Policy Brief

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Regional Variations in Contraceptive Use in Kenya: How Can the Gaps be Bridged?

Overview of Contraceptive Use

Family planning (FP), which is the use of contraception to delay or limit pregnancy, empowers couples to choose the number of children they want to have and the timing of each birth.

By practicing family planning, couples can improve the health of mothers and children through birth spacing and avoiding high risk pregnancies. In addition to this, family planning can help to slow down population growth thereby contributing to economic benefits such as poverty reduction.[1] Over the last four decades, Kenya has made good progress in increasing the utilization of contraception among married women. In 1978, the prevalence of contraceptive use among married women in Kenya was 7 percent and this increased over the years to 46 percent in 2009.[2] Despite these improvements, there are huge regional variations in the prevalence of contraceptive use. While the contraceptive prevalence in some of the regions is comparable to that of developed countries, in other regions the prevalence is quite low. These variations have an impact on efforts to increase the overall contraceptive prevalence in the country. What are the causes of the observed regional variations? How can these variations be bridged? This policy brief provides some insight into these questions by comparing the regional variations in contraceptive use against selected factors.

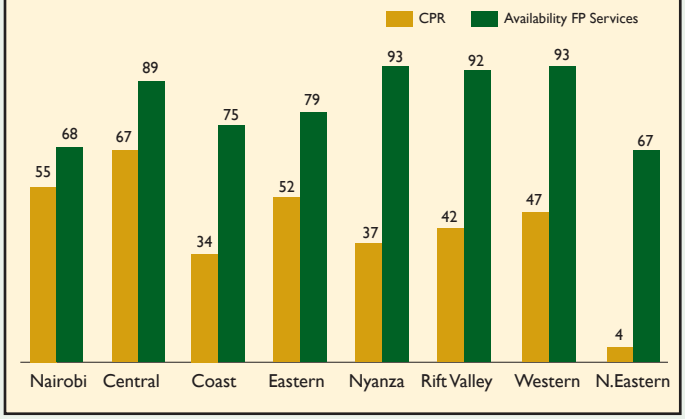
Factors that Influence Contraceptive Use

Various researches suggest that the differences in contraceptive use can be explained by the following broad factors; socioeconomic, cultural and the impact of family planning programmes.[3] Evidence from research conducted in Kenya and elsewhere has provided empirical evidence to support these suggestions.[4] The specific factors that influence contraceptive use include the following; Education, Wealth status, Residence, Religion, Type of marriage, Knowledge of family planning, Desire for more children, Number of living children, and Death of a child.[5]

Disparities in Contraceptive Use

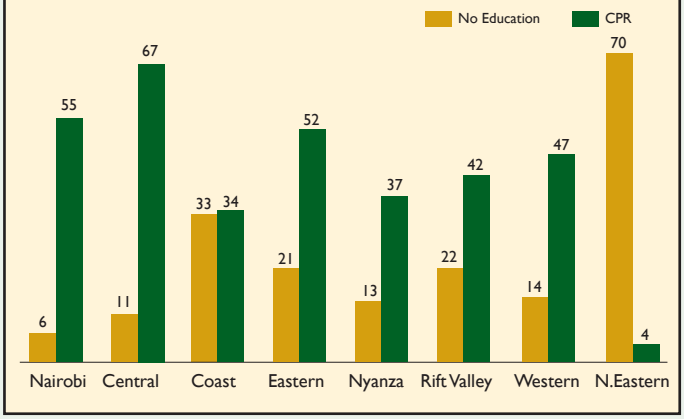
According to the 2008-09 Kenya Demographic and Health Survey (KDHS), the contraceptive prevalence rate (CPR) for Kenya was 46 percent. Figure 1 shows the regional differences in CPR in 2008-09. Central region had the highest CPR of 67 percent followed by Nairobi and Eastern at 55 and 52 percent respectively. These are the only regions in Kenya where over half of the married women use contraception. Regions with the lowest CPR were Nyanza and Coast where about one-third of the married women use contraception and North Eastern where only 1 in every 20 married women use contraception.

Figure 1: Contraceptive prevalence and availability of family planning services by region



Source: *Kenya 2008-09 Kenya Demographic and Health Survey and 2010 Kenya Service Provision Assessment*

Figure 2: Percent of females with no education and contraceptive prevalence by region



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

The 2010 Kenya Service Provision Assessment (KSPA) found that 85 percent of the health facilities in the country provide at least one modern method of family planning. Among the health facilities that provide these services, 9 in every 10 offer these services at least 5 days per week.[6] Further, Figure 1 shows that over two-thirds of the health facilities in each region of the country provide family planning services. These findings suggest that family planning services are widely available in Kenya though this may at times be affected by stock-outs, distance to health facilities, and availability of qualified health workers who can counsel clients on the FP methods and administer the same. Despite the high availability of FP services, the CPR is much lower indicating that other factors could also be responsible for the low prevalence. Some of these factors are discussed below;

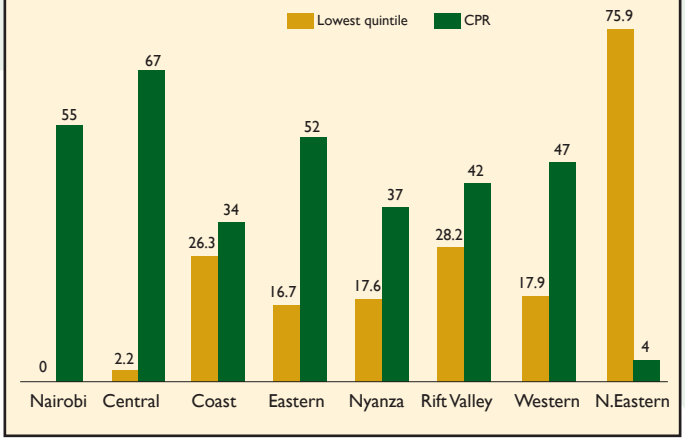
Education Attainment and Contraceptive Use

Education has been shown to be an important determinant of contraceptive use. Figure 2 shows that Central and Nairobi regions, which have the highest contraceptive prevalence, have the lowest proportion of females with no education at about 1 in every 10 compared to Coast and North Eastern regions which have the lowest contraceptive prevalence but the highest proportion of females with no education at one-third and over two-thirds of the females respectively. Interestingly, in Nyanza, the CPR and the proportion of females with no education are both low suggesting that other factors in the region could be responsible for the low CPR.

Wealth Status and Contraceptive Use

From Figure 3 it is evident that Central, Nairobi, and Eastern regions which have the highest contraceptive prevalence in the country also have the lowest proportion of the population in the lowest wealth quintile representing less than 3 percent of their respective populations. On the other hand, North Eastern and Coast regions, which have the lowest contraceptive prevalence rates have also the highest proportion of the population in the lowest wealth quintiles at three-quarters and a quarter of their respective populations. Generally, wealth status has been found to have an influence on contraceptive use in that those who are wealthier have high chances of using contraceptive.

Figure 3: Percent of population in lowest wealth quintile and contraceptive prevalence by region

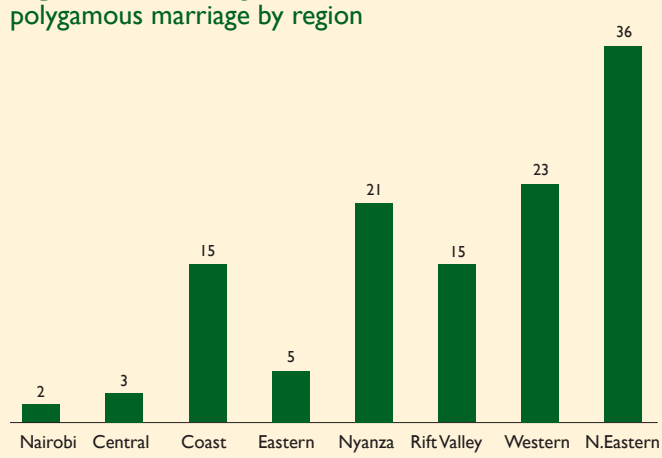


Source: *Kenya 2008-09 Kenya Demographic and Health Survey*

Polygamous Marriages and Contraceptive Use

Women in polygamous marriages have been found to have a lower prevalence of contraceptive use compared to women in monogamous marriages. The 2008-09 KDHS supports this finding as shown in Figure 4. According to the said Figure, in the three regions of Central, Nairobi, and Eastern, where over half of the married women use contraception, the prevalence of polygamous marriages is 5 percent and below. However, in the remaining regions, where less than half of the married women use contraception, the prevalence of polygamous marriages ranges from 15 percent in Coast and Rift Valley to over two-thirds of the marriages in North Eastern region.

Figure 4: Percentage of married women in a polygamous marriage by region

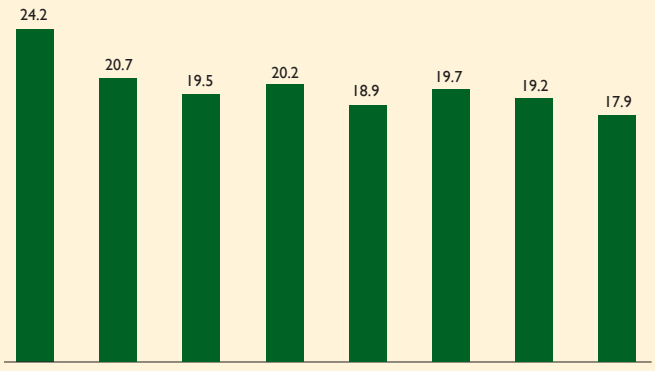


Source: *Kenya 2008-09 Kenya Demographic and Health Survey*

Age at First Marriage and Contraceptive Use

The age at which a woman gets married has an important bearing on the length of time she may be exposed to the risk of pregnancy and hence the number of children she may bear before attaining the age of 49 years. Generally, the longer the period the higher the risk of pregnancy and child bearing. Figure 5 shows the median age at first marriage for women aged 25 – 49 years by region. From the said Figure it is evident that the three regions where over half of the married women use contraception, the median age at first marriage is over 20 years with Nairobi having the highest age of 24 years. However, in the other regions, where the contraceptive prevalence is below 50 percent, the median age at first marriage is below 20 years with North Eastern having the lowest age of 18 years.

Figure 5: Median age (years) at first marriage for women aged 25-49 years by region



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

From the findings of the 2008-09 KDHS, it is apparent that the regions with higher levels of contraceptive use also have lower proportions of; females without education, population in the lowest wealth quintile, and women in polygamous marriages. These regions also have higher median ages at first marriage for women aged 25 – 49 years.

Implications

The findings of the 2008-09 KDHS suggest that the differences in contraceptive use between the various regions of the country are influenced by disparities in education attainment, wealth status, prevalence of polygamous marriages, and median age at first marriage among other factors. In order for the country to achieve its population programme goal of attaining a high quality of life for its citizens by matching the population growth with available resources,[7] the disparities in contraceptive use will have to be bridged by addressing the regional differences in the factors that influence contraceptive use. By addressing these factors, the regions that are lagging behind in contraceptive use will be able to register improvements thus raising the overall CPR of the country. An increase in the CPR is expected to contribute towards the lowering of the country's population growth rate that stands at 3 percent per annum.[8] This, coupled with expected improvements on the economic front, will enhance the quality of lives of Kenyans and the achievement of Vision 2030 goals.

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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Recommendations

Based on the findings of the 2008-09 KDHS, the National Council for Population and Development (NCPD) makes the following recommendations that are aimed at improving the country's CPR;

1. **Reduce population without education:** The Government, through the Ministry of Education, needs to increase its effort in ensuring that the proportion of people, especially females, without any education is reduced to a minimum. Over the next decade, these efforts should be concentrated in North Eastern, Coast, Rift Valley and Eastern regions where more than 1 in every 5 females aged 6 years and above have no education.

2. **Diligent implementation of the Vision 2030** is required to improve the wealth status of households in Kenya. Improvements in the wealth status of households, especially poor households, will impact positively on the welfare of the population which in turn is expected to have a positive influence on contraceptive use. In this regards, the Vision 2030 Secretariat should ensure that the flagship projects for the Vision are effectively and efficiently implemented during the 5 years of the second Medium Term Plan (2013 – 2017) and the period leading to the year 2030.

3. **Intensify family planning campaigns** in areas where the prevalence of polygamous marriages is high. These campaigns should be spearheaded by NCPD and the Ministry of Health from 2013 to 2030. The campaigns should be tailored to address the needs of those who are in polygamous marriages. This will require that the two institutions endeavor to understand the contraception use challenges faced by those who live in areas where polygamous marriages are more prevalent.

4. **Increase median age at first marriage** in the regions that have low levels of contraceptive use. This should be done through Information, Education, and Communication (IEC) activities lead by NCPD and aimed at encouraging young people to stay longer in school and develop their careers before they become parents. The Ministry of Education should also play a major role in increasing the median age by ensuring that education and vocational training are accessible to the public and especially the poor.

5. **County Governments** need to work in partnership with NCPD, Ministry of Health, Vision 2030 Secretariat, and Ministry of Education in implementing the above recommendations. These institutions will first need to build the capacities of the County Governments to identify and tackle population issues in their respective counties which may impede efforts to improve the well-being of the public.

The participation of all stakeholders in implementing the above recommendations will complement efforts towards bridging the differences in contraceptive use between the various regions in Kenya. This will in turn reduce the population growth thus facilitating improvements in the economic and social development of the country.

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