



Collaborating Organizations: Population Studies and Research Institute,  
 National Council for Population and Development, UNFPA

## Accelerating Fertility Decline in Kenya

Fertility is one of the factors that cause population change, alongside mortality and migration<sup>1</sup>. A question, therefore, arises on what would it take to step up the pace of fertility decline? Despite Kenya's significant progress in promoting access to, and utilization of, reproductive health services in the past, progress has been slow in the last decade. Evidence shows changing trends in fertility levels in Kenya, with an initial rapid decline followed by some stagnation. Moreover, the pace of fertility reduction was not uniform across women of different socio-economic groups. Much of the decline took place among the better educated and economically well-off women, while little change occurred among the less educated and poor women. The slow pace of fertility decline is probably due to increases in desire for more children among women who are poor or non-educated. Besides, the observed gradual reduction in investment in strategies for influencing fertility preferences and family size, such as information, education and communication and community-based distribution programmes, may be responsible for such trends. With sustained gap in the use of modern contraceptives among various socio-economic groups, it is likely that inequalities will persist unless innovative strategies to address issues of access to information and services are put in place.

This policy brief provides an analysis of fertility levels and trends in Kenya. Specifically, the brief examines the levels and trends in fertility, policy development efforts, key challenges, prospects, and policy implications.

### Fertility Levels and Trends in Kenya

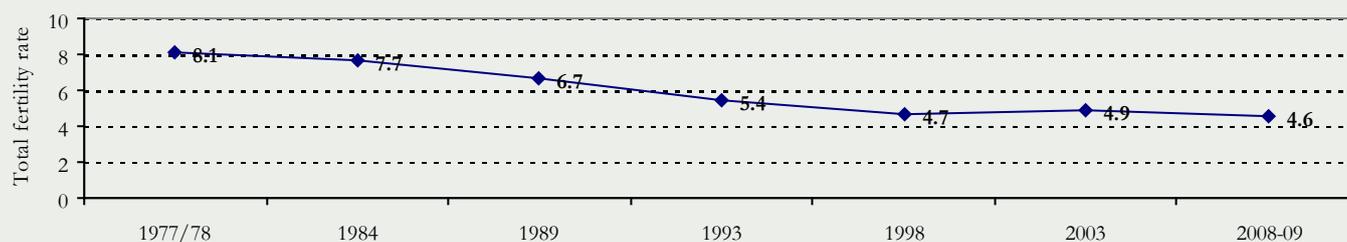
Evidence shows that in 1970s, Kenya had one of the highest fertility rates in the world, with a fertility (birth) rate of 8 children per woman. The high fertility rate in the 1970s has been attributed to good economy, good climate, large land holdings by families, and affordable essential commodities such as food, health care, housing and education<sup>2</sup>. However, as illustrated in Figure 1, the country experienced a remarkable fertility decline from the early 1980s to the late 1990s, attributed in part to socio-economic development, improvements in child survival and educational attainments, and increased contraceptive uptake due to vigorous national and international support of family planning programmes<sup>3</sup>.

A key feature of Kenya's fertility change is the stall (stagnation) between 1998 and 2003 (Figure 1). Much of the literature that has sought to explain stall in fertility transition has identified three approaches, namely; the reproductive behaviour, socio-economic, and institutional approaches<sup>4</sup>. The reproductive behaviour approach attributes stall in fertility transition to a lack of improvements in proximate

determinants. The stalls in fertility transition were due to the levelling off in contraceptive use and a decline in the proportion of women who want no more children<sup>5</sup>. The social and the economic approaches, on the other hand, attributes the stalls to declines in the levels of development, as reflected in changes in women's education, infant and child mortality and real per capita economic growth<sup>6</sup>. According to the institutional model, the stalls are due to deterioration in family planning programmes resulting from declining national and international commitments as resources are diverted to other programmes, such as HIV/AIDS.

However, the models are not conclusive over the ultimate determinants of such stalls. In Kenya, it is possible that the three models jointly explain the stall in fertility transition between 1998 and 2003. For example, while the same period was characterized by a stall in CPR, the 1980s and 1990s were characterized by deteriorating socio-economic conditions related to structural adjustment programmes (SAPs)<sup>7</sup>. Additionally, there was a decline in support for family planning programmes at national and international levels between 1990s and 2000s as the focus shifted to HIV/AIDS

Figure 1: Trends in Total Fertility Rate, Kenya 1977/78–2008/09



Sources: KNBS and ICF Macro (2010)

## Policy and Programme Efforts

Kenya was among the first sub-Saharan African countries to establish a family planning programme through the *National Family Planning Policy* of 1967. By the late 1980s, the National Family Planning programme was considered a success story in the region. In 1984, the government developed the first population policy - *Population Policy Guidelines* - that involved an update of the *National Family Planning Policy*. In 2000, Kenya developed the *National Population Policy for Sustainable Development* that integrated a domesticated Programme of Action (PoA) of the ICPD to guide the implementation of population, health and development programmes in the country for the period 2000-2010<sup>9</sup>. With respect to fertility-related indicators, the policy aimed to increase: (1) the availability, accessibility, acceptability and affordability of quality family planning services; and (2) the involvement of men in family planning. The policy set to reduce fertility (birth) rate from 5.0 in 1995 to 4.0 by the year 2000, 3.5 by 2005 and 2.5 by 2010. The policy further aimed to increase contraceptive use from 33 percent in 1993 to 43 percent by the year 2000, 53 percent by 2005 and 62 percent by 2010. In 2012, the government issued a new population policy (*Population Policy for National Development*)<sup>10</sup> after the expiry of the previous one. In terms of fertility-related indicators, the new policy aims at; reducing fertility, providing equitable and affordable reproductive health services including family planning,

and assisting individuals and couples who desire to have children but are unable to. The targets include; reduction of fertility from TFR of 4.6 in 2008/09 to 2.6 children per woman by 2030 and increasing use of family planning from 46 percent to 70 percent over the same period. In 2003, the government developed the *Adolescent Reproductive Health and Development (ARH&D)* policy to address adolescent sexual and reproductive health and rights as well as other developmental issues. One of the objectives of the policy was to strengthen the capacity of institutions, providers and communities to offer appropriate information and services such as family planning to adolescents and youth<sup>11</sup>.

## Challenges to fertility decline in Kenya

There are a number of challenges that need to be addressed for the country to achieve its national goals as articulated in Vision 2030 and the Millennium Development goals:

**Poverty and Inequity:** The socio-economic disparity between the rich and the poor in Kenya remains a major impediment to the achievement of sexual and reproductive health goals. There is clearly a correlation between wealth status and education on the one hand, and access to, or utilization of, sexual and reproductive health services on the other. Women from the poorest 20 percent households continue to have high unmet need for contraception, which translates into high fertility rates.

Table 1: Trends in Fertility (Children per woman) by Women's Wealth Quintile, Kenya 1993–2008/09

| Wealth Quintiles | 1993 | 1998 | 2003 | 2008-09 | Percent change 1993-2008/09 |
|------------------|------|------|------|---------|-----------------------------|
| Lowest           | 7.2  | 6.5  | 7.6  | 7.0     | 2.8                         |
| Second           | 6.2  | 5.6  | 5.8  | 5.6     | 9.7                         |
| Middle           | 5.6  | 4.7  | 5.1  | 5.0     | 10.7                        |
| Fourth           | 5.3  | 4.2  | 4.0  | 3.7     | 30.2                        |
| Highest          | 3.3  | 3.0  | 3.1  | 2.9     | 12.1                        |

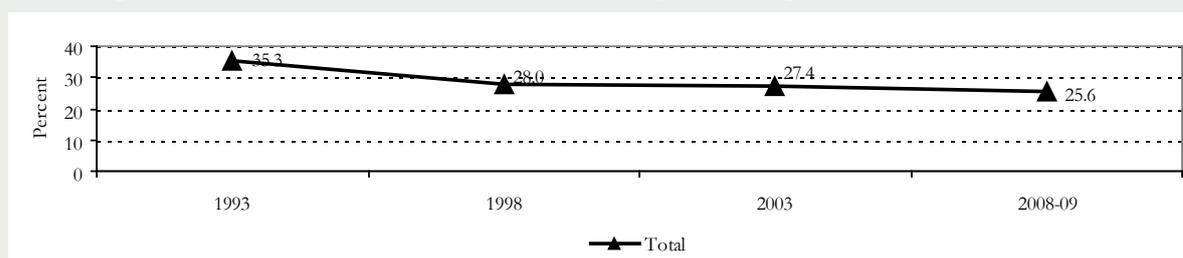
Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999).

## High Unmet Need for Family Planning

A woman has 'unmet need' for family planning (FP) or contraception if she is fertile, sexually active, and does not want a child for at least two years (spacing), or wants to stop childbearing altogether (limiting), but is not using any effective contraceptive methods<sup>12</sup>. Women who rely on traditional FP methods may be regarded as having unmet need because of the higher probability of becoming pregnant. The 1994 ICPD recognised access to safe and effective contraceptive methods as a fundamental human right. Trends in unmet need for spacing and limiting in Kenya

over time are shown in figure 2, below. Although the total unmet need has been declining since 1993, it has remained above 25 percent. The persistent high levels of unmet FP need have largely been attributed to poor access to services, persistent FP commodity stock-outs, and limited resource allocations by the government<sup>13</sup>. Women could also choose not to use FP methods for other reasons, including fear of side effects, health concerns, cultural and religious objections, lack of knowledge, and objections from a spouse<sup>14</sup>. Evidence shows that prior to 2008/09, unmet need for spacing has been consistently higher than unmet for limiting<sup>15</sup>.

Figure 2: Trends in Unmet Need for Family Planning in Kenya, 1993–2008/09



Sources: KNBS and ICF Macro (2010);

**Harmful Social and Cultural factors:** Despite the government's commitment to provide reproductive health and family planning services to all Kenyans, cultural and religious beliefs and values pose persisting challenges, which affect the realization of goals on sexual and reproductive health and rights. For example, early marriages contribute to high fertility rates in many community settings.

**Inadequate Funding:** Over the years, reproductive health has received little attention in terms of financing. The end result has been inadequate access to services, poor service delivery and high maternal and child mortality rates. Although maternal, newborn and child health (MNCH) have received specific budgetary allocation since 2008, funds allocated remain too little. Furthermore, a major challenge is the fact that the MNCH budget and projections is not broken down by service components such as family planning, maternal and infant care, management of sexually transmitted infections, and management of other SRH problems.

**Inadequate Integration of information and Services:** Although efforts have been made towards integrating sexual and reproductive health (SRH) and HIV/AIDS services, it is evident that greater attention has been paid to the latter.

**Illiteracy:** Fertility trends by educational attainment show that among women with no education, fertility declined sharply between 1989 and 1998 and then rose to a plateau by 2003. Despite the slight increase in fertility in 2003, for women with primary education, the general trend was a steady decline from 1989 to 2008/09. Overall, the greatest fertility decline over the last two decades was among women with at least secondary education. These findings suggest that women's education has strong influence on their fertility.

### **Are there opportunities for rapid fertility decline in Kenya?**

Despite the observed challenges, there are number of opportunities that would accelerate fertility decline in Kenya. These include:

#### **Policy and Legal Framework**

The various policy statements and action strategies provide an enabling environment for addressing population issues. Many of these policies and strategies are aimed at promoting universal access to reproductive health services. If implemented, Kenya is well-placed to achieve the envisioned sexual and reproductive health goals. The Bill of Rights in the Constitution<sup>16</sup> (Chapter 4) guarantees healthcare services, including the provision of reproductive health and family planning services, to all Kenyans. It therefore provides an enabling framework for scaling up access to contraceptives and the expansion of family planning services.

#### **Devolved System of Government**

The devolved system of government under the Constitution provides an opportunity to bring reproductive health services closer to the people, and to better deploy health workers in all parts of the country. Although implementation will be challenging, including competition over funding, devolution in the health sector represents a good opportunity for advocacy over SRH at the local level, especially in geographical areas that have lagged behind. People will be able to participate freely in decision-making

on issues affecting them, including reproductive health issues.

### **The New Drive to Reposition Family Planning**

The new drive to reposition family planning under the *Population Policy for National Development* provides impetus for the implementation of family planning programs accelerating achievement of the health-related MDGs and the objectives of ICPD PoA. Kenya's Vision 2030—the development blueprint that aims to transform the country into a new industrializing, middle-income nation by 2030 - emphasizes the government's commitment to reducing health inequalities and to providing access to those previously excluded from health care for financial reasons<sup>17</sup>.

### **The Free Primary Education Programme**

The government has continued to finance the free primary education program and to subsidize secondary education while also enabling the expansion of public and private universities. These initiatives present good opportunities for realizing reproductive health goals as they will enable many women to be educated. Education, in turn, enhances women's bargaining power within the family while keeping girls in school will reduce instances of early marriages and early childbearing.

### **Increased Donor Funding for Family Planning**

A number of bilateral donors have increased their financial assistance specifically for reproductive health. In 2012 the UK Government, Bill and Melinda Gates Foundation, UNFPA and other partners hosted a Global Summit on Family Planning to mobilise global policy, financing, commodity and service delivery commitments to support the rights of an additional 12 million women and girls from the poorest countries to use contraceptives services and information free of coercion and discrimination. This renewed commitment by donor community presents an opportunity for developing countries such as Kenya to mobilize additional resources for family planning and other reproductive health services

### **Policy Implications**

The trends in fertility levels indicate that Kenya is in the stage of demographic transition characterized by substantial decline in mortality and persistent relatively high fertility. This is deemed contrary to expectation of having experienced a rapid fertility decline between 1979 and 1998. During the period birth rates declined from 8.1 births per woman to 4.7 births per woman, respectively. This was followed by a period of stagnation between 1998 and 2003 and a slight decline in 2009 with a birth rate of 4.6 children per woman. So for Kenya to achieve a rapid decline in fertility levels from the current 4.6 to 2.6 children per woman in 2030, the country will need to invest in both short term and long term strategies such as family planning and women education, respectively. If adequate efforts are not put in place to accelerate the fertility decline then, the Country might not achieve the national development goals as articulated in the Vision 2030.

### **Recommendations**

To speed up the decline in fertility from the current 4.6 to 2.6 per woman by 2030, and eventually 2.1 children per woman by 2050, as articulated in the *Population Policy for*

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

### National Council for Population and Development (NCPD)

P.O. Box 48994 - GPO,  
Nairobi 00100, Kenya  
Tel: 254-20-271-1600/01  
Fax: 254-20-271-6508  
Email: info@ncpd-ke.org  
www.ncpd-ke.org

The Population Studies and Research Institute (PSRI), University of Nairobi, was established in 1976 with the mandate to undertake postgraduate training, research and Government backstopping in the field of population and development.

### Population Studies and Research Institute (PSRI)

P.O. Box 30197 – 00100 NAIROBI  
Tel: 020 318 262  
Email: psri@uonbi.ac.ke  
Website: <http://psri.uonbi.ac.ke>



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*National Development 2012*, would call for a concerted effort by all stakeholders to address the obstacles facing the Kenyan woman:

- The National and County Governments should support the full implementation of population and reproductive health policies that promote attainment of reproductive health and rights of both males and females within the framework of the new constitutional dispensation and the laws of the land to create an enabling framework for scaling up access to contraceptives and the expansion of family planning services. The National and County Governments should create a favourable environment for the development partners to support the implementation and review of existing policies and strategies
- The National and County Governments should contribute to the implementation of Kenya Vision 2030 poverty reduction programmes to reduce the gap between the rich and the poor to achieve the sexual and reproductive health goals of all Kenyans;
- The National and County Governments should work with development partners to strengthen the free primary education programme and subsidization of secondary education. Education has been found to enhance women's bargaining power within the family while keeping girls in school reduces the chances of early marriages and early child bearing;
- Relevant Government Agencies should work with the relevant civil society organization (CSOs), faith based organizations (FBOs) and private sector to lobby policy makers and community leaders to allocate more resources to family planning and other reproductive health services. This should also include targeting the communities with appropriate messages on behaviour change and the benefits of adopting a small family size norm.

### Conclusion

Despite Kenya's significant progress in access to, and utilization of, reproductive health services in the past, progress has been slow in the last decade. The analysis shows changing trends regarding fertility decline in Kenya, with initial rapid decline followed by a stall. This clearly shows that for Kenya to achieve a fertility of 2 children per woman over the next few decades, concerted and well coordinated efforts will be required on the part of all stakeholders at both the national and sub-national levels.

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