FERTILITY AND FAMILY PLANNING TRENDS IN URBAN KENYA: A RESEARCH BRIEF

BACKGROUND

Rapid urbanization in Kenya is putting pressure on infrastructure and eroding the quality of life.

Kenya’s urban population grew from about 600,000 in 1960 to over 9 million in 2010. About 32 percent of all Kenyans live in urban areas, according to the 2009 national census.¹ That proportion is projected to grow to almost half by 2050.² Urban planning and infrastructure have not kept pace with this rapid growth, leaving many urban residents without adequate housing, sanitation, safe water, garbage collection or other services. An estimated 55 percent of Kenya’s urban population lives in slums.³

The Kenya Urban Reproductive Health Initiative (known as Tupange) seeks to increase use of modern contraceptives by the urban poor.

Tupange’s objective is to raise the contraceptive prevalence rate by 20 percentage points over five years in five urban areas across Kenya. To achieve this goal, Tupange is designing and implementing interventions to:

• Improve the quality and accessibility of family planning services for the urban poor;
• Generate demand for family planning through community mobilization;
• Guarantee the availability of contraceptives;
• Partner with the private sector;
• Strengthen policies that support family planning use among the urban poor; and
• Build capacity for sustainability.

A reanalysis of Demographic and Health Survey data sheds light on fertility and family planning trends among the urban poor.

To expand the knowledge base on urban reproductive health and help Tupange design effective interventions for Kenya, the Measurement, Learning & Evaluation (MLE) Project undertook a secondary analysis of urban data from the 1993, 1998, 2003 and 2008/09 rounds of the Kenya Demographic and Health Survey (KDHS) and the 2010 Kenya Service Provision Assessment (KSPA).⁴ This is the first time such an analysis has been done.

Data from urban survey respondents and health facilities were recoded and reanalyzed to describe levels and trends in key fertility, family planning and reproductive health indicators. The analysis also examined differentials by province, household wealth and education. The wealth and education variables reflect two different dimensions of poverty: material well-being and knowledge.

In an urban slum in Nairobi, Kenya, a man washes plastic bags collected from the trash to sell and reuse for human waste disposal. Most urban slum dwellers do not have access to clean water or sanitation services.

URBAN FERTILITY LEVELS

Fertility rates in urban areas have declined in recent years, but remain high in some provinces.

Nationwide, urban women had an average of 2.9 children in 2008/09, compared with 3.5 children in 1993. However, urban women in Nyanza, Western and North Eastern provinces have more than 4 children—twice as many as women in Eastern and Rift Valley provinces (Figure 1).

Figure 1. TFR in urban areas, by province, 2008/09

A large proportion of the urban population is young.

Over 34 percent of the urban population in Kenya is less than 15 years old, while less than 2 percent is aged 65 or older. A disproportionately large share of women ages 20 to 29 contributes to a growing number of young children. A high ratio of dependents to workers strains the ability of urban areas to meet residents’ essential needs, including health, education, food and shelter.

There is a widening gap between the rich and poor, and the more and less educated.

The burden of high fertility and its associated health risks falls more heavily on the poor and less educated. From 1993 to 2008/09, fertility rates in urban areas declined more among rich than among poor and middle-income women (Figure 2). Over the same period, fertility rates increased among women with less education, while decreasing among women with secondary or higher education. By 2008/09, the urban
poor had 1.7 more children, on average, than the rich; women with no education had 2.7 more children than those with secondary or higher education.

**Figure 2. Trend in urban TFR, by household wealth**

Early childbearing, especially among the poor and less educated, increases health risks for some women.

Adolescent childbearing and short birth intervals increase health risks for mothers and children. The proportion of urban teenagers ages 15 to 19 who were pregnant or mothers rose from 17 percent in 1993 to 22 percent in 2003, before declining to 19 percent in 2008/09. Teen pregnancy rates are especially high among the poor and uneducated (Figure 3).

**Figure 3. Percent of urban teenagers ages 15 to 19 who were pregnant or mothers, by wealth and education, 2008/09**

Short birth intervals (less than two years) preceded 20 percent of births in urban areas of Kenya in 2008/09, down from 29 percent in 1993. Short birth intervals are equally common among rich and poor women. However, the proportion of urban women who delivered a child after a short birth interval is 2.1 times higher among those with no education than among those with secondary or higher education.

**MODERN CONTRACEPTIVE USE**

Almost half of urban women now use modern contraceptives, and the gap between rich and poor has disappeared in recent years.

Overall, modern contraceptive use rose from 38 percent of urban women in 1993 to 47 percent in 2008/09, with the greatest gains occurring since 2003.

The gap between rich and poor has virtually disappeared because of a recent decline in contraceptive use among rich women, even as contraceptive use rose sharply among poor women (Figure 4). Targeted efforts to increase access to family planning among the poor may have contributed to the trend.

**Figure 4. Percent of urban women currently using modern contraception, by household wealth**

Differences in contraceptive use by education and province remain large. The proportion of urban women who use a modern method is 3.7 times greater among those with secondary or higher education than among those with no education. Less than one-third of women in Nyanza and North Eastern provinces use modern contraception, compared with more than half of women in Central, Eastern and Rift Valley provinces (Figure 5).

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In all four surveys, modern contraceptives included the following methods: female and male sterilization, oral contraceptive pills, intrauterine devices (IUDs), injectables, implants, male condoms, diaphragms, foam and jelly. Female condoms and emergency contraception were added to the list of modern methods in the 2003 and 2008/09 surveys, and the Lactational Amenorrhea Method (LAM) was added in the 2008/09 survey.
Urban women increasingly use contraceptive methods to postpone the first birth and space subsequent births.

From 1993 to 2008/09, the percentage of married urban women who wait until they have three or more children before using contraception fell by half. Women increasingly adopted contraception when they had just one or two children or even before they had any children (Figure 6).

ATTITUDES TOWARD FERTILITY AND FAMILY PLANNING

Desired family size has declined in recent years but remains higher than two decades ago, especially for men and women with no education.

Desired family size increased in urban Kenya through the 1990s, before starting to decline after 2003. However, desired family size was still higher in 2008/09 than in the early 1990s. For example, women in 2008/09 preferred to have, on average, 3.1 children, compared with 3.4 children in 2003 and 2.9 children in 1993.

Men want larger families than women, regardless of household wealth and education (Figure 7). Poor urban women and men want 0.7 and 0.9 more children, respectively, than rich women and men. Urban women and men with no education want 2.5 and 7.4 more children, respectively, than those with secondary or higher education.

A large majority of women and men approve of using contraceptive methods.

Disapproval of family planning can act as a barrier to contraceptive use. Although the 2008/09 KDHS did not ask respondents whether they approved of contraceptive use, data are available from earlier surveys. Approval levels fell from 92 percent in 1993 to 88 percent in 2003 among urban women, and from 90 percent in 1993 to 82 percent in 2003 among urban men. The proportion of women who approved of couples using contraceptive methods in 2003 was 1.6 times higher among those with secondary education than among those with no education; the proportion was 3 times higher among men with secondary education than men with no education (Figure 8). Differentials were relatively small by household wealth.
wealth and province, except for North Eastern province where approval levels were extremely low.

**Figure 8. Percent of urban women and men who approve of contraceptive use, by household wealth and education, 2003**

Many urban women, especially the uneducated, do not intend to use contraceptives in the future.

Among urban women who are not currently using a contraceptive method, the proportion who do not intend to use contraception in the future rose from 33 percent in 1993 to 38 percent in 2008/09. The proportion of urban women who say they do not intend to use contraception in the future is 1.3 times higher among rich than poor women. The proportion is 1.8 times higher among women with no education than those with secondary education.

**SOURCE OF CONTRACEPTIVES**

*The percentage of women who obtain contraceptives from the private sector has changed little since 1993.*

The private sector has the potential to increase coverage of reproductive health services, especially for women who cannot or choose not to access government services. The proportion of urban women in Kenya who obtain modern contraceptives from the private sector, including mission facilities, private hospitals/clinics and pharmacies, rose from 40 percent in 1993 to 45 percent in 2008/09. Private-sector sources have increased in importance in just three provinces: Nairobi, Eastern and Nyanza (Figure 9).

**Figure 9. Percent of urban women obtaining modern contraceptives from the private sector, by province**

Poor urban women largely rely on the public sector for modern contraceptives.

Private-sector sources are more important for middle-income and rich women; only about one-quarter of the urban poor rely on the private sector for contraceptives (Figure 10). The proportion of urban women who obtain contraceptives from the private sector is about three times higher among those with at least primary education than among those with no education.

**Figure 10. Percent of urban women obtaining modern contraceptives from the private sector, by household wealth**
Long-acting contraceptive methods are less widely available than short-acting methods.

According to the 2010 KSPA, 76 percent of urban health facilities offer at least one short-acting contraceptive method, but only 55 percent offer a long-acting method. Government or municipal facilities are the most likely, and facilities operated by faith-based groups the least likely, to offer contraceptives. Both short- and long-acting methods are most widely available in Nyanza province (Figure 11).

Progestin-only injectables, male condoms and combined oral contraceptive pills are the most widely available methods, in stock at about two-thirds of urban health facilities, followed by progestin-only pills, in stock at about half of facilities. More facilities stock IUDs than implants (39 percent and 28 percent, respectively), while 40 percent stock emergency contraceptive pills.

Figure 11. Types of contraceptives in stock at urban health facilities, by province, 2010

At least two-thirds of urban households in every province own a radio, but television ownership is concentrated in Nairobi.

Radio is the most common media source of family planning messages for urban women and men, regardless of sex, age, education, household wealth and province, followed by television and newspapers (see Figure 12 for data by sex). The impact of those messages depends on their content and execution, but that information is not available from DHS surveys.

Women have greater exposure to family planning messages in the mass media than men.

Women’s exposure to family planning messages in the media has increased since 1998 (Figure 12). In 2008/09, a larger proportion of women than men recalled hearing or seeing family planning messages on radio and television; the proportion of women who recalled seeing these messages in newspapers was almost as large as the proportion of men. Around one in six women and men have no exposure to family planning messages in any of these media.

Figure 12. Percent of urban women and men who recall hearing or seeing family planning messages in the mass media during the past month

Exposure to mass media increases with wealth and education.

Higher proportions of rich and middle-income urban women than poor women have heard or seen family planning messages on radio, television and newspapers (Figure 13). In 2008/09, the proportion of poor women who recalled hearing family planning messages on the radio was about twice as large as the proportion who recalled seeing family planning messages either on television or in the newspaper. Exposure to family planning messages in all three mass media also increases with education.
Many poor and uneducated urban women are not exposed to family planning messages in the mass media.

In urban areas, 30 percent of poor women and 47 percent of women without education did not recall hearing, seeing or reading family planning messages in any of the mass media. Many women in North Eastern (67 percent) and Eastern provinces (35 percent) also reported no media exposure.

COUPLE COMMUNICATION

About two-thirds of urban couples have discussed family planning.

Couple communication about family planning is an important step on the path to adopting a contraceptive method. In urban areas, the proportion of married women who had discussed family planning with their husbands in the past year rose from 69 percent in 1993 to 79 percent in 1998, but then declined to 66 percent in 2003, the last year for which there are DHS data.

Equal proportions of poor and rich women discuss family planning with their husbands.

Couple communication declined in every income group from 1998 to 2003, but more so among the rich than the poor, almost erasing the gap between them (Figure 14). The gap between the most and least educated is much larger and has persisted over time. In 2003, the proportion of urban women who reported discussing family planning with their husbands was 1.8 times higher among those with primary education than among those with no education. There is little difference in couple communication between provinces, except for North Eastern province, where only 5 percent of women reported discussing family planning with their husbands in 2003.

Figure 14. Percent of married urban women who discussed family planning with their spouse in the past year, by household wealth
HIGHLIGHTS

Fertility levels have been declining slowly in urban Kenya, but remain high among the poor and uneducated. A large proportion of the urban population is young, which fuels high fertility rates. Teen pregnancies and short birth intervals contribute to higher fertility among the uneducated and, to a lesser extent, the poor. A larger proportion of poor women than rich women reports unwanted or mistimed births, suggesting a greater unmet need for family planning.

Fertility levels and contraceptive use vary more by education than household wealth. Differences in fertility levels between the most and least educated urban women have grown faster and wider than differences between the rich and poor. As for contraceptive use, the gap between rich and poor has almost disappeared in recent years, while differences by education remain large. Among uneducated women, only one in seven uses a modern contraceptive and half of the rest do not intend to use contraception in future.

Nearly half of urban women use modern contraceptives, increasingly to space rather than limit births. Use of modern contraceptives has been rising slowly in Kenya, and women have become more likely to adopt a method when they have only one or two children for spacing purposes. There is also growing interest among wealthy and more educated women in using contraception to postpone first births.

Attitudes toward fertility and family size have changed markedly among the uneducated. Over the past two decades, desired family size has jumped and approval of contraception has plummeted among women and men with no education, leading to wide differences by education. Attitudes have changed far less among the poor, and differences by household wealth are relatively small.

Men may pose an obstacle to family planning in urban areas. Compared with women, urban men—especially uneducated men—want larger families, are less likely to approve of using contraception and are less likely to be exposed to family planning messages in the mass media. Discussion of family planning by spouses also declined through 2003, although almost two-thirds of couples reported discussing the topic.

Poor urban women largely rely on the public sector for modern contraceptives. Only three provinces have seen an increase in the proportion of women who obtain modern contraceptives from the private sector. Most urban women—especially poor women—continue to rely on the public sector for contraceptive supplies.

Women’s exposure to family planning messages in the mass media is growing. Women are increasingly likely to hear or see family planning messages in all three mass media: radio, television and newspapers. However, radio remains the best way to reach the urban poor.

Provincial differences in fertility and family planning indicators are complex. Fertility levels and most family planning attitudes and practices show clear differences by province, but the pattern changes from one indicator to another. Eastern and Rift Valley provinces are notable for a combination of low fertility and high contraceptive use.

For more information about urban reproductive health, please visit www.urbanreproductivehealth.org.

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