure 16: Percentage-Point Contribution to Change in mCPR by Wealth Category



Source: Avenir Health analysis of Demographic and Health Surveys.

In many countries, growth in mCPR has been more concentrated among women in the poorest households than increases in facility delivery.

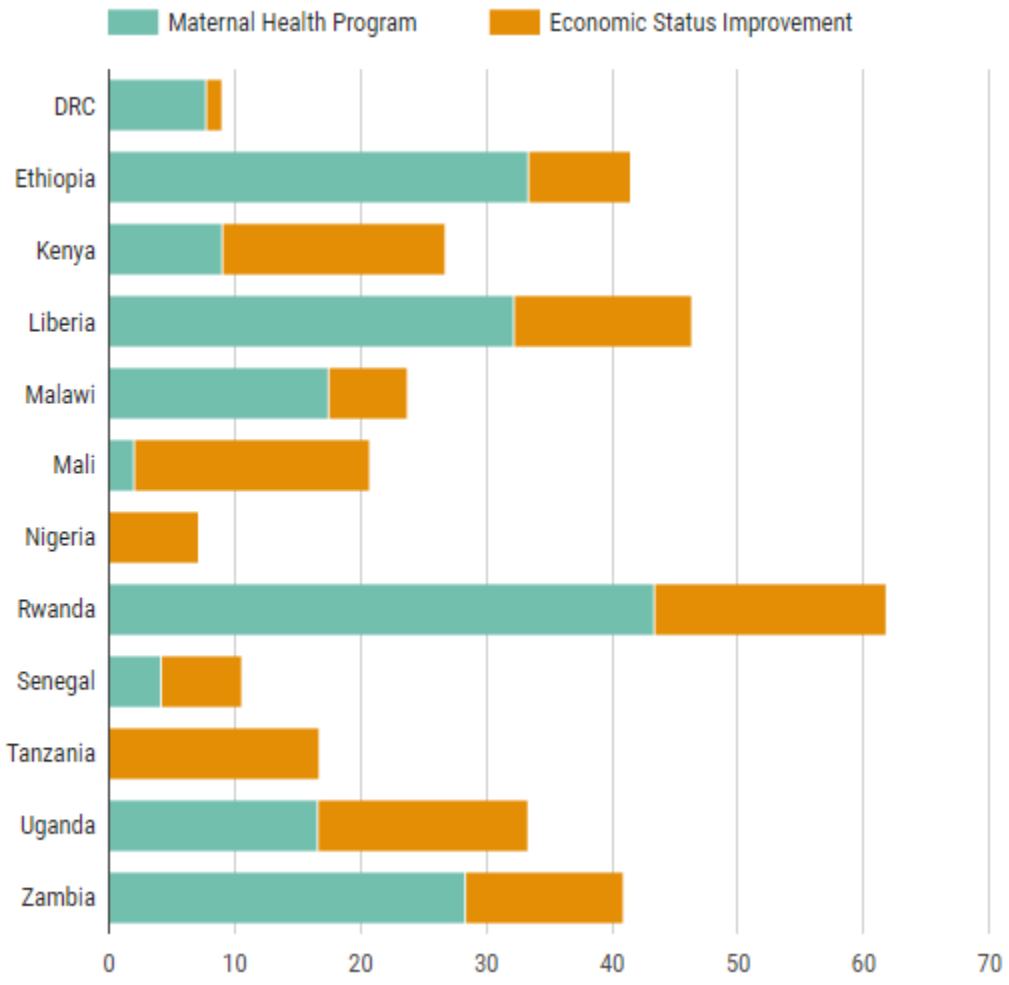
Using the same methodology, we further explored how increases in mCPR among women in the very poor wealth category of our analysis compare with another core health indicator, the percent of women delivering babies in a health facility, also called facility delivery. This analysis can help us better understand if the trends seen in mCPR are unique to the family planning program or if they reflect broader trends in health programming. As in the analysis of mCPR, we assess the extent to which increases in facility delivery are driven by economic status

improvements. Increases that are not attributed to economic status improvements are attributed to maternal health programs targeting facility delivery.

In all countries, health facility delivery increased among very poor households. Rates of facility delivery increased the least among women in very poor households in Nigeria (0.9 percentage points). The largest gains among very poor households were made in Rwanda, where average health facility delivery increased from 19% in 2005 to 81% in 2015.

In six out of 12 countries (all except Kenya, Mali, Nigeria, Senegal, Tanzania, and Uganda), most growth in health facility delivery is attributed to maternal health programs, illustrated in **Figure 17**.

Figure 17: Percentage-Point Contribution of Maternal Health Improvements and Economic Growth to Increases in mCPR

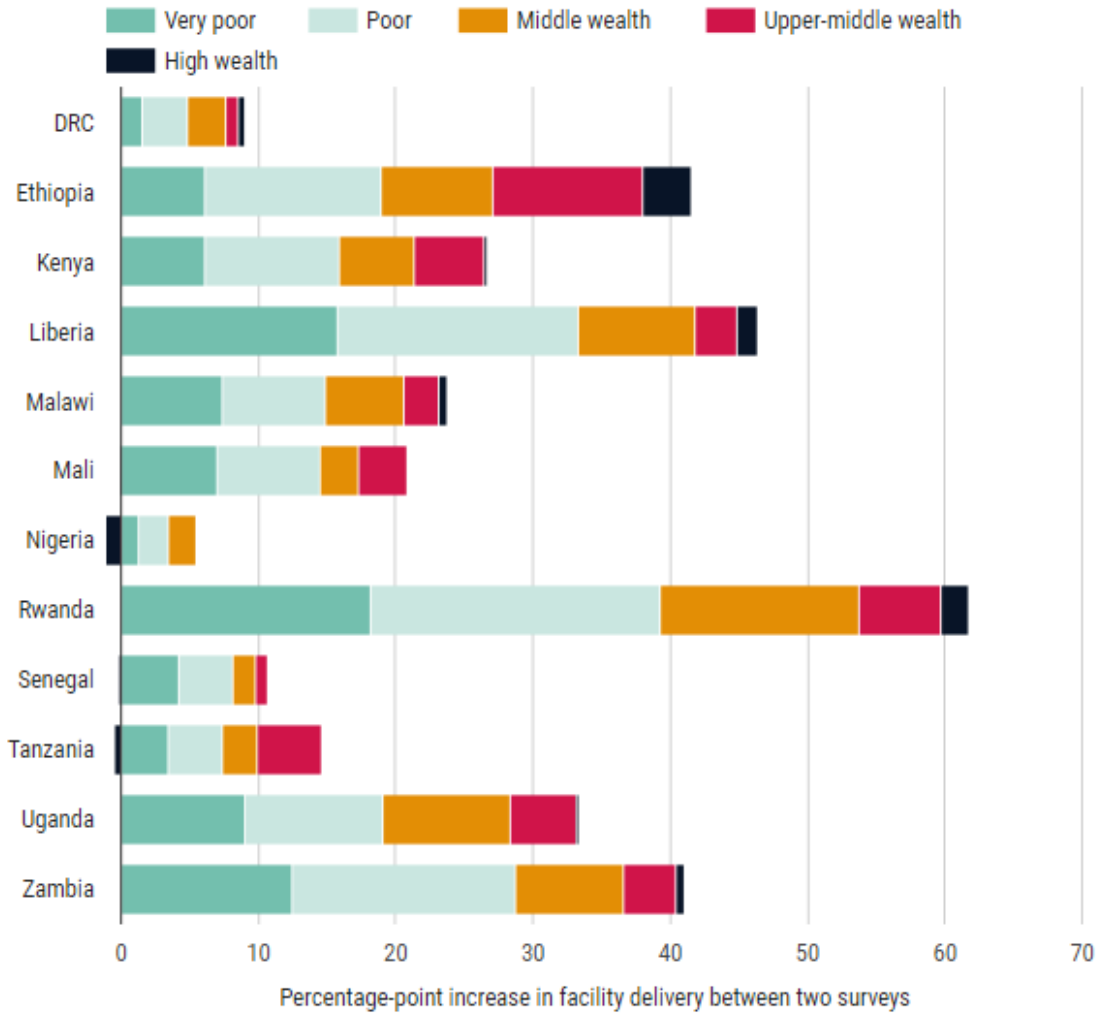


Source: Avenir Health analysis of Demographic and Health Surveys.

By comparing **Figure 16** and **Figure 18**, we can assess the extent to which increases in both mCPR and facility delivery were concentrated among women in the very poor households

category of our analysis. Several countries show unique patterns and characteristics. Kenya, Malawi, and Senegal saw larger gains in modern contraceptive use than in health facility delivery. Most increases in mCPR were contributed by the very poor and poor households, and in three countries—Kenya, Liberia, and Senegal—the very poor group was the primary contributor. In contrast, most of the percentage change in facility delivery is seen among poor households. Only in Senegal was the very poor group responsible for the most change in facility delivery between surveys. The larger contribution to mCPR gains by women in very poorhouseholds, compared with the relative contribution of other wealth categories to facility delivery gains, may signal that family planning programs have been particularly effective at reaching all women regardless of their economic status.

Figure 18: Percentage-Point Contribution of Maternal Health Improvements and Economic Growth to Increases in Facility Delivery by Wealth Category



Source: Avenir Health analysis of Demographic and Health Surveys.

This observation may be in part due to concerted efforts within the family planning community to address equitable access to information and services. Efforts to bring family planning services closer to communities and clients—including through task-shifting to community health workers and flexible, targeted mobile outreach approaches—have helped ease financial, logistical, and cultural barriers. Efforts underway in many countries to ensure family planning is integrated into universal health coverage schemes as part of the package of essential services will further address cost-related barriers to access that disproportionately harm women in the poorest households.

Notably, while concerted programmatic efforts to ensure family planning programs reach women with information and services regardless of economic status are important, such programs must be implemented with accountability mechanisms that protect women's autonomy and choice and prevent coercion. The increases in mCPR among women in the poorest households that we observe in our analysis may signal the success of family planning programs in enhancing equitable access to contraception, but may also warrant further examination to ensure these successes were not accompanied by coercive practices.