



REPUBLIC OF KENYA

KENYA POPULATION SITUATION ANALYSIS



Kenya Population Situation Analysis

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LIST OF ACRONYMS AND ABBREVIATIONS

AASF	African-American Students Foundation
ACP	Africa, Caribbean and Pacific
AEZ	Agro-Ecological Zones
AHR	Adult Household Ratio
AIDS	Acquired Immune Deficiency Syndrome
AMADPOC	African Migration and Development Policy Centre
ANC	Antenatal Care
ARH&D	Adolescent Reproductive Health and Development Policy
ART	Antiretroviral Treatment
ARV	Antiretroviral Vaccine
ASAL	Arid and Semi-Arid Lands
ASFR	Age-Specific Fertility Rate
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
AWP	Annual Work Plan
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BPO	Business Process Outsourcing
CBD	Community-Based Distribution
CBD	Community Based Delivery
CB-DOTS	Community-Based Dots
CBK	Central Bank of Kenya
CBO	Community Based Organization
CBS	Central Bureau of Statistics
CDE	Centre for Demography and Ecology
CDF	Constituency Development Fund
CDR	Case Detection Rate
CEN-SAD	Community of Sahel-Saharan States
CNR	Case Notification Rate
COMESA	Common Market for Eastern and Southern Africa
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPR	Contraceptive Prevalence Rate
CRED	Centre for Research on the Epidemiology of Disasters
DALY	Disability-Adjusted Life Years
DFID	Department for International Development
DHMB	District Health Management Boards
DHS	Demographic and Health Survey
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DMC	Drought Monitoring Centre
DOTS	Directly Observed Therapy Short Course
DRF	Development Results Framework
DRH	Division of Reproductive Health
DRR	Disaster Risk Reduction
DRTB	Drug Resistant TB
DSS	Demographic Surveillance System

EAC	East African Community
EDBI	Ease of Doing Business Index
EDRR	Early Detection and Rapid Response
EM-DAT	Emergency Events Database
EmOC	Emergency Obstetric Care
ERS	Economic Recovery Strategy
ESR	Economic Support Ratio
FAO	Food and Agriculture Organization of the United Nations
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
FPE	Free Primary Education
FSE	Free Secondary Education
FY	Financial Year
GBV	Gender-Based Violence
GCI	Global Competitiveness Index
GDP	Gross Domestic Product
GDS	Geneva Declaration Secretariat
GER	Gross Enrolment Ratio
GER	Gross Enrolment Rate
GFDRR	Global Facility for Disaster Reduction and Recovery
GGGI	Global Gender Gap Index
GIS	Geographic Information Systems
GoK	Government of Kenya
GPS	Global Positioning System
HACT	Harmonized Approach to Cash Transfers
HDI	Human Development Index
HDR	Human Development Report
HERAF	Health Rights Advocacy Forum
HFA	Hyogo Framework of Action
HIV	Human Immunodeficiency Virus
HIV-AIDS	Human Immunodeficiency Virus- Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HQ	Headquarter
HTP	Human Trafficking Protocol
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
ICT	Information and Communications Technology
IDMC	Internal Displacement Monitoring Centre
IDNDR	International Decade for Natural Disaster Reduction
IDPs	Internally Displaced Persons
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
IGAD	Inter-Governmental Authority on Development
IHL	International Humanitarian Law
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
IMF	International Monetary Fund

IMR	Infant Mortality Rate
IOM	International Organization for Migration
IPAS	International Pregnancy Advisory Services
IPs	Implementing Partners
IPTp	Intermittent Preventive Treatment in Pregnancy
IRD	Institute for Resource Development
IRH/FP	Integrated Rural Health and Family Planning Program
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
IUD	Intrauterine Device
IUSSP	International Union for the Scientific Study of Population
IVM	Included Integrated Vector Management
JAMA	Journal of American Medical Association
KAIS	Kenya AIDS Indicator Survey
KANU	Kenya National African Union
KCO	Kenya Country Office
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package For Health
KESSA	Kenya Scholars and Studies Association
KFS	Kenya Fertility Survey
KFSSG	Kenya Food Security Steering Group
KfW	Kreditanstalt Für Wiederaufbau
KHPF	Kenya Health Policy Framework
KHSSP	Kenya Health Sector Strategic Plan
KIE	Kenya Institute of Education
KIPPRA	Kenya Institute for Public Policy Research and Analysis
KNBS	Kenya National Bureau of Statistics
KNCHR	Kenya National Commission On Human Rights
KNSPWD	Kenya National Survey For Persons with Disabilities
KPTJ	Kenyans for Peace with Truth and Justice
LASDAP	Local Authority Service Development Plan
LATF	Local Authority Transfer Fund
LLIN	Longer Lasting Insecticide Nets
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MDG	Millennium Development Goal
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
MHS	Mean Household Size
MICs	Multi Cluster Indicator Surveys
MIS	Malaria Indicator Survey
MISP	Minimum Initial Services Package
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoE	Ministry of Education
MoH	Ministry of Health
MoMS	Ministry of Medical Services
MOPAN	Multilateral Organization Performance Assessment Network
MoPHS	Ministry of Public Health and Sanitation

MoT	Mode of Transmission
MoYAS	Ministry of Youth Affairs and Sports
MSP	Migrant Smuggling Protocol
MTCT	Mother-To-Child Transmission
MTO	Money Transfer Organization
MTP	Medium Term Plan
MTP I	First Medium Term Plan
MTP II	Second Medium Term Plan
MTR	Mid-Term Review
MWC	Migrant Workers Convention
NACC	National AIDS Control Council
NARC	National Rainbow Coalition
NASCOP	National AIDS and STI Control Programme
NCAPD	National Coordinating Agency for Population and Development
NCPD	National Council for Population and Development
NER	Net Enrolment Rate
NGO	Non-Governmental Organization
NHSSP	National Health Sector Strategic Plans
NLC	National Land Commission
NMR	Nairobi Metropolitan Region
NMS	National Malaria Strategy
NRC	Norwegian Refugee Council
NTA	National Transfer Accounts)
NUPI	Norwegian Institute of International Affairs
OAU	Organization of African Unity
OECD	Organization for Economic Cooperation and Development
OMP	Office Management Plan
PD	Population and Development
PDRTB	Poly-Drug Resistant TB
PEPFAR	Presidential Emergency Plan for AIDS Relief
PoA	Programme of Action
PPMDOTS	Public-Private Mix for Dots
PRB	Population Reference Bureau
PSA	Population Situation Analysis
PSRI	Population Studies and Research Institute
PwDs	People with Disabilities
RBM	Result-Based Management
RCMRD	Regional Centre for Mapping of Resources for Development
REC	Regional Economic Communities
RFB	Results Based Financing
RH	Reproductive Health
RoK	Republic of Kenya
RSP	Remittance Service Provider
SADC	Southern African Development Community
SAPs	Structural Adjustment Programmes
SGBV	Sexual and Gender-Based Violence
SID	Society for International Development
SMAM	Singulate Mean Age at Marriage
SRH	Sexual and Reproductive Health

SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
SWAp	Sector Wide Approach
SWTS	School-To-Work Transition Survey
TB	Tuberculosis
TFR	Total Fertility Rate
U5MR	Under-Five Mortality Rates
UK	United Kingdom
UN	United Nations
UN/DPI	United Nations Department of Public Information
UNAIDS	Joint United Nations Programme on AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDESA	United Nations Department of Economic and Social Affairs
UNDESA/PD	Nations Department of Economic and Social Affairs/Population Division (
UNDHA	United Nations Department for Humanitarian Affairs
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV&AIDS
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
UNISDR	United Nations International Strategy on Disaster Reduction
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNOHCHR	United Nations Office of the High Commissioner for Human Rights
UNPD	United Nation Population Division
UPR	Universal Period Review
US	United States
USAID	United States Agency for International Development
UTFR	Unwanted Total Fertility Rate
VMMC	Voluntary Medical Male Circumcision
WDR	World Development Report
WFS	World Fertility Survey
WHO	World Health Organization
WTFR	Wanted Total Fertility Rate
XDRTB	Extremely Drug Resistant TB
YEDF	Youth Enterprise Development Fund
YESA	Youth Employment Scheme Abroad
YFS	Youth Friendly Service
YSO	Youth Serving Organization
YwDs	Youth with Disabilities

FOREWORD



The Population Situation Analysis (PSA) Report for Kenya is the first to be undertaken in Africa based on the new PSA Conceptual and Methodological Guide prepared and published by United Nations Population Fund (UNFPA).

Kenya's prevailing population growth rate remains above the country's resources in spite of endeavours to manage the population growth to levels that are consistent with the country's socio-economic development. There are also inadequate population and development programme indicators for Kenya. The Kenya Government through the National Council for Population and Development (NCPD) and Population Studies Research Institute (PSRI) with the support of UNFPA undertook the population situation analysis to provide current population status in Kenya. The PSA Report coincides with the Government's development and launch of the second Medium Term Plan, the development framework which all development programmes will be aligned to.

The PSA Report documents the overall situation of the well-being of the people in Kenya, thereby informing the entire spectrum of stakeholders in population and development field the challenges that Kenya is experiencing. The Report also recommends how to address the challenges as well as utilize the available opportunities.

The PSA Report presents information on a whole spectrum of the Kenyan population situation under the following key thematic areas: Population Dynamics and Development; Population Size, Growth and Structure; Fertility and Family Planning; Health Systems and Service Delivery for Sexual and Reproductive Health; Infant, Child and Maternal Mortality; HIV, Sexually Transmitted Infections, Malaria and Tuberculosis; The Youth-Status and Prospects; Marriage and Family; Emergency Situations and Humanitarian Response; Urbanization and Internal Migration, and International Migration and Development. The Report also gives the context for strategic interventions by the United Nations Population Fund (UNFPA).

The Report provides a summary of key indicators that will serve as baseline information for utilization in the development of various national and county policies and developmental plans. It will also guide policy makers and programmers on areas to prioritise and focus for fast economic development.

Anne Waiguru, OGW
Cabinet Secretary
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The process of carrying out the Population Situation Analysis for the first time in Kenya was accomplished through concerted efforts of various organizations, institutions and individuals. We recognise the very important role of the United Nations Population Fund (UNFPA) Kenya Country Office, which provided funding and valuable technical assistance at all stages during the Population Situation Analysis (PSA).

Sincere gratitude goes to the PSA Taskforce, under the chair of the National Council for Population and Development (NCPD) represented by Dr. Boniface K'Oyugi, former Director General, NCPD and the Late Dr. Paul Kizito, former Director, Technical Services, NCPD; and its entire membership comprising members drawn from various key government agencies and civil society that provided oversight and guidance to the whole PSA process. Special appreciation is extended to Population Studies and Research Institute (PSRI), University of Nairobi who provided technical coordination and support of all aspects of the PSA process.

We would like to acknowledge the valuable professional support received from different groups: 14 authors who analysed and drafted all the chapters of this report; 8 reviewers (4 local, 1 from UNFPA ESARO, and 2 from UNFPA HQ) who critically reviewed and moderated all the draft chapters; and 1 editor who technically and professionally edited the PSA report. All these groups sustained the PSA process with enthusiasm and unwavering support and sound professional advice.

We also extend our unreserved appreciation to the core team for the hard work and commitment in accomplishing the PSA: Prof. Lawrence Ikamari PSRI; Prof. Alfred Agwanda, PSRI; Mr. Ben Jarabi, PSRI; Ms Cecilia Kimemia, UNFPA KCO; and Mr. Ezekiel Ngure, UNFPA KCO.

To all who contributed in one way or another to the development and production of this report, we say thank you.

A handwritten signature in black ink, appearing to read 'G. Kichamu', with a long horizontal line extending to the right.

Mr. George Kichamu
Ag. Director General
National Council For Population And Development (NCPD)

EXECUTIVE SUMMARY

Background

In developing countries like Kenya, which are still struggling to meet the needs of rapidly growing populations, large shares of the populations are vulnerable to food insecurity, water shortages, weather-related disasters and conflicts. These circumstances persist despite several national and global initiatives to ameliorate the effects of these adversities. Indeed, for some countries, the experience has been one of regression rather than progress. Consequently, countries like Kenya must acquire new resolve to tackle adversity.

Rationale

Against the backdrop of the Millennium Development Goals and Kenya's long-term development blueprint, Kenya Vision 2030, the Government of Kenya is committed to mainstreaming population dynamics, reproductive health and gender issues into national development strategies. While Kenya has made significant strides in its bid to contain population growth at levels that are consistent with the country's growth and development potential and experiences, the prevailing population growth rate remains above the country's resources. However, there is lack of a comprehensive set of indicators for population and development programmes in Kenya. For example, in the Vision 2030, population issues have not been captured yet they are relevant for the realization of the same. There is also need to consider issues of inequality and human rights approach to development planning in Kenya. These are among the underlying rationale behind undertaking a population situation analysis that coincides with the Government's development of the second Medium Term Plan, which will be the development framework against which Kenya's development partners will arrive at their own priority interventions.

Objectives

The purpose of undertaking a Population Situation Analysis in Kenya was to document incisively the overall situation of the well being of the Kenyan society, and to inform the citizens, civil society, Government and wider stakeholder community, of the current challenges and opportunities in the country with respect to population and development. The specific objectives of the Analysis were to:

- equip users with an instrument for advocacy;
- contribute to greater understanding of population and development paradigm for better public policy formulation and implementation with specific reference to MTP II of Kenya Vision 2030 and MDGs;
- inform development of the UNDAF, on the critical need to prioritize and integrate population issues in development planning; and
- be utilized by various national actors in Government, civil society, and private sector, as well as cooperation agencies, in developing and implementing interventions in listed policy areas.

Process of conducting PSA

The process and documentation of PSA required working together with national actors in order to analyze and demonstrate the relevance of population issues in a country's development strategy, and practical implications for public policies. Imperatively, the need arose for extensive dialogue involving participation at high levels of Government for effective identification of priority needs and of proposals for action, while at the same time building ownership and enhancing national capacities. In this regard, a task force was formed to provide guidance and oversight during the PSA process, headed by high-level Government officials and comprising members drawn from various key Government agencies

and civil society. The task force held deliberations over a period of several months during which the various areas covered by this PSA were discussed. These deliberations took place alongside the work of independent consultants who were assigned to write chapters of this PSA that related to their respective areas of specialization.

Key Issues

Overview of Population Dynamics and Development

A key challenge for Kenya is sustaining the high economic growth target set in Vision 2030 (over 10%) in order to enhance the quality of life of the increasing numbers implied in Kenya's population dynamics which would in turn facilitate the achievements of the ICPD goals and MDGs including reducing the high levels of poverty. Some of the specific challenges implied by the current population dynamics include realizing the full potential of the increasing youth population by creating employment; meeting the needs of the growing ageing population; putting appropriate social and physical infrastructure for the increasing urban population; minimizing the adverse environmental impacts arising from the increased pressure on natural resources due to increasing population density; and enhancing human capital by investing in health, education and women's empowerment. Investing in both education and health would contribute to the attainment of more favourable demographic indicators, such as lower fertility through enhanced contraceptive use, lower ideal family sizes and reduced under-five and maternal mortality – indicators which remain high.

The increasing number of people implied by population dynamics and current demographic transition, including the bulging youth population, and aged population provide both challenges and opportunities. The increasing number of the youth, for example, can become a powerful force for economic development and positive change if they are educated, healthier and availed suitable employment opportunities. On the other hand, women in Kenya can become more productive if the existing gender inequalities are overcome by empowering them, ensuring that they have equal employment opportunities with men, but also ensuring they have access to reproductive health services as they might require, including FP. As implied by the UNDP Gender Inequality Index of 2010, 65.4 percent of potential in human development of the Kenyan woman is not being realized because of the inequalities. Overcoming inequalities would lower fertility, reduce poverty levels and attain better health towards overall development. It is further observed that none of the MDGs can be achieved without promoting women's reproductive health and protecting maternal and newborn health. Investing in education and health for the increasing numbers of the youth and empowering women, providing them with reproductive health services and putting in place programmes for taking care of the aging population are key challenges arising from the prevailing population dynamics.

Population Size, Growth and Structure

One issue surrounds the realization of the policy objective of reducing TFR from the current level of 4.6 to 2.6 children per woman by 2030. This is because the demand for children is still high and is unlikely to change unless substantial changes in desired family sizes are achieved.

The quantification of the demographic dividend raises two policy challenges with regard to achievement of economic growth: the need for rapid decline in fertility; and the substantial increase in labour productivity. The challenges arise because the demographic dividend is likely to be small given the large child population that has resulted from the high fertility levels over a long period of time.

The age structure of a population also has implications for political and socio-economic characteristics. A youthful age structure is likely to undermine sustained development, security and governance will

likely precipitate corruption. However, it can also create opportunities for a country.

Fertility and Family Planning

Although Kenya has made significant progress in increasing the CPR, the level is still below the target of 53 percent by 2005 and 62 percent by 2010 envisioned in the *National Population Policy for Sustainable Development* of 2000. At the same time, TFR has remained below the target set by the policy. Moreover, although the *National Reproductive Health Policy* of 2007 emphasized reduction in unmet need for family planning, unplanned births, as well as regional and socio-economic disparities in CPR, the level of unmet need among Kenyan women remains high.

Health Systems and Service Delivery for Sexual and Reproductive Health

Overall, there is a lack of investment in systems development. Government expenditure in healthcare has remained flat despite the growing economy and demand for health care. Donors generally do not provide for infrastructure or systems development as suggested. Current national policy calls for social health insurance as the primary way of financing health care. However, there is still a lack of a substantive health financing strategy. While social health insurance has the potential to increase investment in healthcare, the downside is that it is complex and can potentially leave out the poor and informal sector. Weak accountability manifested by poor monitoring and evaluation systems means inefficient health service delivery. Inequity in service provision affects particularly the poor, the informal sector and consequently, women and their reproductive health needs. Inadequate investment in logistical systems has resulted in a weak commodity supply chain.

Overall, Infant, Child, and Maternal Mortality

In general, it is noted that high childhood mortality rates pertaining in Kenya make it difficult for individuals to adopt small family norms. This situation is compounded by persistent regional and socio-cultural disparities in mortality rates. From available data, it is evident that the level of utilization of maternal health care services remains low. Raising uptake of maternal health care services such as facility delivery and skilled attendance to reasonable levels will contribute towards achievement of national goals in maternal health.

Another major challenge lies in the inadequacy of requisite data to effectively monitor progress towards the achievement of MDGs 4 and 5. This situation arises due to the inefficiency of the current civil registration system in Kenya that is supposed to be the principal source of such data. Clear indications that Kenya is unlikely to achieve set targets of MDGs 4 and 5 is another challenge to the country.

HIV, Sexually Transmitted Infections, Malaria and Tuberculosis

Care of HIV infected and affected people is a big problem, especially for families. One component of this population is the number of AIDS orphans that has been growing steadily from 27,000 in 1990 to 1.2 million in 2002, and further to 2.4 million by 2007. Delayed sexual debut and condom use have been listed as the main avenues for reduction of HIV prevalence in Kenya.

HIV-related stigma throughout society continues to pose a challenge. It inhibits many people from seeking HIV testing services and accessing ART, and is also a major contributor to the poor adherence by many people to ART regimes. Given that about 90 percent of the resources for HIV response comes from development partners, unpredictability and sustainability of financing for the epidemic remains a challenge to the Government of Kenya.

To meet the MDG target on TB, several challenges need to be overcome, including: infrastructure. There

is inadequate space for the increased demand for laboratory and chest clinic services; equipment for TB diagnosis is limited in supply; involvement of all stakeholders in TB control, especially the involvement and empowerment of communities hosting people living with or affected by TB; the evolution of MDR-TB that has a very high mortality rate; threat of HIV which continues to fuel TB; and misconception that TB is not treatable, delaying infected people's search for treatment.

Among the current challenges in combating the malaria menace include: impact of investment in malaria control over the past ten years and the gains made in reducing morbidity and mortality are difficult to measure within the routine health system as nearly all fevers are diagnosed and treated as malaria; parasitological diagnosis of malaria is still low; general knowledge about the recommended malaria treatment in the communities remains low; poor diagnostic equipment; weak distribution of ITNs, and diversion of the same to other uses; and malaria drug resistance.

The Youth: Status and Prospects

The principal challenge lies in ensuring optimal utilization of the youth's potential contribution towards achieving social, economic and political goals. The country will never achieve Vision 2030 without adequately responding to the needs and challenges of the present and future generation of young people.

Adolescent pregnancy and childbearing is correlated with low education levels for girls, and poses a major challenge due to the fact that apart from the inherent health risks, adolescent childbearing and the conditions associated with it are fundamental factors determining the quality of life and role of women in society.

Due to idleness, especially after formal education, the youth become restless, with some ending up in crime or with deviant behaviour, including self-destructive tendencies. Slightly more than half of Kenya's prison population is persons aged between 16 and 25. Poverty coupled with drug and substance use are responsible for the increased vulnerability of youth to crime. High unemployment rates among the youth means that the Government misses out on their potential contributions to social security systems. Analysis of youth employment context shows that Kenya faces five key challenges, namely: high unemployment; rapidly growing labour force; under-employment; problem of the working poor; and gender inequality in employment.

Marriage and Family

In Kenya, the Civil Registration Department has never published annual marriage statistics, thereby limiting research work on household transformations and productivity. Furthermore, national censuses which provide vital data for planning and policy formulation also lack information on the specific date at first marriage, type of marriage and duration of marriage. It is estimated that among the 13.7 million youth in Kenya in 2011, 7.6 million lived in poverty. Poverty often triggers early entry into marriage, motherhood and family establishment, denying young people greater prospects for further career development.

The programmes of free primary education and subsidization of secondary education create suitable opportunities for delaying entry into marriage, if effectively implemented. However, their implementation is a challenge to the Government because of the enormous resources required, human capital investment and infrastructure development. In Kenya, 60 percent of the active labour force consists of young people and 80 percent of the unemployed are youth. Such a situation creates critical challenges in families and the society in terms of security, petty crimes as well as drug and alcohol abuse that involve majority of unemployed youth and cause marital abuse and instability.

The key messages for policy are as follows: Marriages are still stable; there is a slow shift from early age at first marriage to intermediate ages among women; new forms of marriages are still few and not adequately captured by data; and poverty is more likely to be associated with early entry into marriage.

Emergency Situations and Humanitarian Response

Kenya does not have a coordinated framework for the management of emergency situations based on clear mandates and responsibilities. Consequently, the country's approach to managing situations such as disasters has been *ad hoc*, often characterized by fire-fighting. However, the Government's awareness of this deficiency in preparedness and long-term capacity, has led to its taking measures to build a national framework. Kenya's current legal framework is fragmented and hence the need for a single framework law that could specifically deal with issues of management of emergency situations in the country.

One of the critical concerns is Kenya's lack of preparedness for emergency management. For example, during the post election violence of the 2007/2008, public healthcare system was unprepared to deliver critical services within an emergency situation due to several factors: massive displacement of people in a short time span; lack of sufficient capacity to bring healthcare services to the community level because provision of health services is fundamentally premised on physical access; and disruption of logistics and supply chain coordination severely caused shortages of medical supplies even where there were adequate supplies in stock.

The continuing influx of refugees (especially from Somalia) has overstretched existing facilities in the host communities around Dadaab and Kakuma refugee camps. For example, the inter-agency assessment of the education sector in Dadaab noted that the pupil-classroom ratio is 113:1, while the teacher-pupil ratio is 1:85, with over 48,000 refugee school-age boys and girls are currently out of school. In the Kakuma Refugee Camp Primary School, classrooms can only accommodate 37 percent of school going population.

Urbanization and Internal Migration

Since urbanization is inevitable, the main challenge is not to slow it down, but rather to learn how to deal with the rapid growth it generates. Already, it is estimated that about 50 percent of Kenya's population will be living in urban areas by the year 2015.

The growth of Nairobi city has spilled over to adjacent urban centres, pointing to prospects of a metropolis. Other large urban centres will gradually experience the same growth trend. At the same time, there is no doubt that small and medium-size urban centres will continue to grow and absorb a larger proportion of the urban population.

Urban centres are central places where people converge on a daily basis. Consequently, they serve not only the urban residents, but also the populations living on the peripheries. However, the itinerant daytime population of urban centres is hardly ever captured in the population censuses, yet such inclusion is imperative for comprehensive planning purposes.

Internal migration is important and is increasingly becoming even more dynamic and complex. However, informed policy and interest on internal migration have been hampered by lack of adequate, reliable and comprehensive data, such as can be generated by national-level surveys. More research and data on all aspects of internal migration are needed to shape academic debates on the phenomenon and inform policy debates.

International Migration and Development

Among the biggest challenges in discussing international migration is the dearth of data which constrains meaningful and detailed analysis and interpretation of context. In Kenya, while the periodic censuses have generated immigration data, and lately emigration data, a number of potential datasets remain untapped. Such sources include data on visas and work permits, border-post data and passenger surveys at international airports. Second, no international labour market surveys have been undertaken to inform Kenya about its immigrant labour, especially those trafficked and smuggled to undertake jobs that Kenyans are overqualified for. Third, information on emigrant Kenyans is incomplete, leaving room for speculation on the size and profile of the Diaspora, including such information as current and previous employment and residence. While the nature and character of the Diaspora can be gleaned from its involvement in Kenya's development, its meetings at emigration destinations, and occasional homecoming ventures, these do not provide a comprehensive perspective of the phenomenon. Kenya's comparative peace, stability and prosperity in Eastern Africa means it is likely to continue to offer refuge to people from unstable states, making it imperative for policy-makers to address refugee burden in the context of the country's international obligations.

Immigration to Kenya, and emigration from it, has taken place devoid of a national migration policy. It is time, however, for Kenya to devote attention to desirable effects of immigration and emigration with a view to sustaining them while taking steps to eliminate undesirable effects. To this end, the Kenya Citizen and Foreign Nationals Management Services Board has the onerous task of reviewing existing migration management policies, and promptly acting on the findings.

Inequalities and the Exercise of Rights

For the design, implementation, follow-up and evaluation of policies, statistical information is an indispensable tool. During the past decade, there have been efforts globally to use population information in the field of social public policies, and in inequality and poverty analyses, in order to improve the design of interventions with which to improve the living conditions of middle and low segments of society. However, targets and indicators employed have not been designed based on the monitoring of inequalities and entrenched discrimination, or the extent to which social and economic rights are exercised. Many indicators are based on averages which ignore the disaggregated picture of how the disadvantaged fare relative to the most advantaged in society.

Another gap is the use of quintiles to assess the extent of poverty and inequalities. Although quintile scores are now commonly used, there is no necessary correspondence between them and poverty lines based on income or expenditure; which is to emphasize the possibility that some households classified as quintile 5 may fall below a country's income-based poverty line.

Article 12 of the International Covenant on Economic, Social and Cultural Rights provides for the development of the appropriate right to health indicators. The Covenant states: "State parties are invited to set appropriate national benchmarks in relation to each indicator of the right to health by identifying appropriate right to health indicators and benchmarks to monitor the extent of the framework law." This is a critical gap in the health policy framework even though it aims at using the rights to health approach in developing health interventions. That is, all the Kenyan policy and strategy documents lack right to health benchmarks. A human rights-based approach to programming must ensure that all processes, including data collection and use, are in line with human rights principles. It requires taking into account the extent to which existing services are available, accessible and acceptable to, and of high quality for, the population.

Although coverage and investments in safety nets have increased overtime, coverage of safety net

programmes remains low in comparison to the population in need, part of the problem lying in the weak monitoring and evaluation. Additionally, the weak alignment of existing programmes with the changing social, political, and economic context threatens their sustainability. The Government notes that previous assessments have indicated insufficient capacity in ministries and other agencies to implement a coordinated and harmonized social protection system.

Relationships and their Relevance to Public Policies

A number of analysts have tried to identify strengths and limitations of the MDG approach in the development process. However, some analysts have argued that the MDGs have been misinterpreted and were less successful at framing the development agenda at country level. MDGs were set in terms of aggregates and, therefore, mask tracking of progress in reducing inequalities and provide no incentives to focus on the poorest and hardest to reach. The MDG approach has been criticized for missing key issues at national level that are critical for development such as; equity, human rights, sustainability and empowerment as well as important policy areas such as climate change, growth, job creation, security and demographic change. Evaluations of effect of relationships between intervention, poverty, inequality and parameters of population processes have not been done and therefore no clear policy directions can be determined. In particular, interrelationships between migration and poverty, migration and health as well as migration and development.

Recommendations

The demographic dividend due to increase in the youth population relative to adult population is an opportunity that arises from demographic transition. Kenya should take advantage of Article 55 of the Constitution of Kenya (2010) which recognizes the importance of investing in the youth. The article declares the need for *“the State to take measures, including affirmative action programmes, to ensure that the youth: access relevant education and training; have opportunities to associate, be represented and participate in political, socio-economic and other spheres of life; and access employment”*.

Kenya should endeavour to accelerate its demographic transition through increased access to family planning; a reduction in child mortality; enhanced female school enrolment and general female empowerment; and the creation of labour market opportunities for women.

Kenya should put in place policies and programmes to address issues of access to information and services focused on modern contraceptives among various socio-economic groups.

The human rights approach recognizes the need to focus on areas of inequality in provision of services. This calls for relevant interventions tailored to mortality situations as depicted by sub-regional differentials.

Further, one of the major challenges is that routine data required for monitoring progress towards the achievement of the MDGs and Vision 2030 are incomplete and inaccurate. Given the paucity of routine data, there is need for concerted efforts to ensure that the systems expected to generate these data are functional. There is also need for specialized surveys that can assist to generate these data in the short-run to assist the Government and other key stakeholders to monitor achievements of the MDGs at all levels on a continuous basis.

In order to reduce maternal mortality, it is necessary to address several challenges, including the need to ensure availability of and access to quality maternity health care services.

HIV-stigma continues to be a challenge that needs attention in order to sustain the decline in HIV prev-

alence in the country. Priority recommendations for ensuring long-term success in Kenya's AIDS response are as follows:

- Intensified efforts are needed to enhance coordination, harmonization and alignment of the national response;
- Support should be expanded for grassroots community action and capacity development;
- A high-profile, multi-pronged strategy should be implemented to ensure sufficient financial resources to address the long-term challenge posed by AIDS;
- Kenya should elevate the priority accorded to efforts to prevent new HIV infections, including focused efforts to maximize the prevention impact of antiretroviral therapy;
- Strategies to reduce HIV risk must be supported by energetic, courageous efforts to address the social determinants of vulnerability; and
- Kenya should accelerate scaling up of comprehensive HIV treatment, care and support;

Article 55 of the Constitution of Kenya (2010) calls upon the state to take measures, including affirmative action, to ensure that the youth have access to relevant education and training. Young people must be provided with relevant and appropriate tools to develop their capabilities so they can make use of opportunities presenting themselves in today's competitive economy. They can do this only if they are equipped with advanced skills in thinking, behaviour, specific knowledge and vocational skills to enable them perform jobs that require clearly defined tasks.

To respond to, and address, some of the identified challenges, the Government should collaborate with other stakeholders to take advantage of the many opportunities that exist in favour of the country's adolescents and youth to:

- Ensure effective implementation, monitoring and evaluation of existing youth related policies across all sectors; and
- Put in place targeted programmes and interventions that address varied needs of adolescents and youth, particularly in health, education and employment creation.

Recognizing the dynamism in adolescent and youth programming, there will be need for timely dissemination of data to inform the design and development of targeted programmes and interventions for the ever increasing and varied needs of youth in Kenya.

It is recommended that Kenya invests in delaying age at first marriage and first birth. Investment in social services, such as education for young people will guarantee delays in family formation, promote entry into formal employment, and make the youth become more responsible citizens.

There is also need to invest substantially in the Vital Registration System in order to produce flows of data that are more relevant for annual planning for the changing needs of family households. There is also need to invest in studies on fragile families in order to inform policies and programmes for social protection.

Political commitment is the most important ingredient to addressing emergency situations. Political commitment should be demonstrated through declaration, legislation, institution-building, public policy decisions and programme support at the highest level of national politics. At the policy level, DRR can be integrated into Vision 2030 and performance contracting in all Government ministries and institutions. At the local level, DRR should be an integral part of county and community-based development planning. The right of the people affected by emergency situations to live in dignity is a matter of principle that should be upheld at all times and by all actors.

A comprehensive and up-to-date information database should document all disasters, conflicts, and displacements in Kenya and provide a basis for risk mapping and vulnerability assessments, and development of emergency plans focusing on all aspects of DRR. The database will be vital for building disaster scenarios in the country to inform policy and action (plans, programmes and projects). In establishing databases, particular attention should be paid to demographics of emergency situations.

These challenges call for a national urban policy to guide urban development countrywide. In addition, the policy should aim at guiding the urbanization process by reducing risks and maximizing opportunities attributed to urban growth. The challenges associated with urbanization demand a proactive approach to urban planning, which considers future demographic and environmental aspects while responding to current priorities. Such an approach demands, in turn, a sound understanding of urban development processes, locally, nationally and internationally.

There is a need to encourage area-wide metropolitan planning and governance, as well as planning for the spatial growth and development of small and medium-size urban centres, alongside strengthening their governance capacities.

As Kenya lacks a comprehensive internal migration policy, there is need to integrate internal migration into the wider urban, regional and national development policies and planning.

Like many other SSA countries, Kenya has a dearth of data on international migration, among the reasons for this being the lack of a broad-based migration data policy. To this end, the country should gauge the extent of Kenya's brain drain, brain waste and brain circulation in the West and in other loci of emigrant labour, including the Middle East and rest of Africa.

With the dual citizenship policy adopted recently, Kenya must be prepared to compete with the countries where its citizens reside in wooing them to acknowledge the ambivalence of some of their lifestyles abroad and its implications for individuals and the country.

Kenya's involvement in international migration agenda in RECs, at the AU and at the global level should be manifested in its ratifying and implementing international migration instruments. Given that Kenya is a country of origin, transit and destination of legal and illegal migrants, it should complete its commitment to the entire slate of statutory migration management instruments by signing the Convention Governing the Protection of Workers and Members of Their Families (1990). However, given the many challenges in comprehensive adoption or domestication of international instruments, Kenya has to establish a carefully designed domestic programme for accession to the requirements of such frameworks.

The country should develop policy to guide the judicious utilisation of Diaspora remittances, while recognising them as private flows subject to market forces. Such endeavours should draw on international experiences, such as the Mexican three-in-one system, to ensure the injection of county and central Government funds into the pool of remittances, thereby augmenting revenue for development. An important recommendation is for Kenya to appreciate "social remittances"- norms, non-monetary remittances such as practices, identities and social capital.

With respect to refugees, research should target the South Sudanese, Ethiopians and Somalis to investigate their unwillingness to return to their countries even after normalcy has been restored. There could be legitimate apprehension behind their reluctance to return, or they might have become so Kenyan that returning to their countries might disrupt their lifestyles. Another research area would be to have a matched survey of home-based citizens to establish the extent to which they share certain

events in Kenya, or whether they are polarised in their perceptions of and attitudes toward each other.

The present stage of development and demographic transition calls for studies that interrogate the past literature and research results alongside contemporary national and devolved governance structures in the country. Areas that lack requisite data and information include; migration and its determinants and consequences, maternal mortality at sub-national levels, cause of death data to determine burden of disease as well as data and information that link poverty, inequality, population, and reproductive health indicators.

There is need to include issues of equality and equity as one of the guiding principles underpinning the whole framework or more goals that specifically focus on inequality by type of inequality (social economic or political). Inequalities can also be integrated as a concern into goals and targets on different sectoral issues (politics, security, justice, health, education and poverty) in order to uphold inclusion, fairness, responsiveness and accountability to all social groups throughout the framework.

The Kenyan education system will have to quickly and significantly ratchet up skills of those who go through it. This entails building on Kenya's progress with Free Primary Education, improving school quality and ensuring that more Kenyans complete secondary school. It is imperative that the Kenyan education system is better aligned with the job market. This calls for labour-intensive initiatives, entrepreneurship development, elimination of skills mismatch, policies on labour migration and productivity improvement. This requires an integrated National Employment Policy which should integrate all employment opportunities in a time-bound national action plan with clear targets for different agencies. It is suggested that a National Employment Council with membership, drawn from workers, employers, private sector and academia, be created to coordinate implementation of a National Action Plan on Job Creation.

It is, therefore, recommended that the Government targets programmes to nurture, incubate and encourage talents exhibited by youth at an early age. It is further noted that some sectors – such as livestock, horticulture production, irrigation, hotels and restaurants – have the potential to yield more job opportunities than others, and should, therefore, be targeted first. To tackle the challenge of unemployment in Kenya, the following measures are necessary:

- Simplify business registration processes, improve governance and physical infrastructure, and reduce crime rates. Financial assistance programmes are a popular intervention to promote entrepreneurs. International experience indicates that such programmes have been successful in stemming unemployment;
- The new labour laws should be implemented in a consultative manner to take into account the concerns of social partners. This will safeguard Kenya's competitiveness in international markets;
- Given that the sectors with the largest potential for job creation are agriculture based, there is need for increased investment in agriculture, such as in livestock management and irrigation (to reduce seasonal vulnerability);
- The Government should commission a School-to-Work Transition Survey (SWTS) to improve the design of employment policies and programmes for the youth. This will help assess the relative ease or difficulty of the youth's transition from school to work life. It will also help identify levels of skills, perceptions and aspirations in terms of employment, job search process, barriers to entry into the labour market, and preference for wage employment versus self-employment; and
- The analysis of some aspects of unemployment is hampered by lack of sufficient data. The labour force survey instrument should be modified to capture unemployment spells and transitions

into and exit from unemployment. The Kenya National Bureau of Statistics should deepen the employment data collection instruments, ensure quarterly data collection and release to show the number and types of jobs created across Kenya and sectors more frequently.

The Government needs to get serious about eliminating corruption, which acts as a chokehold on the private sector. Most transactions involving Government officials, from obtaining contracts to paying taxes, seem to have a corrupt element. The World Bank estimates that if the private sector could redirect the money it now spends on corruption to creating jobs, it could create 250,000 jobs, sufficient to hire most unemployed urban Kenyans between the age of 15 and 34. In addition young people seeking jobs often have to pay bribes to get them, a practice that can discourage would-be entrants into the labour force. It will be easier to stop petty corruption if the Government takes it seriously, and individuals not only lose their jobs, but also go to jail for corrupt behaviour.

Kenya needs to continue to make quality education a priority, not just emphasize on quantity. Kenya has made good progress in providing universal primary education and has greatly increased availability of secondary education. Kenya will need to continue to make significant investments in education, not just in expanding access, but also in upgrading quality. It will be imperative for the Government to make special effort to ensure that education outcomes match the skills needed by the private sector, as it also expands to meet new opportunities. The Government should focus on facilitating and enhancing education for all. With greater accessibility to education, young people will spend more years studying, therefore become more productive, delay marriage and consequently end up having fewer children.

Policies to address population growth and to promote social protection are vital for reducing poverty, as are national employment strategies formulated and implemented with full involvement of key stakeholders. Actions to expand jobs and labour productivity should focus on widening access to complementary inputs such as machinery and equipment, strengthening the business environment in which the private firms can thrive, boosting quantity and quality of physical and institutional infrastructure, and improving working conditions.

Policy and decision makers need to recognize that continuing population growth will contribute to increased urbanization. They will have to develop and implement urban planning policies that take into account consumption needs and demographic trends while capitalizing on the potential economic, social and environmental benefits of urban living.

There is dire need to form a National Health Services Commission that will be responsible for regulating matters in health, quality assurance and standards, monitoring and evaluation, strategic planning and management, inter-sectoral collaboration, enforcing the Bill of Rights and ensuring universal access to health care.

Empowering women, removing financial and social barriers to accessing local accountability of health systems are all policy interventions that will enhance equal access to health services and reduce mortality.

Kenya should strive to tap into new global resources to strengthen the country's sustainable development. Natural resource management strategies, including reforestation that have until now often been ignored, should be given priority. Similarly, well-thought-out public-private partnerships for addressing climate change should be brought into play.

Policy and decision makers need to use existing knowledge more effectively and to prioritise research

in natural and social sciences that will provide innovative solutions to challenges of sustainability.

In order to gain better understanding of the policy and programme environment, there is need to contribute to undertaking of socio-demographic surveys in order to continue building the knowledge base on population dynamics, reproductive health, HIV and AIDS and gender equality. It will be necessary to support further analysis of modules of selected socio-demographic surveys such as the KDHS, among others. In addition, undertaking of socio-cultural, demographic and health research to support programme planning and implementation as well as policy dialogues will be added advantage.

On the basis of the challenges identified and the strategic direction for UNFPA, it is recommended that agency focuses on the following:

a. Universal access to sexual and reproductive health and reproductive rights

In line with the ICPD Programme of Action, Kenya has two policy instruments that address the issue of universal access to sexual and reproductive health:

The National Reproductive Health Policy of 2007 which aims at enhancing the reproductive health status of all Kenyans, and Article 43 of The Constitution of Kenya 2010 which provides that every person has the right to the highest standard of health, which includes the right to health care services, including reproductive health care. However, universal access to sexual and reproductive health is still being constrained by a number of factors that are economic, social and cultural. UNFPA is expected to be in the forefront in supporting implementation of the RH Policy as well as other policies that promote attainment of reproductive health and rights within the framework of the new constitutional dispensation.

b. Improve maternal, new born and child health

In line with MDG 5, relevant policies and programmes in Kenya aim at reducing maternal deaths. However, trends in maternal mortality ratio provide clear evidence that this is one of the goals at highest risk of not being met. Uptake of maternal health care and voluntary family planning services are vital to reducing maternal deaths. This makes family planning critical in its own right. In this regard, UNFPA should support relevant interventions that promote increased uptake of maternal health care services including family planning.

c. Support efforts towards a strong information base

Sustainable development requires Kenya to be in a position to proactively address, rather than only react to, the population trends that will unfold over the next decades. Requisite data must inform forward-looking development policies, strategies, and programmes. To measure progress in population and reproductive health and rights outcomes, and to hold associated actors accountable, a set of robust indicators must be clearly defined. The Kenyan community has not only a need, but also a right to monitor the impact of the development agenda. Development results data must be positioned to reveal the actual impacts on people, environment, economy, security, etc. In all instances, indicators must allow for impacts to be disaggregated by various characteristics including age, sex, socio-economic status and related variables, so as to track how the most vulnerable groups progress. UNFPA's role will be to enhance capacity of institutions responsible for population related data collection, analysis, dissemination and use to generate accurate and user-friendly data for integration of population issues into development planning at all levels.

PART 1

CHAPTER 1: INTRODUCTION

Background

Globally, people are living longer and healthier lives, and couples are choosing to have fewer children; yet, huge inequities persist and daunting challenges lie ahead. While rich countries are concerned with low fertility and ageing, nations like Kenya are still struggling to meet the needs of rapidly growing populations amid huge disparities between the poor and rich. In developing countries like Kenya, large shares of the populations are vulnerable to food insecurity, water shortages, weather-related disasters and conflicts. These circumstances persist despite several national and global initiatives to ameliorate the effects of these adversities. For example, the world is two years away from end date of the Millennium Challenge of 2000 which spawned the Millennium Development Goals; yet for majority of signatory countries, there is little to show for the amount of resources and rhetoric that has gone into striving for the eight goals and related targets. Indeed, for some countries, experience has been one of regression rather than progress. Yet, even as multi-faceted obstacles – some self-inflicted; others unavoidable – emerge to undermine progress towards development, countries like Kenya must acquire new resolve to tackle adversity. This report analyses the state of the Kenyan population with a view to generating practical recommendations on the ways in which the human welfare gains to date can be safeguarded and built on, even as new initiatives are designed and implemented with which to further the struggle to improve the quality of life of people in the country.

Against the backdrop of the Millennium Development Goals (MDGs) and the long-term development blueprint, Kenya Vision 2030 and in the context of several developmental frameworks agreed upon by the international community, the Government of Kenya is committed to mainstreaming population dynamics, reproductive health and gender issues into National Development Strategies. While Kenya has made significant strides in its bid to contain population growth at levels that are consistent with the country's growth, development potential and experiences, the prevailing population growth rate remains above the means of the country's resources. The country fully recognises the potential contribution that can be made to population management by development and sustained implementation of efficacious reproductive health policies and practices. The Government also appreciates the potential contribution of effective gender management that appreciates the differentiated impact of policies and actions on men and women, on the sustained success of population policies in general, including reproductive health policies and initiatives.

The strategic population, reproductive health and gender axes is anchored on the ability of all relevant stakeholders to be able to not only understand how population dynamics interrelate with the development process, but also how to integrate population, reproductive health and gender dynamics, and their linkages and impacts, in interventions against poverty and inequality. These are among the underlying rationale behind undertaking a population situation analysis that coincides with the Government's development of the second development plan of the Kenya Vision 2030 era, the Medium Term Plan 2014-2019, or MTP II. Critically, MTP II will be the development framework against which, in the spirit of the development co-operation strategies for aid effectiveness agreed on in Paris (2005), Accra (2008) and Bushan (2011) where Kenya's development partners will arrive at their own priority activities¹.

¹ Such as is impending for the Kenya UN Country Team's fourth UN Development Assistance Framework (UNDAF).

Objectives

The purpose of the Population Situation Analysis (PSA) is to document incisively the overall situation of the well being of Kenyan society, and to inform the citizens, civil society, Government and wider stakeholder community, of the challenges and opportunities that Kenya has with respect to population and development. The Assessment will suggest ways to address these challenges even as existing and emerging opportunities are gainfully employed. Specifically, the PSA is expected to:

- equip users with an instrument for advocacy;
- contribute to greater understanding of population and development paradigm for better public policy formulation and implementation with specific reference to MTP II of Kenya Vision 2030 and MDGs;
- inform development of the UNDAF, on the critical need to prioritize and integrate population issues in development planning;
- be utilized by various national actors in Government, civil society and private sector, as well as cooperation agencies in developing and implementing interventions in the listed policy areas.

The process and documentation of PSA required working together with national actors in order to analyze and demonstrate the relevance of population issues in a country's development strategy, and the practical implications for public policies. Hence, the need arises for extensive dialogue involving participation at high levels of Government for effective identification of needs and proposals for action, while at the same time building ownership and enhancing national capacities. In this regard, a task force was formed to provide guidance and oversight during the PSA process, headed by high-level Government officials and comprising members drawn from various key Government agencies and civil society. The task force held deliberations over a period of several months during which various areas covered by this PSA were aired. These deliberations took place alongside the work of independent consultants who were assigned to write chapters of this PSA that related to their respective areas of academic and/or intellectual specialization.

Components of this Report

The PSA report comprises six core thematic areas, namely: this introductory section outlining objectives of PSA, its background and guiding principles; a comprehensive overview of the country situation, including its progress towards meeting national and international development goals; a synthesis of data and information on population dynamics, sexual and reproductive health in the context of economic and social processes; an examination of the extent to which inequalities exist, including in the exercise of rights; highlights of relationships, impacts and relevance of public policies; and a final section providing a summary of the foregoing issues, including core challenges and opportunities for action. These thematic areas are better organized along four parts outlined here below.

Part 1: Introduction

This consists of objectives of PSA, background and guiding principles, a comprehensive overview of the country situation, and progress towards meeting national and international development goals.

Part 2: Overview of Population Dynamics and Development

This forms the background of the country and includes a review of population dynamics and the potentialities or constraints imposed by the national context. The review consists of: a global analysis of the country with regard to most important characteristics of demographic transition; economic, socio-cultural, political and institutional context; the country position with respect to its international commitments, with emphasis on the MDGs and the ICPD Programme of Action.

Part 3: Population Situation

This identifies more specifically main characteristics of the population processes and main challenges or problems confronted by the country in these areas. It, therefore, considers all population related behaviours – whose emphasis will be determined by the importance that each has in the country, according to the stage of the demographic, epidemiological and urban transitions, as well as the availability of information. There are 10 thematic areas namely:

1. Population Size, Growth and Structure;
2. Fertility and Family Planning;
3. Health Systems and Service Delivery for SRH;
4. Overall Infant, Childhood and Maternal Mortality;
5. HIV/Sexually Transmitted Infections, Malaria and Tuberculosis;
6. The Youth: Status and Prospects;
7. Marriage and Family;
8. Emergency Situations and Humanitarian Response;
9. Urbanization and Internal Migration; and
10. International Migration and Development.

Part 4: Inequalities and Exercise of Rights; Relationships and Impacts; Challenges and Opportunities

Inequalities and Exercise of Rights

This serves as a synthesis of results presented in previous chapters as well as examining conceptual linkages with development parameters. In particular, this chapter presents a detailed overview of inequalities according to socio-economic, regional and gender groups, thus demonstrating the contrasting situations that characterize these different groups in the country. The PSA illustrates not only manifestations of inequality/poverty, but also the extent to which these social inequalities persist despite advances in the demographic transition. It also describes attempts to reduce these socio economic inequalities through application of a rights-based programming.

Relationships and Impacts: Relevance for Public Policies

This documents the relationships between components of population dynamics, reproduction and gender, and their implications for public policies. It also highlights the need to reduce poverty and inequality as well as extend capacities and protection of rights of the most disadvantaged or marginalized groups of the population, as basic requirements for overcoming poverty.

Challenges and Opportunities

This is the final section of the PSA, and:

- a. serves as a summary and conclusion, and identification of main challenges that confront the country, and opportunities available for addressing these challenges;
- b. defines the context for strategic interventions that the United Nations Population Fund (UNFPA) can undertake as part of joint effort of the United Nations system to support development of the country; and
- c. provides a summary of the trends in key indicators that will serve as baseline information for utilization in the development of MTP II, UNDAF and the eighth GoK/UNFPA Country Programme.

Process of conducting PSA

In order to have a succinct and well prepared document that is also owned by, and useful to all stakeholders, the PSA process required working together with national actors across the board in order to analyze and demonstrate the relevance of population issues in the country's development strategy.

- a) The PSA process was designed to:
 - take place within the context of an extensive process of dialogue involving high levels of involvement and participation;
 - build consensus on, and ownership of, the findings of the report; and
 - enhance national capacities in analysis, dissemination and dialogue on matters relating to population issues and national development .
- b) To achieve these objectives, it was necessary to:
 - constitute a taskforce that would provide the overall oversight of the PSA process;
 - hold orientation workshops to highlight the rationale, guiding principles, methodology, and their role in the PSA process;
 - carry out analysis and compile reports on selected thematic areas and the overall report; and
 - hold appropriate review workshops to interrogate the document, build consensus on the challenges, opportunities and inform various audiences of the findings.
- c) Since the PSA methodology and outputs require wide consultations, there was need for technical assistance from the UNFPA African Regional Office and Headquarters to obtain inputs from, and experiences of other countries to inform the process, analysis and synthesis of available information, as well as on how to disseminate the PSA products.

PART 2

CHAPTER 2: OVERVIEW OF POPULATION DYNAMICS AND DEVELOPMENT

2.1 Introduction

Enhancement of the wellbeing of the population is the key objective of any nation's development agenda, objectives for which Kenya is no exception. Such enhancement is achieved through sustainable development, the broader and more comprehensive concept of development that was adopted by the Brundtland Report of 1987. The key components or pillars of sustainable development are economic development, social development and environmental protection². Sustainability implies that meeting the needs of the present population does not jeopardize meeting the needs of the future. Wellbeing has traditionally been reflected in the levels of income and access to basic needs, such as food, housing, healthcare, education and employment. In the broader definition above, meeting the basic human rights of the population, including the right to participate in the development process itself, are also in addition perceived as aspects of wellbeing. These concerns have been included in both the International Conference on Population and Development (ICPD) Programme of Action (PoA) (UNFPA, 2004) and MDGs (United Nations, 2012).

The close linkages between population, sustainable development and human wellbeing were reaffirmed at the 1994 ICPD Conference in Cairo. The Conference observed that everyday human activities within communities and in countries as a whole are interrelated with population change, the state of environment as well as economic and social development. Consequently, the conference urged countries to develop appropriate population policies and programmes in order to enhance the quality of life of their people. In Kenya, these inter-linkages had been recognized soon after independence when the country became the first in Sub-Saharan Africa to integrate population management in its development strategy by establishing a family planning programme in 1967³. Since then, this population concern has been articulated in several policy documents, including the current population policy by the National Council for Population and Development (NCPD) of 2012.

This chapter examines the interrelationships between population and sustainable development. The chapter starts with a brief presentation of the country setting covering the key administrative, political, agro-ecologic and economic features (Section 2). Section 3 reviews the population situation while the country's socio-economic situation together with the policy and cultural environment are presented in Section 4. The conclusions and recommendations are discussed in Section 5.

Country Setting

Kenya is situated in eastern part of the African continent, bordering Ethiopia, Somalia, Sudan, Uganda, Tanzania and the Indian Ocean (Figure 2.1). The country has a total area of 582,646 sq. kms, with a land area of 571,466 sq kms. Only about 20 percent of this land is arable, along the narrow tropical belt in the coast region, the highlands east and west of the Rift Valley and the lake basin lowlands around Lake Victoria – and consequently accommodates a large proportion of the country's population. The arable area includes the very high humid forests and highlands of Mt. Kenya and the Abedares Ranges in eastern highlands of the Rift Valley, and Mount Elgon, Cherangani, Mau and Nandi Hills in western highlands; the humid highlands of moist and dry forests with high agricultural potential in central

² See elaboration in 'Sustainable Development Policy and Guide for The EEA Financial Mechanism & The Norwegian Financial Mechanism'. Adopted: 07 April 2006 Available at http://www.eeagrants.org/asset/341/1/341_1.pdf - accessed 21/12/2012

³ For a review of Kenya's commitment to population policy, see Crichton, Joanna (2008).

Kenya; the dry forest and moist woodlands which are of high and medium agricultural potential in Rift Valley; and the humid and dry transitional areas in lower parts of Rift Valley (NCPD, 2010a). The rest of the country – the north and north eastern and much of the southern areas towards the Tanzania border – consist of arid or semi-arid lands (ASALs) primarily covered with bushes and shrubs, unsuitable for agriculture, but affording opportunity predominantly for pastoralism and wildlife conservation. Table 2.1 shows the Agro-ecological Zoning 4 (AEZ) of Kenya’s total area. Out of 582,646 square kilometres of area, about 1.9 percent is covered by water and the dry land mass is commonly divided into six major agro-ecological zones.

Table 2.1: Agro-ecological zones of Kenya

Zone	Approximate. Area (km ²)	Percent of Total	Examples of regions	
I. Agro-Alphine	800	0.1	Mt. Kenya and Mt Elgon areas Little agricultural value, except as source of rain and some rivers/streams	
II. High Potential	53,000	9.3	Parts of Meru, Embu, Kirinyaga and Nyeri; parts of the Rift Valley around Mau and Aberdares mountains (e.g. Kericho and Nyahururu respectively); Mt Elgon (e.g. around Kitale and Webuye).	Highlands between 1980 and 2700 m and occurs as a forest or open grasslands, Minimum, rainfall 1000mm
III. Medium Potential	53,000	9.3	Vast parts of Nyanza, Western and Central provinces; Central Rift-Valley (Nandi, Nakuru, Bomet, Eldoret, Kitale) and a small strip at the Coast province.	Between 900-1800 m with an annual rainfall between 950 and 1500 mm Most significant for agricultural cultivation.
IV. Semi-Arid	48,200	8.5	Naivasha, vast parts of Laikipia and Machakos counties; vast parts of central and southern Coast Province.	Between 900-1800 m with an annual rainfall between 950 and 1,500mm but with annual rainfall of about 500-1,000mm
V. Arid	300,000	52.9	Prevalent in northern Baringo, Turkana, lower Makueni and vast parts of North Eastern Province.	Much drier than Zone IV and occurs at lower elevations; Annual rainfall is 300-600mm

⁴ AEZ refers to the division of an area of land into smaller units with similar characteristics related to; land suitability, potential production and environmental impact (FAO 1996)

VI. Very arid and desert area	112,000	19.8	Semi desert areas found in Marsabit, Turkana, Mandera and Wajir counties.	The driest part. Annual rainfall is 200-400mm and is quite unreliable
			Chalbi Desert in Marsabit County.	Chalbi is a salt desert with very sparse salt bushes as the only vegetation found. It is vast and of beautiful scenery. Pastoralists use it as a source of mineral lick for livestock, particularly during the rainy season.
Rest (waters etc)	15600	2.6		

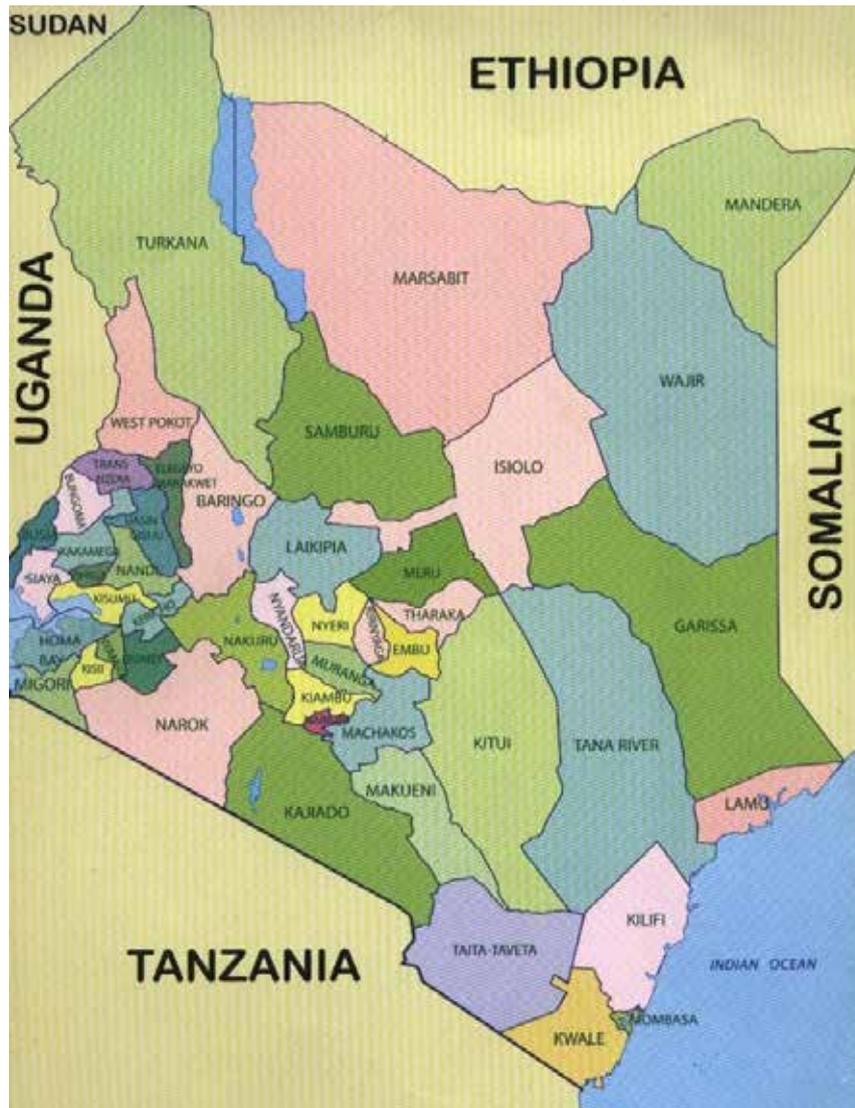
Modified from http://www.infonet-biovision.org/default/ct/690/agrozones_6th March 2013

Kenya attained independence from Britain in December 1963 after a protracted struggle that included a short-lived guerrilla war. The country is a multi-party democracy and was until March 2013 governed by a coalition Government that was crafted in the wake of the disputed 2007 General Election. The new Constitution promulgated in 2010 provides for a republican system with a bicameral Parliament elected every five years. The Constitution provides for 47 devolved county Governments which are distinct from, but interdependent with the national Government, each with a governor and a county assembly. The counties replace the previous 8 provinces and the over 250 districts they presided over.⁵ The counties are in turn subdivided into sub-counties, wards and villages. The main distinction in governance introduced by the Constitution is that while the provinces and districts had been administered by direct appointees of the President to whom they were accountable, counties elect their respective governors, which is anticipated to enhance accountability to the grassroots. Each county elects ward representatives to its county assembly whose role is to legislate locally and to monitor the performance of the governor's county executive committee. A major deviation from the old constitutional order is that the Constitution provides Parliament the powers to legislate for the mode of recalling non-performing legislators.

Kenya has about 42 ethnic groups, among the largest in number being the Kikuyu, Luo, Kalenjin, Luhya, Kamba, Kisii, Mijikenda, Somalia and Meru. The smallest ethnic group, the El Molo, is estimated to number about 400. The main religions in Kenya in terms of following are Christianity and Islam; but other religions thrive with numerically smaller congregations even if they have high profiles, such as the religions of the Asian communities. The country also has isolated groups which espouse indigenous faiths. English is the official language while Kiswahili is the national language.

⁵ On the August 26, the eve of the promulgation of the new Constitution, Kenya had 41 legally established districts. From the early 1990s, the sub-division of districts for political expediency led to about 71 districts by 2008. This practice eventually led to some 250 ad hoc districts which were ignored by the Committee of Experts which drafted the Constitution, to set the number of constitutional counties at 47.

Figure2. 1: The Map of Kenya



Map of Kenya showing the 47 counties
Photo: www.herstorycentre.org

2.3 Overview of Kenya's Population Situation

The status of Kenya's population is contained in several recent population policy and situation reports, as well as other documents (NCPD, 2009; 2010a; 2010b; 2011; 2012; KNBS, 2010). Analyses of these documents reveal that Kenya's rapid population growth first noted in the early 1960s will continue against the backdrop of relatively high fertility and mortality rates, even if these indicators reflect substantial regional variations. The country will, therefore, continue to experience demographic and development challenges associated with a rapidly growing population, such as an increase in the numbers of youth. In turn, and especially in the face of constrained employment growth, population growth could lead to a high dependency burden. In addition, the population growth momentum created by the youthful population is such that overall population would increase even if Kenya were to attain an immediate reduction of its current total fertility rate (TFR) of 4.5 births per woman to the replacement level of about 2.2 births per woman.

Population trends have resulted in increased population densities in some of the rural areas, such

as Kiambu, Kakamega, Vihiga, Kisii and Kisumu counties, with densities of over 500 persons per sq km, compared to a national average of 68. Such high densities have created increasing pressure on the land and other natural resources, the consequences being evident in the extensive loss of forest cover, land degradation, dwindling water resources and emerging climate change (NCPD, 2010a). A further characteristic of the distribution of the population is the rapid urbanization rate even if current urbanization levels remain relatively low. The 2009 Population and Housing Census shows that slightly less than one-third of the population lived in urban areas, a substantial increase from the 19.3 percent recorded in the 1999 census. The growing urban population has over-stretched existing infrastructure and services, leading to growth of informal settlements characterized by overcrowding, and the lack of basic infrastructure (such as sewage, safe drinking water and decent housing), and consequently increased poverty and delinquency.

Although the Government continues to implement measures to influence demographic trends, the population of the country currently estimated at 42.0 million, is expected to reach nearly 60 million in 2030 and 77 million by 2050. On average, each woman will be expected to have attained a fertility level of less than 3 births (TFR= 2.6) by that time with an associated infant mortality rate of 25 per 1000 children born alive, a life expectancy of 64 years, and a maternal mortality ratio (MMR) of 200, resulting in a population growth rate of 1.5 percent per annum (Republic of Kenya, 2012). Even with the attainment of the above targets, these statistics will still not be comparable to those of developed countries which often have zero population growth rates due to fertility rates below replacement levels, with child and maternal death rates below 3 per 1000 population and 100,000 live births respectively, and a life expectancy above 80 years. The development challenges of the demographic scenario as indicated in the Sessional Paper no. 3 of 2012 will include attaining and sustaining economic growth levels that create employment, reduce poverty levels and enhance accumulation of human capital through improvements in the status of health and education.

In spite of the expected increase in population size, Kenya can benefit greatly from the changing age structure arising from the demographic transition that the country has been undergoing since the late 1980s (Cross et al., 1991). This could result in a situation in which a large number of the working age population is sufficiently productive to support the dependent population, namely children and old-age population. This situation is often referred to as the Demographic Dividend, in which the changing age structure results in the increase in proportion of the working age population relative to the youthful population, consequently releasing resources for investments in economic development. Such a transformation occurred in South Korea in the mid-1960s when falling birth rates reduced elementary school enrolment with the resulting savings being invested in improving the quality of education at higher levels. In appreciation of the opportunity afforded by the demographic transition, ICPD@15 urged countries to invest in education and create employment opportunities for young people so as to reap the dividend.

Population growth and development are inter-linked in complex ways. Economic development generates resources that can be used to improve education and health, the two key contributors to the quality of human capital. Such improvements, along with associated changes, can reduce both fertility and mortality rates. Conversely, high rates of population growth eat into investment resources for economic and social development, and can hinder improvements in both education and health, and the reduction of poverty. A growing population also poses challenges over housing and employment and increases the risk of social unrest, amongst other concerns. These potential linkages have been recognized in Kenya and are articulated in past policy and other documents, such as Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development. The foregoing dynamics are expounded on in the next section.

2.4 Socio-economic, Policy and Cultural Context

The following sub-sections review the status of the Kenyan economy and that of various rights, policies and programmes, and constraints encountered, in the context of population dynamics.

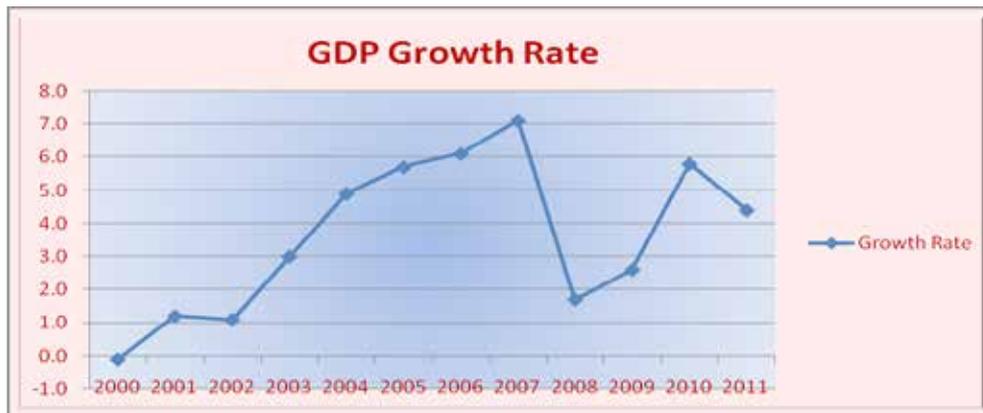
2.4.1 Status of Economy

The growth of the economy and the re-distribution of its benefits were recognized early as the bases for raising the standards of living of the Kenyan people. Soon after independence in 1963, Kenya produced its inaugural development blue-print, Sessional Paper No. 10 of 1965 on African Socialism and its Application to Planning in Kenya (Republic of Kenya (RoK), 1965), which became the source of policies and strategies for many years. In retrospect, the Sessional Paper was problematic: it advocated the focus of scarce investment resources in high absorption areas in the hope that their benefits would trickle to the rest of the country; but provided no effective framework for the anticipated trickle down, underscoring the inequalities inherited from nature and colonialism. However, the Sessional Paper's championship of free enterprise became the bedrock of the Kenyan economy whose performance under successive KANU party regimes was chequered due to internal and external factors, reaching its nadir in 2002. The accession of the National Rainbow Alliance Coalition (NARC) party regime led to the launch of the Economic Recovery Strategy for Wealth and Employment Creation 2003-2007 hereafter, ERS, whose focus on wealth creation was the unsuccessful strategy adopted to reduce poverty (GoK, 2003). In the successor long-term framework, Kenya Vision 2030, the economy is conceived to consist of three pillars of development, namely economic, social and political pillars (GoK, 2008).

Traditionally, the Kenyan economy has been predominantly agricultural, though the services sector has grown in importance especially against the backdrop of weak growth in manufacturing. Directly or indirectly, the agriculture sector contributes about 50 percent of GDP, 65 percent of exports and 18 percent of formal employment. The other key sectors that are expected to contribute to the attainment of the 10 percent economic growth anticipated by Vision 2030 are tourism, wholesale and retail trade, manufacturing and financial services (such as business process outsourcing (BPO)). The Economic Survey of 2010 lists some of the sectoral contributions to Kenya's overall growth of the economy of 4.6 percent in 2010, including: agriculture (6.3%); wholesale and retail trade (7.8%); manufacturing (4.4%); and money, banking and finance (8.8%) (GOK, 2011).

During the first and second independence decades, the Kenyan economy recorded remarkable growth due to the entry of numerous Africans into small-holder cash crop production, which had previously been barred under colonialism. As the limits of agricultural growth set in, coinciding with the double oil crises of the 1970s, the decades of the 1980s and 1990s saw a rise in poverty to a 1997 peak of 57 percent, the product of poorly implemented and/or ineffective structural adjustment policies, and general poor governance. The 2002 general elections ended the 40-year tenure of the Kenya African National Union (KANU) party, giving way to NARC party and its highly successful ERS which raised growth year on year from 0.5 percent in 2002 to seven percent in 2007. This positive trend was, however, interrupted in 2008 following the post election violence when the economy grew at only 1.7 percent. Although post-violence recovery has occurred, growth performance is still far below the 10 percent envisaged by Vision 2030: In 2010, the economy grew by 5.6 percent compared to 2.6 percent in 2009, with the 2012 outlook being 4.5 percent.

Figure 2.2: Trends in Economic Growth in Kenya: 2000-2011



Source: Economic Survey (various) Reports

The described performance is also reflected in the overall Human Development Index (HDI) which is a composite index capturing a country's attainments with respect to per capita income, education and life expectancy at birth (UNDP, 2003)⁶. Kenya's HDI grew during the strong economic performance of the 1970s but declined during the economic recession between 1990 and 2000, standing at 0.533 and 0.513 respectively. In 2011, Kenya still scored a lowly 0.509 giving it a rank of 143 out of 187 countries (UNDP, 2011). Substantial regional disparities exist within the country, with highest-performing Nairobi and Central provinces having HDI scores of 0.653 and 0.624 respectively compared to the lowest performers North Eastern and Nyanza provinces at 0.417 and 0.497 respectively, according to UNDP.

According to World Bank classification, Kenya remains a low income country. The World Bank's Report of 2011 shows that Kenya's GDP was estimated at US\$18.0 billion in 2009, making it the eleventh largest economy in Africa, but a mere one-tenth the size of South Africa's, and second to that of Tanzania in the East African region (World Bank, 2011). The resulting Kenyan GDP per capita of US\$452 was much lower than the African average of US\$879. If the economic growth rate of 10 percent per annum projected in Vision 2030 were realized, then the GDP would expand by about 6.7 times to US\$121 billion by 2030. Taking the population size of 60 million projected for 2030 (NCPD, 2012), this translates to a GDP per capita of slightly over US\$2,000 thus the economy should expand to US\$180,000 billion (roughly the current size of South Africa's economy or Maryland State in US) to attain the projected GDP per capital of US\$3,000 to make Kenya a middle level income economy by 2030.

2.4.2 Poverty

Poverty is a multi-dimensional indicator of the lack of- well-being, reflected in the lack of access to necessities, such as food, clothing and shelter. While the possession of money is important for access to basic necessities, it is not imperative: self-provisioning communities' access necessities without using money. This is one reason why poverty measures focus on consumption (expenditure) rather than income⁷. Poor households are characterized by low consumption of food and on-food needs, including poor access to services such as water and sanitation, healthcare and education among others. Consequently the poor experience poor health and low productivity. Poor health is reflected in health indicators and higher fertility which are revealed in KDHS and census reports. Poverty is reflected by whether households have enough resources or abilities to meet their needs, inequalities in

⁶ HDI indicates how far the country is from attaining a life expectancy of 85 years, 100 percent access to education and per capita income of US\$40,000. It ranges between 0 and 1 with best performing country for 2006, Norway, scoring 0.965.

⁷ For Kenya, KNBS estimates regional baskets of basic consumption choices as the basis of estimating household consumption. For self-provisioning households, KNBS imputes what would have been spent on the basket.

the distribution of income and consumption and vulnerability defined as the risk of being in poverty or falling deeper into poverty in the future. UNFPA (2012) notes that although there are many advantages of defining poverty in terms of income or consumption — such as enabling policy makers to monitor levels of poverty and/or the impacts, this definition has limitations. For example where schools and health services infrastructure does not exist or some sections of the society are discriminated against, even with income these services may not be accessible.

Overcoming poverty has, therefore, been a key Kenyan development objective since independence and has been emphasized in several Government documents (GOK, 1965: 2001: 2003: 2004: 2010: 2012). In spite of the policy initiatives contained in these documents, sustained progress has not been made. Poverty levels in Kenya remain high and incomes unequally distributed (World Bank, 2008). The overall poverty level was estimated at 47 percent from the 2005-2006 household budget survey, which is nearly the same level as the 44.8 percent estimated in 1992 although the levels rose in the second half of the 1990s and early 2000s, reaching 56.0 percent in 2003 (IMF, 2010) and most recent estimates put it at 46.0 percent.

Although the percentage of population below the poverty line in recent years has continued to decline (55.5% in 2000 to 46% in 2006), the absolute numbers have increased, one report estimating the figure to have increased from 13.4 million in 1997 to 16.6 million in 2006 (KIPPRA, 2009). The same report also illustrates inequalities in expenditure distribution: the 10 percent poorest households in Kenya control only 1.63 percent of total expenditures, while the richest 10 percent control nearly 36 percent of expenditure. This inequality is also captured by the 2009 Gini coefficient estimated at 0.41, a status that compares badly with other African countries, such as Ethiopia, Tanzania, Egypt and Ghana (KIPPRA, 2009)⁸.

Poverty levels vary substantially across and within regions (i.e. counties) and residence (rural versus urban), often closely corresponding to population dynamics, the rate being higher in regions with unfavourable demographic indicators. Thus, poverty levels are higher in rural areas (50%) compared to urban areas (34%), and lower in Central Province (30.4%) and Nairobi (21.3%) and substantially higher in North Eastern (73.9%) and Coast (69.7%) regions (GOK, 2008). Some of the strategies being adopted to reduce poverty and inequalities are: increasing resources in the social sector (education and health), development infrastructure, decentralized funding, such as Constituency Development Fund (CDF), and creation of development institutions for disadvantaged regions such as Ministry for North Eastern and Other Arid Lands. The Constitution also provides further opportunities to reduce poverty through the devolved 47 county Governments; while anti-poverty initiatives have to date been based on the national capital and policy-makers' understanding of the scourge, devolution enables the local level design of policy and interventions.

2.4.3 Education

Education is recognized as a basic human right in Article 26 of the Universal Declaration of Human Rights (UDHR), and in other international conventions and regional charters, such as in Article 17 of the African Charter on Human and People's Rights and Welfare of the Child. Indeed, under these conventions, as in MDG 2 on universal primary education, countries are required to ensure access to free primary education or full basic education⁹. The significance of education for demographic processes is also reflected in ICPD/PoA, and in MDG 2 which requires countries to ensure that children — both boys

⁸ The Gini coefficient ranges between 0 and 1, with 0 implying perfect equality and 1 perfect inequality (when all income is accounted for by one individual).

⁹ While some countries emphasise full primary education, others recognize the inadequate preparation that primary education offers for the employment market, including for self-employment. Such countries instead follow the global Education for All ideal of basic education which in many countries translates into the 14 pre-university years whose graduates are more mature for informed life decisions.

and girls — complete a full course of primary schooling. Further, successive demographic and health surveys show that education is associated with lower levels of fertility and mortality. Finally, education is also closely linked to the reduction of poverty as it raises productivity among better informed citizens and broadens livelihood options (Keriga and Bufra, 2009).

Consequently, the Kenya Government has committed to offering quality education and training as a human right in accordance with the Constitution and the above conventions, for the development of human resources needed to attain national development goals. This commitment is reflected in policy and other Government documents since independence, and has resulted in extensive growth in budgetary allocations to the sector, with public education's share of the national budget rising from 23 percent in 2004/2005 to 32 percent in 2008/2009 (KIPPRA, 2010: 13). There has been a matching expansion of educational facilities, primarily financed by catchment communities through harambee fund-raising activities. At the time of independence in 1963 for example, there were 6,058 primary schools with 891,533 pupils, and 150 secondary schools with 31,120 students (GOK, 2004). These numbers have increased to 27,567 primary schools with 9.86 million pupils and 7,297 secondary schools with 1.77 million students in 2011 (KNBS, 2012). However, these impressive national aggregates hide extensive regional inequalities: research has shown that the distribution of community-driven education infrastructure favours the less poor (Miguel, 2000). While Kenya has had a free primary education and tuition free secondary education since 2003 and 2008 respectively, the resulting upsurge in enrolments has undermined quality teaching, as there has not been a proportionate growth in teacher numbers. The introduction at the university level of the parallel degree programmes has also created an influx into university studies, which have also admitted students without substantive qualifications, but who are attractive for their fee-paying capacity. These developments have over-stretched the teaching capacity, with adverse implications for quality.

The gross enrolment rate (GER) and net enrolment rates (NER) at primary schooling level suggest that Kenya is likely to attain the MDG targets on primary education by 2015¹⁰. Since 2004, primary school GER has been over 100 percent, rising to about 110 percent in 2010, compared to a growing NER which stood at 91.4 percent in the same year (GOK, 2012). However, a number of challenges remain in the sector including: high primary level drop-out rates; low transition rate to secondary and higher levels of education. Completion rates at primary level has improved substantially in recent years from about 43 percent in 1990 to 78.2 percent in 2010 while transition from primary to secondary has similarly improved to reach 72 percent in 2010 (GOK, 2012). Secondary school GER was only 32 percent in 2010, having improved marginally from 26.8 in 1990. According to the 2009 census, a total of 2.8 million boys and girls of school going age were not enrolled in a school. In spite of the recent expansion in university education opportunities, enrolment levels remain low with 2003/2004 data estimating a secondary school to university transition rate of 12 percent. Indeed, much of the growth in university enrolment is accounted for by already employed people across the country, seeking to augment their paper qualifications.¹¹ In addition, the Kenya national adult literacy survey report of 2007 indicates that 38.5 percent (7.8 million) adults aged 15 years and above were illiterate, most of them females. There are greater gender disparities in education at higher education where only 36 percent of those admitted in public universities in 2007 were females.

Projections based on the 2009 census data reveal that there shall be substantial increases in the school going population at the pre-primary, primary and secondary levels of education between 2010 and 2030, from 3.5 to 5.5 million, 8.5 to 13.0 million and 3.5 to 5.7 million respectively (KNBS, forthcoming).

¹⁰ Gross enrolment refers to enrolled students of all ages, while net enrolment refers to the share of students only of the official school going age, such as 6 to 14 for primary school education. Thus GER data included the late Maruge while NER did not.

¹¹ This search for additional paper qualifications is a major driver behind the mushrooming of rural-based constituent colleges of urban universities which are especially targeting primary and secondary school teachers.

These growth numbers underscore the emerging challenges of managing existing shortfalls while also coping with the anticipated increases.

2.4.4 Health

Improved health has increasingly been recognized as a fundamental right of every human being since the establishment of World Health Organization (WHO) in the mid 1940s. Health is related to well being and to other rights, such as food and housing. In addition, improved health contributes to economic growth through, amongst other avenues, reducing production losses caused by workers' illness. Countries are, therefore, encouraged to provide basic medical services (preventive and curative) to the entire population including access to reproductive health and family planning services.

Since independence in 1963, the Government of Kenya has considered good health of the people as a fundamental right. While public health services have focused on prevention, eradication and control of diseases, a disproportionate share of spending has focused on curative, hospital-based health care. This bias arguably breeds a cost-ineffective health care delivery system which allows people to fall sick, then tries to cure them. This wrong strategy of provisioning health care has added to the constraint provided by Kenya's fast-growing population, rising poverty and inadequate Government support. Consequently the Government has adopted policies and strategies since 1992 to reform the sector, with varying levels of success. These reforms began with the development of the *Kenya Health Policy Framework* (1994-2010), which has been implemented through successive strategic plans, the National Health Sector Strategic Plans (NHSSP). Since the first plan (1994-1999) was never implemented, the current status of the health sector is the product of the implementation of NHSSP I (1999-2004) and NHSSP II (2005-2010). The implementation of these plans, however, produced modest improvements — and indeed, reversals — in human resources and infrastructure for health, as well as in health status outcomes (GOK 2008; NCAPD, 2004; GOK 2012). While improvements have been made in health determinants during NHSSP II (such as on maternal education, and provision of safe water and adequate sanitation), little improvement has been made on nutritional status while coverage in maternal and child health stagnated, with improvements only recorded in use of modern contraceptives. Interventions against HIV and AIDS had positive impacts, TB control improved and malaria related deaths were reduced.

In spite of the desire by the Government to improve health services, these remain inaccessible to most of the population with slightly over half of the population being within a five kilometre radius of a health facility (GOK, 2012). Yet, the actual situation is even worse considering that over 50 percent of the equipment in these health facilities is not operational alongside the facilities lacking essential medicines and non pharmaceuticals. Additionally, Kenya has an average of 16 doctors and 53 nurses per 100,000 population, compared to the recommended 36 doctors and 356 nurses respectively. These ratios translate to about 5,000 doctors and slightly over 21,000 nurses, implying that Kenya will require about 7,500 doctors and about 30,000 nurses just to maintain the current doctors and nurses ratios respectively, when the population reaches the anticipated 60 million in 2030. However, if the WHO ratios were to be achieved, this would imply over 21,000 doctors and 210,000 nurses, alongside proportionate increases in the budget and other resources. The spending in the health sector was only US\$12.6 per capita in the financial year 2010/2011, far below WHO's recommended US\$44 per capita (GOK, 2012). Further, Government public health spending has never risen above 10 percent of total public spending, despite the Abuja agreement of 2000 to raise this to 15 percent (KIPPR, 2010: 34)

In response to the challenges identified in implementing health policies and strategies to date, the new *Kenya Health Policy 2012-2030*, was developed in line with the Constitution and the goals of Kenya Vision 2030. The policy has, therefore, adopted a rights-based approach to health, and seeks to make the right to health for all Kenyans a reality. The objectives of the new health policy include the: elimination of

communicable diseases and reversing the rising burden of non communicable diseases; reduction of the burden of violence and injuries; provision of essential health care; minimization of exposure to health risk factors; and strengthening collaboration with health related sectors. These objectives will be attained through supporting provision of equitable, affordable quality health care to all Kenyans using the primary health care approach. This, in turn, is expected to result in the attainment of health indicator targets that are comparable to those of a middle income country by 2030¹² including: a life expectancy of 72 years up from 60 in 2010; crude death rate of 5.4 down from 10.6 per 1000 in 2010; and a reduction of the years lived with disability from 12 to eight over the same period.

2.4.5 Population Policies

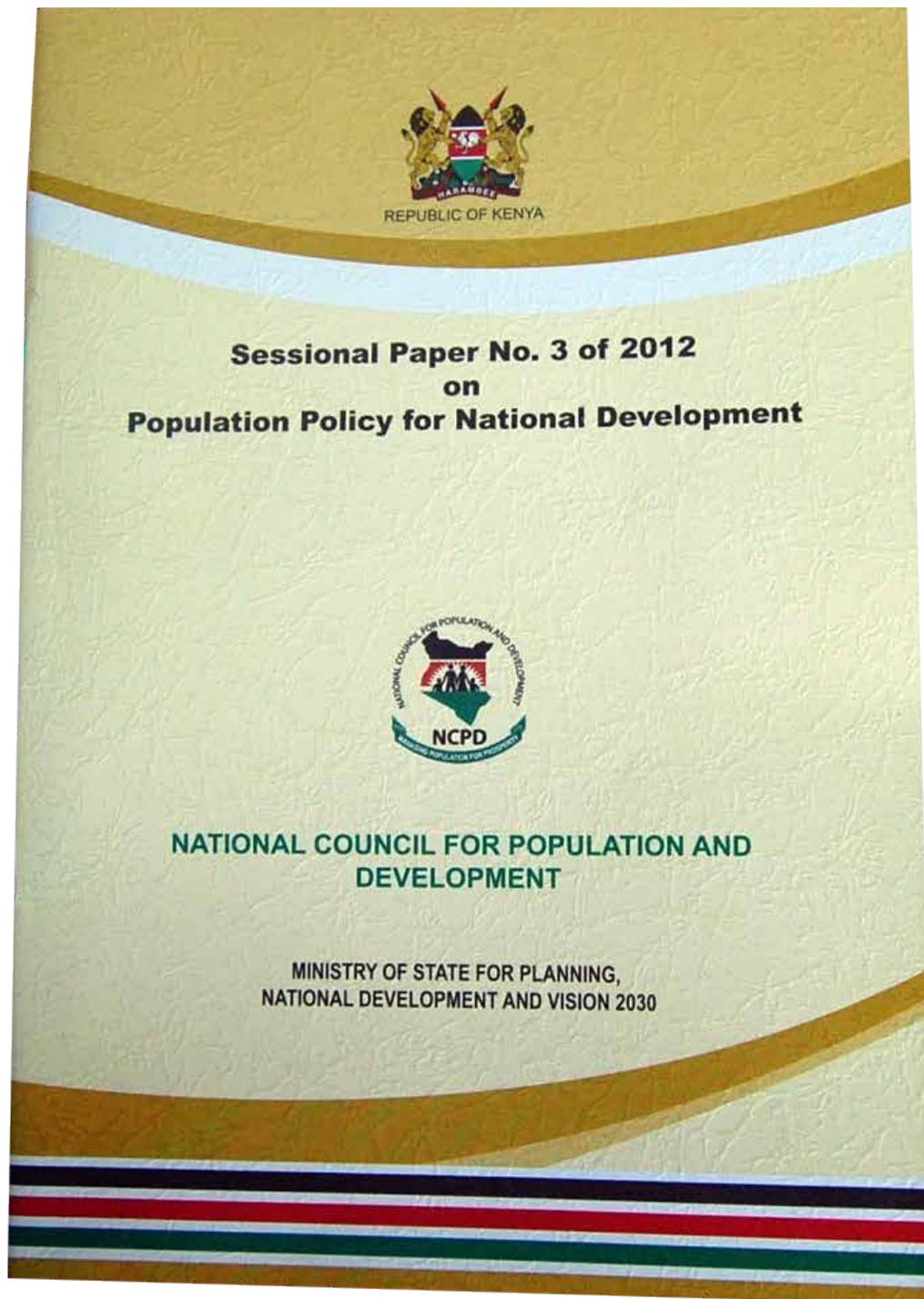
Since 1965, Kenya has recognized the potentially adverse effects of high population growth on the benefits of economic growth, to emphasize the trade-off between high population growth and the ability to deliver quality education and health to as well as reduce poverty. Indeed, the Government's Economic Survey of 1979 noted that a high population growth rate would require higher levels of investment to achieve a given increase in GDP per capita¹², or expansion of infrastructure for education to accommodate the increasing demand for places occasioned by the youthful age structure.

Kenya espoused FP in 1967 as one of strategies to contribute to the achievement of its development goals. However, the programme which had a narrow focus within the Ministry of Health was largely ineffective (Ajayi and Kekovole, 1998). The subsequent National Population Policy of 1984 adopted a broader perspective which managed various notable achievements outlined in the succeeding policy, Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development. The 1984 policy's achievements included a decline in population growth and fertility, increasing knowledge of family planning (FP) methods and raised levels of contraceptive use, reduction in ideal family sizes, and increased immunization among children. However, the following challenges were encountered in the policy's implementation: unmet need for FP; quality of services; regional and rural-urban disparities in fertility and mortality; high prevalence of sexually transmitted diseases, including HIV and AIDS; and high adolescent fertility (NCPD, 2012).

The Sessional Paper No 1 of 2000 domesticated ICPD/PoA of 1994 which had also identified the above challenges. The 1994 action plan had emphasized the interdependence between population, development and the environment. It noted that population change is interrelated with patterns and levels of use of national resources, the state of the environment as well as the pace and quality of economic and social development (UN, 1994). However, as the plan had noted, population considerations are often not taken into account in economic growth and development policies in the context of long-term sustainability.

Several issues related to population which PoA had recommended for inclusion in national population and development policies included: poverty; inequalities in the participation of men and women in economic and political activities; family as basic unit of society; promotion and access to health and reproductive health services, including FP. Implementation of these initiatives would reduce fertility, infant under-five and maternal mortality, and enhance the standard of living. It would also accelerate economic growth, reduce poverty, enhance education uptake, and ensure safe and sanitary living environments by avoiding crowded housing conditions, ensuring access to clean water and sanitation, and improving waste management.

¹² For example, that year's population growth rate of 4 percent required an economic growth rate of 7 percent to attain the projected GDP per capita growth of 3 percent.



The Population Policy for National Development.

Photo: NCPD

Some of the above issues that were addressed in the Sessional Paper of 2000 include: integration of population in development; attention to gender disparities; attention to the population structure covering, children, youth and the elderly; persons with disabilities; reproductive health and rights; sexually transmitted diseases as well as HIV and AIDS; population and environment; population distribution; urbanization and migration; plus population, development and education. These activities were expected to stabilize population growth by reducing fertility, infant, under-five and maternal mortality, and enhancing access to, and utilization of, health services, and raising educational

attainment levels for both sexes.

While Kenya has made substantial progress in implementing population policies to date, several challenges remain. As noted in the progress reports on the implementation of the ICPD/PoA 1994-2004 and ICPD@ 15, the integration of population concerns into national development strategies and district development plans has not been fully achieved because of the limited use of population data in planning and capacity. Review of several sectoral plans also reveals this situation. However, these documents do not, for example, indicate whether the projected population is taken into account in planning for the provision of health, education and security, among other areas, and whether their budgetary implications have been considered. For example, it is not clear how many more doctors will be needed by 2030 to attain the WHO-recommended ratios given attrition rates. The status of the education sector is also not clear given, for example, the recommended teacher-pupil ratio of 1: 42. Additionally, it is also not clear whether the projected 2030 income per capita of Vision 2030 takes into account the increased numbers.

The high population growth estimated at 2.9 percent in 2010 remains a key challenge in the attainment of the goals of Kenya Vision 2030, ICPD-PoA and the MDGs, due to the previously discussed interrelationships between population growth and socio-economic development. Similarly although both fertility and mortality have started to decline again, the levels remain high above replacement levels and the regional variations persist. Thus, articulating strategies to facilitate the integration of population into development strategies, and for the continued reduction of population growth, fertility and mortality, and the reduction of regional disparities, appears to be the greatest challenge in NCPD's development of the new population policy. As with other sectors in the economy, the other challenge is that of acquiring the increased resources needed to attain the demographic and other operational targets. For example, the attainment of the target contraceptive prevalence rate of 70 percent by 2030 translates into more than a 3-fold increase in the number of users from about 2 million in 2010 to about 6.7 million in 2030, which in turn more than doubles new acceptors of FP from 140,000 to 316,000 (NCPD, 2012).

Sessional Paper No. 3 of 2012 on Population Policy for National Development succeeds Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development., which guided implementation of population programmes up to 2010. Sessional Paper No. 3 of 2012 presents a policy framework whose goal is to attain high quality of life for the people of Kenya by managing population growth to a level that can be sustained with the available resources. The principal objective of this Policy is to provide a framework that will guide national population programmes and activities for the next two decades. It recognizes and puts into consideration national and international emerging and continuing population concerns. It also responds to Kenya's development agenda as articulated in Kenya Vision 2030 blueprint and the Constitution of Kenya, 2010. This Policy will be implemented in a multi-sectoral approach. Specific targets have been identified to guide successful implementation. The various sectoral policies and strategies will complement this Policy and guide the implementation of the identified population concerns in each sector.

2.4.6 Cultural Environment

Some of the cultural practices that are associated with population dynamics include low age at marriage, high levels of polygyny, low social status of women, large desired family sizes, widow inheritance and circumcision of males and females. Marriage is universal and occurs earlier in some communities, such as among the Maasai, and is associated with low status of women and low educational levels. Polygyny is more common in Nyanza and at the Coast and is associated with low contraceptive use (Kimani et al.,

2012). Male circumcision is less common among the Luo, absence of the practice being associated with high HIV prevalence (KNBS et al, 2010). Further, female circumcision is associated with adverse maternal health outcomes, and is prevalent among Somalis and Maasai, but is not practised by the Luo and Luhya. On the other hand, the low status of women due to a number of socio-cultural and economic factors is associated with low use of contraception, large ideal family sizes, low use of reproductive health services and high unmet need for contraception.

2.4.7 Status in Achievement of ICPD Goals, MDGs and Programmes/Plans of Action

Kenya is a signatory of ICPD-PoA endorsed by the 179 countries in Cairo in 1994, and of the Declaration of the Millennium Summit in 2000 endorsed by 189 countries, from which the MDGs arose. The goals agreed on by the two meetings integrate those of several previous agreements, conventions and declarations to which Kenya is a signatory and which are aimed at guaranteeing human rights and promoting development. Among the pertinent documents are the: UN Universal Declaration of Human Rights (adopted in 1948); International Convention on Civil and Political Rights (1976); universal primary education; promote gender equality and empowerment of women's; reduce child mortality; improve maternal health; combat HIV and AIDS, malaria and TB, and other diseases; ensure environmental sustainability; and develop global partnerships for development.

Several ICPD-PoA areas that overlap with the MDGs include: the integration of population issues in sustainable development and environment strategies; the role of sustainable economic growth in raising the quality of life and achieving poverty reduction; the promotion of gender equality, equity and the empowerment of women in order to realize their full potential through involvement in policy and decision-making processes; elimination of all forms of discrimination against the girl child; development of laws and policies to enhance the stability of the family; facilitating the demographic transition to achieve a balance between demographic processes and social, economic and environment goals; meeting the needs of children and youth, elderly and persons with disability; establishing a suitable socio-economic and political environment to arrest brain drain and skilled manpower and attracting foreign investment; and achieving universal access to quality education and combating illiteracy. The programme also recognized the role of research on sexuality and gender roles, and vaccine development for HIV prevention and fertility regulation.

Implementation of MDGs in Kenya started in 2002 with the assistance from development partners who have committed substantial resources towards meeting the targets. These initiatives included setting up of a unit within the Ministry of Planning, National Development and Vision 2030 to be responsible for mainstreaming MDGs in Kenya's development processes, championing increased allocations of resources to MDGs, and monitoring sectoral indicators for progress. The fourth and most recent MDGs status report published in 2010 concluded that progress has been slow except over universal primary education for which NER had reached nearly 93 percent in 2009. The report in particular, notes that poverty in Kenya remains high, currently estimated at 46 percent. Gender equality and empowerment as reflected in the participation of women in political and economic decision-making remains low.

Although the 2008/2009 KDHS revealed that infant and child mortality declined substantially between 2003 and 2008/2009, the levels are still above the MDG targets. Similarly, although some progress has been made for maternal health, such as increased contraceptive use, maternal mortality is still high and visits to antenatal care and delivery of births in health facilities remain below targets. Although progress has been made against HIV and AIDS between 2003 and 2008-2009, and the incidence of malaria reduced, the incidences of tuberculosis remain high.

Progress has also been made at the policy level in integrating sustainable development principles into

development planning, as reflected by several policies, such as Sessional Paper No. 6 on environment and development. The destruction of forests has, however, continued, and air pollution remains above recommended levels (GOK, 2010). Some progress has also been made on MDG 8 on global partnerships for development which were aimed at ensuring that all exports from Kenya to developed countries entered these countries duty free. The impact of reforms in the ICT sector since 1997 has resulted in increased subscription to cellular phones to 36.7 percent in 2010 and internet usage per 100 population (GOK, 2010). A summary of the status in the implementation of the MDGs is provided in Table 2.2.

Table 2.2 Status in attainment of MDGs in Kenya

Goal	Indicator	Baseline Year	Baseline Status	MDG Target	Current Status
Goal 1: Eradicate extreme poverty and hunger	Proportion living below poverty line (%)	2002	48.4	23.5	46.0 (2010)
Goal 2: Achieve universal primary Education	Net Enrolment Ratio (NER)	2005	82.8	100	92.9 (2010)
	Primary Completion Rate (PCR)	2008	83.2	100	76.8 (2010)
Goal 3: Promote gender equality	Gender Parity Index at Pry	2007	0.94	100	0.98 (2009)
	Proportion of female in modern sector (%)	2003	29.6	50	30.1 (2007)
	Proportion of female MPs (%)	2002	8.1	50	8.6 (2012)
Goal 4: Reduce child mortality	Infant Mortality Rate (IMR)	2003	77/1000	26/1000	52 (008/09)
	Under five Mortality Rate	2003	115/1000	33/1000	74 (2008/09)
Goal 5: Improve maternal health	Maternal Mortality Ratio (MMR)	2003	414/1000	130/1000	488 (2008/09)
Goal 6: Combat HIV and AIDS, malaria and other diseases	HIV Prevalence for adults 15-49 (%)	2003	6.7		6.3(2008/09)
	TB Prevalence (%)	2000	6.0		5 (2006)
Goal 7: Ensure environmental sustainability	Forest cover (% of land area)			10	1.7 (2012)

The status of the implementation of ICPD-PoA is reported in most recent of the three ICPD status reports such as ICPD +5, ICPD +10 and ICPD@15, and in several statements to UN meetings. Generally,

the conclusions of the status reports are consistent with the updates on the MDGs. The implementation of the Economic Recovery Strategy 2003–2007 enabled a recovery of the economy that peaked at an annual growth rate of seven percent for 2007. Population issues are being integrated into development concerns by incorporating population variables in national, sectoral and other plans. The constitutional imperatives around basic rights provide additional challenges and opportunities. Regarding gender equality, equity and empowerment of women, several policy and legislative measures have been taken to promote the participation of women in development processes, and to promote their rights and those of boys and girls. A lot more needs to be done to improve reproductive health since most births still take place outside health facilities and under the assistance of unskilled personnel (KNBS and ICF Macro, 2010). Although the use of contraceptives has increased, one in every four women has unmet need for contraception. In addition the desired family size of four children remains above the replacement level of 2.1, presenting a continuing fertility reduction challenge.

The various aspects of human rights and development are also captured in several Articles in the Constitution of Kenya 2010 particularly in Chapter 4 on the Bill of Rights where these are recognized as human rights. The Constitution requires the state to take legislative, policy and other measures to achieve progressive realization of the economic and social rights guaranteed under Article 43, and to enact and implement legislation to fulfil its international obligations in respect of human rights and fundamental freedoms. In particular the Constitution obliges the state to ensure access to justice for all persons, non-discrimination, attainment of gender parity (including in marriage (Article 45)) and implicitly outlaws Female Genital Mutilation (FGM). It reiterates access to healthcare (including reproductive health), education, food, clothing and clean and safe water and social security. Thus, the Constitution provides a legal framework for the realization of both the ICPD goals and MDGs. In addition, a framework for monitoring the realization of the various rights has been put in place through the Kenya National Commission on Human Rights (KNCHR) which was originally established by the Government in 2002 and was eventually transformed into a constitutional commission in 2010. KNCHR acts as the principal organ of the State in ensuring compliance with obligations under the international and regional treaties and conventions relating to human rights and prepares annual progress reports to the Universal Period Review (UPR) on the implementation of international human rights instruments.

2.5 Challenges and Opportunities

The population of a country is recognized as its most important and valuable resource that contributes to the development activities and also benefits from it. NCPD (2011) has identified the key challenges and opportunities that the 42 million Kenyan population faces. The key challenge is sustaining the high economic growth target set in Vision 2030 (over 10%) in order to enhance the quality of the life of the increasing numbers implied in Kenya's population dynamics which would in-turn facilitate the achievements of the ICPD goals and MDGs including reducing the high levels of poverty. Some of the specific challenges implied by the current population dynamics include realizing the full potential of the increasing youth population by creating employment; meeting the needs of the growing ageing population; putting appropriate social and physical infrastructure for the increasing urban population; minimizing the adverse environmental impacts arising from the increased pressure on natural resources due to increasing population density; and enhancing human capital by investing in health, education and women's empowerment. Investing in both education and health would contribute to the attainment of more favourable demographic indicators, such as lower fertility through enhanced contraceptive use, lower ideal family sizes and reduced under-five and maternal mortality – indicators which all remain high.

Thus, the increasing number of people implied by the population dynamics and the current demographic

transition, including the bulging youth population, and the increase in the aged population provide both challenges and opportunities. The increasing number of the youth, for example, can become a powerful force for economic development and positive change if they are educated, healthier and availed suitable employment opportunities. On the other hand, women in Kenya can become more productive if the existing gender inequalities are overcome by empowering them, ensuring that they have equal employment opportunities with men, but also ensuring they have access to reproductive health services as they might require, including FP. As implied by the UNDP Gender Inequality Index (based on reproductive health, empowerment and labour force participation) of 2010, 65.4 percent of potential in human development of the Kenyan woman is not being realised because of the gendered nature of inequalities.

Overcoming inequalities would, as observed in the *UNFPA 2011 State of the World Population Report*, lower fertility, reduce poverty levels and attain better health towards overall development. Thus investing in education and health for the increasing numbers of the youth and empowering women, providing them with reproductive health services and putting in place programmes for taking care of the ageing population are key challenges arising from the prevailing population dynamics.

The 2010 promulgation of the new constitution, the Kenya Vision 2030, the new population policy, the on-going reforms in various sectors (such as health and education) and Kenya's commitment to fulfilling its international obligation provide a favourable environment for overcoming the above population and sustainable development challenges.

2.6 Conclusions and Recommendations

Although Kenya's population is its greatest resource for enhancing wellbeing, the population's ability to do so may be constrained by its poor health status, low levels of education and skills, and weak employment opportunities. Enhancing the status of this population is closely associated with the country's population dynamics. However, Kenya can seize the opportunity afforded by the on-going demographic transition to capitalize on the 'demographic dividend' by investing in education and creating employment for the youth. It is important to note that there is heavy education investment (30% of the budget). The big question is probably whether that investment is well focused to produce expected results. Additionally, but related to expected education outcomes is the weak employment creation over the past decade almost 90 percent of the jobs created have been in the informal sector jobs with low pay.

The overall standard of living of Kenya's population is compromised by persistent high levels of inequality (see Chapter 14 in Part 4 for discussions). This has, in turn, resulted in high levels of poverty and low accessibility to health services. The majority of the population lives in crowded households in poor environments without water and sewerage services. While progress has been made in the attainment of universal primary education, access at secondary and higher levels remain below expectation while levels of illiteracy are still high in some parts of the country. In addition, a considerable part of the population belongs to culturally conservative ethnic communities characterized by low status of women, high levels of gender violence, early and universal marriages, female circumcision and polygyny. The unfavourable socio-economic and cultural context noted above is reflected in the overall population dynamics situation which is characterized by high population growth, and a youthful population structure as a result of the high fertility. Mortality levels remain high with wide regional variations.

Given the unfavourable socio-economic conditions for the majority of the population, and the resulting

demographic situation and their interrelationship, formulating and implementing socio-economic and population policies to improve both situations seems to be the greatest challenge.

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PART 3

CHAPTER 3: POPULATION SIZE, GROWTH AND STRUCTURE

3.1 Introduction

The population and development policy goal of the Kenya Government is to attain a high quality of life for the people by managing population growth to a level that can be sustained with the available resources. A people's quality of life is closely interrelated with population change in relation to the patterns and levels of use of natural resources, the state of environment as well as the pace and quality of economic and social development. Demographic parameters, such as population growth, structure and distribution, strongly influence and are in turn influenced by poverty and social inequalities, such as gender inequalities. Therefore, there is need to explicitly integrate population issues into economic development strategies as specified in Sessional Paper Number 3 of 2012 (GoK, 2012). This Chapter presents the nature of Kenya's population, addressing its size, structure, composition, changes over time, and its impact on social and economic development.

3.2 Trends in Trends in Size and Growth

The population of Kenya has increased greatly since it stood at 2.5 million in the first count in 1897, rising to 5.4 million by 1948 (KNBS, 2010). During the first post-independence census in 1969, the population was estimated at 10.9 million, and had increased to 38.6 million by the time of the 2009 census (KNBS, 2010). The crude birth rates (CBR) and crude death rates (CDR) presented in Table 3.1 are the primary determinants of the growth in the population growth since international migration to Kenya is negligible (KNBS, 2012). Both CBR and CDR declined by 25 percent since 1979, which is the year of highest fertility. The rates of change of both CBR and CDR have meant that annual growth has averaged three percent over the review period. The current growth rate increases the total population by about 1 million persons every year, with an expectation that it will double in the next 23 years.

Table 3.1 Trends in Population Size and Growth Indicators, 1948-2009

	1948	1962	1969	1979	1989	1999	2009
Population (millions)	5.4	8.6	10.9	15.3	21.4	28.7	38.6
Size relative to 1948 (1948=100)	100	159	202	283	396	532	715
Absolute increase per annum ('000)	135	258	360	581	792	850	992
Crude birth rate(CBR) (per 1000)	50	50	50	52	48	41.3	38.4
Crude death rate (CDR)(per 1000)	25	20	17	14	11	11.7	10.4
Annual growth rate (% p.a.)	2.5	3.0	3.3	3.8	3.3	2.9	3.0
Doubling times (Years)	27.7	23.1	21	18.2	21	23.9	23.1

Source: Kenya 2009 Population and Housing Census. Analytical Report on Population Dynamics. Vol. III

Population growth rates in developing countries like Kenya are largely driven by levels of fertility. Bongaarts (1978) indicated that four factors account for most of the differences in fertility levels across societies; marriage initiation and prevalence, contraceptive use, induced abortion, and duration of breastfeeding. However, these factors are affected by complex processes that involve changes in demand for children, diffusion of new attitudes about birth control and greater accessibility to contraception provided by family planning programmes (Cleland and Wilson, 1987; Freedman and Freedman, 1991).

Potts (1997) noted that the primary factor responsible for fertility decline is the unconstrained access to fertility regulating technologies. Thus changes in fertility occur not only as a result of changes in the desired number births but also the ability of couples or individuals to implement their fertility desires.

The high fertility rates observed in Kenya in the 1970s had been attributed to low ages at first marriage, low levels of education, low contraceptive use, high infant mortality rates, cultural norms and practices that value children, and improvements in socio-economic development (CBS, 1984). Rapid fertility decline in Kenya began in the mid-1980s, with the total fertility rate (TFR) dropping from 8.1 births in the mid-1980s to 6.7 births in 1989. This was attributed to increased contraceptive prevalence that rose from seven percent in 1977/1978 to 33 percent in 1993 and to 39 percent in 1998. The rapid decline in fertility was attributed not only to a greater use of contraception, but also to changing marriage patterns and the decline in desired family sizes. Studies also show that increased utilization of contraceptives was driven by attitudinal and behavioural changes that resulted from balancing the costs and benefits of high fertility amidst socio-economic and culture changes (Blacker, 2002; Population Council, 1998; Brass and Jolly, 1993; Robinson 1992; Watkins, 2000). For example, in a review of findings based on small-scale surveys conducted in a number of parts of the country, Robinson (1992) observed that fertility declined in rural and urban areas because many adults perceived large families as an economic strain.

However, fertility decline stalled in Kenya in the late 1990s and early parts of 2000 due a deficit in contraceptive supplies and a slight increase the desire for more children, the stall being more pronounced in urban areas (Shapiro and Gebresellassie, 2008; Garenne, 2007; Ojaka, 2007; Westoff and Cross, 2006; Bongaarts, 2005). The stall has been associated with the upsurge in the childhood mortality between 1993 and 2003 largely attributed to HIV and AIDS through reduced breastfeeding and the demand for children (Westoff and Cross, 2006; Monica and Agwanda, 2007). More recently, the Kenya Demographic and Health Survey (KDHS) 2008-2009 indicated that after the stall in fertility decline, there has been a modest decline, with TFR falling to about 4.6 births per woman compared to 4.9 births in 2003 (KNBS and ICF Macro, 2010). This outcome was corroborated by the 2009 census estimate of 4.4 births per woman. The sustained fertility decline has been attributed to falling infant and under-five mortality and the increase in contraceptive use from 39 percent in 2003 to 46 percent (KNBS and ICF Macro, 2010). Since 2003, fertility has declined in all provinces except Nairobi and Central which have respectively experienced a slight increase and a stalling.

3.3 Changes in Age Structure

The age structure of a population is simply the distribution of its various age groups in that population, and is influenced by parameters of population change such as fertility, mortality and migration (KNBS, 2011). Table 3.2 shows trends in distribution of the Kenyan population by age since 1969. The share of children (under age 15) declined from 48 percent in 1969 to about 43 percent in 2009. In the recent past, the share of the youth (aged 15 to 24) has remained about one fifth while that of persons aged 25 to 34 has increased from about 12 percent in 1969 to nearly 15 percent in 2009. As a result of high birth rates in the last two decades, and the declining mortality in the early part of 1980s, the population in age group 35-39 has increased while the share of the elderly has remained at around five percent since 1969.

Table 3.2 Trends in Percentage Distribution of Population by Age 1969-2009

Age groups	1969	1979	1989	1999	2009
0-4	19.2	18.5	17.7	15.8	15.4
5-9	16.5	16.3	16.2	13.8	14.5
10-14	12.6	13.5	13.9	14.1	13.0
15-19	10.1	11.4	11.1	11.9	10.8
20-24	8.0	8.7	8.9	9.9	9.8
25-29	7.0	6.9	7.6	7.9	8.3
30-34	5.3	5.3	5.4	5.9	6.5
35-39	4.7	4.0	4.3	4.9	5.2
40-44	3.6	3.5	3.4	3.6	3.8
45-49	3.1	2.9	2.7	2.9	3.3
50-54	2.5	2.4	2.2	2.4	2.5
55-59	2.0	1.8	1.7	1.6	1.8
60-64	1.8	1.4	1.5	1.4	1.5
65+	3.6	3.2	3.3	3.3	3.5
Not stated	-	0.2	0.1	0.7	0.1
Total	10,944,664	15,329,040	21,450,763	28,688,599	38,610,097

Source: Kenya 2009 Population and Housing Census. Analytical Report on Population Dynamics Vol. III

3.4 Projections

Projections of the size, composition and distribution of population are important for planning for service delivery and for capacity to monitor the same. Kenya's population stands at approximately 43 million (medium variant) and is projected by the United Nations Department of Economic and Social Affairs/Population Division (UNDESA/PD) to reach 53.4 million by 2020, and 67.8 million by 2030 (see Table 3.3)¹³.

Table 3.3 Projected Population 2012-2050

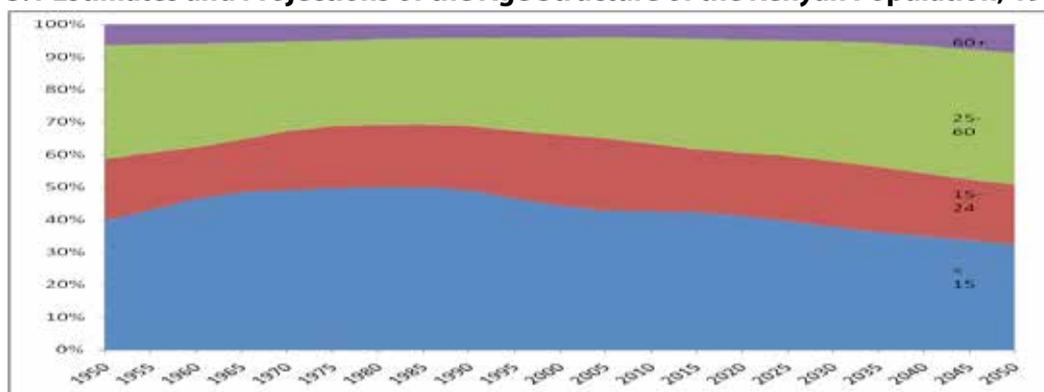
Variant	2012	2015	2020	2025	2030	2035	2040	2045	2050
Low	42,911,515	46,388,253	52,283,533	58,231,961	64,377,086	70,697,142	77,014,342	83,091,892	88,749,456
Medium	43,038,833	46,813,114	53,460,584	60,440,476	67,812,732	75,661,869	83,936,674	92,448,096	100,960,657
High	43,166,150	47,237,974	54,637,633	62,648,989	71,257,758	80,689,497	91,070,768	102,297,804	114,088,560

Source: UNDESA/PD (2011).

Figure 3.1 shows estimates and projected populations to 2050 by broad age groups. During the same period, the children's share of the population is expected to decline from the current 43 percent to about 32 percent, while that of the working age population (25-64) is expected to increase from the current 33 percent to about 41 percent. Meanwhile, the elderly's share is expected to reach nine percent from the current 4.5 percent.

¹³ The national projections are lower than UN projections by about 6 percent between 2015 and 2030. However, for international comparisons, the UN projections will apply since national projections are only up to 2030. The differences between various projections are based on the assumptions and data utilized, and not necessarily on the relative accuracies of the data.

Figure 3.1 Estimates and Projections of the Age Structure of the Kenyan Population, 1950-2050



Source: UNDESA/PD (2011)

3.5 Youth and the Working Population

A notable feature of Kenya's population structure is the increase of the youth. Some authors note that a youth share of at least 20 percent of total population, or 30 percent of adult population, constitutes a "youth bulge" (Urdal, 2006, UNFPA, 2010), which Westley and Choe (2002) explain to represent a transition from high to low fertility about 15 years earlier. In effect, the 'bulge' of adolescents and young adults are the product of the last births before fertility declined.

The passage of bulge through the age structure can produce a "demographic dividend", also known as a 'demographic bonus' or 'demographic window of opportunity' (Gribble, 2012). Such a window of opportunity arises when a country's population is dominated by people of the working age, resulting in a low dependency ratio (of those below and above the working age to those of working age), and occurs late during the demographic transition (Mason, 2008; Mason et al., 2003). The reduced dependency burden enables increased savings and investments towards improved economic growth, such as by increased education investments improving the quality of labour, and through agriculture modernization (Gribble, 2012).

Table 3.4 compares Kenya's ratio of the youth to the adult population to those for South East Asian countries, which are currently enjoying a demographic dividend, starting from the 1960s when the fertility rate was comparable across the whole sample. At the onset, Kenya's proportion of the youth to adult population was the lowest except for Vietnam. The most significant feature of the table, however, is that Kenya's proportion grew consistently to 2000, and eventually closed the 50 year period – many family planning interventions later – at a higher level than that of all the other countries 50 years earlier in 1960. By definition, Kenya has had a youth bulge throughout the review period.

Table 3.4 Proportion of Youth age 15-24 Relative to Adult Population

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005	2010
Kenya	29.5	31.4	35.7	37.9	38.4	38.6	38.9	39.0	39.3	38.9	36.2
South Korea	31.5	30.6	30.8	33.9	33.5	30.2	27.6	24.1	20.7	17.8	16.2
Malaysia	31.8	32.4	35.3	35.6	35.8	34.3	30.6	29.2	28.2	27.3	25.8
Philippines	33.9	34.5	37.0	38.5	37.1	35.6	34.2	33.4	32.8	31.9	30.8
Singapore	30.6	31.1	35.5	35.6	33.1	26.9	23.8	18.4	16.5	15.8	16.3
Thailand	32.8	31.7	32.6	34.2	34.6	33.2	30.3	27.0	22.5	20.6	19.1
Vietnam	24.5	24.6	29.6	34.6	35.4	34.6	32.8	30.7	29.6	28.9	26.7
Indonesia	31.8	29.8	30.2	32.8	34.2	34.0	33.0	31.3	29.5	27.2	24.7

Source: UNDESA/PD (2011).

Demographic dividend occurs when the growth rate of the Economic Support Ratio (ESR) – that is, the ratio between the economically active part of the national population is higher than the ratio of economically inactive part to the total population (Mason 2008, Mason et al 2003, Lee and Mason 2011, NTA, 2012, Olaniyan 2012)¹⁴. This ratio is often derived from the accounting identity that links income per capita (Y/N) to labour productivity (income per worker) and the labour force¹⁵. The growth rate of output is composed of (i) the growth rate of productivity, and (ii) the growth rate of ESR. In turn, ESR is the growth rate of the difference between the growth rate of effective producers (working population) and effective consumers (total population). The demographic dividend is thus derived from the ESR growth rate.

Table 3.5 shows demographic and economic indicators derived from national transfer accounts (NTA) for some low and middle low income countries. The support ratio is the effective number of workers divided by the effective number of consumers (column six). The effective number of workers is less than one-third for Kenya and Nigeria, partly due to high fertility rates and partly to very low income for young adults (NTA, 2012). While Kenya’s ESR begun to improve from around 1981, this was from a very low level, undermining sustained improvement (NTA, 2012). However, Kenya’s ESR growth rate is above the group average.

Table 3.5 Demographic and Economic Indicators for Low and Middle Income Countries (NTA)

	Total Population ('000')	Total Fertility Rate (TFR)	Gross National Income (GNI) per capita international dollars	Effective Workers (% of total population)	Effective Consumers (% of total population)	ESR	Annual ESR Change 2005-2010
Group average				45.3	83.8	0.54	0.6
Cambodia	14,137	2.8	2,080	57.5	83.6	0.69	0.9
India	1,224,614	2.7	3,330	47.3	85.3	0.55	0.54
Indonesia	239,871	2.2	4,180	51	88.1	0.58	0.68
Kenya	40,513	4.8	1,640	32.5	82.1	0.40	0.75
Nigeria	158,423	5.6	2,160	30.9	74.9	0.41	0.24
Philippines	93,261	3.3	3,950	43.2	88.5	0.49	0.46
Senegal	12,434	5.0	1,910	46.5	76.6	0.61	0.33
Vietnam	87,847	1.9	3,050	53.2	91.4	0.58	0.81

Source: NTA Bulletin December 2012

Figure 3.2a presents the estimated and projected growth rates of effective producers and effective consumers, with the latter dominating the former until the 1980 to 1985 period. The growth rate of effective producers peaked at four percent between 1990 and 1995, a full ten years after the peak growth rate of effective consumers. The two periods represent the highest growth and rapid fertility decline respectively, with the 1980 to 1990 decline in birth and death rates reflecting the largest difference between the two indicators. Between 2000 and 2005, fertility decline stalled while both childhood and adult mortality surged creating a ‘plateau’ in growth rate of consumers as well as decline

14 A support ratio of 0.5, for example, means that each worker is, on average, supporting own consumption and that of one other consumer.

15 Given total income Y, the total population N and the total number of workers L; then

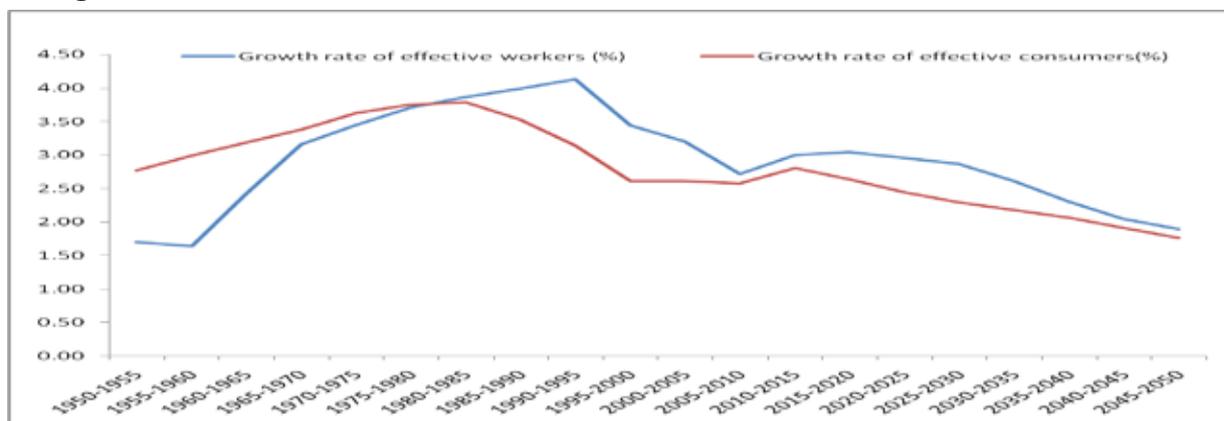
$$Y(t)/N(t) = (Y(t)/L(t)) \times (L(t)/N(t)) \dots\dots\dots(1)$$

Taking natural log on both sides of equation (1) and differentiating with respect to time leads to growth rates as: $gy=gz+(gl-gn) \dots\dots\dots(2)$

Where gy is the growth rate of per capita income, gz is the growth rate of income per worker, gl is the growth rate of labour force and gn is the growth rate of total population.

in growth rate of effective producers. This was partly due to the impact of HIV and AIDS which often affected society's most productive members. While a large difference between effective producers and consumers is anticipated, it should be of a lower level than that of 1990s. For example, the growth in effective producers will peak again at about 3.1 percent between 2015 and 2020.

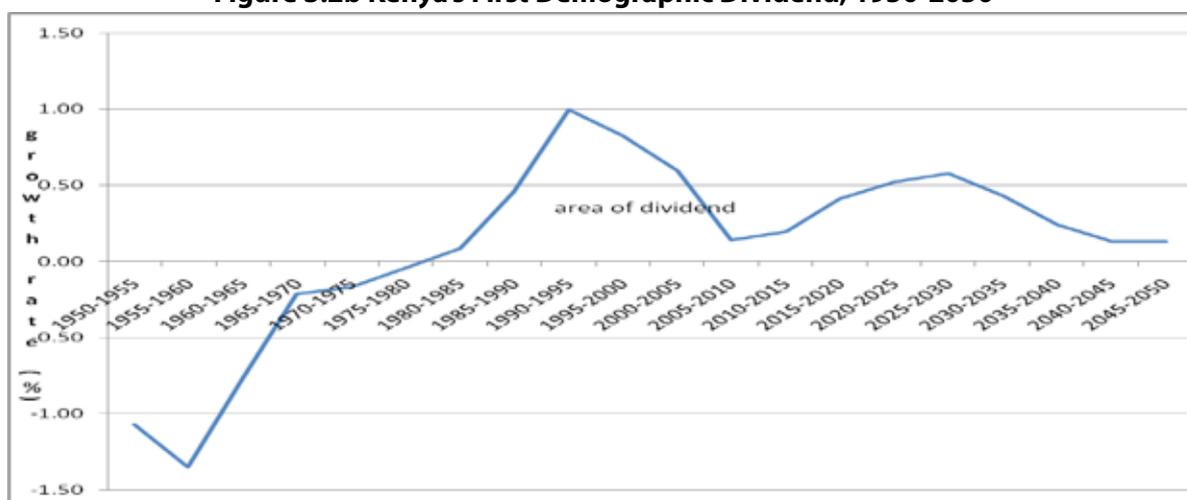
Figure 3.2a The Growth Rate of Effective Consumers and Effective Producers, 1950-2050



Source: computed from UNDESA/PD (2011)

The difference between the growth rates of effective producers and that of consumers determines the population window of opportunity. A prospect for the first demographic dividend (Figure 3.2b) was unfavourable up to 1980, after which it peaked at just about one percent between 1990 and 1995. This was followed by a rapid decline to a low of 0.14 percent between 2005 and 2010. A modest recovery is projected to about 0.6 percent between 2025 and 2030, after which the rate will decline again. Experience from other countries show that the typically transitory dividend period lasts between 30 to 60 years (Olaniyan, et al, 2012), the average for industrial countries being 29.7 years. For Kenya, the on-going window of opportunity should have a larger effect on income growth if fertility declines rapidly, alongside an immediate substantial improvement in output per worker, but its gain is unlikely to average above 0.7 percent per annum.

Figure 3.2b Kenya's First Demographic Dividend, 1950-2050

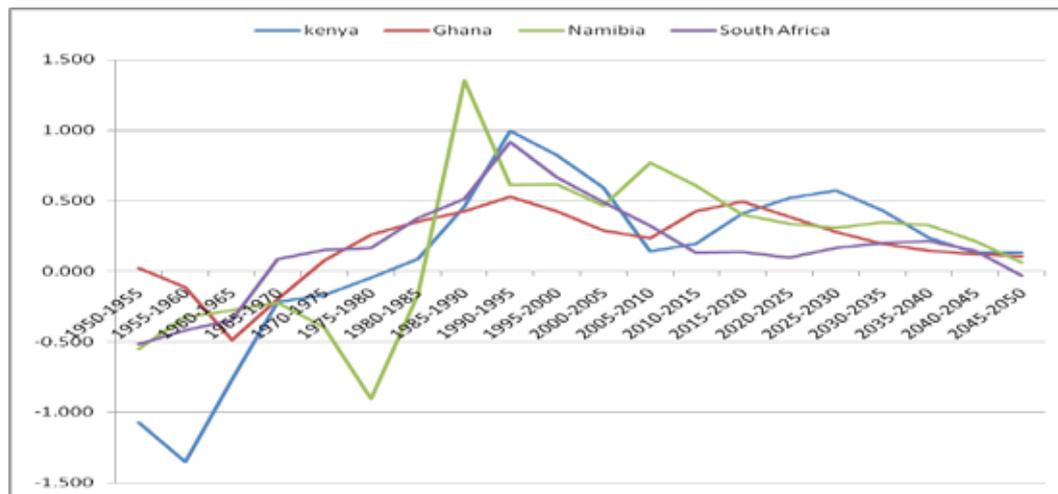


Source: computed from UNDESA/DP (2011).

Figure 3.2c shows the first demographic dividend for selected African countries, including Kenya,

Namibia, Ghana and South Africa. Bloom et al (2007) had indicated that as at 2007, only Ghana, Ivory Coast, Malawi, Mozambique and Namibia, were likely to experience a demographic dividend hence the selection of Ghana and Namibia while South Africa have had substantial decline in fertility rate but have high rates of HIV and AIDS that affects the potential labour force. The onset in South Africa and Ghana of favourable demographic circumstances was much earlier than was the case for Namibia and Kenya whose sequence of highest peaks quickly followed each other, the likely effect of rapid fertility decline in fertility. Subsequently, all the countries experienced rapid dividend declines which coincided with high HIV prevalence rates. While Kenya and South Africa's patterns of prospects towards demographic dividend have been similar, the latter country should expect a substantial decline in the near future (between 2015 and 2050) while the former should expect a second lower peak between 2025 and 2030.

Figure 3.2c The First Demographic Dividend Kenya, Ghana, South Africa and Namibia, 1950-2050



Source: computed from UNDESA/DP (2011).

The demographic dividend played a role in the “economic miracles” of the East Asian Tigers –Thailand, Malaysia, South Korea, Taiwan and Singapore (Gribble, 2012; Ezeh et al., 2012; Bongaarts, 1997), countries which had similar development indicators to many African countries, including Kenya. The magnitude of the demographic dividend depends on the ability of the economy to absorb and productively employ the extra labour joining the work force, rather than such labour being a mere demographic characteristic. The ratio of workers to dependents in the country improved due to lower fertility, an increase in female labour force participation, and a reversal of outward migration to a net inflow. The ‘Asian Tigers’ were able to take advantage of the demographic window of opportunity to accelerate growth in their economies, investing heavily in improving the quality of their labour force, agricultural modernization and social services, such as education, health and housing. Smaller family sizes and lower dependency ratios reduced population pressure, enabling higher savings and investments to drive economic development.

3.6 Future Population Size under Different Scenarios of Reproductive Health

Family planning has been considered the main policy instrument for lowering fertility rates in countries experiencing high fertility and consequent rapid population growth. However, the achievement of this policy option is complicated by differences between individual fertility preferences and desirable fertility levels in these countries (Bongaarts, 2009). For instance, while the ideal family size in Kenya averaged 3.82 based on KDHS 2008/2009, this is likely to change in the long run; but there is no guarantee that

such change will be brought about by reliance solely on family planning. Changes in individual fertility preferences will depend on structural transformations, such as rising levels of education, urbanization, greater participation of women in the labour market, and extension of social protection schemes, such as old age pensions. The possible interactions between these indicators offer multiple scenarios with competing policy implications and possible outcomes.

Scenario 1: Substantial decline in unwanted fertility

Bongaarts (2009) projected Kenyan population using the decomposition method which was based on the 2008 revision of the World Population Prospects of the United Nation Population Division (UNPD), in which unwanted fertility was factored out. The population would reach 73 million by 2050, which would be a lower figure than UNPD's medium projection of 85.4 million. This would represent a 14.5 percent reduction in the 2050 population, and a reduction in the average annual growth rate from 1.86 percent to 1.46 percent between 2010 and 2050. This method assumes that during the period from 2010 to 2050, the proportion of unwanted fertility will gradually fall to zero by 2050, in addition to the fertility reduction already implied by the Medium population projection. While these effects are significant, the underlying assumptions are based on more than just the elimination of unwanted fertility from 2010. An implicit assumption is that UNPD's fertility reduction projections are purely structural, with the unwanted fertility elimination simply being added on. To assume otherwise would result in double counting the family planning effect.

Scenario 2: Reduced fertility rates but unwanted fertility remains constant

The second approach which is more or less similar to the first method bases population projections on Age Specific Fertility Rates (ASFR) of respective 5-year periods starting in 2010, using an adjustment factor¹⁶. It assumes that fertility preference will remain at 3.8, which may not hold over time. However, under this relatively simple 'reduced TFR' scenario — represented by the green lines in Figures 3.3 and 3.4 — population growth would initially register a moderate if erratic decline, such as within the 2.72 percent to 2.14 percent range between 2010 and 2015. Eventually, the growth rate would converge around two percent per year, the same rate that the UNPD Medium Projection — the 2010 revision, rather than the 2008 revision used by Bongaarts — would reach by about 2036. By 2056, the projected population size under the wanted fertility scenario would exceed that of the UNPD Medium Projection. This projection is based on the arguably unrealistic assumptions that the effect on ASFR in all age groups will be the same, the ideal family size of 3.82 would unlikely change over time, and that birth spacing and maternal and child mortality would remain unchanged.

Scenario 3: Perfect reproductive health

To overcome the above limitations, projection is done for the "Perfect Reproduction Health" scenario. This scenario assumes that ASFR for women aged below 20 and above 40 is equal to zero (meaning births occur only between ages 20 and 40), and that women have a birth interval of 2.5 years. It also assumes that dead children are not replaced, and that the mortality and migration rates are the same ones used in the original UNPD medium projection for each respective period. The population growth rates implied by this scenario are moderately higher than the previous scenario, converging at just below 2.5 percent, rather than two percent. By 2050, the population implied by this scenario would be 104.1 million, compared to 96.9 million under the UNPD medium projection, and 94.6 million under the previous scenario with uniform reduction of the ASFRs. By 2070, the Perfect Reproductive Health scenario would imply a population of 168.6 million, compared to the 127.3 million projected by UNPD. If maternal mortality is completely eliminated and a further reduction of 50 percent in child mortality is assumed, the former number rises to 176.1 million.

¹⁶ ASFR measures the annual number of births to women of a specified age or age group per 1,000 women in that age group.

Policy Implications of three reproductive scenarios

The main implication of the foregoing is that the immediate attainment of perfect reproductive health scenario would lower population growth rates in the short run. However, without changes in fertility preferences, such improvements would soon exhaust their potential, resulting in long-term population growth rates rising to 2.5 percent. In order for long-term population growth to fall below this level, other structural transformations will be needed to change women's and couples' preferences over ideal family sizes. Thus the main policy focus for reduced population growth lies in reducing fertility preferences in addition to providing appropriate family planning services.

Figure 3.3 Projected Annual Population Growth Rates under Alternative Scenarios

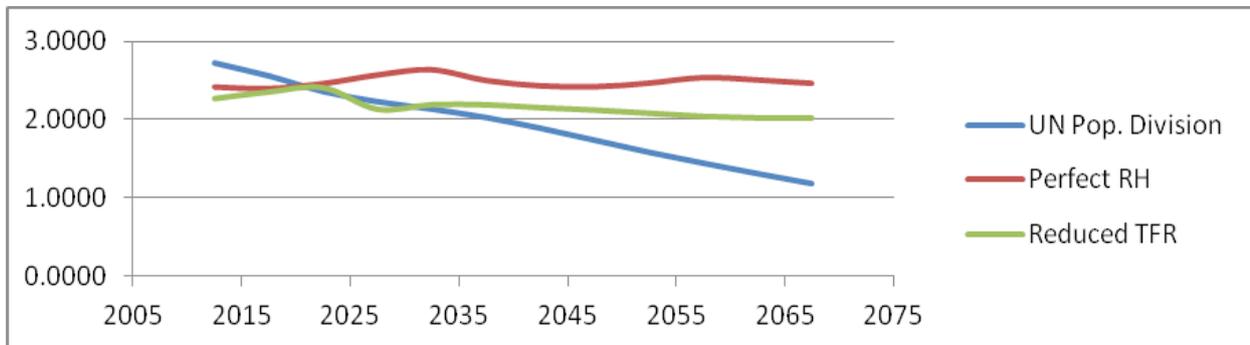
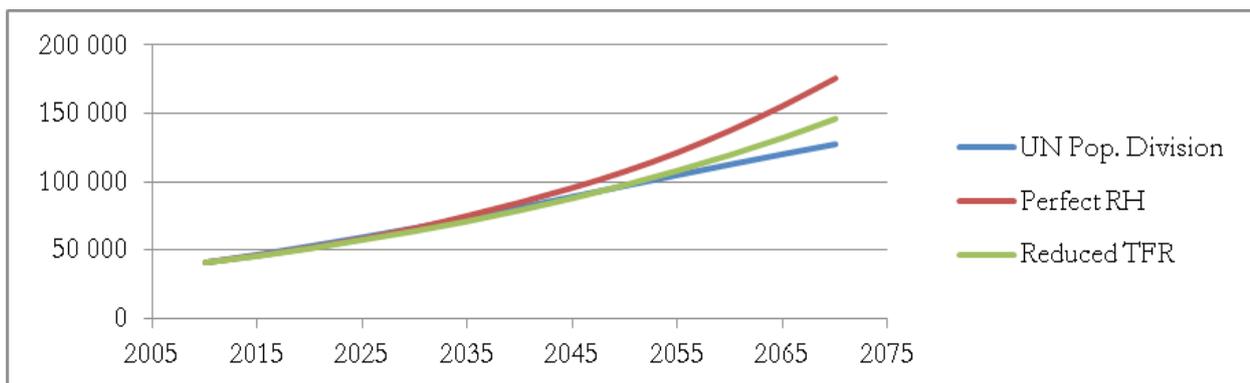


Figure 3.4 Projected Population Sizes under Alternative Scenarios



3.7 Existing Policies and Programmes

Kenya has had comparatively good and facilitative policy frameworks on population issues. It was the first country in Sub-Saharan Africa to establish a national family planning programme in 1967, even if this saw no action for many years (Ajayi & Kevole, 1998). The National Council for Population and Development (NCPD) was established in 1982, to guide population policy and coordinate all research activities in the country.

Following the review of the 1967 Family Planning Programme, the Government issued its Population Policy Guidelines in the form of Sessional Paper No. 4 of 1984, to guide the implementation of an expanded population programme. Following the 1994 International Conference on Population and Development (ICPD) held in Cairo, the Population Policy Guidelines were reviewed to integrate the ICPD Program of Action. This culminated in the development of the National Population Policy for Sustainable Development presented in Sessional Paper No.1 of 2000, designed to guide the country's population programme up to 2010. The Government has recently developed Sessional Paper No.3 of

2012 on Population Policy for National Development, as the new population policy from 2012 to 2030. The Sessional Paper incorporates continuing and emerging national and international population concerns, and is designed to contribute to the realization of the Kenya Vision 2030, which aims to uplift the quality of life of all Kenyans through the management of population growth given available resources.

Sessional Paper No.3 of 2012 is geared towards further reducing fertility through the improved provision of family planning services and attention to reproductive rights. The policy envisages that fertility will decline to 2.6 children per woman by 2030, with contraceptive prevalence increasing to 70 percent. This will be achieved through:

- regular updating of a comprehensive National Population Research Agenda that generates relevant baseline data;
- an expansion of family planning service delivery points, including community-based distribution that promotes male involvement;
- ensuring appropriate contraceptive method mix and commodity security in service delivery points;
- strengthening the integration of family planning, HIV and AIDS, reproductive health and other services;
- an intensification of advocacy for increased budget allocation for population, reproductive health and family planning services;
- enhancing advocacy and public awareness on population issues at the national and county levels;
- mobilization of adequate resources to increase availability and use of population data for integration of population variables into development planning in all spheres and at all levels; and
- improving the performance of population programme to accelerate population stabilization and to bring a balance between population and economic growth at all levels.

3.8 Challenges and Opportunities

3.8.1 Challenges

The first challenge lies in the realization of the policy objective of reducing TFR from the current level of 4.6 to 2.6 children per woman by 2030. This is because the demand for children is still high and is unlikely to change unless substantial changes in desired family sizes are achieved among the poor in general, notably in the northern arid and semi-arid areas of the country (see next section on fertility and family planning). The growth scenarios presented in this chapter indicate that a rapid decline in fertility can only occur if fertility preferences declined substantially. Thus the challenge is how reduce further the continued high demand for children. The high demand for children need to take into account the need for further reductions in childhood mortality¹⁷.

The quantification of the demographic dividend raises two policy challenges with regard to achievement of economic growth: the need for rapid decline in fertility; and the substantial increase in labour productivity. The challenges arise because the demographic dividend is likely to be small given the large child population that has resulted from the high fertility levels over a long period of time.

Bloom et al. (2007) argued that despite the fact that many African countries, like Kenya, were expected to have a marked growth in the working-age share of the population between 2005 and 2025, not all such countries have strong institutions and economies to take advantage of the bulge in workers. Two major factors will determine Africa's future economic growth prospects (including Kenya's): growth

¹⁷ Demographic transition hypothesizes that mortality must decline substantially before further fertility decline. High childhood mortality makes families have more children.

in the working-age share of the population; and institutional quality (Bloom et al., 2007). Thus the challenge is how to convert youth bulge into dividend.

The age structure of a population also has implications for political and socio-economic characteristics. A youthful age structure is likely to undermine rapid and/or sustained development, security, governance, and precipitate corruption; but it can also create opportunities for a country. For instance, during the 1990s, countries with a very young age structure were three times more likely to experience civil conflict than countries with more mature age structures (Leahy et al., 2007).

3.8.2 Opportunities

The demographic dividend due to increase in the youth population relative to adult population is an opportunity that arises from demographic transition. Since these opportunities are unlikely to reoccur, country must act expeditiously to implement the policy mix required to accelerate the demographic transition and make its beneficial effects more pronounced (Bloom et al., 2001). Experiences of South East Asian countries indicate that demographic dividend is delivered primarily through three mechanisms (Bloom et al., 2003: 39):

- Labour supply – the numbers available to work are larger than the non-workers, and women are more likely to enter the workforce, while family size decreases;
- Savings – the working age people tend to have a higher level of output and a consequent higher level of savings; and
- Human capital investments – with smaller numbers of children and cultural changes there will be greater investment in education and health.

Gribble (2012) recently noted that what contributed to the early economic growth of South Korea and the other Asian Tigers was that, as they were making investments in health, education, and family planning; Governments also created policies that attracted foreign investment, promoted export of locally manufactured goods, and created substantial minimum wages that raise the standards of living. For Kenya, at least one policy opportunity is found in Article 55 of the Constitution which recognizes the importance of investing in the youth. The article declares the need for *“the State to take measures, including affirmative action programmes, to ensure that the youth:*

- (i) access relevant education and training;*
- (ii) have opportunities to associate, be represented and participate in political, socio-economic and other spheres of life;*
- (iii) access employment.*

3.9 Conclusion

In conclusion, Kenya’s population growth and age structure have important implications for socio-economic development. Kenya has a large population share of young people and a high rate of population growth. Such a large youth share of the population which drives the dependency ratio adds a considerable burden to the country’s budget for providing health, education and other social services. However, the large youthful population also offers opportunities which require investments in human capital development, and appropriate economic reforms and policies to ensure that the surplus labour force is gainfully employed and facilitated to make savings and investments as Bloom et al., (2003) report for East Asia. These factors suggest the country could accelerate its demographic transition through expanded family planning access, a reduction of child mortality, enhanced female school enrolment and general female empowerment, and the creation of labour market opportunities for women.

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CHAPTER 4: FERTILITY AND FAMILY PLANNING

4.1 Introduction

The 1994 International Conference on Population and Development (ICPD) gave new impetus for the international community and Governments to focus on reproductive health. For the first time, many Governments recognized and adopted reproductive rights as contained in international human rights documents (UN/DPI, 1995). According to the ICPD and World Health Organisation (WHO), reproductive health refers to the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes (UN/DPI, 1995; WHO, 2013). Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often they want to have children (UN/DPI, 1995). In particular, the ICPD emphasised the rights of individuals and couples to safe, effective, affordable and acceptable methods of family planning (FP) of their choice, as well as the right of women to safe pregnancy and childbirth services (UN/DPI, 1995).

As a signatory to the ICPD declaration, Kenya embarked on formulating reproductive health policies aimed at improving the quality of life and well-being of her people. With substantial national commitment and international support, there have been notable reproductive health attainments in the country. For example, there had initially been considerable progress in increasing the contraceptive prevalence rate (CPR)¹⁸ from 17 percent in 1984 to 39 percent in 1998 (Magadi and Curtis 2003), and in reducing the fertility rate from 8.1 to 4.7 children per woman between 1977/1978 and 1998 (Westoff and Cross, 2006). However, since 1998, the pace of improvement in reproductive health indicators has been slow (Askew et al., 2009).

This chapter examines the status of reproductive health in Kenya with emphasis on fertility from 1977/1978 to 2008/2009. It uses data from the 1977/1978 Kenya Fertility Survey (KFS), the 1989-2009 Kenya Demographic and Health Survey (KDHS), published reports, policy documents and materials provided by Government agencies. Analysis is descriptive and entails examining changes in fertility-related indicators over time, by socio-economic characteristics, such as region, urban-rural residence, education level and household wealth status. The indicators include the total fertility rate (TFR)¹⁹, CPR, unmet need for family planning, wanted and unwanted fertility and birth intervals. The chapter ends by highlighting existing policies and strategies as well as gaps, opportunities and challenges in addressing reproductive health issues in the country.

Rationale

Fertility is one of the dynamics of population change, alongside mortality and migration. Fertility analysis is, therefore, important for understanding past, current and future trends in population size, composition and growth. In addition, childbearing is linked to other reproductive health components, such as sexual health, antenatal care, delivery and postnatal care. For instance, pregnancy signifies exposure to sexual intercourse; hence the need for sexual health services. Moreover, expectant women need access to skilled antenatal, delivery and postnatal care services to realize safe pregnancies and childbirth, as stipulated by the 1994 ICPD. Information on levels, patterns and trends in fertility and related indicators in the country is, therefore, important for socio-economic planning, monitoring and evaluation of reproductive health programmes.

¹⁸ CPR is the percentage of currently married women aged 15-49 years who are using any method of family planning.

¹⁹ Total fertility rate is the average number of children a woman would give birth to if she went through her entire reproductive life at the prevailing age specific fertility rates.

4.2 Fertility

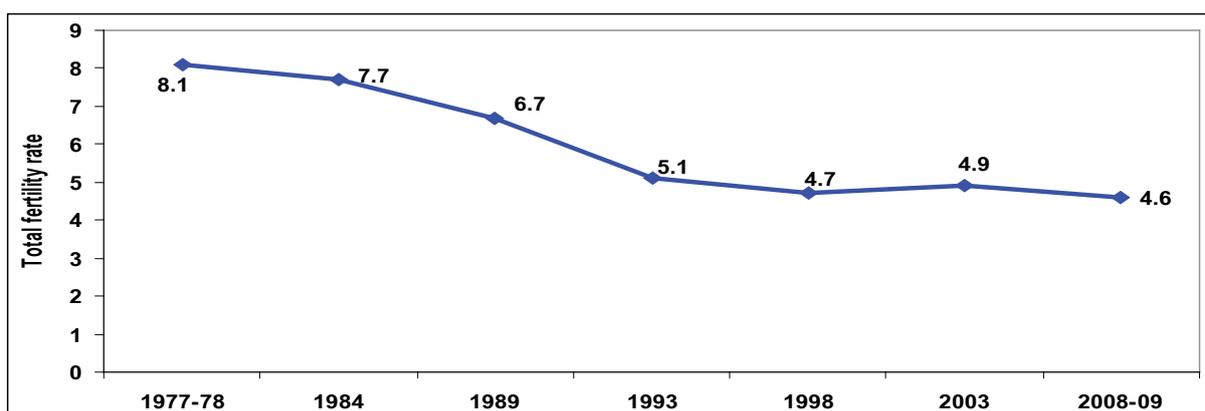
4.2.1 Fertility Levels and Trends

The World Fertility Survey (WFS) of 1977 showed that Kenya had one of the highest fertility rates in the world, with a TFR of eight 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 (Ekisa, 2009). However, as illustrated in Figure 4.1, 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. There was also increased contraceptive uptake due to vigorous national and international support of family planning programmes (Blacker, 2002; Kizito et al., 1991).

A key feature of Kenya's fertility transition is the stall between 1998 and 2003 (Figure 4.1). Much of the literature that has sought to explain stall in fertility transition has identified three models, namely; the reproductive behaviour, socio-economic and institutional (Askew et. al., 2009; Ezeh et al., 2009; Cetorrelli and Leone, 2012). The reproductive behaviour model attributes stall in fertility transition to a lack of improvements in proximate determinants. For instance, Westoff and Cross (2006) found that 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. The socio-economic model, on the other hand, attributes the stalls to declines in the levels of socio-economic development, as reflected in changes in women's education, infant and child mortality and real per capita economic growth (Bongaarts 2006; Westoff and Cross, 2006). 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 and 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) (Riddell, 1992). 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 and AIDS (Askew et al., 2009).

Figure 4.1 Trends in Total Fertility Rate, Kenya, 1977/78–2008/09



Sources: CBS (1980; 1984); CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994; 1999); NCPD and IRD (1989).

4.2.2 Fertility Patterns by Socio-economic Characteristics

Table 4.1 presents TFR trends by place of residence, level of education and region. Kenyan women living in rural areas bear on average two or more children than those living in urban areas. Whereas fertility decline occurred in both rural and urban areas, the magnitude of the decline was greater in urban areas. For example, between 1989 and 2008/2009, urban TFR declined by 36 percent compared to 27 percent in rural areas. The urban-rural disparity in fertility was due to; higher literacy levels, higher contraceptive use, and later age at first marriage in urban compared to rural areas. However, fertility trends in rural and urban areas mirror the national trend of steady decline between 1989 and 1998, a stall between 1998 and 2003, and further decline between 2003 and 2008/2009.

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 (Table 4.1). Despite the 2003 kink for women with primary education, the general trend for them and those with secondary and above education was a steady decline from 1989 to 2008/2009. 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.

Table 4.1 Trends in TFR According to Place of Residence, Education and Region, Kenya 1989–2008/2009

Socio-economic characteristics	1989	1993	1998	2003	2008-09	Percent change (1989-2008/09)
Residence						
Urban	4.5	3.4	3.1	3.3	2.9	35.6
Rural	7.1	5.8	5.2	5.4	5.2	26.8
Education						
No education	7.5	6.0	5.8	6.7	6.7	10.7
Primary	6.9	5.7	5.0	5.5	5.2	24.6
Secondary +	4.9	4.0	3.5	3.2	3.1	36.7
Province						
Nairobi	4.2	3.4	2.6	2.7	2.8	33.3
Central	6.0	3.9	3.7	3.4	3.4	43.3
Coast	5.4	5.3	5.0	4.9	4.8	11.1
Eastern	7.2	5.9	4.7	5.1	4.6	36.1
Nyanza	6.9	5.8	5.0	5.6	5.4	21.7
Rift Valley	7.0	5.7	5.3	5.8	4.7	32.9
Western	8.1	6.4	5.6	5.8	5.6	30.9
North Eastern	n/a	n/a	n/a	7.0	5.9	-
Kenya	6.7	5.4	4.7	4.9	4.6	31.3

Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999); NCPD and IRD (1989).

Note: n/a = Not applicable because the region was not covered in the surveys.

The table shows there are also substantial regional differences in fertility levels across Kenya. For instance, between 1993 and 2008/2009, TFR was consistently lower in Nairobi and Central provinces, the two provinces which experienced the greatest fertility decline between 1989 and 1998. Over the last two decades, Central Province also had the greatest fertility decline, followed by Eastern, Nairobi

and Rift Valley provinces respectively.

Table 4.2 presents fertility trends by household wealth status. Over the years, fertility remained more than twice as high among women from the poorest 20 percent of the population – the ‘lowest quintile’ – compared to those from the richest 20 percent households. This lowest quintile’s fertility was erratic, resulting in little substantial change between 1993 and 2008/2009. This allowed the gap to increase between it and the other quintiles whose period declines stood above 10 percent over the same period. In effect, fertility decline mostly occurred among women from better-off households.

Table 4.2 Trends in Total Fertility Rate According to Wealth Quintile, Kenya 1993–2008/2009

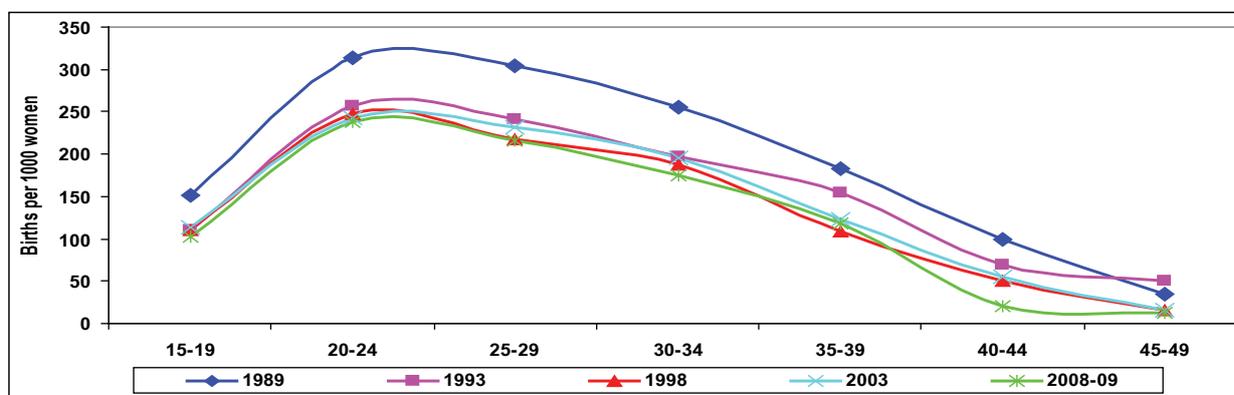
Wealth Quintiles	1993	1998	2003	2008-2009	Percent change 1993-2008/2009
Lowest	7.2	6.5	7.6	7.0	2.8
Second	6.2	5.6	5.8	5.6	9.7
Middle	5.6	4.7	5.1	5.0	10.7
Fourth	5.3	4.2	4.0	3.7	30.2
Highest	3.3	3.0	3.1	2.9	12.1

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

Age-Specific Fertility Rates (ASFRs)

ASFR measures the annual number of births to women of a specified age or age group per 1,000 women in that age group, and consequently allows the comparison of fertility behaviour at different ages or within different age groups. Figure 4.2 presents the age-specific fertility rates for the period 1998 and 2008/2009. The ASFR pattern has remained largely unchanged over the years: low in the age 15 to 19 bracket, increasing rapidly thereafter before declining sharply from age 30. Fertility rates also declined sharply for the 15 to 44 years group between 1989 and 1998.

Figure 4.2 Trends in Age Specific Fertility Rate, Kenya 1989–2008/2009



Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999); NCPD and IRD (1989).

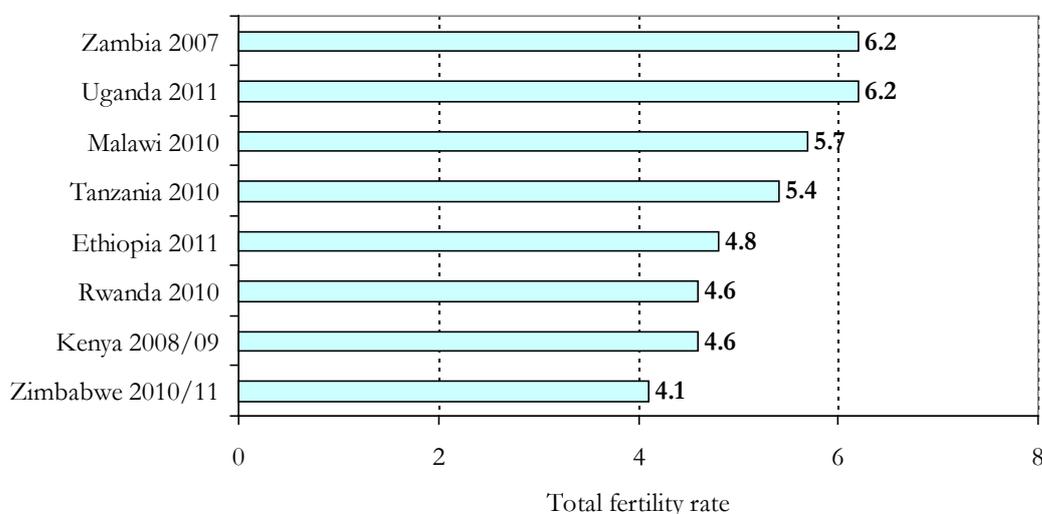
The results further show that adolescent fertility remains high in Kenya. ASFR among women aged 15–19 was estimated at 103 in 2008/2009, contributing about 11 percent of total fertility. Besides its contribution to overall population growth, adolescent fertility has been singled out as a major contributor to overall maternal mortality (WHO, 2008). Complications of pregnancy and childbirth are

the leading causes of mortality among women between the ages 15 and 19 mostly because of poor access to good-quality health care, including antenatal care and skilled delivery. WHO estimates show that the risk of maternal death is twice as great for women between 15 and 19 years as it is for those between the ages of 20 and 24. Moreover, babies born to adolescent mothers also face a significantly higher risk of early death compared to those born to older women.

4.2.3 Regional Comparisons of Fertility Rates

Sub-Saharan Africa has the highest fertility levels compared to other parts of the world: TFR of 5.1 children per woman compared to 1.6 in Europe, 2.2 in Asia, Latin America and the Caribbean, and 2.5 in Oceania (Population Reference Bureau, 2012). On the African continent, fertility ranges from 2.5 in Southern Africa to 5.9 in Central Africa, according to the Bureau. In Eastern Africa, the average is 5.3, slightly higher than the Sub-Saharan Africa average. Kenya's fertility rate is, however, comparatively lower than that of the countries in Eastern Africa region, except Zimbabwe, as shown in Figure 4.3.

Figure 4.3 Average TFR for Eastern African Countries, 2007–2011



Source: ICF International, 2012. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - July 10 2012.

Note: reported rate if the average for the three years to the survey.

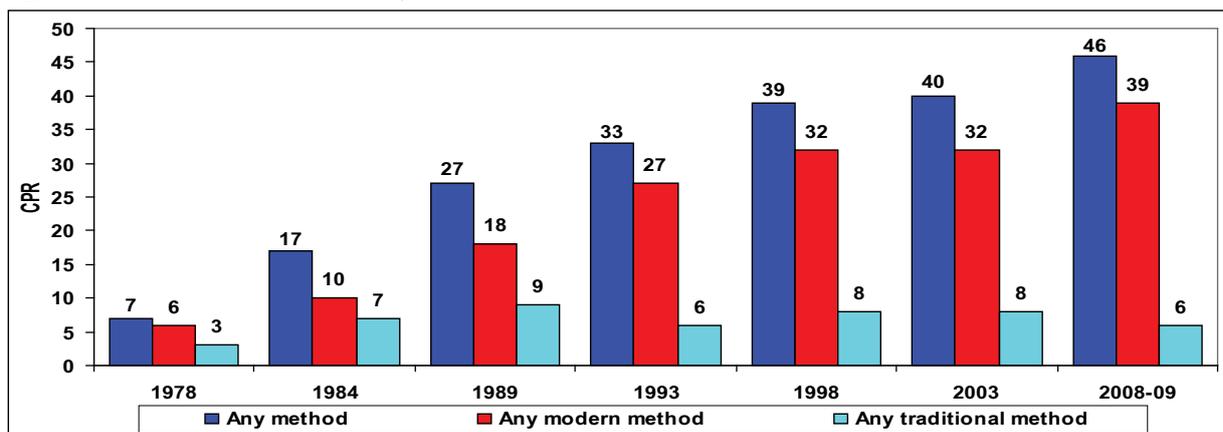
4.3 Family Planning

4.3.1 Levels and Trends in Family Planning

Figure 4.4 shows trends in the use of contraceptives by type of method between 1978 and 2008-2009. There was a steady increase in CPR between 1977/1978 and 1998, largely driven by the use of modern methods. However, CPR stalled between 1998 and 2003 before increasing to 46 percent in 2008/2009. The sustained increase in the use of FP during 1990s has been identified as the main driving force behind rapid fertility decline in Kenya (Ajayi and Kekovole, 1998). During late 1990s, the national FP programme was substantially affected by declining Government and donor funding resulting from the shift of priorities to HIV and AIDS (Aloo-Obunga, 2003; Crichton, 2008). This adversely affected the large-scale community-based distribution (CBD) programmes that had facilitated low-cost contraceptive information and services, together with information education and communication (IEC) campaigns advocating for small families and the use of contraception. The effect of the decline in the institutional

support for FP was reflected in the stall in CPR, and the corresponding stagnation in fertility decline between 1998 and 2003 (Askew et al., 2009).

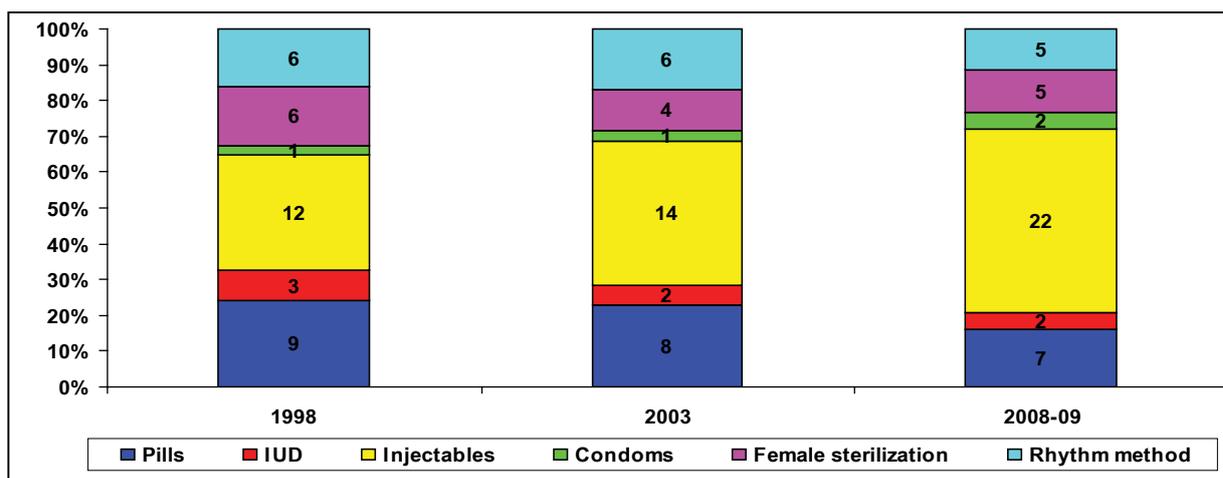
Figure 4.4 Trends in CPR in Kenya, 1978–2008/2009



Sources: CBS (1980, 1984); CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999); NCPD and IRD (1989).

Figure 4.5 shows changes in current use of specific FP methods since 1998. Injectables have been most popular throughout, followed by the pill. Subscription to the various contraception options has been unstable, the most significant development being the sustained growth in the use of injectables.

Figure 4.5 Trends in Current Use of Specific Contraceptive Methods, Kenya 1998 –2008/2009

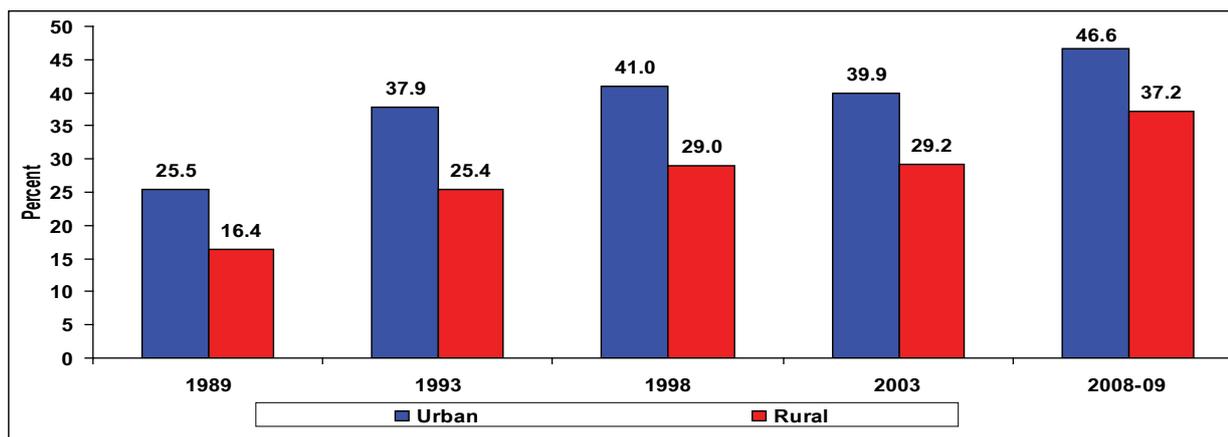


Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1999).

4.3.2 Use of Modern Contraceptives by Place of Residence

The urban and rural use of modern contraception has risen consistently in the two decades to 2009, as shown in Figure 4.6. However, the use rate has been higher among urban compared to rural women, although the gap has been narrowing over time.

Figure 4.6 Use of Modern Contraceptives by Place of Residence, Kenya, 1993–2008/2009

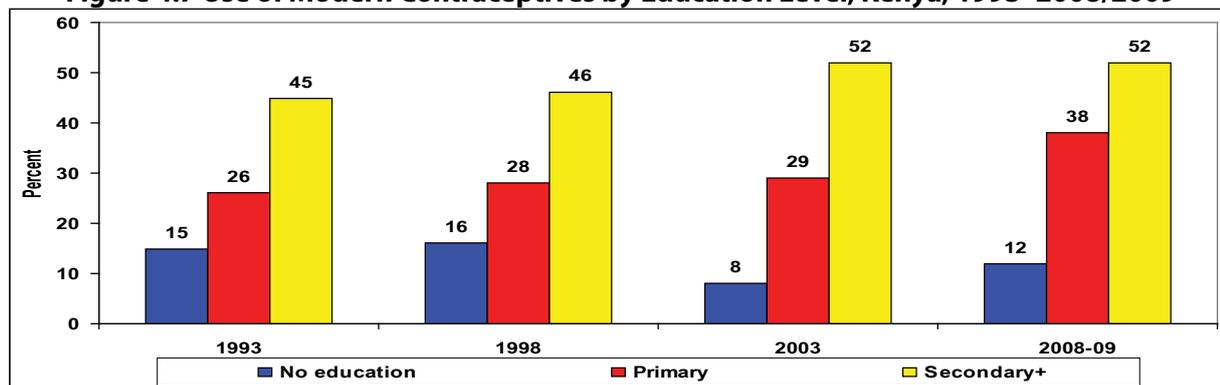


Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999); NCPD and IRD (1989).

4.3.3 Use of Modern Contraceptives by Level of Education and Wealth Status

There is a strong relationship between contraceptive use and levels of education, as is illustrated in Figure 4.7. Over the years, the use of modern contraceptives has been consistently lower among women with no education compared to those with primary or secondary and above level of education. In addition, the gap in the use of modern contraceptives between women with no education and those with some education has widened since 1998. While the gap between primary education women and those with a higher level of education widened to 2003, it had closed substantially by 2008/2009.

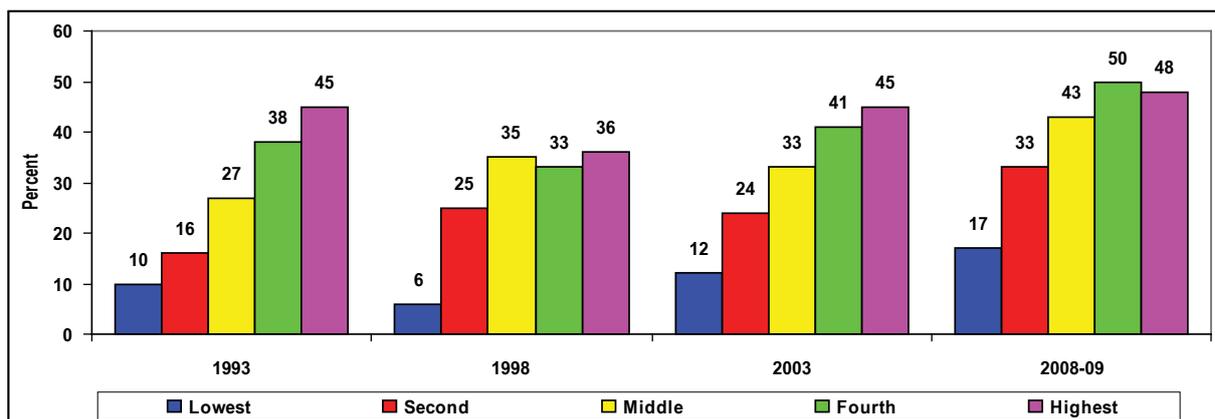
Figure 4.7 Use of Modern Contraceptives by Education Level, Kenya, 1993–2008/2009



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

In terms of wealth status, Figure 4.8 shows that over the years, poor women in Kenya are the least likely to use modern contraceptive methods. Although CPR has increased in the last two decades, the wide gap in contraceptive use between poor women (lowest quintiles) and better-off women (fourth and highest quintiles) implies that poor women have benefited less from FP programmes. These results are consistent with other findings that show that contraceptive use is lower in developing compared to developed countries and among poor compared to better-off women (Clements and Madise, 2004). In the Kenya data, the use gap between the poorest and richest women has narrowed considerably, from a factor of 4.5 in 1993 to close to 2.8. Additionally, while quintile 4 use has been unstable, its closing level was above quintile 5.

Figure4. 8 Use of Modern Contraceptives by Wealth Quintiles, Kenya, 1993–2008/2009



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

The gap in the use modern contraceptives between poor and non-poor women and between non-educated and educated women could be due to complex pathways relating income and enlightenment to both the demand for and supply of contraceptive information and services.

4.3.4 Regional Variations in CPR

Extensive differences exist in the regional CPR trend for both modern methods and any other, as presented in Table 4.9. Nairobi, Nyanza and Rift Valley provinces experienced wide fluctuations in CPR between 1993 and 2008/2009. Conversely, Central, Coast, Eastern, and Western provinces experienced steady increases over the same period. Excluding North Eastern Province which was not covered by the 1989-1998 surveys, CPR remained consistently lower in Coast compared to other regions over the years. For the years covered, however, North Eastern Province’s use rate for any contraceptive is remarkably low, and makes her TFR of eight look quite modest.

Table 4.9 Regional Trends in Contraceptive Use by Type of Method, Kenya, 1993–2008/09

Region	ANY METHOD				MODERN METHOD			
	1993	1998	2003	2008-09	1993	1998	2003	2008-09
Nairobi	45.4	56.3	50.7	55.3	37.7	46.8	44.3	49.0
Central	56.1	61.1	66.4	66.7	49.8	54.8	57.9	62.5
Coast	20.3	22.1	24.1	34.3	16.7	20.0	19.1	29.7
Eastern	38.4	45.6	50.6	52.0	30.5	36.0	38.4	43.8
Nyanza	23.8	28.2	24.7	37.3	21.5	25.0	21.0	32.9
Rift Valley	27.9	37.7	34.4	42.4	21.0	26.4	24.5	34.7
Western	25.1	30.2	34.1	46.5	21.7	21.9	27.3	41.4
North Eastern	-	-	0.2	3.5	-	-	0.2	3.5

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

4.3.5 Unmet Need for Family Planning

A woman has 'unmet need' for FP or contraception if she is 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 (Westoff, 1988). 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 (UN/DPI, 1995).

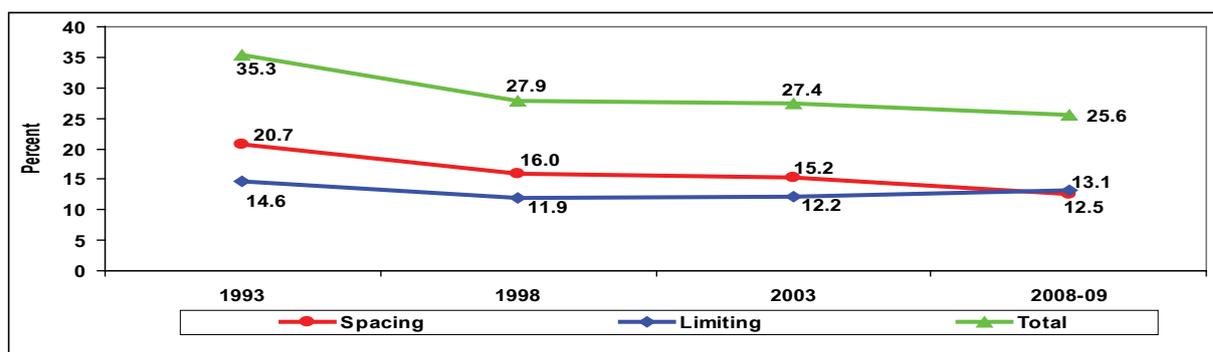


A couple explores suitable family planning methods at a health clinic.

Photo: UNFPA

Trends in unmet need for spacing and limiting in Kenya over time are shown in Figure 4.9. 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 (Republic of Kenya, 2007a). 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 (Mills et al., 2010). Figure 4.9 further shows that prior to 2008/2009, unmet need for spacing has been consistently higher than unmet for limiting (KNBS and ICF Macro, 2010).

Figure 4.9 Trends in Unmet FP Need in Kenya, 1993–2008/09

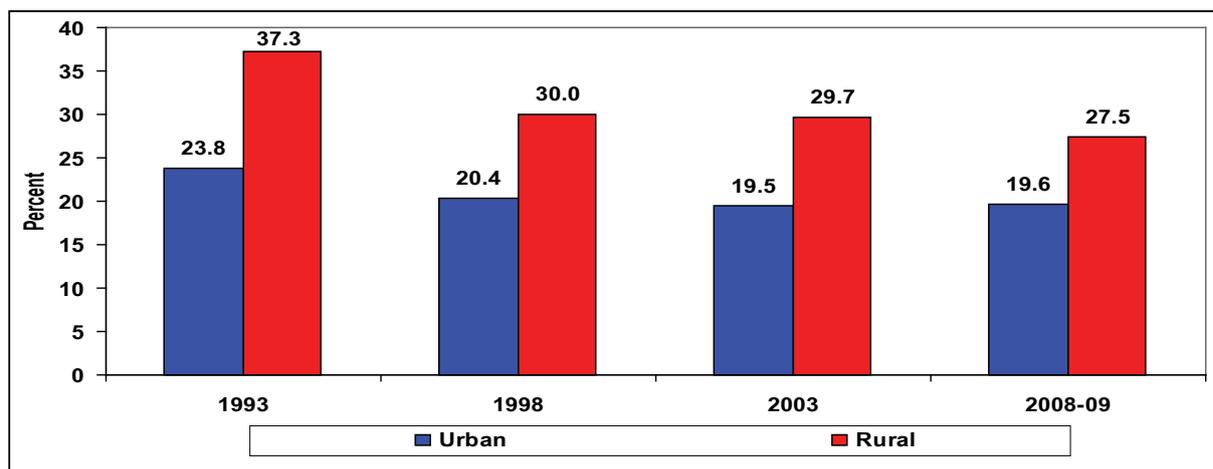


Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999).

Unmet Need for FP by Place of Residence

Across the survey years, rural women in Kenya have higher unmet FP need than their urban counterparts (Figure 4.10). Trends over time indicate that between 1993 and 1998, there was a remarkable decrease in total unmet need in both rural and urban areas. For subsequent surveys, however, the decline slowed in rural areas while it stalled in urban areas.

Figure 4.10 Unmet Need for FP by Place of Residence, Kenya, 1993–2008/2009

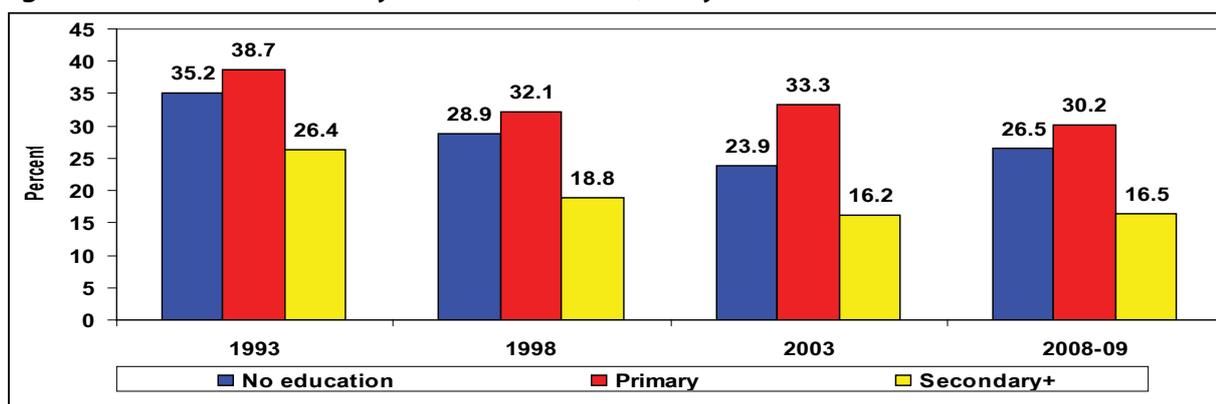


Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International 1994, (1999).

Unmet Need for FP by Level of Education and Wealth Index

Across the survey years, total unmet FP need was greater among women with primary education than among those with no education or those with secondary and above, as shown in Figure 4.11. The total unmet need decreased among women of all education categories between 1993 and 1998, after which the pattern is mixed, the gap between the educated women widening considerably.

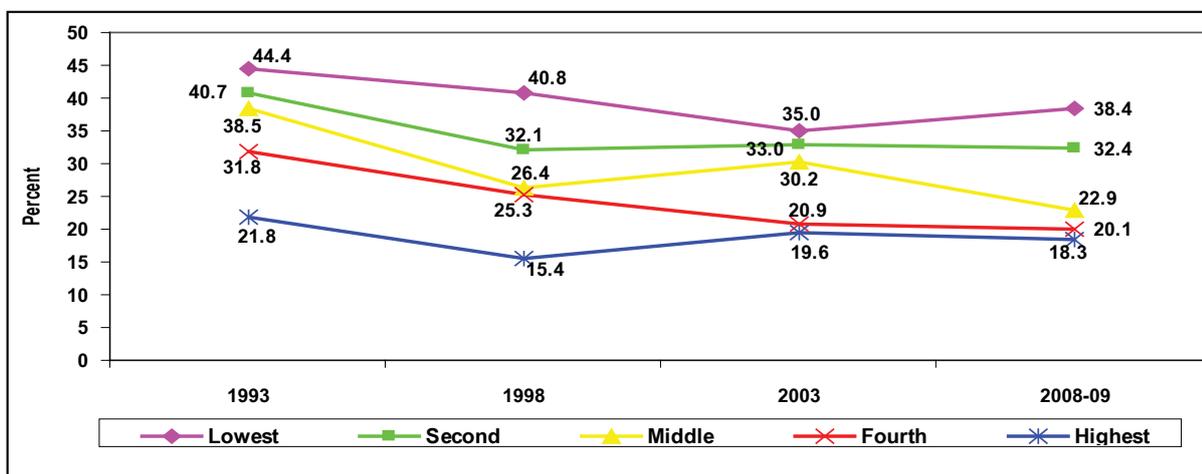
Figure 4.11 Unmet FP Need by Level of Education, Kenya 1993-2008/2009



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

Trends in unmet need by wealth quintiles are shown in Figure 4.12. Across the survey years, unmet need was greater among the poorer women than among the non-poor women. However, the trend shows a mixed pattern in unmet need for women of various wealth quintiles.

Figure 4.12 Unmet FP Need by Wealth Quintiles, Kenya 1993-2008/2009



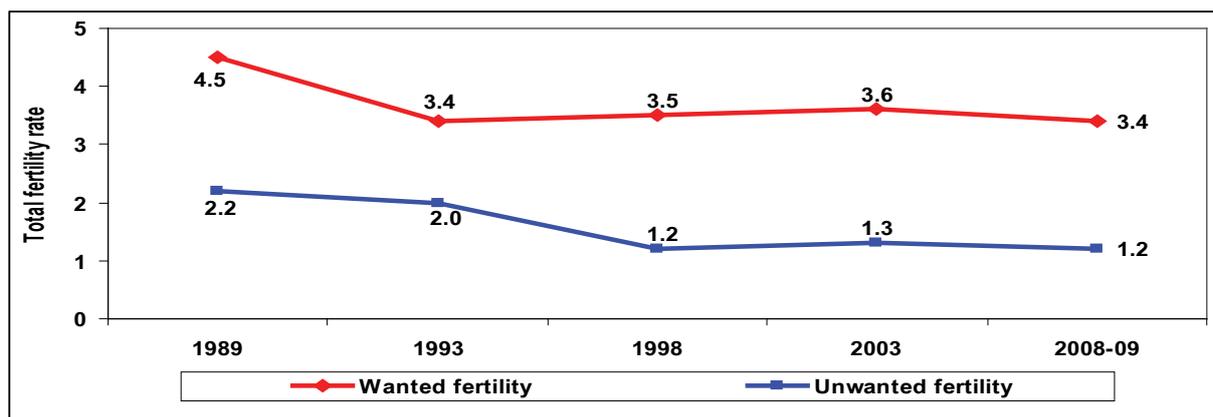
Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999).

4.4 Wanted and Unwanted Fertility

4.4.1 Levels and Trends

The level of unwanted fertility — defined as the actual fertility in excess of desired fertility — declined rapidly during the 1989-1998 period after which it stalled, as shown in Figure 4.13. Unwanted fertility declined by almost 50 percent during the period 1989-1998, mainly due to highly effective contemporaneous FP programmes, according to Askew et al. (2009). Wanted fertility also declined by 25 percent between 1989 and 1993, after which it stabilised at about 35 percent. Interestingly, the 50 percent rate of decline in unwanted fertility over the two decades was nearly double the decline in wanted fertility.

Figure 4.13 Trends in Wanted and Unwanted Fertility, Kenya, 1989–2008/2009

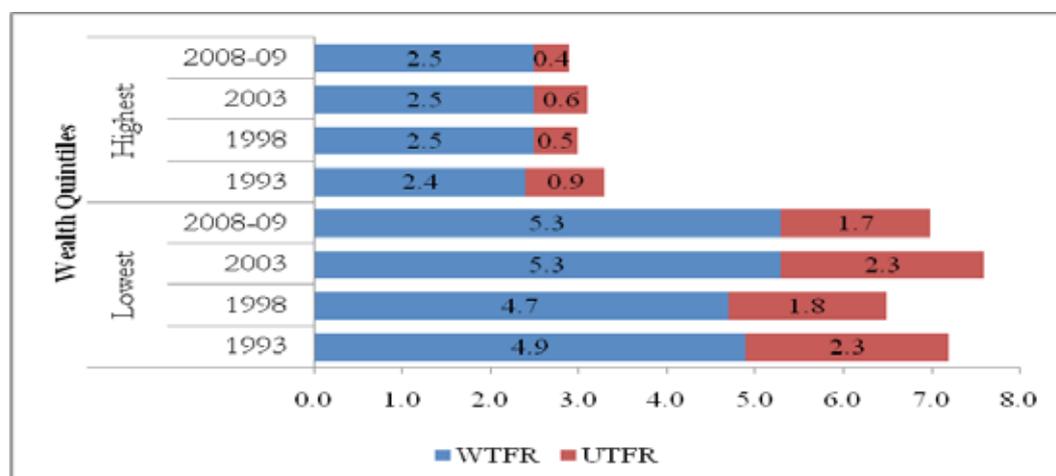


Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999); NCPD and IRD (1989).

4.4.2 Wanted and Unwanted Fertility by Wealth Index

The poorest women are less likely than the least poor to achieve their desired fertility, as reflected in Figure 4.14. The data for the four surveys reported show an average difference of two children between their TFR and their preferred fertility for the poorest women in contrast to an average of less than one for the least poor women. There has been an increase over time in wanted TFR (WTFR) among poorest women while their unwanted TFR (UTFR) reflects no clear trend. The persistently high UTFR among the poorest women suggests that FP programmes are not effectively reaching this segment of the population. This may be due to service delivery outlets serving the growing number of users in higher wealth quintiles, and the increasing role of the private sector in providing FP services, with a corresponding increase in fees for services (Askew et al., 2009).

Figure 4.14 Wanted and Unwanted Fertility rates by Wealth Quintiles, Kenya 1993–2008/2009

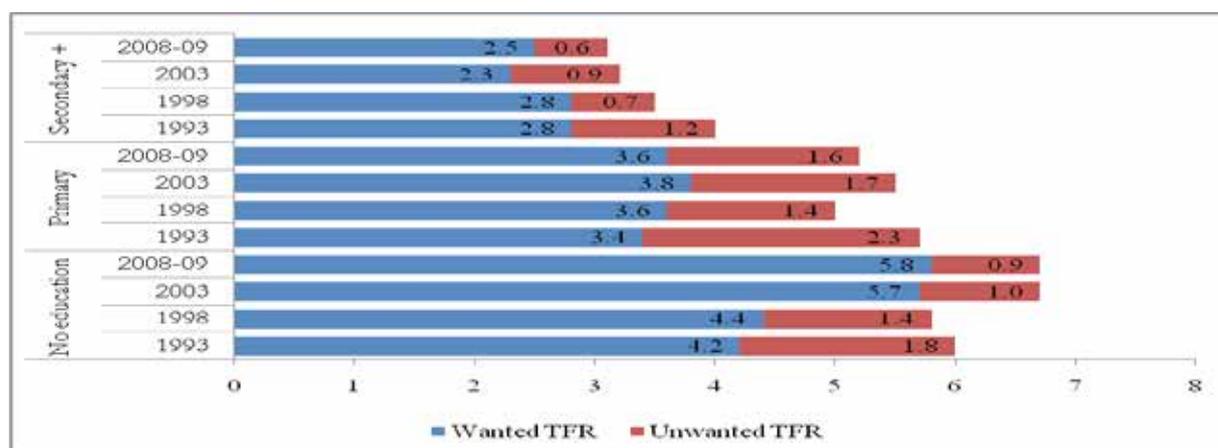


Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999).

4.4.3 Wanted and Unwanted Fertility Rates by Education Level

Figure 4.15 presents the patterns of WFR and UFR by level of education. The data show that WFR among women with no education has been increasing consistently since 1993 while their UFR declined by half during the same period. The net effect was an overall increase in TFR among this segment of the population. In contrast, WFR among women with secondary and above level of education generally declined between 1998 and 2008-2009, as did their UFR which halved. It is also interesting to note that women with primary level education have higher UFRs than both those with no education and those with secondary and above level of education.

Figure 4.15 Trends in Wanted and Unwanted Fertility Rates by Education, Kenya 1993-2008/2009



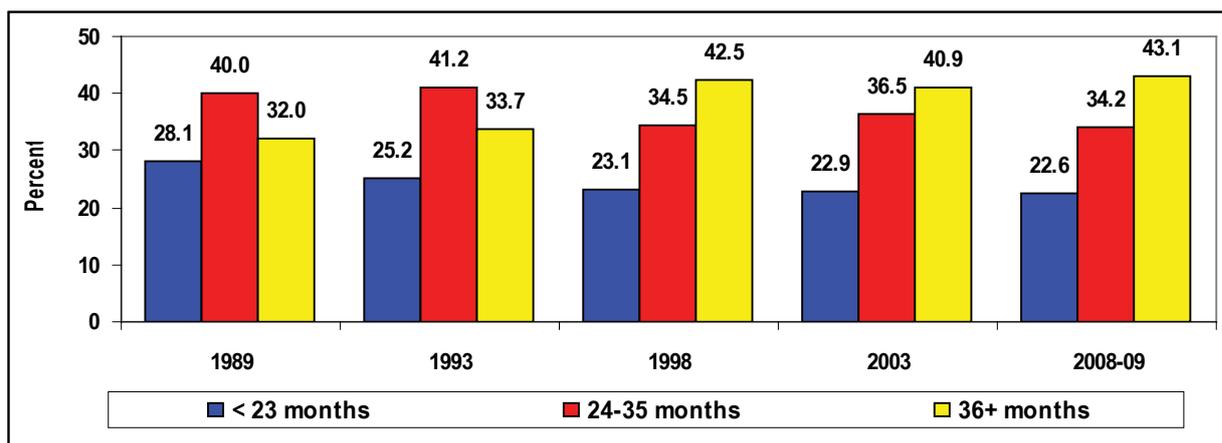
Sources: CBS, MOH and ORC Macro International (2004); KNBS and ICF Macro (2010); NCPD, CBS and Macro International (1994, 1999).

4.5 Birth Interval

A birth interval refers to the length of time between two successive live births and it indicates the pace of child bearing. The interval between births plays an important role in improving the health of a mother and her child. Shorter and longer intervals between pregnancies are independently associated with increased risk of adverse maternal, perinatal, infant and child outcomes (Rutstein, 2008). WHO has recommended an interval of at least 24 months before a mother considers becoming pregnant again in order to reduce the risk of adverse maternal and perinatal infant outcome (WHO, 2006). In Kenya, the median open birth interval has remained more or less the same at about 33 months (KNBS and ICF Macro, 2010).

Figure 4.16 presents data on spacing of non-first births in the five years preceding the survey by number of months since previous birth. The number of non-first births occurring less than 23 months reduced from 28 percent in 1989 to 23 percent in 1998, but has since stalled. The proportion of births occurring between 24 and 35 months dropped from 40 percent in 1989 to 34 percent in 2008/2009. Since 1998, however, majority of non-first births to Kenyan women have been occurring 36 months or more after the previous birth.

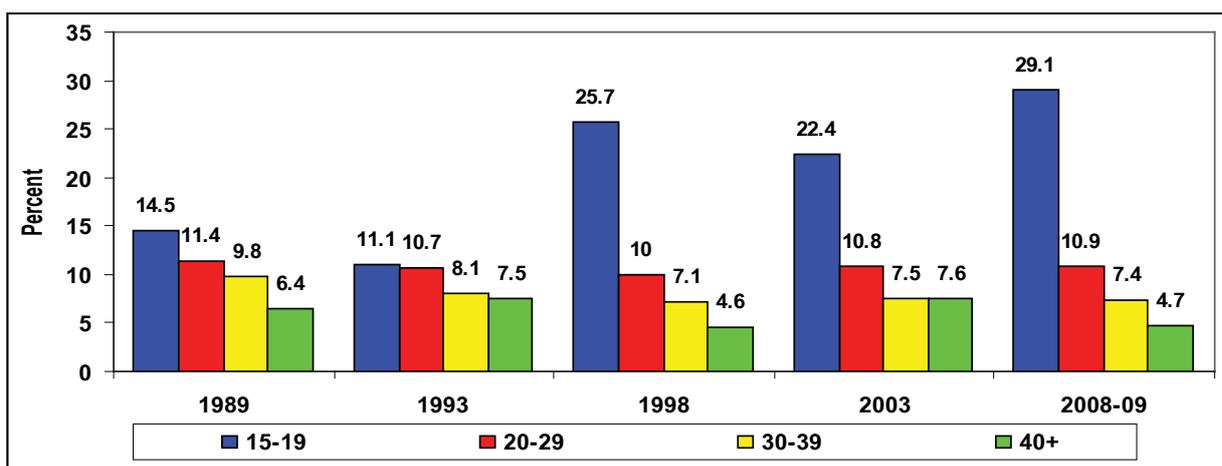
Figure 4.16 Non-first Births by Number of Months since Previous Birth, Kenya, 1989–2008/2009



Sources: CBS, MOH and ORC Macro International 2004; KNBS and ICF Macro 2010; NCPD, CBS and Macro International 1994, 1999; NCPD and IRD 1989.

The majority of non-first births within 7-17 months occur among younger women, notably those in the 15 to 19 age bracket (Figure 4.17). This implies that younger mothers continue to experience greater risk of poor child and maternal health outcomes. On the other hand, the percentage of women within each age bracket with non-first births declined over time across all age groups.

Figure 4.17 Non-first births occurring between 7-17 months by age of the mother, Kenya 1993-2008/2009



Sources: CBS, MOH and ORC Macro International 2004; KNBS and ICF Macro 2010; NCPD, CBS and Macro International 1994, 1999; NCPD and IRD 1989.

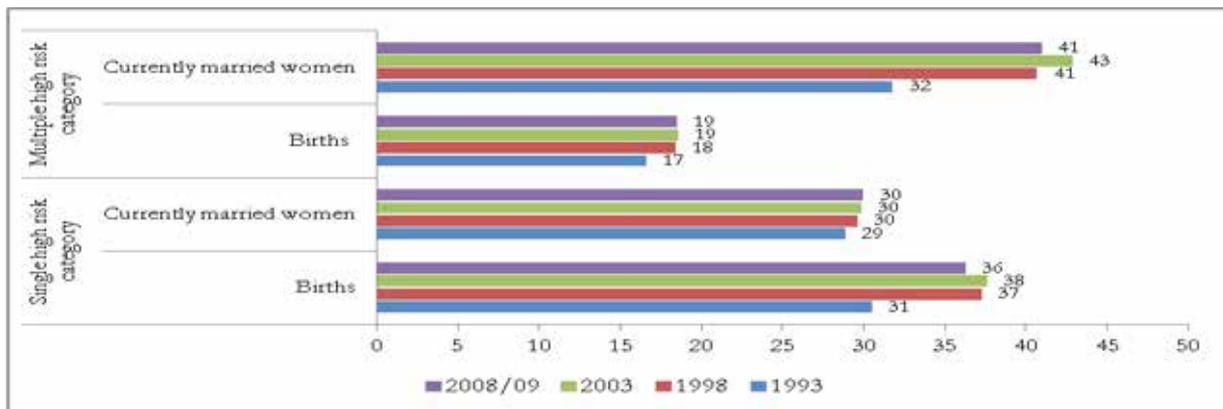
4.6 Emerging Issues in Fertility and Related Indicators

4.6.1 High-risk Births

Births are defined as 'high risk' if the mother was under age 18 or over age 34; already had three or more children; gave birth less than 36 months after a previous live birth; or gave birth more than 60 months after a previous live birth (KNBS and ICF Macro, 2010). Women are classified as having a single high-risk factor if only one of these criteria applies, and multiple high-risk in case of more than one criterion.

Figure 4.18 shows trends in the distribution of children born in the five years preceding the survey by risk category, and percentage of currently married women by category of risk if they were to conceive a child at the time of the survey. The percentage of births falling in the single high risk category in the last five years preceding the survey is higher than those falling in the multiple-risk category. There has been a greater increase in the levels of single high-risk compared to multiple high-risk births between 1993 and 2008/2009. In addition, the percentage of women with multiple high-risk births increased dramatically between 1993 and 1998 before stabilizing at between 41 and 43 percent thereafter (Figure 18). These results underscore the need for targeting FP services to prevent high-risk births and thus reduce maternal and infant mortality.

Figure 4.18 Trends in High Risk Fertility-related Births, Kenya, 1993–2008/2009



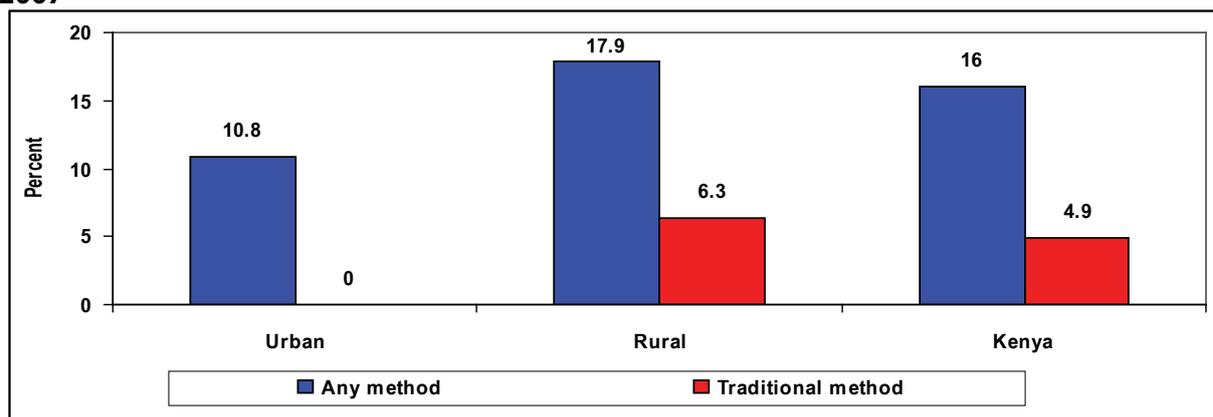
Sources: CBS, MOH and ORC Macro International 2004; KNBS and ICF Macro 2010; NCPD, CBS and Macro International 1994, 1999.

4.6.2 Vulnerable Groups

Vulnerable and marginalized groups include adolescents, people with disabilities, people living with HIV and AIDS, internally displaced persons, and refugees. In Kenya, these groups are systematically disadvantaged in terms of access to reproductive health care. Inequities in access to reproductive health services exist mainly due to weak health infrastructure especially in remote areas and among the urban poor (NCPD and KNBS, 2008). In addition, there is lack of disaggregated data on the reproductive health of disadvantaged populations to inform decision-making (NCPD and KNBS, 2008).

Figure 4.19 provides information on women with disabilities aged 12–49 years who are currently using family planning based on data from the 2007 Kenya National Survey for Persons with Disabilities (KNSPWD). Use of family planning among these women is generally low compared to the general population, with only 16 percent of them using any method while about five percent use traditional methods. In terms of place of residence, disabled women in rural areas use contraceptives more than their urban counterparts.

Figure 4.19 Contraceptive Prevalence among Women with Disability aged 15-49 years, Kenya, 2007



Source: NCPD and KNBS 2008

4.7 Existing Policies and Programmes

This section discusses the policy framework relating to fertility and related indicators in Kenya. Kenya was among the first sub-Saharan African countries to establish a family planning programme through the *National Family Planning Policy* of 1967 (Graff, 2012). By the late 1980s, the national FP 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 (Republic of Kenya, 2000).

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 (Republic of Kenya, 2000). The policy set to reduce TFR from 5.0 in 1995 to 4.0 by the year 2000, 3.5 by 2005 and 2.5 by 2010 (Republic of Kenya, 2000). The policy further aimed to increase CPR from 33 percent in 1993 to 43 percent by 2000, 53 percent by 2005 and 62 percent by 2010 (Republic of Kenya, 2000). In 2012, the Government issued a new population policy after the expiry of the previous one: *Population Policy for National Development* (Republic of Kenya, 2012). 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 (Republic of Kenya, 2012). The targets include; reduction of fertility from TFR of 4.6 in 2008/2009 to 2.6 children per woman by 2030 and increasing CPR from 46 percent to 70 percent over the same period (Republic of Kenya, 2012).

There are also a number of international, regional, and national legal and policy frameworks in place guiding the fulfilment of citizens' rights to sexual and reproductive health goals. For example, Kenya committed herself to implementing the ICPD Programme of Action that emphasized equality between women and men in reproductive decision-making, voluntary choice in determining the number and timing of one's children, and freedom from sexual violence, coercion and harmful practices (UN/DPI, 1995). 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 (Republic of Kenya, 2003).

In 2007, the *National Reproductive Health Policy* was developed with the overarching goal of enhancing the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving the quality, efficiency and effectiveness of service delivery; and improving responsiveness to client needs. One of its objectives was to reduce unmet need for family planning, unplanned births as well as regional and socio-economic disparities in contraceptive use (Republic of Kenya, 2007a). In addition, the Constitution of Kenya 2010 promotes various rights aimed at removing any barriers that hinder men and women from accessing FP services. In particular, Article 43 (1) (a) provides the right to health including reproductive health care (Republic of Kenya, 2010). The Government further developed various strategies to operationalize these policies including the *Adolescent Reproductive Health and Development Policy Plan of Action*, the *National Reproductive Health Strategy 1997-2010* and the *National Reproductive Health Strategy 2009-2015* (Republic of Kenya 1996, 2005, 2009). The availability of multiple policy frameworks covering various components of reproductive health including fertility and family planning is clear evidence of a favourable policy environment for achieving the goals set in the ICPD PoA and the health-related MDGs.

4.8 Gaps, Challenges and Opportunities

4.8.1 Gaps

Although Kenya has made significant progress in increasing the CPR, the level is still below the target of 53 percent by 2005 and 62 percent by 2010 envisioned in the *National Population Policy for Sustainable Development* of 2000. At the same time, TFR has remained below the target set by the policy. Moreover, although the *National Reproductive Health Policy* of 2007 emphasized reduction in unmet need for family planning, unplanned births, as well as regional and socio-economic disparities in CPR, the level of unmet need among Kenyan women remains high. The State of Kenya Population report, for example, shows that approximately 1.1 million currently married women would like to delay or stop childbearing, but are not using any contraception, and another 1.8 million women have unplanned births each year (NCAPD, 2011).

Although Kenya has put in place numerous policies focusing on population and reproductive health, the complete operationalization and implementation of the policies and strategies is to a large extent lacking partly due to lack of funding. For instance, Kenya is far from delivering on the promise made in Abuja in 2000 to allocate 15 percent of the national annual budget to the public health sector. Moreover, there is lack of proper coordination among the donor community. In particular, although intra-donor coordination and adherence to the Paris Declaration and the Accra Agenda's principles on ownership remain shared common long-term goals, progress has been slow in the health sector (OECD *n.d.*). It is also unclear how various stakeholders in the country implement their reproductive programmes and/or projects. Lack of monitoring and evaluation of existing policies makes it difficult to assess the progress made.

4.8.2 Challenges

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. Poor people do not have access to sexual and reproductive health information and services thereby making

them vulnerable to poor health outcomes, such as unwanted pregnancies, higher maternal mortality and morbidity, HIV infection and sexual violence.

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 among some communities contribute to high fertility rates in many settings. The inability to negotiate sex on equal terms, such as use of contraception, exposes women and girls to the risk of unwanted pregnancy, illness and death from pregnancy-related causes and sex-related diseases.

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 FP, maternal and infant care, management of sexually transmitted infections, and management of other SRH problems. As a result, costing of SRH has not been properly done. The bulk of essential SRH services continue to be funded by donors and international aid agencies in a context where budget predictability and donor funding are becoming even more uncertain due to the global financial crisis.

Parallel management structures: Although efforts have been made towards integrating SRH with HIV and AIDS services, it is evident that greater attention has been paid to the latter. In Kenya, the Government declared HIV and AIDS a national disaster and a public health emergency in 1999. For this reason, key responsibilities in the HIV and AIDS campaign were transferred from the Ministry of Health to the Office of the President. Consequently, this created parallel systems for managing the response to HIV and AIDS, which undermined initiatives to strengthen health systems and provide integrated SRH and HIV and AIDS services.

Weak operationalisation of the joint financing agreement: The Sector Wide Approach (SWAp) was adopted in Kenya in 2005 and was intended to bring increased sector coordination, national leadership and management in order to improve aid effectiveness. However, progress has been slow and it is impossible to assess if aid effectiveness has improved in Kenya.

4.8.3 Opportunities

The various policy statements and action strategies provide an enabling environment for addressing population issues. Many of these documents 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 (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 in Kenya.

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 areas that have lagged behind in development. People will be able to participate freely in decision-making on issues affecting them, including reproductive health issues. This can lead to better provision

and use of health services, including reproductive health services.

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 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 (Republic of Kenya, 2007b).

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.

A number of bilateral donors have increased their financial assistance specifically for reproductive health. A new financial commitment by donors and the private sector at the 2012 London Summit on Family Planning presents funding opportunities for developing countries to increase allocations for family planning services. Although it is unlikely that Kenya will meet the MDG 5 by 2015, the initiative presents an opportunity to improve further the reproductive health indicators in the country.



From left: Former NCPD Director General Dr. Boniface K'Oyugi; former UNFPA KCO Representative Mr. Fidelis Zama Chi; former Permanent Secretary in the Ministry of Planning, National Development and Vision 2030 Dr. Edward Sambili; and Hon. Wycliffe Oparanya, the Minister of Planning, National Development and Vision 2030 at the re-launch of the Family Planning Campaign in Kenya 2012.

Photo: UNFPA

4.9 Conclusion

Although Kenya had made 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 in the transition. Moreover, the pace of the decline was not the same among different socio-economic groups. Much of the decline took place among the better educated and better-off women, while little change occurred among the less educated and poor women. During the stall, fertility increased among those with no education and those in the lowest wealth quintile, while the decline continued among the most educated. The stall or slow fertility decline is probably due to increases in wanted fertility among women who are poor or non-educated. The 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 some active policies to address issues of access to information and services are put in place.

The initial sustained increase in the use of family planning services was a major factor in fertility transition. The stall in CPR coincided with the stagnation in fertility rates. There are also disparities in the use of modern contraceptives among Kenyan women of different socio-economic groups. Contraceptive prevalence rates for women residing in urban areas continue to be higher than the rates for their rural counterparts. Over the years, there has been a wide gap in the use of modern contraceptives between poor and non-poor women as well as between non-educated and educated women. There is also continuous change in the method mix, with an increase in the use of injectables and a decline in the use of the pills, sterilization and IUD which are regarded as the most reliable and cost-effective methods.

There has been no significant progress in reducing the levels of unmet need for family planning. About one-quarter of currently married women do not have access to safe and effective contraceptive methods, which are a fundamental human right. The highest levels of unmet need are among women living in rural areas, those who have completed primary education, and those in the lowest wealth quintiles. The wide poor-rich gaps in the utilization of reproductive health services present major social and economic challenges. The failure to achieve the desired targets for fertility and contraceptive use are to a large extent a result of programmes not meeting the reproductive health needs of the poor who tend to be non-educated and from rural areas. Poor women continue to have more children and are least likely to achieve their desired family size.

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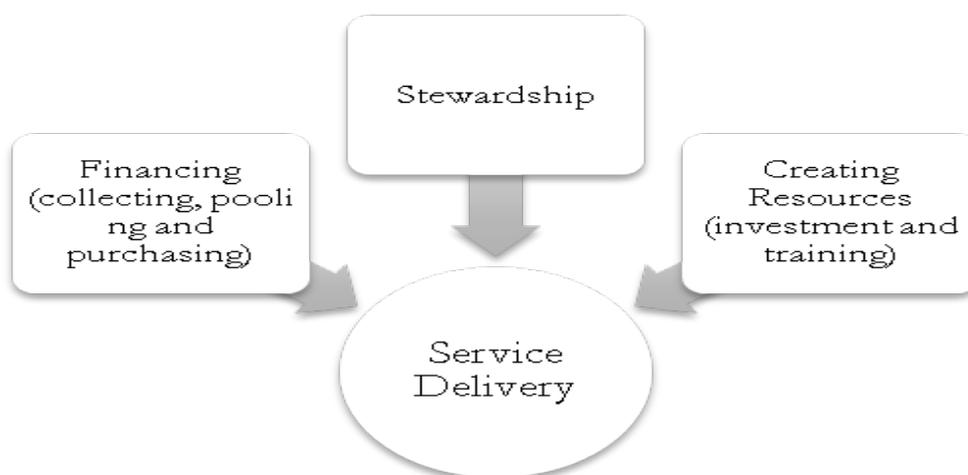
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CHAPTER 5: HEALTH SYSTEMS AND SERVICE DELIVERY FOR SEXUAL AND REPRODUCTIVE HEALTH

5.1 Introduction

A good health system delivers quality services to all people, when and where they need them. In order to do so, there must be reliable information on which to base service delivery policies and interventions; a robust financing mechanism; a well-trained and adequately paid workforce; and well maintained facilities and logistics to deliver quality medicines and technologies. A health system can be defined as “all the organizations, institutions, and resources that are devoted to producing health actions” (WHO, 2000). The *World Health Report 2000* identifies four key functions of the health system: stewardship or governance; financing; human and physical resources; and organization and management of service delivery. The interaction of these four functions is illustrated in Figure 5.1.

Figure 5.1 Functions of the Health System

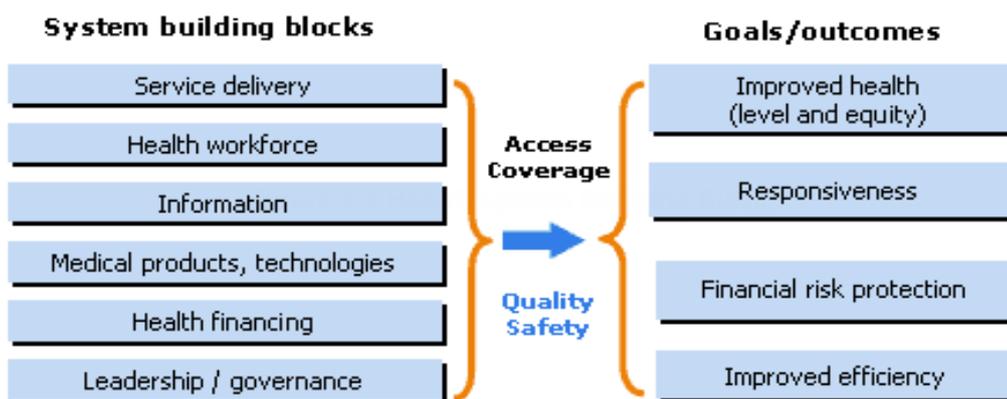


Source: Adapted from WHO (2001)

The Government has the responsibility of providing stewardship for the sector by developing, implementing and enforcing policies that affect functioning of the whole health system. Health financing is a key determinant of health system performance because it directly affects equity, efficiency and quality of health services. Health financing refers to “the methods used to mobilize the resources that support basic (public) health programmes, provide access to basic health services and configure health service delivery systems” (Schieber and Akikiom, 1997). The third group of functions of the health system is recruitment, training, deployment and retention of qualified human resources as well as procurement, allocation and distribution of essential medicines and supplies. It also includes investment in physical health infrastructure including facilities and equipment. These three functions combine into ‘service delivery’. However, some the determinants of health status lie outside the health care system. These include factors such as state of the economy, level of education of individuals and infrastructure such as all weather roads. Therefore, the health care system is dependent on a multiplicity of factors most of which lie outside the system itself.

Reproductive health addresses reproductive processes, functions and systems at all stages of life. This implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability of reproducing and the freedom to decide if, when and how often to do so.

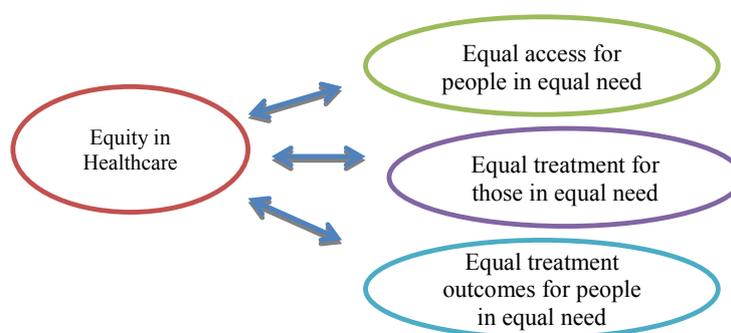
By definition, a system is made up of interrelated parts that interact with each other. As such, no single indicator or group of indicators, easily capture health system performance. Nevertheless a simple model, such as the WHO health system building block in Figure 5.2, can be used to examine the health system, allowing diagnosis of its performance by identifying system strengths and weaknesses (Islam, 2007).



Source: Adapted from WHO (2000).

The goal/outcomes of the health system — improved health status and equity; responsiveness; financial risk protection; and improved efficiency — can be used to gauge overall health system performance. Improved health levels begin with access to health-producing interventions inside and outside the health sector. Access to health care can be defined as “the ability to secure a specified range of services at a specified level of quality, subject to a specified maximum level of personal inconvenience and costs, whilst in the possession of a specified level of information (Goddard and Smith, 2001). Equity in health care can be framed in terms of horizontal and vertical (Culyer, 2001), with Figure 5.3 presenting a conceptual framework for the same. An equitable health care policy should seek to reduce inequality in health (life expectation, self-reported morbidity, quality of life in terms of personal and social functioning) at every stage of the life cycle.

Figure 5.3 Conceptual Framework for equity in healthcare



Source: Boeckxstaens et al. (2011).

The chapter reviews the health system with special reference to reproductive health using the six building blocks framework. Key policy documents used in this analysis are Kenya national policy documents and sector strategic plans. To determine performance, a couple of surveys have been reviewed, including the Kenya Demographic and Health Survey (KDHS), Kenya Service Provision Assessment (KSPA) and relevant published research papers. The period under review is the last 10 years.

5.2 Policy Background

It is widely accepted that health is a key component to good development, a claim validated by policy and research (Suanders, 2004). Poor health slows down economic growth directly as societies lose potential workers and consumers to disease and disability. In Kenya, the Vision 2030 development blueprint recognizes the role of health in development. Its overall vision is to *“create a globally competitive and prosperous nation with a high quality of life by 2030 that aims to transform Kenya into a newly industrializing, middle-income country providing a high quality of life to all its citizens by 2030 in a clean and secure environment”* (Republic of Kenya, 2008). The Vision is based on three key pillars; economic, social and political, with the health sector falling under the social pillar. Vision 2030 has three main objectives for the health sector: 1) Revitalize the health care infrastructure; 2) Strengthen health care service delivery; and 3) Develop equitable health care financing mechanisms.

Recent health policy reforms can be traced to the Kenya Health Policy Framework (KHPF) of 1994-2010, whose strategic theme was ‘investing in health’ (Ministry of Health (MoH), 1994).

The Kenya Health Policy Framework’s six strategic imperatives:

1. Ensure equitable allocation of Government resources to reduce disparities in health status
2. Increase the cost effectiveness and cost efficiency of resource allocation and use
3. Continue to manage population growth
4. Enhance regulatory role of the Government in all aspects of health care provision
5. Create an enabling environment for increased private sector and community involvement in health service provision and finance
6. Increase and diversify per capita financial flows to the health sector

With an overall goal of restructuring the health sector to make it more effective, affordable and accessible, KHPF was expected to guide the country towards maximizing its health stock. Besides its strategic theme of ‘investing in health’, its overall stated goal was *‘to promote and improve the health of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable.’*

The goal was to be achieved through six strategic imperatives that were operationalized in the first and second National Health Strategic Plans (NHSSP) I of 1999-2004 (MoH, 1999) and II of 2005–2012 (MoH, 2005). A Health Ministry evaluation of KHPF concluded that *“(F)or the most part of the period of the health policy, there was little impact on overall health in general terms”*(MOPHS, 2011).

Based on the Vision 2030, ‘Comprehensive National Health Policy Framework 2011–2030’ has been developed and its goals include 16 percent improvement in life expectancy at birth, from the current 60 years; 50 percent reduction in deaths, from the current 11 deaths per 1,000 persons; and 25 percent reduction in ill health (years lived with disability) from the current 12 years. Of significance for reproductive health is that the policy is based on two obligations of health: the human rights based approach, and health contribution to development.

The current national reproductive health policy, *Enhancing Reproductive Health Status for All Kenyans*, has the following goals: increasing equitable access to reproductive health services; improving the quality, efficiency, and effectiveness of service delivery at all levels; and improving responsiveness to client needs (MoH, 2007). Reproductive health is deemed an essential priority in the KEPH system, with the minimum package for sexual and reproductive health and rights being defined as: essential antenatal

and obstetric care; family planning; adolescent reproductive health; and gender-based violence issues. Out of 363 interventions listed in the KEPH, 104 — about 29 percent — are on reproductive health.

5.3 Reproductive Health Delivery System

As in many other developing countries, reproductive health (RH) services in Kenya are delivered through a multi-sectoral approach involving many implementing partners coordinated and supervised by the Division of Reproductive Health in the Ministry of Public Health and Sanitation (MOH, 2007). There are two major RH delivery mechanisms and these are the clinic based systems and non-clinic based delivery systems (which include the community based delivery arrangements) (Miller et al., 1998). The major provider of RH services in Kenya is the Government through the Ministry of Public Health and Sanitation: for example, in 2008-2009, more than half of the current family planning (FP) users (57%) obtained their methods from public facilities, with 36 percent being supplied by private facilities while six percent obtained supplies from other sources, such as shops (KNBS et al, 2010). Nearly all the 3,807 public health facilities (hospitals, health centres and dispensaries) which are distributed across the country offer FP/RH services (NCPD et al, 2005, 2010).



A view of the Kenya Medical Supplies Agency headquarters in Nairobi.

Photo: www.businessdailyafrica.com



A view of the Casualty Department of the Kenyatta National Hospital, which is the largest referral hospital in East and Central Africa.

Photo: Photo: www.businessdailyafrica.com

The public health facilities are organized in a pyramidal structure. At the peak of the hierarchy are the two national referral and teaching hospitals (Kenyatta National Hospital and Moi Teaching and Referral Hospital), distinguished in the KEPH framework as Level 6 facilities. The national referral hospitals provide sophisticated diagnostic, therapeutic and rehabilitative services. The equivalent private referral hospitals are the Nairobi Hospital, Karen Hospital and the Aga Khan University Hospital in Nairobi. In the next level are the provincial general hospitals (level 5) to which patients are referred by district hospitals (level 4) in the KEPH framework. The provincial hospitals also provide specialized care and act as intermediaries between national and district levels. The district hospitals coordinate and supervise implementation of the health policy — including FP and RH policies and guidelines – at the district level. They also maintain quality standards as well as coordinate and control all district health activities (NCPD et al, 2005). The district hospitals provide health services at the district level and act as referrals for the health centres (level 3) and dispensaries (level 2). Finally, at the bottom of the KEPH pyramid is Level 1, the household and community which is the focus of all preventive and promotive health care interventions, such as behaviour change campaigns.

a) **Clinic based delivery of FP& RH services**

This is the traditional approach in which FP and other RH services are offered in health facilities (clinics) by trained service providers. Clinic-based programmes offer the widest range of contraceptive methods

including those that can only be administered by clinical personnel (male and female sterilization; intra-uterine devices (IUDs) implants; and injectables), as well as the non-clinical methods (the pill; condoms; spermicides; and diaphragms) (Miller et al, 1998).

In this delivery system the personnel serving the public facilities have received extensive clinical training as medical doctors, nurses and in some cases midwives. Consequently, they are capable of doing clinical examinations in the course of providing FP/RH services. In addition to their training as health professionals, they have also been trained specifically on FP/RH. They also receive in-service training to upgrade their knowledge and skills as often as necessary, in order to keep them abreast of new advances in contraceptive technology and new procedures. Generally, these clinicians will have basic gynaecological equipment, such as FP kits; and in urban areas, they will usually have access to laboratory facilities (either on the premises or nearby) (Miller et al, 1998). The focus of this is to provide a wide range of permanent and temporary FP methods.

During the country's second National Development Plan 1970/1974, the Government decided to establish an integrated mother and child health (MCH)/FP programme launched in 1975. This was followed by the establishment of a comprehensive Integrated Rural Health and Family Planning Program (IRH/FP) which aimed at promoting more cooperation with the non-Governmental organizations (NGOs) and introducing new innovative strategies, such as Primary Health Care (PHC), and demand creation. This shift in policy and strategy led to the establishment of the National Council for Population and Development (NCPD), with members drawn from the public and private sectors as well as civil society and religious organizations. The Council was mandated to coordinate the implementation of the multi-sector FP initiative, and to formulate population policies, mobilise resources and coordinate donor support for the population programme (Vice President's Office and Ministry of Home Affairs, 1994).



A woman is served by a nurse inserting an injectable family planning method, which is one of the popular contraceptives among women in Kenya.

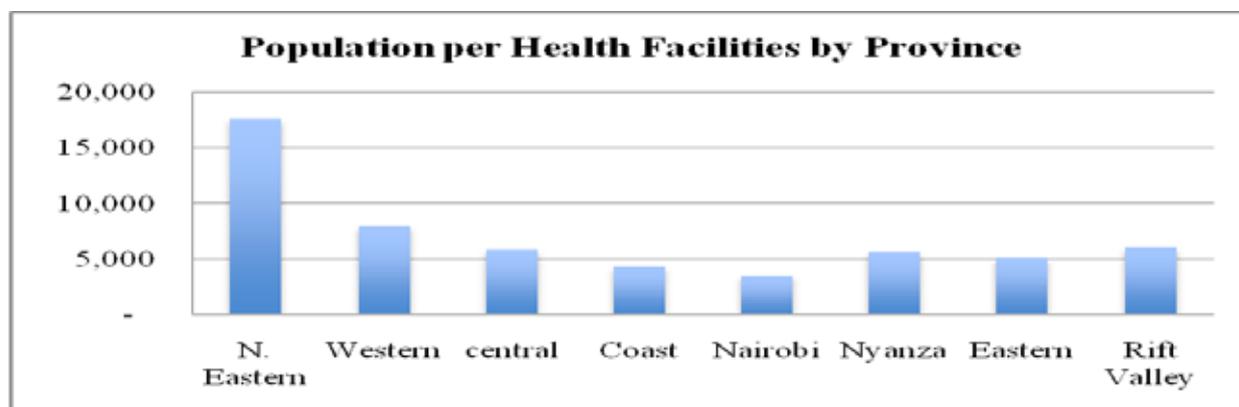


A sampling of family planning methods.

Since the 1970s, FP services have been provided as part of the MCH/FP programme in most of the public health facilities, as well as in a few private and faith-based health facilities throughout the country. The number of facilities have been expanded and upgraded in order to increase supply of FP and RH services to those who need them. For example, in 2004, there were 4,742 registered health facilities in the country (NCPD et al, 2005). The number has increased to slightly over 8,326 registered health facilities in the country in 2012²⁰. In 2010, 85 percent of all health facilities in the country offered some type of temporary modern FP methods, including counseling services; 95 percent of the public health facilities and 84 of the private, and 44 percent of the faith based facilities were offering modern FP services (NCPD et al., 2011). Public health facilities supply about one-quarter of all modern methods to current users, including a large proportion of long term methods, such as female sterilization, implants, and injectables (KNBS et al., 2010). Almost a third of women who are sterilized obtained the procedure at a private facility, especially mission facilities, private hospitals and clinics (KNBS et al., 2010).

Figure 5.4 shows the distribution of the health facilities by province/region, and the population being served. It is evident that North Eastern has the lowest density of health facilities, followed by Western, Rift Valley and Nyanza provinces in that order. Nairobi and Coast provinces have the highest density of health facilities in the country.

Figure 5.4 The ratio of health facilities to population by province, 2010



Source: Luoma et al 2010

However, despite the expansion in the number of health facilities that provide FP/RH services in the country, there are still a number of challenges including:

- Inadequate access to FP/RH services. About 75 percent of all the facilities in the country offer FP/RH services; but these are not evenly distributed with high concentrations in urban areas;
- Very few health facilities offer youth-friendly FP/RH services, meaning the clinic based delivery system leaves out substantial groups of adolescents and the youth;
- The lower level health facilities usually do not provide permanent FP methods, such as female and male sterilization, implants and IUD. Yet these are the facilities preferred by the majority for being near;
- Frequent problem of contraceptive stock out in health facilities;
- Majority of the health facilities in the country (75%) do not have the necessary facilities for quality counseling on FP methods;
- A low percentage of the facilities (34%) provide routine staff training on FP/RH; and
- Long waiting hours is a common feature of the lower level public health facilities.

²⁰ See www.e-health.or.ke/facilities

b) The Community Based Delivery (CBD)

Community Based Delivery (CBD) programme refers to the non-clinic based delivery approaches that use community based organization (CBOs), structures and institutions to promote the use of safe and simple FP methods, such as oral pills, foam tablets and male condoms (Philips et al., 1999; Lewis et al., 1992). CBD programmes providing FP services and information were started in the 1950s in rural areas to complement clinic-based services (Foreit and Haifman, 2011). Due to the need to expand access to FP services, and relying on the success stories of CBD programmes in Asia (Indonesia, Taiwan, Thailand and Korea) and Zimbabwe, Kenya adopted the CBD strategy in the early 1980s (Lewis et al, 1992; Chege and Askew, 1997). As in other countries, the Kenyan CBD strategy was based on the premise that making contraceptives available at convenient locations would increase their acceptability and availability to those who live far from clinics, and those who may not have time to obtain them at the health facilities during the normal working hours. Also, it was assumed that enlisting community members as contraceptive service providers would reduce the social distance usually experienced between FP clients and medically trained providers (Lewis et al, 1992, Chege and Askew, 1997).

As in other developing countries, the CBD programs in Kenya were implemented through various models. They included home visits, fixed and mobile CBD posts, workplace based outlets, as well as one-on-one and group education meetings at which FP commodities were often distributed to continuing and new clients. The services most commonly offered through CBD include distribution of contraceptives (oral pills, foaming tablets and condoms), health education (such as FP, reproductive health and child health), provision of FP information, education and communication (IEC) materials and referrals for clinic-based services. Some of the first CBD programmes were integrated with existing health infrastructure and services were provided by incumbent health programme staff as a means of maintaining efficient service delivery (Philip et al, 1999; Chege and Askew, 1997; Pathfinder Fund International, 2005).

In the mid 1980s and early 1990s, the Kenyan CBD programme consisting of over 25 different initiatives, was considered strong (Philips et al., 1999). Assessments done on some CBD programmes in Kenya indicate that by and large, they led to an increase in FP use (Chege and Askew, 1997; Goldberg et al., 1989; Pathfinder Fund International, 2005). However, the CBD programmes in Kenya began to decline in the mid 1990s due to the declining funding for FP from development partners who shifted their priorities towards HIV and AIDS. The decline has been so dramatic that the 2008-2009 KDHS data indicated less than one percent of the current users of modern FP methods obtain their supplies/ services through the CBD system (KNBS et al., 2010).

b) Social Marketing of FP Services

The Social Marketing of FP/RH Services is another approach that seeks to increase access to, and availability of, FP commodities through market-based outlets, such as retail shops and supermarkets (UNAIDS, 2000). The prices of the commodities are usually subsidized and, therefore, controlled.

1. Social Marketing of Condoms

In Kenya, the social marketing of FP commodities started in late 1980s. In 1990, Population Services International (PSI) Kenya was founded to implement a general social marketing program to support Government efforts to increase access to, and use of, condoms and other products, such as the use of mosquito nets to prevent malaria.

With regard to the social marketing of condoms, the initiative involved creating an affordable brand, establishing a distribution system and generating demand through media campaigns. A key focus was

to increase accessibility in rural and urban outlets by getting more retail outlets to sell a packet of three *Trust* Condoms at ten (10) Kenya Shillings. The focus was also obviously on the reduction of HIV and STI incidences, the prevention of pregnancy and minimization of the embarrassment associated with condom purchase. The subsidized *Trust* Condoms are available in retail outlets across the country.

2. Clinic Social Franchising/Marketing

Clinic social franchising is being spearheaded by PSI through the TUNZA programme, a clinic-based social franchise which was launched in 2010 with the purpose of engaging private health providers and empowering low income Kenyan women to avoid unplanned pregnancies through access to high quality FP services (Tunza Health Network/PSI/Kenya, 2010).

The Tunza programme engaged private health providers to offer high quality FP and other RH services. Tunza clinics provide FP services with an emphasis on the long-term reversible methods, such as the IUD and sub-dermal implants. PSI Kenya provides the FP commodities at highly subsidized prices to the providers who are then required to offer affordable and quality services to their clients. These providers have established a network called Tunza Family Health Network, which is composed of 261 private health practitioners in Kenya as of 2012.

5.4 Financing of FP/ RH Services

In Kenya, the FP/RH services within the health system are financed through a mix of public, private, and donor resources. The public funding is through budget allocations to the Ministry of Public Health and Sanitation and Ministry of Medical Services²¹.

a) Government Funding

Before 2008, there was only one ministry responsible for health in Kenya. Table 5.1 shows the Ministry of Health's (MoH) budget allocations during the financial years (FY) 2003/2004 to FY 2007/2008 period. It is evident from the table that total health budget increased during this period, but the MoH share of Government spending has fluctuated. Since the financial year 2003/2004, MoH's share has been less than half of the recommended Abuja Declaration's goal of ring-fencing 15 percent of all public spending for health²², never rising above 10 percent share of total public spending. This failure over the Abuja commitment underscores the political weakness of the (Kenyan) health sector's lobby in capturing public resources (Cieza and Holma, 2009).

Similarly, the rate of per capita spending falls far below WHO's recommended rate of US\$34 per person in 2007. Although Kenya's per capita spending rose between financial years 2005/2006 and 2007/2008, it remained only 40 percent of WHO's recommended rate. Recurrent expenditures have captured the largest share of the health budget, although that share has decreased throughout the financial year 2003/2004 to 2007/2008 period, falling from a high of 94 percent of the budget in financial year 2003/2004 to a low of 70 percent in financial year 2007/2008.

²¹ From May 2013, the two ministries have been re-merged into a single Ministry of Health in line with the Constitution's objective of minimizing Government ministries.

²² See http://www.who.int/tb/features_archive/commission_for_africa/en/index2.html

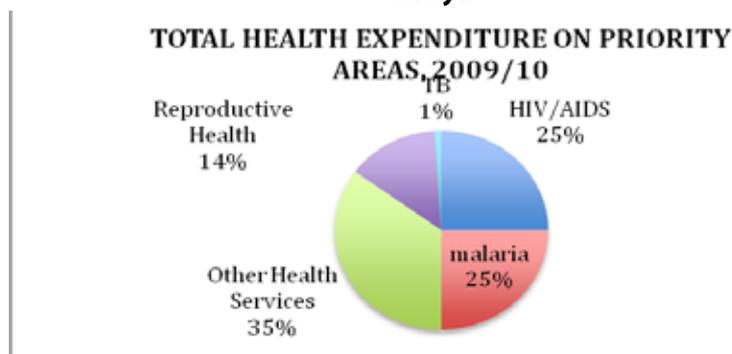
Table 5.1 Trends in Kenya's Health Budget, Financial Year 2003/2004 to 2007/2008

Item	2003/04	2004/05	2005/06	2006/07	2007/08
Total Gross Health Budget (Constant 2007/2008 US \$Million)	317	332	385	437	543
MOH Health Share of GOK Budget (%)	7	6.1	5.7	7,6	6.4
MOH Health Expenditure per capita (Constant 2007/2008 US\$)	9.4	9.6	10.8	11.9	15.6
Preventive/Promotive Health (FP/RH)	5	9	8	10	20
Recurrent Expenditure's share of the Health Budget (percent)	94	91	86	78	70

Source: Cieza and Holm (2010)

In 2008, the MoH was split into two ministries, namely Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MoPHS). In 2008/2009 the Government allocated 6.7 percent of the national budget to the combined ministries of health, which rose in financial year 2009/2010 to a seven percent share (Kshs39.9 billion), equivalent to 1.7 percent of the Gross Domestic Product (GDP). MOMS took 59.5 percent of the allocation while MoPHS took 40.5 percent. Within MoPHS, only 12.7 percent was allocated to Preventive and Promotive Health Care (which includes FP/RH) (Cieza and Holm, 2009). As shown in the Figure 5.5, RH accounted only for 14 percent of the total health expenditure on priority areas.

Figure 5.5 Percentage distribution of total health expenditure according to priority areas, Kenya



Source: Cieza and Holm (2009) Donor Funding

Development partners (donors) have been supporting FP/RH since independence. Historically, the development partners have provided funds for procurement of all contraceptive commodities in Kenya and supported the CBD programmes in the country. For instance, the financial year 2009/2010 Printed Estimates show that MoMS and MoPHS combined were to receive Kshs 7.1 billion from development partners, with each respectively getting Kshs 3.8 billion and Kshs 3.2. The MOPHS share supported the upgrading and strengthening of rural health centres and dispensaries as well as environmental, FP and maternal and child care programmes (MoMS and MoPHS, 2010; Cieza and Holm, 2009).

The majority of FP/RH costs are borne by the Government and donors. Donors fund nearly all the procurement costs of all contraceptive commodities except condoms, including all contraceptives provided by NGOs. However, 75 to 80 percent of the total FP service delivery-related costs are met

by the Government through provision of personnel, facilities and other infrastructure and support activities (Policy Project, 2005). In the recent past, the Government has increased its financial obligation to FP through an inclusion of a specific budget item in the annual budget.

b) Cost-sharing

As part of the response to declining public sector resources since the 1980s, the Government has been implementing a “cost-sharing” programme in the health sector, under which fees are charged to service recipients to cover part of the costs. In its new National Condom Policy and Strategy (RoK/NACC, 2001), for instance, the Government has made the long-term commitment to gradually introduce fees for all public sector health services, including FP, in an effort to shore up the health system and expand access (MoH, 2001). At the same time, the Government is committed to the effective application of a system of waivers and exemptions from fees for poor clients and other designated groups (e.g., youth, persons living with HIV and AIDS)²³.

According to the MOH fee guidelines, MCH/FP and antenatal and postnatal services are to be provided for free. In practice, however, the District Health Management Boards (DHMBs) have directed public health facilities to put in place an “access fee” for FP/RH services. However, these charges are very modest, usually about Ksh 20 for all the services provided.

The 2008-2009 KDHS established that about 20 percent of women using a modern contraceptive method received the method free of charge. The 2008-2009 KDHS data also showed that 28 percent of the women who obtained their contraceptive methods from the public sector (Government health facilities) did not pay for the service. This figure compares with eight percent who obtained their methods in the private sector (KNBS et al, 2010).

c) Results/Output-based Financing (RBF) Programmes

Results Based Financing (RFB) is a ‘strategy for using explicit results or performance based subsidies to support the delivery of basic services where policy concerns would justify public funding to complement or replace user-fees (GPOBA, 2009). In RH, the results or output based financing programmes aim to address hurdles on both the supply and demand sides of factors affecting the use of FP and other RH services by incentivizing provision of a variety of quality services, while removing barriers to access for women in need of those services. Incentives in RBF programmes can come in a variety of forms like subsidies or fees paid to clinics and vouchers sold to women (Morgan, 2012).

In Kenya, the RBF programme was started in 2005 when the Government and the Federal Republic of Germany (through the KfW banking group) entered into an agreement to fund a safe motherhood, FP, and gender violence recovery using a voucher system²⁴. The MoPHS-led project was initially implemented on a pilot bases for three years and targeted economically disadvantaged people in three rural districts (Kisumu, Kiambu and Kitui), as well as two urban slums in Nairobi (Korogocho and Viwandani). In 2012, however, it was scaled up to include Uasin Gishu District.

In Kenya, utilization of assisted deliveries and FP increased at contracted clinics after the voucher programme was implemented. Between 2006 and 2011, 96,000 deliveries were performed in the contracted clinics and 27,000 long-term FP users were serviced at the same clinics (Morgan, 2012; KfW, 2012).

²³ A **waiver** is a release from payment based on financial hardship and is not automatic. Clients must request waivers and a judgment is made to determine the deserving cases. An **exemption** is an automatic excuse from payment based on MOH conditions.

²⁴ See www.output-based-aid.net/e012

In summary, Government furnishes the bulk of FP commodity acquisition and offers such commodities to both public and non-public providers. In addition, social marketers, such as PSI, also provide some commodity supply to non-public providers. This arrangement has grown from the inability of Government to mobilize enough timely financial resources to fund procurement of commodities, even though the relevant Government coordinating mechanisms to ensure availability of RH commodities have been set up. Part of the budgetary gap is supplemented by other agencies such as UNFPA, USAID, World Bank, DFID and KfW (MoPHS and MoMS, 2012).

From an equity perspective, inadequate public contraceptive commodity security exacerbates the high regional and socio economic disparities in FP/RH access²⁵. Low participation of the private sector in FP service delivery also provides additional challenges. The proposed National Social Health Insurance Fund (NSHIF) scheme is meant to finance curative and rehabilitative services, thus leaving the Government health system to concentrate on prevention, research and policy (Republic of Kenya, 2008). However, this shift has implications: health insurance is traditionally better at paying for curative care than preventive services. The private sector is also better at accessing insurance funds compared to public sector. A shift of financing has potential to reduce funding to public sector and in turn worsen commodity security (see Table 5.1 in the appendix to this chapter)

5.5 Health Workforce

Quality service delivery depends on having sufficient numbers of well-trained health workers providing services in all health facilities. Kenya has a relatively high number of health workers as compared to other countries in the sub-Saharan Africa region, with a rate of 1.69 health workers per 1,000 populations (Louma et al., 2010). However, there are shortages of some critical health workers, especially when the distribution of workers by urban/rural areas, regions and level of care, is taken into account (Louma et al., 2010). Table 5.5 below provides a breakdown of health workers by type in 2009. The total number of registered medical personnel increased by 4.7 percent from 76,883 in 2008 to 80,464 in 2009 (see Table 5.2).

Table 5.2 Number of registered medical personnel and personnel in training, 2008 and 2009

	2008	2008	2009	2009
Type of personnel	No.	No. per 100,000 population	No.	No. per 100,000 population
Doctors	6,693	17	6,897	17
Dentists	974	3	1,004	3
Pharmacists	2,860	7	2,921	7
Pharmaceutical Technologists	1,815	5	1,950	5
B.Sc. Nurses	657	2	778	2
Registered Nurses	14,073	37	15,948	40
Enrolled Nurses	31,817	83	31,917	81
Clinical Officers	5,035	13	5,888	15
Public Health officers	6,960	18	7,192	18
Public Health Technician	5,969	16	5,969	15
Total	76,883		80,464	

Source: NACPD et al 2010.

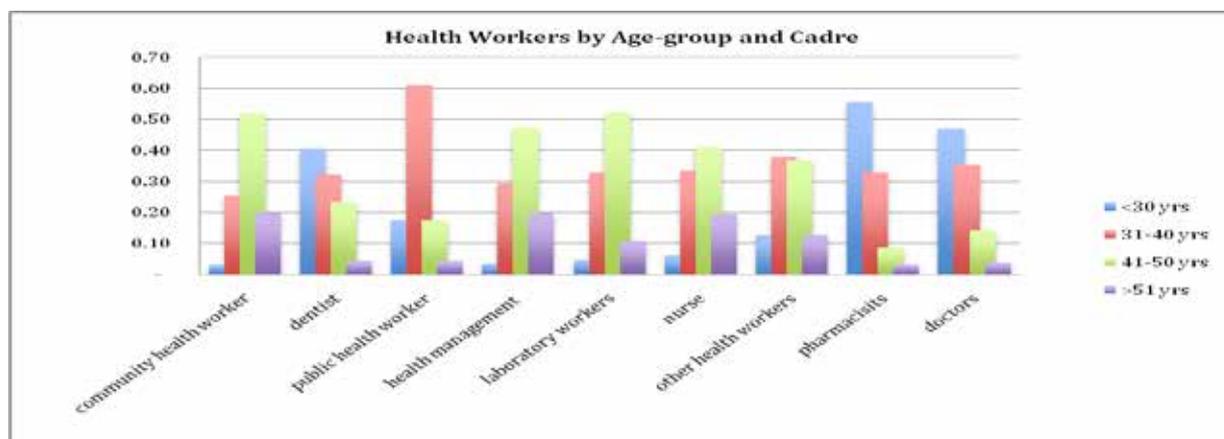
Other than the total and newly trained numbers, key factors in human resources are the distribution and attrition rate of all health workers. The geographical distribution is reflected in the distribution of

²⁵ Regional Disparity: for example; CPR in Central region is 63 percent while in North Eastern it is only 4 percent. (RH commodity strategy 2013-2017)

health facilities across the country. Distribution by facility ownership shows that most health workers are found in the non-Government sector. Certain cadres are hardly found in the public sector. For example only 25 percent of doctors are found in the public sector while for pharmacists and pharmaceutical technologists, it is just 13 percent.

Health workers attrition rates from 2004 to 2005 were similar across type of health facility, with provincial general hospitals losing on average four percent of their health workers, compared to three percent for district hospitals and five percent for health centres (Louma et al., 2010). However, there are differences in the patterns of attrition rates by cadre. Attrition among doctors and registered nurses was much higher at the provincial hospitals than at district hospitals or health centres, whereas the opposite pattern was observed for laboratory and pharmacy staff (lost at a higher rate in lower-level facilities). The major causes of attrition are death and resignation. Figure 5.6 illustrates the age-structure of health personnel, and shows that we can expect the attrition rate for nurses, health managers and community health workers to accelerate in the coming years as they have a significant portion aged above 51 years.

Figure 5.6: Health Workers by Age-group and Cadre



Source: Louma et al, 2010

5.6 Migration of Health Workers

The migration of health-care workers has closely followed general trends in international migration. However, health workers likely fall into a special category because many possess sets of skills and competencies that are so specialized or in such short supply, that they are being sourced globally (Stilwell et al., 2004). Loss of skilled health professionals from care systems in poorer countries weakens the countries supply of care considerably. Against the immediate shortages resulting from staff flight, the long lead times required for training to qualify for many specialized roles in health services can mean that the loss of even small numbers of health professionals cannot be compensated for in a short time. The total cost of educating a single medical doctor from primary school to university is US\$65,997; and for every doctor who emigrates, Kenya loses about US\$517,931 worth of returns from investment in their education (Kirigia et al., 2006). The corresponding figures for a nurse are US\$43,180 and US\$338,868 respectively.

However, a possible *silver lining* is the economic slow down of developed country economies. An analysis by 'The Economist' finds that over the ten years to 2010, six of the world's ten fastest-growing economies were in sub-Saharan Africa. The IMF forecasts that Africa will occupy seven of the top ten places in terms of economic growth over the next five years to 2018²⁶. In addition, rationalization of

26 Africa's impressive growth: http://www.economist.com/blogs/dailychart/2011/01/daily_chart, [accessed 20th February 2013]

medical staff following the new Government's re- structuring may reduce existing geographical staffing disparities.

5.7 Health Information

Reliable and timely health information is an essential foundation of public health action and health systems strengthening (Aqil et al, 2009). Kenya has relatively good data on health service delivery. The Health Management Information System (HMIS) monitors health care use. At community and household levels, community health workers collect some data on the basis of the community health strategy (Otieno et al., 2012). While data is collected from the facility level up to the district level, collation and analysis is still relatively poor partially because collection is poor. A study in two rural district hospitals in western Kenya found that data for the number of antenatal consultations and the use of human immunodeficiency virus drugs were at least 50 percent incomplete for both facilities (Chiba et al., 2012). In addition data categories in the registers did not correspond well with those of monthly reports.

While an online open source district health information system (DHIS) database was launched in 2012, it is still relatively unused. Reports derived from facility HMIS is often incomplete and inaccurate. However, statistics at the national level report total annual outpatient visits of about 20 million, which measured against the national population of over 40 million, indicates use of health services is still low at about 0.5 per person per year²⁷.

There are regular surveys — Demographic Health Surveys, Service Provision Assessments, Client Satisfaction Surveys, Household Health Expenditure Surveys, amongst others — that feed into the health sector's Annual Operational Plans and reviews especially at national level.

Two indicators that are used to gauge health system performance are; FP gauged by modern contraceptive prevalence rate and RH reflected in the unmet need for family planning. Between KDHS 2003 and that 2008-2009, use of contraception rose from 39 percent to 46 percent (KNBS and ICF Macro, 2010).

Among recent improvements in the country's health information systems has been the development of the Master Facility List (MFL), which aims to identify every health facility in the country using a unique identifier code. For each facility, the list provides information on the GIS coordinates of facility level (1 through 6), services offered, facility ownership, and location²⁸. Gradual reforms outlined in the two Health Sector Strategic Plans, District Health Management Boards and District Health Management Teams (DHMTs) have allowed MFL to take on responsibilities for facility-level data operations within their districts (Ndavi et al., 2009). Despite these efforts to improve on data needed for decision-making and planning, actual use of such data remains relatively weak.

5.8 Unmet Need For Family Planning

The 1994 ICPD deemed access to safe and effective contraceptive methods a fundamental human right. Women with unmet FP need are defined as those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child. Unmet need for FP among married women in Kenya has remained high and unchanged since 2003. For married women in 2008, unmet need was evenly split between women who want to wait two or more years before having their next child (spacers), and those who want no more children (limiters).

²⁷ The minimum demand should be 1 visit per person per annum, while an adequate demand should be 1.9 per person per annum

²⁸ <http://www.ehealth.or.ke/facilities/downloads.aspx>

Table 5.7 Unmet need for FP in Kenya 1998-2008

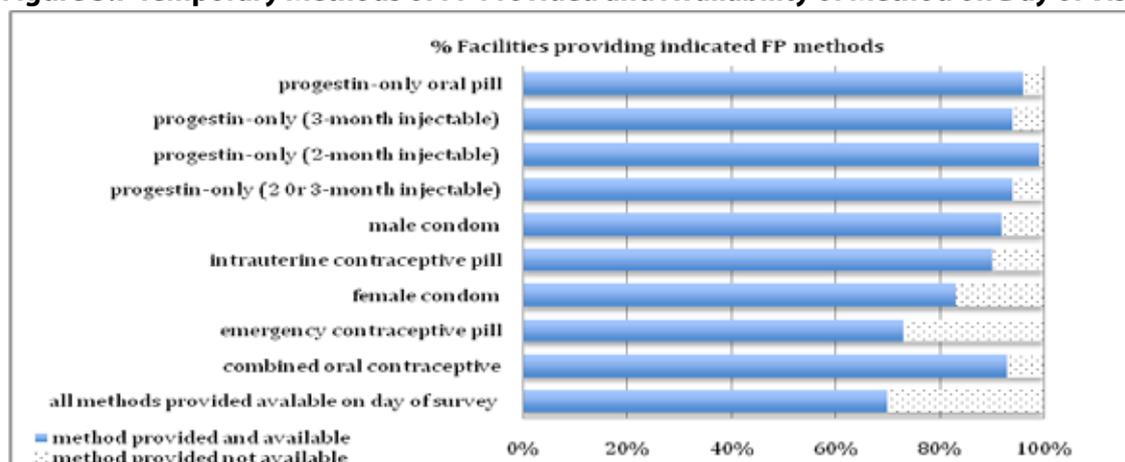
Year	Category of Women	% Women		
		Limiting	Spacing	Total
1998	Married women	9.9	14.0	23.9
2003	Married women	10.1	14.4	24.5
	Unmarried women	0.8	1.9	2.7
	All women	6.4	9.4	15.8
2008	Married women	12.8	12.8	25.6
	Unmarried women	0.9	2.2	3.2
	All women	7.8	8.4	16.3

Sources: KDHS (998, 2003, 2008/9)

As a result of this high unmet FP need, more than one million unplanned pregnancies occur in Kenya every year (NACPD et al., 2010). Unmet FP need has stagnated at about 24 percent with the poorer women being more disadvantaged (Republic of Kenya, 2012). This has been largely due to inadequate service provision and poor access to FP commodities and the lack of support for contraceptive security. The national reproductive health policy cites possible factors contributing to the stagnation as: wide regional and socio-economic disparities in CPR²⁹; lack of security for contraceptive commodities; lack of sustained demand creation for FP services; relatively low community and private sector participation in FP service provision, and low involvement of males; method mix that does not permit wide method choice and cost-effectiveness; inadequate FP training for service providers; and low level of integration of FP with HIV and AIDS services.

In terms of demand creation, the contraceptive knowledge in Kenya is universal at 97 percent. There is no notable variation in knowledge of husbands or partners of the use of FP methods by age or residence. However, knowledge does increase gradually with the education and wealth quintile of the woman. Less than twenty percent of the spouses believe that contraception is women’s business only, while 4 in 10 men believe that women who use FP may become promiscuous. The 2008/2009 KDHS reports that 80 percent of non-users of FP have recently discussed about contraception with a health worker. Facility-wise, the 2010 KSPA shows that 85 percent of all health care facilities provide modern FP methods; but just nine percent of all facilities offer female sterilization, according to the 2010 KSPA survey.

Figure 5.7 Temporary Methods of FP Provided and Availability of Method on Day of Visit

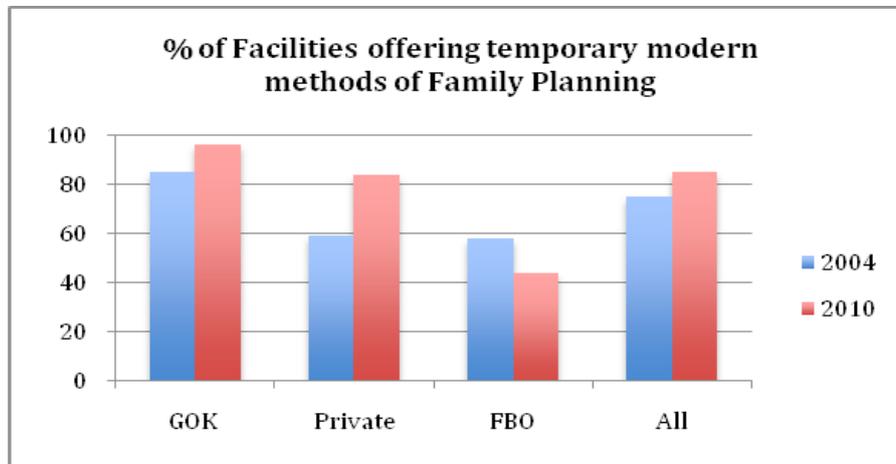


Source: NACPD et al 2010

²⁹ For example, CPR in Central region is 63 percent while in North Eastern it is only 4 percent.

The majority of facilities offer these services on five or more days per week, but there is significant difference geographically. Fewer facilities in North Eastern province (67%) and Nairobi province (68%) were likely to offer modern FP methods compared to over 90 percent of all facilities in Western, Nyanza and Rift Valley provinces. In addition there is some difference in by facility managing authority.

Figure 5.8 Percent of Facilities offering temporary modern methods of FP by Managing Authority



Source: NCAPD et al 2010

KSPA 2010 showed that accessibility was not a major deterrent to use as 15 percent of respondents said the facility they attended was not the nearest to their residence. Reputation and cost were the main reasons why they did not visit the nearest facility to them for FP services. In terms of quality of services, a quarter of the clients reported waiting time to see a provider as a major problem. However, the lack of contraceptive methods and medicines was not a major concern. Regular supportive supervision is important in ensuring the quality of services, with at least 81 percent of facilities offering FP reporting having had a supervisory visit in the preceding six months. Cost wise, 70 percent of the clients reported paying some user fee, with a median payment of Kshs30³⁰. Three quarters of the facilities charge some user fee mainly for laboratory tests which may act as a barrier given high poverty levels.

The RH commodity strategy of 2012-2017 indicates that method mix is not expected to change significantly between 2011 and 2017. Female condom is expected to contribute 0.5 percent of methods used in 2017 up from zero in 2011. Pills are expected to decline by 0.1 percent from 16.6 percent in 2011 to 16.5 percent in 2017, and vasectomy by 0.3 percent to zero in 2017.

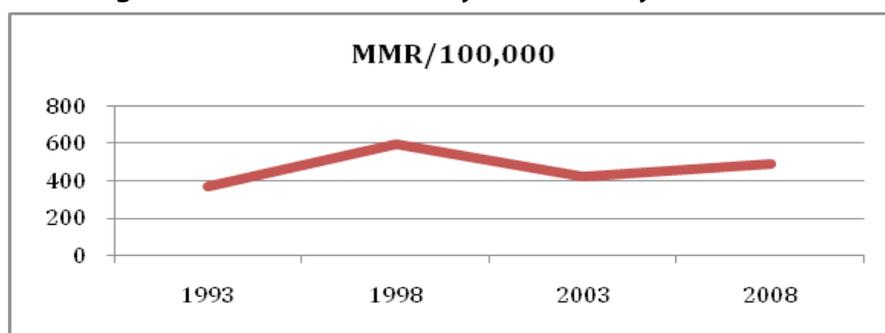
The National Reproductive Health Policy (2007) recognizes that continued unmet RH need among HIV infected persons remains a challenge. Slightly over half of women who are HIV positive have unmet FP need.

5.9 Emergency Obstetric Care

Complications of pregnancy and childbirth are among the leading causes of morbidity and mortality among Kenyan women. Recent estimates suggest that there are 488 maternal deaths per 100,000 live births (KNBS and ICF Macro, 2010). Over the past 20 years there has been no change in the maternal mortality figures with actual number of deaths increasing due to increasing population (Figure 5.9).

³⁰ One US dollar approximately 85 Kenya shillings

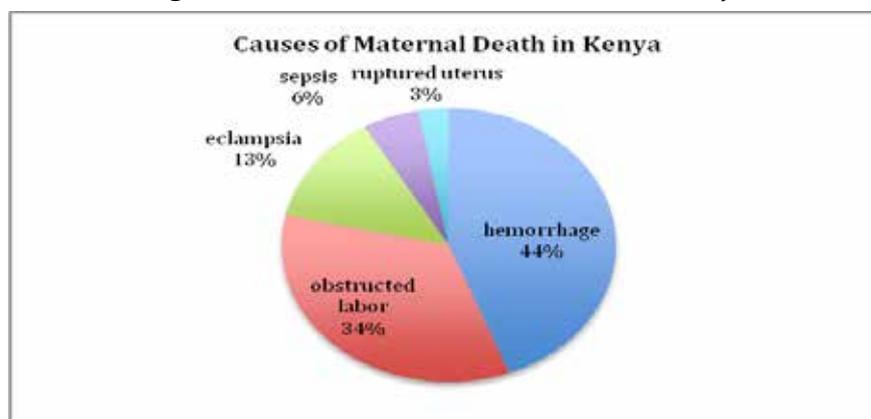
Figure 5.9 Maternal Mortality Ratio in Kenya 1993-2008



Source: KNBS and ICF Macro (2010).

However, significant geographical differences exist in maternal mortality. For example in 2009, the highest facility maternal mortality ratio³¹ was experienced in North Eastern Province (703 per 100,000 live births), followed by Coast Province (428 per 100,000 live births), while the lowest was in Central Province (122 per 100,000 live births). Overall, the leading five causes of maternal deaths are haemorrhage (44%), obstructed labour (34%), eclampsia (13%), sepsis (6%) and ruptured uterus (3%).

Figure 5.10 Causes of Maternal Death in Kenya



Source: KNBS and ICF Macro (2010).

In an effort to reduce maternal mortality, the policy on pregnancy and childbirth as outlined in NHSSP II requires that all women attend antenatal clinics during pregnancy and deliver under the care of a skilled birth attendant. During these visits, pregnant women are given care with emphasis on the woman's overall health, preparation for childbirth and readiness for complications. The aim of antenatal care is to achieve a good outcome for mother and the baby, and to prevent any complications that may occur in pregnancy, labour, delivery and post partum (MoH, 2007).

Emergency Obstetric Care (EmOC) refers to care provided in health facilities to manage and treat the direct obstetric emergencies that cause the vast majority of maternal deaths during pregnancy, labour, delivery and the postpartum period. Facilities are considered EmOC facilities if they provide a series of services or interventions known as 'signal functions' over a designated three-month period. The six signal functions include parenteral administration of antibiotics, oxytocic drugs and anticonvulsants, manual removal of the placenta, removal of retained products of conception and assisted vaginal delivery. Overall, only three percent of the facilities offering deliveries had performed all the six basic

³¹ Facility maternal mortality differs from the maternal mortality rates obtained from household surveys as indicated in the next chapter because of omissions of deaths.

signal functions three months prior to the KSPA 2010 survey.

Whereas the majority of health facilities offer antenatal care (Table 5.8), it is important to note that 79 percent of dispensaries and 17 percent of health centres do not offer normal delivery services. Hospitals remain the facilities best equipped to offer both normal delivery services across the country. Even then, Caesarean Section services are available in only half of Kenyan hospitals and just 30 percent of maternity designated facilities.

Table 5.8 Facilities Offering Maternal Health Services

Type of Facility	ANC	Normal Delivery Service	Caesarean
Hospital	94	95	52
Health Centre	99	83	1
Maternity	93	85	30
Clinic	41	4	0
Dispensary	84	21	0

Source: NCAPD et al 2010

Nairobi has the highest proportion of facilities capable of providing any Caesarean Section deliveries. All the other provinces range from three to six percent of the facilities being able to conduct Caesarean sections (see Table 5.9). Post-natal care is available in 59 percent of all facilities.

Table 5.9 Availability of Maternal Services

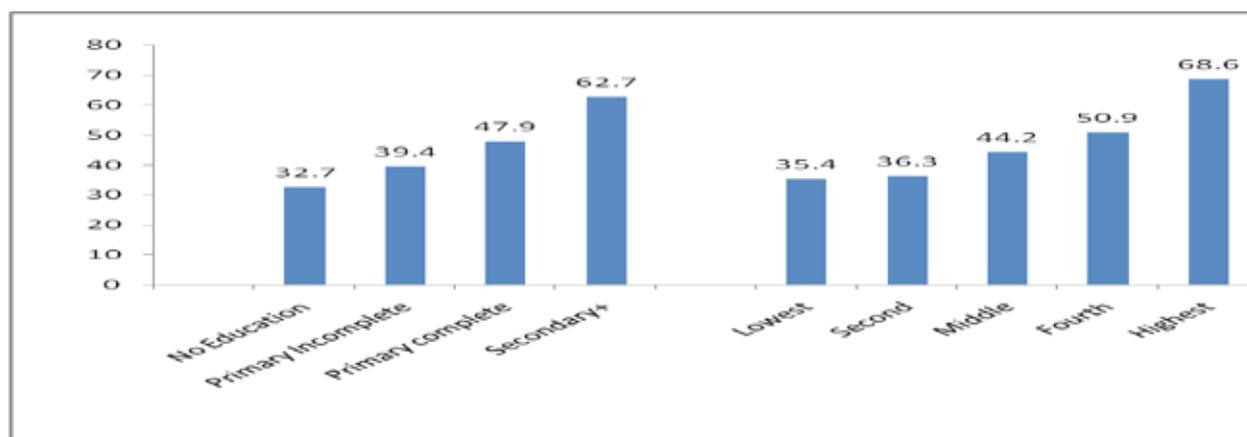
Province	ANC	Normal Delivery Service	Caesarean
Nairobi	79	32	13
Central	56	13	4
Coast	70	27	4
Eastern	71	30	3
North-eastern	69	44	4
Nyanza	94	52	5
Rift Valley	74	27	4
Western	94	47	6

Source: NCAPD et al 2010

According to the 2008-2009 KDHS, just 43 per-cent of births occurred in a health facility, a rate no different from the 40 percent rate of 2003. Women in North Eastern and Western provinces are least likely to deliver in a health facility (25% and less) compared to more than 70 percent in Central and Nairobi provinces. The most common reason women gave for delivering at home was that it was due to the long distance to the facility, or lack of transport. On average in 2008, 44 per-cent of the births were delivered with the assistance of a skilled provider, while traditional birth attendants delivered 28 percent of the mothers.

This low level of use of health facilities for delivery may be a reflection of the quality of service available. According to the KSPA 2010, only half of all delivery facilities had the items needed to handle common obstetric complications. These included medicines, syringes and needles, intravenous (IV) fluids and suture materials. Private and faith based organisation-managed facilities were more likely to have these supplies present. Post delivery, 53 percent of women do not receive any postnatal care, the share decreasing with increasing levels of education. Similarly, mothers in the lowest wealth quintile are twice as likely not to utilize postnatal care services as are women in the highest wealth quintile (Figure 5.11).

Figure 5.11 Percent of Patients Attending a Postnatal Check Up



Source: NCAPD et al 2010

5.10 Obstetric Fistula

Obstetric fistula is a problem in the developing countries, but is almost non-existent in the developed world. About 90 percent of all fistulas occur in Africa. WHO estimates that between 50,000-100,000 women are affected annually with a higher number being in sub-Saharan Africa and South Asia (Hinrichsen, 2004). In Kenya, it is estimated that 3,000 women develop fistula annually, and that there is a backlog of between 30-50,000 cases (MoH, 2004). Rural women are more likely to develop fistula due to less access to obstetric care, low socio-economic status, and early childbearing.

A high proportion of genito-urinary fistulas have an obstetric origin. Close to 80 percent of cases result from neglected prolonged obstructed labour (McFadden et al., 2011). This is compounded by inadequate availability of emergency obstetric care, poverty, malnutrition, low literacy, low socio-economic status, gender inequality, adolescent pregnancies as result of early marriages, lack of awareness and low access to family planning. The majority of them got the fistulas in their first pregnancy and at a young age of less than 30 years. When obstetric fistula occurs, there is an abnormal communication between the vagina and the bladder, or the rectum, or across all three openings. Vesico-vaginal fistulas (communication between the vagina and bladder) are more common than recto-vaginal (communication between rectum and the vagina) fistulas. Non-obstetric causes of fistula are due to lacerations and sexual trauma in times of war and civil strife. Most of the cases due to sexual trauma are not being reported. Though obstetric fistula is rare in developed countries, some of its causes include cervical cancer, radiation therapy and injuries sustained during surgery. The result is uncontrolled passage of urine or faeces from the bladder or rectum into the vagina. Patients often have serious physical, mental and social ill health as a result.

Kenya has about 10 trained fistula surgeons, of whom only four (one retired) are considered sufficiently expert to handle complicated cases and train others, with three of the experts being based in Nairobi. Kenya has only 22 facilities where fistula repair occurs, and compare poorly with other countries in the region (Figure 5.12).

Figure 5.12 A country comparison of number of facilities offering Fistula Repair



Source: <http://www.globalfistulamap.org/>

Obstetric fistula complications arise as a result of lack of access to quality healthcare system. Kenyan healthcare system still has major problems with providing access to care especially for those who are disadvantaged. Much of the investment in management of fistulas has come from a non-profit organization — AMREF. Consequently, obstetric fistula will not cease to be a public health problem until Government investment is elevated.

5.11 Challenges and opportunities, conclusions

The major challenges faced by the health system in delivery of sexual and reproductive health.

- Overall, there is a lack of investment in systems development. Government expenditure in healthcare has remained flat despite the growing economy and growing demand for health care. Meanwhile, donors generally do not provide for infrastructure or systems development as suggested by WHO, meaning that is an area which lags behind.
- Current national policy calls for social health insurance as the primary way of financing health care. However, there is still a lack of a substantive health financing strategy. While social health insurance has the potential to increase investment in healthcare, the downside is that it is complex and potentially can leave out the poor and informal sector.
- Weak accountability manifested by poor monitoring and evaluation systems means inefficient health service delivery.
- Inequity in service provision affects particularly the poor, the informal sector, and consequently, women and their reproductive health needs.
- Inadequate investment in logistical systems has resulted in a weak commodity supply chain.
- The county system offers potential to focus on the areas that most need investment. However, there will be significant challenges in devolving health policies and strategies in a decentralized possible fragmenting system of healthcare.

Appendix 5.1: The shift to SHI, what are the implications

Advantage	Disadvantage
Reduce the risk fragmentation and segmentation presented by multiple pools	National scheme complex and expensive to manage. It involves many different players, complex interactions, and complicated tasks. Therefore administrative costs are higher than in national health service schemes.
Easy and effective way to raise resources to improve health	Social health insurance can generate excess demand for health services, because the costs of the services are heavily subsidized (moral hazard)
Citizens may be more willing to pay their contributions because the destination of the money is visible, specific, and related to a vital need	Social security contributions may increase labour costs and, in turn, lead to higher unemployment
Systems financed through earmarked payroll taxes are less subject to yearly budgetary negotiations than funds coming from general taxation	Contributions alone may not generate sufficient resources, especially if policy makers wish to cover more of the population than those who have contributed through payroll contributions. Indeed, the unemployed, the retired, students, and the poor also need coverage
Social health insurance systems usually are highly redistributive, with cross-subsidies from rich to poor , from high-risk to low-risk participants	Poorer segments of the population (most informal sector workers, unemployed people) often excluded
	Difficult and expensive to add informal sector workers to the covered population

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LETTER OF INTENT

Private Sector Advisory Panel for Advancing Maternal and Newborn Health in Kenya

Recognizing that in Kenya every hour a women dies from a maternal related complication and every 20 minutes a mother loses the precious life of her newborn child;

Realizing that this is unnecessary and avoidable if the public and private sectors join hands and leverage on the capacities, expertise and resources available;

Acknowledging the importance of safe motherhood for the health and economic wellbeing of individuals, families, communities and prosperity of our nation;

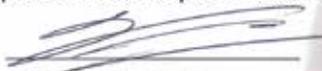
In alignment with the International Conference for Population and Development Plan of Action, Millennium Development Goals and Kenya Vision 2030;

And in support of the Kenya Government Free Maternal Healthcare policy and under the patronage of the Cabinet Secretary of Health for the Ministry of Health;

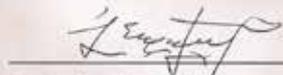
We, as individuals, family members, fellow citizens and business leaders fully commit our support to advocate, mobilize and harness the necessary resources to fight maternal and newborn death and morbidity in Kenya and promote a Kenya in which every pregnancy is wanted, every child birth is safe and every young person can make use of their full potential.

We endorse the High Level Private Sector Advisory Panel for Advancing Maternal and Newborn Health in Kenya as a key forum to build and advance Public Private Partnerships on maternal and newborn health in Kenya and we pledge our full support to its campaign;

We call upon our fellow corporate executives and other development stakeholders to join our efforts to prioritize and mainstream maternal and newborn health throughout its employee welfare policies, common business practices and corporate social responsibility initiatives.



Mr James Macharia
Cabinet Secretary of Health
Ministry of Health
Patron of the PSAP-MNH



Dr Benjamin O. Alli
Representative (ad interim)
UNFPA Kenya Country
Chair of the PSAP-MNH



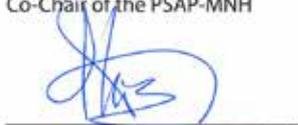
"UNFPA - because everyone counts."



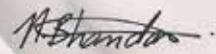
Dr Amit Thakker
Chief Executive Officer
Kenya Healthcare Federation
Co-Chair of the PSAP-MNH



Mr Bob Collymore
Chief Executive Officer
Safaricom Ltd
PSAP-MNH Representative



Ms Betty Maina
Chief Executive Officer
Kenya Association of Manufactures
UN Global Compact Focal Point to Kenya
PSAP-MNH Representative



Ms Neeta Bhandari
Regional Director
GBCHealth Kenya
PSAP-MNH Representative



GBCHealth



Global Compact Network
Kenya

CHAPTER 6: OVERALL, INFANT, CHILD AND MATERNAL MORTALITY

6.1 Introduction

As an indicator of general mortality, life expectancy at birth for the world population rose from 48 years in the period 1950-1955 to 68 years during the 2005-2010 period. However, wide disparities remain across and within countries and regions (UN, 2012).

Childhood mortality is one of the indicators of a country's socio-economic well-being, as well as of the quality of its medical services in general, and its public health services in particular. An increase in childhood mortality is, therefore, not only undesirable, but is an indicator of a decline in general living standards. Thus, infant and under-five mortality rates are useful indicators for assessing progress in overall national development, as well as ability of a country's health care system. The World Health Organization (WHO) estimates that annual deaths among children aged under-five world-wide have declined from 12 million in 1990 to 7.6 million in 2010 (WHO and UNICEF, 2012).

The importance of child health, and the subsequent desire to improve child survival, has been a subject of numerous conferences. The International Conference on Primary Health Care (PHC) held in Alma Ata in 1978 was the first to address the measures to be undertaken in order to reduce child mortality through worldwide systematic PHC development. Further, the Plan of Action adopted by the World Summit for Children in 1990 in New York, incorporated specific targets for the reduction of infant and under-five mortality. The latest being the Millennium Summit of 2000, one of whose eight Millennium Development Goals (MDGs) specifically addresses the reduction of child mortality (MDG 4).

Similarly, efforts to reduce maternal deaths have for decades been a focal point of international agreements and a priority for women's rights and health groups throughout the world. Such agreements include the very same ones that have been concerned with child survival, including: *Alma Ata Declaration* (1978), the *International Conference on Population and Development* (1994), the *Beijing World Conference on Women* (1995), and the *Millennium Development Goals* (2000). The inclusion of maternal health as one of the Goals — MDG 5.A — has increased its visibility on the world agenda.



CARMMA was launched in 2010 in Kenya by the then Minister for Gender, Children and Social Development, Hon. Esther Murugi (center). Looking on was the then Minister for Public Health and Sanitation Hon. Beth Mugo (left) and the then Assistant Minister for Housing Hon. Margaret Wanjiru (right).

This chapter describes progress over overall, infant, child, and maternal mortality in Kenya with a view to assessing the road map to achieving MDGs 4 and 5. The chapter focuses on levels, trends and patterns within the country and comparisons with selected countries.

6.1.1 Rationale

MDG 4 calls for a two-thirds reduction in the mortality rate among children under age five between 1990 and 2015, while MDG 5 targets a reduction by three-quarters in the maternal mortality rate in the same period. In order to achieve these targets, accurate and timely estimates of infant, under-five and maternal mortality rates are required to assist countries set priorities, design interventions and monitor progress. With over a decade since the adoption of the MDGs, an assessment is necessary of how much progress has been made towards their achievement in general, but specifically for this chapter, towards the achievement of MDGs 4 and 5.

6.1.2 Data and Methods

While a considerable amount of data on infant and child mortality in Kenya is readily available, this is still inadequate for generating annual process indicators, such as birth and death rates, required for continuous monitoring of these events. Vital registration systems are the preferred data source on infant and under-five mortality because they collect information continuously and cover the entire population; yet, for Kenya, they are currently inaccurate, incomplete and untimely for this purpose. As a result, most information on infant and child mortality is collected retrospectively from mothers through a census or household survey. National censuses have the advantage of covering the entire population, but are normally conducted at intervals – 10 years for Kenya – and collect limited data in scope and depth. Thus, household surveys, such as the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), have become the primary source of data on infant and child mortality in developing countries such as Kenya.

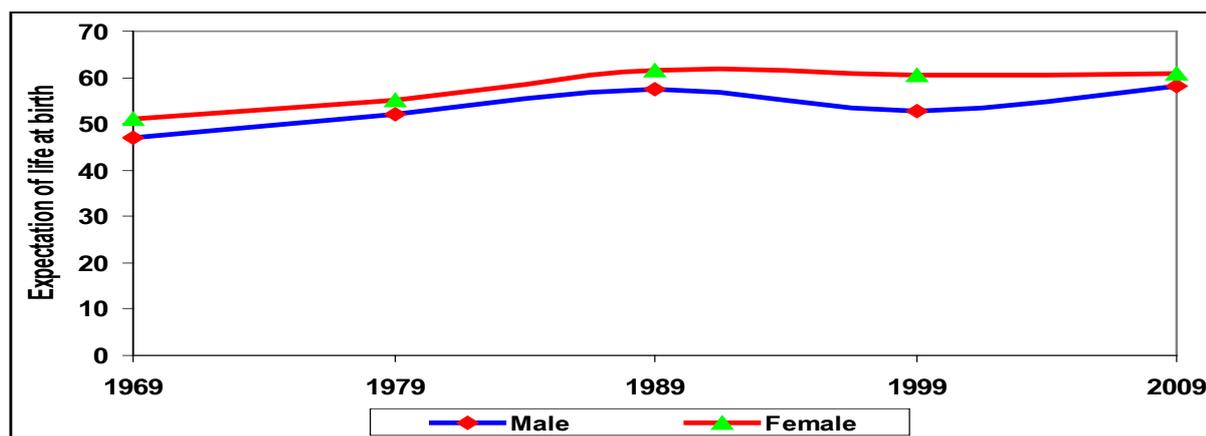
Surveys like DHS and MICs, cover nationally representative samples and are generally conducted every three to five years. They collect detailed birth histories, as well as information on socio-economic and other variables that help target programmes to reduce child mortality. Among the two approaches for calculating infant and under-five mortality rates, the direct method requires each child's date of birth, survival status, and date of, or age at, death. This information can come from vital registration statistics, or household surveys that collect complete birth histories. The indirect method requires less detailed information that is typically available from censuses and general household surveys, including the total number of children a woman has ever borne, the number who survive, and the woman's age (or the number of years since she first gave birth). However, indirect methods require model life tables to adjust the data for the age pattern of mortality in the general population. Finding an appropriate model life table can be challenging since the Coale and Demeny model life tables were derived largely from the European experience. In the 2010 round of censuses, a direct question on recent deaths in the household was included, which facilitated the direct estimation of childhood mortality, as well as maternal mortality.

With regard to maternal mortality, apart from hospital-based data (which has selectivity bias), the estimates presented in this chapter are derived from household surveys, and more recently from the census (deaths in the household in the last 12 months related to pregnancy and child birth). These sources were supplemented with estimates derived from the Inter-Agency Group (IAG) (WHO, World Bank, UNICEF and UNFPA, 2012).

6.2 Overall Mortality

A useful measure of overall mortality in a population is the expectation of life, which summarizes the mortality situation that prevails across all age groups, from children to youth, adults and the elderly. There has been a steady increase in expectation of life over the decades in Kenya, which has been attributed to improved nutrition, better hygiene, access to safe drinking water, effective birth control and immunization, and other medical interventions (Clark, 1990). Expectation of life at birth is closely associated with the level of infant mortality, with the former declining with rising infant mortality. In Kenya, as in other countries, there are differentials in the expectation of life at birth between males and females. Whereas expectation of life at birth has increased over the years, the female life expectancy reached a plateau since 1989, while that of the males dipped to 1999 before increasing to 2009 (see Figure 6.1).

Figure 6.1 Expectation of life at birth by sex, Kenya, 1969-2009



Source: Various Census Reports, Kenya 1969-2009

6.3 Infant and Childhood Mortality

Infant mortality refers to the death of children born alive before their first birthday, while childhood mortality is the death of children aged under five years. High mortality among children remains a serious public health concern in many developing countries, including Kenya. The country started experiencing declines in childhood mortality in the late 1940s (Hill and Hill, 1988; Hill, 1992), which continued through most of the 1970s and 1980s (Ewbank et al., 1986; Brass, 1993; Hill et al., 2001). However, data from the 1998 Kenya Demographic and Health Survey (KDHS) showed that there was a reversal in childhood mortality trends in the 1990s, when Kenya experienced adverse social and economic conditions that had begun in the late 1980s. These adversities included declines in employment opportunities as a result of structural adjustment programmes (Rono, 2002). This also coincided with the onset of HIV and AIDS (Garenne and Gakusi, 2005). Other notable factors that have been cited for the reversals include increased poverty, childhood malnutrition, decreased childhood immunization coverage, low use of skilled attendance at delivery, and the inability of the health care system to provide adequate services (Ikamari, 2004). Data from the 2003 KDHS confirmed the upward trends both in the infant and under-five mortality rates (CBS and ICF Macro, 2004), while the 2008/2009 showed a decline in under-five mortality rate of 35 percent (KNBS and ICF Macro, 2010). Trends in infant and under-5 mortality rates are illustrated in Table 6.1 and Figure 6.2.

Table 6.1 Infant and Childhood Mortality, Kenya, 1969 to 2008/2009

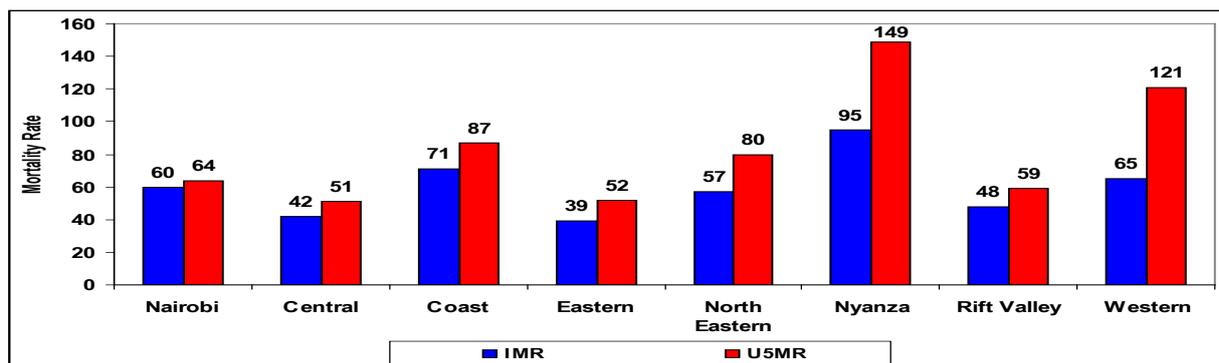
Mortality Indicator	Population Census					Kenya Demographic & Health Survey				
	1969	1979	1989	1999	2009	1989	1993	1998	2003	2008/09
IMR	119	88	66	77	54	60	62	71	77	52
U5MR	190	157	125	116	79	89	93	105	115	74

Source: Various census and KDHS reports

The results in Table 6.1 show a consistent decline in both infant and childhood mortality in the country over the years. The results for the 2009 census and 2008-2009 KDHS are quite comparable at the aggregate level. The census results indicate that there has been a consistent decline in under-five mortality between 1989 and 2009. The changes over time show that the highest decline occurred between 1979 and 1989 where under-five mortality decreased by 20 percent. However, a comparison between the mortality rate for the 2009 census and that of 1999 census should be treated with caution because of the differences in the methodologies employed: the 1999 estimates are based on indirect techniques, whereas the 2009 estimates are based on direct techniques.

There are marked differentials in 2008/2009 infant mortality rates (IMR) and under-five mortality rates (U5MR) by regions, as depicted in Figure 6.2. Nyanza, Western and Coast provinces exhibited higher levels of U5MR, compared to those in Rift Valley, Eastern, and Central provinces. Levels of IMR by region depicted a similar pattern to that for U5MR, with the higher mortality provinces also being malaria endemic.

Figure 6.2 Infant and Under-Five Mortality Rates by Region, 2008-2009 KDHS

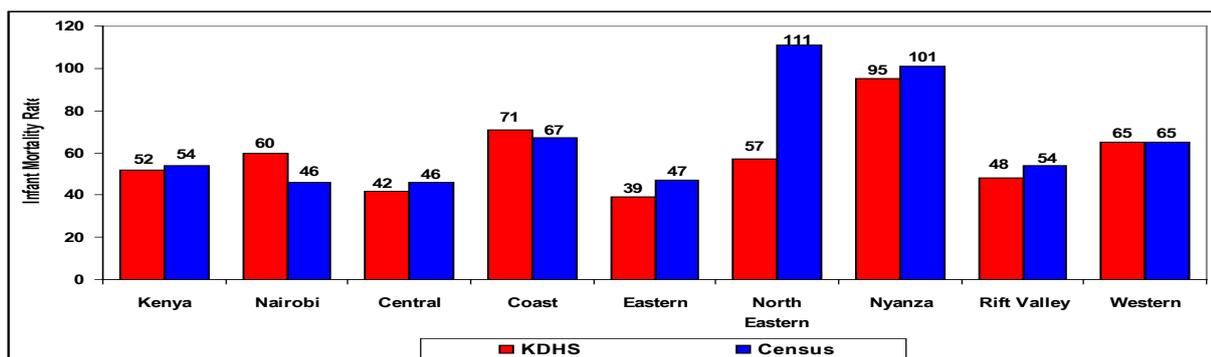


Source: 2008-2009 KDHS

Analytical results from the 2009 Kenya population census are in conformity with the above mortality patterns. However, census data show that Nyanza and North Eastern provinces had higher U5MR of 156 and 148 per 1,000 live births respectively. Western Province ranked third highest with 118 per 1,000 live births. The mortality rates based on census data are comparable to those of 2008-2009 KDHS given that they are based on recent deaths (12 months prior to the census) in the household.

Figure 6.3 below shows a comparison of IMR based on 2008-2009 KDHS and those from the 2009 Kenya population census. The results show that the rates are comparable at the national level, i.e. 52 and 54 per 1,000 live births respectively. The two sources of mortality data yielded similar results for Western Province while KDHS yielded slightly higher rates than the census for Coast Province. Nyanza Province had a higher level of infant mortality from the census data compared to KDHS. The biggest discrepancy in infant mortality from the two sources was for North Eastern Province where the rate based on census was almost double that of 2008/2009 KDHS.

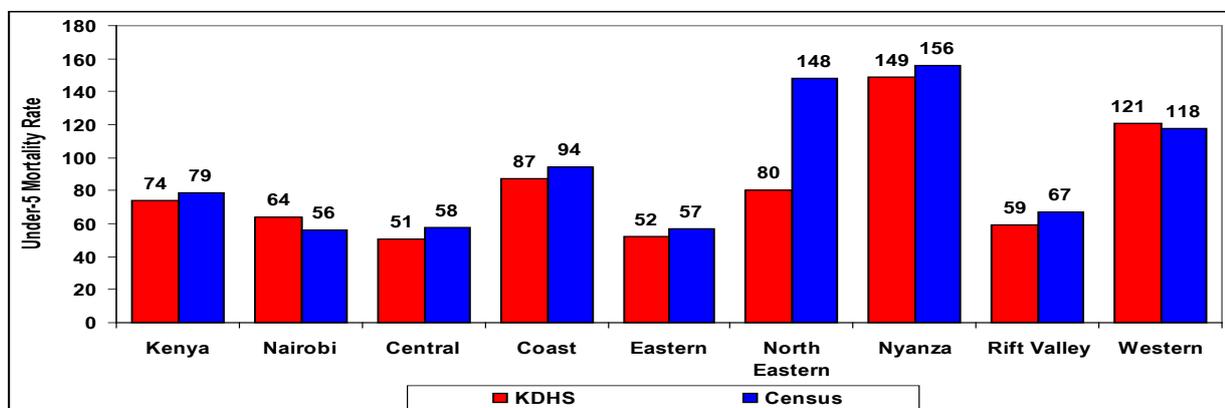
Figure 6.3 Infant Mortality Rate by Region, 2008-2009 KDHS and 2009 Census



Source: 2008-2009 KDHS and 2009 Census Reports

A comparison of U5MR from the two data sources reveals a pattern that conforms to the picture displayed for IMR, except for the reversals for Coast and Western provinces - see Figure 6.4.

Figure 6.4 Under-Five Mortality Rate by Region, 2008-2009 KDHS and 2009 Census



Source: 2008-2009 KDHS and 2009 Census Reports

Other noticeable differences in childhood mortality are observed between rural and urban residence. The 2008-2009 KDHS results indicate that post-neonatal mortality and IMR were higher among the urban populations as compared to rural populations. For example, infant mortality stood at 63 and 58 deaths per 1,000 live births for the urban and rural populations respectively, while the post-neonatal mortality reached 31 and 25 deaths per 1,000 live births for the urban and rural residents respectively. This was rather an unusual result which was not in line with earlier findings in Kenya. The disparity may be attributed to inequities in location, socio-economic factors, socio-cultural beliefs and practices, and individual level risk factors in these populations (Ettarh and Kimani, 2012).

Differentials by the level of education of mother show that under-five mortality is usually lower among children whose mothers had attained primary level education and above. Similarly, with regard to household wealth, child mortality declines as the wealth increases, with the exception of the second quintile (KNBS and ICF Macro, 2010).

The 2008-2009 KDHS results on early childhood mortality by demographic characteristics show that mortality rates are generally higher for male than female children across all such indicators. A summary of these indicators is presented in Table 6.2. The data show that the largest absolute difference was in

the under-five category (i.e. 90 for males and 77 for females). The data also show that the largest relative difference was in the neonatal period with male children having a higher probability of dying in the neonatal period than female children. This is due to the low survival chances of male children in this period as a result of biological factors.

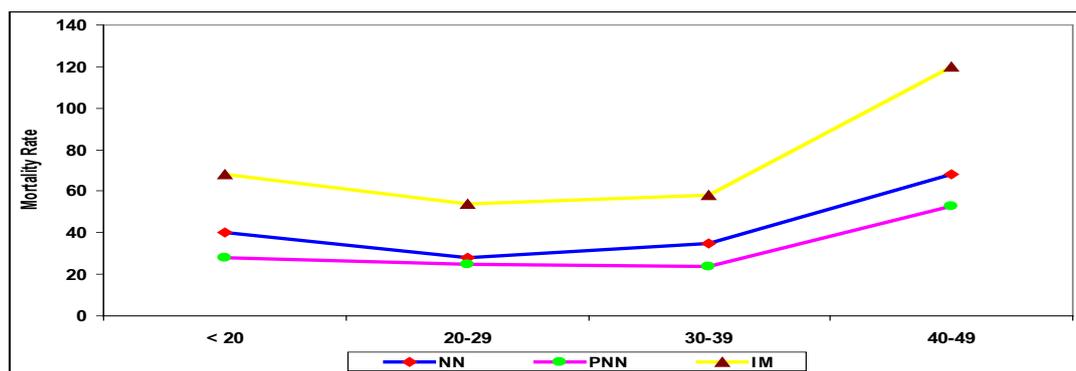
Table 6.2 Early Childhood Mortality Rates by Demographic Characteristics, 2008-2009 KDHS

Demographic Characteristics	Neonatal Mortality (NN)	Post-neonatal Mortality (PNN)¹	Infant Mortality (${}_1q_0$)	Child Mortality (${}_4q_0$)	Under-Five Mortality (${}_5q_0$)
Child's Sex					
Male	38	27	65	27	90
Female	28	26	53	25	77
Mother's age at birth					
< 20	40	28	68	35	100
20-29	28	25	54	25	77
30-39	35	24	58	22	79
40-49	(68)	(53)	(120)	-	-
Birth Order					
1	27	25	62	17	78
2-3	29	22	51	30	80
4-6	28	31	59	29	86
7+	50	30	79	24	102
Previous Birth Interval²					
<2 years	54	36	91	44	130
2 years	21	27	48	27	73
3 years	16	14	31	23	53
4+ years	35	24	60	20	78
Birth Size³					
Small/Very small	41	29	70	na	na
Average or Larger	27	20	47	na	na
Note: Figures in parenthesis are based on 250-499 unweighted months of exposure; na = Not applicable					
¹ Computed as the difference between the infant and neonatal mortality					
² Excludes first-order births					
³ Rates for the five-year period before the survey					

Source: (KNBS and ICF Macro, 2010 pg. 108)

The results further show that mother's age at birth has an effect on the survival chances of their infants. A near 'U'-shaped pattern is displayed for neonatal, post-neonatal and infant mortality rates, as shown in Figure 6.5. This implies higher early childhood mortality for younger and older women and the reverse for women in middle ages. This has policy implications in that births should be discouraged for women below 20 and those over 35 years of age.

Figure 6.5 Early Childhood Mortality Rates by Mother's Age at Birth of Child, 2008-2009 KDHS



Source: 2008-2009 KDHS Report

WHO (2008) cites a number of studies that show the consequences of early childbearing on pregnancy outcomes and child survival, touching on the health of the adolescents and their infants, individual social and economic effects, and societal level impacts. The studies report that children born to teenage mothers experience greater health problems and mortality risks than those born to older mothers. Early pregnancies are associated with significantly worse pre-natal health care and vaccination behaviour, leading to lower birth-weights, earlier weaning, and higher mortality, especially during the second year of life. In addition, a young maternal age can increase the resulting children's health risks. Adolescent mothers also have higher health risks and lower health outcomes. Pregnancy-related deaths are the leading cause of mortality for 15-19 year-old girls worldwide (Ferre, 2007). Studies have also shown that first births to women aged 35 and above may lead to adverse pregnancy outcomes, such as miscarriages, congenital abnormalities, and Down's Syndrome amongst other complications (WHO, 2008).

It is evident from the results in Table 6.2 that short birth intervals have been associated with adverse pregnancy outcomes. Rutstein (2008) observed that the population attributable risk (PAR) for under-five mortality for avoiding conceptions at less than 24 months after a birth was 0.134, meaning that under-five mortality would decline by 13 percent if all women waited for at least 24 months to conceive again. Rutstein further noted that the effect of waiting 36 months to conceive again would avoid 25 percent of under-five deaths. The impact of avoiding these high risk intervals (less than 36 months) would be a total of 1,836,000 deaths avoided annually in less developed countries, excluding China (where there is a one child policy). Rutstein concluded that, parents who want their children to survive and thrive would do well to wait at least 30 months after a birth to conceive another child. Studies have also shown that size of the child at birth has adverse pregnancy outcomes (Magadi et al., 2001).

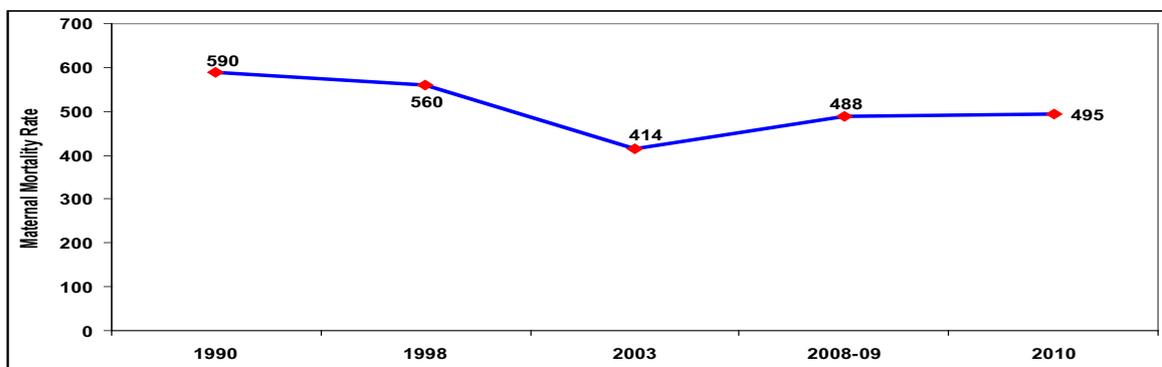
6.4 Maternal Mortality

Maternal Mortality Ratio (MMR) represents the obstetric risk associated with each pregnancy, quantified as the number of maternal deaths during a given time period per 100,000 live births during the same period. This should be differentiated from maternal mortality rate which is defined as the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time period. However, the common indicator used to depict deaths due to pregnancy and childbirth is MMR. According to 2008-2009 KDHS, maternal deaths represent about 15 percent of all deaths to women aged 15-49 in Kenya.

According to a new study by the Institute for Health Metrics and Evaluation (IHME) at the University of Washington, the number of women dying from pregnancy-related causes has dropped by more

than 35 percent in the past 30 years — from more than a half-million deaths annually in 1980 to about 343,000 in 2008 (IHME, 2012). In Kenya, approximately 8,000 women die of the same problems per year. Maternal disabilities and deaths remain high in the country. KDHS 2003 recorded an MMR of 414, which had risen to 488 during 2008-2009 survey. An estimate based on the 2009 census showed a slightly higher estimate of 495 deaths per 100,000 live births. Figure 6.6 depicts the trend in maternal mortality estimates.

Figure 6.6 Trends in Maternal Mortality Ratio, Kenya, 1990-2010

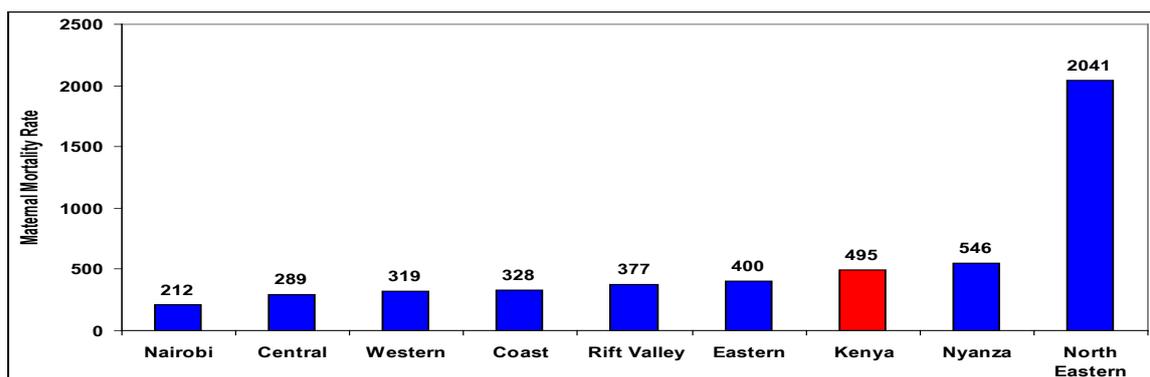


Sources: WHO/UNICEF/UNFPA/World Bank, 2012; 2009 Kenya Census Analytical Report on Mortality

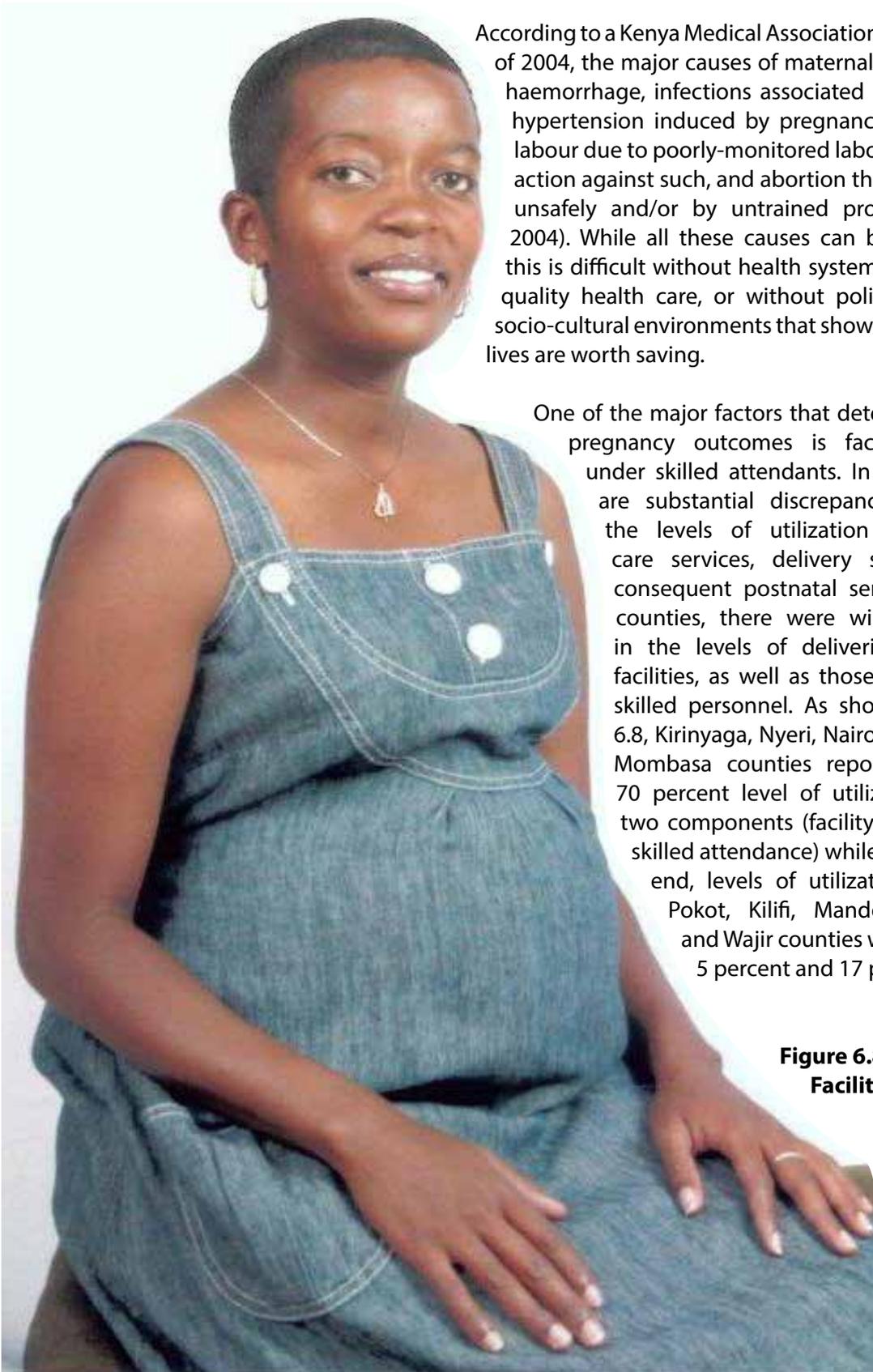
IAG estimates for 2010 indicate that there has been a substantial decline in MMR to 360 deaths (WHO/UNICEF/UNFPA/World Bank, 2012). However, this estimate should be viewed with caution as a result of differences in methodological approaches employed. Nonetheless, even this lower estimate is still well above the MDG 5 target of 147 deaths per 100,000 live births. This kind of situation poses a challenge to the country in its efforts towards attainment of MDG 5 by 2015, and the related objectives in Kenya Vision 2030.

The national averages tend to mask regional differentials, which should be the focus of interventions if the country is to achieve MDG 5. Figure 6.7 shows wide regional MMR differentials based on estimates derived from recent deaths in the household from the 2009 census. North Eastern Province has the highest MMR in the country with 2,041 deaths while Nairobi’s ratio is the lowest at 212 deaths per 100,000 live births.

Figure 6.7 Maternal Mortality Ratio by Region, 2009 Census



Source: 2009 Kenya Census Analytical Report on Mortality



According to a Kenya Medical Association (KMA) report of 2004, the major causes of maternal mortality are haemorrhage, infections associated with delivery, hypertension induced by pregnancy, obstructed labour due to poorly-monitored labour or delayed action against such, and abortion that is procured unsafely and/or by untrained providers (KMA, 2004). While all these causes can be prevented, this is difficult without health systems that deliver quality health care, or without policy, legal and socio-cultural environments that show that women's lives are worth saving.

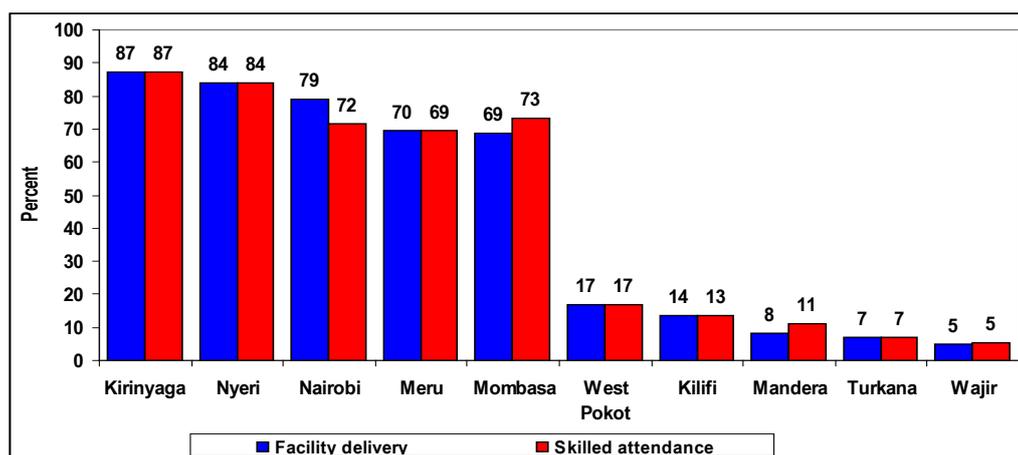
One of the major factors that determine better pregnancy outcomes is facility delivery under skilled attendants. In Kenya, there are substantial discrepancies between the levels of utilization of prenatal care services, delivery services, and consequent postnatal services. Across counties, there were wide variations in the levels of deliveries in health facilities, as well as those attended by skilled personnel. As shown in Figure 6.8, Kirinyaga, Nyeri, Nairobi, Meru, and Mombasa counties reported at least 70 percent level of utilization of the two components (facility delivery and skilled attendance) while on the lower end, levels of utilization for West Pokot, Kilifi, Mandera, Turkana, and Wajir counties were between 5 percent and 17 percent.

Figure 6.8 Percent of Facility Deliveries

A happy pregnant woman.

Photo: UNFPA

and Skilled Attendance by County



Source: www.opendata.co.ke, 2011 County Fact Sheets

6.5 Progress Made Towards Achieving MDG 4

Under MDG 4, the target is to reduce by two thirds, between 1990 and 2015, the U5MR from 99 to 33 deaths per 1,000 live births. In order to achieve this target, Kenya identified three indicators that are being monitored: rates of infant and under-five mortality, and immunization coverage for measles for children aged one year old (GOK, MPND and Vision 2030, 2010). Table 6.3 gives the status of these indicators since 1990.

Table 6.3 Infant and under-five mortality rates, and immunization coverage for measles, 1990-2009

Indicator		1990	2000	2003	2006	2008-09	2009	2015 Target
4.1	Under-five mortality rate (per 1000 live births)	99	105	115	77	74	79	33
4.2	Infant mortality rate (per 1000 live births)	63	67	77	60	52	54	21
4.3	Proportion of 1 year-old children immunised against measles (%)	48	76	74	77	85	85	95

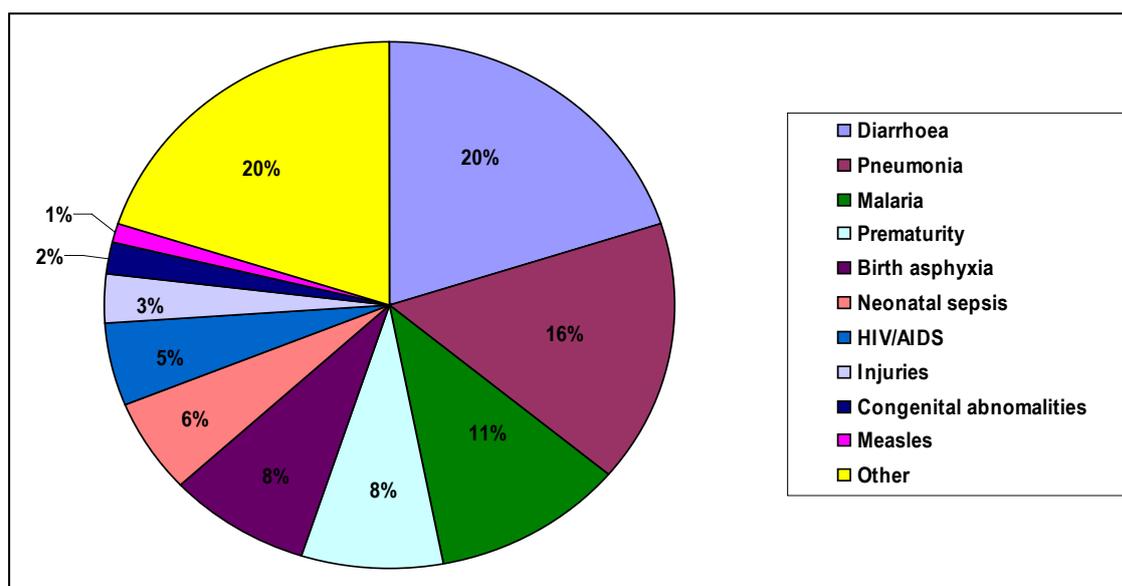
Source: Various KDHS Reports and 2009 Kenya Census Analytical Report on Mortality

Kenya has made great strides in reducing IMR and U5MR as can be observed from childhood mortality trends in section 2.2. Government efforts, with support from development partners, have borne some fruits as shown by the decline in IMR and U5MR between 2003 and 2009, as well as the increase in immunization levels against measles for those aged one year. IMR decreased by 33 percent between 2003 and 2008-2009 while U5MR decreased by 36 percent in the same period. These declines are regarded as a step towards the achievement of the MDGs (NCPD, 2012).

Target 4.1 Under-five mortality rate

The four main global killers of children under-five are pneumonia (18%), diarrhoeal diseases (15%), pre-term birth complications (12%), and birth asphyxia (9%). Malnutrition is an underlying cause in more than a third of under-five deaths (Economic Commission for Africa, 2012). The same report notes that the major causes of under-five mortality in Kenya are diarrhoea (20%), pneumonia (16%) and malaria (11%) - see Figure 6.9. These account for 42 percent of under-five deaths in the country.

Figure 6.9 Major Causes of Under-Five Deaths



Source: Black, et al (2010)

Special efforts to control pneumonia, diarrhoea, malaria and malnutrition, with effective comprehensive interventions that reach the most vulnerable and marginalized children, could save the lives of millions of children. According to the Kenya Malaria Indicator Survey 2010, the country has undertaken measures to control malaria in children and pregnant women, who together constitute the most vulnerable groups. The measures include vector control with insecticide treated nets (ITN), long lasting insecticidal nets (LLIN), indoor residual spraying (IRS), as well as improved access to malaria diagnosis and treatment.

Target 4.2 Infant mortality rate

From the last two rounds of KDHS, 29 percent of under-five deaths occurred in the neonatal period in 2003, rising to 42 percent in 2008-2009. Sixty-five percent of under-five deaths occur within the first year of life. According to KDHS2008/2009, out of 1,356 infant deaths, over half of the deaths — 698 deaths — occurred in the neonatal period (KNBS and ICF Macro, 2010). This implies that interventions in the neonatal period have a direct bearing on children surviving to their first birthday. The country is unlikely to attain the target of 21 deaths per 1,000 live births in 2015.

Target 4.3 Proportion of one-year-old children immunized against measles

Deaths from measles accounted for only one percent of childhood deaths in the country, according to 2008-2009 KDHS. From Table 3, the proportion of one year old children immunized against measles increased from 48 percent in 1990 to 85 percent in 2008-2009, compared to a 2015 MDG target of 95 percent.

National averages tend to mask regional differentials, which also need to be considered when planning for the attainment of MDG 4. The regional differentials in childhood mortality presented in Figure 4, strongly suggest the need for focused interventions against under-five mortality, especially in Nyanza and Western provinces. Nyanza Province has also been recording the highest rates of HIV prevalence and AIDS deaths. It was also observed from 2008-2009 KDHS data that the neonatal mortality rate only reduced marginally from 33 to 31 per 1,000 live births, contributing to 42 percent of under-five mortality,

compared to 29 percent reported by KDHS 2003. Despite the renewed focus on, and recent progress in, child survival, achieving the MDG targets for under-five mortality (33/1000) and infant mortality (26/1000) by 2015 will be a challenge, unless neonatal care, which is closely linked to maternal care, receives more attention. (GOK, MPND and Vision 2030; 2010).

6.6 Progress towards Improvement of Maternal Health

MDG 5 has two targets: 5.A - Reduce by three quarters, between 1990 and 2015, the maternal mortality rate; and 5.B - Achieve, by 2015, universal access to reproductive health. The respective indicators for the attainment of these targets are as follows: 5A - maternal mortality ratio and proportion of births attended by skilled health personnel; and 5B - contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning. Table 6.4 summarizes the progress Kenya has made towards the achievement of these targets.

Table 6.4 Progress made towards achievement of MDG 5 targets in Kenya, 1990-2010

Goal 5: Improve Maternal Health							
Target	Indicator	1990	1998	2003	2008/09	2010	2015 Target
Target 5.A: Reduce by ¾ between 1990 & 2015 the maternal mortality ratio	5.1 Maternal Mortality Ratio (per 100,000 live births)	590	590	414	488	495	147
	5.2 Proportion of births attended by skilled health personnel (%)	44	42	40	44	-	90
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.5 Antenatal care coverage (at least four visits)	-	60	52	47	-	90

Source: KDHS Reports and 2009 Census Analytical Report on Mortality

Target 5.1 Maternal Mortality Ratio

As already noted, Maternal Mortality Ratio in Kenya has remained unacceptably high, i.e. at 488 maternal deaths per 100,000 live births based on 2008-2009 KDHS data, (495 according to the 2009 census, with some regions reporting ratios of over 1,000/100,000), 414 in 2003, and 590 in 1998. Clearly, these figures do not depict a reducing trend towards the target of 147 maternal deaths per 100,000 live births set for 2015.

Maternal Mortality Ratio obtained from large scale surveys, such as DHS and MICS, are based on indirect techniques on the basis of questions asked regarding the death of sisters from a pregnancy related cause. This is known as the 'sisterhood method' (Graham et al., 1989), which has a number of limitations that may influence the estimates, including: distinction of pregnancy-related deaths from maternal deaths; production of estimates with wide confidence intervals, thereby diminishing opportunities for trend analysis; reliance on retrospective rather than a current maternal mortality estimates (referring to a period approximately five years prior to the survey); and the complexity of the analysis.

Estimates obtained from censuses on the basis of recent deaths (one year period) in the household related to pregnancy and child birth also have limitations in that the information is collected after a ten year period, hence limiting the monitoring of maternal mortality. However, this approach allows

identification of deaths in the household in a relatively short reference period (one to two years), thereby providing recent maternal mortality estimates. Another major aspect that needs to be considered is that results must be adjusted for such characteristics as completeness of death and birth statistics and population structures, in order to arrive at reliable estimates.

The IAG estimates are not comparable to estimates from other sources in that they are based on models whose aim is to adjust for lack of data, misclassification and under-reporting to provide the best possible estimates.

Target 5.2 Proportion of births attended by skilled health personnel

Progress on this indicator has been minimal, with the proportion increasing only marginally from 42 percent as reported in KDHS 2003 to 44 percent in 2008-2009 KDHS. Evidently, this attainment remains far below the set target of 90 percent by 2015. As observed earlier, the proportion of mothers who received skilled attendance at birth varies widely across the regions, and is lower in rural areas and among women of lowest socio-economic status. It is doubtful that the MDG target will be attained by 2015, unless there are focused interventions in areas of weakest performance such as North Eastern, Nyanza and Western provinces.

6.7 Comparisons

WHO and UNICEF monitored progress towards the achievement of MDG 4 in 74 countries since 2005 (WHO/UNICEF, 2012). Countries were categorized as being “on track” if their U5MR for 2010 was less than 40 deaths per 1,000 live births, or if it was 40 or more, but with an average annual rate of reduction of four percent or higher for 1990–2010. Countries were deemed to have made “insufficient progress” if their U5MR for 2010 was 40 deaths per 1,000 live births, or more, but with an average annual rate of reduction of between 1 and 3.9 percent for 1990–2010. Finally, countries had made “no progress” if their U5MR for 2010 was 40 deaths per 1,000 live births, or more, but with an average annual rate of reduction of less than one percent for 1990–2010. In the Countdown Report for 2012, 23 countries were on track for meeting the targets for MDG 4; 38 countries had made insufficient progress; and 13 countries had not made any progress by 2010³². Out of the 74 countries considered, only four in sub-Saharan Africa were on track, 27 had made insufficient progress, and 12 (including Kenya) had made no progress (see Appendix 6.1).

Similarly, monitoring of progress with regard to maternal mortality indicates that the only countries that were on track to achieving MDG 5 in sub-Saharan Africa as at 2015 were Equatorial Guinea and Eritrea, as shown in Appendix 6.2. Twenty one countries were making progress; eleven countries (including Kenya) had made insufficient progress; and nine countries had made no progress at all. The Economic Commission for Africa report of 2012 on MDGs cites an article published in *The Lancet* in 2010, which showed that maternal mortality was declining even in Africa. This is in line with UN data which shows that many African countries recorded large declines in maternal mortality during the 1990–2008 period: Equatorial Guinea, Eritrea, Egypt, Morocco, Cape Verde, Tunisia, Ethiopia, Algeria, Rwanda and Mauritius all saw a more than 50 percent reduction, and are thus close to achieving the MDG 5 targets. These countries did this mainly through policy interventions that focused on improving access through various means (such as transport) to referral health institutions, increased information about contraception, and better supply of health attendants. Equatorial Guinea, the closest to achieving MDG 5 with a 72 percent reduction in maternal mortality between 1990–2008, improved the proportion of births attended by skilled personnel from five percent in 1994 to 65 percent in 2000; and emerging data suggest even further progress sincethen. Egypt, Morocco and Rwanda have also made steep

³² Since 2005, Countdown has produced periodic reports and country profiles on key aspects of reproductive, maternal, newborn and child health, achieving global impact with its focus on accountability and use of available data to hold stakeholders to account for global and national action.

gains in the share of births overseen by skilled health attendants, and are among the best performers in reducing maternal mortality. The best performers also coincidentally share high economic growth rates, with Equatorial Guinea experiencing rapid growth over the past 20 years, while Egypt, Morocco and Cape Verde have also had sustained growth rates over the years. That some other countries with impressive economic growth rates are not performing as well against MMR as the aforementioned – Ghana — making progress; Uganda — insufficient progress — suggests that sustained growth may be necessary, but is not sufficient, for progress against MMR.

6.8 Gaps

The lack of reliable and complete datasets on vital events from the registration system is apparent. This is evident in the level of monitoring and evaluation of the MDG indicators. Currently, the indicators are monitored at impact level since they are derived from analysis of data from population censuses and demographic surveys. Process indicators for continuous monitoring of these indicators can only be derived from registration systems. Process indicators would be more desirable because they can assist in identifying areas of intervention in the short run.

6.9 Existing policies and programmes

Kenya has put in place various strategies and programmes in its quest to achieve MDG 4. The first among these is the *Malezi Bora* Strategy initiated in 2007, which has provided a comprehensive and integrated package of services that includes; child immunization, Vitamin A supplementation, deworming of under-fives and pregnant women, treatment of childhood illnesses, HIV counselling and testing, ITNs use in malaria prevention, and improved ANC and FP services.

In addition, the Child Survival and Development Strategy 2008–2015, was initiated to deliver efficient and effective services in order to improve the lives of women and children. Launched in 2009, on June 16 which is the Day of the African Child, the strategy aims at contributing to the reduction of health inequalities and to reverse the downward trend in health-related indicators, with a focus on child survival and development. The development of the Strategy involved the Ministry of Public Health and Sanitation, other line ministries, and representatives of civil society, academia and donor organizations, guided by the National Health Sector Strategic Plan II 2005-2010 and the Vision 2030 Medium Term Plan I (2008-12).

Other Government efforts towards reduction in child mortality, and in line with attainment of the MDG 4 target, include the adoption of the Integrated Management of Childhood Illnesses (IMCI), which aims at increasing immunization coverage among children; this being among the most effective primary health interventions in reducing child mortality. Through IMCI, the Ministry of Public Health and Sanitation continues to strengthen immunization activities throughout the country through the Kenya Expanded Programme on Immunization, as well as management of childhood illnesses.

According to the Sessional Paper No.3 of 2012 on Population Policy for National Development, the policy measures for childhood morbidity and mortality include; support for the implementation of the on-going child survival programmes, including IMCI, prevention of mother to child transmission of HIV, and promotion of ITN use (GoK/MPND and Vision 2030, 2012). It is envisaged that these interventions will lead to improved child survival, desired family sizes, and to the subsequent decline in fertility level. Similarly for maternal health, Sessional Paper No.3 of 2012 prescribes some policy measures which include; the need to intensify advocacy for increased resources to provide comprehensive maternal health care services with special attention to underserved populations and groups, as well as poorly addressed issues such as postnatal care, post abortion complications and fistula.

With regard to maternal and child health, some of the measures that have been undertaken to ameliorate the situation include the Government's preparation of the Contraceptive Security Strategy (2007-2012) with the aim of ensuring uninterrupted and affordable supply of contraceptives. The Government also launched a Maternal and Newborn Health (MNH) Road Map in August 2010, which outlines the strategies, priority actions and broad activities for acceleration of the attainment of MDGs 4 and 5. This will be implemented in phases towards the final reporting year of 2015. In addition, the Government used the Economic Stimulus Programme (ESP) to expand pre- and in-service training of health workers, and to employ and deploy 20 nurses in each constituency. Under ESP, model health centres were to be built in 200 constituencies, with 300 ambulances purchased and distributed to all health centres in the country.

Another measure is the removal of user fees for maternity health care to ensure all expectant mothers access quality health services. Mothers are further being encouraged to deliver in the nearest maternity facility under the supervision of a skilled health worker. In the 2010/2011 health budget, the Government committed to shifting budgetary resources from curative health to preventive health services.

To reduce the high maternal mortality, the Government has to address several challenges including the need to ensure availability of adequate maternity health care services and skilled personnel to attend to complications caused by unsafe/induced abortion, malaria as well as HIV and AIDS, among others.

6.10 Challenges and Opportunities

6.10.1 Challenges

In general, it is noted that high childhood mortality rates in Kenya make it difficult for individuals to adopt small family norms. This situation is compounded by persistent regional and socio-cultural disparities in FP use and mortality rates. All these combine to pose a challenge as the country endeavours to reduce mortality across board.

From available data, it is evident that the level of utilization of maternal health care services remains low in particular regions of the country. The challenge remains raising the uptake of maternal health care services — such as of facility delivery and skilled attendance and post natal care — to reasonable levels so as to contribute towards the achievement of national goals in maternal health.

Another of the major challenges lies in the inadequacy of requisite data to effectively monitor progress towards the achievement of MDGs 4 and 5. This situation arises due to the inefficiency of the current civil registration system in Kenya that is supposed to be the principal source of such data. The fact that the country is unlikely to achieve set targets of MDGs 4 and 5 remain a challenge to the country.

6.10.2 Opportunities

There are specific articles in the Constitution (2010) that present clear opportunities for the improved management of premature mortality. For example, **Articles 26, 43 and 53** — explicitly recognize and address the right to health as a specific individual right. This right can, therefore, be enforced in a court of law in the same way as civil and political rights. In particular, **Article 43** says that "Every person has the right: to the highest standard of health, which includes the right to health care services, including reproductive health care; to accessible and adequate housing, and to reasonable standards of sanitation; to be free from hunger, and to have adequate food of acceptable quality; to clean and safe water in adequate quantities; and to education".

Sessional Paper No. 3 of 2012 on Population Policy for National Development outlines a number of policy objectives, demographic targets, and family planning initiatives which present opportunities for various actors to take advantage of in their efforts to reduce mortality. Examples of such opportunities include:

Policy objective – Provide equitable and affordable quality reproductive health services including family planning.

Demographic targets for the year 2030

- Reduce crude death rate from 13 in 2010 to eight deaths per 1,000 people by 2030
- Reduce infant mortality rate from 52 in 2009 to 25 deaths per 1,000 live births by 2030
- Reduce under-five mortality rate from 74 in 2009 to 48 deaths per 1,000 live births by 2030
- Reduce maternal mortality rate from 488 in 2009 to 200 deaths per 100,000 live births by 2030
- Improve life expectancy at birth for both sexes from 57 in 2009 to 64 years by 2030

Family Planning

- Increase contraceptive prevalence rate for modern methods from 40 percent in 2010 to 70 percent by 2030, thereby contributing to a reduction in total fertility rate from 4.6 in 2010 to 2.6 children per woman by 2030.

6.11 Conclusion

This report aimed at documenting levels, trends and patterns of overall, infant, child and maternal mortality in Kenya. The results show that there have been general improvements in overall mortality as depicted by improved expectation of life at birth. However, among males, there was a decline from 57.5 years in 1989 to 52.9 years in 1999, then picked up to reach 58 years by 2009. Among females, there has been a steady increase in expectation of life at birth over the years.

The results further show that there has been a decline in childhood mortality at aggregate level. Two data sets for comparable periods – 2008-2009 KDHS and 2009 census — yielded consistent results. It is, however, noticeable that as declines were registered in the infant and under-five mortality levels, deaths in the neonatal period accounted for over half of all deaths in infancy. The data also reveal wide regional variations in infant and under-five mortality rates: while childhood mortality has fallen in Nyanza Province over time, its rates remain the highest in the country. Disparities also exist based on socio-economic characteristics. The declines in childhood mortality have been associated with improvements in other childhood health indicators, such as immunization, use of ITNs, and access to treatment for pneumonia.

With regard to demographic characteristics, 2008-2009 KDHS results indicate that mortality rates were higher for males than females and that neonatal, post-neonatal and infant mortality rates exhibit a near 'U'-shape curve, meaning the rates are higher for younger and older women than for those in the middle age groups. Similarly, KDHS findings show that there was generally an increased risk of dying for first births and higher order births. The results also show that children born less than two years after a prior sibling were at a higher risk of death. The size of the child at birth also has a bearing on mortality rates.

The KDHS results show that there have been marginal changes in maternal mortality with wide regional variations; but the various methods of estimation yield different even if consistent results. Progress towards MDGs 4 and 5 is slow, and the targets set for the country are unlikely to be achieved. While the Government has put in place measures to mitigate high levels of childhood and maternal mortality,

much more is required for the country to attain its MDG targets, and by extension, its Vision 2030 goals and targets.

The Government has adopted the IMCI strategy in order to address childhood mortality levels. However, the strategy should be focused on areas where childhood mortality is highest.

Whereas the MDG targets are fixed at the international level, it was hoped that countries would tailor make them to suit their local situations. This has, however, not been done in Kenya where the targets are still at international level hindering the adoption of a human rights based approach. There is need for a human rights approach to interventions as had been envisaged with the adoption of the MDGs.

6.12 Recommendations

The human rights approach recognizes the need to focus on areas of inequality in provision of services. This calls for relevant interventions tailored to mortality situations as depicted by sub-regional differentials.

Further, one of the major challenges is that routine data that is required for monitoring progress towards the achievement of the MDGs and Vision 2030 are incomplete and inaccurate. Two sector reports — ‘Health Situation Trends and Distribution: 1994-2010’, and ‘Projections for 2011–2030’ — observed that, as in many developing countries, registration of deaths and their causes is incomplete in Kenya. The national death registration coverage from the Civil Registration Department for 2012 was estimated to be at about 48 percent. Records from health facilities which feed into the routine Health Management Information System (HMIS) also provide some data on cause of death, but are limited in quantity since they neither capture deaths in non-public health facilities, nor the majority of deaths in Kenya (given that as much as 80% occur outside health facilities). Additionally, HMIS reporting rates from health facilities is erratic and often incomplete over time, meaning the resultant data must be interpreted with caution. Given the paucity of routine data, there is need for concerted efforts to ensure that the systems that are expected to generate these data are functional. There is also need for specialized surveys that can assist generate these data in the short-run to assist the Government and other key stakeholders to monitor the achievements of the MDGs at all levels on a continuous basis.

In order to reduce maternal mortality, it is necessary to address several challenges, including the need to ensure the availability of and access to quality maternity health care services.

Appendix 6.1 Progress towards achieving MDG 4 in selected sub-Saharan Countries, 1990-2010

Under-Five Mortality Rate					
Deaths per 1,000 live births				Average annual rate of reduction (%)	Assessment of progress
Country (Africa)	1990	2000	2010	1990-2010	
Madagascar	159	102	62	4.7	On track
Malawi	222	167	92	4.4	On track
Eritrea	141	93	61	4.2	On track
Liberia	227	169	103	4	On track
Niger	311	218	143	3.9	Insufficient progress
Tanzania	155	130	76	3.6	Insufficient progress
Senegal	139	119	75	3.1	Insufficient progress
Rwanda	163	177	91	2.9	Insufficient progress
Ethiopia	184	141	106	2.8	Insufficient progress
Guinea	229	175	130	2.8	Insufficient progress
Uganda	175	144	99	2.8	Insufficient progress
Gambia	165	128	98	2.6	Insufficient progress
Ghana	122	99	74	2.5	Insufficient progress
Zambia	183	157	111	2.5	Insufficient progress
Mozambique	219	177	135	2.4	Insufficient progress
Equatorial Guinea	190	152	121	2.3	Insufficient progress
Sierra Leone	276	233	174	2.3	Insufficient progress
Benin	178	143	115	2.2	Insufficient progress
Angola	243	200	161	2.1	Insufficient progress
Nigeria	213	186	143	2	Insufficient progress
Comoros	125	104	86	1.9	Insufficient progress
Mali	255	213	178	1.8	Insufficient progress
Togo	147	124	103	1.8	Insufficient progress
Guinea Bissau	210	177	150	1.7	Insufficient progress
Djibouti	123	106	91	1.5	Insufficient progress
Burundi	183	164	142	1.3	Insufficient progress
Congo	116	104	93	1.1	Insufficient progress
Gabon	93	88	74	1.1	Insufficient progress
Botswana	59	96	48	1	Insufficient progress
Sudan	125	114	103	1	Insufficient progress
Swaziland	96	114	78	1	Insufficient progress
Cote d'voire	151	148	123	1	No progress
Chad	207	190	173	0.9	No progress
Burkina Faso	205	191	176	0.8	No progress
Kenya	99	111	85	0.8	No progress
Mauritania	124	116	111	0.6	No progress
DRC	181	181	170	0.3	No progress
South Africa	60	78	57	0.3	No progress
Central African Rep.	165	176	159	0.2	No progress
Lesotho	89	127	85	0.2	No progress
Cameroon	137	148	136	0	No progress
Somalia	180	180	180	0	No progress
Zimbabwe	78	115	80	-0.1	No progress

Source: Countdown Report (2012)

Appendix 6.2 Progress towards achieving MDG 5 in selected sub-Saharan Countries, 1990-2010

Maternal Mortality Ratio (Modelled)					
Deaths per 100,000 live births				Average annual rate of reduction (%)	Assessment of progress
Country (Africa)	1990	2000	2010	1990-2010	
Equatorial Guinea	1200	450	240	7.9	On track
Eritrea	880	390	240	6.3	On track
Ethiopia	950	700	350	4.9	Making progress
Rwanda	910	840	340	4.9	Making progress
Angola	1200	890	450	4.7	Making progress
Madagascar	400	490	360	4.7	Making progress
Malawi	1100	840	460	4.4	Making progress
Burkina Faso	700	450	300	4.1	Making progress
Benin	770	530	350	3.9	Making progress
Niger	1200	870	500	3.6	Making progress
Mali	1100	740	540	3.5	Making progress
Togo	620	440	300	3.5	Making progress
Gambia	700	520	360	3.4	Making progress
Guinea	1200	970	610	3.4	Making progress
Tanzania	870	730	460	3.2	Making progress
Mozambique	910	710	490	3.1	Making progress
Senegal	670	500	370	3	Making progress
Cote d'Ivoire	710	590	400	2.8	Making progress
DRC	930	770	540	2.7	Making progress
Ghana	580	550	350	2.6	Making progress
Nigeria	1100	970	630	2.6	Making progress
Liberia	1200	1300	770	2.4	Making progress
Mauritania	760	630	510	2	Making progress
Uganda	600	530	310	3.2	Insufficient progress
Comoros	440	340	280	2.2	Insufficient progress
Djibouti	290	290	200	1.9	Insufficient progress
Sierra Leone	1300	1300	890	1.8	Insufficient progress
Guinea Bissau	1100	970	790	1.7	Insufficient progress
Sudan	1000	870	730	1.6	Insufficient progress
Burundi	1100	1000	800	1.5	Insufficient progress
Gabon	270	270	230	0.8	Insufficient progress
Kenya	400	490	360	0.5	Insufficient progress
Zambia	470	540	440	0.4	Insufficient progress
Central African Rep.	930	1000	890	0.2	Insufficient progress
Cameroon	670	730	690	-0.2	No progress
Swaziland	300	360	320	-0.3	No progress
Botswana	140	350	160	-0.7	No progress
Chad	920	1100	1100	-0.7	No progress
Somalia	890	1000	1000	-0.7	No progress
Lesotho	520	690	620	-0.9	No progress
South Africa	250	330	300	-0.9	No progress
Zimbabwe	450	640	570	-1.2	No progress
Congo	420	540	560	-1.5	No progress

Source: Countdown Report (2012)

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CHAPTER 7: HIV, SEXUALLY TRANSMITTED INFECTIONS, MALARIA AND TUBERCULOSIS

7.1 Introduction

The AIDS epidemic is one of the world's most significant current public health and development crises. At the end of 2011, 34.2 million people were living with HIV. That same year, some 2.5 million people became newly infected, and 1.7 million died of AIDS, including 230,000 children. More than two-thirds of new HIV infections are in sub-Saharan Africa.

HIV and AIDS disproportionately affects the country's mortality and morbidity. Although its prevalence is higher than the regional average, at 6.3 percent for people age 15-49 (KNBS, 2010), it is much lower than many of the Southern African countries. In addition to HIV and AIDS, tuberculosis, and malaria are among the major killers in Kenya (RoK, 2012).

Other than HIV, Sexually Transmitted Infections (STIs) involve more than 30 different sexually transmissible bacteria, viruses and parasites. Infection with STIs can lead to acute symptoms, chronic infection and serious delayed consequences. The presence of an untreated infection increases the risk of both acquisition and transmission of HIV by a factor of up to 10.

Around the world, 3.3 billion people are at risk of contracting malaria. In 2010, an estimated 219 million cases occurred, and the disease killed approximately 660,000 people — most of them children under five in Africa. On average, malaria kills a child every minute. In a 2007 resolution, the World Health Assembly called for a 75 percent reduction in the global malaria burden by 2015.

There were an estimated 8.7 million new cases of TB in 2011 (including 1.1 million cases among people with HIV) and an estimated 1.4 million deaths (including 430,000 people with HIV), making this disease one of the world's biggest infectious killers. The world is on track to reach the MDG target of reversing TB incidence by 2015. However, incidence is falling very slowly. In addition, all regions, except Africa, are on track to achieve the Stop TB Partnership target of 50 percent decline in mortality by 2015.

This chapter focuses on the relevant health conditions underlying the achievement of the Millennium Development Goal 6. Consequently, it documents the situation and trends in HIV and AIDS and STIs, malaria and tuberculosis in the country.

7.1.1 Rationale

HIV and AIDS and Sexually Transmitted Infections

Kenya has had specialized Sexually Transmitted Infections (STI) clinics since the early years of independence. These include Casino STI Clinic in Nairobi and the Ganjoni STI Clinic in Mombasa, which were established long before the first case of HIV was diagnosed in the country. However, from 1995 onwards, HIV and AIDS management as well as opportunistic infections were given more attention by providers, donors and the programme responsible for STI control in Kenya (NASCOP, 2009).

STIs and reproductive tract infections (RTIs) continue to be a serious public health problem in developing countries like Kenya, particularly among women. Consequences of untreated STIs and RTIs include maternal complications, such as ectopic pregnancy, pelvic inflammatory disease and infertility, cancer, neonatal complications and death. STIs and other RTIs have also been proven to increase the likelihood of contracting or transmitting HIV (Republic of Kenya, 2010). STIs are also responsible for the

loss of a substantial proportion of people's productive years in many countries (World Bank, 1993). The World Development Report 1993 estimated that globally, in high-prevalence urban areas, STIs account for up to 17 percent of productive healthy life years lost.

However, given that there are more virulent types of STIs (such as gonorrhoea) that have become resistant to the available antibiotics, there is need to refocus our attention on STIs/RTIs³³. Although STIs remain among the leading causes of Kenya's overall disease burden, the focus on HIV and AIDS in the last 10-20 years has overshadowed the predominance of STIs (NCAPD et al., 2010).

On the other hand, it is now over three decades since HIV and AIDS was first reported. The disease has become a devastating pandemic, taking the lives of 30 million people around the world. In 2010 alone, HIV and AIDS killed 1.8 million people, 1.2 million of whom were living in sub-Saharan Africa (UNAIDS, 2011). Though life-saving antiretroviral treatment (ART) is available, access is not yet widespread globally: of the estimated 14.2 million HIV-positive individuals in need of the treatment, over half (8 million) are not currently able to access it. It is, however, important to note that according to the Kenya AIDS Epidemic Update (2012), Kenya has one of the world's highest coverage rates for services to prevent mother-to-child transmission (MTCT) of HIV, with 69 percent of HIV-positive pregnant women receiving ARV prophylaxis in 2011. As a result of scaled-up prevention services, the proportion of HIV-exposed infants who contract HIV has fallen from 27 percent in 2007 to 14.9 percent in 2011. The same Update (2012) reckons that Kenya is also the global leader in scaling up voluntary medical male circumcision (VMMC) for adult males, which is deemed to reduce the risk of female-to-male HIV transmission by at least 60 percent.

HIV represents one of the greatest public health and social challenges confronting the Kenyan people. In the face of this challenge, Kenya has put in place policies and programmes to combat the scourge. As at December 2011, 1.6 million people in Kenya were living with HIV, managing to live longer as a result of increased access to ARV treatment. It is projected that the number of Kenyan people living with HIV will continue to grow, placing continuing demands on health and social service systems (Office of the President, 2012). Kenya is experiencing a mixed and geographically heterogeneous HIV epidemic. Its characteristics are those of both a 'generalized' epidemic among the mainstream population, and a 'concentrated' epidemic among specific most-at-risk populations (MARPs). The pattern emerging is of highly variable epidemiological dynamics geographically, with respect to modes of transmission, and with substantial age and sex differentials (Ministry of Health, 2007).

Even more troublesome is the fact that new HIV infections continue to outpace those added onto ARV treatment. Worldwide, more than 390,000 infants and children were newly infected with HIV in 2010, and 2.7 million new HIV infections occurred in the same year, a rate that has held relatively constant since 2006 (UNAIDS, 2010). Further, studies have shown that HIV infection is a potent risk factor for tuberculosis (TB) infection. HIV increases the risk of reactivating latent mycobacterium tuberculosis infection and the rapid progression after infection or re-infection with TB (Bucker et al., 1999: 501-507; Corbett et al., 2003).

Malaria

Malaria is recognized as a health and socio-economic burden by the Government of Kenya. Thus malaria control is a priority investment as articulated in the second National Health Sector Strategic Plan (NHSSP II, 2005–2010, extended to 2012) and the Ministry of Public Health and Sanitation Strategic Plan 2008–2012.

³³ See <http://www.cdc.gov/std/gonorrhea/arg/> Accessed on 2.03.13.



A mother and baby sleep under a treated mosquito net.
Photo: <http://savananewsblogspotcom.blogspot.com>

The Government's vision of a malaria-free Kenya emerged in 2009 as a result of the development of a multi-sector malaria control strategy to run from 2009 to 2017, with clear and focused strategic approaches and objectives. Through the multi-sector approach, the line ministries — Education, Water, Agriculture, Local Authorities, Public Works, and Regional Development — were expected to identify key malaria control roles and activities in which they were involved. These included integrated vector management (IVM), indoor residual spraying (IRS), environmental impact assessment (EIA), and training of health workers (KMPPR, 2009). There is increasing but limited evidence from the Kenya Malaria Indicator Surveys that shows that the epidemiology and risk of malaria in Kenya are declining. However, most of this evidence is available at sub-national levels where interventions have been intensified. Country-wide progress is more difficult to assess due to limited or incomplete data.

Tuberculosis

Observations regarding TB indicate that it is one of the most ancient diseases of mankind and has co-evolved with humans for thousands of years or perhaps for several million years (Hirsh et al, 2004). In spite of newer modalities for diagnosis and treatment of TB, unfortunately, millions of people are still suffering and dying from the disease. Tuberculosis is one of the top three infectious killer diseases in the world: HIV and AIDS kills three million people each year; TB kills two million; and malaria kills one million (WHO, 2010). Even though tubercle bacilli was identified nearly 130 years ago, a definitive understanding of pathogenesis of this disease is still deficient (Brosch et al, 2002; WHO, 2006). In Kenya, TB has been recognized as a major national health problem since it is among the top ten leading causes of morbidity and mortality. According to a World Health Organization Report (2012), it is estimated that the burden of disease caused by TB in Kenya ranges between 11 and 36 per 100,000 for mortality.

The prevalence ranges between 152 and 475 per 100,000; the incidence ranges between 276 and 300 per 100,000 of the population, while HIV prevalence among TB patients ranges between 39 and 40 per 100,000 of the population. TB has been ranked as the fourth leading cause of death among Kenyans of all ages, and ranks sixth amongst the causes of morbidity by disability-adjusted life years (DALYs).

TB affects people in all age groups but has its greatest toll on those above 15 years of age. Kenya is among the top 22 countries that collectively contribute to 80 percent of the world's TB cases (Republic of Kenya, 2012). Several factors that have contributed to the large TB disease burden in Kenya include the HIV epidemic, poverty, rapid urbanization that has led to a proliferation of urban slums, prison congestion and limited access to general health care services. In 1993, the World Health Assembly set up global TB control targets which were to detect 70 percent of infectious cases, and successfully treat 85 percent of the detected cases by 2005. The TB control targets for the Millennium Development Goals (MDG) are to have halved the mortality due to TB by 2010, and to halt and begin to reverse the incidence of TB by 2015. In order to address the growing burden of TB in Kenya, the Ministry of Health formed the Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) to increase support in:

- Strengthening of the human resource capacity at all levels of the DLTLD for effective coordination of TB control activities;
- Decentralisation of TB control services down to the community level to increase access to services;
- Strengthening the collaboration between TB and HIV control programmes in order to promote delivery of integrated TB and HIV services, and public-private partnerships to increase the number of private providers integrated into the TB service provider network; and
- Sustaining public education campaigns coupled with health care worker training and support to promote early care seeking and adherence to treatment at the community level, and better TB case management by health care providers.

The DLTLD adopted the Directly Observed Therapy Short Course (DOTS) strategy for the control of TB in 1993 in line with the Stop TB Strategy, and achieved countrywide geographic DOTS coverage by 1997. The DOTS strategy is considered to be the most cost effective strategy globally, and embraces:

- Sustained political commitment to increase human and financial resources integrating TB control into the national health system;
- Assured access to quality TB sputum microscopy, standardized short course chemotherapy to all diagnosed cases of TB, and case management under direct observation of treatment (DOT);
- Uninterrupted supply of quality assured drugs with reliable procurement and distribution systems; and
- Recording and reporting system enabling outcome assessment of each and every patient and overall assessment of the programme.

Despite nearly a decade of countrywide implementation of DOTS, Kenya is yet to achieve the agreed 70/85 TB control targets. The TB case notification rate (CNR) rose from 51 to 329 per 100,000 of the population between 1987 and 2006. The WHO estimates show that the case detection rate (CDR) for 2004 was around 47 percent while the treatment success rate has been steadily increasing to reach 82 percent in 2006. It is for this reason that the DLTLD, in line with international trends, launched several new approaches to increase access to DOTS, and to truly expand the population DOT coverage. These approaches include the community-based DOTS (CB-DOTS), public-private mix for DOTS (PPMDOTS), collaboration between TB and HIV control programmes, and the development of an elaborate advocacy, communication and social mobilization strategy aimed at influencing communities to seek care early when TB symptoms occur, and to remain on treatment until it is completed. In spite of these new approaches, DLTLD has encountered the challenge of providing integrated TB and HIV services in addition to other interventions without a commensurate increase in the human resource available for

TB control. Additionally, there have been increasing concerns about the emergence of drug resistant TB, a threat that would pose major challenges in the fight against TB in this resource limited country.

7.1.2 Data and Methods

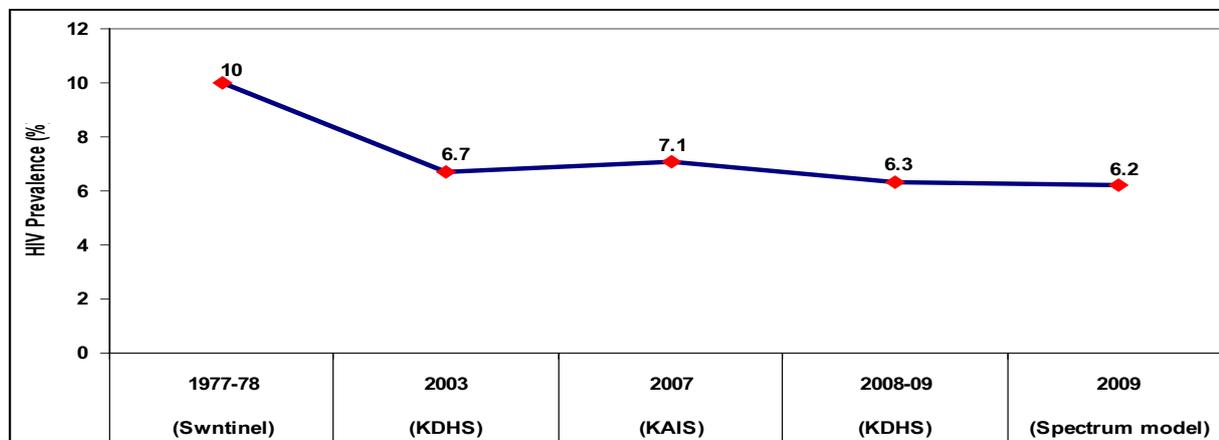
The information contained in the report is based on a review of existing reports. Kenya has a number of sources of information on HIV prevalence levels and trends. Three national surveys all provide reliable estimates of both the HIV prevalence and the trend over those years, including the 2003 and 2008-2009 Kenya Demographic and Health Surveys (CBS, MOH and ORC Macro, 2004), and the 2007 Kenya AIDS Indicator Survey (Ministry of Health, 2009). Additional data is derived from the antenatal clinic (ANC) surveillance which has been conducted since 1990, starting with 13 sites and expanding to 44 sites by 2011. ANC surveillance provides information on trends at surveillance sites, which was particularly in the period before the 2003 KDHS. There is also routine data on HIV and AIDS that is compiled by the National AIDS Control Council (NACC). Information on malaria and TB in this section is based mainly on the Malaria Indicator Survey of 2010, and the Health Situation Trends and Distribution: 1994-2010, and Projections for 2011–2030 (MOPHS and MEDS, 2012).

7.2 Levels, Trends and Patterns HIV Prevalence

The Kenya Country Report for 2010 documented trends in HIV prevalence in the country, including prevalence by sex, place of residence, region, marital status, and among children. It also contains information on MARPs. This section describes these trends.

HIV prevalence in Kenya has been declining in the last two decades; with national estimates showing that in the period 1977-1998, the prevalence among adults aged 15 to 49 was 10 percent (sentinel surveillance). This had declined to 6.3 percent by the time of the 2008-2009 KDHS (see Figure 7.1.). Prevalence declined sharply between 1977-1978 and 2003, after which the rates tapered off.

Figure 7.1 HIV Prevalence among women aged 15-49, 1977-2009



Source: Various Reports: 2003 & 2008-09 KDHS Reports; 2007 KAIS Report

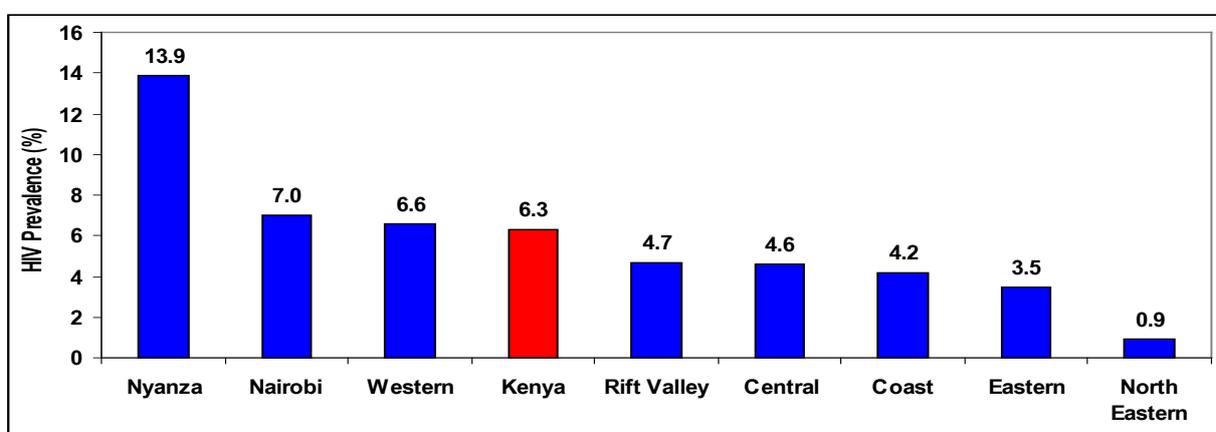
7.2.1 Differentials in HIV prevalence

Studies show that Kenyan women have a prevalence rate almost twice that for men. According to the 2007 KAIS, women had a prevalence of 8.4 percent compared with 5.4 percent for men. These estimates compared somewhat well with the eight and 4.3 percent for women and men respectively in the 2008-2009 KDHS. Young women aged 15 to 24 had a prevalence rate that was four times to that of young

men in the same age group, that is 5.6 percent against 1.4 percent in the 2007 KAIS, and 4.5 percent against 1.1 percent in the 2008-2009 KDHS. The 2007 KAIS was the first study to include older adults aged 50 to 64. The survey estimated HIV prevalence in the 50 to 64 age group at 5.0 percent, which did not differ significantly by sex (5.2% for women compared to 4.7% for men). This shows the need to provide HIV services to this age group which had previously been assumed not to be at such high risk of HIV infection.

There are variations in HIV prevalence across regions, as well as between urban and rural areas. According to the 2008-2009 KDHS, HIV prevalence among adults aged 15 to 64 in rural areas was estimated at 6.7 percent compared to 8.4 percent among adults living in urban areas. For adults aged 15 to 49 in urban areas, 7.2 percent were infected compared with six percent in rural areas. However, given that the majority of people (75%) reside in rural areas, the absolute number of HIV infections is higher in rural than urban areas, with an estimated one million adults in rural areas being infected, compared to 0.4 million adults in urban areas. HIV prevalence also varies by region, ranging from 0.9 percent in North Eastern Province to 13.9 percent in Nyanza Province, as shown in Figure 7.2 below.

Figure 7.2 HIV Prevalence by Region, 2008-2009 KDHS

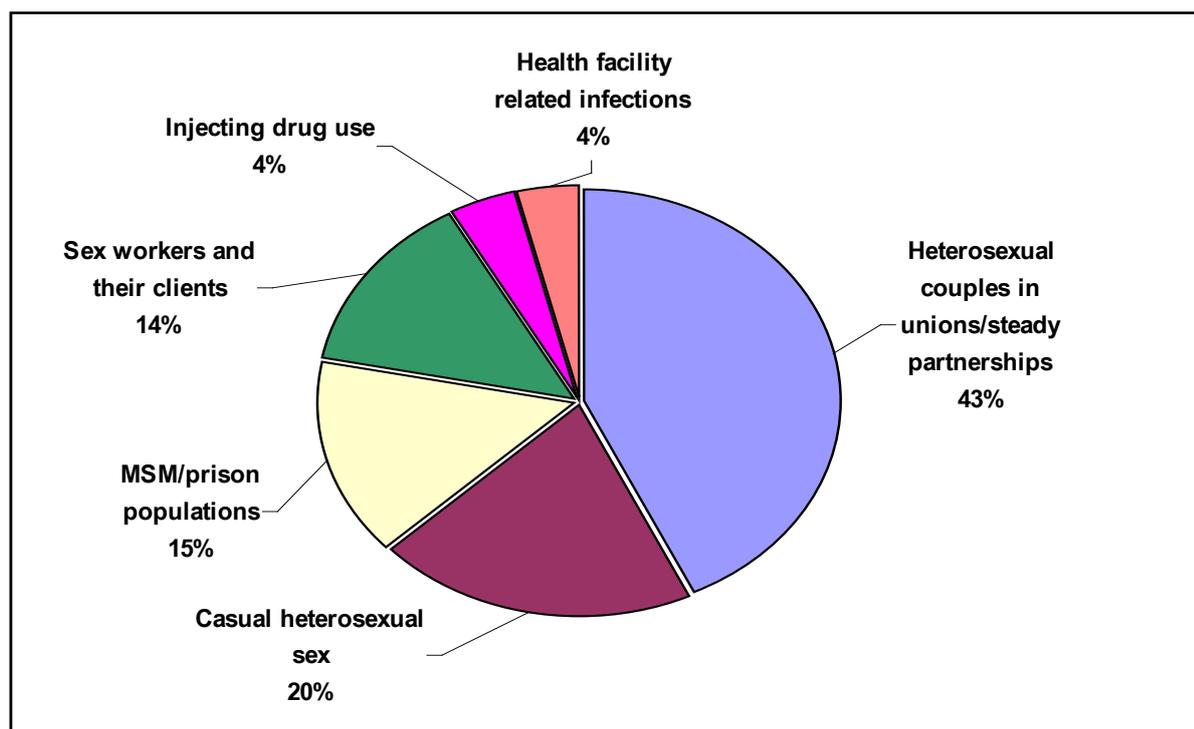


Source: 2008-09 KDHS Report

7.2.2 Sources of new HIV infections

Recent surveys indicated that HIV prevalence had stabilized (2007 KAIS; 2008-2009 KDHS), but the Mode of Transmission Study showed that Kenya had a mixed HIV epidemic (MoT, 2008). These studies revealed a high HIV prevalence amongst a number of key affected groups, including sex workers, injecting drug users (IDUs), men who have sex with men (MSM), truck drivers and cross-border mobile populations (see Figure 7.3 below).

Figure 7.3 Sources of New HIV Infections, Kenya, Mode of Transmission Survey, 2008



Source: NASCOP (2010: 22).

Some of these groups are stigmatized within society; for example, homosexuality is illegal in Kenya and punishable by up to 14 years imprisonment. Therefore, these groups are difficult to reach with HIV prevention, treatment and care. Further, and consequent to the stigmatisation, the extent of HIV incidence in these groups has not been fully explored and understood (UNGASS, 2008).

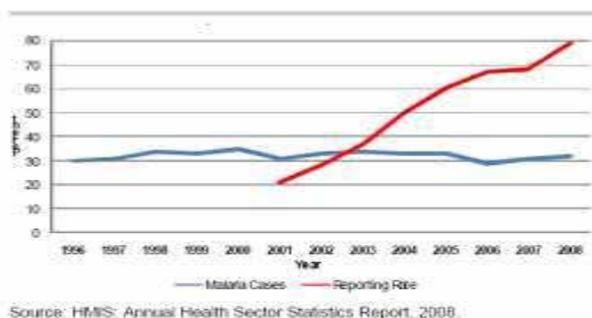
7.3 Malaria

Kenya is ranked fifth in the list of 19 countries that are estimated to account for 90 percent of the malaria cases in the African region, with Nigeria, DR Congo, Ethiopia and Tanzania being the top four (WHO, 2008). Levels of endemicity of malaria in Kenya vary from region to region; and there is diversity in risk largely driven by altitude, rainfall patterns and temperature. An estimated 30 percent of all out-patient morbidity and 19 percent of in-patient admissions in Kenya have been attributed to malaria (KMIS, 2007). Furthermore, about 17 million person-hours are lost annually to malaria illness.

7.3.1 Trends in Morbidity and Mortality

The 2004 Global Burden of Disease report provides the latest national level estimates of the burden of malaria in Kenya. It is estimated that malaria accounts for about six percent of all deaths and seven percent of DALYs in Kenya. Furthermore, about 11 percent of deaths in children under-five years have been attributed to malaria. Figure 7.4 shows the out-patient trends in clinically diagnosed malaria and reporting rates, as captured in the HMIS. While reporting rates increased steadily from 2001, levels of clinically diagnosed malaria had remained fairly stable at around 30 percent from 1996 through 2008.

Figure 7.4 Trends in Malaria Diagnosis in Kenya, 1996 - 2008

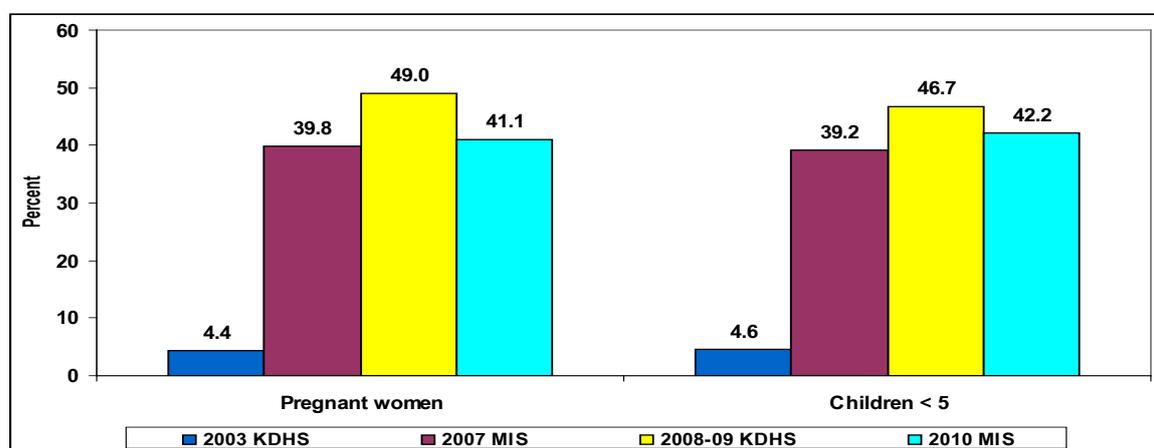


In-patient trends are a bit more difficult to interpret, but there appears to have been an increasing trend in both malaria in-patient morbidity and mortality for the period 2000–2008. However, these conclusions must be interpreted with caution given the likelihood of over-diagnosis of malaria due to the preponderance of clinical rather than laboratory confirmation of cases. Moreover, hospital-based morbidity and mortality data are not nationally representative as they exclude cases occurring outside health facilities. Thus, objective evaluation of true malaria in-patient morbidity and mortality trends in Kenya is difficult. However, data available from sentinel and demographic surveillance sites in various parts of the country provide useful information on malaria trends. For instance, there is documented evidence of decline in mortality in children less than five years in sentinel districts along Kenya’s coast attributed to the use of insecticide treated nets (ITNs) (Okiro et al, 2007; O’meara et al, 2008). This additional data is useful in augmenting facility-based data to develop a more wholesome epidemiological picture.

7.3.2 Coverage of Insecticide Treated Nets

There has been extensive progress in ITN coverage, rising from a low four percent in 2003 to about 48 percent in 2008 for both the targeted population groups, pregnant women and children under-five, as presented in Figure 7.5. However, for both population groups, user levels declined marginally into 2010.

Figure 7.5 Overall Trends in ITN use, 2003-2010

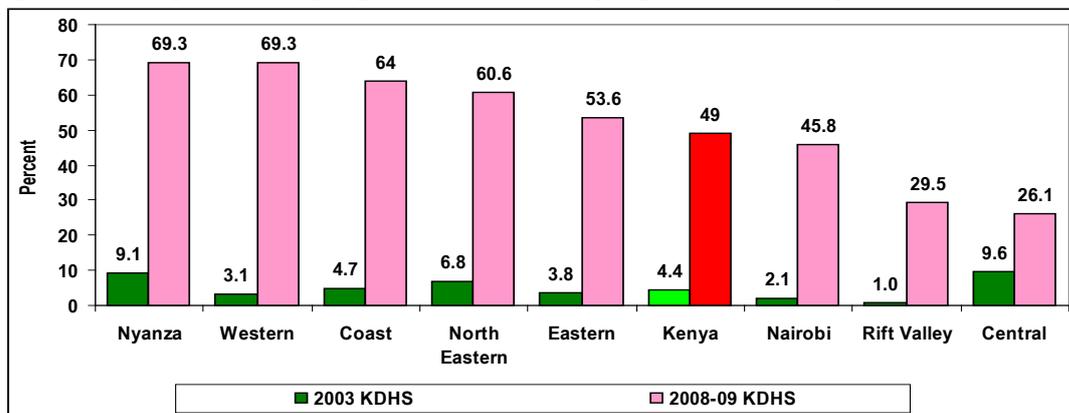


Source: 2003 & 2008-09 KDHS Reports; 2007 & 2010 KMIS Reports

Overall, use of ITNs by pregnant women has increased since 2003, with coverage of about 50 percent by 2008. Regionally, ITN coverage of pregnant women increased significantly in all the provinces between

2003 and 2008. Central and Rift Valley provinces recorded the lowest levels of ITN usage (less than 30%), followed by Nairobi at 46 percent. The rest of the provinces had at least 54 percent of pregnant women using ITNs, as shown in Figure 7.6.

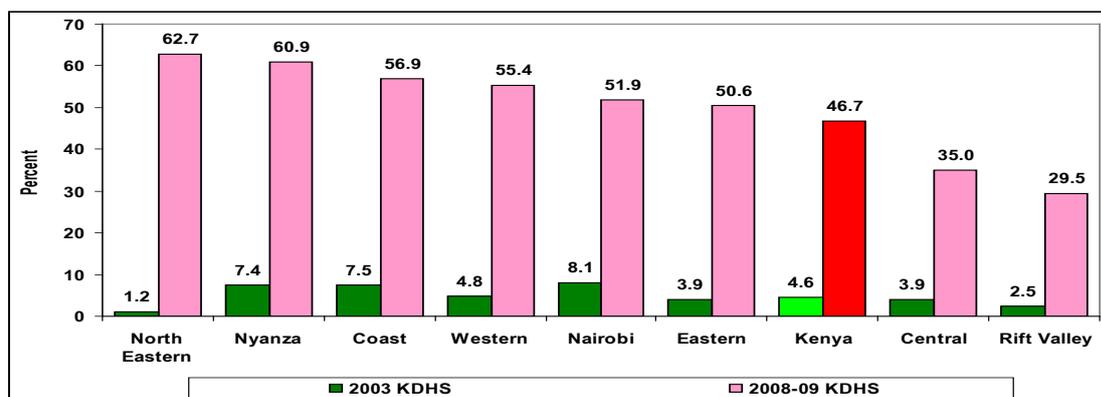
Figure 7.6 Proportion of pregnant women sleeping under ITN by province, 2003-2008



Source: 2003 & 2008-09 KDHS Reports

The overall ITN coverage rate of children under five years increased between 2003 and 2008, as shown in Figure 7.7. However, slightly less than 50 percent of children under-five years of age were using ITNs in Kenya in 2008. As was observed for pregnant women, the 2008 rate of ITN use by children under five years of age in Central and Rift Valley provinces remained lower than the national level, as presented in Figure 7.7. Otherwise more than 50 percent of children under five used ITNs in the other six provinces in 2008.

Figure 7.7 Percent of children under 5 sleeping under ITN by province, 2003-2008

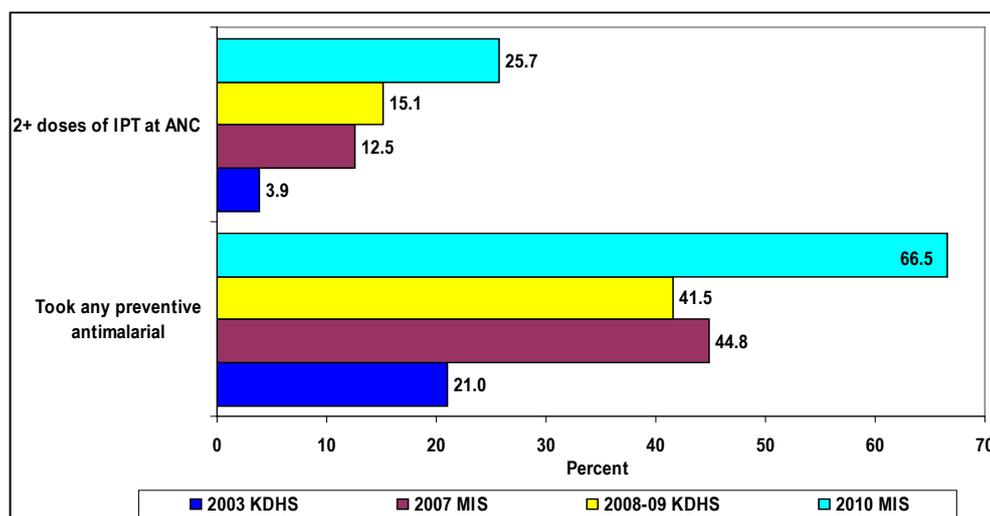


Source: 2003 & 2008-09 KDHS Reports

7.3.3 Intermittent Preventive Treatment in pregnancy (IPTp)

There has been a steady increase in intermittent Preventive treatment in pregnancy (IPTp) uptake from four percent in 2003 to 15 percent in 2008, and eventually to 26 percent in 2010. However, there is still a considerable gap between the proportion of women who reported taking any preventive anti-malarial in pregnancy and those who took two doses of IPTp during ante-natal care. This gap has remained largely unchanged between 2003 through 2010 as portrayed in Figure 7.8.

Figure 7.8 Trends in IPT Uptake, 2003 -2010

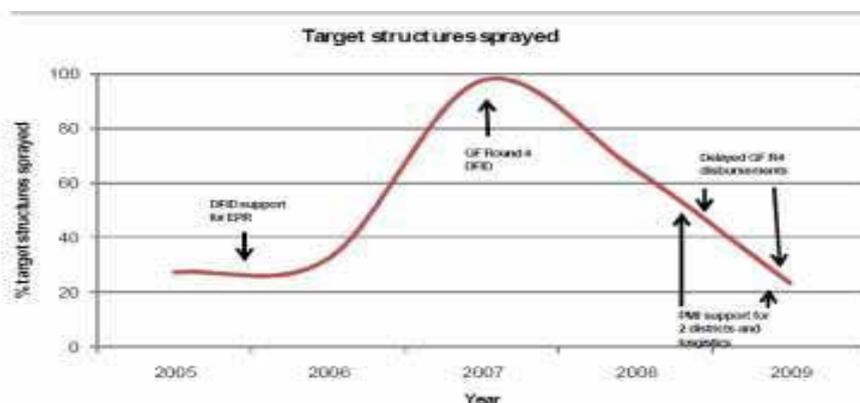


Source: 2003 and 2008-09 KDHS; 2007 and 2010 KMIS

7.3.4 Coverage of Indoor Residual Spraying (IRS)

Indoor residual Spraying (IRS) is conducted for epidemic prevention in highland prone districts and for reduction of the disease burden in three districts in the lake endemic region. Net use is encouraged for all persons whether IRS has been undertaken or not. The peak in IRS coverage occurred in 2007, which coincided with the Global Fund/DFID Round 4 disbursements, as illustrated in Figure 7.9. This peak was, however, followed by a steady decline which coincided with delays in Global Fund disbursements. However, according to the Malaria Indicator Survey (MIS) 2010 results, 44 percent of children under five in highland epidemic prone districts slept under an ITN, while an additional 22 percent slept in a house that had been sprayed in the preceding 12 months. In the lake endemic region, 48 percent slept under an ITN and an additional 10 percent slept in houses that had been sprayed in the preceding 12 months.

Figure 7.9 Trends of IRS coverage, 2005 - 2009



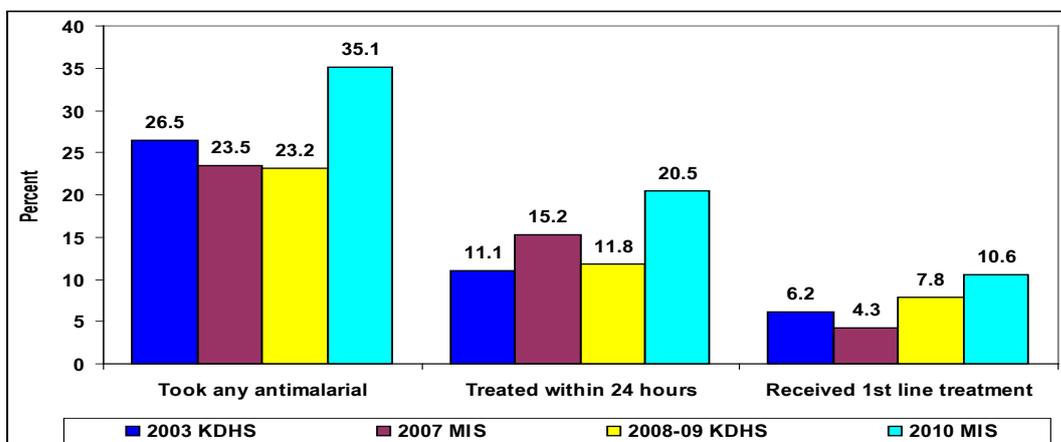
Source: RoK, Kenya Health Policy Framework 1994–2010: Analysis of Performance

7.3.5 Access to Prompt Anti-malarial Treatment

In 2003, about 27 percent of children with fever reported taking any anti-malarial treatment. While this proportion slightly dropped between 2007 and 2009, it increased to 35 percent in 2010 (Figure 7.10). About 11 percent of these children reported being treated with anti-malarial within 24 hours of the

on-set of the illness in 2003. This rose to 15 percent in 2007, then dropped to 12 percent in 2009, and eventually climbed to a level of 21 percent in 2010. By contrast, the proportion of children who reported to have received the first line treatment for malaria decreased from six percent in 2003 to four percent in 2007, only to increase to eight percent in 2009, and to 11 percent in 2010.

Figure 7.10 Access to prompt treatment with anti-malarial for children, 2003-2010

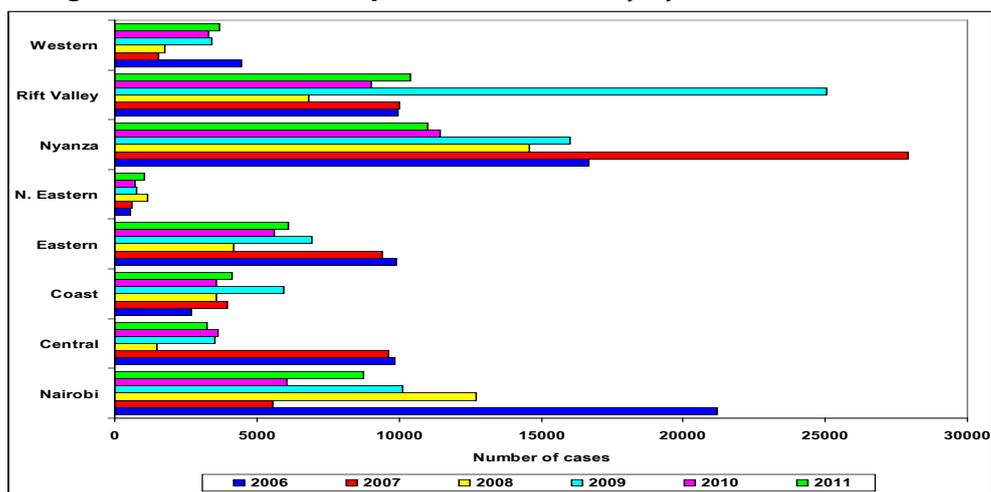


Source: 2003 and 2008-09 KDHS; 2007 and 2010 KMIS

7.4 Tuberculosis

National TB case notification rates have increased steadily from 50/100,000 in 1990 to 288/100,000 in 2007 for all forms of TB. Smear positive pulmonary TB cases ranged from 38/100,000 to 98/100,000 between 1990 and 2008, reflecting an increasing amount of TB in the country. At regional level, TB case notification rates rose steadily from 1996 to 2003, and then either plateaued or decreased between 2003 and 2007 for all provinces except Eastern, Central and Western. Nyanza Province had the highest notification rates for all forms of TB, while North Eastern Province had the lowest. Further, as shown in Figure 7.11, notification rates between 2007 and 2011 decreased in three provinces (Central, Eastern, Nyanza) while they either plateaued or increased in the remaining five provinces (Nairobi, Coast, North Eastern, Rift Valley, Western).

Figure 7.11 Trends in Outpatient TB Morbidity by Province, 2006–2011

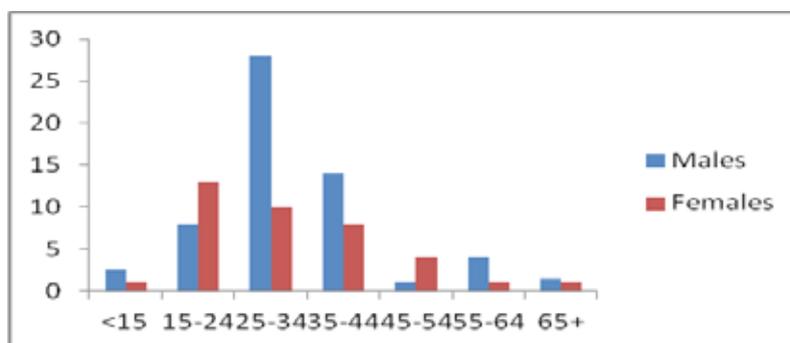


Source: Statistical Abstract, 2012

7.4.1 Drug resistant TB

One of the consequences of treatment failure that is emerging as a major public health problem in Kenya is that of drug resistant TB (DRTB), and its variants, including multi-drug resistant TB (MDRTB), poly-drug resistant TB (PDRTB), and extremely drug resistant TB (XDRTB). Figure 7.12 shows that the majority of the patients diagnosed with DRTB were males aged 25-34, with 40 percent of the cases being seen at Kenyatta National Hospital, the largest referral hospital in the country. Significantly, 27 percent of those with DRTB were also HIV positive.

Figure 7.12 Percentage of DRTB cases by age group and Sex



Source: NTLP administrative Data, 2009

The optimal care and control of TB is dependent on functional laboratory systems. Although the laboratory network in Kenya has been growing, Kenya needs many more facilities and well-trained staff to run them to provide optimal TB care and control services. In support of the provision of quality TB care, attention must also be focused on improving laboratory management, adapting new technologies for speeding up and improving quality of culture and DST diagnostics, and improving the laboratory logistics and commodity management chain. As at 2011, Kenya had a total of 1,581 laboratories which translates to 3.8 laboratories per 100,000 of the population (WHO, 2012). Compared to other countries in the region, Kenya had a higher number of laboratories: Uganda had 1,081 laboratories (3.1/100,000); Tanzania had 945 laboratories (2.0/100,000); and South Africa had only 244 laboratories (0.5/100,000) (WHO, 2012). Children continue to carry a large burden of TB morbidity and mortality, with about 12 percent of the total burden accounted for by children under 15; yet specialists available to treat them are few, and the capacity to diagnose them properly remains limited (Republic of Kenya, 2012).

7.5 Existing policies and programmes

To combat malaria, the Ministry of Health (MOH), through the National Malaria Control Programme (NMCP), developed the National Malaria Strategy (NMS) covering the period 2001-2010. The main goal of the NMS was to reduce the level of malaria infection and consequent deaths by 30 percent by 2006, and to sustain the improved level of control to 2010. These targets are in line with benchmarks for measuring progress in malaria control as stipulated in the Abuja Declaration and the Roll Back initiative (WHO/CDS/RBM, 2000). In order to meet these targets, the current MoH policy on malaria recommends several strategies. Firstly, the policy states that all pregnant women living in areas prone to malaria should have access to at least two free SP doses, or other suitable prophylactic drug regimen – which constitutes IPTp. The policy also provides for personal protection to people at risk of malaria, especially young children and pregnant women through increased access to ITN and longer lasting insecticide nets (LLIN). Furthermore, it is recommended that all fevers in children under five years be presumptively treated for malaria with artemisinin combination treatment (ACT), which is provided free of charge at Government and mission health facilities.

Table 7.1 Intervention Policies and Strategies for Malaria in Kenya

Intervention	WHO-Recommended Policies/Strategies	Yes/No	Year Adopted
ITN/LLIN	ITNs/LLINs Distributed free of Charge	Yes	2006
	ITNs/LLNs Distributed to all age group	Yes	2010
IRS	IRS is recommended	Yes	2009
	DDT is used for IRS	No	-
Case Management	Patients of all ages should receive diagnostic test	Yes	2009
	RDTs used at community level	No	-
	Pre-referral treatment with recommended medicine	Yes	2006
	Marketing Authorization for all oral artemisinin based monotherapies withdrawn	No	-

Source: WHO Malaria Report, 2012

7.6 Challenges

HIV and AIDS Challenges

- Care of HIV infected and affected people is a big problem, especially for families. One component of this population is the number of HIV and AIDS orphans that has been growing steadily from 27,000 in 1990 to 1.2 million in 2002, and further to 2.4 million by 2007.
- Sexual abstinence among the youth is still low. Age at first sexual intercourse has slightly increased when compared with data from KDHS 2003. The median age at first sex among women age 20-49 slightly increased from 17.8 years to 18.2 years, while that of men aged 20-54 increased from 17.1 to 17.6 years. Delayed sexual debut and condom use have been listed as the main avenues for the reduction of prevalence in Kenya.
- HIV-related stigma throughout society continues to pose a challenge. It inhibits many people from seeking HIV testing services and accessing ART, and is also a major contributor to the poor adherence by many people to ART regimes.
- Given that about 90 percent of the resources for the HIV response comes from development partners, unpredictability and sustainability of financing for the epidemic remains quite a challenge to the Government of Kenya.

7.7 Gaps and challenges

Apart from HIV and AIDS, data is scarce for trend analysis for STIs, malaria and TB. According to the WHO Malaria Report (2012), Kenya does not have sufficient data with which to assess trends in malaria morbidity and mortality.

Tuberculosis

To meet the MDG target on TB, several challenges need to be overcome, including:

- Infrastructure:- There is inadequate space for the increased demand for laboratory and chest clinic services;
- Equipment for TB diagnosis is limited in supply;
- Involvement of all stakeholders in TB control, especially the involvement and empowerment of communities hosting people living with or affected by TB;
- The evolution of MDR-TB that has a very high mortality rate;
- Threat of HIV which continues to fuel TB; and
- Misconception that TB is not treatable, delaying infected people's search for treatment.

Malaria

Among the current challenges in combating the malaria menace include:

- Impact of the investment in malaria control over the past ten years and the gains made in reducing morbidity and mortality are difficult to measure within the routine health system as nearly all fevers are diagnosed and treated as malaria;
- Parasitological diagnosis of malaria is still low;
- General knowledge about the recommended malaria treatment in the communities remains low;
- Poor diagnostic equipment;
- Weak distribution of ITNS, and diversion of the same to other uses; and
- Malaria drug resistance.

7.8 Conclusion

There have been efforts to revitalize the national STI/RTI control activities in the country, leading to the **reconstitution of the National STI Technical Working Group** which has developed STI prevention and control targets, and an Action Plan. These initiatives could be incorporated into the National Plan of Action (2009-2011) for KNASP III that covers the period (2009/2010-2012/2013) and the National Health Sector Strategic Plan. Further, there has been a **review of the syndromic management charts** in line with the WHO recommendations that made them consistent with available drugs for managing STIs in Kenya. This activity was meant to support health workers to provide services to clients or patients seeking services at the moment of contact. Studies **of drug sensitivity and STI surveillance have been undertaken in order** to inform comprehensive revision of the national STI/RTI guidelines and curriculum. The STI surveillance system was expected to clearly define syndromic versus aetiologic types to be used to inform information needs and data collection tools. A consistent surveillance system should continuously validate the various treatment algorithms. Three studies are currently at different stages of implementation, including:

- Urethritis pathogens and antimicrobial susceptibility profile of *Neisseria gonorrhoeae* among male patients presenting with urethral discharge syndrome in Nairobi, Kenya;
- Etiologic Surveillance for Genital Infections among HIV-infected Adults in HIV Care Programs in Kenya (data analysis complete); and
- Qualitative Assessment with Health Care Providers (HCPs) to Improve Sexually Transmitted Infection (STI) Management in HIV Care and Treatment Clinics in Kenya.

There are also efforts to scale-up lessons learnt and experiences from integrating the management of STIs/RTIs into reproductive health settings, such as FP, ANC, PNC, maternity units, outpatient clinics, etc. This was done in a national STI/RTI forum³⁴.

With regard to HIV prevalence, there has been a downward trend generally. However, differentials still exist with regard to age and sex and special high risk groups. HIV stigma continues to be a challenge that needs attention in order to sustain the decline in HIV prevalence in the country. According to the Kenya AIDS Update Report, 2012, priority recommendations for ensuring long-term success in Kenya's AIDS response are as follows:

- AIDS must remain a pre-eminent national priority.
- Kenya should take steps to enhance the strategic focus of its AIDS response.
- Intensified efforts are needed to enhance coordination, harmonization and alignment of the national response.
- Support should be expanded for grassroots community action and capacity development.

³⁴ See http://nascop.or.ke/sexually_transmitted_infection.php, 2013

- A high-profile, multi-pronged strategy should be implemented to ensure sufficient financial resources to address the long-term challenge posed by AIDS.
- All partners engaged in the AIDS response in Kenya should intensify efforts to enhance the efficiency of AIDS programmes and quality of AIDS services.
- Kenya should re-commit to the achievement of the 2013 targets in KNASP III.
- Kenya should elevate the priority accorded to efforts to prevent new HIV infections, including focused efforts to maximize the prevention impact of antiretroviral therapy.
- Strategies to reduce HIV risk must be supported by energetic, courageous efforts to address the social determinants of vulnerability.
- Kenya should accelerate scaling up of comprehensive HIV treatment, care and support.
- At the same time that AIDS programmes are brought to scale, dramatically stronger efforts are needed to strengthen the country's health system.

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CHAPTER 8: THE YOUTH: STATUS AND PROSPECTS

8.1 Introduction

In paragraph 8 (a) of the World Programme of Action for Youth (WPAY-1995)³⁵, the UN General Assembly adopted resolution 50/81 of 14 December 1995, which emphasized that “every State should provide its Young People with opportunities for obtaining education, for acquiring skills and for participating fully in all aspects of society”(UN, 2007). Since the adoption of WYPAY-1995, Governments, the international community, civil society and other actors have increasingly recognized the importance of investing in the youth (UN, 2007). Today, adolescents and the youth represent the biggest generation in human history, reports Lam (2006) who adds that between one third and one half of the population in developing countries (including Kenya) is under 20. Their transition to adulthood needs to be understood and taken into account in the larger developmental context. However, increased poverty, social inequalities, low quality education, gender discrimination, widespread unemployment, weakened health systems, and rapid globalization are the realities with which young people grow (UN, 2005). It is worth mentioning that the HIV and AIDS pandemic has made today’s adolescents the first generation growing up with the disease (UNFPA, undated).

This section presents the status of the youth because of their unique situation in planning for, and implementing the development agenda. It specifically focuses on reproductive health and access to education and employment because during this stage young people prepare for, and begin to take on, adult roles in terms of family formation, financial independence and citizenship. This focus is anchored on statement in the World Development Report to the effect that:

“decisions that will affect young people’s well-being and society’s are those that shape the foundational human capital to be productive workers, family heads, citizens and community leaders” (World Bank, 2007: 5)

Human development during the youthful stage of life is not a uniform process. The youth life cycle is also an important critical period of development of the individual, meaning that any significant harm that occurs is likely to produce severe, often irreversible and intergenerational effects (World Bank, 2007).

8.1.1 Rationale

People’s behaviour and needs vary at different stages of the life cycle. Changes in a country’s age structure have significant effects on its social, economic and political performance. Globally, the youth make a very heterogeneous group with a variety of needs determined by age, sex, marital status, schooling levels, residence and other socio-economic characteristics (UNFPA, 2012). This implies that as young people transit into adulthood, their experiences are by no means the same.

Adolescence is also an important time to acquire the necessary skills, health, social networks and other attributes that form the social capital necessary for a fulfilling life. However, the challenges for young people during the transition to adulthood are greater today than ever before (UNFPA, 2012). Whereas young men and women tended to move directly from childhood to adult roles in the past; today the interval between childhood and the assumption of adult roles is lengthening (National Research Council and Institute of Medicine, 2005). In many parts of the developing world, the youth face serious

³⁵ The UN’s World Program of Action for Youth defines “youth” as people ages 15–24, while the World Health Organization (WHO) and UNICEF use the terms “adolescent” for those 10–19, “youth” for those 15–24, and “young people” for those 10–24. The wider band of 10–24 years used by these agencies recognizes that many policies directed at youth often need to influence outcomes before the age of 15. This report uses youth for those in age group 15-24 while young people as those in age group 10-24. Youth represents the transition from childhood to adulthood and involves biological transformation as well as economic, social and institutional adaptation (Lloyd, 2005)

challenges associated with growing up, with some of the most critical ones being those related to sexuality and reproduction. This is because they are at a stage in their lives when they are exploring and establishing their identity in society, needing to develop the life skills that will enable them to be responsible adults and socially fit into society. In sub-Saharan Africa, the combination of poverty and conflict exacerbates the difficult circumstances of the youth, calling for well focused interventions that can enable them to realise economically active lives (UNFPA, 2011).

The youth are also an enormous resource for a nation's growth and development and the potential long-term benefits of the human capital accumulated during adolescence and in youthfulness make a strong macro-economic argument to support increased investment in their health, education and economic development (UNFPA, 2011). Failing to undertake such investment in young people's health and education, and failing to plan for the exploration of their full potential will mean losing the implicit demographic opportunity (Gribble and Bremmer, 2012).

Kenyan youth are vulnerable just like others elsewhere on the globe, with diverse needs that require attention across all sectors. Although the youth have always had the numbers compared to the rest of the population, this had never translated into tangible access to power and other opportunities: of the 13.7 million youth in the national population, more than half (approximately 7.6 million) live in poverty. However, the country's Constitution (2010) has significantly strengthened the context for democratic and accountable Government, particularly through a devolved system of Government to 47 counties (Chapter 11). The Constitution and the legislations arising from it specifically reserve seats in key decision-making bodies in the national and county Governments for hitherto marginalised groups, including the youth. These measures recognise that Kenya is a youthful nation needing to urgently address the social, economic, demographic and even political needs of young people, not only for their sake, but also for national stability, security and socio economic development.

8.2 Trends in Size, Growth rates and Distribution

Table 8.1 shows trends in Kenya's youth population since 1969. The absolute size of the youth grew from about two million in 1969 (nearly 19 percent of the country's total population), to about six million in 1999 and 7.9 million in 2009, making about 21 percent of the total population. This translates into an almost four-fold increase in the youth, which was, however, in concert with the growth in the country's overall population. The country's median age currently stands at 18.7 years (Population Reference Bureau, 2010) indicating a predominantly youthful population. Between 1969 and 1979 youth population grew at about 4.4 percent per annum, but the rate has since declined to about 2.4 percent.

Table 8.1 Trends in population of youth aged 15-24 since 1969

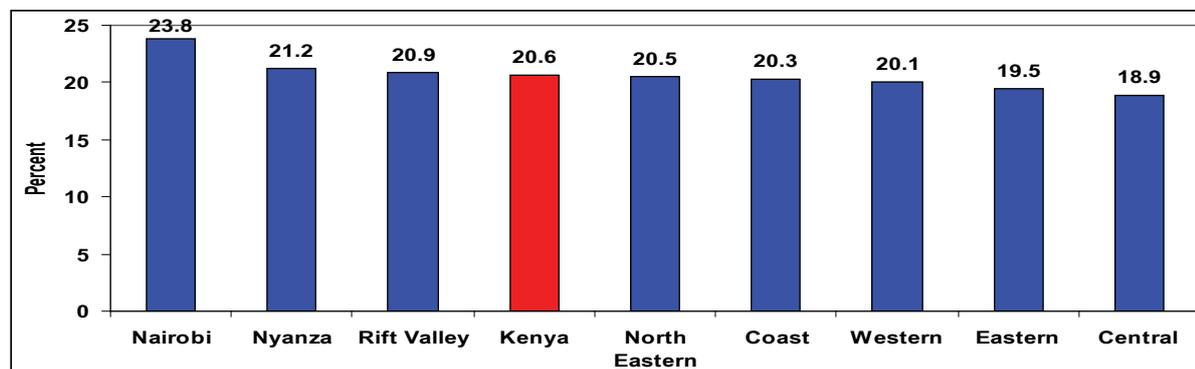
	1969	1979	1989	1999	2009
Total population ('000)	10,944	15,327	21,444	28,687	38,610
Population of Youth (ages 15-24) ('000)	2,032	3,153	4,282	6,236	7,944
Share of the Youth to total population	18.6%	20.6%	20.0%	21.7%	20.6%
Inter-censal growth rates (% per annum)		4.4	3.3	3.8	2.4
Population of Youth in census year relative to youth population 1969 (1969=100)	100	140	196	262	391

Source: Computed from Census 1969, 1979, 1989, 1999 and 2009.

Figure 8.1 shows the regional shares of the youth in the total population. Except for Nairobi Province's 24 percent share, all the other provinces have even shares ranging between 19 to 21 percent, which is also the national share. The larger share of the youth for Nairobi Province is mainly due to migration

into the city in search of employment, while the low share for Central Province is a function of the demographic transition reflected in consistently declining fertility (see Chapter 4), coupled with high out-migration rate of its youth for employment.

Figure 8.1 Youth aged 15-24 as a percent of total population by region, 2009 census



Source: KNBS (2010)

According to 2009 census, the urban youth are about 35 percent of the national youth population, while the youth constitute about 23 percent of the total urban population. Concentration of young people in the country's major cities poses great challenges in the provision of services in health and education and in creating employment for them.

8.3 Sexual and Reproductive Health

Current investments in the reproductive health needs of the youth should provide a healthy labour force and strengthen the future economy of a country. In sub-Saharan Africa, young people are sexually active by their late teens which heighten associated risks; such as HIV infection, unwanted pregnancy and unsafe abortion, economic hardships and school dropouts (CSA and PAI, 2009). The adverse effects of teenage sexual behaviour, pregnancy and child-bearing are well documented (e.g. CSA, 2004; 2009; Katindi, 2010). However, the extent to which the reproductive behaviour of the youth is considered problematic varies across societies in the developing world. Data for several countries suggest that women who marry in their teenage years are at higher risk of domestic violence (UNICEF, 2012). They may be cut off from their families and formal education curtailed their development — and the fulfillment of their human rights — may be compromised, UNICEF adds. A Kenyan study by the Ministry of Public Health and Sanitation confirmed the fact that many young people are sexually active and are at risk of adverse reproductive health outcomes that consequently affect the achievement of life goals and their optimal contribution to national development (GOK, 2011). Although early pregnancy has declined in many countries, it is still a major concern, especially because of the health risks for both mother and child and the impact on girl's education and life prospects (UN, 2005).

8.3.1 Sexual debut

For Kenya, data on first sexual intercourse for specific age categories of both males and females have been available since KDHS 1998, with KDHS 1993 only focusing on first sexual intercourse among females. Table 8.2 presents median age at first sexual intercourse and at first marriage from 1998 to 2008-2009³⁶. The gap between median age at first sex and at first marriage gives a proxy measure on the extent of premarital sex in the country. The data (see Table 8.2) suggests an increase in age at sexual

³⁶ The median ages are only used as proxy measures since it is difficult to obtain data from the most recent cohort. The data used in the table represent different cohorts that may have different experiences.

debut and marriage and a declining propensity for premarital sex among women. Young women on average experienced sex about two years before marriage in 2008, reflecting a marginal decline from three years in 1998. Among the males, the gap between median age at first sex and at first marriage is an even bigger and consistent eight years.

This relatively larger gap for males poses various risks, including unwanted pregnancies among their varied partners as well as STI and HIV infection. The risks are further compounded by the fact that contraceptive use remains low among never-married girls who are sexually active, with a majority 73.2 percent of currently sexually-active single women aged 15-19 not reporting the use of any contraception method (KNBS and IFC Macro, 2010).

Table 8.2 Median age at first sexual intercourse and at first marriage (1993 to 2008)

	1993	1998	2003	2008-2009
Females aged 20-49				
Median age at first sexual intercourse	16.8	16.7	17.8	18.2
Median age at first marriage	19.2	19.5	19.9	20.0
Difference	2.4	2.8	2.1	1.8
Men aged 20-54				
Median age at first sexual intercourse	-	16.8	17.1	17.6
Median age at first marriage	-	24.8	25.1	25.1
Difference		8	8	7.5

Source: KDHS Surveys 1993 1998, 2003, 2008/2009

A recent study found that four in ten Kenyan girls had sex before the age of 19, many of them as early as 12 (CSA, 2009). The KDHS data also show early sexual debut with regional variations (CSA, 2009; KNBS, 2010a). About 40 percent of women in the general population are estimated to carry the human papilloma virus (HPV), a leading cause of cervical cancer (CSA, 2009). Studies have shown that HPV is higher among young, sexually active women who have unprotected sex with multiple partners (Coutrie et al., 2012). A study conducted in five urban areas in Kenya in 2011 reflected the above pattern and showed that many women had engaged in sex by the age of 20 (GOK/MOPHS, 2011). The study further revealed that sexual debut occurred earlier in the poorer wealth quintiles regardless of place residence or origin, and acknowledged the existence of a combination of factors at play among many young women who turn to sex as a source of livelihood, such as transactional sex, lack of economic opportunities, and poverty. This is demonstrated by the GOK/MOPHS (2011) finding that 77 percent of the women in the poorest wealth quintile in Kisumu had engaged in sexual intercourse by age 17, compared to just 36 percent in the richest wealth quintile. This reality is repeated across the other study areas: in Nairobi, it was 46 percent against 21 percent; and 23 percent against six percent in Mombasa by age 15.

8.3.2 Fertility

Teenage pregnancy poses threats to the health of both mother and child, and ultimately narrows women's opportunities in life. Several studies point to the fact that adolescents aged 15-19 are twice as likely to die during pregnancy and childbirth as those aged over 20 (Scholl et. al 1994; UNFPA 2004; WHO 2012). In Kenya, one common consequence of teenage pregnancy for girls is the forfeiture of educational opportunities: pregnant girls are often expelled or forced to leave school when the teachers and the school administrators discover the pregnancy (CSA, 2004). CSA reports that despite Government policies designed to protect a pregnant girl's right to continue her education, a decade ago, 13,000 girls leave school every year due to pregnancy. That only 35 percent of Kenyan girls between the ages of 16 and 20 were still in school, compared to almost 50 percent for boys the same age cohort, despite parity

at initial enrolment, can partly be attributed to teenage pregnancy, argues CSA. According to the same study, pregnant girls cite the stigma of pregnancy and discrimination by teachers and peers as the main reasons that force them out of school.

Table 8.3 shows the 1993 to 2008 trends in the percentages of female youths who were either pregnant or had become mothers. The patterns of teen pregnancies and motherhood did not change much between 1993 and 2003 when 17 percent of women in age group 15-19 were mothers, but reduced marginally to 15 percent in 2008.

Table 8.3 Trends in proportion of adolescents who are either pregnant or mothers by age 19 (1993-2008)

Age	Year			
	1993	1998	2003	2008
15	3.4	1.7	2.4	1.0
16	3.1	4.3	5.3	8.2
17	10.5	14.1	12.0	13.0
18	27.7	26.2	30.4	21.6
19	39.5	39.5	39.4	30.0
15-19	16.8	17.2	17.9	14.8

Source: Kenya National Bureau of Statistics and ORC Macro: 2008/2009 Kenya Demographic and Health Surveys

Table 8.4 shows the percentage of women aged 15 to 19 who have begun childbearing by region of origin and area of residence. At the national level, there was a 30 percent decline to close the period at 18 percent. The incidence of adolescent motherhood varies dramatically by region, with Nyanza and Coast provinces recording the highest cases at 27.0 percent and 25.7 percent respectively for 2008/2009, compared to 10 percent for Central province. Of great interest is the fact that Coast's rate has increased by about 40 percent from its 1989 level. While Nyanza and Nairobi were comparable in 1989, the latter's share has decreased by more than 50 percent. Trends in entry into motherhood in Rift Valley are however inconsistent; initially among the highest in 1989, declined in 1993 but increased again in 1998-2003. In terms of residence, this percentage was slightly higher in urban areas compared to rural areas in 2008/2009. However, both the rural and urban rates have declined quite significantly over the period.

Table 8.4 Percentage of women aged 15-19 who have begun child bearing by area of residence, 1989-2008/2009

	1989	1993	1998	2003	2008-2009
Residence					
Urban	29.2	17.3	17.5	22.2	18.5
Rural	24.5	21.1	21.8	23.3	17.5
Region					
Nairobi	31.1	19.0	10.2	19.5	13.9
Central	22.3	15.6	15.1	15.3	10.1
Coast	18.9	17.0	27.8	29.4	25.7
Eastern	22.1	19.8	15.7	14.8	13.8
Nyanza	30.8	28.0	23.0	27.1	27.0
Rift Valley	25.2	19.5	27.8	30.5	16.5
Western	26.6	21.5	21.6	21.1	15.1
North Eastern	-	-	-	29.0	16.2
Kenya	25.4	20.5	20.9	23.0	17.7

Source: KDHS 1989, 1993, 1998, 2003 and 2008/2009

Table 8.5 shows trends in fertility rates among women aged 15 to 24, with the data showing that the frequency of births among the youth has been declining. Between 1978 and 1988, the adolescent fertility rate declined by about ten percent, while between 1988 and 1998 it declined by 27 percent³⁷. In the last decade, adolescent fertility has declined by only seven percent but the contribution of adolescent fertility to the country's overall fertility (as measured by TFR) has been increasing, from 32 percent in the late 1970s to about 37 percent in 2008. Needless to say, the reproductive decisions the youth make at any point shape Kenya's future socio-demographic landscape.

Table 8.5 Trends in Age Specific Fertility Rates (births per 1000 population) of Youth (15-24) population

Age	Period					
	1975-1978	1984-1989	1990-1993	1995-1998	2000-2003	2005-2008
15-19	168	152	110	111	114	103
20-24	342	314	257	248	243	233
Percent contribution of age group 15 to 24 births to TFR	31.8	34.8	34.0	38.0	36.5	37.0
TFR	8.1	6.7	5.4	4.7	4.9	4.6

Source: 1977/78 Kenya fertility survey; and KDHS 1988/1989, 1993, 1998, 2003 and 2008/2009

While this decline in youth fertility was part of a general fertility decline nationally, adolescent fertility still remains comparatively high in Kenya compared to other countries in the region, as illustrated in Table 8.6. Ethiopia has the lowest adolescent fertility rate while Malawi has the highest.

Table 8.6 Adolescent Fertility Rates for selected East and Southern African Countries

Country	Survey	ASFR (15-19) per 1000 population
Ethiopia	2011 DHS	79
Kenya	2008-2009 DHS	103
Malawi	2010 DHS	152
Rwanda	2010 DHS	41
Tanzania	2010 DHS	116
Uganda	2011 DHS	134
Zimbabwe	2010-11 DHS	115

Source: ICF International, 2012. MEASURE DHS STAT compiler - <http://www.statcompiler.com> - July 10 2012.

8.3.3 Unintended Childbearing and Fertility Preference

Table 8.7 shows births to young women (15-24) by whether they were intended or unintended. The proportion reporting that either the birth was mistimed (wanted later) or wanted no more reflects the extent of unintended childbearing. The proportion that preferred to have their current birth later (mistimed births) increased from 43 percent in 1993 to 45 percent in 1998, and thereafter declined to slightly over 30 percent in 2008 among women aged 15-19. The same pattern emerged among women aged 20 to 24. The extent of unplanned (total unintended) births among teenagers declined from about 50 percent in 1993 to about 37 percent in 2008. The unplanned births among women aged 20 to 24 declined from 45 percent in 1993 to about 40 percent in 2008. However, the ideal family size has remained nearly the same over time.

³⁷ Adolescent fertility rate is number of births per 1000 women of age group 15-19.

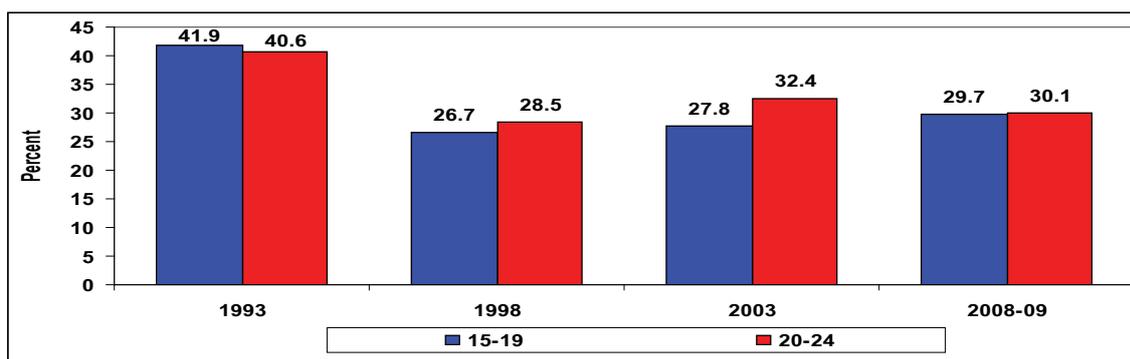
Table 8.7 Trends in ideal number of children and planning status of births

Age at birth	1993 Birth wanted			Ideal # of children	1998 Birth wanted			Ideal # of children	2003 Birth wanted			Ideal # of children	2008/09 Birth wanted			Ideal # of children
	Then	Later	No more		Then	Later	No more		Then	Later	No more		Then	Later	No more	
15-19	48.4	43.4	6.6	3.5	52.0	45.0	2.9	3.5	53.2	26.1	20.5	3.6	53.2	31.9	14.9	3.5
20-24	53.2	39.1	6.3	3.4	54.7	40.3	4.6	3.4	60.7	27.7	11.3	3.4	60.4	29.9	9.6	3.4

Source: KDHS 1993, 1998, 2003 and 2008/2009

The extent of unmet FP need among youth aged 15 to 24 has declined over time, a trend that is similar to the decline in the prevalence of unintended childbearing (Figure 8.2).

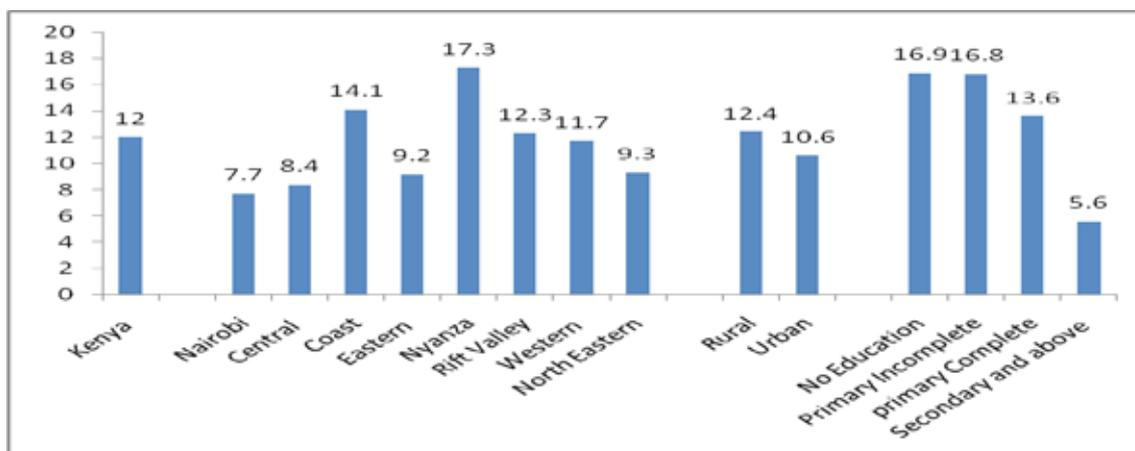
Figure 8.2 Trends in Unmet Need for Contraception among Married Women aged 15 to 24



Source: KDHS 1993, 1998, 2003 and 2008/2009

Figure 8.3 shows the level of unmet need for contraception among all women aged 15 to 24. About 12 percent of all the women had unmet need for FP need. Unmet need was highest among young women in Nyanza and Coast provinces and lowest in Nairobi and Central provinces. The data also show that unmet need declines with an increase in the level of educational attainment, suggesting that education probably raises the initiative and means with which to find contraception.

Figure 8.3 Unmet Need for Contraception among Women aged 15 to 24



Source: 2008-2009 KDHS

8.3.4 Abortion

The persistent high levels of unintended pregnancies are the root cause for women's recourse to abortion. The reasons for unintended pregnancies include the lack of access to, or the non-use or failure of, contraception. Other reasons include unwanted or forced sexual intercourse arising from women's weak empowerment over sexual and reproductive matters. About one-quarter of Africa's unsafe abortions occur among young women aged 15 to 19, a higher rate for that age group than in any of the other continental regions (WHO, 2004). Nearly 60 percent of the unsafe abortions in Africa occur among women under age 25, WHO adds. In 2008, almost one-third of births and pregnancies among teenage girls and those aged 20 to 24 were mistimed, while 15 percent and 10 percent of teenage and 20 to 24 year old women respectively did not want the current birth or pregnancy. In a study of abortion-related complications that presented in public health institutions in Kenya, nearly 50 percent of the complications occurred among the younger women (Onyango and Gabraeselassie, 2003). A study conducted by Ipas in 2004 to estimate the magnitude of abortion complications at public hospitals in Kenya, showed that adolescents accounted for 16 percent of women admitted with abortion complications (Ipas, 2005). According to the same study, more than 300,000 abortions occur in Kenya annually; which translates into 46 abortions for every 1,000 women of reproductive age (Ipas, 2004). There is paucity of national level data on abortion, the only national estimates for Kenya being based on a 2004 study of women treated for post-abortion complications.

8.3.5 HIV and AIDS

The socio-economic bases of national populations continue to be ravaged by HIV and AIDS, especially affecting the youth. In almost all Sub-Saharan Africa countries, HIV prevalence is higher among girls aged 15 to 24 than among boys of the same age bracket. Since 2005, more than half the estimated five million people who contracted HIV worldwide were young people aged 15 to 24, with more than half of them being young women (Ministry of Youth Affairs and Sports (MOYAS), 2010). The growth of the epidemic in this age group is related to, among other causes, the increase in risky activities, social stigma associated with HIV infection, inadequate access to preventive SRH services, difficulties in obtaining related information (both in and out of school) and inappropriate health policies and programmes designed to meet the needs of young people (UNFPA, 2007).

In Kenya too, young people are more vulnerable than other age groups to HIV and AIDS. The country's HIV prevalence rate among the youth has remained at slightly over three percent since 2003. Among the infected population aged 15 to 64, the youth constitute nearly 17 percent, which translates to approximately 228,165 of the 1.33 million infected adults (NAS COP, 2007). Results from KDHS and Kenya AIDS Indicator Survey (KAIS) indicate that for both young men and women, HIV prevalence increased among the 15 to 19 year olds in the 2003-2007 period, but decreased among 20-24 year olds (GOK/NAS COP³⁸, 2007). Prevalence in 15 to 19 year old men rose from 0.4 percent in 2003 to 1.0 percent in 2007, but reduced for the 20 to 24 years old group, from 2.4 percent in 2003 to 1.9 percent in 2007. The trend was quite different among the women, with the HIV prevalence in the 15-19 year old cohort rising from three percent in 2003 to 7.4 percent among the 20 to 24 year old women in 2007. While these changes may not be significant, they may represent shifting patterns of HIV incidence among the Kenyan youth.

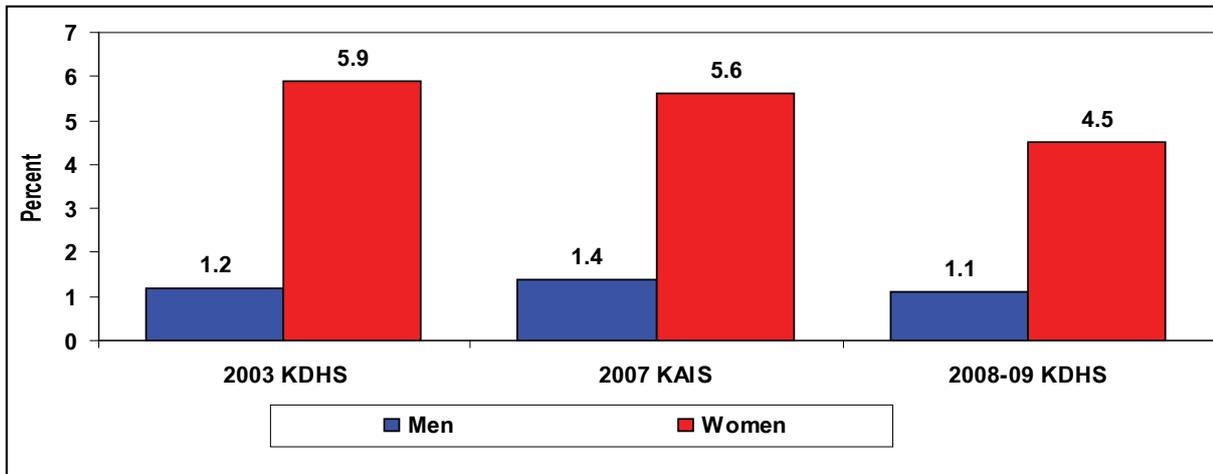
Differentials in HIV prevalence

Particularly in sub-Saharan Africa, the vulnerability of young women to HIV has been associated with age-disparate sex related to early marriage or to relationships with older partners for money or other material gains. Data presented in Figure 8.4 indicates that across successive studies since 2003, young

38 NAS COP: National AIDS and STIs Control Programme

Kenyan women aged 15 to 24 have been four times more likely to be infected than young men of the same age group.

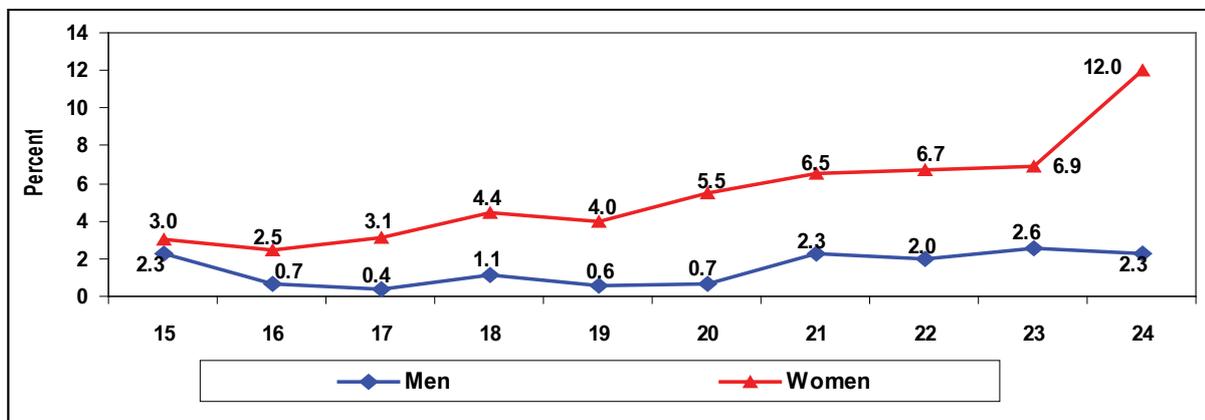
Figure 8.4 HIV prevalence among youth aged 15-24 (2003-2008)



Source: KDHS 2003 and 2008/2009; KAIS 2007

The overall HIV prevalence among the Kenyan youth masks large differences with increasing age, as illustrated in Figure 8.5. Prevalence among the female youth ranges from three percent at age 15 to 12 percent among those aged 24 years. On the other hand, the prevalence range among young men is from 0.4 percent at age 17 to 2.6 percent at age 23. These differences in prevalence rates underscore women’s vulnerability in negotiating safer sex.

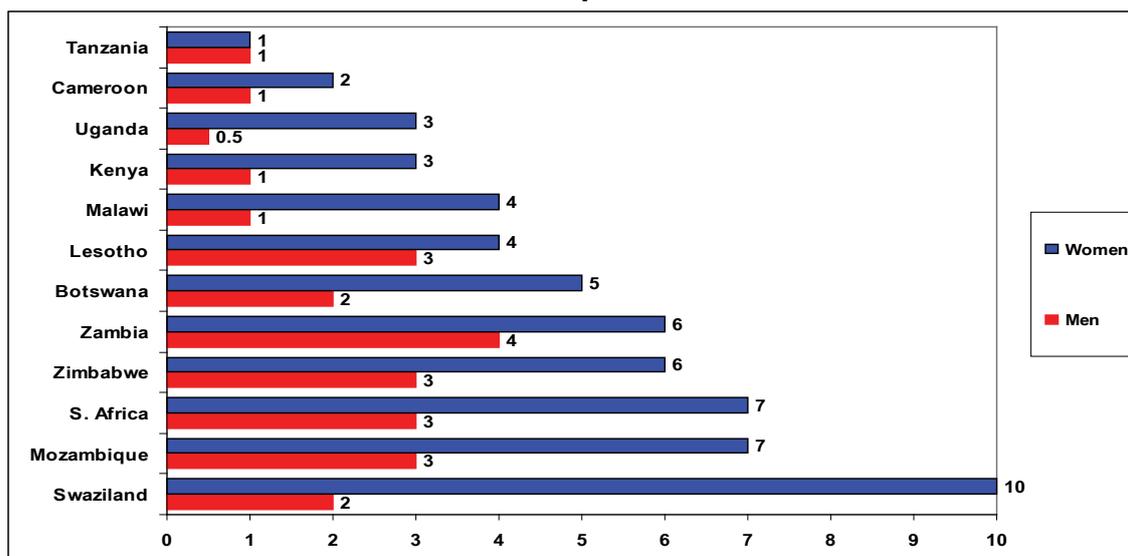
Figure 8.5 HIV prevalence among youth aged 15-24 by single years of age and sex (2007)



Source: NASCOP 2007; KAIS 2007

HIV prevalence among adolescent women is above three percent in most sub-Saharan African countries with a high burden of HIV, as shown in Figure 10.7. This is particularly true of the southern African countries, led by Swaziland, Mozambique, South Africa and Zimbabwe. In East Africa, Tanzania is the only country that does not reflect this differential or disparity in HIV prevalence between male and females. Tanzania women’s higher condom use could explain its lower HIV prevalence rate and gender parity shown in Figure 8.6.

Figure 8.6 HIV prevalence among youth 15-19 in African countries with an adult HIV prevalence above 5 percent



Source: UNICEF global databases, 2011, based on AIS, DHS, MICS.

8.3.6 HIV and AIDS Services

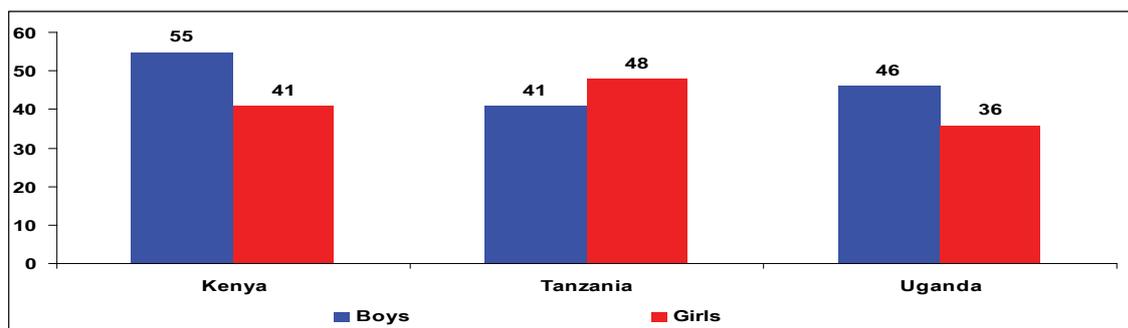
While the extent of the HIV and AIDS epidemic varies greatly in different regions of the world, the young people are invariably at the centre in terms of new infections, as well as by being the greatest potential force for change if they can be reached with the right interventions (Monasch & Mahy, 2006:15). As emphasised at the 1994 ICPD, policies and programmes must be oriented to the need for access to information and education for both young men and women. The following sections discuss the utilization by the youth of the various HIV and AIDS-related services, including condoms, HIV testing, and male circumcision.

(i) Condom Use

Adolescent and youth sexual and reproductive health programmes must consider that a considerable proportion are having sex with more partners (KNBS and ICF Macro, 2010). Young people who initiate sexual activity at an early age are more likely to have higher risk sex and/or multiple partners, and are less likely to use condoms (Monasch & Mahy, 2006). Data from successive Multiple Indicator Cluster Surveys (MICS) and DHS have shown that levels of condom use at the last higher-risk sexual encounter are lower than 60 percent in sub-Saharan Africa³⁹. Figure 10.7 shows the distribution of adolescents (15 to 19 years) who used a condom in the last higher-risk sex encounter in three East African countries — i.e. Kenya, Tanzania and Uganda — which all have an adult HIV prevalence of more than five percent. In consonance with Figure 8.7 not only did Tanzania girls have the highest condom use rate among girls in the region, but their rate was higher than that of their boys. However, there is evidence that the Kenyan youth are improving on their attitudes towards HIV prevention: for example, the proportion of 15 to 24-year-old men and women who used a condom the first time they had sex nearly doubled between 2003 and 2008, from 12 percent to 24 percent among women, and 14 percent to 26 percent for men (UNICEF, 2011).

³⁹ 'Higher risk sex' is defined as sex with a non-marital, non-cohabiting partner during last 12 months.

Figure 8.7 Percent 15-19 year olds who used a condom at last higher-risk sex in East Africa

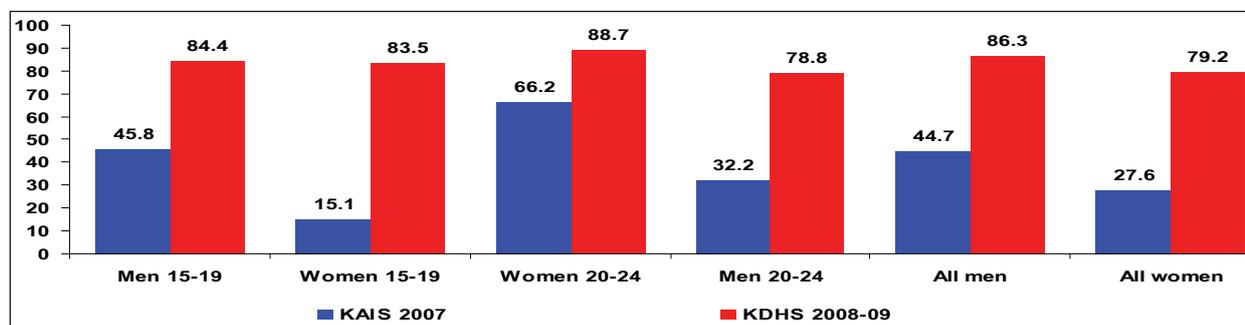


Source: UNICEF global databases, 2011, based on AIS, DHS, MICS.

(ii) HIV testing

The Kenya Government recognizes that HIV counselling and testing are critical measures in a comprehensive response to the epidemic (KAIS, 2007). HIV testing is the only way of knowing one's HIV status and can provide appropriate linkages for HIV-infected persons to access life-saving HIV care and treatment interventions. Additionally, the pre- and post-test counselling sessions offer focused advice for HIV management, helping to reduce conduct which may lead to acquisition, re-acquisition or transmission of HIV. The country has witnessed a significant increase in HIV testing between 2007 and 2009, in both the general population and among young people aged 15 to 24, as shown in Figure 8.8. The data show that women regardless of age were more likely than men to go for HIV testing. The rate of women aged 15 to 24 who have ever taken the test was 50 percent, compared to only 34 percent for men of the same age group. The 2009 data also show that the coverage rate for testing among women is consistent across all age groups, ranging from 84 percent to 89 percent, compared to the men's range from 79 percent to 84 percent.

Figure 8.8 Uptake of HIV testing services among young people (15-24 years) in 2007 and 2008/2009



Source: UNICEF global databases, 2011, based on AIS, DHS, MICS.

(iii) Voluntary Medical Male Circumcision

Recently, male circumcision has been associated with lower transmission of sexually transmitted infections, including HIV (GOK, 2010; UNGASS, 2010). Yet, 2008-2009 KDHS shows that young men in Kenya aged 15 and 19 are the least likely to seek circumcision services. It is in response to this that Kenya's National AIDS/STD Control Programme (NAS COP) developed a policy on male circumcision, aiming to reduce the number of new HIV infections in order to "help create an AIDS free generation" (NAS COP, 2008). According to the policy, approximately 150,000 male circumcisions per year for five years need to be performed in order for Kenya to reach its target rate of circumcision coverage. In many districts of Kenya, circumcision is a mandatory cultural process requiring no inducement, the

likely area of attention only being encouragement of risk-free processes, such as through the multiple use of instruments that can transmit diseases, including HIV infection. Consequently, the voluntary medical male circumcision (VMMC) programme was launched to concentrate on those areas that do not circumcise as a traditional ritual. Under VMMC, the rate of public health facility-based circumcision increased from 10,000 to 90,000 in just over a year in 2009 (UNGASS, 2010). In 2010, the rate rose to an estimated 139,905, falling short of an annual target that had been set (WHO/UNAIDS/UNICEF, 2011).

8.4 Harmful Practices

The country's national youth policy of 2007 recognizes that there are many harmful practices inflicted upon the youth in Kenya which impact on their health in general and reproductive health in particular (MOYAS, 2007). Such practices include early marriage, sexual abuse/exploitation, gender-based violence, female genital mutilation (FGM) as well as alcohol, drug and substance abuse.

(i) Alcohol, drug and substance abuse

Many people have their first experiences with tobacco, alcohol and illicit drugs during adolescence, partly out of a need to explore boundaries as they begin to develop their individuality, and partly due to peer pressure and the need 'to belong'. These are risky behaviours that can have a negative impact on adolescent health and well-being, and bring negative life-long consequences. Abuse of these substances is also associated with poor mental and physical health: tobacco smoking among adolescents can lead to such diseases as lung cancer, and to chronic respiratory infections in adults (UNICEF, 2012). Excessive alcohol use can lead to addiction and dependence, liver cirrhosis, cancer and other general injuries.

In Kenya, the National Campaign Against Alcohol and Drug Abuse (NACADA) estimates that alcohol (with a 36% incidence) and tobacco (28%) are the most abused substances among young people aged 10 to 24, followed by miraa or khat (18%), bhang (13%) and inhalants (5%)⁴⁰ (NACADA, 2011). Alcohol abuse is highest in Western Province — at 90 and 43 percent among non-students and students respectively — and lowest in North Eastern Province at 16 and 1.6 percent among non-students and students respectively. The same source also observes that regular drug use increases with age, and is highest among 23 to 24 year olds. Cigarette smoking also increases with age among the Kenyan youth, rising from 2.7 percent among the 15-19 year olds to 15 percent among the 20-24 year olds. Table 8.8 shows overall picture of substance abuse among the student and non-student youth population (ages 10-24 years). There is significantly more substance use and/or abuse among the non-student youth compared to students. This could be attributed to the fact that substance use increases with age and the non-students are more likely older than those in school. Students are also under the control of not just parents, but also of schools. They, therefore, find it harder to engage in substance use/abuse compared to the non-students who could be independent of such controls. Finally, non-students who are out of employment are likely to seek solace in drugs for their predicament.

Table 8.8 Overall substance abuse among 10-24 year olds (2004)

Substance	% Ever used		% Current use in last 30 days	
	Students	Non-students	Students	Non-students
Alcohol	27.7	77.1	8.6	60.1
Tobacco	8.3	65.7	3.1	58.0
Bhang	2.8	34.9	0.6	21.1
Miraa	9.1	55.1	2.1	20.8
Inhalants	3.4	12.5	1.6	7.2

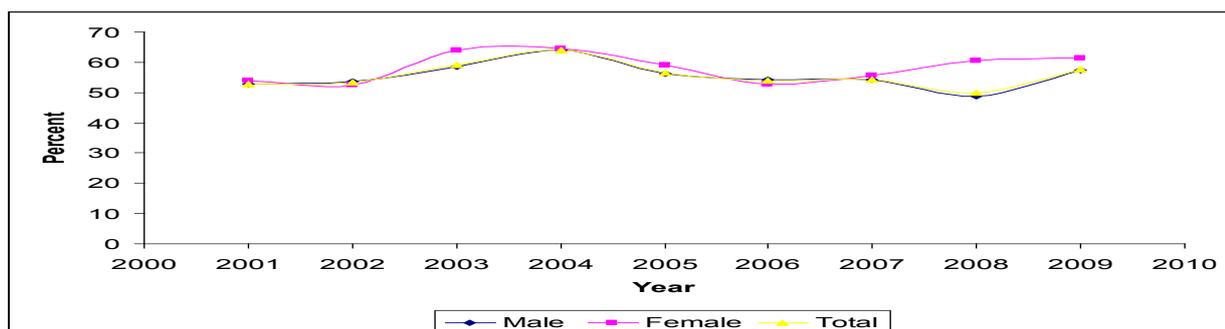
Source: NACADA (2004).

⁴⁰ According to NACADA (2001), inhalants are gaseous chemicals or substances that when inhaled into the lungs, produce a psychoactive or mind-altering condition that may be anaesthetic in its effect, or cause a slowing down of body functions. Examples include glue, gasoline and lacquer thinners.

8.5 Youth and Crime

The national youth policy recognizes that idleness after formal education causes the youth to become restless and vulnerable to peer pressure that exposes them to certain anti-social tendencies. Some such youth end up in crime, or with deviant and self destructive behaviour. Young people who are marginalized are more susceptible to developing and maintaining delinquent behaviour. Poverty, social exclusion and unemployment often cause marginalization. Figure 8.9 shows that the percentage of youths in Kenyan prisons has remained at slightly more than half of the total prison population during the decade of the 2000s.

Figure 8.9 Percentage of prison population aged 15-24 years (2010)



Source: Katindi-Sivi (2010)

8.6 Prospects: Developing Youth Capabilities

8.6.1 Education

While enhancing education is a development goal in itself, it is also widely recognized as the main avenue of social mobility, and therefore of escaping poverty. Education must not be discriminatory and should always promote equality, especially between the genders. The Education for All, launched in Jomtien, Thailand, in 1990, established the commitment of the international community to universalize primary education and reduce large scale illiteracy before the end of that decade. Subsequently, The World Programme of Action for Youth (1995), adopted education as the first of ten priority areas for youth development. Kenya has since espoused the right to education, most notably in the Basic Rights of the Constitution.

Table 8.9 shows gender status of literacy across age groups of Kenyan youths. The female to male literacy ratios are comparable across the regions, except for the under-performing North Eastern and Coast provinces. Interestingly, it is not always the case that the ratio in the 15 to 19 age group is greater than that in the 20 to 24 age group: in Central and Western provinces, for example, women of the older age category out-perform the younger age category, while the reverse is true for Nairobi and Rift Valley provinces.

Table 8.9 Gender Parity in Literacy (Female to Male ratios), 2005/2006

	15-19	20-24	15-24
Kenya	100	97	99
Nairobi	101	93	96
Central	98	105	101
Coast	88	86	87
Eastern	105	104	105
North Eastern	50	32	42
Nyanza	98	97	97
Rift Valley	103	95	100
Western	103	106	104
Rural	100	97	99
Urban	100	107	103

Source: Kenya National Bureau of Statistics, Kenya Integrated Household Budget Survey (KIHBS) 2005/2006

Table 8.10 shows the distribution of Kenyan youth who have never been to school, the declining national figures probably reflecting the effect of the free primary education scheme. At the regional level, North Eastern province has disturbingly high shares of young people who have not been to school, which, despite the province's low population, must contribute to the comparatively poor rural performance. Conversely, Nyanza, Central and Western provinces have the lowest shares of young people who have never been to school.

Table 8.10 Percent of youth with no education by age group (2008)

	15-19	20-24
Kenya	6.2	9.2
Nairobi	4.0	1.7
Central	0.5	2.0
Coast	5.5	13.7
Eastern	4.2	12.4
Nyanza	0.3	1.4
Rift Valley	9.3	10.0
Western	1.5	2.0
North Eastern	32.5	53.9
Urban	4.5	4.7
Rural	6.7	11.7

Source: Kenya National Bureau of Statistics and ORC Macro: 2008/09 Kenya Demographic and Health Surveys

Various indicators are used to capture the coverage of education in a country. The Gross Enrolment Ratio (GER) reflects the general level of participation in education regardless of age, and is a complementary indicator to the Net Enrolment Rate (NER), which refers to the share of pupils in the theoretical age-group for the particular level of education (primary or secondary, in this case) over the total population in that age-group. In Kenya, the NER for tertiary education is not pertinent because of the difficulties in

determining an appropriate age-group due to the wide variations in the ages of students at this level of education.

Table 8.11 shows regional GERs for primary, secondary and tertiary education by gender. As with literacy above, North Eastern province has the lowest scores across the entire education hierarchy, a reality probably explained by the interaction of cultural constraints and dominant nomadic pastoralist livelihoods. The other significant aspect of North Eastern's data is the gender disparity in enrolment, which is especially high – unsurprisingly so – at the tertiary education level.

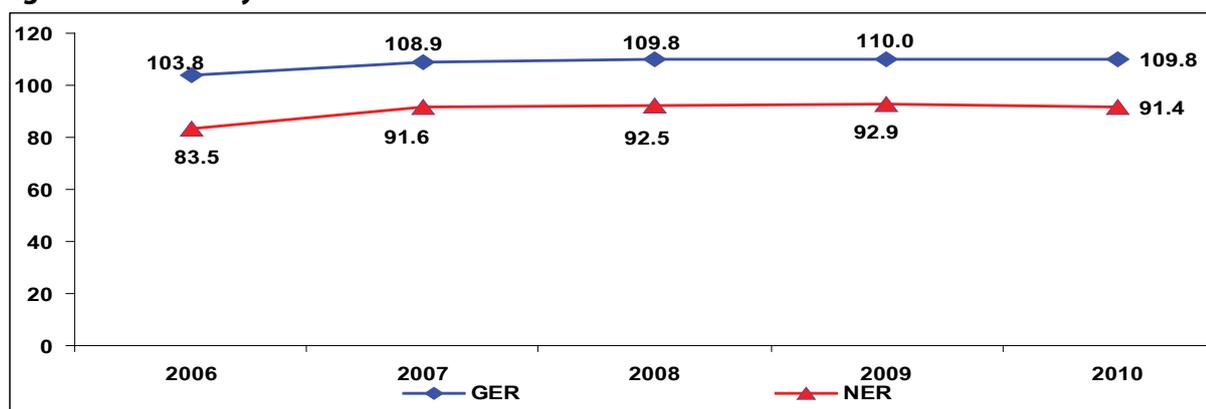
Table 8.11 Gross enrolment ratios at each level of education by region and sex, 2005/2006

	Primary			Secondary			Tertiary			Gender Parity Index (GPI) (M/F) ratio		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Primary	Secondary	Tertiary
Kenya	119	114.8	116.9	42.2	37.5	39.9	10.4	9.3	9.8	104	98	277
Nairobi	103.2	111.7	107.6	82.7	66.9	75.1	26.9	24.9	25.6	92	104	130
Central	119.5	121.1	120.3	55.2	49.9	52.2	7.7	7.3	7.5	99	101	218
Coast	117.6	104.5	111	25.4	20.4	22.9	6.9	7.1	7	113	94	437
Eastern	122.9	127.9	125.3	35.5	33.1	34.3	8.4	8.1	8.2	96	102	353
North-Eastern	87.2	53.8	71.5	21.5	8.8	16.2	0.7	1	0.8	162	75	333
Nyanza	132.2	117.6	124.7	46.3	46.3	46.3	12.8	10.1	11.4	112	94	269
Rift Valley	114.9	110.5	112.8	41	37	39.1	10.4	5.9	8.2	104	98	275
Western	125.7	124.3	125	40.9	29.8	35.2	8.4	7.9	8.1	101	99	306
Rural	118.7	114.3	116.5	42.6	38	40.3	10.5	9.3	9.9	104	98	273
Urban	125.6	122	123.8	36	30.6	33.3	7.2	9.6	8.3	103	99	344

Source: Kenya National Bureau of Statistics, Kenya Integrated Household Budget Survey (KIHBS) 2005/06

NER trends at the primary education level reflect rapid change from 82 percent in 2004 to 83.5 percent in 2006, almost 92 percent in 2007, 93 percent in 2009 and then dropped marginally to 91.4 percent in 2010 (Figure 8.10). These attainments have thus surpassed MTP I's target of 90 percent by 2012, mainly due to the continued implementation of the Free Primary Education programme (GOK, 2012).

Figure 8.10 Primary Schools GER and NER 2007-2011

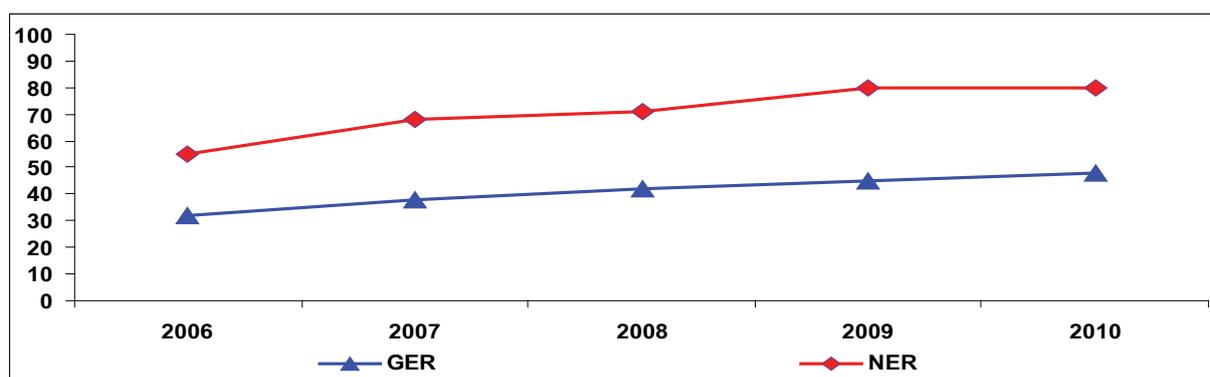


Source: Third Annual Progress Report (2010-2011) - computed from Economic Survey, 2011 & Mo

The country's primary school completion rate increased from nearly 57 percent in 2003 to about 78 percent in 2006 (GoK, 2009). Gender parity in primary education has been impressive at 0.97 in 2007, 0.98 in 2009 and 1.02 in 2010.

The growth in primary school enrolments has, however, not been matched by a similar growth at the secondary school level. The transition rate from primary to secondary schools has increased from 60 percent in 2007 to a mere 67 percent in 2009 and to 73 percent in 2010, against the country's target of 85 percent (GOK, 2012). This has been attributed to the inability of households to afford other secondary schooling related expenses, early marriages, child labour and retrogressive cultural practices and beliefs (GOK, 2012). Secondary school GER increased from 32 percent in 2006 to 38 percent in 2007 and 45 percent in 2009, and then marginally to 48 percent in 2010. Meanwhile, secondary education NER remains quite low at 25 percent in 2006, 29 percent in 2007, 36 percent in 2009 and dipped to just 32 percent in 2010, as shown in Figure 8.11.

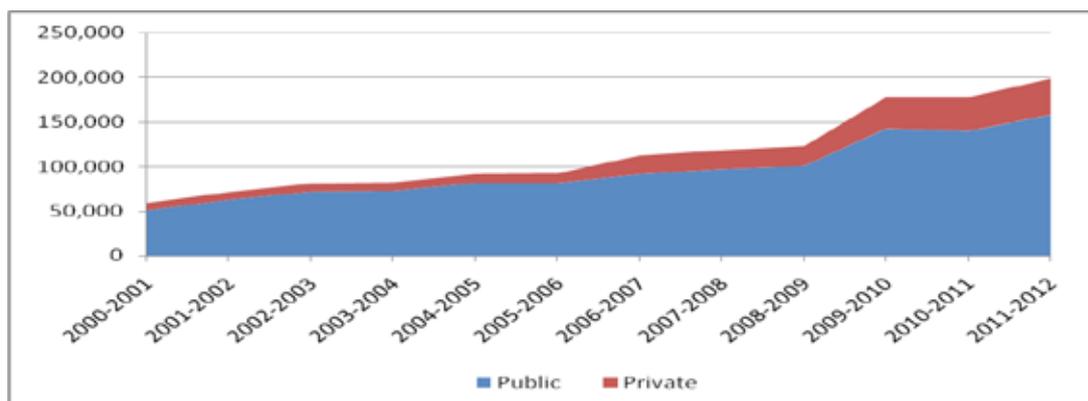
Figure 8.11 Secondary Schools GER and NER 2006-2010



Source: Third Annual Progress Report (2010-2011) - computed from Economic Survey, 2011 & MoE

The transition to university education is even worse, standing at a modest three percent despite the expansion of facilities for university education in the country. Further, female students still constitute only 30 percent of the total university education enrolment (GoK, 2009). Figure 8.12 shows trends in enrolment numbers in both public and private universities in Kenya. By 2009, total enrolment in all the universities rose by about 45 percent from 122,847 students in the 2008/09 to reach 177,735 students in 2009/2010 academic year. Enrolment in public universities increased from 100,649 students in the 2008/2009 academic year to 142,556 students in 2009/2010. Between 2008/09 and 2011/2012 academic years, total enrolment into universities had increased by 63 percent from approximately 123,000 to 200,000 students. In 2009/2010, the male and female student enrolments in public universities were 89,611 and 52,945 respectively. The share of private universities in total enrolment has been increasing gradually as well.

Figure 8.12 Trends in Public and Private University Enrolment, (2000/2001 to 2011/2012)



Source: computed from Various Economic Surveys

The preparation of the youth for work and life in Kenya is inadequate compared to the rising demands for skills and knowledge. Even though basic education has become widespread in the country, many inequalities of opportunity in this area are apparent. Poor young people drop out of school, or receive poorer education than that availed to the less poor. Thus to improve the skills of young people to adequately prepare them for work and life, and thereby improve their welfare, education opportunities must be made more relevant to the needs of all young people as learners, future workers, parents and citizens.



Students from Daystar University celebrate at their graduation ceremony.

Photo: www.businessdailyafrica.com

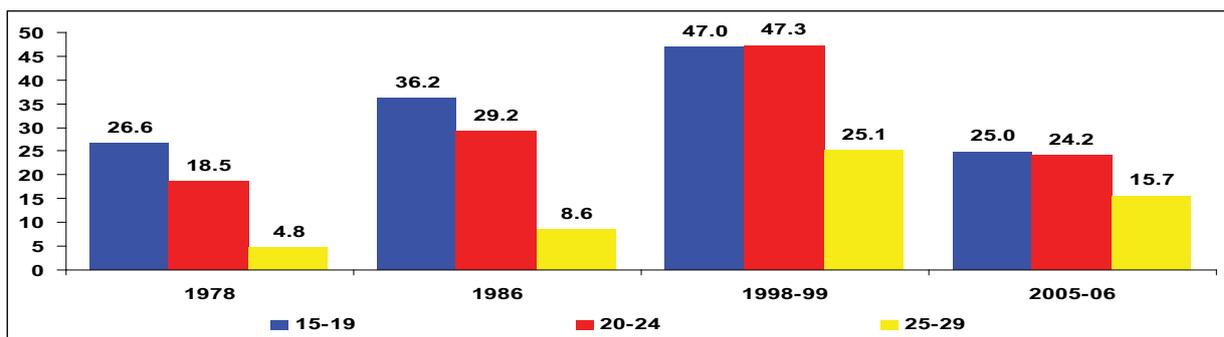
8.6.2 Employment

“A central part of people’s lives is at work, and whether women and men have decent work has a significant impact on individual, family and community well-being. The absence of decent and productive work is the primary cause of poverty and social instability” (ILO, 2009).

The availability of stable high-quality employment is a fundamental dimension of life. Unemployment and underemployment among the youth is a problem everywhere and forms part of the larger struggle to create employment opportunities for all citizens. The problem has worsened in recent years because of the global recession since 2008. The ILO reported in 2010 that 81million of the 620 million economically active youths of ages 15-24 globally (13% of that age group) were unemployed the year before, largely because of the world financial and economic crisis. At the peak of the economic crisis, the global youth unemployment rate saw its largest annual increase ever — from 11.9 percent to 13 percent between 2007 and 2009 (ILO, 2011). Slow growth, stagnation and recession in African economies mean that formal economy cannot create jobs at the rate that the growing pool of young people in developing countries demands.

For the Kenyan case, the 2007/2008 post-election violence, followed by the increase in global food prices and the escalating global oil prices, slowed down Government efforts to scale up measures for youth employment. Figure 8.13a shows the trends in unemployment rates among the youth between 1978 and 2005/2006. Unemployment among persons age 15 to 24 generally increased from 1978 to peak in 1998, after which it declined.

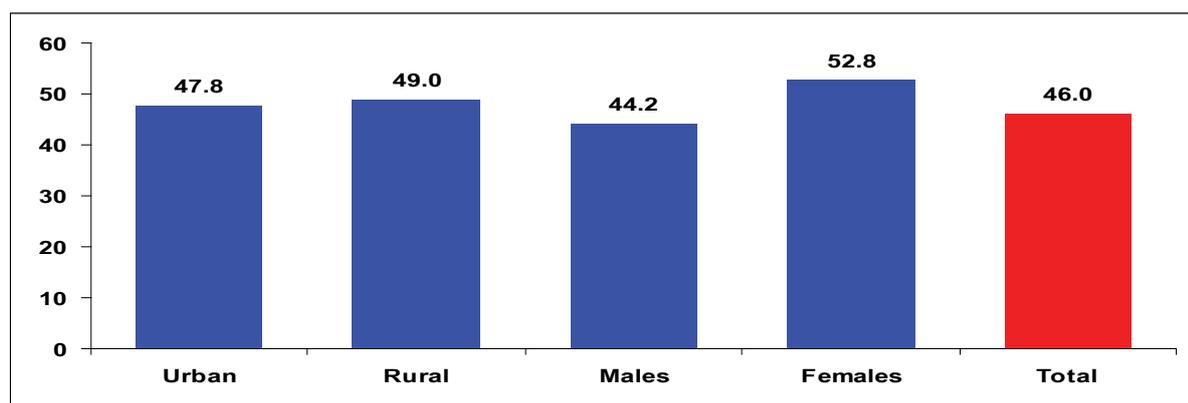
Figure 8.13a Trends in Youth Unemployment rates (1978-2005/2006)



Source: Katindi-Sivi (2010).

In 2005/2006, the open unemployment rate among the youth aged 15 to 24 was 24 percent compared to an overall open unemployment rate of 12.7 percent (National and Economic and Social Council (NESC, 2010). The open unemployment rate in urban areas at 19.9 percent was more than double that in rural areas (NESC, 2010). In terms of absolute numbers, the females in rural areas have the highest unemployment followed by females in urban areas, males in rural areas and males in urban areas (UNDP, 2013). According to World Bank estimates based on Kenyan census data of 2009, unemployment peaked in the 20 to 24 age bracket at eight percent (World Bank, 2012). One of the indicators for demonstrating the depth of youth employment challenge is the share of unemployed youth in total unemployment, which is illustrated in Figure 8.13b. The overall share is slightly higher than that of sub-Saharan Africa’s rate of 40.9 (ILO, 2013). The share is higher in rural areas compared to urban and among females.

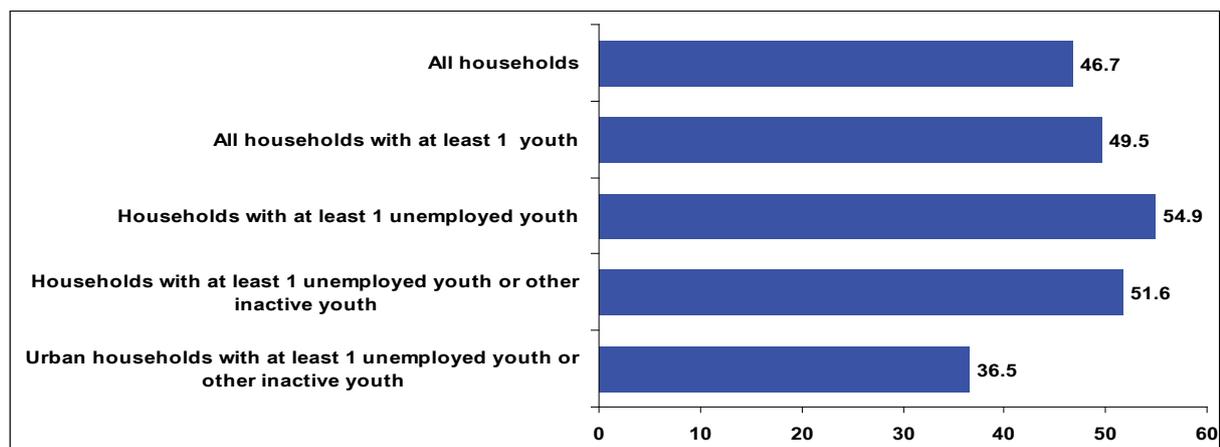
Figure 8.13b Share of Youth Unemployment to overall adult unemployment, 2009 census



Source: computed from 2009 KPHC

Analysis of the 2005/2006 KIHBS indicated that 60 percent of the total labour force in the country consisted of the youth, with 80 percent of them being unemployed (GOK, 2008). In addition, 92 percent of the unemployed youth have no vocation, professional skills or training (GOK, 2008). In the period 1990-2005, Kenya's average annual labour force growth was about 3.0 percent. In 2007, the labour force stood at about 14.6 million, with about 58 percent of it being within the 15-24 year age bracket (KIPPR, 2009). The proportion of youth in labour force is one of the main challenges facing the Government and households (World Bank, 2012). Figure 8.14 illustrates the burden of poverty in households with unemployed or inactive youth. A recent analysis of KIHBS 2005/2006 data showed that in the entire youth years, the proportion of unemployed people is larger in the poorest households (UNDP, 2013).

Figure 8.14 Relative Poverty incidence in Households with unemployed/inactive youth 2005/2006 (%)



Source: World Bank 2012

8.7 Gaps

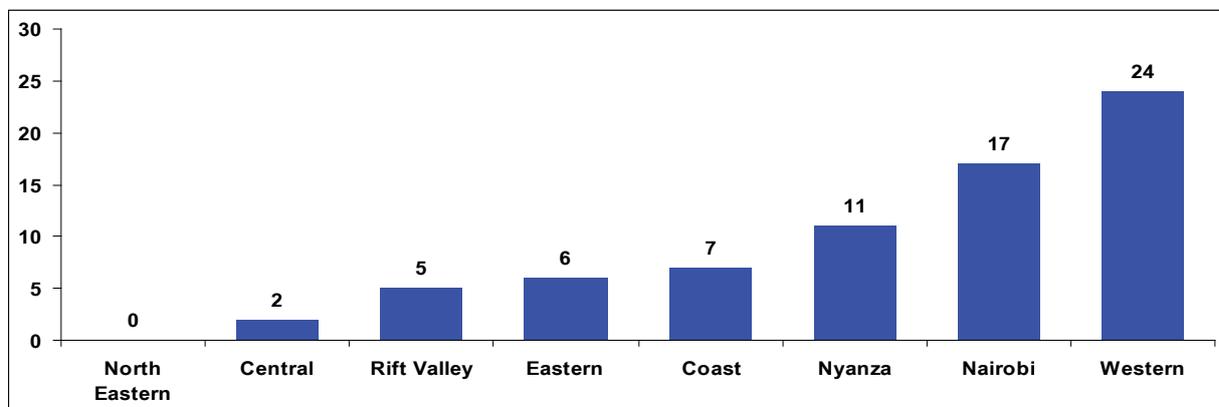
8.7.1 Youth Reproductive Health

Among the critical health problems young people face are those associated with sexuality and reproductive health, such as early, unprotected sexual activity, which has a significant bearing on both their current and future health statuses. The realization of personal goals of these young people and the socio-economic development of the country depend, to a large extent, on the ability of the youth to avoid unintended outcomes, which in turn have a direct bearing on several MDGs. While the Government has formulated or developed many national policies, strategies and programmes to

address the sexual and reproductive health of young people, their sexual and reproductive health is not flagged out in the Vision 2030. Meanwhile, gaps also exist between policy and implementation whose monitoring and evaluation remain weak. Youth Empowerment Centres which were to be promoted, established and operationalised in every constituency with a view to offering integrated health services — including SRH — have taken off rather half-heartedly, there being only eight such centres by the end of 2011, against a target of 210.

There are many factors that determine the levels of utilization of SRH services by young people. These include; poverty, gender issues, stigma and discriminatory laws which may curtail adolescents’ access to services, including HIV prevention and treatment, education levels, assistance in humanitarian emergencies and maternal health and reproductive care for adolescent girls (UNICEF, 2012). Young people in Kenya are unlikely to seek health services, and when they do, they are not likely to get adequate services as the country’s health system and human resource capacity development has been slow in evolving to respond to the needs of this age group both from program and service delivery perspectives (CSA, 2009). For example only seven percent of health facilities in Kenya offer youth friendly HIV counselling services (GOK/NCAPD, 2010), which is inadequate for current and increasing needs (Figure 8.15).

Figure 8.15 Distribution of facilities offering youth friendly HIV counselling services by region (2010)



Source: Kenya Service Provision Assessment Survey (KSPA) 2010

Lack of data on abortion at the national or household level makes it difficult to undertake conclusive analyses of the magnitude of the problem, such as its extent among young people. Most of the studies undertaken on abortion have been health facility-based and provide mere anecdotal insights into the magnitude of the problem in the country. Additionally, the Health Information Management System (HIMS) has a very poor base which cannot capture what happens in public (and private) health facilities.

8.7.2 Education

The right to education is among those stipulated in the Universal Declaration of Human Rights (1948). According to the World Development Report (2007), young people need to acquire the right knowledge and skills to become productive workers, good parents and responsible citizens. From this perspective, education is an indispensable means of unlocking young people’s potential and of protecting their rights by providing knowledge and skills that are required to secure economic well-being, health, liberty and security (UNESCO, 2000). As in the case of adolescent and youth sexual and reproductive health, the country’s Vision 2030 has not put in place any flagship projects targeted at enhancing or promoting tertiary/university education; hence, there are no set targets in the medium term for this level of education for the country.

8.7.3 Employment

Unemployment has remained one of the most daunting socio-economic challenges for development during Kenya's independence years. Kenya's economy is dependent on agriculture, but youth are moving to urban areas in large numbers where most new entrants to the labour force must choose between working in smallscale enterprises and being selfemployed (World Bank, 2012). These factors have led to high levels of youth unemployment. Lack of comprehensive national data sets on youth employment — disaggregated by key variables such as sex, age and types and sectors — is a major gap that hinders any efforts aimed at meaningful analysis to promote clearer understanding of employment dynamics in Kenya.



A group of young peer educators at a training seminar in Mtwapa, Kilifi, Kenya.

Photo: UNFPA



A youth in Mtwapa Kilifi displays one of baskets made by the youths.

Photo: UNFPA

Rapid population growth, poor dissemination of labour market information, skills mismatch, structural reforms, slow or declining economic growth, and high costs of labour are cited as the most frequent explanations of the causes of unemployment (NESC, 2010). Many youth related policies and strategic plans talk about the low or 'mis-matched' skills for the job market; but in most instances, this is expressed vaguely without clarity on the type of skills that are required for meaningful youth employment. Beyond rhetoric about this, there is lack of a clear understanding and interpretation of what exactly the kind of skills the training institutions should impart to satisfy the job market.

8.8 Existing Policies and Programmes

8.8.1 Policies

Kenya is a signatory to various international declarations, treaties and charters, some of which address the development needs of the youth, including their transition into adulthood. It is partly in response to these international instruments that Kenya has instituted a supportive policy environment for the implementation of AYSRH focused programmes and interventions. These initiatives involve multiple ministries, adding to the challenges of coordination (GOK/MOPHS, 2011). In addition to the core interests in AYSRH of the Ministry of Public Health and Sanitation and its sister Ministry of Medical Services, other stakeholding ministries include Youth Affairs and Sports (MOYAS), Education, and Social Services, Gender and Children. Other non-ministerial stakeholders include the National Council for Population and Development, NASCOP, and Kenya Institute of Education, to name just some of the direct Government stakeholders.

This is the institutional context within which the Kenya Government has undertaken initiatives to place the general well-being of the youth on the country's national agenda, with related policies, priorities and budgetary outlays. The major policies and related frameworks include:

1. **The Constitution of Kenya, 2010:** Article 55 of the Constitution supports youth empowerment by providing for: (i) protection of the youth from harmful and exploitative cultural practices, such as female genital mutilation, child marriage and mass circumcision; (ii) access to relevant education and training; (iii) opportunities to associate, be represented and participate in political, social and economic spheres of life; and (iv) access to employment. The Bill of Rights forms the basis upon which the Government guarantees key basic social services to the public, including the right to health care services, which incorporates reproductive health care. Article 21 requires that all state organs and all public officers address the needs of vulnerable groups within the society, which includes the youth, employing affirmative action where necessary.
2. **Kenya Vision 2030:** MTP I (2008-2012) of the Kenya Vision 2030 observed that:

“the minimal involvement of young people in gainful employment and economic participation as well as their exclusion from decision-making poses a threat to the stability of this country... (adding that) it therefore becomes evident that there is a lack of operationally effective mechanisms of integrating the majority of Kenyan youth into mainstream economic activities”(GOK/FMTP, 2008).

The Vision 2030 recognizes the youth as a vulnerable group and calls for increased opportunities for participation for the youth and all disadvantaged groups, in economic, social and political decision-making processes. The Vision also identifies several flagship projects for youth, namely: establishment of youth empowerment centres and talent academies; and increasing the size of the Youth Enterprise Fund and ensuring efficient and productive use of its resources.

3. **National Reproductive Health Policy (2007):** recognizes that adolescent and youth sexual and reproductive health is a national issue, especially in terms of access to quality information and youth-friendly services, and focuses on the varied health needs of young people.
4. **The Adolescent RH and Development Policy (2003):** This policy reinforced the Government's commitment to the integration of young people into the national development process. Developed in 2003, the policy responded to the concerns about adolescents raised in the National Population Policy for Sustainable Development (2000), the National RH Strategy (2000), Children Act (2001), and other national and international commitments on the health, well-being and development of adolescents and youths. It did this by integrating their health and development concerns into the national development process, through their enhanced

participation. It identified five priority concerns, namely: (i) adolescent sexual and reproductive health and rights; (ii) harmful practices; (iii) drug and substance abuse; (iv) socio-economic factors and (v) adolescents and youth with disabilities. Among the implementation strategies were: advocacy; behaviour change communication; provision of adolescent-friendly RH services; research; capacity building; and resource mobilization.

5. **The Gender Policy in Education, 2007:** The Ministry of Education developed a Gender Policy in Education to provide a framework for planning and implementing gender responsive education sector programs, including the proposed measures to increase equality in education between men and women. The policy's elaborated and broadened measures to increase women's participation included: gender responsive research to address gender-in-education issues, including institutional capacity building; the establishment of a gender and education unit; measures to address gender-based violence and sexual harassment in education; and measures for monitoring and evaluating the progress made in the implementation of the proposed measures.
6. **The National Reproductive Health Strategy, 2009-2015:** This spells out strategies for improving the sexual and reproductive health of Kenya's adolescents and youth, which include: advocacy and policy dialogue; networking and partnerships; reproductive health awareness creation among youths; integration of adolescent and youth health information and services in other youth programmes; and expanding the scope and coverage of youth friendly services. It is considered the first step towards the implementation of the National RH Policy.
7. **The Ministry of Youth Affairs and Sports Strategic Plan, 2008-2012:** The Plan outlines the following priority areas requiring coordination and capacity building: (i) youth employment; (ii) youth empowerment and participation; (iii) youth education and training; (iv) youth information and communication technology (ICT); (v) youth and health (vi) youth and environment (vii) youth crime and drugs (viii) leisure, recreation and community services; (ix) sports promotion and development; and (x) youth information management systems.
8. **National Guidelines for Provision of Youth-friendly Services (2005):** These were developed by the Ministry of Health, to rationalize the provision of youth services. The guidelines provide for a minimum package of services considered youth friendly, while at the same time ensuring national uniformity in their provision. To guide implementers/providers of ASRH services, the guidelines have attempted to define youth friendly services as follows:
'Services that are accessible, acceptable and appropriate for adolescents. They are in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are effective, safe and affordable. They meet the individual needs of young people who return when they need to and recommend these services to friends.'

8.8.2 Programmes

Health

ICPD (1994) intensified the worldwide focus on RH policies and programmes. While its Programme of Action did not provide a blueprint for implementing comprehensive, integrated RH services, countries have worked to define their own priorities based on available resources. Thus Governments in many countries have worked to adopt the recommendations of ICPD, shifting their population policies and programmes from an emphasis on achieving demographic targets for reduced population growth, to a focus on improving the reproductive health of their populations. In addition, the policy frameworks and related legislation have empowered civil society to enhance campaigns to inform communities about the consequences of harmful practices, such as early marriages, as obstacles to youth development. Outlawing child marriages and child prostitution in response to Article 6 of the Convention on the

Elimination of All Forms of Discrimination against Women (CEDAW) has been a major milestone in the youth development.

To respond to the SRH needs of young people in Kenya, the Government, individuals and organizations have initiated a variety of programmes, including reproductive health information dissemination and services for adolescents and the youth. The main programme approaches include; peer education, edutainment, service delivery (including outreach services), youth support structures, mass media, ICT, edusports, life skills education, mentorship, adult influencers, and advocacy for policy review or change. The implementation of these approaches is usually in combinations, such as peer education through the mass media alongside related service delivery (GOK/MOPHS, 2011). While youth serving organizations (YSOs) in principle target all youths, they operate primarily in the country's highly populated areas, with Nairobi having the highest concentration of implementers of youth programmes.

In 1999, the Kenya Government declared AIDS a national disaster, causing the diversion of a lot of resources to that area. A decade later, after a lot of successful awareness-raising on HIV and AIDS, development of sex education curriculum, and other interventions, the pendulum appears to be swinging back to a more holistic approach to health in its widest sense. Perhaps, the rise of the international youth culture, promoted through multimedia and cell phone technology, has contributed to this. Or maybe the rise of sexual education programmes has contributed to the slowing down of HIV infection.

Employment

The Government has attempted to address youth unemployment through various policies and programmes overtime. These include elaborate youth employment strategies, such as through youth entrepreneurial training, micro credit schemes, vocational training and career guidance service development, youth leadership training, and ICT skills training. Other policy documents geared to address youth unemployment include: Sessional Paper Number 2 of 1992 on Small Scale and Jua Kali Enterprises, Development Plan 1997-2001, and Sessional Paper Number 4 of 2005. One of the outcomes of the Kenya National Youth Policy (2007) was to put in place strategies to address youth unemployment. A **Youth Employment Marshall Plan** was developed in 2009 aimed at creating 500,000 new jobs annually in both formal and informal sectors. The Plan objectives would be achieved through public and private sector partnerships and collaboration. Some of this Marshall Plan's strategic initiatives include:

1. *The Youth Enterprise Development Fund*: Established in 2007, the Fund has created employment through enterprise development and structured labour exports. It has been able to disburse over KSh2.8 billion to 100,000 youth enterprises and trained over 150,000 entrepreneurs. The fund has also facilitated the marketing of youth enterprise products and services, provision of commercial infrastructure, and the employment abroad of over 3,000 youths through its Youth Employment Scheme.
2. *Kazi Kwa Vijana (Jobs for Youth) Programme*: The Government initiated *Kazi Kwa Vijana* (Jobs for Youth) as an Economic Stimulus Package programme in 2008, as an initiative to spur economic recovery while engaging young people in gainful employment. Between 2007 and 2012, the Government spent US\$.78.9M in this programme, and has been able to provide more than 500,000 temporary jobs annually. MOYAS co-ordinates the "Trees for Jobs" component of *Kazi Kwa Vijana*.
3. *Youth and ICT Development*: The Government has given prominence to ICT in addressing rampant unemployment. MOYAS is collaborating with the Ministry of Information and Communication in setting up digital villages in every constituency. This initiative has seen the establishment of call centres and business outsourcing enterprises around the country, which is expected to create additional 100,000 jobs for youth in the next few years.
4. *Entrepreneurship training for youth out of school*: This is a youth enterprise development programme

that reaches out to youth out of school. The objectives of the programme are to:

- i. Empower youth to become better partners and catalysts of the development process;
 - ii. Enhance youth contributions to and influence in the economic sector by increasing their ownership of the means and factors of production and income generation activities through capacity building and provision of technical support;
 - iii. Enhance business and entrepreneurial skills, and foster an entrepreneurial culture;
 - iv. Stimulate and motivate the young people to spur their innovativeness and creativity; and
 - v. Provide opportunities to young people across the country to share experiences, and to initiate and strengthen a National Youth Entrepreneurship Policy.
5. *Youth Internships, Attachments and Volunteer Schemes*: The Government is encouraging youth to join volunteer schemes in an effort aimed at building skills and knowledge, and strengthening existing youth initiatives that engage more young people to take a proactive role in community development. MOYAS encourages internships and attachments especially in public agencies.
6. *National Youth Service*: The National Youth Service (NYS) trains young people for nation-building and provides a reserve force for the Kenya security services. The servicemen and women are also trained on various technical and vocational courses at artisan, craft and diploma levels under the Technical, Industrial, Vocational Education and Training (TIVET) programme. There are plans to raise enrolment above the current 4,500 annually to 15,000, for this programme in which entrepreneurship is a mandatory course. NYS has successfully implemented development projects that include construction of roads, airstrips, dams and water canals. It has participated in disaster management and other relief operations.
7. *Other initiatives include*: Roads 2000 (designed to create short-term labour-intensive employment for young people, is implemented by the Ministry of Roads and Public Works); and Trees for Jobs, which is partly financed by UNDP, and aimed at planting 90 million seedlings per year while employing over 29,000 youths in its first two years of operation.

8.9 Challenges and Opportunities

8.9.1 Challenges

The principal challenge lies in ensuring the optimal utilization of the youth's potential contribution towards achieving social, economic and political goals. The country will never achieve Vision 2030 without adequately responding to the needs and challenges of the present and future generations of the youth. This section discusses the observed challenges for youth health, education and employment, based on the analysis of the foregoing pages. The challenges are discussed under four main categories or levels — i.e. individual and household; socio-economic; institutional; and policy.

(i) Challenges over the Health of the Youth

Individual and household related challenges

1. Young people in Kenya give health a low priority, a mere four percent of a 2009 study of Kenyans aged 15-20 listing it as a top priority concern, compared to 45 percent who ranked employment opportunities at the top (CSA, 2009). Health also ranked below education, wealth, income distribution and political participation. Another recent assessment conducted by the HIV Free Generation project found that the top three fears of young people were unemployment, unintended pregnancies as well as HIV and AIDS (HIV Free Generation, 2011).
2. *Adolescent childbearing*: Adolescent pregnancy and childbearing is correlated with low education levels for girls, and poses a major challenge due to the fact that apart from the inherent health risks, adolescent childbearing and the conditions associated with it are fundamental factors determining the quality of life and role of women in society.

Social and economic related challenges

1. *HIV prevalence in young people:* The relatively high prevalence of HIV among young people, especially young women, poses a challenge for policies, programmes and service delivery in the country. Providing young people – especially girls – with appropriate HIV-related information and services, and cultivating a protective environment in their homes and schools and in society in general, remains a particularly acute challenge.

Institutional related challenges

1. Challenges here include: improving knowledge and support for youth programmes among stakeholders; planning for integration and decentralized services; strengthening human resource capacities to deliver widely attractive youth friendly services; improving quality of care; and addressing legal, regulatory and social issues.

Policy related challenges

1. A major challenge facing the country as the Government implements adolescent and youth SRH programmes and interventions remains the need to clarify the comparative roles of donors/development partners, technical agencies and communities. Additionally, there is a need to maintain a long-term perspective regarding the implementation of the ICPD agenda.
2. While Kenya has multiple policies and guidelines that favour the provision of information and services to young people, these documents are not well integrated into mainstream sectoral programmes and services. This has translated into inadequate dissemination, utilization and implementation of policies and guidelines, and into weak coordination of youth SRH interventions nationally

(ii) Challenges in Youth Education

Social and -economic related challenges

Poverty entrenches inequalities across activities among the country's young people, with education presenting a curious instance in which inequalities persist despite heavy Government subsidies. These education disparities eventually impact on long-term socio-economic outcomes, including those relating to health. While basic education has become widespread in Kenya, inequality of opportunities are reflected in persisting drop-outs among the poor, who are also likely to receive poorer quality education.

Institutional related challenges

Growth in both primary and secondary school enrolment due to Free Primary Education (FPE) and Free Secondary Education (FSE) respectively, has meant that the education system is overstretched in terms of facilities as well as financial, material and human resources. These realities have negatively impacted on the education sector's ability to achieve quality outputs and the resulting high transition rates to secondary education and above.

Policy related challenges

1. The positive impact of education on people's health outcomes, including adolescent and youth sexual and reproductive health and other demographic indicators, cannot be overemphasized. However, the Government appreciates the challenge at hand, and notes that the proportion of out-of-school children (of those who ought to be in school) remains high, undermining the attainment of the 'Education For All' (EFA) targets (GOK, 2012).
2. Large regional disparities exist in education attainments. This poses major challenges to the attainment of the EFA targets and other initiatives targeting the achievement of equity in education.

(iii) Challenges in Youth Employment

Individual and household related challenges

1. Due to idleness, especially after formal education, the youth become restless, with some ending up in crime or with deviant behaviour, including self-destructive tendencies. Slightly more than half of Kenya's prison population is persons aged between 16 and 25. Poverty together with drug and substance use are responsible for the increased vulnerability of youth to crime.
2. Employment marks an important transition period for young people, characterized by independence, increased responsibilities and active participation in nation building and social development, declares the World Development Report 2007. Young people who are unable to earn their own incomes have to be supported by their families, leaving less for spending and investment in other household needs.
3. Voluntary unemployment is on the rise as the youth become more selective of the types of jobs they prefer not to do, such as manual labour.

Social and -economic related challenges

1. High unemployment rates among the youth means that the Government misses out on their potential contributions to social security systems. As the International Labour Organisation observes: 'This is a threat to the growth and development potential of economies.'
2. The analysis of the youth employment context shows that Kenya faces five key challenges, namely: high unemployment (rates); rapidly growing labour force; under-employment; the problem of the working poor; and gender inequality in employment.
3. While the informal (*Jua Kali*) sector continues to play a critical role in employment creation in the country, it is also faced with many challenges, including: (i) low productivity; (ii) limited technological transfer; (iii) poor occupational health and safety measures; and (iv) inadequate access to markets and marketing channels.
4. A large proportion of young adults and a rapid rate of growth in the working age population have exacerbated the unemployment situation, which in turn leads to prolonged dependency on parents and guardians, diminished self-esteem and fuels frustrations, thereby increasing the likelihood of violence and conflict in the society, as witnessed during the post-election violence in 2008.

Policy related challenges

1. Concentration of young people in the country's major cities, with the youth (aged 15 to 24) making up more than 30 percent of total urban population, poses great challenges to the provision of health and education services, and for the creation of their employment.

(iv) Young people with special needs

The delivery of multi-sectoral services — health; education; employment— to the youth with disabilities poses a great challenge as this requires specific strategies to ensure the beneficiaries' full and effective participation in the country's socio-economic development.

8.9.2 Opportunities

In spite of the challenges and vulnerabilities facing young people, it would be wrong to view them fundamentally as a burden. The youth are an asset to the nation, whose present management is critical for Kenya's future. Indeed, Kenya's Vision 2030 recognizes the youth as a priority group that 'can be tapped into for the benefit of the whole country'. This youthful population offers a one-time window of social, economic and political opportunity. But this requires appropriate investments in policies,

sustainable programmes and good governance focused on the youth. Whether or not a country can take advantage of this demographic bonus depends on whether young people entering the work force are literate, healthy, hopeful and skilled. The Vision 2030 with its Economic, Social and Political Pillars, aspires to achieve a newly industrializing, middle income country, providing a high quality of life to all its citizens by 2030. But this will greatly depend on the extent to which the country nurtures, develops and utilizes her human resources, especially its labour, which is predominantly youthful.

Across the sectors, the MOYAS MTP I's Strategic Plan (2008-2012) also acknowledged that when empowered, the youth can contribute positively towards good governance and democracy for national development. A similar theme is found in other sectoral plans.

Further, Article 55 of the Constitution recognizes the need for:

“the State to take measures, including affirmative action programmes, to ensure that the youth: (i) access relevant education and training; (ii) have opportunities to associate, be represented and participate in political, socio-economic and other spheres of life; (iii) access employment; and, (iv) are protected against harmful cultural practices and exploitation.”

Thus the highest law of the land recognizes the importance of investment potential of the youth. By the same token, youth policies all call for multi-sectoral approaches in planning programmes and interventions for youth development.

Nothing hinders the Government from putting in place robust AYSRH programmes and services to effectively address the SRH needs of the young people in the country given the current supportive policy environment for such programmes and services. The 1994 ICPD-PoA highlighted the importance of holistic action regarding AYSRH. Seven years later, at the 2001 International AIDS Conference in Barcelona, the “Barcelona Youth Force” helped put the risk of HIV among youth prominently on the world stage. This youth advocacy, supported by UNAIDS, together with the creation of the Presidential Emergency Programme for AIDS Response (PEPFAR), pushed the urgency of HIV awareness raising and action among youth to the fore of youth SRH. In Kenya, the pendulum is steadily swinging back from focusing on risks of HIV and AIDS among the youth, to a broader approach to youth development, including the pivotal issues related to sexual and reproductive health (GOK/MOPHS, 2011). Donors, Government agencies, programmes and service providers are increasingly moving towards such a holistic approach to addressing youth issues. Meanwhile, Government agencies have expressed the need for better coordination of the multiple AYSRH programmes being implemented by partners, often in “silos” for particular issues. As a result, the Division of Reproductive Health (DRH) is beginning to explore these issues with special regard to reproductive health for youth.

Other specific opportunities for addressing and/or enhancing adolescent and youth health and development in Kenya include:

1. The observed drop in early childbearing among adolescent girls is an encouraging trend that must be sustained and/or scaled up in current programmes for even better future results;
2. The existence of legislation and policies, such as the Children Act, Disability Act and the National Disabled Persons Policy, provides a timely opportunity to mainstream disability issues and the needs of disabled adolescents and youth into health and other development interventions being undertaken in the country; and
3. Young people are recognized as a major resource that has the potential to drive the economic development of the country to greater heights; but only if policy-makers exploit the demographic dividend they offer.

8.10. Conclusions and Recommendations

8.10.1 Conclusions

Several conclusions that justify adolescents and the youth as an emerging priority group can be drawn from this analysis:

1. Kenya is a youthful nation and the need to address the social, economic, demographic and even political needs of young people in the country is urgent. Available evidence from policies and legislative frameworks indicate that the Government indeed recognizes the developments, issues and challenges that continue to impact negatively on the youth. Consequently, the Government, international agencies and NGOs have rightfully turned attention to the youth and their special needs, a focus reflecting recognition that a nation's youth not only forms a considerable resource for national development, but also forms a significant potential source of problems.
2. The contribution of adolescent or youth fertility to the overall fertility of the country has increased since the 1970s, making the reproductive decisions of contemporary youth significant for Kenya's future socio-demographic landscape.
3. HIV infections are highest among young people aged 15 to 24, and particularly among young women in this age bracket.
4. The country has made great progress towards increasing access to primary and secondary education with a view to achieving gender parity, retention and increased completion and transition rates. However, there still exist significant variations between national targets and achievements made. Key challenges to the complete achievement of the targets include: high shares of out-of-school children; regional and gender disparities in attainments; limited budgets; inadequate and poor quality infrastructure and human resources; weak coordination mechanisms; high illiteracy levels; non formal education; high costs of Special Needs Education; and HIV and AIDS.
5. The Government has made great progress in the development of laws, policies and strategies that support the development and implementation of interventions addressing the sexual and reproductive health needs of young people in the country. Further, many stakeholders are putting in place programmes in line with existing policies. However, implementation of the policies remains weak, as many programmes are being implemented on a small scale, or on pilot basis.

8.10.2 Recommendations

1. Article 55 of the Constitution calls upon the state to take measures, including affirmative action programmes, to ensure that the youth have access to relevant education and training (GOK, 2010). Young people must be provided with the relevant and appropriate tools to develop their capabilities so they can make the most of opportunities presenting themselves in today's competitive global economy. They can do this only if they are equipped with advanced skills in thinking, behaviour, specific knowledge and vocational skills to enable them perform jobs that require clearly defined tasks.
2. To respond to, and address, some of the identified challenges, the Government should collaborate with other stakeholders (development partners, private sector/NGOs) to take advantage of the many opportunities that exist in favour of the country's adolescents and youth to:
 - a. Ensure effective implementation, monitoring and evaluation of the existing youth related policies across all sectors; and
 - b. Put in place targeted programmes and interventions that address the varied needs of adolescents and youth, particularly in health, education and employment creation;
3. Recognizing the dynamism in adolescent and youth programming, there will be need for timely dissemination of data to inform the design and development of targeted programmes and interventions for the ever increasing and varied needs of the youth in Kenya.

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CHAPTER 9: MARRIAGE AND FAMILY

9.1 Introduction

The institution of marriage is the traditional foundation and cornerstone of human survival strategies which exist in varying forms. In many societies, it is the basic means of family formation, socialization and economic production (Benjamin 1968). Traditionally, the family is also a key decision-making unit that impacts on demographic behaviour. In recognition of these vital roles of marriage, Principle 9 of the 1994 International Conference on Population and Development, hereafter ICPD 1994, stated that: *“the family is the basic unit of society and as such, should be strengthened. It is entitled to receive comprehensive protection and support...”* (UN/DPI, 1995). The Kenya Constitution 2010 endorses this view in Article 45 (1) which stipulates that *“the family is the natural and fundamental unit of society and the necessary basis of social order, and shall enjoy the recognition and protection of state”* (Republic of Kenya, 2010). The National Population Policy for Sustainable Development of 2000 and the Population Policy for National Development of 2012 also defined the family as the basic unit of society (Republic of Kenya; 2000, 2012).

As a concept, ‘family’ refers to any group of people who are related by marriage or birth (blood relationship) or adoption. It is a kinship unit that is categorized as nuclear or extended. In a nuclear family, a husband and wife live with their children, or one parent lives with his or her children, while in an extended family, the relationship can extend to other generations such as grand-parents, great-grand parents, uncles, cousins and aunties (Faust, 2004; Ryder, 1987). However, because of difficulties in delineating families, the tradition of household surveys adopted by the Kenya National Bureau of Statistics (KNBS) is to focus on households instead of families.⁴¹ KNBS (2010) adopts the following definition of a household in surveys and censuses:

“A household is a person or group of persons who reside in the same homestead/compound but not necessarily in the same dwelling unit, have same cooking arrangements, and are answerable to the same household head. Households could therefore be family households or non-family households.”

The difference between ‘household’ and ‘family’ is summarized as follows: i) a household may have only one person while a family must have at least two members; ii) members of a multi-person household may not necessarily be related while family members are related; and iii) a household can have more than one family living together with one or more persons who are not related or it could have only non-related persons. Thus in this chapter, we analyse households and not families. The chapter reviews the status of marriage in Kenya over time with special attention to early marriage, and the situation and type of households

9.1.1 Rationale

Marriage is not only fundamental for family formation but also constitutes the most fundamental institution of any society, giving meaning to all other institutions. It is the primary locus of socialization and the unit from which other institutions spring. Family formation patterns are also key determinants of population change. In most societies, marriage has a strong influence on fertility because it influences the length of women’s exposure to the risk of conception. In this regard, age at first marriage is an important indicator for understanding variations in human fertility. More recently, marriage timing has been associated with higher prevalences of HIV and AIDS (Bongaarts, 2007), and has implications for the organization of the family and gender relations in society (Mensch *et al.*, 2005). In addition, the

⁴¹ Another logic behind the choice of household is that individuals who are not related may decide to share a house in which they make the kind of ‘household decisions that families make, such as over food, furniture or rent.

timing of marriage is also of concern because of the potential harm young women face when they get married early (Singh and Samara, 1996; Zabin and Kiragu, 1998; Mensch *et al.*, 2005).

The household and family grouping are the way in which individuals combine to satisfy their living needs. Understanding households and family groupings is, therefore, essential for proper assessment of consumer demand for almost all commodities (Benjamin, 1968.) Many problems facing the African region find their origin in the neglect of the family as a protagonist of development efforts (van de Walle, 1997). Rapid social developments occurring worldwide have generated considerable changes in family and household formation, composition and structure (United Nations, 1999). These include changing social norms such as delayed marriage, gender roles, higher rates of marital dissolution and a growing number of elderly without living spouses. HIV and AIDS have also created new types of households in a number of East and Central African countries, such as child-headed households, due to increased adult deaths and other vulnerabilities, as well as elderly persons living with grand-children (Hosegood, 2009).

9.2 Marriage

In the context of the family, marriage represents the initial step in furthering group survival and expansion. Married individuals can either be in monogamous (one spouse) or polygynous unions. Dissolution of marriage, on the other hand, occurs due to divorce or widowhood. Individuals of marriageable age who are not married fall into the *never married* state. Several biological, social, cultural, religious, economic, legal and political factors influence entry into, and dissolution of, marital unions (UNECA, 1983). This section describes trends in marriage in Kenya over time by sex, types, timing and dissolution. It focuses on marriages between persons of opposite sexes — as opposed to the emerging phenomenon of single sex marriages — which involve rights and obligations fixed by law or custom.

9.2.1 Levels and Trends in Marriage Prevalence

The most commonly used indicator of marriage prevalence is the proportion of the population ever married by age. Table 9.1 shows the trend in the sex distribution of individuals aged 15 years and above who are married. At younger ages (below 25 years), the proportion of men who are married is lower than that of married women, indicating that women enter into marital unions earlier than men. However, by age 34, the proportion of men in marriage is similar to that of women. Beyond age 50, the proportion of women who are married declines indicating probable effects of the earlier adult male mortality, leading to high cases of widowhood. These patterns are consistent across the census years (1989, 1999 and 2009).

The proportion married in age group 45-49 is used to define the universality of marriage; that is, near universal marriage occurs when the proportion of persons aged 45-49 who are married is above 95 percent. The results in Table 9.1 show that the proportion of women aged 45-49 years who are married has remained stable at around 90 percent over the last two decades. In contrast, the proportion of men aged 45-49 years who are married is higher but has remained stable over the last two decades.

Table 9.1 Levels and trends in proportion married by age and sex, Kenya, 1989–2009

	Male			Female		
	1989	1999	2009	1989	1999	2009
15-19	2.1	2.9	3.2	18.8	18.8	15.4
20-24	20.0	22.2	19.7	61.2	58.9	55.7
25-29	60.3	57.0	56.5	76.7	73.7	74.2
30-34	83.7	80.8	78.7	84.5	80.5	79.6
35-39	88.8	88.0	86.4	85.7	82.1	80.2
40-44	89.9	90.5	88.9	84.0	81.8	78.6
45-49	90.2	90.9	90.2	82.9	80.8	77.7
50-59	90.5	91.0	90.7	78.7	70.1	73.0

Sources: CBS (1996; 2004); MPND (Forthcoming), Vol. V.

9.2.2 Patterns of Marital Unions and Dissolution

Table 9.2 shows the distribution of men and women aged 12 years and above by marital status as of 2009. There is a rapid decline in the proportion of never married women after age 19 while for men, the rapid decline in the proportion never married starts after age 24. The pattern reflects the fact that women enter into marriage earlier than men. It is also worth noting that at ages 30 years and below, the proportion of women in monogamous marriages is higher than that of men in similar unions. This pattern is reversed at higher ages with the proportion of women in monogamous marriages being lower than that of men in similar unions. In contrast, between aged 15 and 64 years, the proportion of women in polygynous unions is higher than that of men.

Divorce and separation is low although rates for women are higher which suggests that marriages are fairly stable in the country (Table 9.2). The low levels of divorce or separation may be due to the fact that the majority of Kenyans still marry under customary laws on which divorce is a cumbersome process and is highly stigmatized (Ayiemba, 1990). The major source of marital dissolution is widowhood for both men and women (Table 9.2). However, the proportion of women widowed after age 35 is substantially higher among women than among men. In addition, the higher proportion of men in marriage compared to women at older ages could be due to the practice of polygyny and the fact that men may quickly remarry once a spouse dies (Goldman and Pebley, 1986).

Table 9.2 Percent distribution of men and women aged 12 years and above by marital status, Kenya, 2009

Age Group	Never Married		Married Monogamous		Married Polygamous		Widowed		Divorced		Separated		Number	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
12-14	97.5	97.4	1.5	1.6	0.9	0.9	0.1	0.1	0.0	0.0	0.0	0.1	1532395	1,458,927
15 – 19	96.9	84.6	2.3	13.2	0.7	1.4	0.1	0.1	0.0	0.2	0.1	0.4	2116516	2,044,206
20 – 24	79.6	41.4	19.0	51.5	0.8	4.2	0.1	0.5	0.2	0.8	0.4	1.6	1733980	2,013,675
25 – 29	41.7	20.5	54.8	67.6	1.7	6.6	0.2	1.4	0.5	1.3	1.2	2.6	1506622	1,666,223
30 – 34	18.2	12.2	75.5	70.4	3.3	9.2	0.4	3.2	0.8	1.8	1.8	3.2	1238688	1,258,795
35 – 39	9.8	9.1	81.5	69.3	4.9	11.0	0.7	5.3	1.0	2.0	2.1	3.3	990582	1,001,419
40 – 44	6.6	7.7	81.8	65.7	7.2	12.9	1.2	8.2	1.1	2.3	2.1	3.2	735356	731,572
45 – 49	4.9	6.4	81.3	63.8	8.8	13.9	1.6	10.9	1.1	2.2	2.1	2.9	628803	636,856
50 – 54	4.0	5.1	79.5	58.7	11.3	15.9	2.3	15.9	1.2	2.1	1.9	2.3	474225	477,469
55 – 59	3.4	4.5	78.4	55.6	12.3	16.0	2.9	20.0	1.2	1.9	1.8	2.0	357186	352,405
60 – 64	3.3	3.9	75.6	49.5	14.5	16.2	3.9	27.0	1.1	1.8	1.6	1.5	293614	298,501
65+	8.1	7.3	64.2	36.6	18.0	13.8	7.5	40.0	1.0	1.4	1.3	0.9	600661	728,725

Source: MPND, Vol. V (Forthcoming).

A critical feature of marriage in Kenya is the practice of polygyny, which enjoys *de facto* legality although such unions are no longer fully recognized by the courts. Polygynous marriages are considered to be the main cause of early marriage (Ezeh, 1997). In KDHS, polygyny has been measured by asking all currently married female respondents whether their husbands or partners had other wives, and if so, how many. Table 9.3 shows trends in the distribution of women in polygynous marriages by socio-economic characteristics including place of residence, level of education, and household wealth status. The proportion of women in such unions has generally been declining over successive KDHS rounds, with the greatest decline occurring in urban areas. Women with no education are more likely to be in polygynous unions. In addition, women from the poorest 20 percent households are more likely to be in polygamous unions compared to their counterparts from richer households.

Table 9.3 Trends in the distribution of women reporting being in polygynous marriages, Kenya, 1993–2008/09

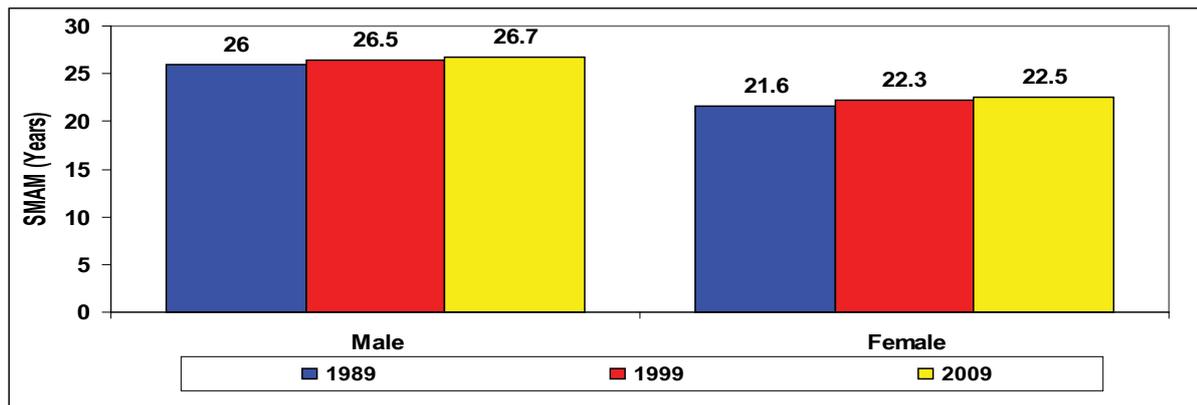
	1993	1998	2003	2008/09
Kenya	19.5	16.0	16.4	13.3
Place of residence				
Urban	13.7	11.0	11.7	7.2
Rural	20.5	17.3	17.8	15.2
Education level				
None	33.3	29.3	36.2	33.3
Primary Incomplete	20.2	17.9	18.2	16.9
Primary Complete	13.0	12.0	10.9	7.8
Secondary+	11.4	10.5	8.0	7.5
Wealth quintile				
Lowest			26.0	25.6
Second			18.4	15.0
Middle			14.7	15.1
Fourth			13.6	8.6
Highest			10.6	5.9

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

9.2.3 Timing of First Marriage

In Kenya, the legal age of marriage — with or without parental consent or approval — is 18 years for men and women (Republic of Kenya, 2010). Age at first marriage is, however, determined by many factors, such as cultural norms and economic factors (UNFPA, 2012). Two indicators are used in the analysis of the timing of first marriage, namely percent married at ages 15-19, and singulate mean age at marriage (SMAM). The proportion married at age 15-19 captures the extent of early marriages while SMAM represents a summary indicator of the entire age distribution of first marriages. Figure 9.1 shows the trends in SMAM in Kenya between 1989 and 2009. For both men and women, there has been no major change in the timing of first marriages over the last two decades. In addition, consistent with findings on prevalence of marriage and patterns of marital unions, women enter into first marriages earlier than men.

Figure 9.1 Trends in timing of first marriages in Kenya, 1989–2009



Sources: CBS (1996; 2004); MPND (Forthcoming), Vol. V.

According to United Nations (1990), the early marriage patterns for women occur when SMAM is less than 21 years, with the intermediate pattern ranging from 21-23 years, and the late pattern between ages 23 and 28. Trends in marriage timing suggest that marriage in Kenya is slowly changing from an early pattern to an intermediate one.

In sub-Saharan Africa, there exist large age differences on average between men and their spouses (United Nations, 1990). Age differences between marital partners are due to a variety of social-demographic factors and norms in societies, including the prevalence of polygyny, bride wealth, migration and levels of education (United Nations, 1990; Garenne, 2004). High costs of bride wealth imply increases in the age of men at first marriage because their families must find sufficient wealth to pay for their sons' marriages (United Nations, 1990). In addition, age difference between spouses can be considered as a proxy for conjugal distance and gender inequalities (Magali and Hertrich, 2005).

Table 9.4 shows trends in SMAM between 1999 and 2009 by sex, place of residence and region. At the national level, the age difference between spouses has not changed over the last decade. However, although the age difference between spouses increased slightly in both rural and urban areas, the increase was greater in the rural than in the urban areas. In addition, there have been increases in age differences between spouses in Central, Eastern and Rift Valley provinces while other regions experienced declines (Table 9.4). The age difference between spouses has been lowest in Nairobi and other urban areas and highest in North Eastern Province and in rural areas.

Table 9.4 Trends in Singulate Mean Age at Marriage by background characteristics, Kenya, 1999–2009

	1999			2009		
	Male	Female	Male/Female difference	Male	Female	Male/Female difference
Kenya	26.5	22.3	4.2	26.7	22.5	4.2
Place of residence						
Rural	26.5	21.9	4.6	26.9	21.9	5.0
Urban	26.5	22.9	3.6	26.9	23.2	3.7
Region						
Nairobi	26.8	23.5	3.3	26.8	23.7	3.1
Central	27.5	23.7	3.8	27.8	23.2	4.6
Coast	26.7	21.3	5.4	26.7	22	4.7
Eastern	27.2	23.1	4.1	27.7	22.9	4.8
North Eastern	26.5	20.5	6.0	27.1	21.8	5.3
Nyanza	25.4	20.9	4.5	25.5	21.4	4.1
Rift Valley	26.3	22.1	4.2	26.7	22.4	4.3
Western	25.3	21.2	4.1	25.4	21.7	3.7

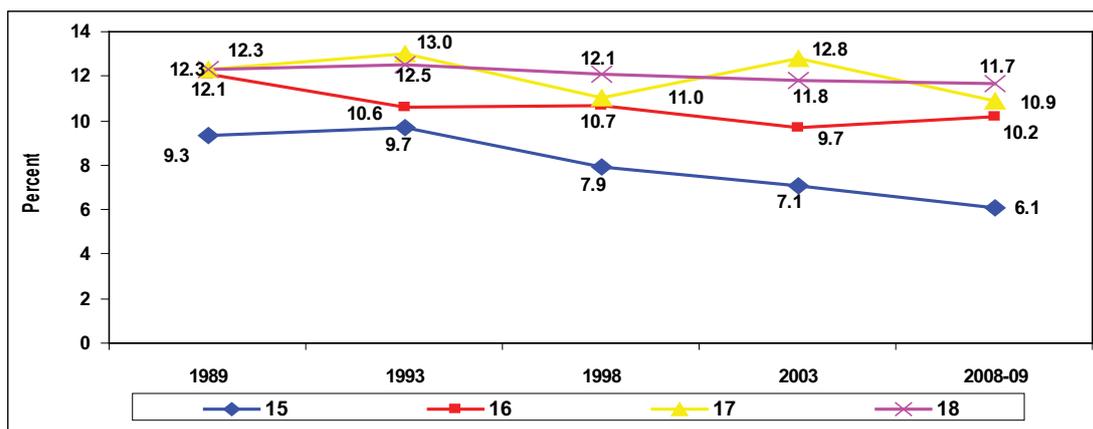
Sources: CBS 2004; MPND (Forthcoming), Vol. V.

9.2.4 Early Marriage

Concern over early marriage arises from the potential harm it occasions on young women who experience it (Singh and Samara, 1996; Zabin and Kiragu, 1998; Mensch *et al.*, 2005). It has also been associated with; polygamous unions, high school drop-out rates, low levels of labour force participation, high fertility as well as high adolescent and maternal mortality (Ayiemba, 1990; Njonjo, 2010; UNFPA, 2010). Kenyans — especially women — who are relatively poor, or who have little education, enter into marriage earlier than their better-off counterparts (KNBS and IFC Macro, 2010:830). Results in Table 9.2 further show that among those aged 15-19 years, the proportion of women who have ever been married is 5 times higher than that of men (15% and 3% respectively).

Figure 9.2 presents the trends in the proportions of women married by exact ages 15 through to 18. The proportion of women marrying by age 18 has been relatively stable. However, very early marriages (by age 15) have been declining overtime. Garenne (2004) found that if income and education are controlled for, early age at first marriage among women (which is a cause of large spousal age differences) is influenced by religion, polygyny and urbanization. Other factors promoting early marriages include customs that encourage early marriage of women as a source of wealth, such as dowry (Ayiemba, 1990).

Figure 9.2 Trends in the women aged 25-49 years married by exact ages 15 to 18, Kenya, 1989–2008/2009



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

Table 9.5 presents the prevalence of early marriages among women aged 25-49 years in Kenya by socio-economic characteristics as of 2008/2009. In addition, the prevalence of early marriage decreases with increasing levels of education and household wealth status. North Eastern Province has the highest prevalence of early marriages. Coast Province has the second highest prevalence of marriages occurring by exact ages 15 and 16 years while Nyanza Province has the second highest prevalence of marriages occurring by exact ages 17 and 18 years.

Table 9.5 Prevalence of early marriages among women aged 25-49 years by socio-economic characteristics, Kenya, 2008/09

Characteristics	Percentage first married by exact age:				Number of women
	15	16	17	18	
Place of residence					
Urban	5.7	10.1	14.6	20.5	1,280
Rural	9.7	15.8	25.2	35.9	3,689
Education level					
No education	23.6	32.6	44.3	54.9	557
Primary education	9.5	16.5	27.6	39.8	2,740
Secondary and above	2.4	4.6	6.8	11.4	1,671
Region					
Nairobi	2.5	5.2	9.2	13.6	443
Central	3.4	5.5	10.4	19.5	584
Coast	13.9	20.1	28.3	35.6	384
Eastern	6.0	9.1	15.7	25.4	857
North Eastern	19.8	28.6	39.5	51.8	109
Nyanza	10.3	18.9	30.0	40.5	754
Rift Valley	11.4	18.2	28.2	38.6	1,323
Western	9.0	16.8	25.2	36.4	515
Wealth quintile					
Poorest	15.0	22.9	33.0	43.7	818
Poorer	11.8	17.2	29.1	40.9	853
Middle	9.6	16.7	26.5	38.7	930
Richer	6.1	11.4	18.0	27.7	1,013
Richest	4.3	8.0	12.5	17.9	1,355

Source: KNBS and ICF Macro (2010).

9.3 Household/Family Characteristics

9.3.1 Household Size and Growth Rates

A household can be regarded as the unit of co-operative living that meets the day-to-day survival requirements of its members. Its organization is influenced by the prevailing social and cultural practices regarding patriarchy and gendered roles, marital patterns and migration (Bongaarts, 2001). In Kenya, the number of households (excluding institutions such as prisons, military barracks and schools) has grown from about 6.3 million in 1999 to about 8.8 million in 2009 (MNPD, Forthcoming). Table 9.6 shows the rate of growth in the number of households since 1979. The growth rate declined in the 1999-2009 inter-censal period. There has been an extensive decline in the household growth rates in rural areas, but a dramatic rise in the urban areas, (MPND, Forthcoming: Vol. X).

Table 9.6 Trends in household growth rates, Kenya, 1979–2009

	1979-89	1989-99	1999-2009
Kenya	3.87	3.81	3.19
Nairobi	6.47	5.28	4.17
Central	3.53	3.31	2.81
Coast	2.93	3.79	3.27
Eastern	2.95	3.36	2.94
North Eastern	-0.27	7.48	7.48
Nyanza	4.14	3.23	2.05
Rift Valley	4.54	3.82	3.57
Western	3.58	3.89	2.54

Sources: CBS 1996, 2004; MPND, (Forthcoming: Vol. X).

The average household size in Kenya declined from 5.7 in 1969 to 4.5 in 1999 and to about 4.4 according to 2009 Kenya Population and Housing Census (KNBS, 2010). One of the key demographic characteristics of a household is the number of members it contains. Table 9.7 shows the distribution of households by size as of 2009. About 16 percent of households have only one person while about four percent have 10 or more persons. Rural households tend to be larger than urban households. Nairobi has the largest proportion of households with only one person. The average household size ranges from 3.2 persons in Nairobi province to 7.4 persons in North Eastern Province.

Table 9.7 Percent distribution of households by size, Kenya, 2009

	Household size										Average Size	Number
	1	2	3	4	5	6	7	8	9	10+		
Kenya	16	13	15	16	13	9.8	6.7	4.4	2.7	3.5	4.4	8,767,954
Place of residence												
Rural	11	10.5	14.1	15.8	14.5	11.6	8.4	5.7	3.6	4.6	4.9	5,429,236
Urban	24	16.7	16.9	15.1	11	6.8	3.9	2.2	1.3	1.7	3.6	3,338,718
Province												
Nairobi	28	19.6	17.9	14.8	9.6	5.1	2.4	1.2	0.6	0.7	3.2	985,016
Central	21	15.7	18.8	18	12.6	6.9	3.4	1.6	0.8	0.7	3.6	1,224,742
Coast	19	13.7	14	13.3	11.3	8.9	6.5	4.6	3.1	5.5	4.5	731,199
Eastern	14	12	15.9	17.1	14.5	10.6	6.9	4.2	2.4	2.4	4.4	1,284,838
North Eastern	2.1	2.9	4.6	6.8	9.9	12.3	13.9	14.3	11.7	21.5	7.4	312,661
Nyanza	13	11.8	14.6	16.4	15.1	11.7	7.8	4.7	2.6	2.7	4.6	1,188,287
Rift Valley	15	11.3	13.9	15.1	13.7	10.9	7.9	5.3	3.3	4	4.7	2,137,136
Western	11	10.8	14.2	15.6	14.8	12.1	8.8	5.7	3.3	3.6	4.8	904,075

Source: MPND (Forthcoming: Vol X).

Household sizes in Africa generally increased between 1970s and 1980s (Locoh, 1988). However, factors driving the increases in household size have not been adequately explained (Bongaarts, 2001). Using data from 43 developing countries, Bongaarts (2001) indicated that the average household size for sub-Saharan Africa is about 5.3 members. Kenya is one of counties in Africa with relatively small household sizes on average.

9.3.2 Household Types

Table 9.8 shows the percentage distribution of households in Kenya by type and province as of 2009. Nearly half the households are nuclear while about two percent are non-family households (persons living together but unrelated). Rural areas have more nuclear households compared to urban areas, while non-family households are more common in urban areas. Regional distribution of households by family type is generally similar except for Nairobi which is urban, with slightly fewer nuclear households and more non-family households. Nyanza and Western provinces have the highest proportions of extended family households (34%) while Central Province has the lowest (22%).

Table 9.8 Percent distribution households by family types, Kenya, 2009

Province and Place of Residence	Household Type					Number of Households
	One person	Nuclear ^a	Extended ^b	Composite ^c	Non-family ^d /other	
Kenya	15.1	49.7	28.4	5.3	1.5	8,789,323
Place of residence						
Rural	10.4	53.4	30.7	4.6	0.9	5,439,435
Urban	22.8	43.7	24.5	6.5	2.5	3,349,888
Region						
Nairobi	26.1	39.7	23.3	7.9	3.1	985,016
Central	19.9	51.8	21.9	4.8	1.6	1,224,742
Coast	17.6	43.4	32.4	4.9	1.7	731,199
Eastern	12.8	50.0	28.7	6.8	1.7	1,284,838
North eastern	1.9	69.1	23.6	5.1	0.4	312,661
Nyanza	11.5	50.4	34.2	3.2	0.7	1,188,287
Rift valley	13.7	51.0	28.0	5.7	1.6	2,137,136
Western	10.5	51.9	33.7	3.4	0.5	904,075

Source: MPND, (Forthcoming: Vol X).

^aConsisting entirely of single family nucleus: married couple family with or without child(ren), father or mother with child(ren); ^bConsisting any of the following: single family nucleus with other persons related to nucleus e.g. father with children and other relatives, two or more nuclei related to each other, two or more family nuclei related to each other plus other persons related to at least one of the nuclei members, or two or more persons related to each other none of whom constitute a family nucleus e.g. brothers and sisters living together none of whom are married; ^cComposite household consisting any of the above either a nuclear or extended family household with at least one nonrelative; ^dPersons living together who are not related to each other.

9.3.3 Household Headship

Households and living arrangements can also be understood by examining the characteristics of the household head. The characteristics of the household head are generally associated with household welfare. The 2008/2009 KDHS showed that about two-thirds of households are headed by men while

households headed by women tend to be poorer (lower wealth quintiles). Household headship is influenced by several factors such as changes in the roles of men and women in society, forms and types of marriage including the extent of marital instability, rural-urban migration and the prevailing economic situations. Table 9.9 shows the distribution of households by age and sex of the head and by province. At the national level, about one in ten households are headed by persons in age group 15-24 while 15 percent are headed by elderly persons (age 60 and above). The proportion of households headed by youth (15-24 years) varies from about 5 percent in North Eastern Province to about 14 percent in Nairobi Province.

Table 9.9 Percent distribution of households by age and sex of the head, Kenya, 2009

Province	Age group of household head				Number of households
	15-24	25-34	35-59	60+	
Kenya	9.3	29.2	46.2	15.3	8,767,954
Males	8.7	31.1	47.2	13.1	5,949,154
Females	10.7	25.2	44.3	19.8	2,818,800
Nairobi	13.8	41.7	40.7	3.8	985,016
Males	12.5	42.6	41.5	3.5	752,007
Females	17.8	39.0	38.3	4.8	233,009
Central	7.1	26.5	47.1	19.2	1,224,742
Males	7.0	28.7	48.6	15.7	829,458
Females	7.4	21.9	44.0	26.6	395,284
Coast	10.4	31.4	46.3	11.9	731,199
Males	9.3	32.6	47.0	11.1	522,236
Females	13.1	28.3	44.6	14.1	208,963
Eastern	7.3	24.9	48.3	19.5	1,284,838
Males	6.4	25.6	49.9	18.1	821,299
Females	8.9	23.5	45.6	21.9	463,539
North Eastern	4.6	22.0	58.4	15.0	312,661
Males	3.6	21.2	60.1	15.1	247,359
Females	8.3	25.2	51.9	14.6	65,302
Nyanza	9.7	27.0	44.5	18.9	1,188,287
Males	9.5	29.8	45.1	15.6	729,457
Females	10.0	22.4	43.5	24.0	458,830
Rift valley	10.3	30.5	45.9	13.3	2,137,136
Males	9.4	32.4	46.5	11.7	1,457,482
Females	12.3	26.4	44.6	16.7	679,654
Western	8.3	25.5	46.9	19.3	904,075
Males	8.2	28.1	47.4	16.4	589,856
Females	8.5	20.6	46.0	24.9	314,219

Source: Computation based on the 2009 Kenya Population and Housing Census.

Young males (15-24 years) head about nine percent of households headed by men while female youth of the same age group head about 11 percent of the households headed by women. Elderly women head about one-fifth of the total households headed by women. Of the households headed by men, the proportion of youth heads varies from about four percent in North Eastern Province to nearly 13 percent in Nairobi Province. Similarly, the proportion of households headed by female youth (among households headed by women) ranges from eight percent in North Eastern Province to about 18 percent in Nairobi Province. The proportion of households headed by the elderly is lowest in Nairobi Province for both men and women. The highest proportion of households headed by elderly males is in Eastern Province (18%) while the highest proportion of households headed by elderly females is in

Central Province (27%) followed by Western Province (25%).

Changes in population as well as other social forces such as female labour force participation and education have produced varied and rapidly changing household and family structures (United Nations, 1999). Table 9.10 shows the distribution of households by size and marital status of the household head. The proportion of households which have more than one person, and are headed by persons who are not married, can be taken as a proxy for single parenthood. Generally, the data show that females are more likely than males to be single parents irrespective of place of residence. However, males who are divorced or separated tend to live alone compared to females, irrespective of place of residence.

Household structure is a result of social and economic changes that bring about reductions in fertility which, in turn, lead to changes in household composition through reduction in the number of children (Bongaarts, 2001). Household size increases as a result of marriage, birth, adoption or immigration, and declines through death, divorce or out-migration, observes Bongaarts, who also notes that the larger a country's average household size, the higher the ratio of children to adults, and the higher the proportion of non-nuclear members (more of composite and extended households).

Table 9.10 Percent distribution of households by size and marital status of the household head, Kenya 2009

	Rural				Urban			
	Single (1 person)	Small (2-4 persons)	Medium (5-8 persons)	Large (9+)	Single (1 person)	Small (2-4 persons)	Medium (5-8 persons)	Large (9+)
Males								
Never married	66.3	27.9	5.2	0.6	67.8	30.4	1.6	0.2
Married	4.8	36.7	47.6	10.9	14	51.1	31.1	3.8
Widowed	36.5	40.2	19.9	3.4	38.9	41.3	17.2	2.6
Divorced/ separated	64.8	27.8	6.7	0.7	68.5	26.8	4.2	0.5
Females								
Never married	26.1	54.2	18.2	1.5	46.5	47.3	5.8	0.4
Married	8.7	48.3	37.9	5.2	13.3	55	28	3.8
Widowed	19.6	46.7	29.2	4.5	18.3	50.4	27.2	4.1
Divorced/ separated	16.7	53.5	26.9	2.9	23.4	59.3	16	1.3

Source: MPND (Forthcoming: Vol X).

Table 9.11 shows the distribution of households by type and marital status of the household head. One-person households have been excluded from the analysis; hence, only households with two or more members are considered. The most common household type is that comprising nuclear families. About seven percent of the households comprise those who are not related (KNBS, 2010). Those who have never been married and those who are divorced, separated or widowed tend to head more of extended households than nuclear households, while those who are married tend to head nuclear households. It is those who have never been married that are more likely to form non-family households. The proportion of non-family households is slightly higher in urban than in rural areas. There are marked differences between men and women in headship by marital status. Males who have never been married are more likely to be in non-family households compared to females (Table 9.11). They are also less likely to head nuclear families than females.

Table 9.11 Percent distribution of households by marital status of the household head and household type, Kenya, 2009

	Rural				Urban			
	Nuclear	Extended	Composite	Non family	Nuclear	Extended	Composite	Non family
Males								
Never married	2.2	24.4	2.4	7.7	1.0	22.6	2.0	9.8
Married	63.5	26.8	4.7	0.5	57.1	21.6	7.3	1.1
Widowed/divorced/ Separated	26.3	19.4	2.1	1.7	20.3	17.9	3.3	3.3
Females								
Never married	34.1	35.5	4.2	2.4	20.9	26.7	4.9	4.4
Married	51.6	35.2	5.3	0.5	45.9	32.9	8.8	0.8
Widowed/divorced/ Separated	31.8	46.3	4.2	0.9	37.7	37.0	5.9	1.1

Source: Ministry of Planning and National Development and Vision 2030, Vol. X (Forthcoming).

9.4 Gaps

9.4.1 Marriage

Statistics on marriage and family patterns for any country constitute vital information for effective development planning. Planning should capture and project the changing family households' demand for goods, services and productivity that promote economic development at individual and societal levels. In Kenya, the Civil Registration Department has never published annual marriage statistics, thereby limiting research work on household transformations and productivity. Furthermore, national censuses which provide vital data for planning and policy formulation also lack information on the specific date at first marriage, type of marriage and duration of marriage.

The United Nations Population Fund (UNFPA, 2010) reports that, "marital unions as the fundamental units of societal socialization sometimes become units of marital conflict, family violence, and family disruption. Marital abuses lead to trauma in families." This occurs mostly in polygynous unions where competition for family resources is more acute. In addition, UNFPA (2010: 75) reports that forced or arranged marriages of children or adolescents "deprive (them) of their freedom, opportunities for personal development, and rights such as health and well-being, education, and participation in civic life. Children from one-parent households are also generally at a disadvantage compared to children from two-parent households and that; the incidence of one-parent households is higher among the poor." However, available data could not allow for analysis of marital conflicts and their implications for various marriage patterns.

9.4.2 Household and Family

There are few gaps with respect to analysis of households including the need to analyse the situation of "fragile families", including "skip generation" households and child-headed households. Child-headed households are among the most widely discussed social consequences of the HIV epidemic in Africa where the prevalence has been high, though evidence for the extent of this phenomenon is controversial (Hosegood, 2009). Skip generation households are typically described as households of a grandparent (typically a grandmother) living with her grandchildren whose parents have died. Children living with grandparents are vulnerable since the grandparents themselves have lost one of

their key support mechanisms, the working sons and daughters.

Although presented in demographic and health surveys, there are other living arrangements for children that make them vulnerable, such as children living with grandparents and other relatives even when their parents are alive. Such circumstances arise from fosterage and circular labour migration where young adults in search of employment leave their own children with their grandparents while seeking work elsewhere particularly in urban centres. Such children are still considered vulnerable; but there is lack of evidence on the prevalence of the phenomenon and its consequences. Again, lack of relevant data could not allow for analysis of these aspects of household and family formation in this chapter.

9.5 Existing Policies and Programmes

The Government's views on marriage and family formation are further seen in the *Population Policy for National Development of 2012* which states that "the policy will be implemented within the framework of Vision 2030 and the new Kenyan Constitution of 2010" (Republic of Kenya, 2012: 23). The policy measures proposed embrace the rights of individuals as stipulated in the Constitution, as well as the broad goals of Kenya Vision 2030, the country's development blueprint that aims to transform the nation "into a newly industrializing middle income country providing high quality of life to all its citizens in a clean and secure environment" (Republic of Kenya, 2007).

In the Population Policy of 2012, direct measures affecting marriage and family patterns are limited. Instead, there are more indirect policy measures which emphasize a wide range of programmes to be implemented. These programmes aim at delaying marriage and include empowerment of the youth, women, and adult populations through better education, increased labour force participation, better reproductive health and family planning services, gender equality and equity, and enhanced decision-making in all spheres of development (Republic of Kenya, 2012). The implementation of the policy is, therefore, guided by several principles including the recognition of the family as the basic unit of society. The policy further identifies the diverse cultural and religious beliefs and practices that encourage early marriages and polygyny as persistent and emerging programme challenges that must be tackled. High levels of adolescent fertility are also recognized as partly contributing to early marriages and polygyny. In order to address these issues, the policy has proposed the following measures to affect marriage and family formation:

- Raising age at first marriage from 20.2 years in 2009 to 23 years by 2030;
- Enhancing information, education and communication in communities that still practise harmful traditional practices such as Female Genital Cutting (FGC) and early marriages; and
- Supporting programmes through advocacy and public awareness campaigns on the implications of a rapidly growing population on individual family welfare, and on national socio-economic development, to create the desired small family norms and high quality of life (Republic of Kenya, 2012: 10-21).

9.6 Challenges and Opportunities

The youth are potential future leaders and are vital human capital for present and future development through family formation and participation in the labour force. It is estimated that among the 13.7 million youth in Kenya (in 2011), 7.6 million live in poverty (NCAPD, 2011). Poverty often triggers early entry into marriage, motherhood and family establishment, thus denying young people greater prospects for further career development.

The programmes of free primary education and subsidization of secondary education create suitable opportunities for delaying entry into marriage, if effectively implemented. However, their implementation is a challenge to the Government because of the enormous resources required, human capital investment and infrastructure development. The challenge at the household level persists as some parents are still required to subsidize their children's education by buying school uniform and text books. Education imparts the right knowledge and skills to make good parents, effectively participate in the labour market and be responsible citizens (World Bank, 2007). Education also unlocks hidden potential, and protects human rights that promote economic well-being, health, liberty and the security of individuals (King and Hill, 1993). All these conditions are a justification for delaying age at first marriage and can make positive contributions to the development and well-being of families (NCAPD, 2011).

Acquisition of gainful employment marks a transition period for young people *"because it imparts a sense of increased responsibility, independence and active participation in nation building, as well as in social development. It also helps young people to make independent decisions in family formation, such as on age at first marriage, child bearing and spacing, and limiting the number of children. In Kenya, 60 percent of the active labour force consists of young people and 80 percent of the unemployed are also the youth"* (NCAPD, 2011: 46). Such a situation creates critical challenges in families and the society in terms of security, petty crimes, drug and alcohol abuse that involve the majority of unemployed youth and cause marital abuse and instability. Slightly more than 50 percent of Kenyan's prison population consists of young people 16-25 years old (Republic of Kenya, 2002).

9.7 Conclusion and Recommendations

Kenya is characterized by a high population growth rate that currently stands at about three percent annually. This growth level leads to the predominance of the youth in the population. The early age at marriage is, however, becoming less common, a trend which is rising in both rural and urban areas, with urban areas having relatively higher age at marriage for both women and men compared to rural areas.

The household is the basic unit in which economic production, consumption, inheritance, child rearing, and shelter are organized. As societies industrialize and urbanize, households become less extended and more nuclear, and also smaller (Bongaarts, 2001). In Kenya, nuclear households are prevalent although non-family households are beginning to emerge, especially in the urban areas. Males who are divorced or separated tend to live alone compared to women irrespective of place of residence.

The key messages for policy are as follows: i) in Kenya, marriages are still stable; ii) there is a slow shift from early age at first marriage to intermediate ages among women; iii) new forms of marriages are still few and not adequately captured by data; and iv) poverty is more likely to be associated with early entry into marriage.

It is recommended that other measures, such as investing in delaying age at first marriage and first birth can, have direct impacts on health and the general well-being of future population. Investment in social services, such as education for young people can; guarantee delays in family formation, promote entry into formal employment and make the youth become more responsible citizens.

There is also need to invest substantially on the Vital Registration System in order to produce flows of data that is more relevant for annual planning for the changing needs of family households. There is also need to invest in studies on fragile families in order to inform policies and programmes for social protection.

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CHAPTER 10: EMERGENCY SITUATIONS AND HUMANITARIAN RESPONSE

10.1 Introduction

An emergency (situation) refers to a condition that poses a threat to health, life, property or environment. Such situations occur as a result of various events: disasters; armed conflict and; displacement crises. A disaster is a serious disruption of the functioning of society, causing widespread human, material or environmental losses which exceed the ability of affected society to cope on normal resources (UNDHA, 2001). Disasters are adversities that are either nature-induced or human-induced.⁴² Human-induced events such as political upheavals, wars, ethnic cleansing, terrorism, or social factors such as racism, exclusion or persecution, can compound nature-induced events and transform them into 'complex disasters'. The occurrence and impact of natural disasters are a function of societal and human-environment relations (Hewitt, 1983)⁴³.

Displacement is often a consequence of population flight or evacuation as a response to natural, technological or social agents⁴⁴. It can be temporary or permanent, voluntary or involuntary; but it is often a response to actual or likely physical or economic harm. Depending on the cause, displaced persons may become refugees, asylum seekers or internally displaced persons (IDPs).



His Excellency Deputy President William Ruto, EGH, EBS dispatches food to displaced populations in Tana River, one of the disaster prone regions in the country. Photo: www.the-star.co.ke

The existence of an emergency situation creates an immediate and serious need for humanitarian response. Humanitarian response refers to actions taken to save lives, alleviate suffering and promote and protect human dignity before, during and after emergencies. Traditional humanitarian responses

⁴² Examples of nature-induced events include earthquakes, windstorms (cyclones, hurricanes, tornadoes, and typhoons), tsunamis, floods, earth movements (landslides, mudslides) volcanic eruptions, avalanches, wildfires, grasshopper and locust infestations, sand and dust storms, and any other calamity of natural origin (UNEP, 2003) while human-induced events often involves human or technological failures such as road accidents, aircraft crashes, railway accidents, building collapse, political unrest and violence.

⁴³ The impacts of disasters can include, but are not limited to, loss of human life, loss of property, displacement, and disruption of economic activities.

⁴⁴ Displacement can be induced by a disaster, armed conflict and or development project. Smuggled or trafficked persons may also become displacees.

often comprise the three components, including (i) relief assistance and services (e.g. shelter, water, and medical supplies); (ii) emergency food aid; and (iii) relief coordination and support services (e.g. logistics and communications). However, depending on the situation, such responses may be expanded to include disaster prevention and preparedness, and recovery. Humanitarian response is characterized by its short-term nature and is guided by the principles of humanity, neutrality, impartiality and independence. This distinguishes it from foreign aid, which often has a long-term nature to address prolonged vulnerability⁴⁵. This chapter focuses on emergency situations and humanitarian response with respect to natural disasters, armed conflict and human population displacement.

10.1.1 Rationale

Emergency situations persist in many parts of the world with increasing scale, frequency, severity and complexity causing ever increasing losses and humanitarian crises, especially in the developing world (Oliver-Smith, 2006). Emergency situations have important implications for population and society, hence the existence of several international frameworks to guide national Governments in preparedness and response. Principle 18(2) of the Guiding Principles on Internal Displacement states that:

“At the minimum, regardless of the circumstances and without discrimination, competent authorities shall provide internally displaced persons with and ensure access to: (a) Essential food and potable water; (b) Basic shelter and housing; (c) Appropriate clothing; and (d) Essential medical services and sanitation”(United Nations, 2001).

Additionally, Principle 11(2)(b) states that:

“Internally displaced persons, whether or not their liberty has been restricted, shall be protected in particular against slavery or any contemporary form of slavery, such as sale into marriage, sexual exploitation, or forced labor of children.”

These principles support the articles of the 1994 ICPD that called on Governments to address the factors that contribute to displacement, and to strengthen their support for international activities to protect and assist displaced persons.

10.2. Status of Emergency Situations

10.2.1 Natural disasters

Kenya is prone to a range of natural disasters notably drought, floods, landslides and mudslides, earthquakes, wildfires and various epidemics/pandemics (UNDP, 2004)^{46 47}. The international disaster database (EM-DAT) shows that during the period 1993-2010, a total of 73 natural disaster events including droughts, epidemics, flood, landslides and a tsunami, occurred in Kenya and affected a cumulative total of 48.46 million people (CREED, 2011). This translates to an annual average of 2.69 million people. During the same period, a total of 5,825 people (averaging 323 people annually) died from the impacts of the 73 natural disaster events. However, drought affected the highest number of people (about 39.2 million) compared to about 6.9 million affected by epidemics and 2.4 million affected by floods. On the average, drought episodes affected between 3-5 million people per event during the period compared to 237,300 by epidemics and 75,600 by flood events.

45 Foreign aid can be a successor of humanitarian response. That is, humanitarian response can address situations arising during and in the immediate aftermath of an emergency situation, while long-term vulnerability caused by the emergency situation can be addressed by foreign assistance.

46 Exposure to drought risk is a function of marginalization, land tenure arrangements, coping capacities, opportunities and availability of Government assistance, while flood risk is a function of precipitation, deforestation, urbanization, and landslides (Perch-Nielsen, 2004). Degradation of flood plain land, unequal patterns of asset ownership and income, land tenure systems, population growth in marginal areas, and Governments land access policies are factors that influence flood risk (Wisner et al. 2004).

47 The most frequent epidemics include bacterial infectious diseases (e.g. cholera, typhoid fever, and meningitis), viral infectious diseases (e.g. Rift Valley Fever, visceral leishmaniasis (Kala-Azar), dysentery, and measles), and parasitic infectious diseases (e.g. dysentery). Aflatoxicosis also contributes to the impact by epidemics.

In the last decade, the scale, frequency, and severity of natural disasters in Kenya have affected larger numbers of people⁴⁸. For example, before the 1990s, drought events occurred at five to ten-year intervals and on average affected less than 50,000 people per year (UNISDR, 2012). These statistics dramatically changed over the 2000-2009 decade when drought events occurred every one to three years and affected an annual average of 1.5 to 4.5 million people (UNISDR, 2012). The 2008/2009 drought alone affected ten million people, and decimated over 20 percent of the livestock population in the arid and semi-arid lands (ASAL) (GOK, 2010). In 2011, drought affected 12 million people in the Horn of Africa countries, of whom four million were Kenyans (GOK, 2010).

10.2.2 Armed conflicts

The war situations that have involved the Kenya Defence Forces (KDF) are few, notably the 1966-1968 Shifta War and the on-going “Operation Linda Nchi” intervention in Somalia⁴⁹. Otherwise, limited armed violence has often erupted before, during and after elections, the most notable surrounding the general elections of 1992, 1997 and 2007, in which the use of both crude and automatic weapons was reported. Most election-related violence has occurred in regions that host ethnic communities that seem to have primary competing political interests, or regions with perceived land injustices. The perennial livestock-related conflicts are often a result of culturally-prescribed ethnic rivalry over livestock wealth, water and pasture resources, or competing political interests, but occasionally involve the use of guns. Fights over water and pasture are more common in northern ASAL areas of the country.

10.2.3 Earthquakes

Although Kenya has not had a major earthquake in recent history, that reality is a possibility due to the latent tectonic activity along the Rift Valley. However, the December 26, 2004 earthquake whose epicenter was off the Sumatran Island of Indonesia triggered a tsunami that killed two people in Kenya, alongside hundreds of thousands who lost their lives in different countries. The significance of this event is that the adverse impacts of one great earthquake can be felt far and wide; meaning that Kenya has to be prepared for earthquake events that occur in other countries.

10.2.4 Health Emergencies

HIV and AIDS are the most well documented disasters in Kenya. Although declared a national disaster in Kenya in 1999, the HIV prevalence rate has declined from a peak of 10.5 percent in 1995/1996 among the adult population to its current estimated level of about 6.2 percent. However, the infection rate among women, at eight percent, is double that of men (UNAIDS, 2008; NACC and NASCOP, 2012). To date the pandemic has left a trail of over 1.2 million AIDS orphans, an enormous burden on the elderly persons in whose care the orphans are often left, and a burden on the economy from which resources must be diverted to provide services to the infected persons and affected families. Although AIDS is a natural disaster in its own right, researchers are still concerned with questions regarding the HIV and AIDS dynamics (prevalence rates; infection rates; treatment rates; ARV use; etc.) in various populations, especially in emergency situations. Consequently, the Kenya Humanitarian Plan 2013 calls for a need to focus on the increased risk of HIV during humanitarian crises, particularly when there are high levels of sexual and gender-based violence (SGBV) (UNOCHA, 2013)⁵⁰. The concern is the direct link between

48 Drought-prone areas include the upper eastern counties of Marsabit and Isiolo, the north eastern counties of Garissa, Wajir and Mandera, the coastal counties of Tana River, Lamu, and Taita Taveta, and the Rift Valley counties of Turkana, Kajiado, Pokot, Markwet, Baringo, and Narok. Flood-prone areas are found in the western parts of the country (Budalangi in Busia county, Nyando and Nyakach in Kisumu county, Rachuonyo in Homa Bay county, and Nyatike in Migori county) and the coastal region (Tana delta in Tana River county and parts of Taita Taveta county). Landslide and mudslide prone zones include Murang'a, Kiambu, Nyeri, Kirinyaga, and Nyandarua counties in the central region; Kakamega county in the western region; Nandi, Elgeyo Marakwet and Pokot counties in the Rift Valley region, and Meru and Tharaka Nithi counties in lower eastern region (Republic of Kenya, 2004).

49 The “Operation Linda Nchi” was a KDF incursion into the Republic of Somalia to secure the country from insurgent terrorist attacks.

50 KENYA Emergency Humanitarian Response Plan 2013. The latest version of this document is available on <http://unocha.org/cap/>. Full project details, continually updated, can be viewed, downloaded and printed from <http://fts.unocha.org>.

food insecurity and the ability to take requisite medication, and the fact that even if commodities are available the problem is compounded by limited ability to deliver these services.

Other than HIV and AIDS, various health emergencies that have been reported include; outbreaks of dengue fever, Rift Valley Fever and other haemorrhagic fevers, cholera, polio, malaria, hepatitis E and measles in refugee camps and host communities. Some of these sporadic outbreaks are often compounded by cross-border challenges than enable easy transmission, according to UNOCHA.

10.3 Displacement

As at January 2012, the number of internally displaced persons (IDP) in Kenya was estimated by international agencies at between 250,000 and 300,000 people down from more than 650,000 at the end of 2008 (UNHCR, 2008)⁵¹. Reference to the 2008-2012 is important because 2008 registered one of the highest rates of displacement in Kenyan history as a result of the December 2007 post-election violence⁵². Besides conflict situations; natural disasters (especially drought and floods), evictions and general insecurity are the other main causes of displacement in Kenya. Besides the internally-displaced, Kenya continues to face the challenge of refugee influx from war-torn neighbouring countries, especially Somalia⁵³.

Population displacement from sporadic episodes of localized inter- and intra-ethnic violence preceded the 2007 post-election violence, and occurred after it. For example, in March 2011, over 20,000 people were displaced from the town of Mandera by fighting between the Kenyan armed forces and members of the Somali Al-Shabaab group who had crossed the border from Somalia to engage in criminal activities in Kenya. In Isiolo, Marsabit and Tana River counties, inter-ethnic violence over natural resources and competition for control of local political power caused the death of many people and displaced thousands of families during the year 2012. In November 2012, heavily armed cattle rustlers ambushed and killed 42 armed police officers in the Suguta Valley of Samburu County, leading to the flight of many manyatta villagers who feared retaliatory attacks from security agencies and rival communities. Sporadic attacks and insurgencies from Ethiopia have caused significant displacement in Kenya, especially along common border. In 2012, more than 80,000 people were displaced by inter-communal violence in Moyale, Tana Delta, Isiolo, Mandera and Wajir (UNOCHA, 2013).



Internally Displaced Persons (IDPs) lived in tents following the 2007/8 post-election violence

Photo: www.friendsofkenyaophans.org

51 The IDP figures by international agencies differ significantly from Government figures which stood at 5,000 households in January 2012 and about 215,000 IDPs by the year 2008 (UNHCR, 2008; UNHCR, 2012). The discrepancy in the figures is blamed on the absence of national data on IDPs as the Government does not regularly profile IDP numbers and their location across the country.

52 The disputed 27th December 2007 presidential election holds the Kenyan record for the greatest displacement in recent years, with estimates of over 650,000 victims, mostly from the Rift Valley region, by the end of year 2008 (UNOCHA, 2008; KPTJ, 2010; IDMC and NRC, 2012b).

53 By January 2012, there were about 566,000 refugees in the Kenya up from 450,000 refugees in 2011, which large numbers had overstretched infrastructural services in the refugee camps (UNHCR, 2012). These large refugee numbers also place enormous pressure on natural resources, such as fuelwood, pasture, and water, over which they compete with host populations.

In most displacement situations in the country, IDP populations have stayed with relatives or other host communities where they were largely unreachable by humanitarian responses (IDMC & NRC, 2012b). The 2007 post-election violence induced displacement led to the creation of many temporary camps to host IDPs in the first quarter of 2008. Although the Government launched operations in 2008 to return and resettle all the IDPs (IDMC dan NRC, 2012b), many displaced people still remained in IDP camps by the end of 2011, unable to return home or rebuild their lives (Jesuit Refugee Service, 2001; IDMC, 2012b). The main reasons for their continued stay in camps were: impunity, homelessness, landlessness, uncertainty, and fear of revenge attacks (Jesuit Refugee Service, 2001; IDMC, 2012b). In some cases, there was resistance to resettle IDPs in several parts of Kenya mainly due to aboriginal feelings over ancestral lands (Jesuit Refugee Service, 2001; IDMC, 2012b). Beside the attendant loss of 'ancestral land' to 'aliens', the resistance to the resettlement of large numbers of IDPs in areas inhabited by other ethnic communities stems from the fear by local political interests that resettlement may upset voter demographics.

In order to create a conclusive framework for the management of the IDP question, Parliament passed the Internally Displaced Persons Act (2012) following the approval of the national IDP Policy in 2011. The policy and legal frameworks are expected to deal effectively with causes of displacement, safe return of IDPs, and resettlement and/or reintegration issues. Further, the formation of the National Cohesion and Integration Commission (NCIC) was a bold step to check on hate speech especially during electioneering periods while police reforms have deliberately targeted strengthening the policing function of the Government to ensure that citizen rights are respected, while civic education is designed to improve the citizens' understanding of their roles in enforcing their own rights. Overall, the country aims at eliminating the root causes of internal displacement.

10.4 Consequences of Emergency Situations and Displacements

Over time, the most disaster-affected sectors of the country's economy have been transport, water supply, health, industry, energy (hydropower), agriculture and livestock. For example, the 1997-1998 El Niño floods caused damage in these sectors equivalent to 11 percent of the national GDP, while the droughts between 1998 and 2000 incurred losses in the same sectors in excess of 16 percent of the national GDP (World Bank, 2006). In Nyanza region alone, the country incurred about Kshs49 million in economic losses and Kshs37 million in humanitarian action annually (World Bank, 2006).

In the reproductive health domain, emergency situations and displacements may exacerbate the infection rates of STIs and HIV, especially among women and girls. Women are sometimes raped by armed individuals or groups while others may engage in illicit sex to earn money for food and other needs. This leads to increased incidences of STIs and HIV among affected populations. In most such situations, the primary causes of sexual and gender-based violence have occurred due to general insecurity, prevalence of weapons, increased poverty, lack of income-generating opportunities, and the general breakdown of law and order (IDMC and NRC, 2006). According to one report by the United Nations Office of the High Commissioner for Human Rights (UNOHCHR), between 27 December 2007 and 29 February 2008, about 322 cases of sexual assault and rape of women and girls were reported to Nairobi Women's Hospital, 26 to the Moi Teaching and Referral Hospital in Eldoret, and two cases to Nyanza Provincial Hospital in Kisumu (UNOHCHR, 2008). Sexual exploitation within IDP camps was also rampant but underreported by victims and authorities.

Emergency situations lead to the disruption of health programs, destruction of health facilities, and to flight or death of health personnel, which hampers provision of vital social services. After Kenya's post-election violence of 2007/2008, IDP populations were reported to live in conditions with inadequate

housing, drinking water and sanitation, insecure or exploitative employment, and high prevalence of common diseases (Women's Commission on Refugee Women and Children, 2008). Feikin et al., (2010) evaluated mortality and morbidity among IDPs who relocated to a demographic surveillance system (DSS) area in western Kenya following the 2007 post-election violence. They found that the leading causes of death among IDPs were; malaria, HIV and AIDS, tuberculosis and malnutrition. The rate of hospitalization among internally displaced children was almost three times higher than among non-displaced children. The study attributed the high mortality rates to the post-election violence, as well as to interruptions to the drug supply and medication regimes, among other factors.

Medical personnel also face challenges of maintaining and initiating medical care in settings where the population is unconfined and less accessible (Spiegel, 2004; Culbert et al, 2007; Hampton, 2008; Bamrah et al, 2009; Vreeman et al, 2009). In a 2008 study by the Health Rights Advocacy Forum (HERAF) on the Effect of Post-Election Violence on the Health System in Kenya, about 1,200 health personnel were displaced from their places of work due to insecurity, lack of transport or other related factors (HERAF, 2008).

10.5 Responses to Natural Disasters

Documented evidence shows that the poor in Kenya use self-help and informal mechanisms as the most preferred strategies for responding to natural disasters, but formal asset insurance is uncommon or absent (Dercon, 2008). Other response strategies included arrangements such as local borrowing schemes, merry-go-rounds, and group revolving funds with friends and neighbours as well as remittances from relatives and Diaspora (De La Fuente and Dercon, 2008). Social capital — who a household knows — is a key aspect of surviving the impacts of natural disasters among many households in Kenya. The capacity of the poor in Kenya to cope with natural disasters is often hampered by fluctuations in the value of assets (such as livestock) due to seasonal variations in prices and distress sales, which lead to low returns on assets, thereby perpetuating a vicious cycle of poverty and vulnerability (Dercon, 2005; De La Fuente and Dercon, 2008).

Emergency situations often lead to distress migration. EM-DAT statistics show that the number of distress migrants as a result of natural disasters varies by time, location and social groups, but that it is highest in low income countries (Raleigh et al, undated). A study on Kenyan responses to climate hazards and droughts observed migrations flows to market centres and a growing dependence on aid for sustainable lifestyles (Little et al., 2001). Some studies found that chronic drought induces far more forced migrations than any other natural disaster in developing countries (Burton et al., 1993; Perch-Nielsen, 2004). Victims of floods have been observed to practice localized temporary out-migration often to relief centres (El-Hinnawi, 1985; O'Neill et al., 2001; and Perch-Nielsen, 2004).

During periods of displacement, loss of assets among the deprived segments of the population seriously compromises their health, recovery and long-term socio-economic development. Studies show that during the famine occasioned by the Horn of Africa droughts of the mid 1980s, it took most poor households more than ten years to attain their pre-drought cattle holdings (Dercon, 2002). This was partly occasioned by subsequent drought episodes in the intervening period that slowed recovery efforts. In other words, increased frequency of disaster events creates asset poverty traps, which make recovery extremely difficult without outside intervention, as observed in drought-prone northern Kenya (Barrett *et al*, 2004; Dercon, 2004). Besides impact on assets, natural disasters have adverse effects on non-monetary indicators such as nutrition, education status, and life expectancy (Alderman *et al*, 2006).

One of the defining factors for the frequency, scale and severity of natural disaster events is the climate change phenomenon, which has led to unpredictable rainfall season patterns, changing disease patterns, rise in sea level and increased frequency and severity of flood and drought events in the country⁵⁴. In order to counter these adverse consequences of climate change, the country has invested in a National Climate Change Response Strategy (NCCRS) to promote adaptation and address community risk and vulnerability⁵⁵.

10.6 Emergency Situation in Regional Context

Natural Disasters

The numbers of people affected or killed by natural disasters have generally decreased except in the developing world (CREC, 2012; Guha-Sapir *et al*, 2012). Although Africa has one of lowest incidences of natural disasters, it remains one the most vulnerable continents due to high levels of poverty, fragile and degraded environments, high prevalence of diseases, low access to social services, prevalence of weak governance structures and of armed conflict events, and low access to disaster reduction technology (UNISDR and World Bank, 2008; CREC, 2009). Floods and droughts are the most prevalent natural disasters on the African continent and have had the highest negative impact on human livelihoods and national economies (World Bank, 2006). In the Eastern African region, Kenya is among the most affected by floods and drought (Table 10.1a), and has recorded one of the highest flood-and-epidemic-related deaths and flood-induced homelessness in recent times (Table 10.1b).

Table 10.1a Number of people affected by natural disasters in Eastern Africa in 2010-2011⁵⁶

Country	Disaster type				Total
	Drought	Epidemic	Flood	Storm	
Burundi	180,000	600	2,675		183,275
Djibouti	200,258				200,258
Ethiopia	11,005,679	967	120,900		11,127,546
Kenya	4,300,000	3,880	306,856		4,610,736
Madagascar	720,000			281,297	1,001,297
Malawi			104,876		104,876
Mozambique	460,000	3,513	80,946		544,459
Rwanda			3,588		3,588
Somalia	4,000,000		18,800		4,018,800
Tanzania UR	1,000,000		59,000		1,059,000
Uganda	669,000	190	63,075		732,265
Zambia			2,575		2,575
Zimbabwe	1,680,000	1,398	820		1,682,218
Total	24,214,937	10,548	764,111	281,297	25,270,893

Source: CREC, 2012

⁵⁴ For example, the long and short rains that farmers had been accustomed to in the country have become increasingly unpredictable, leading to crop failures and chronic food insecurity. Malaria is now endemic in areas where it was unknown.

⁵⁵ Vulnerability refers to the characteristics and circumstances of a community, system or asset that lend to susceptibility to the damaging effects of a natural hazard, measured by various indicators (Blaikie *et al*, 1994). The concept of vulnerability integrates cultural, social, environmental, economic, institutional and political factors defined in terms of both biophysical and socially constructed risk. Thus, vulnerability is embedded in the root causes that reside in ideological, social and economic systems, the dynamic pressures of a demographic, socio-economic or ecological nature and specific sets of unsafe conditions which, when combined with a natural hazard, produce a disaster (Oliver-Smith, 2006). This more complex understanding of vulnerability enables researchers and practitioners to conceptualize how social systems generate the conditions that place different kinds of people, often differentiated along class, race, ethnicity, gender, or age, at different levels of risk from the same hazard. In other words, a single natural disaster can have different effects on different groups of people, thus motivating, in many instances, different responses.

⁵⁶ Population affected or affected people are those requiring immediate assistance during a period of emergency, i.e. requiring basic survival needs such as food, water, shelter, sanitation and immediate medical assistance and includes the appearance of a significant number of cases of an infectious disease introduced in a region or a population that is usually free from that disease.

Table 10.1b Number of people killed or left homeless by natural disasters in Eastern Africa in 2010-2011^{57, 58}

Country	Epidemic		Flood		Storm		Total	
	Killed	left homeless						
Burundi	12				21	1,500	33	1,500
Ethiopia	16		19				35	
Kenya	57		227	5,000			284	5,000
Madagascar					155	25,845	155	25,845
Malawi			4				4	
Mozambique	57		16		12		85	
Rwanda			14				14	
Somalia			11	200			11	200
Tanzania UR			37	6,776			37	6,776
Uganda	48		27		23		98	
Zimbabwe	53						53	
Total	243	none	355	11,976	211	27,345	809	39,321

Source: CRED, 2012

Incidence of armed conflicts

The report on “Global Burden of Armed Violence” by the Geneva Declaration Secretariat (GDS) states that globally, more than 740,000 people die directly or indirectly each year because of armed conflict-related violence (GDS, 2008). Recent data show that in Eastern Africa, some of the highest incidences of armed conflict-related deaths have been observed in Somalia while Kenya recorded one of the lowest figures (Table 10.2).

Table 10.2 Estimates of the distribution of direct armed conflict deaths in East Africa, 2004–2007

Country/region	Year/period				
	2004	2005	2006	2007	2004-2007
Burundi	820	269	108	49	1,246
Ethiopia	824	825	1,091	2,418	5,158
Kenya	40	124	125	-	289
Rwanda	75	92	-	-	167
Somalia	760	285	879	6,500	8,424
Tanzania	-	-	-	-	-
Uganda	1,649	859	196	111	2,815
Africa main armed conflicts (16)	17,572	8,825	7,996	14,350	48,739
Africa all countries (21)	17,651	8,965	7,995	14,388	48,997

Source: adapted after GDS, 2008

10.7 National frameworks for Managing Emergency Situations

On the policy front, the Government has in the past promoted collaboration among the public, private, and civil society sectors as well as working with UN agencies, the media and communities in managing emergency situations. In 2007, the Government unveiled Vision 2030 as a blueprint for the long-term development of the country, and there is an emphasis on the effective and efficient management of emergency situations (e.g. disasters) to the successful implementation of the blueprint. The “National

⁵⁷ Population killed or persons killed means persons confirmed dead and those presumed dead.

⁵⁸ Population left homeless refers to people needing immediate assistance of shelter.

Policy on the Prevention of Internal Displacement and the Protection and Assistance to the Internally Displaced Persons (IDPs) in Kenya” seeks to prevent internal displacements and guarantee assistance to IDPs within the country. Though still at Cabinet level, the draft National Disaster Management Policy aims at establishing and maintaining a coordinated framework for managing disasters in the country. The draft policy suggests the establishment of a National Disaster Management Authority (NADIMA), National Disaster Strategic Plans, and a Disaster Trust Fund, among others.

According to The National Food and Nutrition Security Policy of 2012, the Government commits to implement several disaster-related strategies to ensure food security and population health.⁵⁹ Other national policies that are relevant to disaster management include the National Peace Building and Conflict Management Policy, National Policy for Sustainable Development of ASALs of Kenya, Industrialization Policy, Draft Wildlife Policy, Health Policy, and Water Policy, and National Housing Policy.

The Constitution of Kenya 2010 assigns disaster management responsibilities to the national and county Governments (see fourth Schedule, part 1 no. 24 and part 2 no. 12), with county Governments being responsible for firefighting services. Aspects of disaster management are also addressed in several acts⁶⁰.

Existing institutional frameworks for emergency situations management in the country include all Government ministries and agencies, constitutional commissions such as the National Cohesion and Integration Commission and the Judiciary (system of courts). Specifically, the ministry in charge of Special Programmes has been responsible for coordination of Disaster Risk Reduction (DRR) activities. The National Platform for DRR was established in 2004 as a stakeholder forum that provides a framework for participation of public, private, and civil society sectors as well as academia and media in DRR activities. The Ministry for Northern Kenya Development is responsible for drought risk reduction in ASAL districts. The Drought Management Authority, the Kenya Food Security Structure, and the Kenya Meteorological Department play key roles in disaster management. Inter-ministerial DRR committees exist at the district level while local authorities had a role in the enforcement of by-laws related to DRR⁶¹. Kenya has also acceded to a number of international institutional arrangements relevant to disaster management in the country⁶².

10.8 Challenges and Opportunities

10.8.1 Challenges

Kenya does not have a coordinated framework for the management of emergency situations based on clear mandates and responsibilities. Consequently, the country’s approach to managing situations such as disasters has been *ad hoc*, often characterized by fire-fighting. However, the Government’s

59 The National Food Security Structure brings together the Kenya Food Security Steering Group, Kenya Red Cross Society, Drought Monitoring Centre, Kenya Meteorological Department, African Medical Research Foundation (AMREF), several UN Agencies among others to deliberate and make decisions on food security and response to disasters.

60 These acts include; in the Environmental Management and Coordination Act of 1999, Forest Act of 2005, Factory and other Places of Work Act (Cap 514), Work Injury Benefits Act of 2007, Civil Aviation Act (Cap 394), Grassfire Act (Cap 327), Local Government Act (Cap 265), Physical Planning Act (Cap 286), Explosives Act (Cap 115), Kenya Ports Authority Act (Cap 391), Public Health Act (Cap 242), Petroleum Act (Cap 116), Kenya Railways Corporation Act (Cap 397), Food, Drugs and Chemicals Substance Act (Cap 254), Kenya Bureau of Standards (Cap 496), and the Occupational Health and Safety Act of 2007, Public Order and Security Act, and the National Cohesion and Integration Commission Act.

61 Local authorities became defunct with the accession of county Governments, which should now take over their DRR roles.

62 These include; AU/NEPAD Africa Regional Strategy for Disaster Risk Reduction of 2004; Hyogo Framework for Action of 2005; United Nations Framework Convention on Climate Change of 1992; United Nations Convention to Combat Desertification of 1994; the IGAD Framework for Disaster Management; and the Millennium Development Goals of 2000; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1966; International Covenant on Civil and Political Rights of 1966; International Covenant on Economic, Social and Cultural Rights of 1966; Convention on the Elimination of all forms of Discrimination Against Women of 1979; Convention on the Rights of the Child of 1989; International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families of 1990; the Rome Statute of the International Criminal Court of 1998; Convention on the Rights of Persons With Disabilities of 2007; and the Convention for the Protection and Assistance of Internally Displaced Persons in Africa (the Kampala Convention) of 2009.

awareness of this deficiency in preparedness and long-term capacity, has led to its taking measures to build a national framework. Kenya's current legal framework is fragmented and hence the need for a single framework law that could specifically deal with issues of the management of emergency situations in the country.

One of the critical concerns is Kenya's lack of preparedness for emergency management. One study found a lack of capacity among most hospitals in Kenya to provide reproductive health (RH) services to persons in emergency situations (Agwanda *et al*, 2007). According to this study, the deficient capacity was especially glaring in the areas of emergency transport, emergency communication systems, and staff preparedness to respond to emergencies. Another study that assessed the provision of emergency RH services four months after the Kenyan 2007 post-election violence erupted, reported that: funding was too inadequate to meet the overarching needs of the IDP populations; emergency response operations for provision of RH services lacked coordination; mechanisms to respond to sexual violence (including sexual exploitation and abuse) were weak at the field level; and perpetrators of sexual violence operated in a general atmosphere of impunity (WCRWC, 2008). In addition; care for pregnancy-related emergencies was not readily available, while response to menstrual hygiene emergencies was inadequate. Moreover, sudden increases in sexual activity of young people enhanced their vulnerability to sexually transmitted infections, a situation worsened by their removal from busy rural lives to overcrowded urban camps where they were idle, reported WCRWC.

During the post election violence of the 2007/2008, the public healthcare system was unprepared to deliver critical services within an emergency situation due to several factors: massive displacement of people in a short time span; lack of sufficient capacity to bring healthcare services to the community level because the provision of health services is fundamentally premised on physical access; and disruption of logistics and supply chain coordination severely caused shortages of medical supplies even where there were adequate supplies in stock (HERAF, 2008). On the whole, access to social services is an important aspect of protection and emergency care; and their absence can culminate into a secondary disaster.

The continuing influx of refugees (especially from Somalia) has overstretched existing facilities in the host communities around Dadaab and Kakuma refugee camps. For example, the inter-agency assessment of the education sector in Dadaab noted that the pupil-classroom ratio is 113:1, while the teacher-pupil ratio is 1:85, while over 48,000 refugee school-age boys and girls are currently out of school (UNCHOA, 2013). In the Kakuma Refugee Camp Primary School, classrooms can only accommodate 37 percent of school going population.

Many higher learning institutions in the country — notably the universities — have curricula with components on disaster education and research, and some schools offer disaster preparedness education (UNOCHA, 2013), However, community-based disaster preparedness remains low while traditional indigenous knowledge for DRR remains untapped.

10.8.2 Opportunities

The 2011-2013 Kenya Emergency Humanitarian Response Plan and its multi-year strategy have provided the opportunities and mechanisms for stakeholders to not only plan responses to immediate acute needs, but to also integrate resilience in humanitarian programming. Although 2013 marks the end of the multi-year strategy, the structure of the 2011-2013 Kenya Emergency Plan offers the best transition to longer-term programming for the development of a humanitarian response framework. The 2013 plan also advocates for the integration of humanitarian priorities into national structures and

development plans.

10.9 Recommendations

A number of lessons can be drawn from the experiences of emergency situations and the observed humanitarian responses, particularly with regard to the post 2007 election violence.

Political Commitment

Political commitment is the most important ingredient to addressing emergency situations. Political commitment should be demonstrated through declaration, legislation, institution-building, public policy decisions and programme support at the highest level of national politics. At the policy level, DRR can be integrated into Vision 2030 and performance contracting in all Government ministries and institutions. At the local level, DRR should be an integral part of county and community-based development planning. The right of the people affected by emergency situations to live in dignity is a matter of principle that should be upheld at all times and by all actors.

Capacity Building

In the management of emergency situations, a country's success lies in the existing capacities to prevent and mitigate crisis situations. Aspects of vital capacity include research and information use, institutions, use of technology, resource mobilization and an enlightened citizenry. These capacities should constitute a national infrastructure for emergency situation mapping, prevention, mitigation and response at all levels.

Building local capacity can help local communities to learn and emerge as key initiators of DRR actions. Also, local communities have traditional knowledge, practices and values in DRR that remain largely unrecognized; yet they could be tapped to strengthen DRR programmes in various local contexts. What remains is to have a disaster management framework that can document, revive, apply and share traditional knowledge. DRR depends a lot on the extent to which a country enforces safety standards and rules, which requires strong institutions. Technological capacity such as GIS and remote sensing can combine data from maps, aerial photos, GPS receivers, and satellite images and generate vital information quickly, as well as increase the speed and precision with which disaster operations are undertaken. Institutionalized disaster education is the key to an enlightened public and citizenry. Contingency planning helps to anticipate emergency scenarios and to plan for an appropriate humanitarian response capacity when an emergency situation is declared.

Establishment of Databases

A comprehensive and up-to-date information database should document all disasters, conflicts, and displacement in Kenya and provide for a basis for risk mapping and vulnerability assessments, and development of emergency plans focusing on all aspects of DRR. The database would be vital in building disaster scenarios in the country to inform policy and action (plans, programmes, and projects). In establishing databases, particular attention should be paid to demographics of emergency situations. For example, data should be collected and stored that document specific demographic issues, such as the extent of housing damage, number of people forced out of their homes, where they went (migrating victims), how long they stayed, assistance they received, and whether they returned to their pre-displacement homes. Databases should also capture labour migration flows and household/community resilience differentials. In addition, there is need to understand the social consequences of different emergency situations. Hotspot mapping of emergency situations would be an important aspect of scenario prediction, needs assessment and overall emergency situation management.

Mainstreaming the Marginalised and Affirmative Action

Social values predispose women, girls, children, elderly people and persons with disabilities to the adverse impacts of emergency situations. Integration of these special groups into all the emergency management processes is a key aspect of addressing their unique vulnerabilities. Listening to what they have to say, considering their views and mainstreaming their participation can lead to formulation of interventions that address their specific needs.

10.10 Conclusions

The common disasters and crisis situations in Kenya are triggered by hydro-meteorological processes, such as floods, droughts, landslides and lightning. However, the human induced disasters such as traffic accidents, civil conflicts, terrorism and industrial hazards have also become common. More importantly, the 2007 post-election violence caused the greatest crisis situation in the country's history. In addition, the periodic occurrence of extreme outbreaks of epidemics such as cholera, malaria, meningitis, typhoid and Rift Valley Fever often escalate to disaster levels.

The impact of natural disasters mainly depends on the resilience of the affected populations; but factors like poverty, marginalization and exclusion increase the vulnerabilities of affected populations. The existing frameworks for disaster management in the Kenya are still fragmented, weak and lacking in coordination. A lack of political commitment to addressing emergency situations, and a weak national capacity for the same, remains major impediments. In order to strengthen the national emergency management architecture, Kenya needs to establish policy, legal and institutional frameworks with appropriate DRR strategies and preparedness at all levels of society. Although the country has made major strides in addressing situations of internal displacement; there is great need for a national emergency situations database. The national data base would be a key asset in building emergency situation scenarios that could help inform appropriate policy and programme actions.

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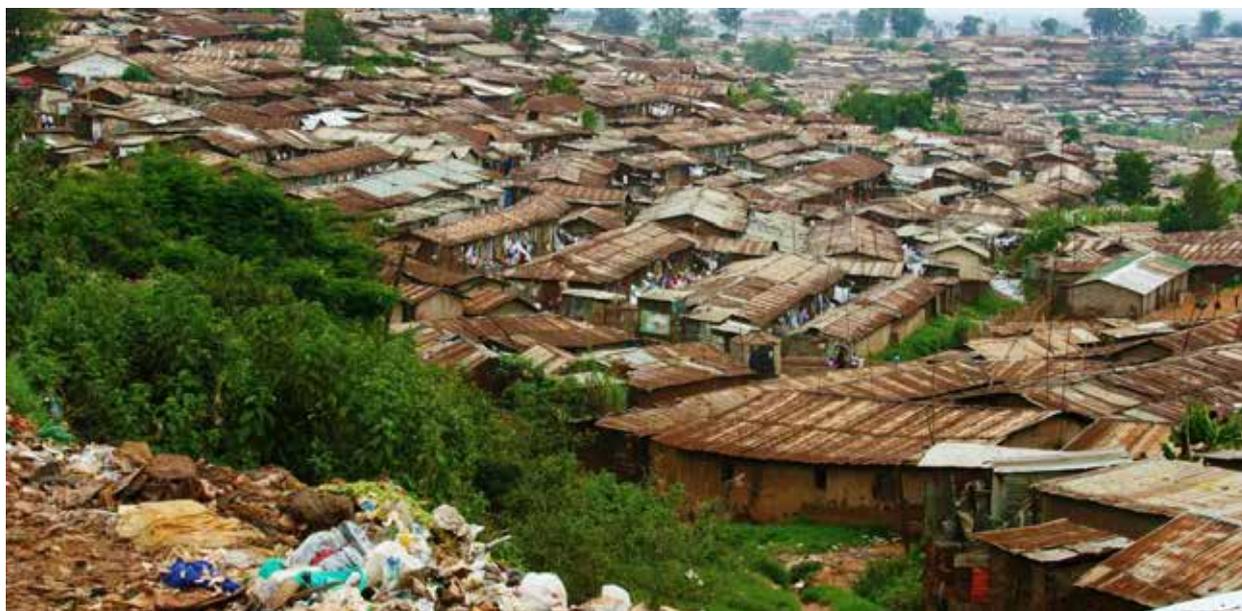


CHAPTER 11: URBANIZATION AND INTERNAL MIGRATION

11.1 Introduction

Settlement patterns and population distribution vary in space and time depending on a combinations of environmental, physical and human factors. Settlement patterns and population distribution are the end products of changes in the population and, for Oucho and Gould (1993) geographic mobility, or migration, which has always been an integral part of the human social process. Migration of human populations is generally recognized as an integral part of the process of socio-economic development (Bilsborrow, 1998; De Haas, 2005). Furthermore, migration is one of the three components of population change, besides fertility and mortality. Internal migration influences population structure and distribution in a country, and is becoming increasingly dynamic and, therefore, complex in nature. New forms of migration have emerged or old ones have intensified and others have slowed down (Tacoli, 1997). However, informed policy and interest on internal migration have been hampered by lack of adequate, reliable and comprehensive data.

Migration from rural areas, the natural increase of population, and reclassification of formerly rural territories have led to urban growth in most Sub-Saharan African countries. Urbanization will be one of the main demographic processes of the coming decades, particularly in those regions that are still largely rural. In 2008, the world passed the 50 percent urbanization mark. From 2018 on, urban population growth in the world will exceed total population growth, as rural areas will start losing populations in absolute terms. In sub-Saharan Africa, the urban population will increase from 324 million in 2010 to 730 million in 2035 (UNFPA, 2010). Consequently, there is an urgent need to acquire the capacity to manage the emerging trends in, and patterns and challenges of urban growth in sub-Saharan Africa. Since urbanization is inevitable, the main challenge is not to slow it down, but rather, to learn how to deal with its rapid growth. The challenges associated with urbanization demand a proactive approach to urban planning, which considers future demographic and environmental issues while responding to current priority needs. Such an approach demands, in turn, a sound understanding of urban development processes locally, nationally and even globally.



Nairobi's Kibera is the largest informal settlement in East and Central Africa.

Photo: www.tatoos.fansshare.com

One way of achieving sustainable urban and regional development is through generating, collecting and analyzing accurate and reliable data, which can better inform local and national decision-making processes. The main objectives of this chapter are:

1. To provide an overview of population distribution in Kenya;
2. To describe and analyze trends and patterns of the urbanization process in Kenya; and
3. To describe and analyze trends and patterns of internal migration in Kenya.

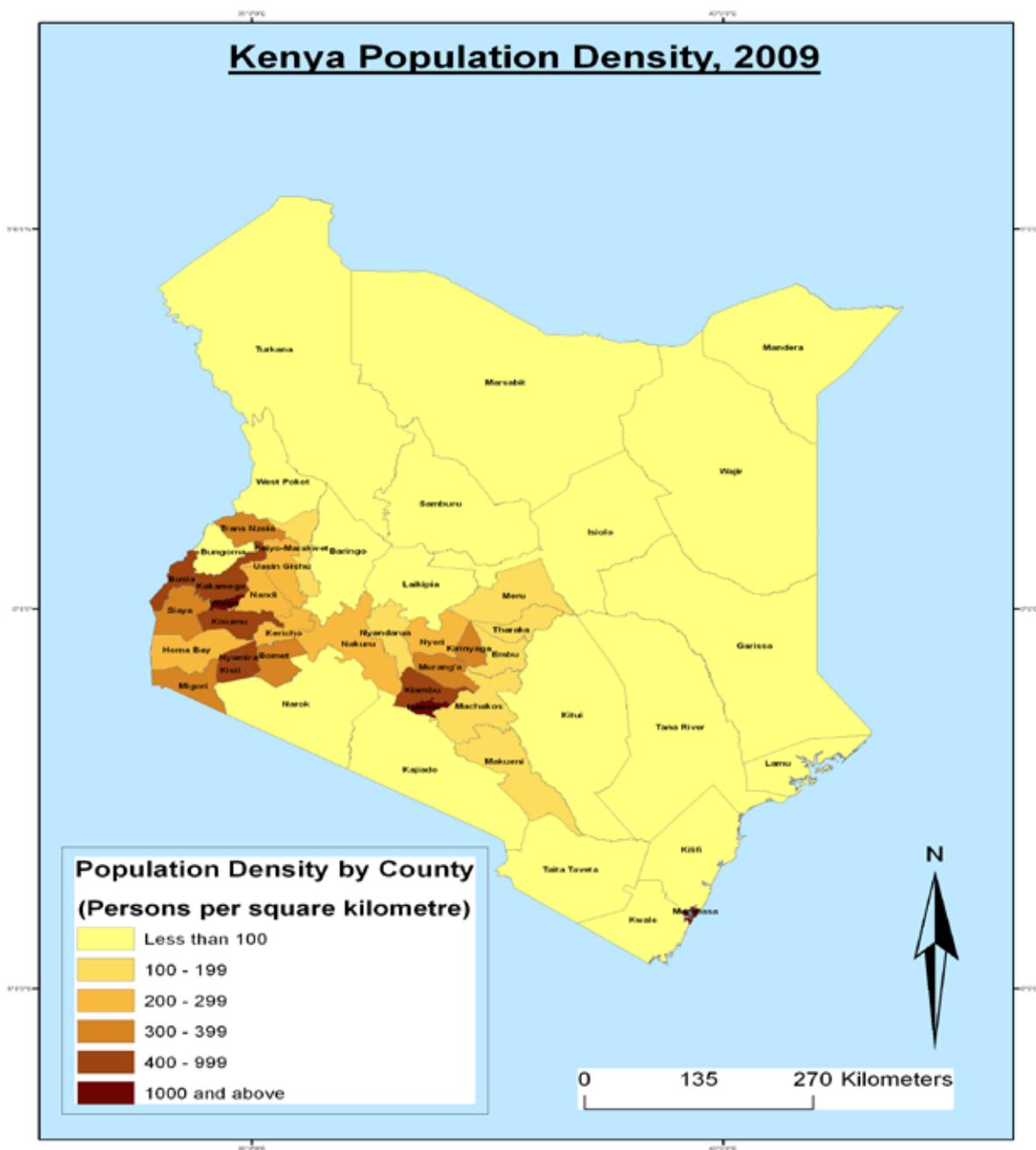
11.2 Population Distribution

Population distribution in Kenya is generally uneven across regions for two important, inter-related reasons which were discussed in some detail in Part 2 of this report. Firstly, Kenyan regions have diverse agro-ecological heritages which shaped the pre-colonial distribution of ethnic groups into pastoralists, agriculturalists and mixed livelihoods. The agro-ecological distribution also subsequently shaped the choices of land for colonial administrators and settlers who followed in their wake. The colonial development of the Kenya-Uganda railway line was the single investment that shaped subsequent settlement, a pattern carried deep into independence by the weak prioritisation of a nationally-rationalised settlement policy. Kenya has done little to open up new parts of the country for new settlement, resulting in over-population in the areas that are viable for farming, under-population in the pastoralist areas, and rural out-migration to the main urban centres.

The current distribution of Kenya's population across the country's 47 counties and various related characteristics are summarised in Appendix 11.1. Among the counties, Nairobi, which is the capital city, has the largest share of Kenya's population (8.1%), with Kakamega, Kiambu and Nakuru each having shares of more than four percent. Other counties with comparatively large populations include Bungoma, Meru, Kisii, Kilifi and Machakos each with shares of about three percent. Counties with small populations are also typically the least densely populated because many of them are quite expansive geographically. As a capital city, Nairobi continues to be a preferred destination for rural-to-urban, urban-to-urban and international in-migration.

Nairobi and Mombasa have the highest population densities of 4,515 and 4,291 people per square kilometre, respectively (Figure 11.1). Vihiga recorded the next highest density of 1,045 persons per square kilometre followed by Kisii (875), Nyamira (665), Busia (656) and Kiambu (638). Tana River, Lamu, Taita Taveta, Marsabit, Isiolo, Garissa, Wajir, Turkana and Samburu are the sparsely populated counties in Kenya with less than 20 people per square kilometre. The pattern of population distribution generally reflects the uneven regional distribution of agricultural potential and uneven distribution of employment opportunities. For example, Nairobi and Mombasa are densely *populated due to employment opportunities while* Vihiga, Kisii, Nyamira, Busia and Kiambu have reliable rainfall with fertile soils. The sparsely populated counties are generally associated with arid and semi-arid conditions.

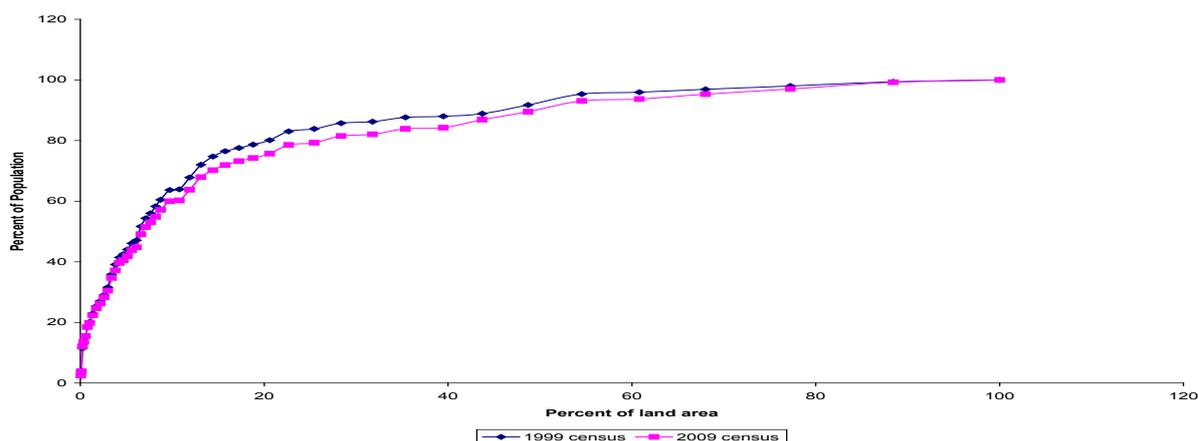
Figure 11.1 Population Density of Kenya by County, 2009



Source: generated from 2009 Kenya Population and housing census

Figure 11.2 shows the Lorenz curve for county population distribution in Kenya based on the 1999 and 2009 censuses. The counties were ranked in descending order of density and the percentage compositions by area cumulated. The curves for both censuses are very close together indicating the unchanging unevenness in population distribution. The index of concentration shows that about 68 percent of Kenya's population lives in slightly over one tenth (12%) of the land area. The population living in 50 percent of the total land area declined from about 92 percent in 1999 to about 90 percent in 2009.

Figure 11.2 Lorenz Curve of Population Distribution, 1999 and 2009



Source: Kenya 2009 population census

11.3 Historical Perspective of Urbanization

11.3.1 Colonial and Post-Colonial Urbanization

Urbanization in Kenya is almost entirely a 20th Century phenomenon and largely a product of British colonial administration. According to Burton (2002), it was during this period (1895 to 1963) that many of Eastern Africa’s major contemporary towns and cities were established. Colonial urbanization shaped Kenya’s urban landscape in a number of ways, directly or indirectly.

First, unbalanced urban — and indeed, nationwide — development can be traced back to colonial urbanization. The emerging urban centres during the colonial period grew at varying rates depending on their location, accessibility, resource base, level of economic activity in their hinterlands, and the population of Europeans and Indians in the surrounding regions (Obudho, 1983). For example, Nairobi and Mombasa emerged as the major urban centres because of their strategic locations as trading and transportation nodes, while the fertile White Highlands attracted a series of medium-size towns. Regions lacking these favourable factors and conditions lagged behind in terms of economic development, modernization and urbanization. As such, North Eastern Province of Kenya remains the least urbanized region in the country to date while Nairobi, Coast, Rift Valley and Central, with strong colonial urban heritages are highly urbanized.

Second, the network of colonial administrative centres, caravan towns and missionary stations laid the foundation for the present urban hierarchy in Kenya. Most of the former colonial administrative centres continue to play their roles as administrative headquarters under successive independence Governments. Beside their administrative roles, these urban centres serve a wide range of market, economic, religious and political functions.

Third, the colonial administration regarded towns as non-African areas in which Africans came only to work temporarily as labourers. Until independence, urban centres were regarded as bases for colonial administrative and commercial activities, not centres for permanent African settlement and participation. Although the laws restricting the movement of Africans were abolished at independence, most indigenous Kenyans still perceived the town as a place where people come to work, accumulate “wealth” and eventually retire “back home”. To many, a town is not a place of permanent settlement. It is common for urban Kenyans to identify themselves with an “urban house” and a “rural home”, which partly explains why a majority are never permanent migrants in towns (Owuor, 2006a; Oucho, 1996).

For example, 75 percent of households in Nairobi live in individual rental units, compared to 13.5 percent who live in their own houses (Ministry of Planning and National Development and Vision 2030 (MPNDV2030), forthcoming, Vol. VIII)⁶³.

Fourth, in most of the colonial urban centres, racial segregation was central in their internal structure. The zoning of residential areas into European, Asian and African locations was based primarily on race, which then fed into other socio-economic 'justifications'. Zoning was used for the purpose of regulating and controlling the use of particular areas. Segregation on racial grounds has now changed to a largely socio-economic status in the major urban centres (Owuor and Mbatia, 2011)⁶⁴.

Lastly, urban primacy is another effect of colonial urbanization. Urban primacy occurs when the largest city in a country dominates the urban hierarchy in terms of its population size, and is measured in terms of a *two-city*, a *four-city* or *11-city* primacy index. For example, a *two-city* primacy index is the ratio of the population of the largest city in the country to the population of the next city in population rank, while *11-city* primacy index is the ratio of the population of the largest city in the country to the combined population of the next 10 cities in population rank. According to UNECA (1989), a primacy index of less than 1 is "low", 1-2.9 is "medium", while three and above is "high". Nairobi, the capital city, the leading commercial and industrial centre and seat of Government, has continued to dominate the urban hierarchy in Kenya to date.

According to Otiso and Owusu (2008), post-independence urbanization in Kenya can be divided into the *national* period from independence to 1980s, and the *global* period from the 1980s to the present. This classification enables the distinction of the major urban changes that the country has experienced in response to national and global political and economic forces. During the *national phase*, urbanization in Kenya was largely influenced by localised and national forces, notably the Government's national development policies. This phase witnessed very high rates of urban growth, in particular, immediately after independence. The problem was, however, not the urbanization process itself, but rather the polarization towards Nairobi. A notable example of the effect of the Government's policies on urbanization and spatial distribution of urban centres in Kenya was the promotion of growth centres leading not only to the growth and development of many urban centres, but also to a high increase in the urban population (Owuor, 2006b).

The *global* phase of urbanization is largely associated with the adoption and implementation of neo-liberal economic reforms in the 1980s. An important feature of the current urban transition in sub-Saharan Africa is the fact that the nature and extent of urban growth is now more dependent on the global economy than ever before. On the one hand, globalization means that growth and development of cities in sub-Saharan Africa will be influenced by the size and structure of foreign markets and the ability of cities to attract foreign investment and technology. On the other hand, the growth and development of cities will be influenced by how they integrate into the global economy, as well as how they will be affected by global changes and forces (Otiso and Owusu, 2008). Such global changes and forces are mainly, but not necessarily restricted to, the Structural Adjustment Programmes (SAPs) imposed by international organizations and donors. Many sub-Saharan African countries, including Kenya, are facing the negative impact of the global recession in the 1980s, and by implication that of SAPs (Owuor, 2006a).

63 Given a national poverty level of about 50 percent, and the demanding pre-conditions to acquiring an own house, it is likely that for the majority of Nairobi tenants, ownership is not an option.

64 Parochial segregation is unconstitutional. However, there are many instances in the formerly exclusively Asian neighbourhoods where houses remain vacant for long durations waiting for a 'culturally-correct' tenant. Amidst rising electoral temperatures, Nairobi landlords have also been reported to evict tenants who belong to undesirable ethnic groups.

The negative impact of both the economic crisis and reform under structural adjustment on urban centres has been well documented. Urban economies in sub-Saharan Africa declined markedly during the 1980s and 1990s and urban poverty increased in much of the continent (Maxwell, 1999). Life in urban areas became more expensive while employment in the formal sector went down, with real wages did not keeping up with price increases, thereby declining in real terms (Dietz and Zaal, 2002; Simon, 1997; Jamal and Weeks, 1988). Standards of living deteriorated and urban unemployment reached unprecedented levels (Beauchemin and Bocquier, 2003). With the fall in formal sector employment and increased unemployment, many urban residents moved into the informal sector (Hansen and Vaa, 2004).

Moreover, increases in food prices and service charges, and cuts in public expenditure on health, education and infrastructure have been felt more severely in the cities than in the rural areas, and particularly by the urban poor. In response to frequent increases in food prices; urban residents have adopted a number of livelihood strategies in their attempts to manage — in particular, but not necessarily restricted to — the changes in their economic environment and circumstances. Engaging in multiple activities or diversifying food and income sources is now part and parcel of the urban economy (Owuor, 2006a; Bryceson *et al.*, 2003; Potts, 1997; Rakodi, 1995).

On the other hand, some of the positive aspects of globalization in Kenya include:

- Principles of good governance and accountability being adopted and implemented in the local authorities (Otiso and Owusu, 2008), for example, the local Government reforms, including Local Authority Service Development Plan (LASDAPs) and Local Authority Transfer Fund (LATF);
- Foreign investment and real estate developers in the major urban centres (Otiso and Owusu, 2008);
- Public-private partnership in urban development and management;
- Springing up of new Central Business Districts, global complexes and malls (Owuor and Mbatia, 2011); and
- Competitiveness and globalization of Nairobi to a “world class” city — leading to the creation of the Nairobi Metropolitan Region (NMR) and a Ministry of Nairobi Metropolitan Development, with an ambitious vision — Nairobi Metro 2030 (Ministry of Nairobi Metropolitan Development 2008).

11.3.2 Urban Policies and Programmes

Kenya has hitherto lacked a comprehensive national urban policy; but one is presently being developed. This presents a major challenge in achieving sustainable urban development. Policies and strategies related to urbanization have traditionally been formulated within the framework of broader national/sectoral development plans and policies. For example, the spatial distribution policies adopted by the Government of Kenya in the post-independence National Development Plans were aimed at reducing the rapid population growth in the major urban centres, promoting the growth of small and medium-size urban centres, and encouraging rural development (Owuor, 2006b). There are also various Acts of Parliament that have guided urban development such as The Local Government Act (Cap 265). However, an urban development policy for Kenya is under formulation. This new policy will aim to guide aspects of urban development countrywide, such as development planning, land management, urban investment and delivery of infrastructure and services.

In a broader national context, Kenya’s Vision 2030 — the national long-term development blueprint — aims to transform the country into a newly-industrializing, middle-income nation providing a high quality of life to all its citizens in a clean and secure environment (Government of Kenya, 2007). Vision 2030 recognizes that Kenya is moving towards a predominantly urban population, requiring planning for high quality urban livelihoods

11.3.3 Urban Population Distribution

Comparative Global and Regional Trends

Urbanization is a process of town formation and growth. It is a function of population increase, both through natural growth and net in-migration, and the spatial expansion of the settlements in order to accommodate the increasing populations. Today, half of the world's population lives in urban areas (Table 11.1). Europe, Latin America and the Caribbean, North America and Oceania have more than 70 percent of their populations living in urban areas. Africa and Asia, in contrast, remain mostly rural, with 40 percent and 45 percent, respectively, of their populations living in urban areas in 2011.

Table 11.1 Percentage Urban and Urban Growth Rate by Major Areas, 2011

Region	Percent urban	Average annual urban growth rate (2005-2010) (%)
World	52.1	2.14
Africa	39.6	3.27
Asia	45.0	2.70
Europe	72.9	0.50b
Latin America and the Caribbean	79.1	1.56
North America	82.2	1.23
Oceania	70.7	1.81

Source: United Nations (2012).

Despite being the least urbanized region in the world, Africa has the highest average urban growth rate of 3.3 percent per annum. Over the coming decades, the level of urbanization is expected to increase in all major areas of the developing world, with Africa and Asia urbanizing more rapidly than the rest (United Nations, 2012). However, urbanization levels and urban growth rates are not uniform in Africa (Table 11.2). Southern and Northern Africa have more than half of their populations living in urban areas, respectively. Eastern Africa is the least urbanized region in the continent with less than one-quarter of its population residing in urban areas, while at the same it is characterized by a high urban growth rate, alongside Middle and Western Africa.

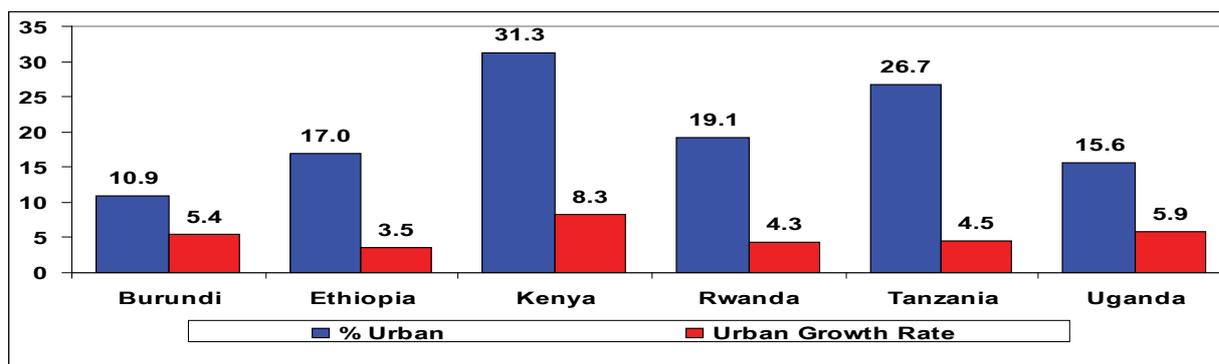
Table 11.2 Percentage Urban and Urban Growth Rate in Africa, 2011

Region	Percent urban	Average annual urban growth rate (2005-2010) (%)
Sub-Saharan Africa	36.7	3.67
Africa	39.6	3.27
Eastern Africa	23.7	3.90
Middle Africa	41.5	3.94
Northern Africa	51.5	2.14
Southern Africa	58.9	1.82
Western Africa	44.9	3.92

Source: United Nations (2012).

In 2009, Kenya had 31.4 percent of its population living in urban areas with an annual growth rate of 8.3 percent. Figure 11.3 provides comparative figures for selected Eastern Africa countries in 2011. Kenya has the highest proportion of population living in urban areas, as well as the highest urban population growth rate.

Figure 11.3 Percentage Urban and Urban Growth Rate for Selected Eastern African Countries



Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII) for Kenya; United Nations (2012) for other countries.

The above trends indicate that urbanization, especially in Africa, is inevitable and managing its trends and patterns constitutes a major challenge. Furthermore, cities are merging together, creating urban settlements on a massive scale, such as mega-regions, urban corridors and city-regions. They are emerging in various parts of the world, turning into spatial units that are territorially and functionally bound by economic, political, socio-cultural and ecological systems (UN-HABITAT, 2010). The regional urban systems of Suez-Cairo-Alexandria (Egypt), Kenitra-Casablanca (Morocco), Gauteng (South Africa), Ibadan-Lagos-Accra (stretching from Nigeria to Ghana), and the emerging Nairobi Metropolitan Region (Kenya) are key examples in Africa (UN-HABITAT, 2008).

11.3.4 Trends of Urban Growth in Kenya: 1948 to 2009

Table 11.3 shows the trends of urbanization in Kenya between 1948 and 2009. At the time of Kenya's first population census in 1948, there were 17 urban centres with an aggregate population of 285,000 people. An urban centre was officially defined as any compact and gazetted town with a population of 2,000 inhabitants and above, a definition which persisted until the 2012 passage of the Urban Areas and Cities Act. The share of the urban population at that census was a mere 5.3 percent of the total population, but it was disproportionately concentrated in Nairobi and Mombasa, with majority of the urban dwellers being non-Africans. Since then, the number of urban centres, the urban population and the proportion of people living in urban centres have been increasing. By 1962, the number of urban centres had doubled to 34 and the urban population increased to 747,000 people, representing an urbanization level of 8.7 percent, growing at 6.3 percent per year. Still, this was disproportionately concentrated in Nairobi and Mombasa, and disproportionately non-Africans.

Table 11.3 Urbanization Trends in Kenya, 1948-2009

Year	Total population	No. of urban centres	Urban population	Percent of urban to total population	Intercensal growth rate (%)
1948	5,407,599	17	285,000	5.3	-
1962	8,636,263	34	747,651	8.7	6.3
1969	10,956,501	47	1,076,908	9.8	7.1
1979	15,327,061	91	2,315,696	15.1	7.7
1989	21,448,774	139	3,878,697	18.1	5.2
1999	28,159,922	180	5,429,790	19.3	3.4
2009	38,412,088	230	12,023,570	31.3	8.3

Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

The growth in the number of urban centres and their populations accelerated after independence when Africans were allowed to migrate to the urban areas without any legal and administrative restrictions. As a consequence, the urban population grew to one million by 1969. The national share of the urban population rose to 9.8 percent, with Nairobi and Mombasa accounting for a relatively larger share (67%) of that urban growth. The influx of Africans into the urban areas subsequently reduced the proportion of non-African population in most towns. By 1979, the overall level of urbanization had risen to 15.1 percent, with 91 urban centres and an urban population of 2.3 million dominated by Nairobi and Mombasa.

Although the urban population increased from 2.3 million in 1979 to 3.8 million in 1989, the growth rate had fallen to 5.2 percent, compared to the 7.7 percent of the previous decade. The number of urban centres increased to 139, with major increases being recorded in Nyanza (seven to 19), Western (six to 14) and Central (13 to 19) provinces. The increase in the number of urban centres and their populations raised the proportion of the population living in urban centres to 18 percent. The majority of the urban population (61%) resided in the six major urban centres: Nairobi, Mombasa, Kisumu, Nakuru, Machakos and Eldoret. Nairobi continued to dominate the urban hierarchy by having 34 percent of the total urban population, and together with Mombasa accounted for 46 percent of the total urban population.

In 1999, about 20 percent of the national population lived in urban areas, more than half of these in the major urban centres of Nairobi, Mombasa, Nakuru and Kisumu. While the urban population shares of Nairobi and Mombasa fell to 32 percent and the urban growth rate also fell to 3.4 percent, the numbers of urban centres increased to 180 with a total population of 5.4 million people. The decline in the urban growth rate between 1979 and 1999 corresponds to a similar decline in Kenya's population growth rate from 3.8 percent in 1979 to 3.3 percent in 1989, and eventually to 2.9 percent in 1999.

In 2009, the number of urban centres increased to 230 with a total population of 12 million people. The urban population as a percentage of the country's total population stood at 31.3 percent, meaning that one out of every three Kenyans lives in urban areas. However, the country experienced one of the highest urban growth rates (8.3%) since independence between 1999 and 2009. This may be attributed to the fact that in 1999, only the "core urban" population was used in the analysis of urbanization in Kenya, while in 2009 both the "core urban" and "peri-urban" populations were used.

'Core urban' refers to the central, built-up area of an urban centre with intense use of land and high concentrations of service functions and activities. The *peri-urban* area is that beyond the central built-up area, and forms the transition between urban and rural areas. As a result of outward extension of town boundaries, peri-urban areas that were formerly rural and agricultural lands are gradually turning to urban land use (Ministry of Planning and National Development and Vision 2030, forthcoming, Vol. VIII). For the purposes of future censuses, there is need for a clearer definition of what constitutes urban, peri-urban, rural, and informal settlement, as well as their spatial contexts.

Table 11.4 presents the population of major urban centres with populations of more than 150,000 people in 2009. The major urban centres (Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, Kikuyu, Ruiru, Kangundo-Tala, Naivasha, Thika and Machakos) contribute half of the total urban population in Kenya. The capital city of Nairobi leads the urban hierarchy with 3.1 million people and a disproportionate percent share of total urban population. Mombasa is the second largest urban centre with 0.9 million inhabitants, followed by Kisumu, Nakuru and Eldoret. The other major urban centres — Kikuyu, Ruiru, Kangundo-Tala, Naivasha, Thika and Machakos — are apparently in close geographic proximity to Nairobi. However, peri-urban population is much higher than the core urban population in Kangundo-Tala and Machakos. Similarly, Kisumu and Naivasha have more than half of their population living in

peri-urban areas. Out of the total urban population in Kenya, 2.9 million are residing in peri-urban areas.

Table 11.4 Population by Major Urban Centres, 2009

Urban centre	Total population	Core urban population	Peri-urban population	Percent of total urban population
KENYA	12,023,570	9,090,412	2,933,158	
Nairobi	3,109,861	3,109,861	0	25.9
Mombasa	925,137	905,627	19,510	7.7
Kisumu	383,444	254,016	129,428	3.2
Nakuru	367,183	343,395	23,788	3.1
Eldoret	312,351	247,500	64,851	2.6
Kikuyu	264,714	200,285	64,429	2.2
Ruiru	240,226	238,329	1,897	2.0
Kangundo-Tala	218,722	13,119	205,603	1.8
Naivasha	170,551	91,898	78,653	1.4
Thika	151,225	136,386	14,839	1.3
Machakos	150,467	40,819	109,648	1.3

Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

While Nairobi continues to have the largest share of Kenya's urban population, small and medium-size urban centres are emerging in the urban hierarchy. Small urban centres have population of less than 10,000 people, while medium-size urban centres have a population of more than 10,000 but less than 100,000 people. Table 11.5 demonstrates that the number and population size of small and medium-size urban centres are growing and are expected to dominate the urban hierarchy in future.

Table 11.5 Urban Population by Size Category of Urban Centres, 1962-2009

Year	Category of urban centres by population size							
	1 million and over		100,000-999,999		10,000-99,999		2,000-9,999	
	No.	Total Population	No.	Total population	No.	Total population	No.	Total population
1962	0	-	2	523,075	5	105,712	27	118,864
1969	0	-	2	756,359	9	79,267	36	153,282
1979	0	-	6	1,321,566	24	717,855	64	276,275
1989	1	1,324,570	5	1,046,588	40	1,080,726	93	426,813
1999	1	2,083,509	4	1,214,927	62	1,508,180	113	623,174
2009	1	3,109,861	22	4,617,114	97	3,665,486	110	631,109

Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

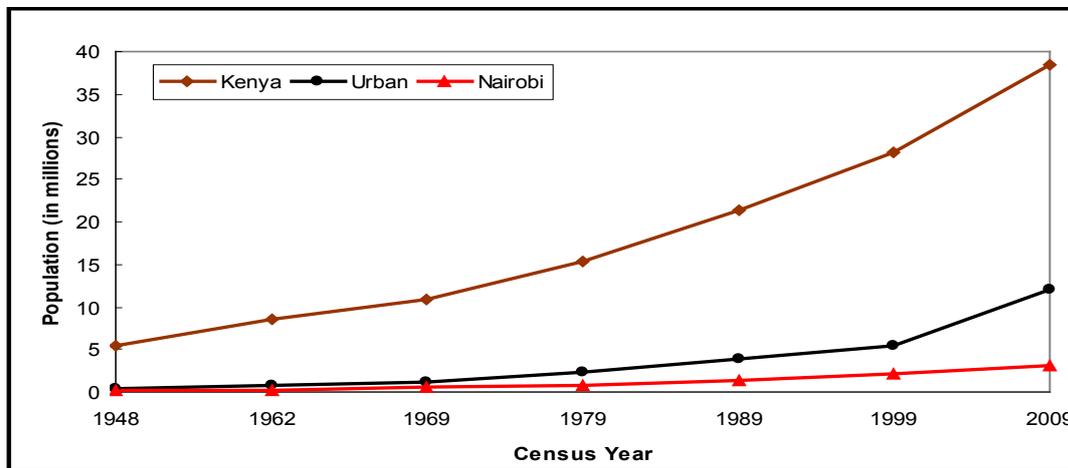
Note: No.= Number (of urban centres).

Most of the urban centres in Kenya are small and medium-size. In 2009, the small and medium-size urban centres were 207 in number with a total population of about 4.3 million people, which amounted to 35.7 percent of the country's total urban population. Additionally, urban centres with populations between 100,000 and 999,999 increased in numbers by 2009. The small and medium-size urban centres play an important role in migration into and out of the major cities. They provide the first opportunity of migration from the rural areas to the major urban centres (step migration), as well as an avenue for counter-migration.

By serving as localized focal points for production, distribution, trade, services and livelihoods, small and medium-size towns can contribute greatly towards the achievement of geographically more balanced national urban development, stimulating the national and regional economies in the process. By building enhanced capacities among local authorities, small and medium-size towns can also play a greater role in efficient service provision to increasing urban populations; assist in poverty reduction as employment and income generators; contribute to the achievement of Millennium Development Goals (MDGs); and secure more equitable and geographically balanced economic and social development (UN-Habitat, 2008; Owuor, 2006b; Satterthwaite and Tacoli, 2003).

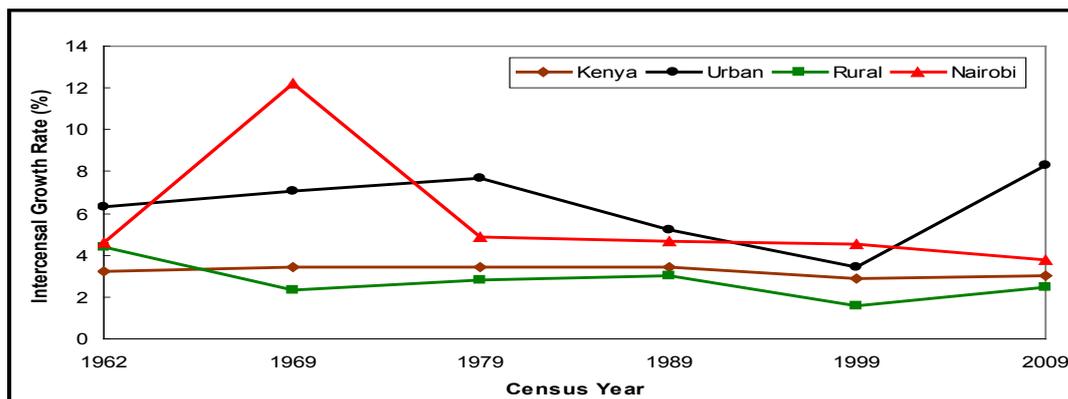
Furthermore, the growth of small and medium-size urban centres has reduced the national primacy index to an average of 0.9 since the 1980s. The 11-city primacy index has reduced from 1.22 in 1969 to 0.89 in 1979, after which it rose to 0.94 in 1989, 0.99 in 1999 and to 0.98 in 2009. However, the dominance of one urban centre is not only experienced at the national level but also at provincial levels. Urban primacy is also evident at regional levels where one urban centre contributes a larger share of the region’s urban population. Figures 11.4 and 11.5 illustrate the declining dominance of Nairobi in terms of contribution to the total urban population and population growth rates, further demonstrating the potential of small and medium-size urban centres.

Figure 11.4 Kenya’s Population Growth Trends, 1948-2009



Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

Figure 11.5 Kenya’s population growth rate trends, 1948-2009



Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

Nairobi's growth rate increased considerably after independence because of its attractiveness to migrants from the rural areas. The growth rate increased from 4.6 percent in 1948 to 12.2 percent in 1969. However, from 1979 to 1999, Nairobi grew at a sustained and constant rate of about five percent a year (4.9% in 1979, 4.7% in 1989 and 4.5% in 1999). In 2009, Nairobi's population growth rate reduced to 3.8 percent. According to UN-Habitat (2006), Nairobi had the highest annual population growth rates compared to similar cities in Africa. Box 11.1 gives a brief history of Nairobi.

Box 11.1 Nairobi: From a transportation centre to a city

Nairobi was originally established as a transportation depot, but grew to become an administrative centre. The site was chosen by the constructors of the Kenya-Uganda railway in June 1899 because it offered a suitable stopping place between Mombasa and Kisumu (Blevin & Bouczo, 1997; Boedecker, 1936). By the end of 1899, the Government then had selected a site on the high ground north of the Nairobi River and away from the railway station, to be its administrative headquarters. This marked the beginning of Nairobi's growth into an administrative and transportation centre. In 1900, Nairobi was incorporated as a township, marking the birth of local Government in the town. In 1905, Nairobi was confirmed as the capital of the country with seven distinct functional zones (Tiwari, 1981). By 1906, the original railway depot and camp had grown into an urban centre of 11,000 people, with definite land-use zones. By 1909, much of the internal structure of Nairobi was already established. In 1919, Nairobi was elevated into a municipality and finally, in March 1950, Nairobi became a city by the Royal Charter of Incorporation.

In response to urban growth projections, and in an attempt to address current and future Nairobi metropolitan region challenges, 2007 saw the Government of Kenya prepare an ambitious *Nairobi Metro 2030* vision to spatially redefine the Nairobi Metropolitan Region (NMR) and create a world class city region envisaged to generate sustainable wealth and quality of life for its residents, investors and visitors. Apart from Nairobi Municipality itself, the NMR vision encompasses 14 other adjacent independent local authorities (Ministry of Nairobi Metropolitan Development, 2008).

11.3.5 Sources and Factors of Urban Growth

Generally, there are five sources of urban population growth in sub-Saharan Africa. These are: 1) rural-to-urban migration; 2) increase in the number of urban centres over space and time; 3) natural urban increase; 4) expansion of urban boundaries; and 5) daily commuters. Though daily commuters from rural areas are important for an urban areas economy, they are rarely captured in population censuses, as they are only seen to increase the daytime population.

Rural-to-urban migration continues to be the major source of urban growth in Eastern Africa, including Kenya. However, urban natural increase, *in-situ* urbanization and refugees from neighbouring war-torn countries, are emerging as significant contributors to urban growth (UN-Habitat, 2008). The natural increase in urban population occurs when there are more births than deaths, while *in-situ* urbanization is the absorption of rural and peri-urban settlements in the expansion of an urban area's boundaries.

Besides the sources of urban population, there are other factors that lead to the continued growth and development of urban centres in Kenya, in addition to acting as "pull" factors. These factors are varied and specific to the urban centres. Proximity to good transport network, a strong economic base, a rich hinterland, better infrastructural facilities and services, and the town's functions (especially in terms of employment opportunities) are examples of some of the factors that stimulate the growth and development of urban centres in Kenya.

11.3.6 Regional Variations in Urbanization

Demographic, social, economic and political factors have impacted greatly on the urbanization process in Kenya, resulting in varied urbanization levels, trends and patterns across counties. Being simultaneously the capital city and a county, Nairobi is the most urbanized part of Kenya with a population that is entirely urban (Table 11.6). The former Coast and Central provinces accounted for one-third of the country's urban population in 2009. Nyanza, Rift Valley and Eastern provinces had between 21 percent and 25 percent, while North Eastern and Western provinces were the least urbanized provinces in Kenya with less than 20 percent of the population living in urban centres.

Table 11.6 Urban Population by Province, 2009

Province	Total population	Rural population	Urban population	Percent of urban population in province	Percent of total urban population
KENYA	38,412,088	26,388,518	12,023,570		
Nairobi	3,109,861	-	3,109,861	100	25.9
Central	4,370,124	2,868,781	1,501,343	34.4	12.5
Coast	3,291,225	1,869,714	1,421,511	43.2	11.8
Eastern	5,640,797	4,448,772	1,192,025	21.1	9.9
North Eastern	2,301,837	1,893,246	408,591	17.8	3.4
Nyanza	5,421,889	4,086,898	1,334,991	24.6	11.1
Rift Valley	9,955,646	7,599,156	2,356,490	23.7	19.6
Western	4,320,709	3,621,951	698,758	16.2	5.8

Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

In addition, Table 11.6 shows that Nairobi Province has the largest share of the *total* urban population in the country, followed by Rift Valley Province. The two provinces contributed 45.5 percent to the total urban population. They are followed by Central, Coast, Nyanza and Eastern provinces, each with between 10 percent and 13 percent share of total urban population. The contribution of Western and North Eastern to the total urban population was relatively small.

Table 11.7 presents the share of each province's urban population to the total urban population for the national census years between 1969 and 2009. The urban population of each province has been increasing except for Eastern Province, whose share fell sharply between the 1989 and 1999. Generally, Nairobi has been dominant with the largest share of the urban population. On the other hand, North Eastern has had the least share of not more than three percent. Rift Valley and Western have had consistent increases in their shares while those of the other provinces fluctuated

Table 11.7 Urbanization Trends by Province, 1969-2009

Province	Percent share of total urban population				
	1969	1979	1989	1999	2009
Nairobi	47.0	35.7	34.1	38.4	25.9
Central	4.3	5.6	8.0	6.7	12.5
Coast	26.3	17.6	15.2	16.5	11.8
Eastern	3.5	10.1	9.2	5.3	9.9
North Eastern	-	2.7	2.3	2.7	3.4
Nyanza	4.1	9.0	9.1	7.9	11.1
Rift Valley	13.8	14.8	17.3	17.4	19.6
Western	1.0	4.6	4.8	5.2	5.8

Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

Two important points to consider in interpreting these regional figures include: 1) the fact that further variations occur at the sub-province level; and 2) only one or two urban centres dominate the urban population populations.⁶⁵ Further analysis by county reveals that the majority of counties have low urbanisation levels, as shown in Figure 11.6. Only five counties — Nairobi, Mombasa, Kiambu, Machakos and Kisumu — have more than half of their population living in urban centres. Nairobi and Mombasa are the two largest cities in Kenya, and are entirely urban. The other counties with significant urban populations include: Nakuru (45%), Isiolo (44%), Kajiado (41%), Uasin Gishu (39%), Kericho (38%), Migori (34%), Vihiga (31%) and Kilifi (25%). The rest of the counties have less than one-quarter of their population living in urban areas. Meru, West Pokot and Narok are the least urbanized counties with less than 10 percent urban populations.

11.3.7 Implications of Urban Growth Trends

The high rate of urbanization in Kenya has resulted in social, economic and spatial development challenges that must be addressed. The fundamental problem is that the urban population is growing very fast without the economic growth and development transformations necessary to support it and enhance the quality of urban life (Bocquier *et al.*, 2009; Owuor, 2006a; Stren and White, 1989). Thus, instead of urbanization being driven or accompanied by economic growth, it is driven by poverty and the need for economic survival strategy (UN-Habitat, 2008).



An aerial view of Nairobi from Kibera informal settlement.

Photo: www.wikimedia.org

Urban growth in Kenya has resulted in social, economic and spatial development challenges, such as:

- Increasing levels of poverty, economic vulnerability (SID, 2004; Odhiambo and Manda 2003), food insecurity and informality (Robertson, 2002). These realities have led to the urbanization of poverty and “informalization” of the urban economy. In 1992, the percentage of Kenya’s urban poor was estimated at 29 percent compared to 42 percent in the rural areas. In 1997, the urban figure had risen to 49 percent compared to 53 percent in the rural areas (Odhiambo and Manda, 2003). In 2004, it was estimated that 44 percent of Nairobi’s population was living below the poverty line of less than one dollar a day (SID, 2004);
- Deepening social differentiation and inequality (SID, 2004), polarization, and segregation and fragmentation of the cities (Owuor and Mbatia, 2011). According to SID, the gap between the rich and the poor is widening with every Kenyan shilling earned by a poor Kenyan, mapping against

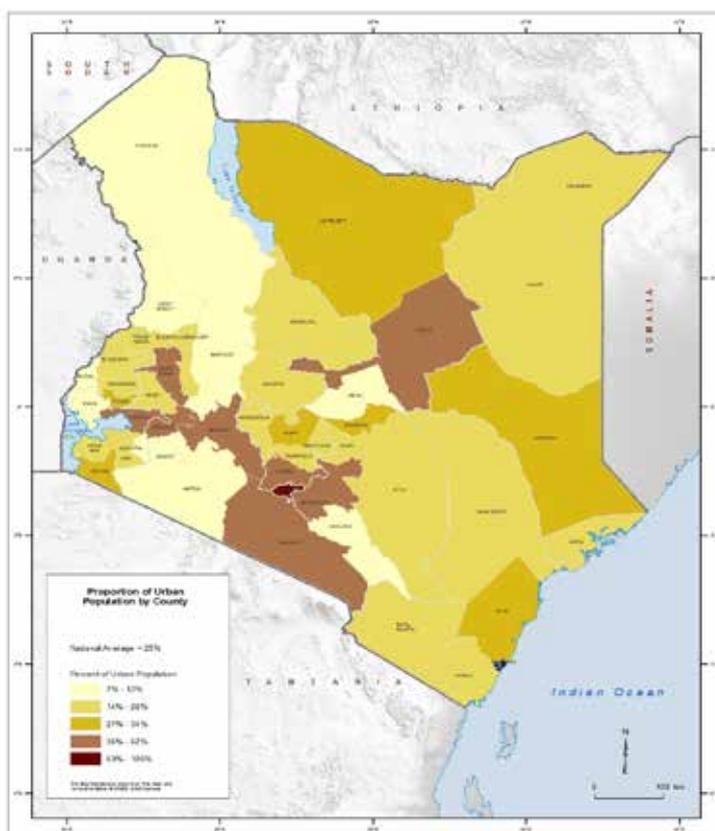
⁶⁵ For example, Garissa and Mandera dominate North Eastern province, while Machakos and Embu dominate Eastern province.

Kenya shilling 56. The wealthiest 10 percent of the population control about 42 percent of the country's income, while the poorest 10 percent earn less than 1 percent;

- Inadequate and poor provision of services (i.e. housing, water and sanitation, security), especially to the urban poor — sometimes leading to privatization of urban services (Owuor, 2006a). For example, the 1999 census reveals that access to main sewer is very poor in urban Kenya. Almost 220 out of 230 urban centres have less than 25 percent of their households connected to the main sewer. Nationally, only three urban centres have more than half of the households connected to main sewer. On the other hand, 213 urban centres have less than 25 percent of their households connected to piped water in the house (Ministry of Planning and National Development and Vision 2030, forthcoming, Vol. VIII);
- Considerable strain on existing urban infrastructural facilities; and
- Proliferation of informal and unplanned settlements popularly referred to as slums (UN-Habitat, 2006) — resulting in declining quality of life and standards of living. According to the 2009 Census, 15 percent of Kenya's urban population lives in informal settlements. Kisumu leads with a high proportion (46.9%) of informal settlements' population, followed by Nairobi (36.2%), Mombasa (23.55), Eldoret (23.3%) and Thika (10.9%), respectively (Ministry of Planning and National Development and Vision 2030, forthcoming, Vol. VIII).

Despite these challenges, cities will inevitably have an increasingly critical role in future economic and social development. According to Martine *et al.* (2008), urbanization can be critical for economic growth, reduction of poverty, stabilization of population growth and long-term sustainability. However, realizing this potential will require a different mindset on the part of policymakers, a proactive approach and better governance.

Figure 11.6 Percent Urban Population by County, 2009



Source: Ministry of Planning and National Development and Vision 2030 (forthcoming, Vol. VIII).

11.4 Internal Migration

Migration has come to the top of political and social agenda across all of Africa and some researchers on migration have advocated for greater inclusion of migration issues in the processes of development planning. Historically, the migration in East and Central Africa were influenced significantly by European settlement (Mitchell 1959; Mitchell 1969, cited in Rempel, 1981) and colonial tax system⁶⁶ (Eicher and Baker, 1984). Immediately after independence, the opening of high-wage jobs in the urban areas following the removal of controls on urban in-migration in 1959, rural-urban migration increased to a level beyond the absorptive capacity of the urban economies in Kenya (International Labour Office 1972, p. 85).

Although migration is one of the three components of population change, besides fertility and mortality, studies on internal migration has been scarce and mainly limited to census data. However, migration influences the population structure, composition and size of a country. Internal migration refers to movement for settlement within and across a country's regional administrative boundaries. Internal migration can be categorized by type (in-migration and out-migration) and directional flow (rural-rural, rural-urban, urban-rural, and urban-urban). 'Recent migration' occurs when a person changes his or her usual place of residence at least once in the year before the census date, i.e. where she/he is enumerated is different from where she/he resided a year before the census date. Lifetime migration occurs when one's area of usual residence at the time of population census differs from the area of birth.

11.4.1 National Policies and Programmes

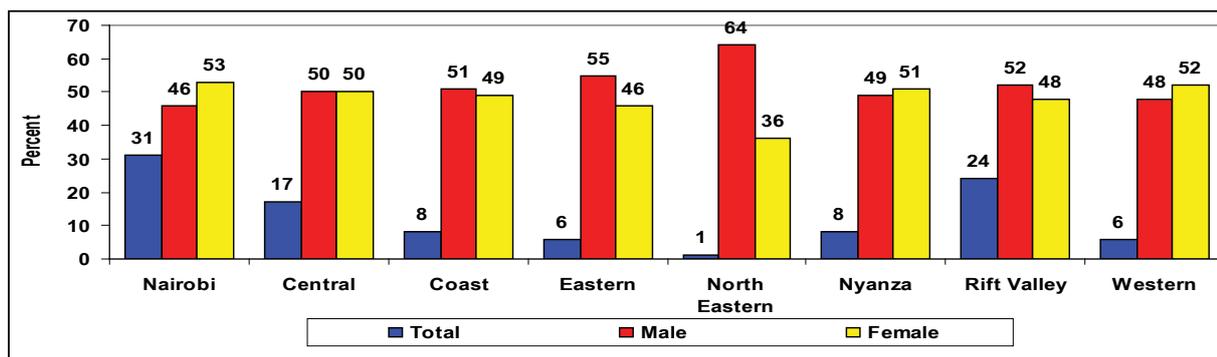
Up to the recent past, Kenya has lacked a comprehensive national migration policy. Much of the policy interest in internal migration has been with respect to rural-urban migration and the rate of growth in urban populations. As noted earlier, the spatial distribution policies adopted by the Government of Kenya in the independence era, National Development Plans were aimed at slowing down the rate of rural-urban migration, promoting growth of small and medium-size urban centres, and encouraging rural development (Owuor, 2006b). Some of these policies include: the growth-pole/growth-centre approach; selective dispersal and selective concentration strategy; service centres strategy; rural trade and production centres; district focus for rural development strategy; growth with distribution policy; rural-urban balance strategy; and more recently, the Local Authority Transfer Fund (LATF) and Constituency Development Fund (CDF). The Government realized that the concentration of all economic, social and political life in the two main urban centres carried the risk of polarising the country.

11.4.2 Recent Migrants

Nairobi Province has the largest share of the country's recent in-migrants (30.5%) followed by Rift Valley (23.7%) and Central (16.6%). Conversely, North Eastern Province recorded the least proportion (Figure 11.7). There are more women recent in-migrants than men in Nairobi, Western and Nyanza provinces; but male recent in-migrants dominate North Eastern and Eastern provinces.

⁶⁶ Colonial tax systems required cash payments and therefore necessitated wage work particularly in colonial farms. The colonialists also introduced cash crops but the white settlers monopolized their production workers from Burundi, Malawi, Mozambique, and Rwanda were recruited to Kenya, Tanzania, and Uganda for employment on agricultural estates.

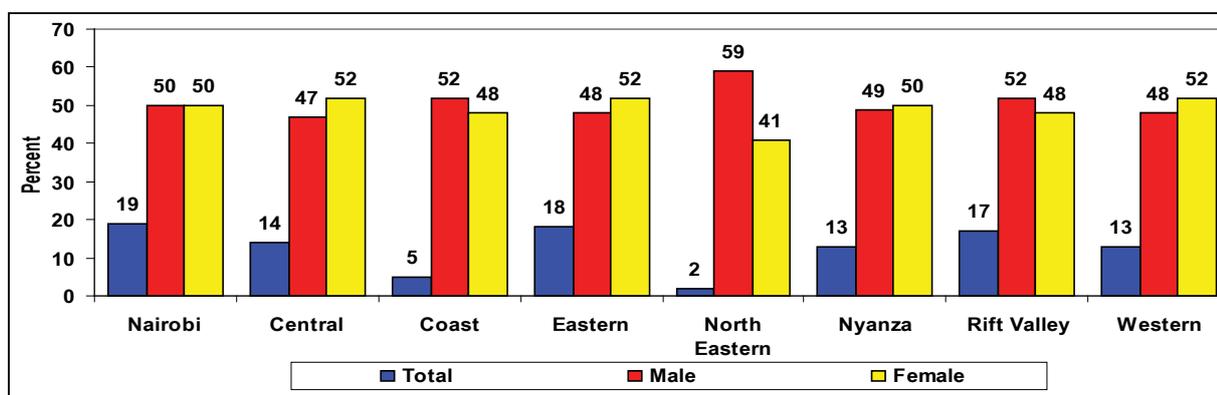
Figure 11.7 Percent Recent In-Migrants by Sex and Province, 2009



Source: Compiled from 2009 Kenya Population and Housing Census Data.

Nairobi Province also has the largest share of recent out-migrants (18.9%) followed by Eastern (18.0%), Rift Valley (16.5%), Central (13.7%), Nyanza (13.2%) and Western (12.9%), while Coast and North Eastern provinces experienced very low recent out-migration (Figure 11.8). Women dominated the recent out-migration stream from Central, Eastern, Nyanza and Western provinces.

Figure 11.8 Percent Recent Out-Migrants by Sex and Province, 2009



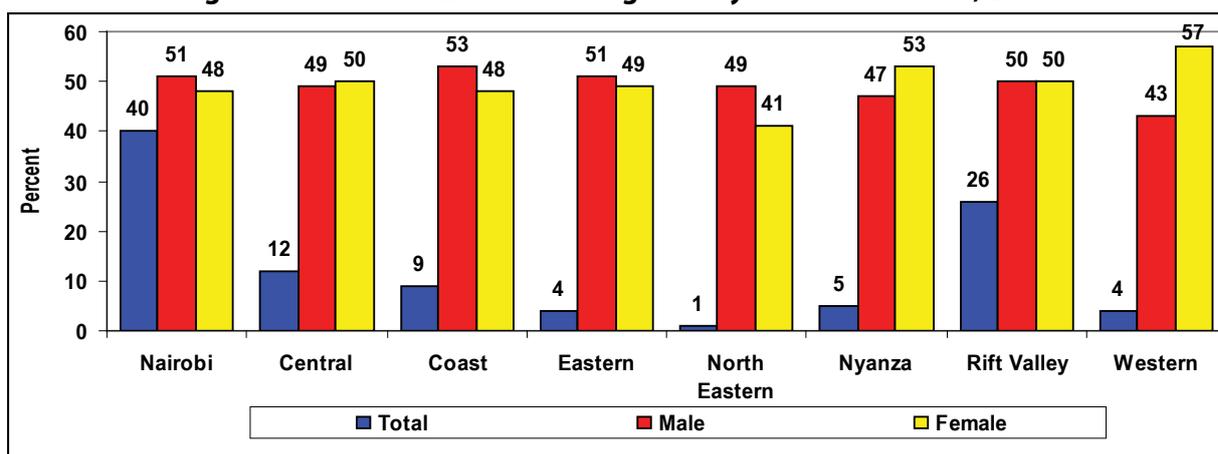
Source: Compiled from 2009 Kenya Population and Housing Census Data.

Further analysis shows that Eastern, North Eastern, Nyanza and Western provinces are areas of recent net out-migration (with net loss of populations), while Nairobi, Central, Coast and Rift Valley provinces are areas of recent in-migration (with net gain in populations). The same trend was experienced in 1999; but Nyanza Province recorded a net gain in that year (Central Bureau of Statistics, 2004).

11.4.3 Lifetime Migrants

Nairobi and Rift Valley provinces have the largest shares of lifetime in-migrants: 39.7 percent and 25.6 percent of their respectively (Figure 11.9). North Eastern has the least share of less than 10 percent of the total lifetime in-migrants in Kenya. Women dominated the lifetime in-migration stream in Western, Nyanza and Central provinces.

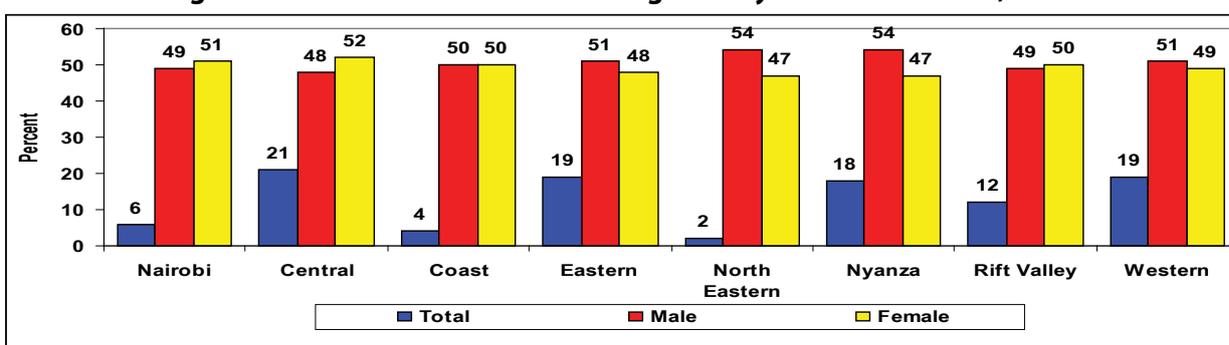
Figure 11.9 Percent Lifetime In-Migrants by Sex and Province, 2009



Source: Compiled from 2009 Kenya Population and Housing Census Data.

On the other hand, Central province has the largest share of lifetime out-migrants (20.8%) followed by Eastern (19.1%), Western (18.6%) and Nyanza (18%). Coast and North Eastern provinces experienced very low life-time out-migration (Figure 11.10). Women dominated lifetime out-migration stream from Nairobi, Central and Rift Valley provinces.

Figure 11.10 Percent Lifetime Out-Migrants by Sex and Province, 2009



Source: Compiled from 2009 Kenya Population and Housing Census Data.

Further analysis reveals that Central, Eastern, North Eastern, Nyanza and Western provinces are areas of lifetime out-migration (with a net loss of lifetime migrants), while Nairobi, Coast and Rift Valley provinces are areas of lifetime in-migration (with a net gain of lifetime migrants). The same trend was experienced in 1989 and 1999, but with varying shares (Central Bureau of Statistics, 1996; 2004).

Nairobi Province is a net receiver of lifetime in-migrants from all provinces, while Western province has net lifetime out-migration to all provinces (Table 11.8). Central province experiences net out-migration to Nairobi, Rift Valley and Coast provinces. Those migrating from Eastern Province go to Nairobi, Coast, Central and Rift Valley provinces. North Eastern, like Nyanza, is a major out-migration province. Coast Province receives most migrants from Eastern and Nyanza provinces, while Rift Valley province has a large proportion of in-migrants from Western, Nyanza and Central provinces.

Table 11.8 Distribution of Net Lifetime Migration Flows Between Provinces (1999)

	Nairobi	Central	Coast	Eastern	North Eastern	Nyanza	Rift Valley	Western
Nairobi	0	422,714	33,894	473,420	41,541	352,283	108,190	314,404
Central	-422,714	0	-44,648	75,820	1,039	41,569	-175,415	46,391
Coast	-33,894	44,648	0	149,567	19,437	67,992	13,149	34,831
Eastern	-473,420	-75,820	-149,567	0	3,335	11,719	-87,660	10,498
N. Eastern	-41,541	-1,039	-19,437	-3,335	0	-1,829	-4,130	3,146
Nyanza	-352,283	-41,569	-67,992	-11,719	1,829	0	-247,649	21,663
Rift Valley	-108,190	175,415	-13,149	87,660	4,130	247,649	0	307,719
Western	-314,404	-46,391	-34,831	-10,498	-3,146	-21,663	-307,719	0

Source: Agwanda (forthcoming).

Table 11.9 presents a general overview of lifetime migrants' characteristics in terms of education attainment, marital status and economic activity. The majority of lifetime migrants in Kenya have completed school (primary or secondary); are either married or unmarried; and are already working. The high proportion of those married implies family migration or spouse's migration as a family obligation. Furthermore, most migrants are young (i.e. with a peak of around 25 years), suggesting that migration is likely inspired by the search for job opportunities (Agwanda, forthcoming).

Table 11.9 Percent Distribution of Lifetime Migrants by Socio-Economic Characteristics, 2009

Education attainment

None	9.9
Primary incomplete	5.2
Primary complete	46.3
Secondary and above	37.9

Marital Status

Never married	45.0
Married	49.8
Widowed	3.2
Divorced	2.0

Economic activity

Working	64.7
Unemployed	6.8
Inactive	38.5

^aWhile the figures were provided by the Kenya National Bureau of Statistics, some of the categories add up to more than 100 percent although they are mutually exclusive.

Source: Compiled from 2009 Kenya Population and Housing Census Data.

Data from the post independence censuses indicate that the migration patterns in Kenya can be summarized into six broad areas (Oucho and Odipo, 2000; Agwanda and Odipo, 2011). These include migration in: (a) resettlement areas, (b) cash crop growing areas, (c) nomadic areas, (d) border areas, (e) Western and Eastern regions of Kenya, and (f) migration in metropolitan areas. However, political factors and resource conflicts may have reversed migration flows into former resettlements areas in the recent past (Agwanda and Odipo, 2011).

In summary, the trends in recent and lifetime internal migration show that:

1. Nairobi, Central, Coast and Rift Valley provinces are the most favoured areas of net in-migration, while Eastern, Nyanza, North Eastern and Western provinces are areas of net out-migration.

As the capital city of Kenya and major urban centre, Nairobi is highly developed and has more opportunities, better infrastructure and services. Rift Valley is a vast agricultural area with large farms and favourable conditions for settlement and farming, while Central is comparatively well developed. Coast attracts in-migrants from all regions of Kenya because of tourism and the port city of Mombasa;

2. Since independence, the general spatial pattern of internal migration has remained relatively stable, implying that there have been no major changes in Kenya's development pattern (Oucho, 2007); and
3. Women are increasingly joining the internal migration stream. This can be attributed to improved access to education and training opportunities; increased participation in labour force and household's income generating activities; and greater social and economic empowerment and independence.

11.5 Rural-Urban Dimensions of Internal Migration

Kenya experiences four types of internal migration defined by the direction of the flow between urban and rural areas. *Rural-rural* migration is typically undertaken in search of pasture and (arable) land, more often than not, due to population pressure and/or landlessness at the point of origin. Migration from one rural area to another also occurs in the search for employment or better opportunities in the rural agricultural plantations. *Rural-urban* migration is the most common ever since colonialism instigated labour migration, and has been one of the major drivers of urban growth in the country. People migrate to towns in search of employment; better opportunities, infrastructure and services; and because of family and social networks. Rural-urban migration is conspicuous because it underlines the disparity between the two locales (Oucho, 2007). In the 1960s and 1970s, high rural-urban migration occurred despite low employment opportunities in the formal sector (Todaro, 1976; 1997) because urban informal sector formed for migrants a transitional sector from the traditional sector (agriculture) towards the urban formal sector.

Urban-urban migration is dominated by formal sector (Government, parastatal) employees, who are occasionally transferred from one town (station) to another, as well as traders and businesspeople seeking (more) viable economic activities. It may also occur during step-wise migration, such as moving from a small urban centre to a medium-size urban centre and lastly to the largest city. *Urban-rural* — or return — migration is associated with retirees going back to their rural homes (Oucho and Gould, 1993). Return migration is not a new phenomenon, and seems to be growing in importance. In addition to the traditional return flows of migrants, a new kind of urban-rural migration is emerging which is linked to flight from persistent economic crisis.

Another component of internal migration in Kenya is *forced migration* which is triggered by development projects, conflicts, civil unrest, ethnic tensions and clashes, political violence, extreme environmental conditions and natural disasters — leading to internally displaced persons (IDPs) (Kamungi, 2009) and environmental refugees (Bates, 2002). For example, the post-election violence of 2007 in Kenya resulted in the displacement of about 663,921 people (Kamungi, 2009). An estimated 350,000 sought refuge in 118 camps spread all over the country, while the rest either integrated within communities or moved to their rural homes (Kamungi, 2009).

11.5.1 Urban-Rural Linkages

As an important part of the urbanization processes in sub-Saharan Africa, urban-rural linkages have been well documented in broader migration and urban-rural interaction studies, which linkages persist to date (Owuor, 2006a). Migrants maintain close relations with their rural homes even from a distance:

they return to visit; they invest in housing, social activities, education and health amenities; they send money home and sometimes receive goods or host visiting relatives (Beauchemin and Bocquier, 2003). Although urban dwellers have always maintained links with the rural areas, economic crisis and structural adjustment in the past decades seem to have produced fundamental and interrelated changes to urban-rural linkages (Owuor, 2007; 2006a).

There are indications that the rate of rural-urban migration has decreased, while return migration, i.e. from the city to the rural home, is emerging (Tacoli, 1998; Potts, 1997), with circular migration between urban and rural areas increasing (Smit, 1998). Second, rural links have become vital safety-valves and welfare options for urban people who are very vulnerable to economic fluctuations (Frayne, 2004). Lastly, to reduce household expenses, a husband may return his wife and all or some of the children to the village while he remains in town. Similarly, migrants unable to find jobs in town may be “forced” to return to the rural home. Furthermore, fostering urban children at the rural home is also common among female-headed households. In short, urban-rural linkages are not only important for the rural households, but are becoming an important element of the livelihood (or survival) strategies of poor urban households (Owuor, 2007).

11.5.2 Implications of Internal Migration Trends

Internal migration not only affects the sizes of populations in areas of origin and destination, but also affects demographic characteristics. In addition, the receiving areas, especially urban centres, are likely to experience the challenges of urban growth and development, such as pressure on existing resources (including infrastructure and services); conflicts in resource use; and competition for job and economic opportunities. On the other hand, sending communities — especially the rural areas, lose farm labour and the young and educated, as a result of the selective nature of migration patterns. This results in changes in affected household dynamics.

11.6 Policy Issues

11.6.1 Policy Issues on Urbanization

1. As with other highly urbanizing sub-Saharan African countries, Kenya should urgently manage the emerging trends, patterns and challenges of urban growth. Since urbanization is inevitable, the main challenge is not to slow it down, but rather to learn how to deal with the rapid growth it generates. Already, it is estimated that about 50 percent of Kenya’s population will be living in urban areas by 2015. These challenges call for a national urban policy to guide urban development countrywide. In addition, the policy should aim at guiding the urbanization process by reducing risks and maximizing opportunities attributed to urban growth. It is indeed possible to move from the spontaneous and, therefore, chaotic cities to harmonious cities, provided good policies and strategies are adopted, investments mobilized, stakeholder participation secured, good governance practiced and human development prioritised. The challenges associated with urbanization demand a proactive approach to urban planning, which considers future demographic and environmental aspects while responding to current priorities. Such an approach demands, in turn, a sound understanding of urban development processes, locally, nationally and even internationally.
2. The growth of Nairobi city has spilled over to adjacent urban centres, pointing to prospects of a metropolis. Other large urban centres will gradually experience the same growth trend. At the same time, there is no doubt that small and medium-size urban centres will continue to grow and absorb a larger proportion of the urban population. There is a need to encourage area-wide metropolitan planning and governance, as well as planning for the spatial growth and development of small and medium-size urban centres, alongside strengthening their governance capacities.

3. Urban centres are central places where people — residents and non-residents alike — converge on a daily basis. Consequently, they serve not only the urban residents, but also the populations living on the peripheries. However, the itinerant daytime population of urban centres is hardly ever captured in the population censuses, yet such inclusion is imperative for comprehensive planning purposes.

11.6.2 Policy Issues on Internal Migration

1. As Kenya lacks a comprehensive internal migration policy, there is a need to integrate internal migration into the wider urban, regional and national development policies and planning. Alternatively, Kenya should develop such a policy. The aim would be to maximize the potential benefits of internal migration, especially for poor people, while minimizing its risks and costs.
2. Internal migration is important and is increasingly becoming even more dynamic and complex. However, informed policy and interest on internal migration have been hampered by the lack of adequate, reliable and comprehensive data, such as can be generated by national-level surveys. More research and data on all aspects of internal migration are needed to shape academic debates on the phenomenon and inform policy debates.
3. Superficially, there is a close relationship between various aspects of regional inequality and the different types of internal migration in Kenya (Oucho, 2007). Unless the country adopts radical changes in regional and national development programmes that redress regional inequalities, the current patterns of internal migration will continue. The more developed counties will continue to attract in-migrants, while the least developed ones continue to be net out-migration areas. Furthermore, urbanization is perceived to be the primary driver of rural-urban migration owing to regional socio-economic disparities between the rural and urban areas, with the latter perceived to offer better opportunities. To correct the resulting imbalances and spread the benefits of urbanization across the country, a starting point could be investment in strategically located flagship projects that even out differences.

11.7 Conclusion

Development theorists and practitioners have until recently viewed rural and urban areas as two mutually exclusive entities with their own unique populations, activities, problems and concerns. However, this does not reflect the reality of urban-rural linkages and interactions, which include both urban and rural elements (Owuor, 2006a). Interactions between urban and rural areas play an important role in processes of rural and urban change. According to Satterthwaite and Tacoli (2002), it is essential that policies and programmes reflect the importance of the “urban” part of rural development and the “rural” part of urban development. In other words, urban development strategies must take into account the rural links and context; and vice versa. The answer to urban poverty cannot be found in the urban areas alone. Policies ignoring this may increase poverty and vulnerability for those groups for whom ‘straddling the urban-rural divide’ is an important part of their survival strategy.

Appendix 11.1 Population Distribution and Densities by County, 1999-2009

County	Area in square km	Population		Percent share of the total		Population density	
		1999	2009	1999	2009	1999	2009
Nairobi	695.1	2,082,191	3,138,369	7.40	8.13	2,996	4,515
Nyandarua	3,245.3	468,458	596,268	1.67	1.54	144	184
Nyeri	3,337.1	647,887	693,558	2.30	1.80	194	208
Kirinyaga	1,479.1	454,090	528,054	1.61	1.37	307	357
Murang'a	2,558.8	907,446	942,581	3.23	2.44	355	368
Kiambu	2,543.4	1,204,009	1,623,282	4.28	4.20	473	638
Mombasa	218.9	643,060	939,370	2.29	2.43	2,938	4,291
Kwale	8,270.2	490,973	649,931	1.75	1.68	59	79
Kilifi	12,609.7	815,994	1,109,735	2.90	2.87	65	88
Tana River	38,436.9	178,609	240,075	0.64	0.62	5	6
Lamu	6,273.1	71,215	101,539	0.25	0.26	11	16
Taita Taveta	17,084.0	241,942	284,657	0.86	0.74	14	17
Marsabit	70,961.2	172,481	291,166	0.61	0.75	2	4
Isiolo	25,336.1	98,971	143,294	0.35	0.37	4	6
Meru	6,936.2	1,096,325	1,356,301	3.90	3.51	158	196
Tharaka	2,638.8	303,932	365,330	1.08	0.95	115	138
Embu	2,818.0	443,409	516,212	1.58	1.34	157	183
Kitui	30,496.5	810,779	1,012,709	2.88	2.62	27	33
Machakos	6,208.2	895,816	1,098,584	3.18	2.85	144	177
Makueni	8,008.8	766,111	884,527	2.72	2.29	96	110
Garissa	44,175.0	262,694	623,060	0.93	1.61	6	14
Wajir	56,585.8	309,268	661,941	1.10	1.71	5	12
Mandera	25,991.5	246,063	1,025,756	0.87	2.66	9	39
Siaya	2,530.4	712,305	842,304	2.53	2.18	281	333
Kisumu	2,085.9	788,539	968,909	2.80	2.51	378	465
Homabay	3,183.3	745,040	917,170	2.65	2.38	234	288
Migori	2,596.4	656,935	963,794	2.34	2.50	253	371
Kisii	1,317.5	943,202	1,152,282	3.35	2.98	716	875
Nyamira	899.3	495,620	598,252	1.76	1.55	551	665
Turkana	68,680.3	389,319	855,399	1.38	2.22	6	12
West Pokot	9,169.4	305,583	512,690	1.09	1.33	33	56
Samburu	21,022.2	135,565	223,947	0.48	0.58	6	11
Trans Nzoia	2,495.5	568,498	818,757	2.02	2.12	228	328
Baringo	11,015.3	400,571	555,561	1.42	1.44	36	50
Uasin Gishu	3,345.2	613,386	894,179	2.18	2.32	183	267
Elgeyo Marakwet	3,029.8	282,793	369,998	1.01	0.96	93	122
Nandi	2,884.2	568,998	752,965	2.02	1.95	197	261
Laikipia	9,461.9	316,791	399,227	1.13	1.03	33	42
Nakuru	7,495.1	1,176,233	1,603,325	4.18	4.15	157	214
Narok	17,933.1	529,711	850,920	1.88	2.20	30	47
Kajiado	2,190.1	395,905	687,312	1.41	1.78	18	31
Kericho	2,479.0	461,651	590,690	1.64	1.53	186	238
Bomet	2,471.3	689,512	891,835	2.45	2.31	279	361
Kakamega	3,051.2	1,289,233	1,660,651	4.58	4.30	423	544
Vihiga	530.9	496,588	554,622	1.77	1.44	935	1,045
Bungoma	3,5828.0	1,005,094	1,375,063	3.57	3.56	28	38
Busia	1134.4	548,163	743,946	1.95	1.93	483	656

Appendix 11.2 Urban and Rural Population by County, 2009

County	Total population	Rural population	Percent of rural population	Urban population	Percent of urban population
Nairobi	3,109,861	0	0	3,109,861	100
Kiambu	1,618,422	611,426	37.8	1,006,996	62.2
Kirinyaga	525,962	444,270	84.5	81,692	15.5
Muranga	940,882	808,326	85.9	132,556	14.1
Nyandarua	595,421	480,814	80.8	114,607	19.2
Nyeri	689,437	523,945	76	165,492	24
Kilifi	1,102,937	823,795	74.7	279,142	25.3
Kwale	645,955	531,554	82.3	114,401	17.7
Lamu	100,398	80,773	80.5	19,625	19.5
Mombasa	925,137	0	0	925,137	100
Taita Taveta	277,475	229,905	82.9	47,570	17.1
Tana River	239,323	203,687	85.1	35,636	14.9
Embu	513,271	431,741	84.1	81,530	15.9
Isiolo	141,711	79,956	56.4	61,755	43.6
Kitui	1,008,156	871,473	86.4	136,683	13.6
Machakos	1,093,503	529,112	48.4	564,391	51.6
Makueni	880,048	779,595	88.6	100,453	11.4
Marsabit	289,337	225,642	78	63,695	22
Meru	1,350,481	1,247,092	92.3	103,389	7.7
Tharaka-Nithi	364,290	284,161	78	80,129	22
Garissa	619,571	479,668	77.4	139,903	22.6
Mandera	1,023,670	845,368	82.6	178,302	17.4
Wajir	658,596	568,210	86.3	90,386	13.7
Homa Bay	961,956	825,241	85.8	136,715	14.2
Kisii	1,148,612	921,077	80.2	227,535	19.8
Kisumu	959,882	462,793	48.2	497,089	51.8
Migori	914,289	606,874	66.4	307,415	33.6
Nyamira	597,730	520,708	87.1	77,022	12.9
Siaya	839,420	750,205	89.4	89,215	10.6
Baringo	553,564	490,321	88.6	63,243	11.4
Bomet	889,447	789,027	88.7	100,420	11.3
Elgeyo Marakwet	369,270	317,356	85.9	51,914	14.1
Kajiado	682,123	402,097	58.9	280,026	41.1
Kericho	587,416	362,228	61.7	225,188	38.3
Laikipia	396,086	317,744	80.2	78,342	19.8
Nakuru	1,593,448	875,125	54.9	718,323	45.1
Nandi	751,815	649,204	86.4	102,611	13.6
Narok	845,196	789,592	93.4	55,604	6.6
Samburu	222,327	185,234	83.3	37,093	16.7
Trans Nzoia	815,810	655,907	80.4	159,903	19.6
Turkana	849,277	748,660	88.2	100,617	11.8
Uasin Gishu	888,043	546,102	61.5	341,941	38.5
West Pokot	511,824	470,559	91.9	41,265	8.1
Bungoma	1,372,020	1,160,283	84.6	211,737	15.4
Busia	740,043	657,865	88.9	82,178	11.1
Kakamega	1,655,013	1,423,717	86	231,296	14
Vihiga	553,633	380,086	68.7	173,547	31.3

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CHAPTER 12: INTERNATIONAL MIGRATION AND DEVELOPMENT

12.1 Introduction

As with many developing countries, Kenya is a country of origin, transit and destination of international migration of three dominant forms, one of which is clandestine and therefore illegal. First, there is the general voluntary 'international migration' defined in terms of movement across international boundaries, which includes labour migration across the skills spectrum. Second, refugee movements — just about exclusively into, as opposed to out of, Kenya — are a dominant form of forced migration involving movement from the contiguous states with the exception of Tanzania. Finally, irregular migration in the form of migrant trafficking and smuggling is becoming increasingly significant with Kenyans moving to the Middle East, and people from the Horn of Africa crossing through Kenya to southern Africa, and subsequently to Latin America or southern Europe notably Portugal and Spain.

This chapter analyses the situation of various types of international migration involving Kenya for which data are available. It consists of five main sections. This introductory section provides the context and thrust of international migration in Kenya, explaining the changing configuration of the phenomenon and highlighting its character involving 'mixed migration'. Section 2 sheds light on the sources of data used for this chapter, pointing to their inherent limitations that provide challenges in analysis, but also offer opportunities for improved work in the area. It highlights the methods of analysis employed on the data and the resulting limitations. The third section examines the status of and trends in international migration in five sub-sections focusing on: i) pertinent issues in analysing international migration in Kenya in the context of eastern Africa; ii) documented immigration from the African, European and Asian regions; iii) refugees in Kenya from contiguous states and further afield; iv) emigration from Kenya, comprising the brain drain, brain circulation, brain waste and emigration of unskilled and semi-skilled Kenyans; and v) irregular migration through migrant trafficking and smuggling. Section 4 uses four sub-sections to draw attention to the consequences and implications of international migration: i) Kenya's position with respect to the signing, ratification and implementation of international migration instruments; ii) the threat of heavy immigration; iii) the Kenyan diaspora and its role in Kenya's development; and iv) the challenges as well as opportunities that emigration and development interrelations raise. The final section draws conclusions based on the main findings of the study.



An aerial view of the Jomo Kenyatta International Airport.

Photo: www.airporsinternational.com

12.1.1 International Migration Scene and the Changing Configuration in Kenya

In keeping with mainstream demographic tradition, Kenya's population analysis, based on the classical demography of the western world, has tended to ignore international migration into and from the country. The best known form of recent international migration for most Kenyan citizens, including its policymakers and planners, is that of refugee inflows from a volatile sub-Saharan Africa (SSA) region that has witnessed diverse disruptive forces, such as civil wars, political upheavals, ethnic strife, and the vagaries of climate (in particular floods and drought).

Typology of International Migration: Various Perspectives

In propounding a general theory of migration, Petersen (1969: 229) argued that:

"Migration is not unitary; it differs from fertility and mortality in that it cannot be analyzed, even primarily in terms of supra cultural, physiological factors but must be differentiated even at the most abstract level with the social conditions obtaining. This means that the most general statement that one can make concerning migration must be in the form of a typology, rather than a law."

This explains why the types of migration considered vary by disciplines, individual analysts, planners and policymakers, institutions and different stakeholders. Against such a multifaceted backdrop, this chapter will endeavour to adopt such contemporary migration typologies as are most pertinent to the Kenyan context.

Conventionally, the Population Division of the United Nations classifies international migration into three categories, namely A, B and C (United Nations, 1998). Categories A and B involve estimation of the migrant stock based on foreign-born persons in a national population, while category C entails estimation based on foreign citizens in the population. However, migration scholars prefer more refined distinctions, such as the taxonomies employed by Appleyard (1991) and Bilsborrow *et al.* (1997).

Table 12.1 Typology of international migration by various analysts and practitioners

Type of migration	Main characteristics
Permanent ^a	Permanent residence status/settlers; naturalisation; amnesty beneficiaries
Labour ^b	Temporary/permanent; skilled/semi-skilled/unskilled; emigrant/immigrant; brain drain, brain circulation, brain waste, brain gain
Refugees and asylum seekers ^a	Categorised by the UN Convention 1951, Protocol 1967; OAU/AU Convention 1969 as forced to move across common borders
Undocumented/illegal/ clandestine/irregular/ unauthorised ^a	Nomenclature differs by country of origin and especially country of destination. Include those lacking entry/work documents, 'overstayers', unsuccessful applicants for refugee/asylum status, amnesty defaulters, trafficked/smuggled migrants
Mixed migration ^b	A concept popularised by IOM for all types of migration

Source: Adapted from Oucho (2006: 50), table 3.1.

Notes: ^aClassification by the Population Division, United Nations Department of Economic and Social Affairs (UNDESA).

^bIncludes different types of voluntary and forced migration caused by wide ranging factors.

Strictly speaking, 'cross-border migration' refers to the movement of people between states that share a common border (Oucho, 2006: 48). In southern Africa, in particular in South African reference to the immigration of nationals of the neighbouring countries, the concept is dominant in the literature with derogatory adjectives: 'border jumpers', 'illegal immigrants' and 'illegal aliens' (McDonald *et al.*, 1998); and 'black tide' from the North and 'barbarians' (Mattes *et al.*, 1999). It is a form of migration that conventionally takes place between contiguous countries, such as among the East African Community

(EAC) partners, as well between them and immediate non-EAC neighbours. As in many other regions of Africa, EAC cross-border migration is heightened not just by shared borders, but also by the fact that colonial balkanisation caused various ethnic communities to be arbitrarily sub-divided into different countries⁶⁷.

Table 12.1 presents the types of migration that have been refined by scholars to enable structured analysis. For example, Appleyard (1991) defines 'permanent migration' as permanent settlement either by residence or naturalisation; 'labour migration' is sub-categorised into temporary contract workers who may be unskilled or semi-skilled, and temporary transients comprising skilled and professional persons; refugees and asylum seekers are seen as a distinctive group; and clandestine/illegal migrants are seen to belong to the various aforementioned categories. In a major methodological work on international migration, Bilsborrow *et al.* (1997) came up with a completely different typology consisting of five main categories: (i) immigrants who may be settlers with unrestricted periods of stay and those moving because of family reunification; (ii) 'foreigners', designated thus because they are permitted to move freely, are frontier workers or a migrant workforce (project-tied, contract, temporary, established highly skilled or business travellers); (iii) asylum migration (conventional refugees, humanitarian admissions or those granted stay of deportation); (iv) unauthorized, regular migrants; and (v) citizens returning to their countries of origin. These varied classifications point to the fact that the distinction of international migration broadly in immigration-emigration contexts is grossly simplistic. However, such classifications are convenient for this chapter's analysis which does not seek to delve into much detail.

The term 'mixed migration' has become popular in recent times, but is viewed differently by institutions that work within its context. Tinde's (2011:89) illuminating clarification of the concept is particularly useful:

"The concept of mixed migration has its origins in the efforts in the 1990s to draw a clearer line between refugees and asylum-seekers that are protected by International Refugee Law, and migrants who are not. As the interest in the concept is widening, it takes on broader connotations, with the risk of confusion between security, economic, political considerations, and humanitarian concerns. Governments focus normally on frameworks and procedures to disaggregate and manage mixed migration."

For example, the Danish Refugee Council (2009) defines mixed migration as "complex population movements including refugees, asylum seekers, economic migrants and other migrants ... such as people displaced due to climate change." Conversely, the United Nations High Commissioner for Refugees (UNHCR) distinguishes between migrants and refugees, stating that:

"Migrant is a wide-ranging term that covers people who move to a foreign country for a certain length of time - not to be confused with short-term visitors such as tourists and traders.... Migrants are fundamentally different from refugees and, thus, are treated very differently under international law.... Migrants, especially economic migrants, choose to move in order to improve their lives. Refugees are forced to flee to save their lives or preserve their freedom (UNHCR, 2011)."

The global migration agency, the International Organisation for Migration (IOM), notes that 'mixed migration':

"(R)efers to flows of people that are migrating for a variety of reasons — to avoid food insecurity, conflict, forced military service, or persecution and includes asylum seekers, economic migrants, and victims of trafficking and smuggling. In many cases, these reasons overlap, and can shift during the journey as a result of hardship, economic and legal reasons, among others. As the initial cause of migration is likely different at later stages, mixed migration is multi-faceted and requires Governments and agencies to adapt operational strategy and capacity to manage appropriately."(IOM, Kenya Mission

67 The most prominent case for Kenya must be that of the Somalis; but others involve the Digo, Maasai and Luo spread into Tanzania; and the Samia, Pokot and Turkana into Uganda.

with Coordinating Missions in the Horn of Africa, n.d.).

To this end, IOM breaks the four categories of Table 1 into 12 categories of mixed migration as: (i) refugees; (ii) asylum seekers; (iii) economic migrants; (iv) trafficking and smuggling victims; (v) stranded migrants; (vi) unaccompanied and separated migrants; (vii) vulnerable persons (pregnant women, children, elderly); (viii); migrants detained in transit or upon arrival; (ix) migrant workers; (x) cross-border traders; (xi) climate-induced factor migrants; and (xii) nomadic peoples. This study analyses only certain types of international mixed migration, limiting itself to immigration in Kenya, refugees inflows and stock, emigration of Kenyans with particular reference to the brain drain and brain waste, emigration of semi-skilled and unskilled workers to the Middle East, irregular migration (specifically human trafficking and migrant smuggling), and the Kenyan Diaspora (which is a distinctive group of emigrants for having sustained links with Kenya).

12.1.2 Data Sources

Data on international migration are drawn from a variety of sources. First, Kenyan data are available from the last five population censuses held in the independence era (1969, 1979, 1989, 1999 and 2009), restricting this study to data only on immigrants and refugees hosted by the country. While emigration data were collected for the first time in the 2009 Kenya Population and Housing Census, the results have not been published. Second, among the Government ministries with international migration data, the Ministry of Immigration and Registration of Persons has useful immigration and emigration data which remains largely unanalysed. The Ministry of Labour and Human Resources is an additional custodian of data on immigrant and emigrant labour, the latter often destined for the Middle East. Further, the Ministry of Foreign Affairs has information on emigrant Kenyans loosely dubbed the “Diaspora”, even though the information is by no means complete. Third, sectoral ministries in charge of improving human capacity — Education and Health — keep data of emigrant Kenyans and immigrant workers serving in the ministries. In the same vein, countries to which Kenyans migrate report their numbers in national censuses or administrative data bases of counterpart ministries. Even Kenya’s diplomatic missions overseas lack complete data on the status of Kenyans in their jurisdictions. A fourth data source is that within the UN system. These include the resources of the Population Division of UNDESA, UNHCR, World Bank — particularly on remittances, Organisation for Economic Cooperation and Development (OECD), International Labour Organisation (ILO), and IOM. These various data sources provide the pieces for a jigsaw puzzle that depicts the diverse forms of Kenya’s international migration.

12.2 Trends and Situation of International Migration

12.2.1 Migration Stock, Remittances and State Parties to International Instruments

This section presents results of the data analysed to provide various perspectives of international migration, namely migration stock, remittances and state parties to international instruments governing international migration. The term ‘international migrant stock’ denotes the number of people born in a country other than that in which they live, including refugees. Table 12.2 shows the trend of international migrant stock in Kenya for the half century 1960-2010. It bears three important features. The international migrant stock rose steadily from 1960 through to 1975, declining between 1980 and 1985, and thereafter increasing dramatically in the 15 years from 1995 to 2010. Perhaps the steady inflow of refugees from Sudan and Uganda in the 1970s, and from Somalia since 1991, account for this dramatic increase, while the drop between 1980 and 1985 is attributable to the departure of Ugandan refugees after the military dictatorship was overthrown in the country.

Table 12.2 Trend of international migrant stock in Kenya, 1960-2010

Year	Migrant stock	Year	Migrant stock
1960	59,330	1990	162,981
1965	101,581	1995	527,821
1970	109,044	2000	755,351
1975	160,512	2005	780,071
1980	159,892	2010	817,747
1985	151,892		

Source: UNDESA (2008).

Table 12.3 presents basic information on migration flows, with refugees as a distinct category, remittances and the status of various UN instruments on international migration. It provides details that often enter the policy locus.

Table 12.3 Data on International Migration in Kenya, 2009

Migration issue	Kenya	Eastern Africa
Total migrant stock ('000)	818	5,034
Percent of total population	2.0	1.5
Percent of female migrants	50.8	49.6
Percent Annual rate of change of migrants (2005-2010)	0.7	-0.4
Net migration among foreign born ('000)	61.8	151.7
Refugees end of 2008 ('000)	320.6	1,074.6
<i>Net migration (2005-2010)</i>		
Average annual net migration (Emigration less Immigration) in '000	-37.9	-323.9
Average annual net migration rate (per 1,000)	-1.0	-1.1
<i>Remittances</i>		
Total in US Dollars (millions)	1,588	2,901
Percent of total GDP	6.6	2.5
<i>State Parties to UN Instruments</i>		
1951 Refugees Convention	1966	14 EA states ¹
1967 Refugees Protocol	1981	13 EA states ²
1969 OAU/AU Protocol	1969	14 EA states ¹
1990 Migrant Workers Convention (MWC)	Not signed yet	3 EA states ³
2000 Human Trafficking Protocol (HTP)	2005	10 EA states ⁴
2000 Migrant Smuggling Protocol (MSP)	2005	10 EA states ⁵

Source: UNDESA (2009).

Table 12.3 shows that in 2009, Kenya accounted for 16.2 percent of total migrant stock in Eastern Africa (818,000 out of 5,034,000), the country's share of female migrants also marginally eclipsing that of the region. Refugees in Kenya in 2008 constituted nearly one-third of all refugees in Eastern Africa. Kenya's share of remittances was also impressive, standing at slightly more than half of remittances to Eastern Africa, which also translated into a much higher percentage share of GDP compared to the other countries in the sub-region. Finally, alongside its Eastern African neighbours, Kenya has signed most of the UN instruments on migration, the exception being the 1990 Convention on Migrant Workers and

Members of Their Families (MWC). The failure of all the countries in the sub-region except three, to sign the MWC is surprising even as the countries receive increasing numbers of immigrants and lose their nationals to other parts of the world. In effect, non-signatories are excluded from demanding privileges for its nationals in accordance with the related instrument(s).

12.3 Documented Immigration

Three major regional origins of immigration into Kenya can be detected from the 2009 census returns, including Africa, Europe and Asia. The 2009 census migration data was more detailed than had been the case with previous censuses, whose scant immigration data was apparently never published by the Central Bureau of Statistics (CBS).

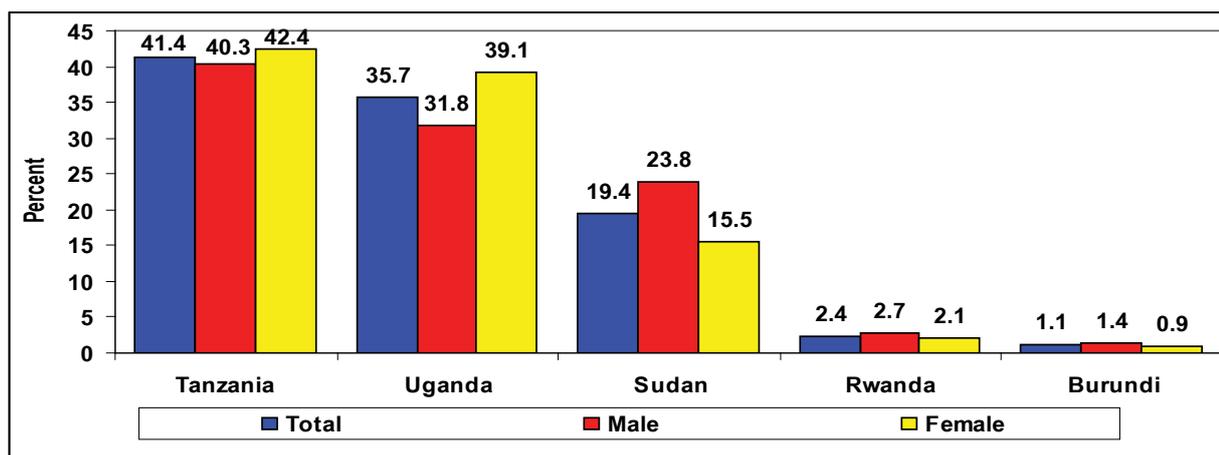
12.3.1 Immigrants from the African region

The 2009 census data show that the vast majority of the immigrants into Kenya were from Africa, their 357,468 numbers amounting to 84.0 percent of the country's entire migrant population, these figures excluding UNHCR refugees. Of the rest of the migrants, Asia accounted for 10 percent, Europe had a four percent share, and North America had two percent. Immigrants from Australia and the Caribbean accounted for less than one percent. By gender, female immigrants at 179,432 were slightly more than the male immigrants numbering 178,036, and females dominated immigrants from the rest of Africa. More than one-third of immigrants in Kenya reported by 2009 census (36.3%) were located in Nairobi Province, followed by North Eastern Province which accounted for 28.7 percent of the nationwide total (Ministry of Planning and National Development and Vision 2030 (MPND), forthcoming, Vol. VI).

A closer look at immigrants from other African countries provides interesting insights. Of the total 298,258 foreign population enumerated in 2009 census, 147,339 were men compared to 150,919 women. The majority of these — 60.5 percent — were from Eastern Africa, notably the greater Sudan (before split into two countries), Ethiopia, Eritrea and Somalia. The migration-distance decay is evident from the analysis made as immigrants from East Africa dominated (31.9%), followed in descending order by Central Africa (2.6%), West Africa (2.2%), South Africa (1.8%) and North Africa (1.0%). Most of the Eastern Africans — 63.5 percent of the men and 57.5 percent of the women — were refugees who had become integrated into Kenyan society. Those from the EAC partner states comprised 31.9 percent of the total immigrants from Africa; evidence of increased cross-border migration attributable to trade, marriage and other factors.

Figure 12.1 summarizes immigration from the four EAC partner states and Sudan, with whom Kenya shares membership of the Inter-Governmental Authority on Development (IGAD) and the Common Market for Eastern and Southern Africa (COMESA). As in previous censuses, immigrants from Tanzania and Uganda continued to come to Kenya in large numbers, followed by Sudanese immigrants. Immigrants from both Rwanda and Burundi were less significant. That women dominated the migrants from peaceful Tanzania and Uganda was as surprising as their not dominating flight from strife-torn Sudan, a possible hindrance in the latter case being distance.

Figure 12.1 Eastern African immigrants by country of origin and gender, 2009

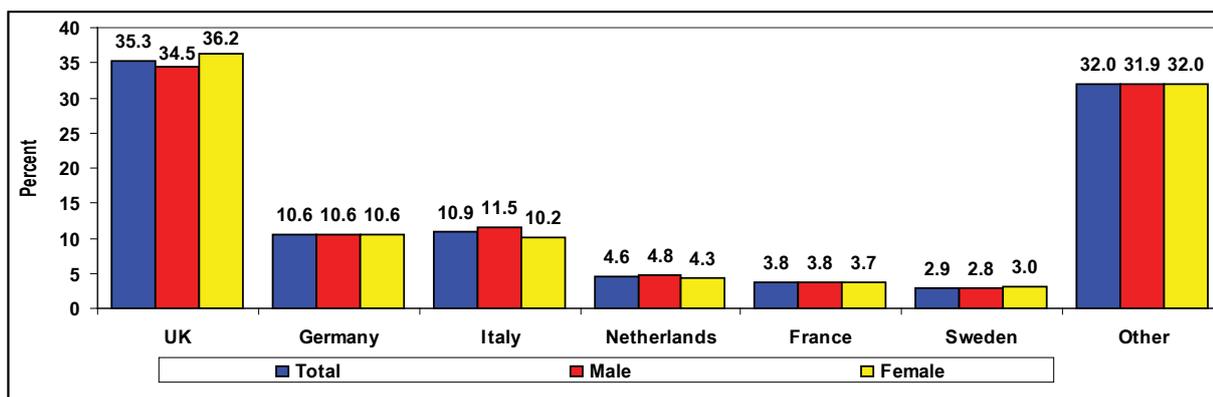


Source: MPND (forthcoming), Vol. VI, Figure 4.3.

12.3.2 European Immigrants

The total number of European immigrants in Kenya was 26,960, of whom 14,129 (52%) were males. UK immigrants led the other European countries with a total share of 35.3 percent, followed by Italy (10.9%) and Germany (10.6%). The rest of the European countries share about 43 percent of the total, led by the Netherlands, France and Sweden. There was no major variation in immigrants from these countries by gender.

Figure 12.2 European immigrants in Kenya by country of origin and gender, 2009



Source: MPND (forthcoming), Vol. VI, Figure 1.

12.3.3 Asian immigrants

Given the long connections between Kenya and Asians (notably the Indians who participated in the late 1896-1901 construction of the Kenya–Uganda railway line), about 78 percent of Asian immigrants to Kenya are of Indian origin. Interestingly, the Kenyan share of Chinese immigrants, a most recent group into the country, even exceeds that of the Pakistanis who have a history largely identical to that of the Indians⁶⁸. The gender distribution of Asian migrants is also interesting: while women constitute

⁶⁸ The Kenyan media has claimed – with the endorsement of public opinion – that many Chinese immigrants working on Kenya’s infrastructure (in particular roads) have increasingly become involved in street vending, which gives them an even higher profile than the earlier, arguably more class conscious Asian migrants, such as the Pakistanis.

about 48 percent of all Asian migrants into Kenya, the Chinese and Israelis do not bring their own women, a likely source of Kenyan inter-racial breeding.

Table 12.4 Immigrants by Asian country of origin and gender, 2009

	Country												
	Total No.	Japan		China		India		Pakistan		Israel		Other	
		Per- cent	No.	Per- cent	No.	Per- Cent	No.	Per- Cent	No.	Per- cent	No.	Per- cent	No.
Total	36,658	1.4	501	4.1	1,507	78.2	28,670	3.5	1,270	0.5	181	12.4	4,529
Male	19,102	1.2	237	6.2	1,191	76.7	14,646	3.0	581	0.6	108	12.2	2,339
Female	17,556	1.5	264	1.8	316	79.9	14,024	3.9	689	0.4	73	12.5	2,190

Source: MPND (forthcoming), Vol. VI, Table 2.

Note: No. = Number of immigrants.

Data from UNDESA's Population Division underscore the huge migrant stock in Kenya (Table 12.5). The country has a substantial proportion of young migrants aged zero to nine years most of who must have accompanied their parents or guardians into the country. This age group constituted more than one half of the migrant stock in Kenya and Eastern Africa, while the youth aged 10 to 19 years constituted one-tenth and just under one-tenth respectively of Kenyan and Eastern Africa migrant stock. The old age population comprises the smallest number of migrant stock in both Kenya and Eastern Africa.

Table 12.5 International Migrant Stock in Kenya and Eastern Africa by 2010

Age group (in years)	Migrant Stock			
	Kenya		Eastern Africa	
(a) Broad age groups	Migrant stock (‘000)	Percent	Migrant stock (‘000)	Percent
0-9	817.7	50.7	19,263.2	57.2
10-19	162.1	10.1	2,397.4	7.1
20-39	177.8	11.0	3,053.8	9.1
40-64	316.3	19.6	8,165.7	24.2
65+	137.5	8.5	820.4	2.4
	1,611.4	99.9	33,700.5	100.0
(b) Youth and old age	24.1			3,719.9
15-24	183.2			1,419.4
60+	41.4			

Source: UNDESA (2011).

Females constitute half of all immigrants across the age brackets in Kenya and in Eastern Africa (Table 12.6). Yet, the migrant stock as percentage of the total population of Kenya is below three percent in the stated age brackets. While the dominant share of females in the Kenyan migrant population persists across all age groups reported, the declining share of females in the Eastern African migrant population suggests that as they grow older, women migrants either return to their country of origin, or leave their country of migration in the region for other countries outside the region.

Table 12.6 Age distribution of female migrant stock in Kenya and Eastern Africa, 2010

Age group (in years)	Female migrants as percent of the international migration stock		International migrants stock as percent of the total population		Percentage distribution of international migrants	
	<i>Kenya</i>	<i>Eastern Africa</i>	<i>Kenya</i>	<i>Eastern Africa</i>	<i>Kenya</i>	<i>Eastern Africa</i>
0-9	50.5	51.9	1.6	1.0	41.6	28.3
20-64	51.0	44.8	2.5	2.8	55.5	67.4
65+	52.7	43.9	2.2	2.3	2.9	4.3

Source: MPND (forthcoming), Vol. VI, Table 5.

12.4 Refugees Inflows and Stock

The United Nations Convention Relating to the Status of Refugees of 1951 (in Article 1A) defines a refugee as a person who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country”. This definition was expanded by the 1967 UN Protocol, and by regional conventions in Africa and Latin America, to include persons who had fled war or other violence in their home country. Thus, refugees constitute a distinct category of international migrants. The 1969 Organisation of African Unity (OAU — which became the African Union (AU) in 2001) Convention Governing the Specific Aspects of Refugee Problems in Africa adopted the 1967 UN Protocol’s expanded definition of refugee to include people who left their countries of origin not only because of persecution, but also due to acts of external aggression, occupation, and domination by foreign powers, or serious disturbances of public order. The OAU/AU 1969 Convention was adopted soon after much of Africa became independent from colonialism and succumbed to the scourges of civil strife and wars.

Kenya’s relative peace and tranquillity during its independence years in a politically volatile region, has rendered it a dependable host country for a huge number of refugees, even if there were periods of declining numbers, as illustrated in Table 12.7⁶⁹.

Table 12.7 The Annual Stocks and Flows of Refugees in Kenya, 1991 to 2010

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Stocks	120,163	402,194	301,595	252,423	234,665	223,640	232,097	238,187	223,696	206,106
Arrivals/Departures	105,914	282,031	-100,599	-49,172	-17,758	-11,025	8,457	-6,090	-14,491	-17,590
Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Stocks	239,221	233,671	237,512	239,835	251,271	72,531	265,729	320,605	358,928	402,905
Arrivals/Departures	33,115	-5,550	3,841	2,323	11,436	-178,740	193,198	54,876	38,323	43,977

Source: World Bank (2013).

The data show that the majority of refugees in Kenya come from countries in the region that have had civil strife for decades. The stock of refugees from Somalia, Sudan, Burundi and other African countries dropped, while those of all other nations increased between 1999 and 2009 (Table 12. 8). This explains the volatility of the refugee stock in Kenya. Repatriation and voluntary return of Somalis, Sudanese, Ethiopians, Ugandans, Rwandese and nationals of other African countries explain the large drops in their respective stocks.

⁶⁹ The discrepancy in the stock of refugees shown in tables 7 and 8 might be attributable to the difference in data sources used.

Table 12.8 Stock of refugees in Kenya by country of birth, 1999 and 2009

	<i>Stock in 1999</i>									Total Refugees
	Somalia	Sudan	Ethiopia	Uganda	DRC	Eritrea	Rwanda	Burundi	Other African countries	
	141,088	64,254	8,191	5,947	251	90	2,858	205	303	
<i>Stock by sex in 2009</i>										
Total	103,345	7,657	3,832	405	706	32	238	236	77,230	193,681
Male	53,452	4,523	2,186	221	400	20	119	125	40,085	101,131
Female	49,893	3,134	1,646	184	306	12	119	111	37,145	92,550

Sources: MPND (forthcoming, Vol. I, p. 47; and Vol. VI).

Human Rights Watch (2012) noted that the overstretched refugee camp in Dadaab in north-eastern Kenya continued to receive thousands of new arrivals during the year, including some 34,000 people between January and September 2011. It further noted that many of the new arrivals from Somalia endured serious abuse at the hands of the Kenyan police as they crossed the border which had been officially closed, including violence, arbitrary arrest, unlawful detention in inhuman and degrading conditions, threats of deportation and wrongful prosecution for “unlawful presence”. This mistreatment was experienced by men, women and children alike with the Kenyan police reportedly raping women and consequently failing to investigate and/or prosecute related cases. In early 2010, huge numbers of Somali refugees were sent back to Somalia by the Kenya Government in flagrant violation of its own and international laws on managing refugees. Yet, the Somali refugee inflows will persist as long as Somalia remains a country without a strong Government.

12.5 Emigration of Kenyans

This section provides insights into the emigration of Kenya to other countries, primarily composed of skilled, semi-skilled and unskilled persons, those seeking education and/or employment abroad, and irregular migrants. One characteristic of all these categories is that they often maintain links with Kenya through remittances. The size of the stock of Kenyans abroad differs by source of data, since data is often reported either by citizenship or country of origin. Thus, the World Bank, OECD and the European Union countries (through EUROSTAT or national censuses) provide data whose numbers vary considerably even though the magnitudes are indisputable.

A survey by IOM in 2006 noted that the vast majority of emigrant Kenyans residing outside the African continent are in the United Kingdom, and that Tanzania ranks as the major country of destination of Kenyans residing elsewhere in Africa (Table 12.9). The table also provides insights on Kenyan emigrants’ remittances. The highest amount of remittances is from the United Kingdom, with United States a distant second.

Table 12.9 Number of Kenyans residing abroad and remittances sent by country of residence, 2006

Country of residence	Number of Kenyans residing	Percent of emigrant Kenyans residing	Workers' remittances sent through regular channels (Millions of US Dollars)	Percent of remittances sent through regular channels
United Kingdom	144,089	33	254	51
Tanzania	109,552	26	32	6
United States	48,250	11	94	19
Uganda	32,910	7	10	2
Canada	22,236	5	36	7
Germany	7,210	2	12	2
Other countries	63,077	14	56	11
Total	427,324	100	494	100

Source: IOM (2010), Table 1, page 5 (for details, see references).

Note: This table is inconsistent with Figure 3, which implies reliance on different sources of data.

The 2009 census reported 160,331 emigrants from Kenya, their origins almost evenly distributed in four main provinces of emigration: 20.8 percent from Rift Valley province, 17.8 percent from Central, 17.1 percent from Nairobi and 15 percent from Nyanza (Government of Kenya, forthcoming). The conflicting figures suggest that the various sources of data are irreconcilable.

Another study provides a picture of remittance flows into Kenya in 2004-2009, based on household survey data (Table 12.10). On aggregate, remittances increased steadily until 2009 when they dipped presumably because of the world economic crisis and the post-election violence in Kenya in 2008. While remittances from 'other' sources increased steadily over the six-year period, those from North America and Europe performed erratically.

Table 12.10 Remittance Flows in Kenya, 2004-2009

Aspect of remittance	Year					
	2004	2005	2006	2007	2008	2009
Volume (US \$ millions)	338.3	382.0	407.6	573.6	611.2	609.2
<i>By source</i>						
North America	61	59	57	50	50	52
Europe	26	27	28	34	32	26
Other	12	14	15	15	18	22

Source: Ngugi (20XX : 157), Table 6.1.

12.6 Brain Drain and Brain Circulation

The term *brain drain* denotes emigration of highly educated and skilled persons, often from the less developed to the more developed countries. It has dominated literature since the 1960s when it was considered a curse to the countries of origin (Glaser, 1978), but has since the 1980s been considered an asset to those countries, particularly as a contributor to development (Oucho, 2003; yet other studies consider its effects indeterminate (Ikenwilo, 2007; Oucho, 2010). There is no universally accepted definition of 'highly skilled' worker; but popularly, highly skilled workers are individuals whose jobs require knowledge and experience equivalent to a higher education/university degree, or those with scientific or technological training obtained through the completion of tertiary level education. According to the definitions cited by Özden (2005), skilled workers are those with an average education

of at least 16 years, and include managers, accountants, engineers, social workers and teachers, medical and legal professionals, and scientists. The same author defines semi-skilled workers as those with an average education between 12 and 16 years, including engineering technicians, police, secretaries, and administrative assistants. However, McDonald and Crush (2001: 6-7) provide a definition of “skilled” which goes beyond the conventional interpretation, arguing that:

“The functional core of an economy does not only consist of people with post-graduate degrees, in well-paying, high-level corporate positions...It is also sustained by people, who, despite having no advanced formal education, have started their own successful businesses, or play a critical role in the public sector... anyone who has special training or work experience which is in relative short supply in relation to the labour market as a whole.”

Whatever the connotation, “skilled” migration involves the movement by nationals with desired vocational attributes that, when lost to other countries, denies the losing country opportunities for developing itself if it had deployed such skills optimally. When both highly educated and skilled Kenyans emigrate, they leave gaps in the country’s labour market, which can potentially undermine development. To this end, Iredale (2001:16-18) identifies five typologies of skilled migration distinguished by: 1) motivation (forced exodus; ethical emigration; brain drain; Government induced; and industry led); 2) nature of source and destination (originating in less developed or more developed countries and moving to more developed or less developed destinations); 3) channel or mechanism of movement; 4) length of stay — permanent or circulatory/temporary; and 5) by mode of incorporation (through integration) of the skilled into destination economies.

A study of the levels of international skilled emigration to OECD countries in 1990 and in 2000 ranked Kenya in 29th position, with an emigration rate of 38.4 percent (Docquier *et al.*, 2006).⁷⁰ The study ranked Kenya fourth in brain drain intensity when the sample was restricted to countries with populations of up to five million; and third among African countries. The study reported further that immigrants constituted 38 percent of Africans in the EU-15 in 2000, compared to 82 percent of the African stock in the United States, *implying heavier emigration to the latter* (author’s emphasis). Indeed, the 2006 study found that the share of Kenyan emigrants with tertiary education was much higher than that of the unskilled: in 1990, 11 percent of Kenyan emigrants to the US had tertiary/university level education, while only 0.2–0.3 percent had up to secondary level education, and 0.1 had only primary school education (Docquier *et al.*, 2006). If this is a pattern rather than a one-off situation, then these findings suggest that Kenyans and African immigrants in general, are likely to be highly skilled. One of the most adversely affected sectors by emigration in Kenya is the health sector, about which a 2005 study made startling findings. It found that the total cost of educating a Kenyan medical doctor from primary school to university was US\$65,997; and that for every doctor who emigrates, the country loses about US\$517,931 worth of returns from the initial investment (Kirigia *et al.*, 2006). The total cost of educating one nurse from primary school to a college of health sciences was US\$43,180, with their emigration resulting in a loss of about US\$338,868. The study concluded that developed countries continue to deprive developing countries like Kenya of much needed, scarce human resources for health (and other professionals), thus undermining the prospects of achieving development objectives, such as those contained in the Millennium Development Goals.

⁷⁰ In the abstract of their article, Docquier *et al.* (2006) clarify their methodology as follows: “An original data set on international migration by educational attainment for 1990 and 2000 is used to analyze the determinants of brain drain from developing countries. The analysis starts with a simple decomposition of the brain drain in two multiplicative components, the degree of openness of sending countries (measured by the average emigration rate) and the schooling gap (measured by the education level of emigrants compared with natives). Regression models are used to identify the determinants of these components and explain cross-country differences in the migration of skilled workers.”

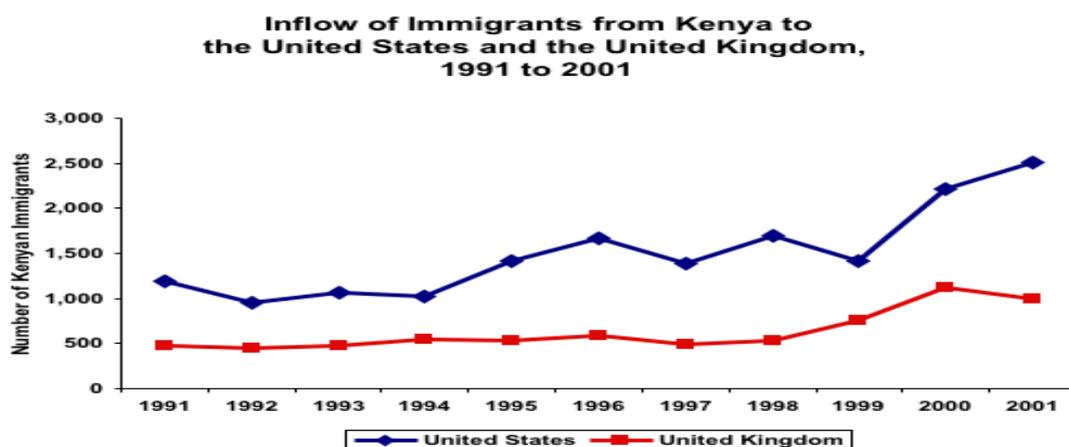
12.6.1 Triggers of Emigration

Against the backdrop of persistent labour activism over terms and conditions of employment in both the health and education sectors in Kenya, emigration is likely to persist. In Kenya, there are educational institutions that, through accreditation, recognise educational equivalents from curricula of immigrants' countries of origin. In Nairobi and other major urban centres in the country, the country has permitted the establishment of schools offering non-Kenyan curricula, such as the German, Swedish, and French schools, the International School of Kenya, and a handful of other British and American preparatory schools. While such schools are primarily for expatriates, they also attract a few Kenyans who can afford their often exorbitant fees. Various foreign missions in Kenya also invest extensively in marketing their cultures to Kenyan youths, including the British Council, Goethe Institute, French Cultural Centre, and Italian Cultural Centre, to name a few. Such exposure to foreign values enhances the desire of, or prospects for, young Kenyans' emigration to the respective home countries of the various institutions.

Yet, such outcomes merely follow a tradition whose foundations were laid around the time of independence when a large number of Kenyans were sent overseas for higher education and skills training. In the context of the emerging Cold War, the United States received the young Kenyans through the *Mboya Airlift*, even as the defunct Soviet Union and its Communist satellite states also received students under the *Odinga Airlift*⁷¹. Yet both the Western and Eastern bloc investments in the education of Kenyans and peoples from other newly independent developing countries were not entirely altruistic: the anticipated influence of such graduates in the soon-to-be independent Governments contained potential political and material benefits for their respective benefactors. However, while virtually all the eastern-trained Kenyans promptly returned, some among the western trained ones never did, laying the foundations of the contemporary brain drain phenomenon.

Figure 12.3 provides a ten-year record of emigration of Kenyans to the United States. Given Kenya's colonial links with the UK, it is interesting that three decades after independence, the number of Kenyans going to the US was more than double that of those going to the UK.

Figure 12.3 Inflow of Immigrants from Kenya to the United States and United Kingdom



Source: Migration Policy Institute (2013).

Note: This figure depicts information that is inconsistent with data on Table 9, which implies reliance on different sources of data.

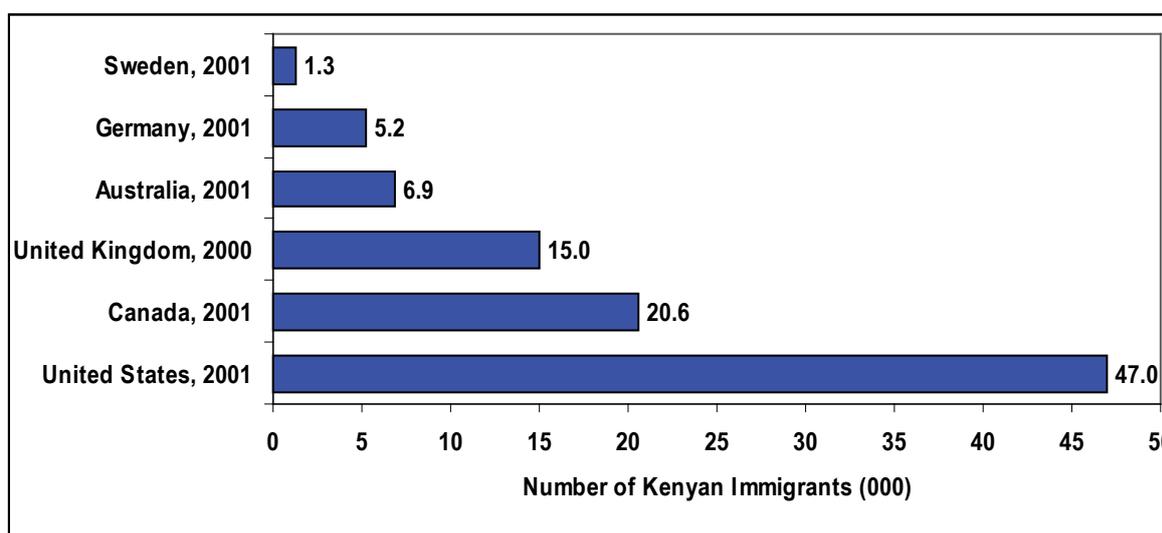
⁷¹ As in the Cold War, newly independent Kenya's politics soon became polarized between a right wing led by Tom Mboya who managed the US airlift, and a left wing led by Oginga Odinga who oversaw the Eastern European scholarships.

During the middle years of ex-President Moi's two and a half decades tenure (1978-2002), and especially in the wake of the abortive 1982 *coup d'état*, political repression and general economic uncertainty drove a large number of Kenyans into self-exile, while many others who were already overseas either postponed their return, or abandoned the idea of ever returning. The defeat of the independence party KANU at the 2002 general elections encouraged some Kenyans to return and contribute to the National Alliance Rainbow Coalition (NARC) party's *Economic Recovery Strategy* which revived the economy. However, rampant political parochialism would lead the country to near disaster over the 2005 national referendum on the proposed constitution, and the 2007 presidential elections, deterring further return migration from the Diaspora. Additional to these deterrents, the old Kenya constitution had provided for exclusive Kenyan citizenship, meaning returning Kenyans who had struggled to acquire permanent residence status in country of exile would have had to surrender such status, or return to Kenya as non-citizens. With the dual citizenship provided for in the Kenya Constitution 2010, and the increasing embrace of the Kenyan Diaspora in development, previous generations of emigrant Kenyans are likely to become trans-national citizens.

Unemployment, rampant corruption, ethnicised politics and nepotism conspired with other shortcomings to bring the country's development to a halt under former President Moi (Oucho, 2002). Unsurprisingly, by 2001 sizeable numbers of Kenyans resided in different countries in the developed world, amongst others, US, Canada, UK, Australia, Germany and Sweden (Figure 12.4). Meanwhile, Kenyan students have continued to dominate the African student populations abroad: in 2001-2002, for example, Kenya had the highest number of African students in the US, numbering 7,097 compared to 3,820 Nigerians, 2,672 Ghanaians, 2,409 Egyptians and 2,232 South Africans. In 2009, the top five countries of origin for the 1.5 million African immigrants in the United States were Nigeria (14.1%), Ethiopia (9.9%), Egypt (9.3%), Ghana (7.3%) and Kenya (5.8%) (McCabe, 2011).

It is, therefore, not surprising that the Kenya Government puts a premium on the Kenyan Diaspora and its engagement with their motherland. The move towards the realisation of a Diaspora Policy and the adoption of Citizenship Act 2011 underline the importance Kenya has attached to its Diaspora over the last decade. In December 2011, the First Diaspora Homecoming Conference was held in Nairobi to woo Kenyan investors to their country (Mwakilishi, 2011).

Figure 12 .4 Stock of Kenyan Immigrants for selected Countries



Source: Migration Policy Institute (2013)

Even in Germany, a most unlikely destination, the number of Kenyans more than doubled from 576 in 1980 to 1,222 by 1990, and reached more than 5,200 by the end of 2001. These figures reveal the geographical spread of Kenyan emigrants across Europe, beyond the country's historical European partner, the UK. In sub-Saharan Africa, Kenya is perhaps the most dependable source of the kind of human resources that emigrates among countries in the region. Throughout the 1990s, Kenyan elementary and high school teachers were recruited to work in the island states of Comoros and Seychelles, as well as in Rwanda, Burundi and Democratic Republic of the Congo. This skilled emigrant traffic has also gone to the buoyant southern African economies of South Africa, Botswana and Namibia, and to Zimbabwe before its economic decline (Oucho, 1998).

Often neglected whenever Kenyan emigration is considered is the emigration of Kenyan Asians (notably Indians and Pakistanis) who have been an integral part of the country. At Kenya's independence, some of these took advantage of existing loopholes/permissiveness, to become triple citizens, of Kenya itself, of the Asian country of origin, and of Britain which initially brought them and/or their ancestors to Kenya. Today, many Kenyan emigrants of Asian origin have achieved economic success overseas while maintaining links with the home country, such as Pakistan (Poros, 2001), and with Kenya where some of their relatives still live. They have gone through successive phases from being indentured labour to becoming business magnates, as globalisation has taken a firm grip on the world economy (Heizig, 2006). Clearly, Asians will be great beneficiaries of the new constitutional provision for dual citizenship, as it will enable them to enjoy the economic fortunes they are likely to make in the country.

With stringent immigration controls in most developed countries of destination, Kenyans, like all other African emigrants, have resorted to *brain circulation*, the movement back and forth between a country of origin and a country of destination without recourse to permanent residence. The free spirit nature of this practice might even make it more attractive than dual citizenship.

12.6.2 Brain Waste: An Unknown variant of Brain Drain

Most countries of emigration fail to grapple with the *brain waste* experienced by their nationals who emigrated. Torres and Wittchen (2010), for instance, argue that most Kenyan immigrants who arrive in developed countries experience brain waste working in situations, and consequently drawing remuneration beneath their qualifications⁷². Yet, Torres and Wittchen's (2010) evidence is contradictory: in the 1970s, the probability of a Kenyan Bachelors degree holder getting skilled employment in the US was 34 percent, rising to 38 percent in the 1980s, and to 59 percent in the 1990s. Additionally, the authors found that about 71 percent of Kenyan emigrants with a Master's degree got skilled jobs, compared to 63 percent of those with professional/bachelor degrees. Thus, these data demonstrate that brain waste diminishes among migrants with enhanced qualifications.

12.6.3 Imperfect knowledge of Emigration of Unskilled and Semi-skilled Kenyans

These unskilled and semi-skilled emigrant Kenyans are normally mainly destined for the Middle East where they work as domestic workers, office assistants, truck drivers and such like occupations. Kenyan newspapers report numerous cases of emigration of unskilled and semi-skilled Kenyan labour to the Middle East, in particular domestic workers whose contractual agreements and individual rights were violated by their employers, and who returned to the country under duress. Unfortunately, Kenyan censuses have no figures on emigrants by occupation or skill levels, and the African countries receiving large numbers of Kenyans might be reluctant to divulge their numbers through unofficial circles. While some of the emigrant labour had been recruited by private recruitment agencies of low integrity in

⁷² The authors note that they included Kenya among their case studies because it is located centrally on the continent, with a population abroad that is among highest of African countries, and is also among the top five African countries suffering from brain drain, and likely brain waste.

Kenya, resulting in problems at the emigrants' destinations, others went out of the country as irregular emigrants: part of human trafficking and/or migrant smuggling. Kenya's Ministry of Foreign Affairs receives Kenyan workers' complaints ranging from mistreatment, lack of payment of salaries, overwork, denial of food and lack of communication opportunities with their relatives back home. As a result of frequently reported cases of maltreatment of emigrant Kenyan workers in the Middle East, the Government has had to suspend the recruitment of Kenyan workers to the region (Sing'oei, 2012). This move might inadvertently spur irregular emigration: migrant trafficking and smuggling to the Middle East. This category of emigrants can be considered illegal in the destination countries where they possess no immigration documents, and irregular given the mode of migration as interpreted by the two trafficking and smuggling protocols – HTP and MSP respectively.

12.7 Irregular Migration: Human Trafficking and Migrant Smuggling

There are good prospects for irregular emigration of Kenyans, especially to the Middle East, involving both trafficking and smuggling. Broadly speaking, irregular migration is "international movement or residency in conflict with migration laws", or "crossing borders without proper authority, or violating conditions for entering another country" (Jordan and Duvell, 2002:15). The confusion in academic and policy discourses in interpreting trafficking as opposed to smuggling might arise in Kenya where both phenomena are occurring, with Kenya as an origin, transit or destination country, or a combination of all three. 'Trafficking' involves dealing in people who have been deceived, threatened or coerced into exploitation (including prostitution), whereas 'smuggling' involves the willing purchase by a prospective migrant of services to circumvent immigration restrictions (Carling, 2006: 9). While Articles 27-30 of the Kenyan Constitution underscore freedom of movement, Article 30 specifically protects against slavery and servitude, which are characteristic of human trafficking and migrant smuggling. The country criminalizes the trafficking of children and adults for sexual exploitation through its Sexual Offences Act, enacted in July 2006, which prescribes penalties considered sufficiently stringent and commensurate with those for rape. This Act is in tandem with the Employment Act of 2007 which outlaws forced labour and which contains additional statutes relevant to labour trafficking (US Department of State, 2008). Trafficking does not affect unskilled and semi-skilled emigrant labour only; it also involves graduates from Kenya: Haddadi (2012) reports that an international human trafficking ring works with employees of some embassies in Kenya to trick gullible Kenyans into forced labour in the United Arab Emirates, Saudi Arabia, and Qatar; but the exact numbers of graduates trafficked or smuggled is unknown given the sensitivity of the matter.

Through research, IOM sought to establish a baseline on human trafficking in Eastern Africa, distinguishing the push factors from the pull factors (IOM, 2008: 5-6). The research also sought to establish the profiles of trafficked persons and the traffickers, the processes through which victims are recruited, and for what alleged purposes, the origins, transit modes and routes, and the destination areas of trafficking, and the health challenges faced by trafficking victims. The IOM research established that for Kenya, the groups most predisposed for trafficking included bar workers, prostitutes, domestic workers, orphans, refugees and street children (p. 18). Kenya was the destination of human trafficking from Tanzania, Uganda, Sudan, and Somalia and as far away as South Africa (p. 14). Except for domestic work in trafficking destinations that the media has been reporting as reserved for women and girls, men worked as manual labourers, skilled/semi-skilled/professionals, in the streets, as entertainers and in other informal/illegal work (p. 32).

The main lesson drawn from the IOM study is on the extent of destruction human trafficking visits on the victims who may never overcome their trauma despite extensive rehabilitation. An IOM counter-trafficking officer stated that:

“Mombasa is a source, destination and route of trafficking. Individuals, especially girls from as far as Uganda, Tanzania and Democratic Republic of Congo come to Kenya with hopes of linking up with rich tourists but some of them unfortunately turn them into sex slaves. Brothels and massage parlours have turned to be exploitation dens for foreign young women... victims are trafficked from Rwanda, Democratic Republic of Congo, Ethiopia, Uganda and Somalia and are coerced to work in these establishments, increasing their vulnerability to sexual exploitation or (are) forced into prostitution.”

The Executive Director of Trace, a counter trafficking organisation based in Mombasa, observed that other victims of trafficking and smuggling are ferried by traffickers through Mombasa as a transit route: the victims are brought from Asia and Pakistan through the town, learn Kiswahili and then work for other Asians, eventually heading to Canada and Europe (Mudi and Oriedo, 2009).

For Kenyans, research established that the main perpetrators of human trafficking were owners of stores (15%), followed by unskilled manual labourers (14%), semi-skilled manual labourers (10%) and other persons (11%) (IOM, 2008: 56). The health risks of trafficking that were identified at rehabilitation centres were extensive, and were experienced at recruitment points, in transit, at destinations and on return migration (IOM, 2008: 63). Mudi and Oriedo (2009) report that in November 2008, the police discovered a Nairobi syndicate from which it rescued 76 women who were being trafficked to Saudi Arabia, having already received money for their medical tests and visas. It is likely that many such enterprises are undetected, disguised as private agencies recruiting unskilled labour for overseas placement. The victims of human trafficking and migrant smuggling fall prey to various tricks. The IOM's (2008) baseline study of Eastern Africa provides useful insights into this criminalised phenomenon, whereby the main traffickers were females.

12.8 Kenya in the Regional Migration context

Kenya is a member of four Regional Economic Communities (REC) serving different African sub-regions, as listed in Table 11. All the RECs embrace — even if only nominally — protocols underlining the “free movement” of populations, as well as capital and products, to enhance the scope for sharing common opportunities and challenges. In several contexts within these RECs, Kenya enjoys a comparative advantage which in some instances attracts admiration, while in others, it incurs displeasure, as Kenya is seen to benefit disproportionately, such as over employment opportunities. The latter prejudice is surprising given that emigrant skilled labour is readily recruited in virtually all the member states of respective RECs, and that virtually all African RECs have, albeit incompletely, adopted protocols on free movement (‘facilitation of movement’ in the case of the Southern Africa Development Cooperation) of the factors of production. As the RECs have not made major strides in implementing existing protocols, the ‘free movement’ ideal remains just that, an ideal. Table 12.11 suggests that free movement is important in the listed protocols; but prejudices such as mentioned above suggest the need for research to delve into and document citizen perceptions of the protocols and their implementation (Oucho, 2012).

Table 12.11 Kenya’s membership in Regional Economic Communities

REC	Date of formation	Member States
CEN-SAD (Community of Sahel-Saharan States) Free movement of persons, capital and observance of the interests of member states’ nationals	1998	Benin, Burkina Faso, Central African Republic, Chad, Cote d’Ivoire, the Comoros, Djibouti, Egypt, Eritrea, the Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Libya, Kenya , Mali, Mauritania, Morocco, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Somalia, Sudan, Togo, Tunisia
COMESA Free movement of persons, labour, services, right of establishment and residence	1993	Burundi, the Comoros, Democratic Republic of Congo , Djibouti, Egypt, Eritrea, Ethiopia, Kenya , Libya, Madagascar, Malawi, Mauritius, Rwanda, Somalia, Seychelles, Sudan, Uganda, Zambia, Zimbabwe
EAC Protocol on the Establishment of the EAC Common Market has Free Movement of goods, persons, labour, services and capital, right of establishment and residence	2001	Burundi, Kenya , Rwanda, Tanzania, Uganda
IGAD ^a Development of a protocol underway	1996	Djibouti, Ethiopia, Kenya , Somalia, Sudan, South Sudan, Uganda

Source: Ouchou (1998: 266), Table 7.1; updated from Wikipedia.

^aEritrea has withdrawn its membership of the REC, a decision which IGAD endorsed given the intransigence of the state.

12.9 Consequences and Implications of International Migration

12.9.1 UN International Migration Instruments and Policymaking in Kenya

The signing of a UN instrument is one thing; but its ratification never guarantees implementation. That Kenya has signed five of the six UN instruments on the different characteristics of international migration, suggesting commitment⁷³; yet, the country has dithered on implementation. Most surprising is Kenya’s failure to sign the 1990 MWC when it is both a country of origin and a destination of huge numbers of migrant workers who might be accompanied by members of their families. Thus, Kenya can both expel immigrant workers and receive Kenyan workers expelled from other countries.

12.9.2 Threat of Heavy Immigration from Different Regions

A cursory review of how Kenya handles immigration issues suggests that heavy inflows of people from diverse origins threaten the political and socio-economic fabric of the society. While the Congolese, South Sudanese, Ethiopians and Somalis came into the country as refugees, many of these have remained in the country long after the restoration of order in their respective countries. The last three groups have taken undue advantage of coming from contiguous states to stay and do business, some of them without the necessary immigration papers or work permits. A more curious feature is the growing number of West Africans in Nairobi. A number of citizens of Mali, Senegal, Cameroun and Nigeria, who live in Nairobi engage in street vending and other unskilled occupations that should be reserved for

73 Except for the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the country has signed the refugee-based Convention relating to the Status of Refugees (1951), the Protocol relating to the Status of Refugees (1967); the OAU/AU Convention Governing the Specific Aspects of Refugee Problems in Africa (1969); the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000); and Protocol Against the Smuggling of Migrants by Land, Sea and Air (2000). The latter two fall within the United Nations Convention against Transnational Crime.

Kenyans. It is a category of immigrants requiring careful research into who they are and what they do for a living because they could be a great expense to the country. Kenya's *Business Daily* (2013) reported a ban on foreign workers earning below Kshs168,000 (about US\$1,976) per month, or those below 35 years of age from securing work permits⁷⁴.

There is some evidence that the unstable situation in Somalia has adverse consequences for Kenya. Remittances to Somali refugees — most probably also financed by piracy revenues — are enabling Somalis in Kenya, including refugees, to take over key areas of the Central Business District economy, such as forex bureaux, restaurants, business and residential real estate, and are moving deeper into the countryside, such as in introducing high-tech fishing methods in Lake Victoria. Moreover, the refugees unwillingness to live in designated camps compounds the threat already posed by the Al Shabaab terrorist group. Indeed, it is conceivable that the refugee situation could have been one of the causes of the mismanagement of 2009 census in North Eastern Province, which led to delayed publication of the comprehensive census results.

12.10 Contribution of the Kenyan Diaspora in Homeland Development

Some analysts have observed that migration by Africans is an emigration–Diaspora–return continuum (Adepoju, 2006, quoted in Kinuthia and Akinyoade (2012). In the 1960s and 1970s, emigration, especially of the highly skilled and educated, was considered a drain of a country's human resources. However, some analysts like Glaser (1978) considered the brain drain a "safety valve" to leverage unemployment. Thus, emigration of highly educated and skilled Kenyans was to be seen as an employment opportunity for graduates at various levels of the education system who increasingly failed to obtain paid jobs while also finding it difficult to go into viable self-employment. Today, a growing number of developing countries and international institutions now view migrants in the Diaspora as an antidote to the very brain drain that some people saw their departure to have created, with a great role to play in national development. A paramount factor here is that migrants can contribute to developing their countries of origin through remittances, gifts or even investments.

12.10.1 Foundations of the Kenyan Diaspora

It was earlier stated that the foundations of the Kenyan Diaspora were laid by the academic airlifts of the late 1950s and early 1960s. The initiative was part of a cultural programme organised under the auspices of the African-American Students Foundation (AASF), which sponsored African students at the height of Africa's decolonisation between 1959 and 1963. This US initiative was countered by one to the communist East; and India and later China, which also offered further opportunities for Kenyan students. Yet one important phenomenon emerged in the US airlift: some Kenyan students opted for US citizenship, which became an implicit challenge to other young Kenyans to follow in their wake to the 'El Dorado'.

The number of emigrant Kenyans has increased, with large communities being found in UK, US and the Far East. It is estimated that in 2006, approximately 430,000 Kenyans — approximately 1.1 percent of the current national population — were residing abroad (World Bank, 2007a, quoted in IOM, 2010: vii). Recent evidence suggests that Kenyans in the Diaspora represent eight percent of all Kenyans, with some working and others studying (World Bank, 2011). The big increases in the volume of remittances, and in the face of threats to the country's traditional exports, such as tea and coffee as well as tourism, Kenya places a special interest in remittances. This explains the Government's encouragement for the Diaspora to participate in national development, with the real estate sector attracting a substantial

⁷⁴ See <http://www.businessdailyafrica.com/Corporate-News/Kenya-locks-out-young-and-low-paid-foreign-workers/-/539550/1450584/-/1408lhs/-/index.html>; accessed on 17 February 2013

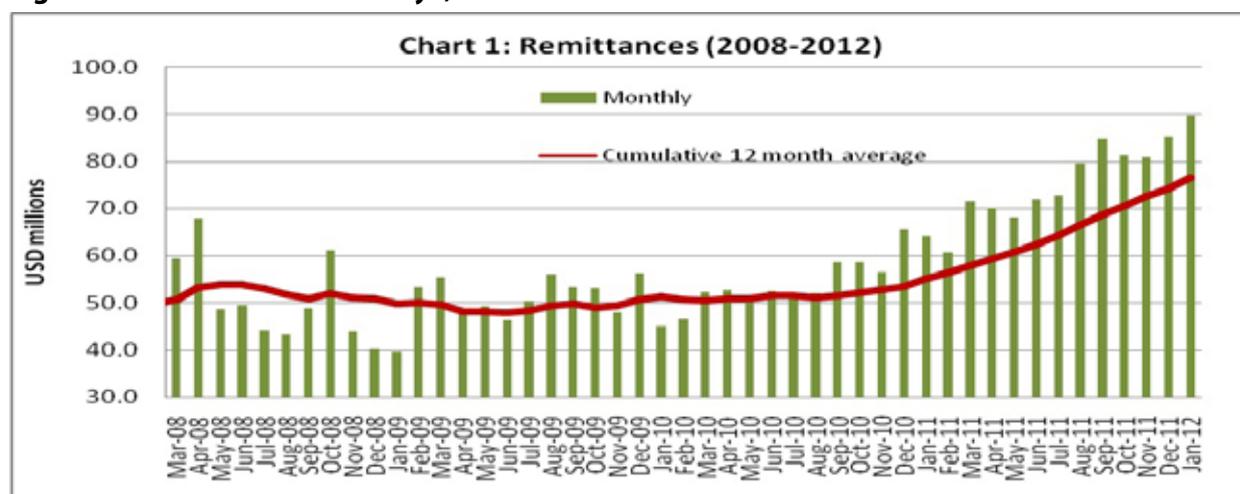
part of remittances. According to Matunda Nyanchama, a successful Kenyan information computer technologist, entrepreneur, and publisher in Canada, “Kenyans occupy almost every profession and job as engineers, business people, professors, doctors, nurses, technicians, factory workers, babysitters, and watchmen, among others.” During preparations for the 2013 General Election, it was estimated that about one million Kenyans live in North America alone. Some estimates put the Kenyan Diaspora at over 2.5 million in North America, Southern Africa and the neighbouring Eastern African countries.⁷⁵ These divergent estimates are, however, not based on sound Kenyan data or from the countries of destination. The Diaspora growth can increase remittances that could substitute foreign exchange constraints.

12.11 Migrants’ Remittances

Kenya receives, on average, 60 percent of total remittances to East Africa, and an average of 10 percent of all remittances to the sub-Saharan Africa region (Ngugi, 2011:157). In 2009, inward remittances to Kenya stood at US\$1.7 billion, representing 5.4 percent of GDP (World Bank, 2011). A study by the World Bank put total remittances by Kenyans in the diaspora in 2010 at \$1.9 billion, about 20 percent of Kenya’s current annual budget. As with most such data, however, the figures differ according to data sources and conceptualisation.

One analysis of the remittance service provider (RSP) market in Kenya found service gaps, inefficiencies, and unmet demand, especially among low-income groups and micro- and small-business enterprises (Kabbucho, Sander and Mukwana 2003, quoted in Ngugi, 2011). FinScope Kenya (2007) found that the mobile-phone money transfer service *M-PESA* — which entered the domestic remittance market in 2007 - had become the most popular mode of domestic money transfers, and is currently working with Western Union to kick off cross-border money transfer services (Ngugi, 2011). Other mobile telecommunications providers, such as Airtel and Yu, have followed in *M-PESA*’s wake. Additionally, various commercial banks have also introduced mobile-phone money transfer facilities to any of the networks in Kenya, such as Kenya Commercial Bank with *MOBI*⁷⁶. The Central Bank’s (CBK) record of remittances to the country summarised in Figure 12.5 shows a rising trend in the four years under review, even if the figures have not been adjusted for inflation (2008-2012).

Figure 12.5 Remittances to Kenya, 2008-2012



Source: Central Bank of Kenya (2012)

⁷⁵ The draft Diaspora Policy of Kenya, dated 9 March 2011, estimates a 3 million Kenyan Diaspora, a figure that has been quoted almost everywhere; see Republic of Kenya, Diaspora Policy of Kenya (draft), March 2011, p.6.

⁷⁶ Kenya is the first country in Africa to use M-PESA—a Safaricom service (in partnership with Vodafone) that provides a fast, safe, and affordable way to transfer money by mobile phone. The system has been introduced for Kenyans living in diaspora with the result that they now transfer funds through mobile-phone system rather than through the more expensive money transfer organisations (MTOs) such as Western Union or Money Gram.

The 2010 IOM study found that majority of its respondents sent remittances to support their families (83.1%); but other non-exclusive priorities included businesses and investments (23.8%) and community development (19.9%) (IOM, 2010: 14). Remittances for business and investment, and for community development, were more common among the respondents with a household income above £50,000 and those educated to the Masters level. This indicates that there may be a positive correlation between level of education and ability to initiate investments in a migrant's country of origin. Perhaps the mushrooming of the real estate sector in Nairobi and other Kenyan towns is attributable — even if only partially so — to the steady inflow of diaspora remittances to the country.

12.12 Diaspora Participation in Kenya's Political Changes

The Kenyan Diaspora has played an important role in Kenya's political advances, leading to significant improvements in democratisation and good governance, witnessed especially since 2002. In their associations and links with other well-wishers, the Kenyan Diaspora has participated effectively in the socio-political and economic discourses taking place at home. These include raising funds to support presidential and parliamentary candidates in the 2002 and 2007 general elections, and sustained technical contributions to the 20 year constitutional review that eventually led to the August 2010 promulgation of a new constitution incorporating dual citizenship. The Diaspora has also helped Kenya to nurture modern technology, notably increased ICT utilisation.

Diaspora Kenyans have also sustained their national identity by participating in a variety of cultural activities and commercial ventures; yet, certain parochial stereotypes still constrain solidarity among them to the extent of reconstructing ethnic identities abroad, such as in Kikuyus dominating the Boston area, while Luos identify with New Jersey and Dallas, and Kisiis with Minneapolis. This characteristic is, however, consistent with the network theory of international migration (Massey *et al.*, 1993: 448-9) which argues that "migrant networks are sets of inter-personal ties that connect migrants, former migrants, and non-migrants in origin and destination areas through ties of kinship, friendship, and shared community origin." Such ties — effectively, social capital — increase the likelihood of international movement by lowering the costs and risks of movement, while increasing the expected net returns to migration.

One way in which to gauge the Kenyan diaspora's vibrancy is with its solidarity in scholarship. In 2008, the Kenya Scholars and Studies Association (KESSA) was founded to promote scientific research and scholarship, cooperation and to facilitate the dissemination of information and publications on Kenya. Its role can be clearly accessed in the website <http://kessa.org/home/conferences> and on its online peer-reviewed academic journal, the *Kenya Studies Review*, as well as through the books it has published. Meanwhile, Kenyan students and its enterprising professional class have been attracted to seek greener pastures in Australia because of its liberalised immigration policy.

12.13 Challenges and Opportunities

12.13.1 Challenges

Among the biggest challenges in discussing international migration is the dearth of data which constrains meaningful and detailed analysis and interpretation of context. In Kenya, while the periodic censuses have generated immigration data, and lately emigration data, a number of potential datasets remain untapped. Such sources include data on visas and work permits, border-post data and passenger surveys at international airports. Second, no international labour market surveys have been undertaken to inform Kenya about its immigrant labour, especially those trafficked and smuggled to undertake jobs that Kenyans are overqualified for. Third, information on emigrant Kenyans is incomplete, leaving room for speculation on the size and profile of the Diaspora, including such information as current and

previous employment and residence. While the nature and character of the Diaspora can be gleaned from its involvement in Kenya's development (such as through remittances), its meetings at emigration destinations, and occasional homecoming ventures, do not provide a comprehensive perspective of the phenomenon. The perpetually growing refugee stock (see Table 12.8) poses serious challenges to Kenya's development, including the peaceful implementation of the Constitution (2010) and successful containment of the threat of terrorism in contiguous states. Kenya's comparative peace, stability and prosperity in the Eastern Africa means it is likely to continue to offer refuge to people from unstable states, making it imperative for policy to address the refugee burden in the context of the country's international obligations.

Immigration to Kenya, and emigration from it, has hitherto taken place devoid of a national migration policy⁷⁷. Yet UNDESA data, presumably collected from authoritative Government sources, reveals that Kenya views both its immigration and emigration situations as satisfactory and wishes to maintain the status quo. It is time, however, for Kenya to devote attention to desirable effects of immigration and emigration with a view to sustaining them while taking steps to eliminate undesirable effects. The country's dual citizenship policy has far-reaching implications for substantive or would-be takers that need to be periodically monitored and evaluated to assess impact; which has led to the Government's launch of new regulations for work permits⁷⁸. To this end, the Kenya Citizen and Foreign Nationals Management Services Board has the onerous task of reviewing existing migration management policies, and promptly acting on the findings. Given the persistent complaints from Kenyan emigrants to the Middle East, the country requires properly crafted bilateral arrangements for the mutual benefit of both emigrant labour and its employers.

A related issue that is emerging among Kenyans, who have hitherto not been xenophobic, is concern with the growing number of immigrants of diverse backgrounds who come to, or stay on in the country after retirement. This is an area that policy must target before it precipitates into the xenophobia that has been observed in southern Africa's buoyant economies (Crush and Pendleton, 2004). The Kenyan case appears in recent newspaper reports which indicate that Kenyans are increasingly becoming wary of immigrants from non-English speaking countries, and even from English-speaking ones whose nationals were formerly banned from coming to the country. The wave of xenophobia has been building especially against Somalis, following a spate of bomb and grenade attacks on churches and minibuses attributed to the Al-Shabaab insurgents of Somalia and their recruited agents operating in Kenya.

12.13.2 Opportunities

The challenges mentioned in the previous sub-section can be transformed into opportunities. For example, the large Kenyan Diaspora has been sufficiently active in the country's recent political deliberations as to achieve the constitutionalisation of dual citizenship, which has opened up avenues for enhanced Diaspora participation in national development. Also, Kenya has made significant contributions to brokering peace in countries formerly torn apart by the war: South Sudan's 2009 peace accord with Khartoum led to the birth of Africa's newest nation in July 2011; and Kenya's intervention in Somalia has uprooted insurgents, allowing the re-establishing of a civilian Government. Additionally, since NARC Government's accession to power in 2003, Kenya has introduced legislation that should improve the context within which international migration occurs, such as the Counter-Trafficking in Persons Act (2010) which seeks to manage human trafficking.

To the extent that constrained opportunities for gainful employment drove emigration, the Kenya

⁷⁷ During 20XX, IOM sponsored work on a Kenyan migration policy which is yet to be presented to stakeholders. It is hoped the policy will be broad enough to capture different types of international migration discussed above, and strategies for managing them.

⁷⁸ See <http://www.businessdailyafrica.com/Corporate-News/Kenya-locks-out-young-and-low-paid-foreign-workers/-/539550/1450584/-/1408lhs/-/index.html>

Vision 2030 and constitutional devolution to county Governments will provide great opportunities for prospective returnees, or individuals wishing to exploit dual citizenship and/or brain circulation. An underlying imperative of Vision 2030 is that the Government will make Kenya an increasingly attractive investment destination, attracting international capital, including that held by Kenyans in the Diaspora. In turn, devolved system of Government has shifted the locus of extensive public spending from Nairobi to the counties, which will now become a new locus for investment spending, including by Kenyans in the Diaspora.

12.14 Some Policy Recommendations

Like many other SSA countries, Kenya has a dearth of data on international migration, among the reasons for this being the lack of a broad-based migration data policy⁷⁹. To this end, the country should emulate the IOM (2010) study in the United Kingdom and the work of countries, such as India, the Philippines, and Jamaica that have succeeded in accounting for their people in the Diaspora. Such work should gauge the extents of Kenya's brain drain, brain waste and brain circulation in the West and in other loci of emigrant labour, including the Middle East and the rest of Africa. Indeed, attention to South-South migration has already been the focus of research designed to develop bilateral and multilateral arrangements with pertinent partners⁸⁰. With the dual citizenship policy adopted recently, Kenya must be prepared to compete with the countries where its citizens reside in wooing them to acknowledge the ambivalence of some of their lifestyles abroad and its implications for individuals and the country.

Kenya's involvement in international migration agenda in RECs, at the AU and at the global level should be manifested in its ratifying and implementing international migration instruments. Given that Kenya is a country of origin, transit and destination of legal and illegal migrants, it should complete its commitment to the entire slate of statutory migration management instruments by signing the Convention Governing the Protection of Workers and Members of Their Families (1990). However, given the many challenges in the comprehensive adoption or domestication of international instruments, Kenya has to establish a carefully designed domestic programme for accession to the requirements of such frameworks.

The country should develop policy to guide the judicious utilisation of Diaspora remittances, while recognising them as private flows subject to market forces. Such endeavours should draw on international experiences, such as the Mexican three-in-one system, to ensure the injection of county and central Government funds into the pool of remittances, thereby augmenting revenue for development. An important recommendation is for Kenya to appreciate "social remittances" — norms, non-monetary remittances such as practices, identities and social capital (Levitt, 2001). While values such as democratization, good governance and transparency have been dear to Kenyans throughout the independence years, it is likely that Diaspora pressure was instrumental in shaping and bringing to closure the Constitution promulgated in August 2010, after two decades of a tussle on this landmark political change.

With respect to refugees, research should target the South Sudanese, Ethiopians and Somalis to investigate their unwillingness to return to their countries even after normalcy has been restored. There could be legitimate apprehensions behind their reluctance to return, or they might have become so Kenyan that returning to their countries might disrupt their lifestyles. Another research area would be

79 Through the Africa, Caribbean and Pacific (ACP) Observatory on Migration, IOM recently commissioned a study on the availability of migration data, and the capacity building needs for that data's effective management. That commission's output should chart the way forward for improved data management.

80 The ACP Migration Observatory, Brussels, commissioned the African Migration and Development Policy Centre (AMADPOC) to conduct an "Assessment of the Kenyan Policy Framework concerning South-South Labour Migration".

to have a matched survey of home-based citizens to establish the extent to which they share certain events in Kenya, or whether they are polarised in their perceptions of and attitudes toward each other. A research carried out in Kenya and Tanzania in 2009 found that home-based citizens have both positive and negative perceptions of, and attitudes towards, the Diaspora (AMADPOC, 2012).

Conclusion

Kenya finds itself at a crossroads of increasing immigration and emigration which policymakers have to grapple with despite the lack of substantive research evidence, and the consequent absence of pertinent policies and programmes.

Diaspora remittances are playing a key role in Kenya's development. They need to be studied more closely to acquire an improved picture of the context in which they are made, such as knowing remitters by background characteristics, reasons for, and frequencies of remittances, the recipients of remittances and their utilisation of the resources, and the overall socio-economic impacts of remittances..

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PART 4

CHAPTER 13: INEQUALITIES AND THE EXERCISE OF RIGHTS

“Inequality reduces the pace of human development and in some cases may even prevent it entirely.”

(UNDP, Human Development Report 2013, Page 29)

13.1 Introduction

Inequality refers to differences or variations in an attribute or group of attributes of individuals, households, communities and society. These differences or variations may be biological or natural, while others are artificial — due to social, economic and political arrangements in society. Inequalities that arise from social arrangements that are unjust — i.e. contrary to the common notions of fairness, are referred to as inequities (Whitehead, 1990). According to Whitehead’s conceptualization, all inequities arise from some form of inequality, but not all inequalities may be considered inequitable, i.e. unjust. Although poverty and income inequality are different, they are intimately connected because a significant fraction of the high poverty rates encountered in some societies are attributable to acute levels of economic inequality (UNFPA, 2010)⁸¹. High levels of inequality have been associated with a greater prevalence of conflict and violence in societies which consequently become unable to respond to economic development challenges (Development, 2007). Besides linkages between levels of poverty, average income level and income inequality (Ravallion, 1997; Bigsten and Levin 2000), human rights advocates suggest that discrimination, which is a key underlying cause of inequality, is also linked to poverty because it limits the ability of people to participate in the development of poverty reduction strategies (Human Rights Watch, 2013; Development, 2007). Inequalities related to human rights violations partly result from weak accountability mechanisms, and partly from the lack of knowledge among the excluded and vulnerable groups, on how to make their voices heard.

Previous studies in Kenya show striking inequalities in human welfare that are manifest in various dimensions (World Bank, 2008; Nyanjom, 2011; Kiringai, 2006). These differences are not only due to climatic and agro-ecological differences, but also from the effects of Government policies. Although Kenya is well-known for devoting resources to relatively wealthier populations rather than to those who are poor or hard to reach (HPI, 2010), evidence indicates that this mis-prioritisation applies to other developing countries as well (HPI 2007; Castro-Leal et. al., 2000). It is in this respect, that the Government of Kenya has placed greater emphasis on developing strategies and policies to overcome the challenges of inequality and poverty in relation to development (Republic of Kenya, 1965; 2003; 2008 and 2012a). The observed substantial intra- and inter-regional disparities in poverty and inequality levels in Kenya (KNBS, 2007a; World Bank, 2008) may reflect complex features resulting from interactions between agro-ecological heritages and public policies, as well as due to socio-cultural beliefs and practices (social arrangements).

This chapter summarizes the population related inequalities in Kenya with an emphasis on reproductive health, a domain which is linked to poverty through various choices that people make, which govern

⁸¹ The definition of poverty has been debated extensively. The most commonly used measures of poverty have been based on food/calorie intake or expenditure levels. The 2005/06 Kenya Integrated Household Budget Survey (KIHBS) estimated the absolute poverty based on expenditure levels. Kenya’s 2001 Poverty Reduction Strategy Paper (PRSP) defined poverty as: the inadequacy of income needs and the lack of access to productive assets; social infrastructure, and markets (Ministry of Finance and Planning, 2001). More generally, poverty is multidimensional and denotes people’s exclusion from socially adequate living standards and it encompasses a range of deprivations that include: economic (income, livelihoods, decent work), human (health, education), political (empowerment, rights, voice), socio-cultural (status, dignity) and protective (insecurity, risk, vulnerability) (see also 1995 United Nations World Summit on Social Development). While a concern between poverty and income is understandable and immediate; but inequality is a step beyond. Poverty is the lack of access to acceptable/decent levels of social, political and economic opportunities, which income is just one of the set. There can be massive income inequalities without poverty, such as if the Government subsidises goods and services.

mortality, pregnancies, births, marriage and reproduction. With respect to population sizes and trends, inequality typically refers to three aspects of demographic change, namely the: (i) risk of early mortality; (ii) final fertility intensity; and (iii) timing of fertility (UNFPA, 2012). These three areas of potential disparity reflect the systemic pattern inherent in the population dynamics of poverty (UNFPA, 2012). It also examines attempts to reduce inequalities through the application of a rights-based perspective in policy and interventions targeted towards the most socially vulnerable groups.

13.1.1 Rationale

Historically, Kenya has been characterized by sharp inequalities across key socioeconomic dimensions (Republic of Kenya 2007, World Bank 2008). A critical feature of inequalities among Kenyan communities is their respective agro-ecological heritages (Okwi et al, 2006; see also Appendix 2)⁸². However, a key driver of the differences based on natural heritages stems from the significance placed on them by colonial policies since the late 19th Century, which shaped colonial settlement patterns and resulted in imbalanced infrastructural development. Thus, areas that were inhabited by the settlers had better access to education, health and roads infrastructure (World Bank, 2008; ILO, 1972). Colonial settlement largely focused on the high agricultural potential areas of Central and Rift Valley provinces, and led to the emergence of a class society based largely on land ownership. The first independence Government did little to redress the inherited inequalities, and instead, espoused policies that underscored them. Contemporary Kenya has not moved substantially away from the policies that ignored nature-based differences, or those that exacerbated their effects, the net effect being that these are the bases of the country's unequal patterns of development, and levels of poverty and inequality.

Sessional Paper No. 10 of 1965 is widely recognized as the inaugural post-independence policy instrument that guided subsequent Government programs. Some of the key concerns were to foster rapid economic growth, and to Africanize the economy by correcting past racial imbalances (Republic of Kenya, 1965). However, its implementation created more imbalances, particularly with respect to the management of the acquisition of land left by European settlers, and in terms of access to education and employment (ILO, 1972). The National Development Plan 1964-1970 re-emphasized investments and allocation of funds in the high potential areas since these areas had the greatest return on investment (Republic of Kenya, 1964), with the gains being shared equitably (ILO, 1972). Similarly, Sessional Paper No. 1 of 1986 further indicated the need to invest in high priority potential areas. In the late 1980s and early 1990s, the Kenya Government implemented Structural Adjustment Programs⁸³. As a result, Kenya introduced cost sharing in the health and education sectors, which, for example, worsened existing inequalities in access to health services by preventing vulnerable groups from seeking appropriate health care (Huber 1993; Quick and Musau, 1994).

Kenya Vision 2030, the country's current long-term development blueprint, not only aims at improving equity in access to opportunities by geographical units, income status, sex and age, but also emphasizes equal political liberties and entitlements to human rights for all. In order to achieve the goal of a socially-just and equitable society, Vision 2030 specifies the following objectives, among others: raising average annual incomes; avoiding gross disparities while rewarding talent and investment risks in a manner that is deemed socially just and therefore not politically destabilizing; reducing poverty from the current level (46%) by between three and nine percent; and implementing policies that minimize the differences in income opportunities and access to social services across Kenya's geographical regions (Republic of Kenya, 2012: 152).

⁸² See also <http://www.infonet-biovision.org>

⁸³ The immediate reason for implementing SAPs was to fulfill World Bank/IMF conditions for qualifying for development aid

13.1.2 Measurement Inequality

According to UNDP's Human Development Report (HDR) 2011, measuring inequalities and inequities can be problematic because they have aspects that are not easily quantifiable or observed (UNDP, 2011). HDR 2011 indicated that because of difficulties in measuring inequities, distribution in inequalities can be used as proxy measures of inequity. In this chapter, we use a wealth index (wealth quintiles) generated from the Kenya Demographic and Health Survey (KDHS) to measure aspects of poverty⁸⁴. Inequalities can be measured by three indicators, namely; absolute differences, relative differences and concentration index (see technical note number 1 in the Annex)⁸⁵.

The concentration index lies between -1 and +1. The magnitude of the index reflects both the strength of the relationship and the degree of variability. That is, for outcomes that decline as conditions improve (e.g. mortality or total fertility rates) the index ranges from -1 reflecting perfect inequality to zero for perfect equality. For outcomes that increase as conditions improve (e.g. contraceptive prevalence), one indicates perfect inequality and zero means perfect equality.

13.2 Overview of Poverty Levels and Income Related Inequality

Based on analyses of data from the Kenya Integrated Household Budget Survey of 2005/2006 (hereafter, KIHBS), almost half of the Kenya population (47%) lived in poverty, 85 percent of whom were in rural areas, meaning the poverty incidence was considerably lower in urban areas (KNBS, 2007a). These KIHBS data reported in Table 13.1 suggest that the national poverty level had declined markedly from the 57 percent level estimated from the household welfare survey of 1997 (World Bank, 2008).

Table 13.1 Poverty Estimates 2005/2006

	Poverty Measure ⁵	Headcount (%)	Number Poor (millions)
National	Overall	46.6	16.6
	Food	45.8	16.3
	Severe	19.5	6.9
Urban	Overall	34.4	2.5
	Food	40.4	2.9
	Severe	8.3	0.6
Rural	Overall	49.7	14.1
	Food	47.2	13.4
	Severe	22.3	6.3

Source: World Bank 2008

The Fourth Participatory Poverty Assessment (PPA-IV) of 2006 conducted by the Kenya National Bureau of Statistics (KNBS) gathered qualitative information on community perceptions of poverty (KNBS, 2006b7). It revealed that both rural and urban communities considered extreme poverty to be closely linked to food consumption. The report further indicated that a majority of respondents described poor people as those who are never sure of their next meal, depend on others for survival, have dilapidated housing, and are poorly dressed and cannot even afford second-hand clothes (KNBS, 2007b; World Bank, 2008). Generally, poor people do not own property (such as land) and work on other households' farms to earn a living. Poor people were said to be always in poor health and unable to afford to educate their children.

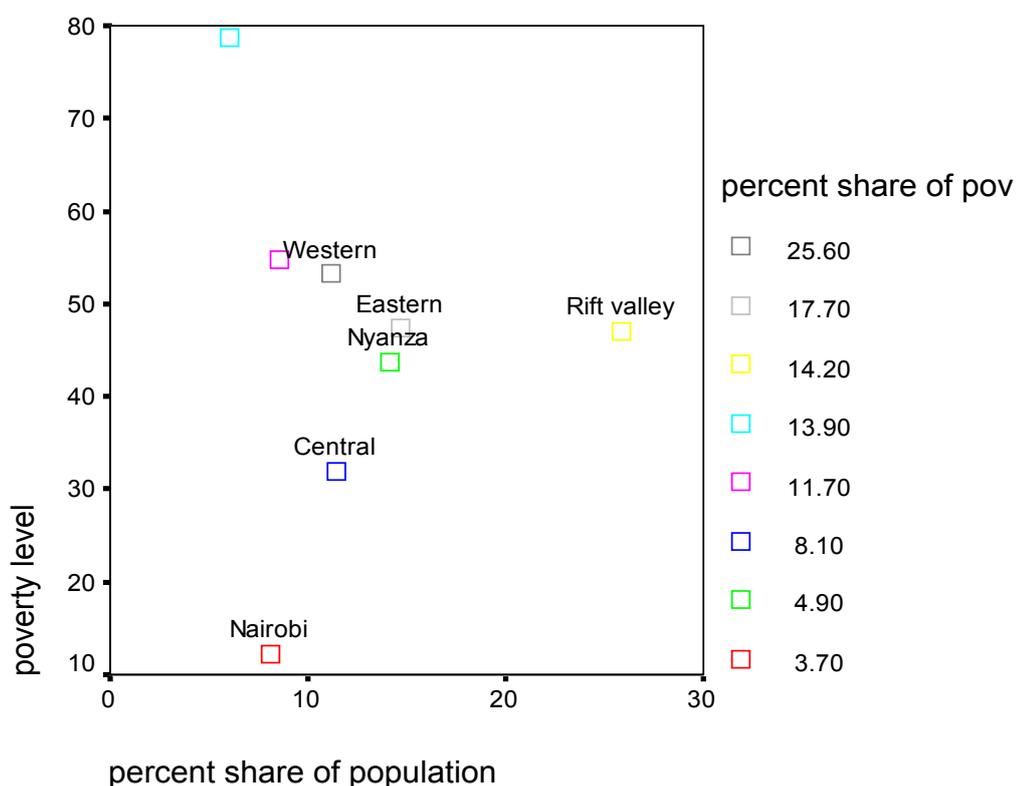
⁸⁴ If a sample or population is arranged from the lowest (earner, consumer, etc) to the highest, and the distribution is divided into 5 equal groups, the group of the poorest members is termed quintile 1 while the richest/least poor group is quintile 5.

⁸⁵ Indices showing differences or ratios between the lowest quintile (Q1) and the highest quintile (Q5) are simple and easy to understand. The concentration index is more complex; but it has the advantage of measuring inequality across the whole distribution at once.

World Bank (2008) estimates of Kenyan inequality showed that the national consumption decile ratio rose from 13 to 19 between the 1997 and 2005/2006 household surveys, indicating large and growing inequality⁸⁶. Further, almost 28 percent of overall inequality was attributed to the differences between the rural and urban populations. However, the bulk of inequality is within rural areas alone, *and* within urban areas alone.

Kenya has been characterized by considerable variation in poverty levels across provinces and districts. Analysis of KIHBS data found that the poverty incidences in Nairobi and Central provinces are far below the national average (see Figure 13.1), with the two regions combined contributing only 12 percent of national poverty (KNBS, 2007). Conversely, the poverty incidence was higher in Coast and Western provinces, which together accounted for a quarter of the poor, and in sparsely populated North Eastern Province which had the most pronounced poverty incidence (top left of Figure 13.1)

Figure 13.1 Scatter Plots between Poverty Level, Population and Percent Share Population

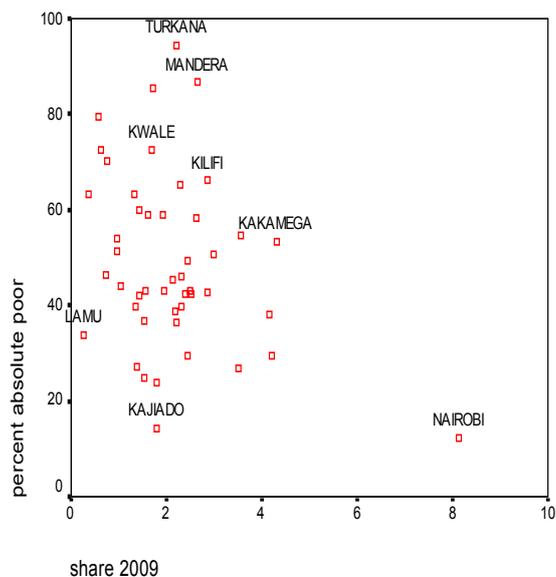


Source: Computed from KIHBS 2005/2006

The variation in the poverty incidence is more pronounced at the district level, from 94 percent in Turkana to 12 percent in Kajiado (KNBS, 2008: 13). Further, the poverty gap in Turkana is 70 percent compared to two percent for Kajiado (World Bank, 2008). Moreover, one quarter of the population that is poor resided in only seven districts (World Bank, 2008).

⁸⁶ Decile ratio is the ratio of the average consumption or income of the richest decile, i.e. richest 10 percent of the population, divided by the average income of the bottom decile or 10 percent. This ratio can also be calculated for other percentiles, and is easily understood as a measure of the income of the rich as a multiple of that of the poor.

Figure 13.2 Scatter Plot Between Percent Absolute Poor With Share of Population Size (counties)



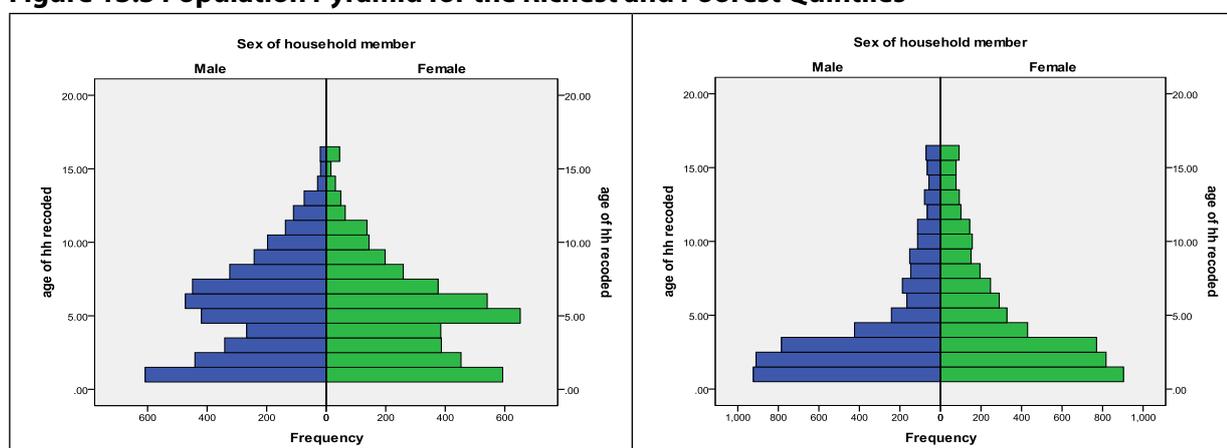
Source: Computed from 2005/6 KIHBS

13.3 Demographic Inequalities

13.3.1 Population Age-Sex Structure

In Chapter 3 of Part 3, the national population age sex structure shows that Kenya is still a youthful population. The two parts of Figure 13.3, parts (A) and (B) respectively show the age structure of the richest and poorest quintiles based on KDHS data. The pyramid for richest quintile shows a structure typical of societies that have experienced rapid changes in birth and death rates, while the one for the poorest quintile reflects a persisting high dependence for the future on children.

Figure 13.3 Population Pyramid for the Richest and Poorest Quintiles



Source: Computed from 2008/9 KDHS

13.3.2 Household Size and Composition

According to the 2009 population census, the average household size was about 4.4, almost similar to the average size in the 1999 census, except for North Eastern Province whose average size was

7.4. About 3.4 percent of households have a single person while about 14 percent have nine or more members.

Table 13.2 Percent distribution of Households by Size and Wealth Index

	single person	2-4 members	5-8 members	9+ members	Number
Poorest	0.9	21.7	58.0	19.3	9,373
Poorer	1.8	24.2	56.5	17.5	6,694
Middle	2.2	30.2	51.4	16.1	6,862
Richer	3.1	35.5	49.5	11.9	7,103
Richest	8.4	49.5	37.3	4.9	8,483
Total	3.4	32.3	50.4	13.9	38,515

Source: Computed from 2008/2009 KDHS

The data suggest that poor households have large average sizes and are therefore more likely to have higher dependency ratios. According to previous poverty reports, poverty increases as the household size and age of the head of household increase (World Bank, 2008). Table 13.3 shows calculations of poverty incidence by presence of children under age six and household size based on World Bank calculations using KIHBS data. While those households which had no children under age six consisted of one third on total population, nearly four in ten of them are poor. In contrast, about 18 percent of the households had 3 or more children and a poverty rate of 63 percent. About 47 percent of the population lived in households with seven members or more, 60 percent of which were poor.

Table 13.3 Poverty Incidence by Presence of Children under six years and Household Size

No of children under age 6	Poverty Headcount (%)	Distribution of the Poor (%)	Population share (%)
None	37.7	23.6	29.2
1	43.2	25.3	27.3
2	48.7	26.7	25.6
3 or more	63.4	24.4	18.0
Household size			
1	10.8	0.4	1.9
2	22.6	1.7	3.4
3	25.9	3.8	6.8
4	30.3	7.8	11.9
5	38.1	11.8	14.4
6	46.6	15.0	15.0
7 or more	59.8	59.6	46.5
Total	46.6	100.0	100.0

Source: World Bank 2008

13.4 Early Mortality

The risk of early mortality is one of the aspects of inequalities in population behavior. Early mortality reflects features of systematic patterns in the differences in health status (Whitehead and Dahlgren, 2006; UNFPA, 2010). In general mortality and morbidity increase with declining social position, but this near universal pattern vary in magnitude and extent among countries. Table 13.4 shows trends in childhood mortality rates by wealth index. The children born in poor families are clearly disadvantaged

and face early mortality compared to children from the wealthier groups. However, the differences have been declining over the last one and a half decades.

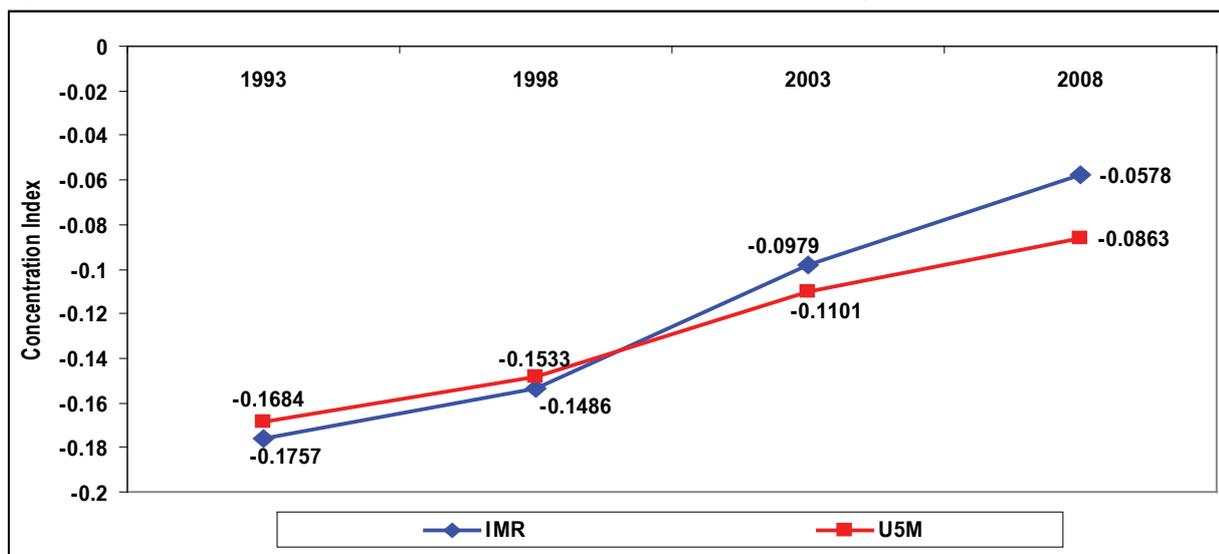
Table 13.4 Trends in Childhood Mortality by Wealth Index

Year	Mortality	Wealth Index						Avg.	Ratio of Low/High	Difference Between. Low-High
		Low	2nd	3rd	4th	High				
1993	Infant mortality rate	90.0	79.3	52.7	39.1	43.3	62.5	2.08	46.76	
	Under-five mortality rate	129.3	120.2	81.2	61.5	61.9	93.2	2.09	67.44	
1998	Infant mortality rate	95.8	82.9	58.5	61.0	40.2	70.7	2.38	55.60	
	Under-five mortality rate	136.2	130.4	92.3	84.9	60.7	105.2	2.24	75.50	
2003	Infant mortality rate	95.8	75.2	81.9	53.1	62.2	75.5	1.54	33.58	
	Under-five mortality rate	148.9	109.5	120.9	77.3	91.1	112.7	1.63	57.77	
2008	Infant mortality rate	66	64	67	39	57	58.6	1.16	9	
	Under-five mortality rate	98	102	92	51	68	82.2	1.44	30	

Source: Gwatkin et al 2007; 2008/2009 KDHS

Figure 13.4 shows trends in concentration index (CI) for infant and under-five mortality. Unlike the rise and fall as shown in absolute and relative differences (Table 13.4), the trends in CI show a monotonic decline. Initially, there was larger inequality in the infant mortality rate compared to under-five mortality rate, but there was a crossover in 2000, with greater inequality being experienced in the under five mortality compared to the infant mortality rate.

Figure 13.4 Trends in Concentration Indices for Childhood Mortality



Source: Gwatkin et al 2007; CI for 2008 is computed from 2008/9 KDHS

Table 13.5 shows trends in early mortality by region, place of residence and level of education of the mother. The last row shows the ratio of the highest to lowest for each group. The largest differences occur by region of residence. For all the groups, the greatest variation occurred between 1993 and 2003 when there was an upsurge in early mortality. One noticeable fact was that when early mortality was low, urban rural differences was minor (see data for 1989 and 2008 in Table 13.5). In addition, as

the mortality situation worsened between 1993 and 2003, early childhood mortality was highest for women with some primary education.

Table 13.5 Trends in Infant Mortality and Under Five Mortality

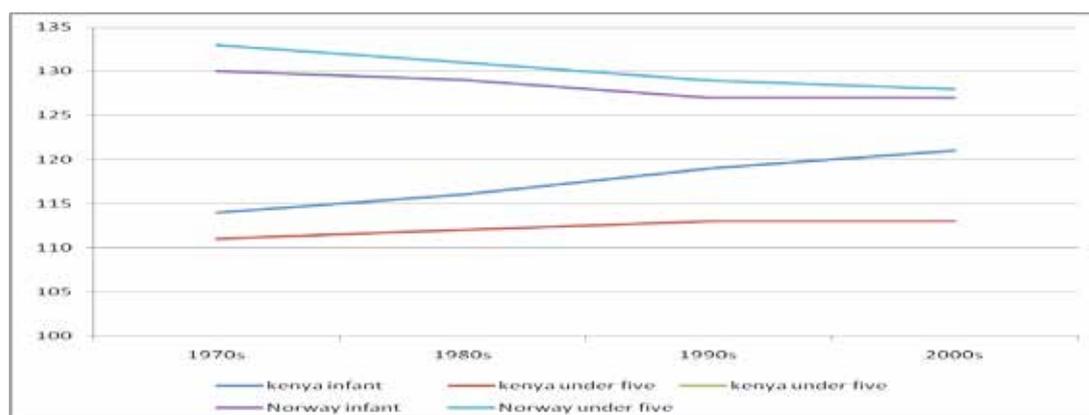
	Year of Survey									
	1989		1993		1998		2003		2008/9	
Residence	IMR	U-5MR	IMR	U-5MR	IMR	U-5MR	IMR	U-5MR	IMR	U-5MR
Urban	56.8	89.0	45.5	75.4	55.4	88.3	61	93	63	74
Rural	58.9	91.2	64.9	95.6	73.8	108.6	79	117	58	86
Rural – urban ratio	1.04	1.02	1.43	1.27	1.33	1.23	1.30	1.26	0.92	1.16
Region										
Nairobi	46.3	80.4	44.4	82.1	41.1	66.1	67	95	60	64
Central	37.4	47	30.9	41.3	27.3	33.5	44	54	42	51
Coast	107.3	156	68.3	108.7	69.8	95.8	78	116	71	87
Eastern	43.1	64.3	47.4	65.9	53.1	77.8	56	84	39	52
Nyanza	94.2	148.5	127.9	186.8	135.3	198.8	133	206	95	149
Rift	34.6	50.9	44.8	60.7	50.3	67.8	61	77	48	59
Western	74.6	132.8	63.5	109.6	63.9	122.5	80	144	65	121
North Eastern							91	163	57	80
Ratio of highest to lowest region	3.10	3.16	4.14	4.52	4.96	5.93	3.02	3.81	2.26	2.92
Education										
None	71.7	108.7	66.3	99.8	82.2	122.5	80	127	64	86
Some Primary	59.1	95.2	80.1	120.6	91.4	138.1	97	145	73	112
Primary complete	49.3	72.5	57.4	78.8	61.4	86.9	69	98	51	68
Secondary	41.8	64.2	34.8	53.7	40	59.9	44	63	45	59
Ratio of None to sec +	1.72	1.69	1.91	1.86	2.06	2.05	1.82	2.02	1.42	1.46

13.4.1 Sex Differentials in Early Mortality

In many societies where boys and girls have the same access to resources (mainly food and medical care), boys have lower survival chances compared to girls. Some studies have indicated that as survival chances in childhood increase (mortality levels fall), the female advantage in infant and child mortality would normally increase (Hill and Upchurch, 1995; Tabutin 1998). Figure 13.5 shows trends in sex ratios of infant mortality and under-five mortality for Kenya and Norway⁸⁷. Female advantage for Norway is very high and trends for Kenya also indicate increasing female advantage.

⁸⁷ Norway is one of the countries with lowest childhood mortality rates in the world, and is also one of the most equitable with regard to gender disparities.

Figure 13.5 Male/Female Disparities in Early Mortality for Kenya and Norway



Source: Sawyer, 2012.

The national female advantage in childhood mortality reflects important differences across the regions. The female advantage in survival can be eroded if girls are deprived relative to boys in access to health care or to proper nutrition⁸⁸. According to the 2009 Kenyan census, some regions show male advantage, the largest being in childhood mortality for Mombasa followed by Kwale. Situations in which the survival of girls is lower than that of boys may imply differential treatment or access to resources that put girls at a disadvantage, argues Sawyer (2012) who reports that such situations have been observed in southern, eastern and western Asia as well as northern Africa.

Table 13.6 Male Female Differences in Childhood Mortality

	Male		Female		Female to male ratio	
	1q0	5q0	1q0	5q0	1q0	5q0
Coast Province	69	100	70	87	1.014	0.870
Mombasa	78	114	97	116	1.244	1.018
Kwale	53	78	60	76	1.132	0.974
Tana River	79	114	82	102	1.038	0.895
Lamu	79	116	72	95	0.911	0.819
TaitaTaveta	62	86	60	70	0.968	0.814
Marsabit	44	55	45	54	1.023	0.982
Tharaka	43	57	48	60	1.116	1.053
Embu	46	49	43	50	0.935	1.020
Mandera	116	152	120	158	1.034	1.039

Source: 2009 census analytical report on mortality

13.4.2 Child Malnutrition

The period from birth to two years of age is of great importance for growth, health and development of a child. Adequate nutrition is critical at this stage because well-nourished children have strong immune systems which reduce their chances of dying prematurely from communicable diseases. Infants who are undernourished in the first 36 months of their lives can suffer irreparable damage to their physical and mental development, debilitating them throughout their life. Malnutrition affects children's cognitive learning, educational performance and even status in life. A child's nutritional status is the result of complex interactions between food consumption and the overall status of health and care

⁸⁸ Historically this was mainly observed in India and China

practices. One of the 48 Millennium Development Goal indicators is to reduce by half the proportion of malnourished children by 2015. Table 13.7 shows trends in indicators of nutritional status of children by wealth index and concentration index (shown in column 7). Stunting reflects failure to receive adequate nutrition over a long period of time and may also be caused by recurrent and chronic illness. Underweight reflects either acute malnutrition (wasting) or chronic malnutrition (stunting) or both. Overtime, inequalities in stunting have been irregular and do not show clear trends while inequalities in underweight have been increasing. There is greater inequality in the proportion underweight compared to stunted children.

Table 13.7 Trends in Child Nutrition Status

Year of Survey (KDHS)		Low	2nd	3rd	4th	High	Avg.	CI	Ratio of Highest to lowest
1993	Stunting	48.60%	43.30%	37.40%	41.70%	23.10%	39.80%	-0.103***	2.10
	Underweight	28.30%	21.60%	18.70%	19.20%	9.80%	20.20%	-0.164***	2.89
1998	Stunting	49.10%	41.20%	35.50%	35.90%	21.00%	37.80%	-0.134***	2.34
	Underweight	26.10%	21.80%	16.10%	14.70%	8.60%	18.30%	-0.196***	3.03
2003	Stunting	44.00%	38.70%	34.40%	33.70%	25.20%	36.10%	-0.103***	1.75
	Underweight	24.90%	15.80%	14.60%	14.10%	7.50%	16.10%	-0.208***	3.32
2008	Stunting	45.10%	40.00%	33.80%	28.90%	24.10%	35.50%	-0.126***	1.87
	Underweight	24.60%	18.00%	13.70%	12.00%	9.10%	16.30%	-0.221***	2.70

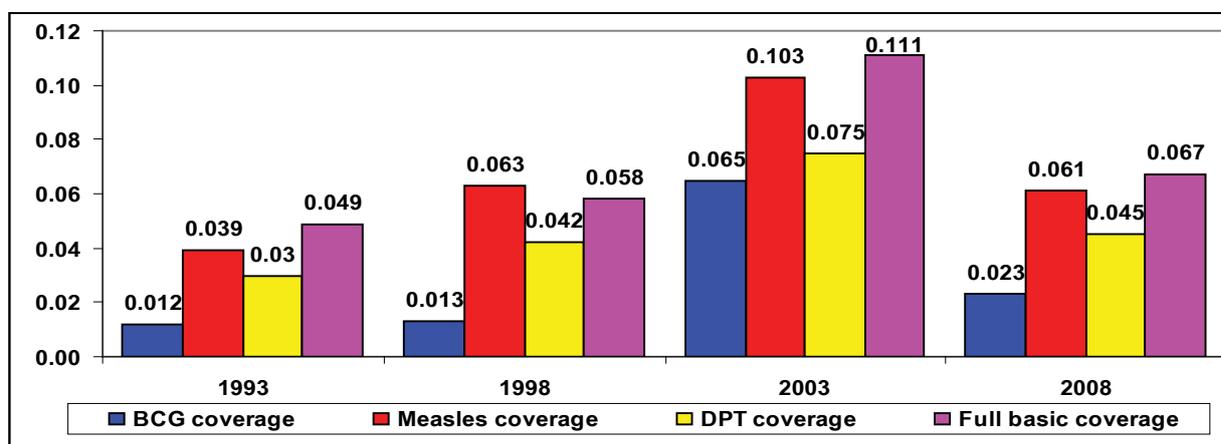
*** refers to P- value < 0.001

Source: World Bank. (2012).

13.4.3 Utilization of Child Health Services

Figure 13.6 shows trends in CIs in the utilization of childhood health care services. One noticeable effect is the increase in inequalities during 2003 when use of services declined (CBS and ICF Macro, 2004). The trends in CIs are not similar to those of the early mortality.

Figure 13.6 Trends in the CIs of Childhood Immunization

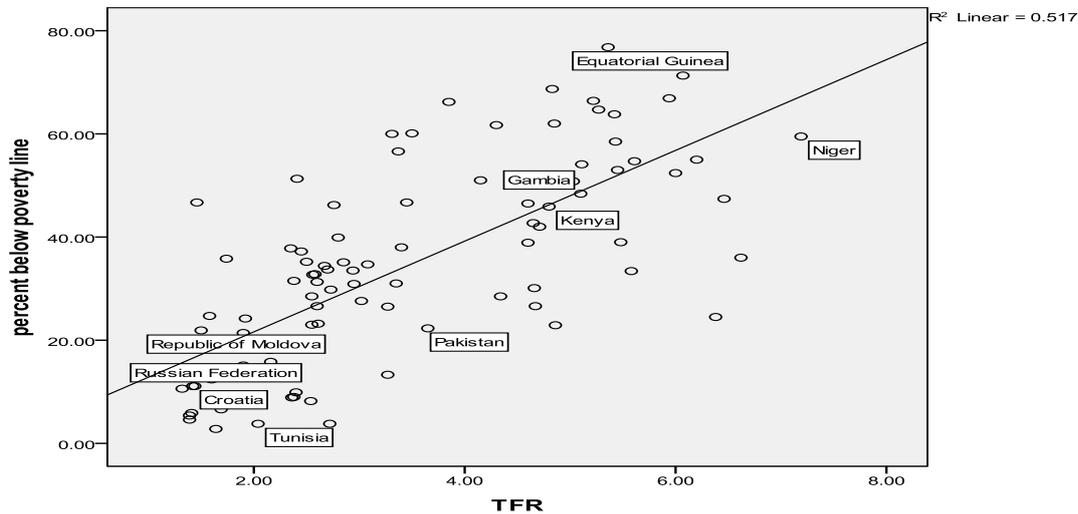


Source: Gwatkin et al 2007; CI for 2008 is computed from 2008/9 KDHS

13.5 Reproductive Behaviour — Fertility

There is a wide and growing body of evidence in all developing regions showing that larger households have a much higher incidence of poverty (UNFPA, 2004). This is largely due to the increased dependency burden, where more family members must divide a relatively fixed level of income and consumption. The close association between trends in fertility and poverty is shown in Figure 13.7 Over time, UNFPA (2010) notes, this poverty is likely to be transmitted inter-generationally, as fewer resources are available to invest in children’s welfare.

Figure 13.7 Scatter Plots Between the Below Poverty Line Population and Fertility



Source: Computed from United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, CD-ROM Edition; World Bank Data base.



Mothers await treatment for their children at a mobile clinic in Samburu.

Photo: www.UNFPA

Table 13.8 shows TFR trends by wealth index. Fertility levels among the poor have not changed much over the 15 year period of the data while those for the higher quintiles have steadily declined. There is an apparent increase over time in the relative differences in fertility levels among the highest and lowest socioeconomic levels. Similarly the absolute differences between the highest and the lowest quintiles have been increasing. Generally, while all the indicators of inequality show similar trends, year 2003 appears unique; fertility among the poorest increased by slightly over one birth per woman (about 17 percent) while among the richest it increased by about three percent. This may explain the apparent increase in the indices of inequality.

Table 13.8 Trends in Total Fertility Rates by Wealth index

	low	2 nd	3rd	4 th	high	Average	Low/High ratio	Low-High Difference	CI Value
1993	7.2	6.2	5.6	5.3	3.3	5.4	2.17	3.91	-0.1351
1998	6.5	5.6	4.7	4.2	3.0	4.7	2.17	3.50	-0.1514
2003	7.6	5.8	5.1	4.0	3.1	4.9	2.44	4.50	-0.1741
2008	7.0	5.6	5.0	3.7	2.9	4.6	2.41	4.10	-0.1130

Source: Gwatkin et al 2007; CI for 2008 is computed from 2008/2009 KDHS

13.5.1 Utilization of Maternal Health Services

a) Family Planning

Table 13.9 shows some inequalities in the use of modern contraception for all women. The use of modern contraception by all women rose over the years to 2003, and then declined to 2008. For the poorest women, use has not changed, but it has declined among the richer groups. The positive values of CI mean that richer women are more likely to use modern contraception methods. The relative decline in use among the richer group partly explains the decline in the CI since 1993. The poor continued to have high and unchanging fertility rates (Table 13.8) because of low uptake of contraception. Although the need for contraception is not being adequately addressed among all segments of society, given evidence of declining use among all women, the need for contraception is still considerably high among the poor (Townsend, 2010). However, it is important to note that the differences in contraceptive prevalence may be due, not only to difference in access to and ability to pay for them, but also to the differences in women's interest in, and motivation to, regulate their fertility (Foreit et al., 2010).

Table 13.9 Trends in Percent of all Women Using Modern Contraceptives

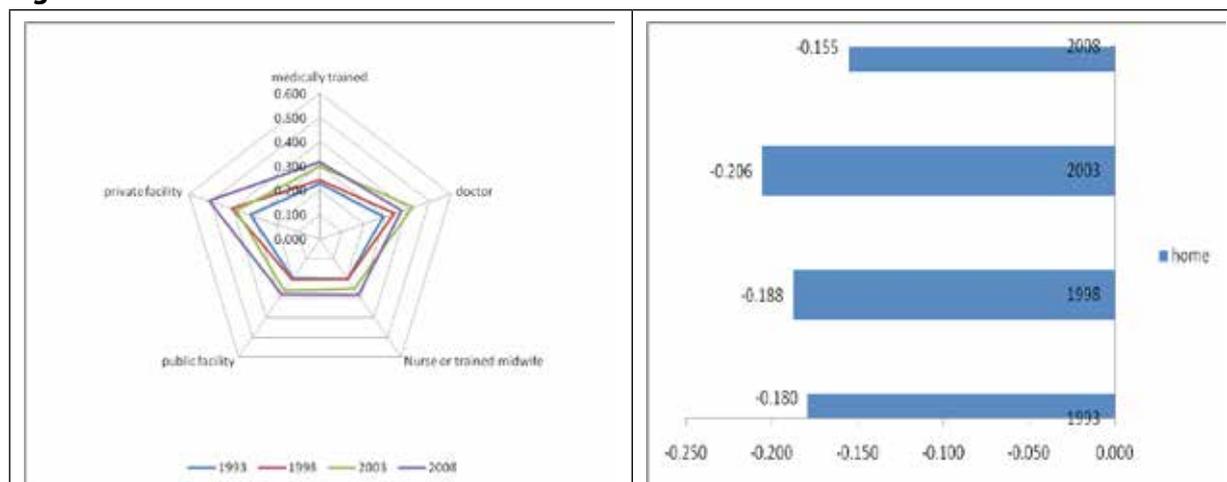
	Low	2nd	3rd	4th	High	Ave	Low/high	High -low	CI index
1993	10.3	15.7	27.3	37.5	45.0	27.3	0.2289	34.7	0.2638
1998	12.6	24.1	30.7	39.7	50.0	31.5	0.2520	37.4	0.2312
2003	11.8	24.2	33.4	41.0	44.5	31.5	0.2652	32.7	0.2332
2008	10.4	23.4	29.3	32.3	33.6	26.4	0.3095	23.2	0.1403

Source Gwatkin et al 2007; CI for 2008 is computed from 2008/9 KDHS

b) Delivery Care

The spider graph in part (A) of Figure 13.8 shows CI trends for persons assisting in delivery over successive KDHS studies. High inequality is indicated by values closer to one while lower inequality is reflected by values closer to zero (root of the spider graph). The use of doctors and delivery in private facilities were the most unequal, the latter indicator simply reflecting the ability to pay. Overall, the trends indicate increased inequality in skilled attendance (use of medically trained personnel) over the course of the successive surveys. Utilization of skilled attendance has been low (KNBS, ICF macro 2010); but this trend analysis also shows there has been an increase in inequality overtime.

Figure 13.8 Trends in the CIs of Assisted Deliveries and Home Deliveries

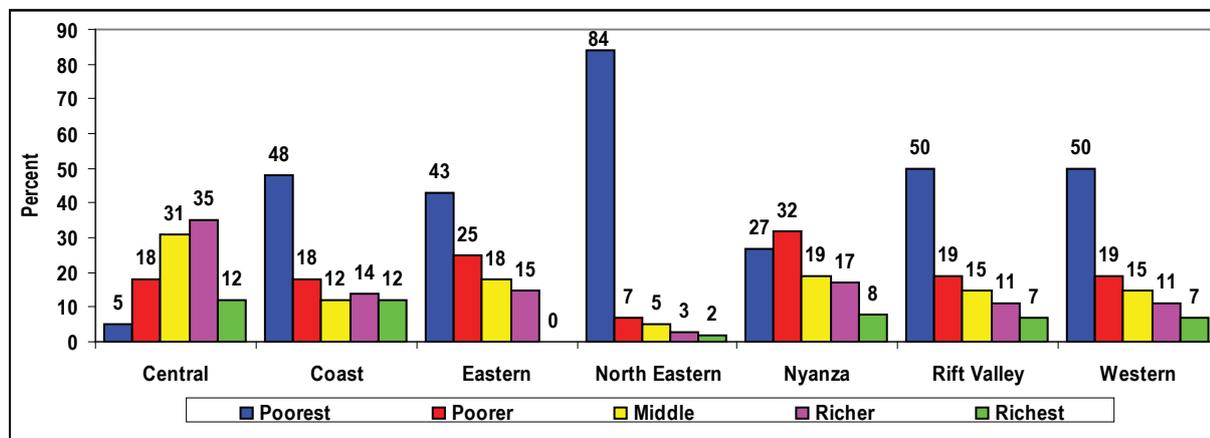


Source: Gwatkin et al 2007; CI for 2008 is computed from 2008/2009 KDHS

Part B of Figure 13.8 shows trends in the CIs for delivery at home, the negative values reflecting the poorer women's greater likelihood of choosing that option. There was an increase in inequality between 1993 and 2003, suggesting an increase in women delivery at home rather in facilities. However, 2008 showed a remarkable decline from the previous KDHS.

Figure 13.9 shows the extent of non use of facility deliveries by province, Nairobi excluded, and by wealth index. In all provinces except Central, women of the poorest quintile are greatly disadvantaged, the rate of non-use in North Eastern being nearly 85 percent. If services are improved, inequalities would be substantially reduced: for example, the poorest women in Central Province are even more likely to use facilities during delivery than the richest women in the same province.

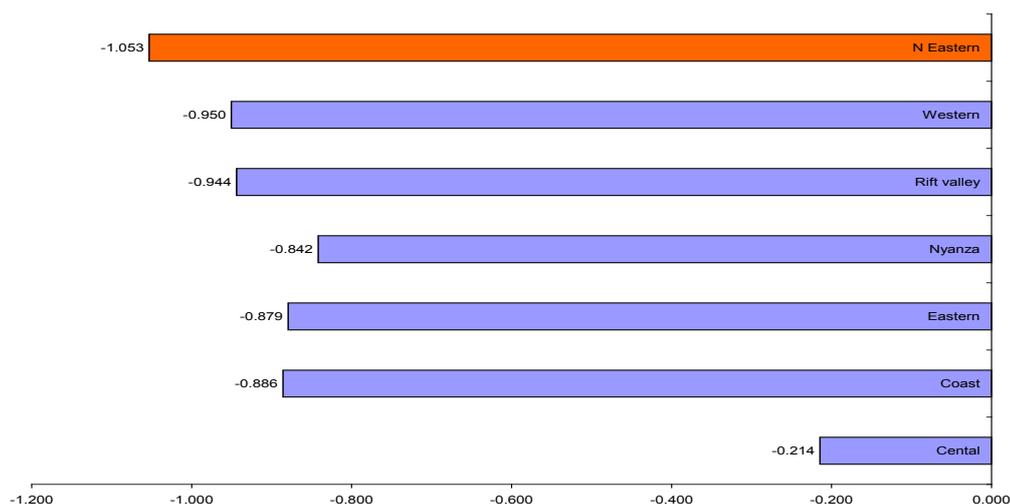
Figure 13.9 Non Use of Facility Delivery by Wealth Quintile and Region



Source: computed from 2008/9KDHS (unweighted data).

Figure 13.10 shows the CI for non-facility deliveries within regions. The index is highest in North Eastern Province: where non use is very high, the extent of inequality is even higher. Put simply, in regions where non utilization is high, the poor are disproportionately more disadvantaged.

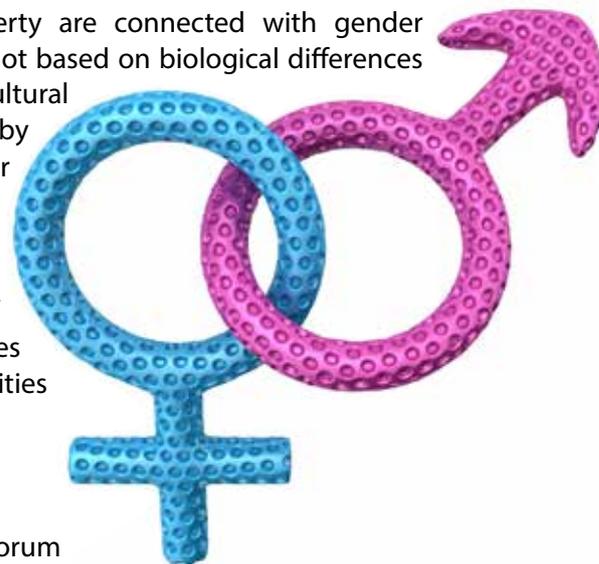
Figure 13.10 Concentration index for Non-facility Deliveries Within Regions



Source: computed from 2008/2009 KDHS

13.6 Gender Inequalities

Some of the mechanisms that perpetuate poverty are connected with gender inequalities. The existence of these inequalities is not based on biological differences between males and females; instead they arise from cultural and institutional reasons that are often reinforced by public policies that lack a gender focus⁸⁹. Gender inequality affects the spheres of culture, religion, home, work, income groups, politics, sexuality, power, and violence. To examine the magnitude of gender-based disparities in the distribution of resources and opportunities, this section examines trends and progress over time in gender inequalities using Global Gender Gap Index (GGGI)⁹⁰.



Gender symbols for male (blue) and female (pink).

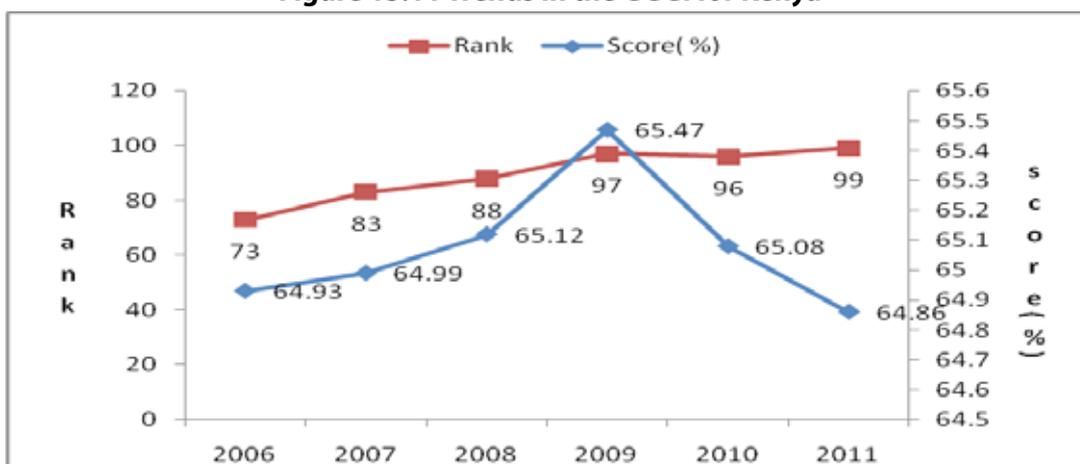
13.6.1 Global Gender Gap Index

The GGGI was introduced by the World Economic Forum in 2006, and examines the attainment gap between men and women in four fundamental realms: economic participation and opportunity; educational attainment; health and survival; and political empowerment. An index of one indicates complete equality while an index of zero indicates complete inequality. The Global Gender Gap Report of 2011 shows overall ranking of nations by revealing those countries that are role models in dividing their resources equitably between women and men, regardless of the overall level of those resources (ILO, 2012). Figure 13.11 shows trends in GGGI for Kenya since 2006, reflecting improvements to 2008 after which there has been a sustained decline to 2012. However, in terms of global ranking, there has been a sustained decline since 2006.

⁸⁹ A 'gender focus' would for instance require a policy maker to determine how a particular policy proposal affects men as distinct from women, and girls as distinct from boys.

⁹⁰ See <http://www.weforum.org/issues/global-gender-gap>. Accessed 6th March 2013.

Figure 13.11 Trends in the GGGI for Kenya



Source: Hausmann et al 2011

The four highest GGGI-ranking countries — Iceland, Norway, Finland and Sweden — have closed between 80 and 85 percent of their gender gaps (ILO, 2012). Table 13.10 shows the GGGI ranking among sub-Saharan African countries for 2011. The best performing country is Lesotho ranked 9th globally. Kenya’s performance is much poorer than most of her neighbours, with Uganda, Tanzania and Zimbabwe ranked 29, 59 and 88 respectively, compared to Kenya’s position 99.

Table 13.10 GGGI Performance Among sub-Saharan Africa Countries, 2011

Country	Score	Rank	Country	Score	Rank
Lesotho	0.7666	9	Zimbabwe	0.6607	88
South Africa	0.7478	14	Senegal	0.6573	92
Burundi	0.7270	24	Mauritius	0.6529	95
Mozambique	0.7251	26	Kenya	0.6493	99
Uganda	0.7220	29	Zambia	0.6300	106
Namibia	0.7177	32	Burkina Faso	0.6153	115
Tanzania	0.6904	59	Ethiopia	0.6136	116
Malawi	0.6850	65	Cameroon	0.6073	119
Botswana	0.6832	66	Nigeria	0.6011	120
Ghana	0.6811	70	Benin	0.5832	128
Madagascar	0.6797	71	Côte d’Ivoire	0.5773	130
Gambia, The	0.6763	77	Mali	0.5752	132
Angola	0.6624	87	Chad	0.5334	134

Source: Hausmann et al 2011

Table 13.11 shows the trends for Kenya’s GGGI sub-indices. Although the best ranking is in economic participation, the actual score has declined since 2006. Meanwhile, the best scores have been in health followed by education, but ranking in these items has been declining; and the worst score is political empowerment.

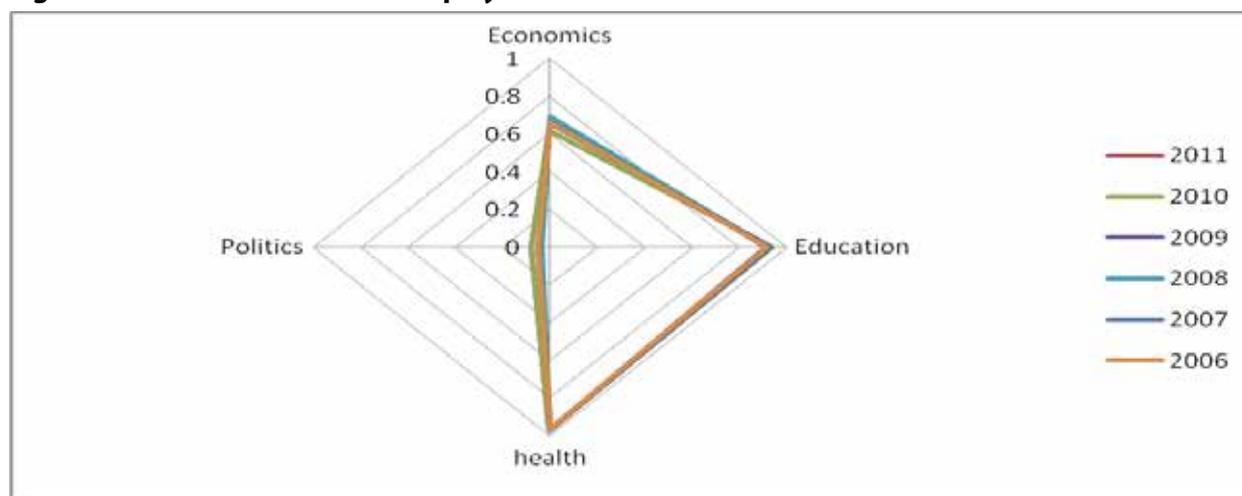
Table 13.11 Trends in Kenya’s gender gap by sub-indices, 2006-2011

GGGI year/ (no of countries)	Overall		Economic participation		Educational attainment		Health and survival		Political empowerment	
	Rank	score	Rank	score	Rank	score	Rank	score	Rank	score
2011 (135 countries)	99	0.649	83	0.616	101	0.936	102	0.968	100	0.077
2010 (134 countries)	96	0.650	82	0.615	102	0.940	101	0.968	98	0.077
2009 (134 countries)	97	0.651	50	0.683	106	0.909	110	0.968	122	0.045
2008 (130 countries)	88	0.655	41	0.693	102	0.926	105	0.968	121	0.032
2007 (128 countries)	83	0.651	59	0.649	97	0.934	104	0.968	104	0.053
2006 (115 countries)	73	0.649	40	0.657	88	0.918	96	0.966	93	0.053

Source: Hausmann et al 2011

The spider chart (Figure 13.12) shows the trends since 2006 for the country’s score for each of the four sub-indices. There is near equality in health and education but complete inequality in political empowerment. Economic participation is, however, average. The implication here is that initiatives directed at improving gender equality have focused more successfully on education and health but not political empowerment. Vision 2030 acknowledges that Kenya has the lowest representation of women in Parliament compared to countries such as South Africa and Malaysia (Republic of Kenya, 2012b).

Figure 13.12 Trends in Gender Gap by sub-Indices.



Source: Hausmann et al 2011

Table 13.12 section gives an overview of Kenya’s GGGI rankings and the scores on the four sub-indices for 2011. For each of the GGGI sub-indicators, column one in this section displays ranks for the overall rank, column two displays the country scores, column three displays the population-weighted sample average (135 countries), columns four and five display the female and male values of individual sub-indicators respectively, and, the final column (six) displays the female-to-male ratio. The best rank for Kenya is in primary school enrolment where it is ranked first worldwide. The worst rank is for legislators, senior officials and managers under the economic participation and opportunity indicator.

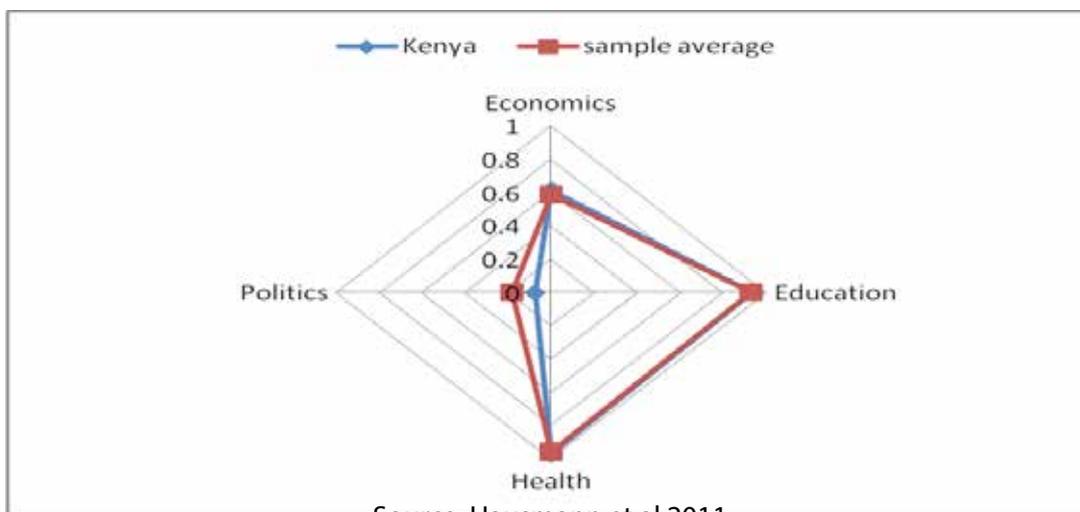
Table 13.12 GGI Rankings and the Scores on the Four sub-Indices, Kenya, 2011

	Rank	score	sample average	female	Male	Female-to-male ratio
Economic participation and opportunity	83	0.616	0.588			
Labour force participation	30	0.88	0.68	78	89	0.88
Wage equality for similar work(surveys)	52	0.69	0.65	—	—	0.69
Estimated earned income(PPP US\$)	40	0.66	0.52	1,249	1,897	0.66
Legislators, senior officials and managers	121	0.05	0.26	5	95	0.05
Professional and technical workers	—	—	—	0.64	—	—
Educational Attainment	101	0.936	0.928			
Literacy rate	96	0.92	0.86	84	91	0.92
Enrolment in primary education	1	1.00	0.98	0.83	0.83	1.01
Enrolment in secondary education	105	0.94	0.9	48	51	0.94
Enrolment in tertiary education	108	0.70	0.86	3	5	0.7
Health and survival	102	0.968	0.956			
Sex ratio at birth	1	0.94	0.92	—	—	0.98
Healthy life expectancy	107	1.02	1.04	48	47	1.02
Political Empowerment	100	0.077	0.185			
Women in parliament	105	0.11	0.22	10	90	0.11
Women in ministerial positions	68	0.18	0.18	15	85	0.18
Years with female head of state (last 50 years)	52	0	0.16	0	50	0

Source: Hausmann et al 2011

Kenya's scores are comparable to the GGI 2011 report's global average in education, health and economic empowerment, (as illustrated in Figure 13.13) but below average in terms of political empowerment. However, Kenya's performance with respect to political empowerment across the gender divide is below the report's global average.

Figure 13.13 Comparing Kenya's Gender Gap sub-Indices with the GGI Sample Averages



Source: Hausmann et al 2011

In terms of labour force participation, most Kenyan women who are employed work as family workers whose interest is dependent on family generosity (KNBS, 2008:35). This is similar to the position of women in labour force in sub-Saharan Africa, for which ILO (2011) reports the share in vulnerable

employment to have been 84 percent, as compared with 69.5 percent of male workers in 2009.

13.6.2 Female Genital Mutilation/Cutting

Female circumcision, commonly known as female genital mutilation (FGM), is now widely recognized as a violation of human rights⁹¹, added to the fact that the procedure has no medical benefits and is not mandated by any religion. The practice is deeply rooted in the socio-economic and political structures of certain Kenyan communities and targets young women as a rite of passage into adulthood. In such communities, the procedure is perceived as a way of curtailing premarital sex and of preserving virginity among girls, with parents believing their daughters will not be marriageable if they are not cut. FGM is some form of gender violence and also an aspect of private discrimination (Human Rights Watch, 2013). FGM poses a major challenge to young women's long term SRH because the cutting destroys parts of the female reproductive organs, and often leads to complicated pregnancies, difficult births and lifelong emotional pain, among other complications.

FGM is still prevalent in Kenya, with Figure 13.14 showing the trends by age since the 1998 collection of the first FGM data in the country. Among the youth, and indeed across all age categories, the share of circumcised girls has been declining. While this suggests that efforts to eradicate the practice may be yielding some fruits, the incidence remains unacceptably high.

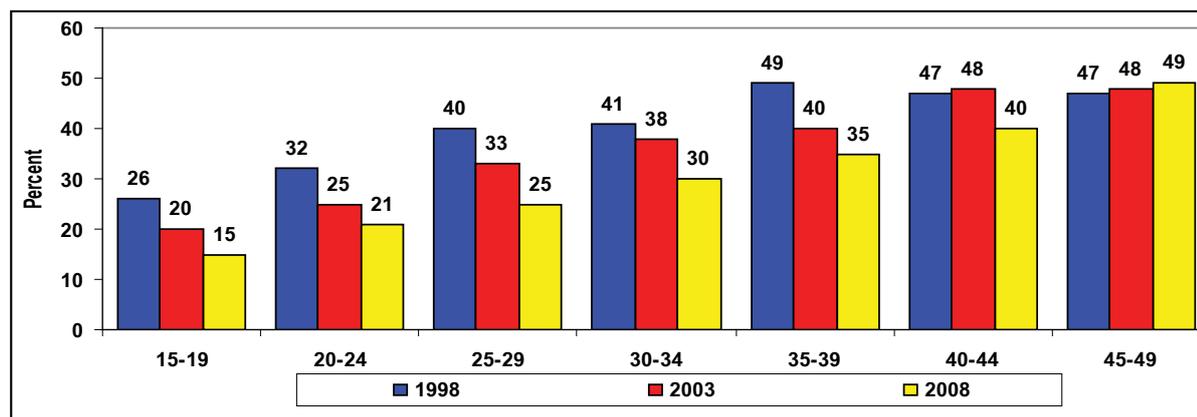


Samburu Girls celebrate after an alternative rite of passage seminar where they declared they will not be circumcised

Photo: www.UNFPA

⁹¹ The UN Declaration on Human Rights condemned FGM/C as a violation of human rights as early as 1952, while the 1989 Convention on the Rights of the Child identified the practice as both a violent and a harmful traditional practice.

Figure 13.14 Trends in the Proportion of Women Circumcised by Age (1998-2008)



Source: KDHS 1998, 2003 and 2008/2009

13.7 Vulnerable Population

Kenya Vision 2030 defines vulnerable groups to include widows and widowers, orphans and children at risk, persons with disabilities, under-age mothers, the poor of the poorest, internally and externally displaced persons and the elderly.

All these groups are faced with multiple challenges in their daily life, such as high levels of poverty and various forms of deprivation. The commitment to provide for these vulnerable — or marginalized — populations is contained specifically in Article 204 of the Constitution; but the document has numerous instances where it recognizes the inherent inequalities in Kenya to date, which is why it champions equity, affirmative action, and positive discrimination. Kenya Vision 2030 affirms that no society can gain social cohesion if significant sections of the population live in abject poverty: thus, reducing vulnerability and poverty is a key element of many social policies that have recently been enacted (Republic of Kenya, 2012a).

13.7.1 Persons with Disability

According to the World Health Organisation (WHO), a disability is “any restriction or lack (resulting from any impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (WHO, 1980; 2001). A disability may be physical, cognitive, mental, sensory, emotional, and developmental or some combination of these. A disability may be present from birth, or occur during a person’s lifetime. Persons with Disabilities (PWDs) are at greater risk of experiencing restrictions in performing tasks, or participating in community activities. There is need for the promotion of human rights, participation and inclusiveness to

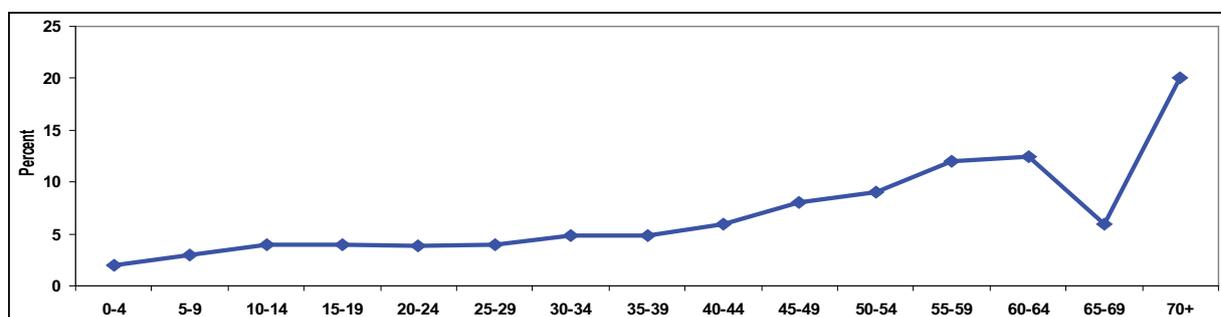


A woman living with disability with her family.
Photo: UNFPA

ensure that those with any form of disability are not excluded from enjoying health and development interventions, thus calling for advocacy for greater awareness of the issues faced by young women and men with mental, physical or other impairments.

The Plan of Action for the African Decade of Persons with Disabilities (1999-2009) explicitly recognizes that disability may severely affect one’s chances of getting an education, an issue that is particularly pertinent to young people. Furthermore, the number of people living with disabilities is growing as a result of factors such as population increase, aging, and medical advances that preserve and prolong life, thus increasing their demand for health care and rehabilitation services. According to WHO, disability affects ten percent of every population. However, according to the Disability Statistics Compendium, prevalence rates vary from 0.2 percent to 21 percent globally, and from country to country. In Kenya, almost five percent of the population has some form of disability, and while there are no major differences in prevalence in rural or urban areas, or by sex, prevalence does increase with age as depicted in Figure 13.15 (NCAPD, 2008).

Figure 13.15 Percent Distribution of Persons With any Form of Disability by Age (2008)



Source: KNSPWD, 2008

According to the Kenya National Survey for PwDs (KNSPWD) of 2008, 97 percent of PwDs had some problem accessing their natural environment, with more females than males reporting such difficulty. The survey report also noted that most PwDs in Kenya were unlikely to have active or viable socio-economic livelihoods⁹². Consequently, they require some assistance in the form of social security and disability grants or any other forms of financial assistance compared to their able-bodied counterparts.

Table 13.13 shows the distribution of women aged 12 to 49 who have some form of disability by age at first pregnancy and background characteristics. About 17 percent had their first pregnancy during their teenage years. Very early teenage pregnancy among persons with disability is highest in Nyanza and Eastern provinces. However, pregnancy before age 19 is highest in Rift Valley Province and lowest in North Eastern and Western provinces. Teenage pregnancy among women with disability is slightly higher in urban compared to rural areas.

⁹² Additionally, some cultures consider disability a curse, and consequently hide its victims from public view. In one northern Kenya County, a mentally disturbed young man in his mid-teens had been chained to a post in hut all his life.

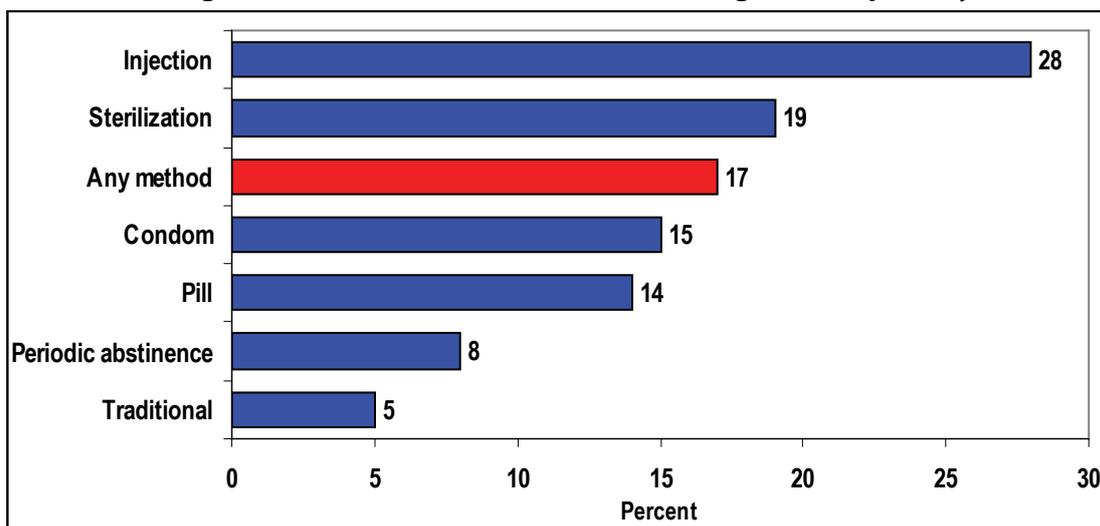
Table 13.13 Percent Distribution of Women age 12-49 with Some Form of Disability by Age at First Pregnancy and by Background Characteristics

Characteristic	Age group at First Pregnancy				
	12-14	15-19	20-24	25-29	30+
Rural	4.6	11.7	13.1	10.8	59.9
urban	2.4	16.2	15.4	16.8	49.2
Nairobi	2.9	11.8	23.6	19.2	42.6
Central	2.9	18.8	5.2	12.6	60.6
Coast	2.9	8.7	6.8	17.9	63.8
Eastern	7.8	8.0	15.9	10.1	58.2
North Eastern	0.0	0.0	0	0	100
Nyanza	7.0	12.3	16.2	12.7	51.8
Rift Valley	0.0	22.0	9.3	7.3	61.3
Western	0.0	4.2	18.6	12.1	65
Kenya	3.9	13.1	13.8	12.7	56.5

Source: KNSPWD (2008)

While contraceptive prevalence among all sexually active women in Kenya is 51 percent, and that of currently married women is 46 percent, only about 17 percent of women with disabilities reported using some form of family planning. In all instances, use of any type of contraceptive is lower among women with disabilities than among the other categories of women in the same age range. Factors contributing to the low uptake of contraception and other sexual and reproductive health services by Kenyan women with disabilities included: ignorance/lack of information; inaccessible facilities and equipment; lack of privacy and confidentiality (e.g. presence of a third party during service provision for deaf and blind); providers' insensitivity to such women's RH needs; and providers' inadequate knowledge/experience and capacity to deal with RH needs of women with disabilities. While it is recognized that the SRH needs and rights of PwDs are similar to those of the rest of the population, almost 40 percent of youth with disabilities reported experiencing problems accessing health care. The KNSPwDs also found a disproportionately high 19 percent use of female sterilization as a method of contraception among the disabled, compared to the same method's 4.8 percent rate among both currently married women and sexually active women of reproductive age (15-49) (Figure 13.16).

Figure 13.16 Percentage of Females (15-49) with Disabilities Using Contraception by Method (2008)



Source: KNSPWD (2008)

13.8 Youth and Social Exclusion

The Chapter on Youth in Part 3 provided a specific focus on youth as an emerging group that requires special attention. While it is not intended to replicate the issues raised in that chapter, this section pays particular attention to the extent to which some aspects of inequality exist between this group and older persons.

13.8.1 Youth Reproductive Health

One of the critical reproductive health concerns is the prevalence of unintended pregnancies. Births to unmarried teenagers are often unintended, and most such young mothers face precarious economic circumstances (Magadi et al., 2007) which often increase the chance of poor reproductive health outcomes both in the short and long-term (Singh, 1998). It is often teenagers who are more likely to experience premarital and unintended births compared to older women, with such births receiving poorer maternal health care (Gage, 1998; Magadi et al., 2000; Marston & Cleland, 2003). Using bivariate analysis on DHS data for several sub-Saharan Africa countries, Magadi et al (2007) find little variation in maternal health care by age. However, after controlling for the effect of background factors such as parity, premarital births, educational attainment and urban/rural residence in a multivariate analysis, teenagers do have poorer maternal health care outcomes compared to older women with similar background characteristics. However, there is a marked improvement in reproductive health outcomes between the current youth and those of the same age group a decade ago in Kenya.

13.8.2 Youth Employment

Worldwide, the youth are faced with multiple social, political and cultural exclusion issues among which unemployment and underemployment are likely to have the highest profile (ILO, 2011). Poverty among youth is closely tied to their unemployment and underemployment, as well as to poor reproductive health outcomes (UNFPA, 2010).

Youth aged 15-24 in Kenya accounted for less than 20 percent of total employment in 2011, but made up 37 percent of the working population (ILO, forthcoming). The gap between youth and adult employment was about 43 percentage points in 2011, making Kenya among the countries in sub-Saharan Africa with the highest age-based employment disparities. Kenya is said to be seventh among the sub-Saharan Africa countries with the greatest fall in the youth labour force participation rate, largely attributed to a slow-down in job creation (ILO, forthcoming). There are other marked differentials in youth employment: large gender gaps exist as do rural/urban differentials. In 2011, the proportion of young women (age 15-24) in employment declined to about 29 percent compared to 36 percent among men of similar age. Kenya is the country with largest the gender gap in youth employment in Sub Saharan Africa ((ILO, forthcoming). Unemployment among the youth is much higher in the urban areas compared to the rural areas, mainly fueled by high rural–urban migration in Kenya (World Bank, 2012).

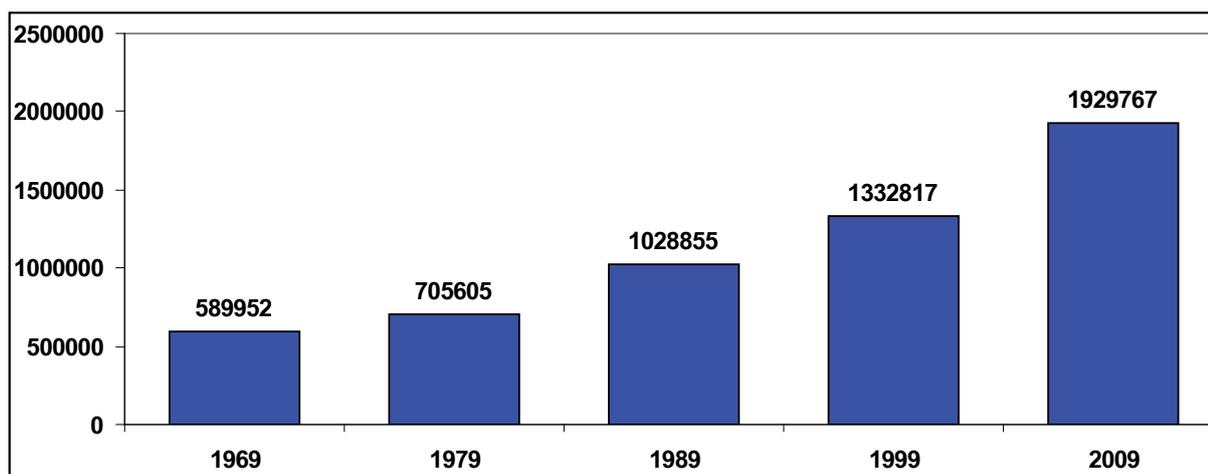
Although the youth presently have more education compared to a decade ago(KNBS, 2010), they are faced with labour markets that are increasingly unable to absorb low-skill workers and to guarantee coverage of social benefits traditionally tied to the performance of stable jobs (see ILO, 2011; World Bank, 2012). There are families that are unable to invest in their children’s education, and labour market constraints tend to exclude such young people from the best-paying jobs, leading to the vicious cycle of poverty (UNFPA, 2010). Young people with relatively low levels of education demonstrate higher fertility rates (see Chapter on Fertility in Part 3) than their peers with higher education levels, contributing to concentration of poverty in the first stages of the family life cycle.

Policies to address youth poverty must, therefore, focus as a matter of priority, on eliminating barriers to youth employment. That employment — specifically, access to decent work — is central to poverty reduction was firmly acknowledged by the Millennium Development Goals (MDG) through the inclusion of an employment-based target in halving the share of the world’s population living in extreme poverty.

13.9 Elderly Population

The elderly population is defined as persons aged 60 years and above. The proportion of these considerably vulnerable people in Kenya is still low because of, amongst other things, the country’s low life expectancy; but their absolute size has increased tremendously since 1969 (see Figure 13.14). For example, between 1969 and 1979 the growth rate of the elderly population was about 1.8 percent per annum, rising to 3.7 percent between 1999 and 2009 (KNBS , 2011).

Figure 13.17 Trends in Population Aged 60 and Above in Kenya, 1969-2009



Source: Kenya 2009 Population and Housing Census. Analytical Report on Population Dynamics. Vol.III

The age distribution of the population by gender shows that older women are more than their male counterparts in all age groups (Table 13.15). Census data show that most of households headed by aged persons are headed by women, mostly widowed. Welfare surveys (KIHBS 2005/2006; 2008/2009 KDHS) indicate that women-headed households (particularly the elderly) are more likely to be poor and more vulnerable to shocks.

Table 13.15 Distribution of the Elderly by Age Group and Gender, 2009

Age group	Males	Females	Sex ratio
60-64	295,197	298,581	98.9
65-69	183,151	207,612	88.2
70-74	160,301	179,000	89.6
75-79	99,833	118,675	84.1
80+	159,125	224,576	70.9
Total	897,607	1,028,444	87.3

Source: Population and Housing Census, 2009 Vol. 1C.

According to HelpAge International (2012a), a number of issues face the elderly in Kenya. These include poverty, poor health and nutrition, HIV and AIDS, poor housing, insecurity over incomes and social services, weak community and family support systems and weak legal frameworks to protect their rights. Although the absolute number of people age 60 and above has been increasing, less than 10 percent receive any kind of pension (Help Age International, 2012b). With the waning of family support and the prevailing economic systems, older people lack alternative sources of income⁹³, and therefore face hardship in a number of areas. This has caused them to slide deeper into vulnerability on the margins of society. In Kenya, current older person statistics show that over 47 percent of them living in urban areas seek shelter in informal settlements, which are poorly constructed in neighbourhoods of high unemployment, crime and increasing cases of HIV and AIDS (HelpAge International, 2012). Although health needs increase in old age, the vast majority of older adults in Africa have no healthcare coverage (Help Age International, 2004). However, information concerning the living conditions of the older people in Kenya is lacking, undermining any initiatives to develop interventions to improve the circumstances of the elderly.

13.10 Exercise of Rights

13.10.1 Policies and Programmes

For the first time since independence, 2010 saw Kenya fully articulate the principles of human rights in her Constitution. The relevant articles dealing with population related issues include Sections 26, 42, 43, 45 and specific applications delineated Sections 53 to 57 (Republic of Kenya, 2010). Article 21 recognizes the fundamental duty of the state and every state organ to observe, respect, protect, promote and fulfill the rights and fundamental freedoms outlined in the Bill of Rights (Chapter 4). The Bill of Rights forms the basis upon which the Government provides key basic social services to the public.

Health holds a special place in human rights: everyone has the right to enjoy the highest attainable standard of health in their society (WHO, 1946)⁹⁴. In addition, health is a unique resource for achieving other objectives in life, such as better education and employment. Health is, therefore, a way of promoting the freedom of individuals and societies (Sen., 2000). Article 43 of the Kenyan constitution recognizes the right of every person to the highest attainable standard of health, including reproductive health. Kenya Health Policy of 2012-2030 aims at not only employing human rights based approach in health care delivery, but also integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions. The Committee on Economic, Social and Cultural Rights noted that the right to health depends on different factors, which do not derive directly from medical services but from the realization of other rights such as food, housing and clean environment, among others.

Articles 53 to 59 of the Constitution have specific provisions relating to the management of vulnerable groups. Article 53 provides for children's right to free and compulsory basic education, including quality services, while Article 54 seeks to ensure access to educational institutions and facilities for persons with disabilities. The measures taken to reduce inequalities in education have been informed by a number of policy initiatives that focused on the attainment of education for all, in particular, the Universal Primary Education (UPE) policy. The implementation of the Free Primary Education and Free Day Secondary

⁹³ This is because of low levels of pension coverage in Kenya, (only public sector and employees of large private companies are covered), and pension recipients represent only a small fraction of the total elder population. For this reason, men and women in often carry on working until an advanced age, generally as long as their health permits.

⁹⁴ The right to health appears in several paragraphs of the Vienna Declaration and Program of Action and the Program of Action of the United Nations International Conference on Population and Development. The Declaration and Program of Action of the Fourth World Conference on Women contains definitions concerning, respectively, reproductive health and women's health rights.

Tuition programmes enabled the country to make significant progress towards attaining Education for All (EFA) and the education MDG, basically number 2. More recently, there has been a re-alignment of education sector policies to the Constitution and to Vision 2030 (Ministry of Education, 2012). In all, Kenya ranks highly with regard to gender parity in primary education as reported in the recent Global Gender Gap Report of 2011 (Hausmann et al, 2011).

Whilst the Bill of Rights has detailed various rights to services, including health and education, it is expected that the people will increasingly demand their rights through a more empowered civil society. The provisions of Article 46 (1)(a) and (b) are important as they grant consumers the right to goods and services of reasonable quality and to information necessary for them to gain full benefit from goods and services.

One of the key strategies aimed at addressing inequalities is improved management of public spending. Article 201 of the Constitution states that: 'Expenditure shall promote the equitable development of the country'. Further, Article 203 (1)(a) to (k)⁹⁵ of the same chapter elaborates the criteria for determination of the equitable sharing of resources. Articles 174 and 201 and Vision 2030's goals emphasize bringing equity to the centre of development, and reducing disparities across socio-economic groups, with emphasis on human rights for all (Republic of Kenya, 2012b).

According to the Universal Declaration on Human Rights⁹⁶, the International Covenant on Economic, Social and Cultural Rights⁹⁷, and other international conventions on human rights to which Kenya is a signatory, poverty is a violation of human rights. In acknowledgement of these fundamental human rights, the Kenya Government signed the 1974 Universal Declaration on the Eradication of Hunger and Malnutrition whose Article 1 states that: every man or woman has the inalienable right to be free from hunger and malnutrition in order to develop fully and maintain their physical and mental faculties. In recognition of the persistence poverty and inequality, however, Kenya Vision 2030 also states that the Government shall adhere to the rule of law as applicable to a modern, market based economy, while at the same time respecting human rights (Republic of Kenya, 2012b: vii). Specifically, Vision 2030 seeks to align national policies and legal frameworks within the needs of a market based economy, national human rights and gender equity commitments.

With respect to gender, youth and vulnerability, Kenya Vision 2030 seeks to: increase the participation of women in all economic, social and political decision-making processes, and in particular through higher representation in Parliament; (ii) improve access to services for all the disadvantaged; and (iii) minimize vulnerabilities through the prohibition of retrogressive practices, such as FGM and child labour, and by scaling up training for people with disabilities and special needs (Republic of Kenya, 2012b:vii).

By launching several schemes⁹⁸ through which to provide social protection⁹⁹ for the vulnerable population in the last decade, the Kenya Government has now recognized that social protection is essential for achieving poverty reduction and inclusive growth. In 2010, a commitment to social protection was enshrined in Kenya's Constitution, which now asserts the "right for every person ... to social security" and "binds the State to provide appropriate social security to persons who are unable to

95 Article 203 parts 1(a) to 1(k) states that in the allocation there is need to: (i) ensure that the county Governments are able to perform their functions (ii) take into account the fiscal capacity and efficiency (iii) take into account developmental and other needs and (iv) take into account economic disparities

96 See Articles 25 and 26 of Universal Declaration of Human Rights

97 See articles 10,12 and 13 of the International Covenant on Economic, Social and Cultural Rights

98 The social protection schemes include; Orphans and Vulnerable Children Cash Transfer (OVC-CT), the Older Person's Cash Transfer (OPCT), the Urban Food Subsidy Programme (UFSP-CT) and the Cash Transfer Programme to Persons with Severe Disabilities (CT-PWD).

99 Social protection schemes are policies and actions, including legislative measures, that enhance the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare.

support themselves and their dependants". This was followed by a new policy on social protection, the National Social Protection Policy (NSPP), backed by parliamentary legislation in May 2012.

The NSPP recognizes many of the existing social protection initiatives that have been established over time (Ministry of Gender, Children and Social Development, 2011). The policy imperative seeks to expand social protection by establishing a minimum package as defined in the African Union Social Policy Framework of 2008. For old age, the policy seeks to provide a benefit, grant, or pension payable to the older persons on either a targeted or universal basis (often referred to as social pension).¹⁰⁰ For the social security, the focus is a compulsory contributory scheme, while occupational retirement schemes and voluntary social insurance will also provide pension benefits to their beneficiaries.

The Constitution champions access to social and economic rights and provides for equality of, and representation for, persons with disabilities and other marginalized groups. Through the Constitution, implementation of Vision 2030, and the fact that Government has established various legal frameworks — such as Sexual Offences Act, 2006 and the Convention on the Elimination of all Forms of Discrimination against Women — the Government provides evidence of its commitment to the obligation to respect, protect and fulfill rights, as required in Article 12 of the International Covenant on Economic, Social and Cultural Rights of May 2000¹⁰¹.

13.10.2 Measurement of the extent of exercise of rights

The Kenya Government's commitment to the 1994 ICPD) principles shifted the focus of development from the basic needs approach to the rights approach. Thus, population as well as other social and economic needs must be pursued based on the human rights-based framework. Vision 2030 seeks to mainstream gender equity in all aspects of society, embrace rights approach in programming, and thereby reduce observed inequalities. Specifically, Vision 2030 addresses four key areas namely; opportunity; empowerment; capabilities; and vulnerabilities — all of which are inextricably linked to population related inequalities.

According to ICPD, population and reproductive health implies two rights: a) the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of FP of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law; and b) the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (ICPD PoA, 1994, para 7.2). The extent to which couples are able to exercise their reproductive rights largely determines the reproductive health status of the population. Kenya is not likely to achieve the desired goals with respect to maternal mortality and infant mortality (see Part 2 and Chapter on Mortality in Part 3). There exists a wide regional and socio-economic inequality in maternal and early mortality. The skewed ill health of the poor as well as their high propensity to early mortality indicates that they have not yet fully enjoyed the rights associated with reproductive health. Computations from the 2008/2009 KDHS and 2009 KPHC show that every year:

- nearly 7,500 women die as result pregnancy related conditions;
- approximately 1.1 million currently married women have unmet need for contraception;
- nearly 1.8 million currently married women have an unplanned birth; and
- slightly over 7 out of every 10 women have risky birth.

¹⁰⁰ A social pension is defined as a Government-provided regular non-contributory cash transfer to older people.

¹⁰¹ Art. 12.1, of the International Convention on Economic, Social and Cultural Rights:

http://www.unhchr.ch/html/menu3/b/a_ceschr.htm. Also see Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), par. 1. Full text in Annex 1 [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.)

These results show that many women of reproductive age are unable to exercise their reproductive rights as envisaged by ICPD.

Kenya's health conditions as measured by infant and child mortality, and fertility rates, demonstrate the association between high levels of poverty and poor health outcomes. Analysis of trend data from various KDHS since 1993 reveal that poor health conditions are disproportionately concentrated among the least wealthy segments of society. The least wealthy are also unlikely to utilize the available interventions as measured by the various indicators of inequality discussed in this chapter. Poverty, lack of education and information as well as inadequate access to health and related social services compromise to a large extent the reproductive health of men, women and their children. The implication here is two-fold: - the need to not only increase access to all, but also to effectively target the poor.

13.11 Gaps/Limitations

For the design, implementation, follow-up and evaluation of policies, statistical information is an indispensable tool. During the past decade, there have been efforts globally to use population information in the field of social public policies. The information should also be used in inequality and poverty analyses, in order to improve the design of the interventions with which to improve the living conditions of the middle and low segments of society. However, targets and indicators employed have not been designed based on the monitoring of inequalities and entrenched discrimination, or on the realization on the extent to which the social and economic rights are exercised. Many indicators are based on averages which ignore the disaggregated picture of how the disadvantaged fare relative to the most advantaged in society¹⁰².

Another gap is the use of quintiles to assess the extent of poverty and inequalities. Although quintile scores are now commonly used, there is no necessary correspondence between them and poverty lines based on income or expenditures (Foreit et al, 2010); which is to emphasize the possibility that some households classified as quintile 5 may fall below a country's income-based poverty line. For the 2008/2009 KDHS, national wealth quintiles obscure the differences in urban and rural wealth gaps, pointing to the need to re-estimate quintile scores for urban areas.

Another aspect not included on this chapter is the service coverage gap. This would explore both provision and use of services and interventions, and for example, estimate the proportion of people receiving a specified service or intervention among those requiring that service. Analysis could then determine the additional investment necessary for universal coverage for that service.

Article 12 of the International Covenant on Economic, Social and Cultural Rights provides for the development of the appropriate right to health indicators¹⁰³. The Covenant states that: "State parties are invited to set appropriate national benchmarks in relation to each indicator of the right to health by identifying appropriate right to health indicators and benchmarks to monitor the extent of the framework law." This is a critical gap in the health policy framework even though it aims at using the rights to health approach in developing health interventions. That is, all the Kenyan policy and strategy documents lack right to health benchmarks. A human rights-based approach to programming must ensure that all processes, including data collection and use, are in line with human rights principles. It requires taking into account the extent to which existing services are available, accessible and acceptable to, and of high quality for, the population (UNFPA, 2010).

¹⁰²See also <http://www.hrw.org/news/2013/01/11/discrimination-inequality-and-poverty-human-rights-perspective>.

¹⁰³ Art. 12.1, of the International Convention on Economic, Social and Cultural Rights:

http://www.unhcr.ch/html/menu3/b/a_ceschr.htm. Also see Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), par. 1. Full text in Annex 1 [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4)

Although coverage and investments in safety nets have increased overtime, coverage of safety net programmes remains low in comparison to the population in need, part of the problem lying in the weak monitoring and evaluation (M&E)(Republic of Kenya 2012a). Additionally, the weak alignment of existing programmes with the changing social, political, and economic context threatens their sustainability. The Government notes that previous assessments have indicated insufficient capacity in the ministries and other agencies to implement a coordinated and harmonized social protection system. NSPP recognizes two core challenges, namely: the huge gaps in policy coverage; and the fragmentation in existing systems (Ministry of Gender, Children and Social Development, 2011; Help Age International, 2012b).

13.12 Conclusions

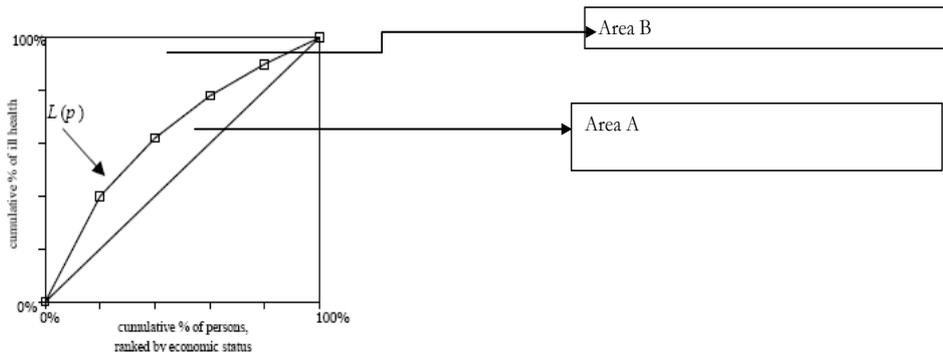
Although Kenya has diverse inequalities, this chapter has concentrated only on population related inequalities. Trend data shows that population-based inequalities have been declining, especially in the cases of early mortality and final fertility intensity. Inequality in the utilization of services delivered at the community level (e.g. family planning and immunizations) is slightly lower than to services delivered in health facilities, e.g. antenatal care visits and skilled birth attendance (see also Ahmad et al, 2011). Studies show that the level of inequality in service use is partly due to the fact that the Government and its partners have disproportionately devoted resources to relatively wealthier populations rather than to those who are poor or hard to reach (HPI, 2010; World Bank, 2008). However, some of the sources of inequality may not be just weak accountability mechanisms, but also the lack of knowledge among excluded and vulnerable groups, on how to make their voices heard.

The Government is now committed to the decentralization of services through devolution of political power, equitable distribution of national revenue and commitment to equity laws and regulations. Equitable or fair resource allocation can only be accomplished by considering variation in needs across geographic and economic groups (Brain et al., 2010). The implication here is two-fold, pointing to the need to not only increase access to all, but to also effectively target the poor.

Many of the existing policies have indicated that interventions will take into account the human rights approach. However, targets and indicators have not been designed to actualize a human rights approach to programming. There is a need to identify existing approaches that link human rights and social and economic concerns, and then to determine the best ways to assess their impacts on the effectiveness and outcomes of policies and programmes.

Appendix 13.1 Technical Note on Estimation of Concentration Index (summary measure for inequality)

Concentration curves can be used to identify whether socio-economic inequality in some variable exists and whether it is more pronounced at one point than at another. Figure 1 shows the concentration curve defined by the line marked $L(p)$. The resulting concentration index (CI) is a summary measure of the extent of inequality across the whole distribution, and is defined as twice the area between the concentration curve and the line of equality (the 45-degree line) divided by the sum of the areas A (under the curve) and B (above the curve) (Kakwani, Wagstaff and van Doorslaer 1997). In case there is no inequality, the curve coincides with the diagonal, meaning CI equals zero.



Formally, the concentration index is defined as

$$CI = 1 - 2 \int_0^1 L_h(p) dp$$

In discrete terms, $CI = (2/N\mu) \sum_{i=1}^n h_{ir} - 1 - 1/N$

Where h_i is the health sector variable, μ is its mean, and $r_i = i/N$ is the fractional rank of individual i in the living standards distribution, with $i = 1$ for the poorest and $i = N$ for the richest. The index is bounded between -1 and 1 . The sign of the concentration index indicates the direction of any relationship between the health variable and position in the living standards distribution, and its magnitude reflects both the strength of the relationship and the degree of variability in the health variable. The index takes a negative value when the curve lies above the line of equality, indicating disproportionate concentration of the health variable among the poor, and a positive value when it lies below the line of equality. A negative value of the concentration index means ill health is higher among the poor. That is outcomes that decline as conditions improve (e.g. mortality, or total fertility rates,) the index ranges from -1 to 0 . -1 for perfect inequality and 0 for perfect equality. With outcomes that increase as conditions improve, 1 indicates perfect inequality and 0 means perfect equality.

The concentration index for $t=1, \dots, T$ groups is easily computed in a spreadsheet program using the formula by Fuller and Lury (1977).

$C = (p_1L_2 - p_2L_1) + (p_2L_3 - p_3L_2) + \dots + (p_T - 1L_T - p_T L_T - 1)$ where p_t is the cumulative percentage of the sample ranked by economic status in group t , and L_t is the corresponding concentration curve ordinate.

Multiplying the concentration index by 75 gives the percentage of the health variable that would need to be redistributed from the richer half to the poorer half of the population to arrive at a distribution with an index value of zero (Koolman and van Doorslaer, 2004).

Appendix 13.2 Indicators of inequality for child health interventions

								Low/High	Low-High	Concentration index
		Low	2nd	3rd	4th	High	Average	Ratio	Diff.	Value
2008	A: Childhood Immunization									
	BCG coverage	70	88.7	92.9	96.4	96	87.3	0.73	25.93	0.0648
	Measles coverage	54	67.9	80	80.6	87.6	72.3	0.62	33.61	0.1025
	DPT coverage	56.3	71	85.7	81.3	72.7	72.2	0.77	16.36	0.0753
	Full basic coverage	37.8	50.2	62.3	56.6	59.5	52.1	0.64	21.68	0.1114
	No basic coverage	19.7	5.3	4.1	1.1	3.1	7.6	6.45	16.67	-0.5321
	B: Antenatal and care delivery									
	<i>Antenatal visits</i>									
	medically trained	75.1	87.4	92.4	93	94	88.1	0.8	18.81	0.0583
	Doctor	15.6	16.4	17.3	14.8	24.9	17.9	0.63	9.33	0.1193
	Nurse or trained midwife	59.5	71	75.1	78.2	69	70.2	0.86	9.48	0.0428
	Multiple visits to a medically trained	64	75.5	75.9	78.4	84.3	75.5	0.76	20.28	0.0713
	<i>Antenatal care content</i>									
	Tetanus toxoid	71.5	87.6	88.9	90.2	90.4	85.4	0.79	18.98	0.0512
	Prophylactic anti malarial treatment	20.2	18.7	21	17.9	19.5	19.5	1.03	0.68	0.0111
	Iron supplementation	46.3	47	46.9	42	45.8	45.7	1.01	0.48	0.0175
	C: Delivery attendance									
	medically trained	17	32.8	38.1	55	75.4	41.6	0.23	58.38	0.2989
	doctor	4	7.8	7.4	13.4	27.5	11.4	0.15	23.45	0.4228
	Nurse or trained midwife	13	25	30.8	41.5	47.9	30.2	0.27	34.93	0.2521
	public facility	9.2	19.1	27.8	38.5	43.5	26.1	0.21	34.33	0.2644
	private facility	6.8	12.3	8.7	14.7	30.3	14	0.22	23.52	0.3806
	home	82.9	66.7	62.3	45.8	25.8	58.7	3.22	57.12	-0.206
2003	A: Childhood Immunization									
	BCG coverage	92.8	97.4	95.5	96.1	96.5	95.6	1.04	3.7	0.023
	Measles coverage	75.6	80.8	85.5	89.8	93.9	85.0	1.24	18.3	0.061
	DPT coverage	77.3	86.7	91.2	88.8	89.6	86.4	1.16	12.3	0.045
	Full basic coverage	65.9	74.6	80.2	82.5	85.1	77.4	1.29	19.2	0.067
	No basic coverage	6.1	2.2	3.6	1.9	2.0	3.2	0.33	-4.1	-0.193
	B: Antenatal and care delivery									
	<i>Antenatal visits</i>									
	medically trained	83.6	92.7	3.2	2.7	95.6	91.5	1.14	12	
	Doctor	19.9	23.3	8.6	3.2	39.2	28.9	1.97	19.3	0.038
	Nurse or trained midwife	63.7	69.5	4.6	9.5	56.4	62.6	0.89	-7.3	0.144
	Multiple visits to a medically trained	65.8	74.4	3.2	5.3	74.1	72.5	1.13	8.3	
	<i>Antenatal care content</i>									
	Tetanus toxoid	49.3	54.4	6.7	58.3	56.9	55.0	1.15	7.6	
	C: Delivery attendance									
	medically trained	20.3	31.3	1.9	2.9	81.4	43.8	4.01	61.1	0.316
	doctor	5.6	11.8	4.5	19.1	32.9	16.0	5.88	27.3	0.374

	Nurse or trained midwife	14.7	19.6	7.4	3.7	48.5	27.8	3.30	33.8	0.287
	public facility	16.0	23.1	6.2	9.9	52.9	32.3	3.31	36.9	0.282
	private facility	2.1	7.3	5.4	11.6	28.0	10.3	13.33	25.9	0.507
	home	80.9	68.3	56.7	7.2	18.4	56.2	0.23	-62.5	-0.155
1998										
	BCG coverage	93.5	92.7	8.3	7.4	99.0	95.9	0.94	5.50	0.0129
	Measles coverage	64.3	79.6	4.7	3.8	88.7	79.2	0.72	24.40	0.0632
	DPT coverage	67.4	78.2	5.9	4.0	84.1	79.2	0.80	16.70	0.0418
	Full basic coverage	48.1	57.6	1.0	64.6	59.9	59.5	0.80	11.80	0.0577
	No basic coverage	4.8	3.0	1.1	2.6	1.0	2.7	4.80	3.80	-0.2791
	To a medically-trained person	88.5	90.0	93.2	5.3	96.2	92.3	0.92	7.70	0.0168
	To a doctor	23.7	23.2	5.8	2.7	38.8	28.3	0.61	15.10	0.1307
	To a nurse or trained midwife	64.7	66.8	7.3	2.5	57.5	64.0	1.13	7.20	-0.0330
	Multiple visits to a medically-trained person	77.4	78.5	2.4	4.3	86.5	81.4	0.89	9.10	0.0188
	medically-trained person	23.2	33.3	1.9	6.1	79.6	44.4	0.29	56.40	0.2419
	doctor	5.1	8.0	1.6	3.5	28.0	12.3	0.18	22.90	0.3403
	nurse or trained midwife	18.1	25.3	30.3	42.7	51.6	32.0	0.35	33.50	0.2042
	public facility	15.9	24.9	3.3	40.2	48.2	30.9	0.33	32.30	0.2076
	private facility	4.4	5.5	7.7	3.2	30.1	11.2	0.15	25.70	0.4028
	At home	78.2	68.0	58.1	45.1	21.3	56.6	3.67	56.90	-0.1878
1993	BCG coverage	93.3	94.6	95.7	99.1	99.1	96.2	0.94	5.77	0.0120
	Measles coverage	69.7	88.5	82.6	90.4	89.8	83.8	0.78	20.13	0.0392
	DPT coverage	76.7	86.2	86.4	92.8	93.6	86.8	0.82	16.86	0.0302
	Full basic coverage	64.8	78.0	77.1	86.7	86.4	78.2	0.75	21.59	0.0487
	No basic coverage	6.2	3.7	4.3	0.9	0.9	3.3	6.67	5.23	-0.2873
	To a medically-trained person	89.0	96.1	96.1	95.9	97.6	94.8	0.91	8.64	0.0141
	To a doctor	21.1	22.5	23.1	19.1	31.8	23.4	0.66	10.67	0.0723
	To a nurse or trained midwife	67.9	73.6	73.0	76.8	65.8	71.4	1.03	2.03	-0.0050
	Multiple visits to a medically-trained person	76.3	85.1	83.9	84.9	87.7	83.4	0.87	11.36	0.0247
	By a medically-trained person	23.1	33.1	45.7	56.7	76.5	45.1	0.30	53.40	0.2270
	By a doctor	5.7	9.4	11.8	13.6	23.6	12.2	0.24	17.87	0.2891
	By a nurse or trained midwife	17.3	23.7	33.9	43.1	52.8	32.9	0.33	35.53	0.2040
	In a public facility	17.7	26.8	34.7	44.0	51.9	33.8	0.34	34.23	0.2021
	In a private facility	4.8	5.1	9.6	11.3	22.5	10.0	0.21	17.66	0.3198
	At home	75.8	66.1	54.4	43.8	24.3	54.7	3.12	51.51	-0.1795

Source: Gwatkin et al 2007; data for 2008 computed from 2008/9 KDHS

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CHAPTER 14: RELATIONSHIPS AND THEIR RELEVANCE TO PUBLIC POLICIES

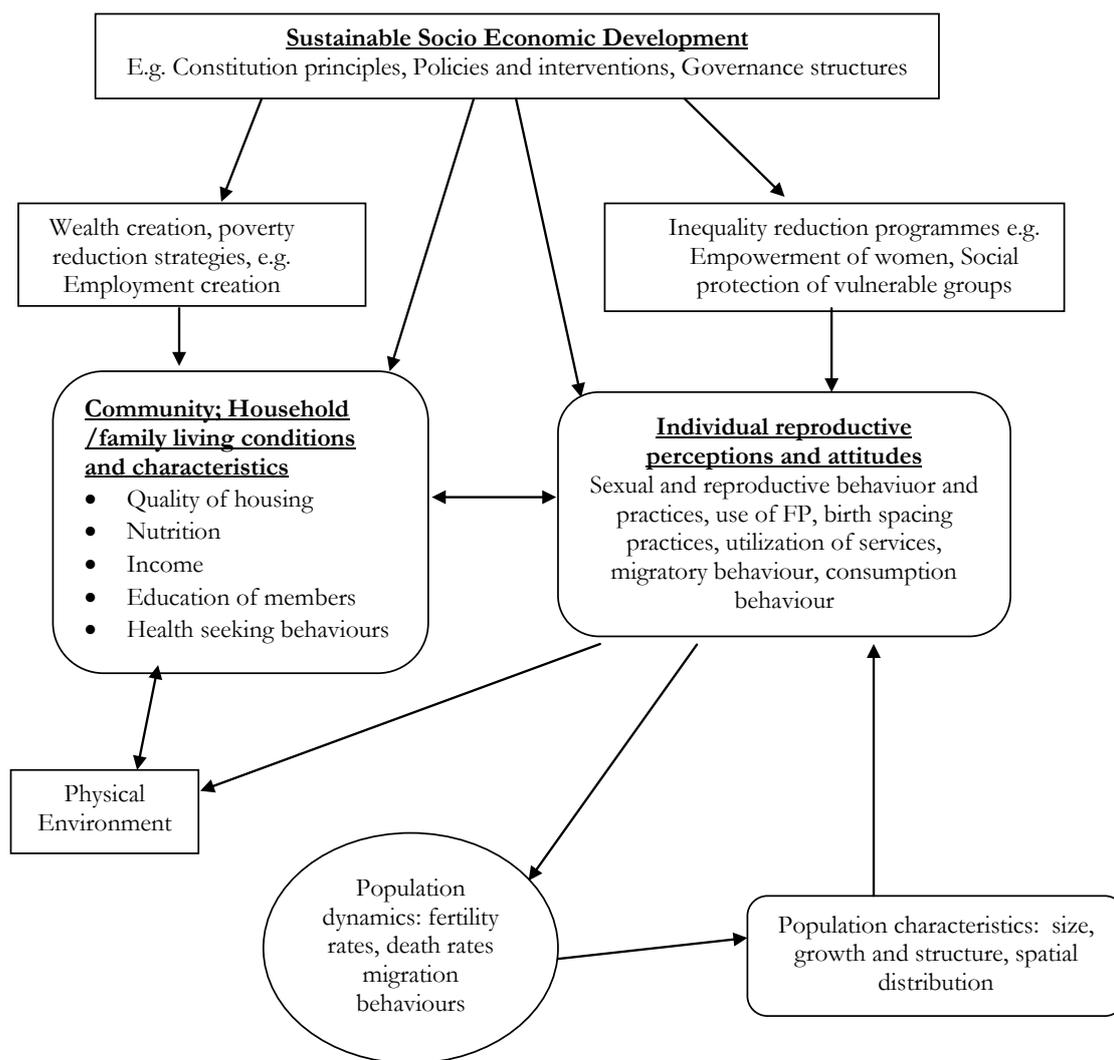
14.1 Introduction

Kenya's development agenda as stipulated in a number of policies and programs have pointed out the need to reduce poverty and inequalities and guarantee human rights (Republic of Kenya, 2012a; 2012b). Population and reproductive health issues are also inextricably linked to issues on poverty and inequality reduction (UNFPA, 2007). The country population policy framework since 1984 recognizes these inter-linkages and explicitly states that population processes influence development and vice versa. The Sessional Paper No. 1 of 2012 as well as the Sessional Paper No. of 2000 called for multi-sectoral approach to addressing population issues including the integration of demographic factors into the activities of; health, education, women's development, urbanization, housing, environment, poverty alleviation, elimination of social and economic disparities (Republic of Kenya, 2012). The interconnections between population dynamics, a reproductive health and development can operate at the individual, household (micro) level and also the societal (macro) level. For example, it has been argued that faster reduction of gender inequality would increase economic growth as was observed in South Asia (UNFPA, 2012), while participation of women in the labour force of low-income countries is often undermined by the vital roles they play at home (UNFPA, 2012).

This chapter reviews some of the important connections between the various components of population dynamics, reproduction and gender as well as their actual or potential implications for public policies. The Sessional Paper No. 1 of 2012 on population policy envisages these interrelationships as shown in the conceptual framework presented in Figure 15.1 below. Nevertheless attributing causal effect relationships to deduce the impacts is still difficult to entangle given the data availability and measurement issues (see UNFPA, 2007).

The key assumption in the inter-linkages is that poverty is multidimensional and denotes people's exclusion from socially adequate living standards and encompasses a range of deprivations (UNDP, 2013). Further, dimensions of poverty cover distinct aspects of human capabilities: economic (income, livelihoods, decent work), human (health, education), political (empowerment, rights, voice), socio-cultural (status, dignity) and protective (insecurity, risk, vulnerability). However, causes of poverty vary widely but it is acknowledged that factors that shape development patterns can mitigate or perpetuate poverty. Sustainable development aims at improving human well-being, particularly by alleviating poverty, lowering inequality, and improving health, human resources, and stewardship of the natural environment is closely linked to population factors (Global Science Panel on Population and the Environment; 2002).

Figure 14.1 Conceptual Framework on Population and Development Linkages



Source: Adapted from Republic of Kenya, 2012b

The ICPD and ICPD+5 placed population, reproductive health, and gender equality in a rights-based framework that is linked to and plays a key role in human development, sustained economic growth and sustainable development. The Millennium Declaration which generated a series of quantified targets for ending extreme poverty by 2015 constitute a summary of key commitments from different United Nations conferences from the 1990s (WHO, 2003). This chapter discusses the linkages between population dynamics, reproductive health (RH) and gender and their actual or potential implications within the MDG framework. It essentially draws on the analyses presented in part II and III of this document.

14.2 Population Dynamics and Development: Linkages

14.2.1 Population Dynamics

As reported in Chapter 3, Kenya's population has been growing rapidly over the last 30 years and is projected to double in about 23 years. Currently, the population is 40 million people and has a sex ratio of 110. Its growth rate is estimated at 2.9 per cent per annum. Annually the population increases by slightly over a million people and it will double after 21 years i.e. by 2034. The high population

growth is due to relatively high fertility and declining mortality. Currently, fertility is estimated at 4.6 children per woman, but with substantial regional and socio-economic differentials observed across the country. Fertility is high in Western, Nyanza, Eastern, Rift Valley and North Eastern provinces, but is below the national average in Central, Coast and Nairobi provinces.

Similarly, the analysis shows that Kenya has recorded a remarked improvement in reducing mortality; currently, infant and child mortality are estimated at 52 and 74 deaths respectively per 1,000 live births. In 1969 the comparative mortality rates were 119 for infants and 190 for children under age five. As in the case of fertility, there are wide regional and socio-economic differentials in infant and child mortality. Generally, mortality is high in the Nyanza, Western and Coast provinces, and low in Nairobi, Central, Rift Valley and Eastern provinces. Furthermore, the analysis shows that maternal mortality is relatively high in the country, estimated at 488 deaths per 100,000 live births in 2008-2009.

Further, Chapters 2 and 3 show that international migration is not a significant factor in influencing overall population change in the country. However, migration is an important determinant of population change at sub-national level. Internal migration is influenced by socio economic and social disparities. Migrants also move in search for training and employment opportunities as well as land to settle on. In this regard, rural-urban migration is a major factor in the rapid urban growth in Kenya.

Age structure

With regard to the age-structure of the population, the analysis clearly shows that Kenya has a youthful population with 63 percent of the total population being below the age of 25, the majority of whom are dependents. Only five percent of the population is aged 60 and above. About 48 percent of women are in the reproductive age. The analysis also shows that early marriages are common in Kenya, where marriage is an almost universal institution. The youthful age structure, combined with early marriage, creates a great momentum for further population growth.

Economic Progress

Chapter 2 also indicated that Kenya has on average recorded impressive economic development since independence in 1963. Kenya's policy initiatives and development programmes have been concerned with the improvement of average standards of living of its people. For example, the Economic Recovery Strategy for Wealth and Employment creation 2003-2007 (ERS) aimed at reducing poverty and narrowing inequalities through employment and empowerment, and improving access to social services, including education, for all people (UNICEF and GOK, 2010). From a 2002 economic growth rate of less than one percent, ERS was able to revive the economy, which grew year on year from two percent in 2003 to seven percent during in 2007, the final year of the strategy. While the 2007-2008 post-election violence interrupted progress, 2009 witnessed a resumption which has allowed a growth rate of 4.5 percent in 2012.

The Government has been committed to attending to the factors that fuel morbidity and mortality in the country. Consequently, an extensive public health infrastructure to provide both preventive services — including family planning (FP) services — and curative services has been established. Efforts have also been made to improve food security and provision of clean drinking water and adequate sanitation.

However, the welfare of the Kenyan people is still characterized by wide socio-economic inequalities, including unemployment, poverty, malnutrition, and a huge burden of preventable diseases (KNBS, 2007; KIPPRA, 2004; and Kimani and Kombo, 2010). For example, despite Government efforts since independence to eradicate poverty, nearly half of the country's 2009 population lives in poverty, with

children, women and rural population bearing the brunt of it (UNICEF and GOK, 2010). According world global monitoring report of 2013 Kenya is the world's third most unequal society after South Africa and Brazil¹⁰⁴, and the gap between the country's rich and poor is widening (World Bank, 2013). These outcomes suggest that growth has not been broad-based, that certain areas and sectors of the economy have been able to flourish through socio-economic transformations that have not touched other parts of the country.

Interrelationships

The interactions between population and development have long been recognised in the literature¹⁰⁵ (UNFPA, 2007; 2010). On the one hand, development can affect population dynamics while on the other hand population dynamics can either enhance or hinder development. As earlier indicated, the development recorded in Kenya since independence has contributed to the reduction in morbidity, mortality and fertility and population growth. A consequence of declining infant and child mortality alongside the high but declining fertility, development has contributed to the emergence of a youthful age structure ('demographic dividend') — a resource which can spur further development if it can be harnessed and gainfully employed (see Chapter 3 and Chapter on Youth in Part 3). However, in the Kenyan context, the rapid population growth makes it difficult to adequately invest in the human capital that is the youth and to create adequate employment opportunities for them. Furthermore, improvements in communications have facilitated the ease of both internal and international migration, which have development consequences in both the areas of origin and of destination.

Kenya's persisting rapid population growth has had negative effects on its development. Rapid population growth increases its density and reduces the amount of land available for agricultural use. This exerts pressure on arable land leading to encroachment of forest land which are water catchments and cultivation of hillsides, and/or to out-migration. Whichever option people choose — to stay or migrate — rapid population growth increases demand for the resources with which to provide basic social services, such as health and education. For example, high birth rates, childbearing at early and advanced ages, and short birth intervals increase maternal and child morbidity and mortality (Cleland *et al*, 2006). In turn, these demands reduce the country's ability to invest in the expansion of the economy, thereby undermining the challenge of achieving the MDGs and Vision 2030 (NCPD, 2001; 2011).

The Government's efforts to improve the quality of social services are made and continue to be made more difficult by the rapidly growing number of people that need to be served (Birdsall *et al*, 2001, NCPD, 2001). Some studies conclude that a rapidly growing population often leads to reduced economic growth because of the high dependency ratio (i.e. a high ratio of young to working age people), which reduces income per head and contributing to low savings (see for example Birdsall *et al*, 2001).

Rapid population is just one among the many factors that have led to rural-urban labour migration. As a way of escaping poverty, many young Kenyans migrate to urban areas in search of employment and training opportunities. The rapid rural-urban migration fuels rapid urbanization, and in the absence of equally rapid economic growth and investments, it has increased urban unemployment, under-employment and poverty. It has also spawned economic vulnerability adversely affecting access to social services (notably health care, education and housing), undermined infrastructure development, and has led to overcrowding as well as unplanned and informal settlements (slums) (NCPD, 2001; UN-HABITAT, 2006).

Rapid population growth's adverse impact on health care access leads to poor health since the available health-care facilities are often unable to adequately serve the ever increasing needs of the population.

¹⁰⁴ Gini Coefficient for South Africa is estimated at 0.65, Brazil at 0.54 and Kenya at 0.50.

¹⁰⁵ A detailed summary of studies and debates is provided in UNFPA 2007.

Currently, facility congestion amidst shortages of medical personal are common features of urban Kenya's health delivery systems (NCPD, 2001). An additional negative effect of rapid population growth is the resulting stress on the environment, leading to degradation (NCPD, 2001).

14.3 Women Empowerment

This sub-section examines how women's empowerment — Millennium Development Goal (MDG) 3, and MDG 5 on maternal health (choices) — are linked to the achievement of the other MDGs. In this analysis, women empowerment is defined more broadly to encompass efforts to improve the welfare of women as individuals.

14.3.1 Women Empowerment and Poverty

Both at the micro and macro levels, gender issues are relevant to poverty reduction in several ways. In Kenya as in many developing countries, poverty has a gender dimension since women and men experience and react differently to its impact (Kimani and Kombo, 2010). Generally, women are more likely to be affected by poverty than men especially because of their unequal access to economic, social and educational opportunities. As earlier indicated, about half of Kenyans are poor, the majority of these being women who along with children bear the brunt of poverty (Ministry of Planning and National Development, 2000, Kimani and Kombo, 2010, UNICEF and GOK, 2010). This state of affairs is a violation of women's right to the determinants of improved human welfare, including food, clothing and shelter.

Traditional beliefs and practices across many Kenyan communities have meant that women have had little or no ownership and control of, or access to family assets, including resources such as land, as compared to their male counterparts. Further, education is among the multiple basic rights secured in Chapter 4 of the Kenyan constitution, and an important vehicle for accessing employment and other economic opportunities. Yet, until recently, disproportionately fewer women in Kenya accessed educational opportunities due to the low value placed by traditions and cultures on the girl child, as compared to the boy child. Education empowers both girls and boys as they acquire a wide range of knowledge, skills, attitudes and values critical for obtaining gainful formal employment and for negotiating an equal place in society (UNICEF and GOK, 2010).

In Kenya, the participation of women in the labour force is relatively low and is often undermined by the traditional domestic roles which tend to confine them to the household and informal economic activities, and to prevent their participation in the formal labour market where they could earn a wage. The Gender Status Index (GSI) by economic activity as reported during the 2009 Population and Housing Census is shown in Table 14.1¹⁰⁶. For the two categories, 'working' and 'working for pay', the respective GSI scores of 0.8 and 0.6 mean that men have advantage over women. As expected, however, women dominate own/family business and own/agricultural business, reflected in GSI scores of 1.2 and 1.4 respectively.

Table 14.1 Gender Status Index by Economic Activity

Activity	Women	Men	GSI
Working	49	57	0.8
Worked for pay	27	44	0.6
Own/Family business	21	18	1.2
Own/Agriculture business	50	36	1.4

Source: KNBS, 2012: Gender Dimensions Monograph

¹⁰⁶ GSI is a measure of relative gender equalities, interpreted as the ratio of women to men's participation in a particular activity.

Increasing women’s participation in economic activities, particularly in the formal labour market, would enable more women to earn incomes and therefore increase total household incomes which enable escape from extreme poverty¹⁰⁷.

14.3.2 Decision-making and Achievement of MDGs

Participation in decision-making at the household and society levels is a key element of women’s empowerment which is closely linked to the achievement of MDG-1 to MDG-7¹⁰⁸ and indeed Article 10 (2) of the Constitution. It is important for women to be involved in household decisions and this is a direct measure of gender relations and of women’s autonomy within their families. A number of studies have shown that households where women have a larger say in redistribution of resources tend to allocate a larger share of the resources to health and education to support the most vulnerable household members, such as children (Caldwell, 1979; Basu, 1994). Female education, which is often used as the proxy for women’s influence on the distribution of resources, has been shown to enhance survival probability of infant and children under age five. The same association between female education and early childhood mortality is observed in Kenya (Table 14.2).

Table 14.2 Mother’s Education, Wealth Index and Childhood Mortality in Kenya

Characteristic	Infant mortality	Child mortality	Under five mortality
Mother’s education			
No education	64	23	86
Primary incomplete	73	42	112
Primary complete	51	18	68
Secondary+	45	14	59
Wealth Quintile			
Lowest	66	34	98
Second	64	40	102
Middle	67	26	92
Fourth	39	12	51
Highest	57	13	68

Source: KNBS and ICF Macro (2010)

14.3.3 Women Empowerment and Fertility Reduction

Women empowerment is critical for lowering fertility in the country. Poverty is closely associated with high fertility; poor women and those with little or no education often have higher fertility than well off and educated women. In many communities in Kenya, poor women tend to start childbearing early (see Chapter 4 in Part 3), and often resort to having many children as a means of gaining recognition (status) and having a say in the household. This, coupled with the strong desire for sons over daughters, props high fertility and contributes to increasing poverty at the household and national levels. High fertility leads to high population growth, other factors being constant, such as is experienced in Kenya.

The analysis of Chapter 13 on household composition, wealth and total fertility clearly showed that poverty drives both fertility and average household sizes (see Tables 14.3 and 14.4). This is unlikely to happen where the women are empowered through increased education (KIPPRA, 2004), labour participation and power to make decisions about fertility (UN, 1995; Jejeebhoy, 1995; Riley, 1997; Mason *et al*, 1999).

¹⁰⁷ For poverty reduction, it is actually even better to improve returns to all employment, including informal jobs, such as by raising the quality of the products of the informal sector and finding them stable markets.

¹⁰⁸ There is some evidence that both women’s education and labour force participation are directly related to increased women’s participation in decision-making (domestic power at the household and community level) (Malhotra and Mather, 1997; Balk, 1997).

Table 14.3 Percent Distribution of Households by size and Wealth Index

	Single person	2-4 members	5-8 members	9+ members	Number
Poorest	0.9	21.7	58.0	19.3	9373
Poorer	1.8	24.2	56.5	17.5	6694
Middle	2.2	30.2	51.4	16.1	6862
Richer	3.1	35.5	49.5	11.9	7103
Richest	8.4	49.5	37.3	4.9	8483
Total	3.4	32.3	50.4	13.9	38515

Table 14.4 Trends in Total Fertility Rates by Wealth Index

Year	Low/1st	2 nd	3rd	4 th	High/5 th	Average	Low/High ratio	Low-High Difference
1993	7.2	6.2	5.6	5.3	3.3	5.4	2.17	3.91
1998	6.5	5.6	4.7	4.2	3.0	4.7	2.17	3.50
2003	7.6	5.8	5.1	4.0	3.1	4.9	2.44	4.50
2008	7.0	5.6	5.0	3.7	2.9	4.6	2.41	4.1

Sources: Gwatkin et al 2007; calculations from KNBS and ICF 2010

14.3.3 Women Empowerment and Environment

Women empowerment also contributes to the achievement of MDG 7 on the environment. Women empowerment has been considered to contribute to saving the environment and overcoming the dangers of overcrowding and other adverse consequences of population pressure. Sen and Chen (1994) have argued that:

“Advancing gender equality, through reversing the various social and economic handicaps that make women voiceless and powerless, may also be one of the best ways of saving the environment and countering the dangers of overcrowding and other adversities associated with population pressure. The voice of women is critically important for the world’s future — not just for women’s future” (Sen and Chen (1994).

14.3.4 Policy Measures to Address Empowerment

In Kenya, a number of measures have been put in place to realize progress towards gender parity in various sectors, thereby empowering women. For instance, the Women Enterprise Fund has been created to enable women access to credit. The Government has also placed the university entrance cut-off score for girls at two points lower than that for boys, and ring-fenced that at least 30 percent of all public appointments are for women as part of the affirmative action to address the gender gap. The new constitution states that women and men have the right to equal treatment, including the right to equal opportunities in politics, economic, cultural and social spheres (National Council for Law Reporting (NCLR), 2010). However, these measures have not yet had substantial impacts, which is why there remain wide gender disparities in the country.

With regard to MDGs 2 and 3, the Government has put in place a raft of measures to improve access to education in the country for both boys and girls. These include free primary education and subsidized secondary education. There is also a bursary scheme for bright students from poor households (Ministry of State for Planning and National Development and Vision 2030, 2007). As a result of these measures, the country is likely to achieve full net primary school enrolment by 2015, given its gross primary enrolment for 2009 stands at 110 percent, up from 107.6 percent in 2007/2008 and 73.7 percent in 2002. The net primary enrolment rates rose from 77.3 percent in 2002 to 92.9 percent over the same

period, while the primary school completion rates improved from 62.8 percent in 2002 to 83.2 percent in 2009. The enrolment figures for boys and girls in primary school enrolment also point to a near gender parity of 0.958 in 2009 (UNICEF and GOK, 2010).

14.4 Family Planning: Linkages

Family Planning and Fertility

The sustained increase in the use of family planning (FP) during 1990s has been mentioned as the main driving forces behind rapid fertility decline in Kenya (Ajayi and Kekovole, 1998). During late 1990s, the national FP programme was substantially reduced due to declining Government and donor funding and the shifting of priorities to HIV and AIDS. As a result, the large-scale community-based distribution (CBD) programmes that allowed low-cost contraceptive information and services together with information education and communication (IEC) campaigns advocating for small families and the use of contraception were severely undermined (Aloo-Obunga 2003, Crichton, 2008). The decline in the institutional support to FP was reflected in the stall in CPR during 1998-2003, and the corresponding stagnation in fertility rate.

The high unmet FP need and incidence of unintended births have largely been attributed to inadequate service provision, and poor commodity access due to erratic supplies. As response to this problem, the Government prepared the Contraceptive Security Strategy 2007-2012 with the aim of ensuring uninterrupted and affordable supply of contraceptives. However, little progress seems to have been made against the supply problem as Kenyan women continue to experience high levels of unmet FP need and unintended childbirths.

Family Planning and Women's Productivity

Reproductive illnesses and unintended pregnancies weaken or kill women in their most economically productive years, besides exacting a financial toll on individuals and families as well as undermining the country's economic development. In the late 1990s, ill-health conditions related to sex and reproduction accounted for 25 percent of the global disease burden in adult women but in sub-Saharan Africa, they accounted for over 40 percent (Lopez and Murray, 1998). In the early periods of this decade, sexual and reproductive health conditions account for nearly one fifth of the global burden of disease and 32 percent of the burden among women of reproductive age worldwide (WHO, 2001). One of the outcomes of unplanned pregnancies is abortion, which is fairly common, mostly unsafe and accounts for a significant percentage of all gynaecological emergency hospital admissions in Kenya (Guttmacher Institute, 2012), with Gebreselassie et al., (2005) specifically placing the share at 60 percent. In Kenya, abortions are reported to contribute to about 25 percent of the maternal deaths (Ipas, 2004). Preventing unwanted pregnancy through meeting the unmet FP need would substantially reduce the need for procuring abortion and the related maternal deaths. As in other developing countries, women in Kenya make significant contributions to household incomes and wealth, a potential which is lost in the event of death.

Smaller family sizes have potential to contribute to economic opportunities, as they have implied lower dependency ratios; and they have also made it easier for household members, especially mothers, to seek formal employment or engage in income generating activities outside the home. Increased access to desired RH services, including voluntary FP programmes, and their impacts on fertility have led to higher ratios of workers to dependent children. This allowed families and Governments to invest more in children by ensuring access to education and health care, and over time, increase the ability to save and invest more productively, stimulating economic growth. Further, analysis of longitudinal data in Matlab showed that increased FP access and use leads to substantial improvement in women's health

and earnings as well as /children's health and schooling (Schultz, 2009b). Similarly, a recent study in the slums of Nairobi found that families with fewer children had a higher socio-economic upward mobility than the families with many children (Faye, 2009). Another study in Nicaragua found that households with fewer children had higher intra-generational mobility rates than those with many children, and that households with fewer children living in extreme poverty also had a higher chance of escaping from extreme poverty than those with more children (Andersen, 2004 cited in UNFPA, 2010).

At the macro level, reduced fertility enhances women's health and that of their children, opportunities for their participation in education (and consequently) formal employment — reducing gender inequalities, and economic growth as a result of the re-investment of surpluses released by reduced youth dependency. The reduction in fertility will have long term effects on economic development when the next generation of healthier and better educated children enter the labour force (Canning and Schultz, 2012; Shultz, 2009a, 2009b; Joshi and Schultz, 2012).

Family Planning and the Reduction of Maternal Mortality

FP use is indispensable to the achievement of MDG 5 that seeks to improve maternal health. There is evidence that FP averts over 52.2 percent maternal deaths in Kenya every year, meaning that without it, the number of maternal deaths would double. Ahmed et al. (2012) estimates that worldwide, 11,831 maternal deaths would occur without contraceptive use compared with 5,659 with contraceptive use. FP methods, such as condoms, are also used to prevent the spread of HIV and other sexually transmitted infections. Regulation of pregnancies also enable women of child bearing age to be healthier and better able to ward off or fight diseases and, therefore, avert untimely deaths. Improving FP access enhances the achievement of the MDG 5 and 6.

Family Planning and Child Survival

FP use has been found to potentially improve perinatal outcomes and child survival. The analysis done in the mortality Chapter 6 in Part 3 showed that early childhood mortality has been declining in Kenya over the last three decades. It also points to wide socio-economic and regional differentials in early childhood mortality. For instance, in 2008-2009, the infant mortality rate was 52 deaths per 1,000 live births, down from 77 in 2003. In turn, under-five mortality rate was 74 deaths in 2008/2009 down from 115 in 2003. The data mortality chapter also showed that children born within short birth intervals (< 2 years) have higher mortality risks. The use of FP lengthens birth intervals and, thereby, averting childhood deaths (Cleland *et al*, 2012). According to Cleland et al., FP use to space children's births by at least two years can reduce the infant mortality rate by 10 percent and child mortality by 21 percent in a developing country, such as Kenya. Recent analyses of the economic consequences of RH carried out on data from Matlab, Bangladesh and Navirongo, Ghana, showed that at household level, FP use reduces fertility and improves birth spacing (Schultz, 2009; Ahmed et al, 2012).

14.5 HIV and AIDS and Other MDGS

As with other parts of the world, Kenya has been affected by the HIV and AIDS epidemic since it was first reported 1984 (NACC, 2005; NASCOP, 2005). An estimated 1.6 million people are living with HIV, around 1.1 million children have been orphaned by AIDS, and in 2011, nearly 62,000 people died from AIDS-related illnesses (UNGASS, 2011). HIV and AIDS prevalence peaked during the late 1990s and has dramatically reduced to around 6.2 percent (KNBS and IC Macro, 2010).

A common theme emerging from the few studies on adult mortality suggest that that HIV and AIDS has been a major factor in the rise in mortality in sub-Saharan Africa (Lopez et al, 2006). HIV and AIDS in sub-Saharan Africa is, therefore, an essential reproductive health issue and three-quarters of the burden of disease attributable to unsafe sex is in sub-Saharan Africa (Lopez et al, 2006).

HIV and AIDS has affected the Kenyan population in various ways. Women have been and are still being disproportionately infected by HIV, and affected by it and AIDS. In 2008/2009, HIV prevalence among women was twice as high as among men at 8 percent and 4.3 percent respectively (UNGASS, 2010). This disparity was even greater among young women aged 15-24 who were four times more likely to be infected with HIV compared to men of the same age. These realities adversely affect the drive to achieve MDGs¹⁰⁹ on promotion of gender equality and the empowerment of women. The most obvious effect of HIV and AIDS has been its impact on morbidity and mortality; but the impact has certainly not been confined to the health sector: households, schools, workplaces and the economy have also been affected adversely.

As in many countries of sub-Saharan Africa, AIDS is erasing decades of progress in extending life expectancy in Kenya. Life expectancy had been reduced from around 64 to 43.7 due to HIV and AIDS (Fourie and Schonteich, 2001). The impact that AIDS has had on average life expectancy is partly attributed to child mortality, as increasing numbers of babies are born with HIV infections acquired from their mothers and consequently die early. UNAIDS (2006) reports that under-five mortality in Kenya was 118 per 1,000 live births when HIV and AIDS is factored in, but that it drops to 98 if HIV and AIDS is excluded. However, the increase in mortality occasioned by AIDS has been among the economically productive population of adults aged between 20 and 49 (see also Bell, Bruhns, and Gersbach 2006 on the impact on youth). Additionally, it has been estimated that about 20 percent of maternal deaths in Kenya could be attributed to HIV and AIDS (WHO, UNICEF and World Bank, 2012).

The impact of HIV and AIDS on households can be very severe, especially if mitigation measures are not employed. Although no segment of the Kenyan population has been spared by the pandemic, it is often the poor and consequently most economically vulnerable for whom the consequences are most severe. In many cases, the presence of AIDS causes the household to break up, as parents die and children are sent to relatives for care and upbringing. A study in rural South Africa suggested that households in which an adult had died from AIDS were four times more likely to break up than those in which no deaths had occurred (Hosegood et al., 2004). Much happens before this break up takes place: AIDS strips families of their assets and income earners, further impoverishing the poor. Taking care of a person with HIV and AIDS is not only stressful and emotionally draining on household members, but is also a major strain on household resources. Loss of income, additional care-related expenses, the reduced ability of caregivers to work, and mounting medical fees push affected households deeper into poverty. It is estimated that, on average, HIV and AIDS related care can absorb one-third of a household's monthly income (Steinberg et al., 2002). These realities make it difficult to achieve the overriding MDG 1 objective of reducing extreme poverty and hunger, which relates to all the other MDGs.

The HIV and AIDS also adversely affects food production in households in which key members are either infected and/or consequently die. A study by Yamano and Jayne (2004) involving 1,500 farms in Kenya found that food production in households in which the head of the family died of AIDS were affected in different ways, depending on the sex of the deceased. As in other sub-Saharan African countries, the death of a male head reduced the production of 'cash crops' (such as coffee, tea and sugar), while the death of a female head reduced the production of grains and other crops necessary for household survival (UNAIDS, 2006).

¹⁰⁹ HIV and AIDS affects women through MDG 1 because they bear the burden of household (food) poverty, MDG 2 because they have to prepare children for school, MDG 4, 5 and 6, because each mother is also a house 'doctor' and nurse, and MDG 7 because they are the ones to fetch water, firewood.

14.6 Gaps and Limitations

A number of analysts have tried to identify strengths and limitations of the MDG approach in development process. For example, Aryeetey et al. (2012, 5-6) argued that MDG conceptualization distilled the broad challenges of extreme poverty and sustainable development into a suite of simple, compelling, and understandable goals. While Manning (2009) and Nayyar (2011, 21) concluded that MDGs were ambitious and framed around the highly motivating concept of tackling global poverty. However, some analysts have argued that the MDGs have been misinterpreted (Fukuda-Parr, 2012), 16) and that they were less successful at framing the development agenda at the country level (Klasen 2012, 1).

- MDGs were set in terms of aggregates and therefore masked tracking of progress in reducing inequalities and provided no incentives to focus on the poorest and hardest to reach (Melamed 2012a, 2; Nayyar 2011, 21).
- MDG approach been criticized for missing key issues at national levels that are critical for development such as; equity, human rights, sustainability and empowerment (Fukuda-Parr 2012, 21) and other some important policy areas such as such as climate change, growth, job creation, security, and demographic change (Karver, Kenny, and Sumner 2012, 3).
- Evaluations of effect of relationships between the interventions, poverty and inequality as well as parameters of population processes have not been done. Therefore, there are no clear policy directions that can be determined. In particular, interrelationships between migration and poverty, migration and health and migration and development.

14.7 Conclusion and Recommendations

Conclusion

In summary, the analyses reports in the preceding chapters and this chapter show that; population dynamics, women empowerment, reproductive health and population age structure are each closely linked to poverty reduction, reduced fertility, reduced population growth as well as to the attainment of the MDGs and Vision 2030. Therefore, concerted efforts should be made to empower women across the board, improve educational attainment of both boys and girls, improve access to reproductive health services, including FP and post-abortion care services, particularly among adolescents and youth.

Recommendations

Although a number of relationships have been envisioned in this document, the studies are still at associational level and do not take into account cause-effect relationships. Most notable is the fact at the present stage of development and demographic transition, there is need for studies that interrogate the past literature and research results alongside contemporary national and devolved governance structure in the country. Areas that lack requisite data and information include; migration and its determinants and consequences, maternal mortality at sub-national levels, cause of death data to determine burden of disease and data and information that link poverty, inequality and population as well as reproductive health indicators. The DHS data lack information on poverty but has information on demography and health while household budget surveys that have poverty data lack relevant population and reproductive health indicators.

As in the framework in this chapter, there is need to include issues of equality and equity as one of the guiding principles underpinning the whole framework or one or more goals that specifically focus on inequality by type of inequality (social, economic or political equality). Inequalities can also be integrated as a concern into goals and targets on different sectoral issues (politics, security, justice, health, education and poverty) in order to uphold; inclusion, fairness, responsiveness and accountability to all social groups throughout the framework.

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CHAPTER 15: CHALLENGES AND OPPORTUNITIES

15.1 Introduction

Chapter Two of this report provides a comprehensive overview of Kenya's situation, both with regard to the main aggregate characteristics of its demographic trends and the progress of Kenya's economy, their social, political and institutional dimensions, as well as all issues pertaining to the analysis of social expenditure. The intention was to provide a background against which to assess the effectiveness of investments carried out in social policy areas, especially in education and health. In addition, it also documented Kenya status in terms of its compliance with its international commitments, with emphasis on the MDGs. The purpose was to give the reader a broad view of national realities against which to consider the status of the population, progress made towards improvements, and the possibilities or constraints imposed by the economic, social and political context.

In turn, Chapter Three outlines all components of population dynamics (including internal and international migration) and the main components of sexual and reproductive health (SRH). It has also detailed how the national population size, its composition and distribution have been changing over time. It has also considered the national management of various factors affecting the national population positively or negatively. The various changes have been and will continue occurring at different rates, presenting a variety of challenges and opportunities.

15.2 Justification

This final chapter is expected to fulfill a threefold function. Firstly, it serves as a summary of the foregoing chapters, with an emphasis on the relevance of the key findings in the various areas covered in the analysis, and the identification of the main challenges and priorities that confront Kenya, as well as the contribution that can be made from the viewpoint of population analysis. That means putting the main messages of the analysis into place and relating them creatively to the political and institutional context existing and with the way the United Nations works in Kenya. Based on the analysis in Chapters Two and Three, the second function of this chapter is to highlight the opportunities available with which to attend to the challenges identified in the various chapters. The Constitution's imperatives of equity and participation underscore the need for nurturing the political will with which to invest in rights-based public policies for reducing inequalities. The foregoing considerations focus on the Government of Kenya and its development of its Medium Term Plan II, providing the issues that could be considered at this stage of Vision 2030's long development journey to transforming Kenya into a middle income country by 2030. The third purpose of this chapter is to define in the context of population and development, what the strategic interventions are that UNFPA can undertake as part of a joint effort of the United Nations under its Development Assistance Framework (UNDAF) to support the development of Kenya.

15.3 Main Population Challenges Confronting Kenya

In 2007, Kenya imploded into a morass of intense localized violence that threatened the very fabric of its society. However, the existence of national goodwill enabled by the encouragement of the international community — notably the Panel of Eminent African Personalities of the African Union (AU) was able to midwife a process that not only restored public order, but also developed a road map to greater heights for the country, encapsulated in the National Accord which gave birth to the Grand Coalition Government. The National Accord incorporated the Agenda Four reforms of long-standing issues and solutions' among whose components of immediate interest to the current report is the finalization of the constitutional review process commenced in 2000. The other Agenda Four areas

of interest to the current report are attention to poverty, inequality and regional imbalances as well as youth unemployment. The constitutional review process was finalized by August 2010, and the General Election held under the new Constitution in March 2013. However, much remains to be done with respect to poverty, inequality, regional imbalances and youth unemployment. The overriding challenge into Kenya's future — and certainly with respect to the issues mentioned here — lies in the full implementation of the Constitution. Besides its emphasis on good governance, the Constitution provides a substantive framework with which to address poverty, individual and regional inequalities and youth unemployment. In that sense, the Constitution presents a challenge, inherent in its successful implementation. However, the Constitution and the policy, legislative and institutional frameworks arising from it also provide great opportunities for addressing population issues that are raised in this report.

The evidence from the analysis carried out in the previous chapters confirms that population behaviours are not neutral. The patterns and situation of SRH, survival conditions, population mobility and settlement facilitate or hamper efforts to overcome poverty and social exclusion, according to the prevailing living conditions, the structure of opportunities available and the public policies applied in Kenya. This, therefore, emphasizes the need to highlight the main challenges facing population issues in Kenya and the main opportunities provided by the circumstances discussed in the previous chapters.

15.3.1 Poverty

Among the most important challenges for Kenya 50 years after independence is breaking the grip of poverty. In this respect, nearly 18 million (out of approximately 40 million) people in Kenya are living in poverty. Further, there is a major problem of inequality with about 10 percent of the population accounting for over 43 percent of the income, making Kenya one of the most unequal countries in the world. Consequently, Kenya's seven million poorest people need to be pulled out of extreme poverty, as a critical pre-condition to reducing national inequality and ensuring well-being of all people. Since most of these poor people are in the self-provisioning or informal sectors, it becomes necessary to devise socio-economic reforms that raise their entitlements disproportionately in comparison to the rise in the entitlements of the non-poor. This would enhance their welfare in multiple ways, such as through increased per capita consumption — hopefully in ways that do not enhance health risks, allowing improved nutritional status while also improving access to necessary health care. The evidence from the literature shows that such changes coincide in the medium to long term, with a lowering of fertility that also reduces family size. In turn, such achievements improve population management in its many facets.

Significantly, the strategic goal for the Kenya Vision 2030 is to *achieve a socially-just and equitable society* by:

- Raising average annual incomes per person from an estimated US\$650 in 2006 to above US\$3,000 (at 2006 prices);
- Avoiding gross disparities while rewarding talent and investment risks in a manner that is deemed socially just and not politically destabilising;
- Reducing poverty from 46 percent of total population by between three and nine percent;
- Implementing policies that minimise the differences in income opportunities and access to social services across Kenya's geographical regions; and
- Increasing community empowerment through “devolved” public funds, weighted in favour of the most disadvantaged communities, to be allocated in accordance with locally-determined priorities through transparent and participatory procedures.

15.3.2 Unemployment

The current demographic transition Kenya finds itself in is both a challenge and an opportunity. The challenge is that while an increasing share of the population is of the working age, an equally increasing proportion of young Kenyans is facing formidable hardships in landing a 'decent' job. With so many job-seekers competing for scarce opportunities, a disempowering environment has been created whereby employment often goes to those with the right and timely social capital (connections; the 'right' tribal affiliations), or the ability to bribe. The Kenya Economic Update (2012) has noted the disproportionate growth in decent work: employment in the modern wage sector has been growing by just 50,000 jobs a year, compared to expansion in the working age of roughly 800,000 a year. Thus, the Kenyan economy needs to create decent jobs at a much more rapid pace; otherwise employment will continue to be rationed in large part through exploitative practices.

The Constitution (2010) outlaws discrimination and promotes equal opportunity for all Kenyans. However, the resulting legislative and institutional frameworks will remain unequal to the task of managing the distribution of scarce employment opportunities which are perpetually threatened by parochialism, meaning that abuse of office and other forms of corruption will remain in the job market. The Kenya Economic Update notes that although high youth unemployment and inactivity rates are in part transitional, focus group interviews with young Kenyans indicate that they have legitimate concerns about their limited job opportunities. Many find that nepotism, tribalism, demands for bribes, and sexual harassment are major barriers to obtaining a job. Young people coming from wealthier and connected families are seen as having large advantages in finding work, regardless of skills and qualifications.

The private sector contributes about 90 percent of new jobs in Kenya. Consequently, boosting national employment creation is chiefly about removing key obstacles that inhibit dynamic Kenyan and foreign investment firms from flourishing. Some such obstacles include:

- Poor infrastructure — transport costs in Kenya are prohibitive and power supplies unreliable, putting Kenya at a clear disadvantage compared to its competitors such as South Africa; and
- Corruption — Kenyan firms devote an average four percent of their sales incomes to bribes. This proportion could be used to hire a quarter of a million people — roughly the number of young unemployed Kenyans in urban areas. Corruption related losses are bound to be higher given that many firms shun coming to Kenya in the first place (World Bank, 2012).

The state of unemployment in Kenya was captured in a report prepared by the National Economic and Social Council (2011). Besides underscoring the persisting unemployment challenge, the report offered the following key highlights:

- Lack of employment appears to be the main constraint that prevents people from escaping from poverty;
- Public offices are under funded and understaffed. On the other hand, private employment services are fragmented and not accessible to the disadvantaged groups. Allocation of more resources to the public schemes and offering incentives for private services may make job search programmes more effective;
- Kenya offers a diverse range of skills and training programmes in both public and private institutions. Further, there have been several interventions to improve labour market laws and regulations;
- There are a few programmes for overseas employment of young people, such as the Youth Employment Scheme Abroad (YESA) under the Youth Enterprise Development Fund (YEDF);
- On average, the livestock sub-sector has the highest potential for increasing employment in general, as well as employment of women; and

- The horticulture sector, especially vegetables, generates the highest labour demand in response to a stimulus.

In its report on the employment situation in Kenya, the Ministry of Labour has singled out employment creation as one of the most effective routes to poverty reduction and economic growth. Some of the key challenges in employment creation include: ineffective coordination of available opportunities; mismatch between college training curricula and employers' requirements; lack of an enabling investment environment; high population growth; and low productivity.

Other challenges for job creation include weak targeting mechanisms of job creation programmes, and lack of clear exit plans. The public employment offices which assist job-seekers were under funded, understaffed, had weak job search infrastructure, and concentrated on youth who are looking for jobs in urban areas. Further, employment offices were largely located in urban areas, whereas the majority of initial job seekers were in rural areas without the resources with which to frequent employment agencies.

15.3.3 Inadequate Access to Health Care Information and Services

The health status of the people in Kenya has improved only marginally in the last two decades. For example, expectation of life at birth increased from 59 years to 60 years; maternal deaths have remained at an average of 500 for every 100,000 live births; skilled attendance during delivery dropped from 50 percent to 44 percent; fertility rate decreased from 6.7 to 4.6 live births per woman. Some of the manifestations of the persisting unsatisfactory state of affairs include:

- Wide differentials persist in mortality based on age, sex, and geographical location;
- New health challenges that are a product of economic transition, such as diabetes, heart diseases, high blood pressure, and cancer;
- Households remain the largest contributors of health financing at about 36 percent, followed by the Government and donors, who contribute approximately 30 percent each;
- The ratio of health personnel to the population is still inequitable: for example, there are only 14 physicians for every 100,000 people, against a WHO recommended ratio of 120 to 100,000 people;
- Medical products and technologies are poorly regulated due to competing interests in the field and to institutional weaknesses in the sector. Furthermore, the financing of medical products and technologies remains low despite the critical role they play in overall health service delivery;
- Weak information capacity of the sector as a result of low funding for the development of health information systems, leading to the use of parallel information generation systems resulting in duplication of efforts; and
- Poor linkages across service delivery levels, partly due to a weak referral system.

15.3.4 High Population Growth Rate

Population is an important component of a complex nexus of processes that determine the economic and social development of a country, such as Kenya. Population dynamics and trends (including changes in size, structure, composition and spatial distribution) are key determinants of socio-economic development and environmental sustainability. The current high population growth rate of 2.9 percent per year for Kenya is an obstacle to improving the standards of living of Kenyans, eliminating poverty, and reducing gender inequality.

High population growth rates contribute to movements of people, for example, from rural to urban areas. By 2050, 70 percent of the world's population is expected to live in urban areas with

significant challenges for urban planning and logistics. While urbanization and migration may present opportunities for economic and social development, and for resource efficiencies, if the two phenomena are unexpected and unplanned, they can be economically and politically disruptive. They can also result in adverse environmental impacts. The common view is that a rapidly increasing population (that undermines savings and capital formation) has a negative effect on economic growth and consequently on employment, if natural resource opportunities stagnate or do not expand at the same rate as the population, undermining per head shares.

A Ministry of Local Government report on urbanisation and national development shows that at independence in 1963, Kenya's urban population share was eight percent. The share increased to 19 percent in 1999, 31 percent in 2009, and about 34 percent in 2011. By 2030, the urban population is projected to rise to 63 percent. This rapid urban transition Kenya is undergoing presents both an opportunity as well as a development challenge. Urbanization can be associated with economic prosperity; but if rapid, it can also present enormous challenges unless the economy transforms fast enough to generate jobs for the growing labour force. Additionally, good governance and planning are required to develop the urban infrastructure and social services that meet the needs of the growing population, including decent housing and amenities for low income people.

15.3.5 Environmental Unsustainability

Preserving and properly managing the environment is an essential foundation for sustainable development and poverty reduction. However, a number of challenges exist in Kenya, including global warming and climate change in general; lack of coordination among authorities, stemming from an unclear definition of roles and responsibilities, coupled with lack of harmonization of laws and policies related to environmental management.

15.3.6 Inadequate Information Base

Hitherto, Government and UNFPA programmes for monitoring of the millennium development and ICPD indicators have been reported as weak. In addition, the Health ministry's Health Management Information System (HMIS) does not provide timely and comprehensive data. The increased demand for data indicates the inherent weaknesses of the national systems for data generation and storage, meaning that the many agencies involved in monitoring of Millennium Development Goals and ICPD indicators continue to rely on (cross-sectional) national surveys. While the implementation of development programmes is being devolved to the county level, the planning departments at this level will not immediately have the capacity to generate and utilize data for monitoring and evaluation of such programmes. There is need to build and/or strengthen the capacities of the relevant departments to put in place appropriate monitoring and evaluation (M&E) systems, and to utilize the information generated by these systems for programme improvement, advocacy and policy review/formulation at all levels. Secondly, social, bio-demographic and biomedical research is needed to enable programmes to provide appropriate quality services to beneficiaries, especially vulnerable groups. Research outcomes must also be translated and utilized appropriately for the welfare of the people. This makes imperative, the need for improvements in the knowledge value chain across the different organizations providing services to the people. Requisite data and information, both from routine and non-routine sources, for various population and health interventions at different levels remain inadequate. Inadequacy of such data and information seriously hamper effective planning (e.g. when setting programme targets) and monitoring and evaluation.

15.4 Main Opportunities Available for Kenya

In response to the challenges identified in the previous analysis, this sub-section identifies some strategic areas for action, which will go beyond developing relevant policies, to preparing for their implementation towards improvements in people's quality of life; reducing poverty and social inequality; and promoting greater gender equality. The following are the key opportunities available for Kenya.

15.4.1 Kenya Vision 2030

The adoption of *Sessional Paper No. 10 of 2012* transformed Kenya Vision 2030 into a national policy, rather than it just being a strategy paper. That action by the National Assembly in December 2012 will play a key role in providing a legitimate anchor for Vision 2030 as Kenya's framework for sustained economic, social and political transformation up to 2030. The key import of that transformation is that Vision 2030 now transcends a mere Government of the day and becomes the property of Kenyans of all cultures, races and religious affiliations. Most importantly for its duration to 2030, Vision 2030 becomes an integrated development reference point from which sector stakeholders can generate broad guidelines to specific policy-making.

15.4.2 The Constitution of Kenya 2010

The Constitution (2010) in and of itself, is a great opportunity for the transformation of Kenyan society. In terms of attention to the issues raised in this PSA, two chapters of the Constitution are critical in very general ways, Chapter 5 on Land and Chapter 6 on National Leadership and Integrity. Provisions of Chapter 6 are noble; yet, persisting bad governance means the country is yet to derive as much benefit as it should have from the provisions of the chapter. Such weak governance is, for example, manifest in the management of the provisions of the chapter on land, where the President only sanctioned the National Land Commission (NLC) into existence because the High Court ordered it. Ultimately, land was the driving force behind the 2007/2008 violence whose causes are an impending agenda. While Treasury only allowed NLC five percent of its financial year 2013/2014 budget request, it is imperative that the body be facilitated to deliver on its mandate. Undermining NLC's mandate merely postpones a problem whose roots precede Kenya's independence, but was played out with unprecedented ferocity in the 2007/2008 violence. Streamlining the requirements of these two chapters will provide an enabling environment in which to pursue the areas of the Constitution with specific opportunities for population issues.

Articles 26, 43 and 53 explicitly recognize and address the right to health as a specific individual right. This right is enforceable in a court of law in the same way that Kenyans have hitherto been used to seeking to enforce their civil and political rights. Article 43 provides that *every person has the right: to the highest standard of health, which includes the right to health care services, including reproductive health care; to accessible and adequate housing, and to reasonable standards of sanitation; to be free from hunger, and to have adequate food of acceptable quality; to clean and safe water in adequate quantities; and to education.* While the immediate interest here is in the right to health in general and to reproductive health in particular, the article significantly appreciates the roles of non-health factors in promoting the individual's health, by emphasizing the rights to housing, food, water and sanitation.

Article 69 requires the State to: ensure sustainable exploitation, utilization, management and conservation of the environment and natural resources, and ensure the equitable sharing of the accruing benefits; eliminate processes and activities that are likely to endanger the environment; and utilize the environment and natural resources for the benefit of the people of Kenya. Amongst other

reasons, this provision is important in the wake of the recent discovery of various minerals across the country. Additionally, while the traditional inclination of the Government has been to extract such resources for the benefit of the more developed parts of the country, this articles concern with “sustainable exploitation” and the “equitable sharing of the accruing benefits” obliges the Government to conduct itself differently from what it has been doing in the last 50 years.

Article 174 articulates the objects of the devolution of Government to be: to give powers of self-governance to the people and enhance participation of the people in the exercise of the powers of State and in making decisions affecting them; to recognize the right of communities to manage their own affairs and to further their development; to promote social and economic development and the provision of proximate, easily accessible services throughout Kenya; and to ensure equitable sharing of national and local resources throughout Kenya. In this respect, the Constitution appreciates the fact that 50 years of centralized Government has not achieved the development promise during which, as provided by Sessional Paper No. 10 of 1965, development resources have been concentrated only in the parts of the country with “high absorptive capacity”, at the expense of the rest.

Article 201 (b) – The public finance system shall promote an equitable society, and in particular, expenditure shall promote equitable development of the country, including by making special provision for marginalized groups and areas. The management of public finance — whether it is revenue generation or its spending — is at the heart of the long-standing suspicions that Kenyans have harboured since independence and which led to the conflagration in the wake of the disputed 2007 presidential elections. The provisions of all the articles cited above depend, for their effective implementation, on the sound, equitable and transparent management of public finances at the national and county Government levels.

Article 204 provides for the Equalisation Fund which shall be used: “only to provide basic services including water, roads, health facilities and electricity to marginalized areas to the extent necessary to bring the quality of services in those areas to the level generally enjoyed by the rest of the nation, so far as possible.” Set at one-half percent of national revenues, the Equalisation Fund is deemed small to redress the extents of inequality and marginalisation that have been illustrated in the foregoing chapters. Eventually, the Commission of Revenue Allocation has proposed some 17 (out of 47) counties as the exclusive beneficiaries of the Equalisation Fund, meaning its outreach will be limited. This reality illustrates the need to exploit the opportunities offered by the Constitution in a synergistic manner, as it is likely that their eclectic or even partial exploitation might generate benefits that are lesser than the sum of the parts.

15.4.3 Sessional Paper No. 3 of 2012 on Population Policy for National Development

This Sessional Paper has outlined various policy measures which present opportunities for various actors to take advantage of (NCPD, 2012). A summary of such key policy measures are presented below:

Population Size and Growth: Support for programmes that will intensify nationwide advocacy and public awareness campaigns on implications of rapidly growing population on individual family welfare and national socio-economic development. Rather than focusing on FP alone, programmes should always emphasise the evidence that associates socio-economic ascendancy with reduced or improved population indicators — lower fertility, FP use, smaller family size, etc.

Population Structure: Advocate for and support the implementation of the Youth Policy, including expanding and strengthening of Youth Empowerment Centres to implement region specific youth

development initiatives. Support the implementation of policies and programmes aimed at increasing investment in education and technology, new innovations, health care, and infrastructure to cater for this productive segment (active age) of the population. There is need to integrate population issues in all these interventions so that the youth espouse ‘the positive population’ message long before they become family people, and indeed make it part of the agenda in deciding on marriage partners. Support the implementation of the National Policy on Ageing, in the context of the provisions of Article 47 of the Constitution.

Persons with disabilities: Advocate for and support the implementation of a database on the magnitude, characteristics, and RH/FP needs of persons with disabilities (PwDs). Arising from Constitution’s recognition for PwDs — expressed in Articles 21, 27 and 54 — there is a need to mainstream PwDs’ issues sector frameworks.

Information, Education and Communication (IEC) and Advocacy:

There is an urgent need to improve the knowledge and information base on population issues, such as by balancing attention to cross-sectional survey data with the longitudinal data from service delivery points. This will provide a sounder basis against which to prepare IEC and advocacy materials which are critical for delivering appropriate messages to disaggregated audiences. Such intentions call for intensified advocacy for increased budget allocations for population, RH and FP services. Mobilise adequate resources to increase availability and use of population data for integration of population variables into development planning in all spheres and at all levels, as suggested above regarding PwDs. Finally, it is necessary to enhance the capacities of institutions responsible for population data collection, analysis and dissemination to generate accurate, timely and user-friendly population data for integration of population issues into development planning at all levels.

Population and environmental sustainability: Intensify the use of population variables in environmental planning and resource management, using tangible issues that grow out of everyday contexts within which different target audiences operate.

Population, Technology, Research and Development: Intensify efforts in the collection, documentation and timely dissemination of population information. Update the national population research agenda on a regular basis. Mobilise funds for population and development research. Enhance the capacities of counties to generate and use county level data.

15.4.4 Global and regional initiatives

Kenya should endeavour to take advantage of some of the international and regional initiatives that have provided frameworks for heightening political commitment to addressing various health concerns, or have actually manifested such commitment. These include the Global Fund for AIDS, Malaria and TB, Abuja Declaration, Stop TB, African Leaders’ Malaria Alliance, WHO’s basic primary health spending package (US\$34 pp/year), and Roll Back Malaria Partnership. The Rio+20 Conference on Sustainable Development, the UN General Assembly’s intention to revisit the International Conference on Population and Development (ICPD+20) scheduled for 2014/2015, and the review of the Millennium Development Goals in 2015 present opportunities to reframe the relationships between populations and environments. If successfully reframed, these relationships will open up a prosperous and flourishing future for present and coming generations.

15.4.5 Low global competitiveness index

Kenya's ease-of doing-business score has been worsening in conjunction with its declining rank in Global Competitiveness Index (GCI), undermining attraction of foreign investments. In 2010/2011, Kenya's GCI rank was 106 out of 139 countries, and stood at 98 out of 183 in the World Bank Ease of Doing Business Index (EDBI). These declines were mainly due to the country's poor showing with respect to five pillars of competitiveness among low income countries, including: (i) macroeconomic environment; (ii) health and primary education; (iii) infrastructure; (iv) technological readiness; and (v) higher education and training. In view of the importance of Kenya's improved performance in relation to these global indices, the following measures might be useful:

a) Strengthening and mainstreaming the activities of the Productivity Centre of Kenya should be undertaken, while the agenda of Kenya's competitiveness needs to be mainstreamed fully into legislative and institutional frameworks that represent the five pillars cited above, so that activities within the pillars are constantly guided by a consideration of their proposed activities' impacts on EDBI and GCI.; and b) There already exist several institutions that can monitor Kenya's EDBI and/or GCI, which include KAM, Productivity Centre, etc. Correct institutional framework to progress the agenda on competitiveness either in one central institution or in a centralised manner through the performance contracting framework and ministerial and parastatals strategic planning as well as monitoring and evaluation in electronic form should be identified. In addressing the creation of a globally competitive country, ongoing reforms such as the implementation of the constitution, the police reforms, Judiciary reforms, Companies Act and Insolvency Law, are important in addressing issues of competitiveness and productivity.

15.5 The Strategic Role of UNFPA in Kenya

UNFPA's strong presence in over 140 countries provides on-the-ground infrastructure for working with Governments on population-informed development strategies. As demonstrated by its previous support to Kenya, the Population Fund has a strategic operational niche based on the experience acquired in the generation and analysis of data on socio-demographic issues, population, SRH, and gender. Besides the agency's participation in strategic political dialogue, UNFPA's mandate encourages it to employ its capacity to bring population issues, SRH and gender into development policy-making at local, national, regional and global levels. UNFPA brings these comparative advantages to the negotiations on related evidence-based policy making and development planning.

The end-term evaluation of the GOK/UNFPA 7th Country Programme reckons that the Country Programme is aligned to the UNFPA Strategic Plan (2008-2012) with its focus on meeting the millennium development goals by addressing Reproductive Health and Rights, population and gender equality. This Programme focuses on areas that are considered most strategic for UNFPA in the context of national priorities, the UNDAF results framework and UNFPA comparative advantage. However, key elements of the ICPD agenda remain incomplete. Of particular concern is the fact that the MDG 5 - that UNFPA most directly contributes to — has recently been found to be the furthest from attainment¹¹⁰. Partly as a result, maternal health, and sexual and reproductive health (SRH) more broadly, has been the focus of renewed attention in recent years, both at the United Nations as well as at the regional and national levels, creating an opportunity for UNFPA in Kenya to act accordingly.

The mid-term evaluation (MTR) report of the Government of Kenya and UNFPA 7th Country Programme (2009-2013) notes that despite a number of successes by UNFPA, the overall progress has clearly been insufficient. The MTR has documented four key lessons that have been learnt:

¹¹⁰World Bank and International Monetary Fund, *Global Monitoring Report 2011*.

- Strategic focus: As a result of a siloed approach with three focus areas that were insufficiently integrated, UNFPA appeared not to have a clear strategic focus, reducing cohesion internally and weakening the organization's brand externally. Although resources were not split equally across the three focus areas — RH and rights receives by far the largest share of programme resources; approximately 60 percent per year — the fact that the focus areas are officially coequal makes it more difficult to clearly identify the organization's focus;
- Fragmentation: UNFPA resources continue being spread too thinly, reducing the organization's ability to show impact. Trying to reach everywhere means that insufficient resources are available for the regions facing the largest problems. The impact of these resources is further diluted when the country office tries to work in numerous outcome areas despite having a relatively very small budget; and
- Measurement: Several challenges associated with the measurement system have made it more difficult to assess progress over the initial years of the UNFPA Strategic Plan. For example, the outcome indicators included in the development results framework (DRF) were often not measurable on a regular basis. Additionally, UNFPA contributions to higher-level results were often difficult to capture accurately, since the DRF indicators were primarily the joint responsibility of countries and UNFPA, and were not complemented by other metrics that enabled assessment of the Fund's direct contributions.

Resource Mobilization

The MTR report of 2010 notes that the UNFPA Kenya Country Office (KCO) developed a comprehensive strategy for resource mobilization. This strategy had been regularly refined and updated in line with the UNFPA Strategic Plan and in response to programme needs. The main objectives of resource mobilization were to: a) identify UNFPA KCO and implementing partners (IPs) needs for funding and prioritize for the same; b) identify corresponding needs with regard to above donor priorities and funding opportunities; c) develop quality concept notes and funding proposals; d) enhance communications and partnerships; e) increase visibility of UNFPA KCO and its programme of assistance; f) enhance advocacy; g) use aid effectively and leverage resources; h) demonstrate transparency and accountability in the utilization of mobilized and/or leveraged resources; and i) ensure and strengthen office resource mobilization capacities.

Programme Coordination

As provided for in the Country Programme Action Plan (CPAP) of 2009-2013, the Ministry of Finance had the overall responsibility for coordinating not only the UNFPA-sponsored programme, but also all programmes supported by the UN System in Kenya. In the context of the Country Programme (CP) implementation, the Ministry of Finance, through the External Resources Department, had the responsibility for budgeting, monitoring of expenditures and facilitating issues such as delayed disbursement of funds.

At the operational level, the CP was coordinated by the Ministry of State Planning, National Development and Vision 2030. The Ministry of Public Health and Sanitation coordinated the RH component while the Ministry of State for Planning and Vision 2030 coordinated the PD component through the National Coordinating Agency for Population and Development. The Ministry of Gender, Children and Social Development, in collaboration with the National Commission on Gender and Development, coordinated the Gender Equality component.

Failure by the UN agencies to synchronize their funding cycle (January to December) with that of the Government of Kenya (July to June) continued to affect fund absorption, financial reporting and the timely implementation of the annual work plan activities. Any financial transaction not processed

by the end of April gets stuck until August or even September when the Government fiscal year is implemented.

Partnerships

UNFPA has worked along with the rest of the UN system in Kenya, to support Government's efforts to deliver on the goals and targets embodied in the Kenya Vision 2030 and the first Medium Term Plan (2008-2012). To this end, the UNFPA KCO teamed up with other UN agencies within UNDAF and through the UNCT, UN PCG, HACT and Joint Programmes to render a more coherent and more effective assistance.

Apart from Joint Programmes, the UNFPA KCO joined hands with other agencies for specific activities. For example, UNFPA worked with WHO and UNICEF to assist the Government of Kenya to develop a Road Map on maternal and new born health. In the context of Aid Effectiveness, UNFPA is an active member of the Aid Effectiveness Group and related sector working groups relevant for CO programming. There is a high degree of coordination between UNFPA and other UN Agencies particularly in programme areas where there is potential overlap. For example although both UNFPA and UNICEF work on FGM/C; each agency is in charge of a defined geographical area to avoid overlap and this reflects a high level of complementarity.

In the 2010 assessment on organizational effectiveness by the Multilateral Organization Performance Assessment Network (MOPAN), a partnership 16 donor countries with a common interest in assessing the organizational effectiveness of major multilateral organizations, UNFPA Kenya received ratings of adequate or better on its performance and was seen as strong in performance-oriented programming, financial accountability and supporting national plans among other areas.

National Ownership

The Paris Declaration and the Accra Plan of Action (AAA) put a particular emphasis on national ownership and leadership in development assistance. The MTR found ample evidence of such ownership and leadership in relation to the CP under review. The Government's commitment is shown through both funding and the key role it plays in spearheading the Aid Effectiveness Group and related sector working groups. For example, the Government of Kenya: chairs meetings of Development Partners for Health and many other such groups; contributed 90 percent of the cost of the 2009 Population and Housing Census; is contributing 70 percent of funding for reproductive health commodities; and contributed 100 percent towards the cost of condoms. The one area where the majority of funding comes from external assistance is HIV and AIDS and the Government has been asked to increase its contribution.

It is worth noting that the GOK/UNFPA 7th CP is completely aligned with Kenya's own National Development Strategies as spelled out in Vision 2030 and the first Medium Term Plan (MTP I) and with the Strategic Priorities outlined in the second Kenya Health Sector Strategic Plan (KHSSP II). Programme implementation has involved participation of the Civil Society. Furthermore, in order to enable the Government lead its own programming, UNFPA has enhanced different types of capacities within the public sector. These include the capacity of key ministries to lobby parliament, cabinet and media to pay close attention to the high population growth rate (2.9%) and the unacceptably high maternal and child mortality through the launch of the campaign for accelerating reduction in maternal mortality in Africa (CARMMA), Road Map on maternal and new born health, the establishment of health centres of excellence, and integration of obstetric fistula management in public hospitals. Additional capacities contributing to promoting ownership included result-based management (RBM), M&E and the country's demographic expertise that made it possible to process, analyse, publish and disseminate in record time the 2009 Population and Housing Census data. If exploited fully, the resultant data sets can provide the requisite baseline for evidence-based planning for the next decade. This will, however,

require additional efforts in the data analysis phase for which most developing countries (including Kenya) often allocate insufficient funds.

Monitoring and Evaluation

The MTR found that the UNFPA KCO is fully compliant with UNFPA guidelines on Monitoring and Evaluation. It has put in place an elaborate system of planning, regular and periodic reviews so as to ensure that programme implementation remain on track. The process involves at the planning level the joint development of UNDAF by UN agencies, Government and civil society; development of the Country Programme Document (CPD); development of the Office Management Plan (OMP) at the beginning of the year; and the Annual Work Plan (AWP) with IPs and other partners as appropriate.

15.6 Recommendations

Arising from the key challenges and opportunities identified, the following recommendations are offered:

15.6.1 Job Creation

The Kenyan education system will have to quickly and significantly ratchet up skills of those who go through it. This entails building on Kenya's progress with Free Primary Education, improving school quality, and ensuring that more Kenyans complete secondary school. More importantly, it is imperative that the Kenyan education system is better aligned with the job market.

This calls for labour-intensive initiatives, entrepreneurship development, elimination of skills mismatch, policies on labour migration and productivity improvement. This requires an integrated National Employment Policy which should integrate all employment opportunities in a time-bound national action plan with clear targets for different agencies. It is suggested that a National Employment Council with membership, drawn from workers, employers, private sector and academia, be created to coordinate the implementation of a National Action Plan on Job Creation.

It is, therefore, recommended that the Government targets programmes to nurture, incubate and encourage talents exhibited by youths at an early age. It is further noted that some sectors — such as livestock, horticulture production, irrigation, hotels and restaurants — have the potential to yield more job creation opportunities than others, and should therefore be targeted first. To tackle the challenge of unemployment in Kenya, the following measures are necessary:

- Simplify business registration processes, improve governance and physical infrastructure and reduce crime rates. Financial assistance programmes are a popular intervention to promote entrepreneurs. International experience indicates that such programmes have been successful in stemming unemployment;
- The new labour laws should be implemented in a consultative manner to take into account the concerns of social partners. This will safeguard Kenya's competitiveness in international markets;
- Given that the sectors with the largest potential for job creation are agriculture based, there is need for increased investment in agriculture, such as in livestock management and irrigation (to reduce seasonal vulnerability);
- The Government should commission a School-to-Work Transition Survey (SWTS) to improve the design of employment policies and programmes for the youth. This will help assess the relative ease or difficulty of the youths' transition from school to work life. It will also help identify levels of skills, perceptions and aspirations in terms of employment, job search process, barriers to entry into the labour market, and the preference for wage employment versus self-employment; and
- The analysis of some aspects of unemployment is hampered by lack of sufficient data. The labour

force survey instrument should be modified to capture unemployment spells and transitions into and exit from unemployment. The Kenya National Bureau of Statistics should deepen the employment data collection instruments and ensure quarterly data collection and release to show the number and types of jobs created across Kenya and sectors more frequently.

The World Bank (2012) contends that the policies for job creation are very closely linked to the factors that would make Kenya's business climate more attractive and the economy as a whole more successful. The report highlights four key elements to a wage job creation strategy for Kenya: (i) achieving political and macroeconomic stability; (ii) continuing to invest in transport and electricity; (iii) eliminating job-smothering corruption; and (iv) up-grading skills and making schools work for all Kenyans, not just the well off. The private sector has indicated that the Government needs to act on the above elements for the private sector to make substantial new investments in manufacturing and industry, and in the process, generate new high wage jobs. While the Government has had a mixed track record to date, there are signs that it is taking most of these elements seriously. New investments in transport and electricity will spur manufacturing and industrial growth, creating more jobs.

The Government needs to get serious about eliminating corruption, which acts as a chokehold on the private sector. Most transactions involving Government officials, from obtaining contracts to paying taxes, seem to have a corrupt element. The World Bank estimates that if the private sector could redirect the money it now spends on corruption to creating jobs, it could create 250,000 jobs, sufficient to hire most unemployed urban Kenyans between the age of 15 and 34. In addition young people seeking jobs often have to pay bribes to get them, a practice that can discourage would-be entrants into the labour force. It will be easier to stop petty corruption once Government takes corruption seriously, and individuals not only lose their jobs, but also go to jail for corrupt behaviour.

Kenya needs to continue to make quality education a priority and not just its quantity. Kenya has made good progress in providing universal primary education and has greatly increased the availability of secondary education. Kenya will need to continue to make significant investments in education, not just in expanding access, but also in upgrading quality. It will be imperative for the Government to make special effort to ensure that education outcomes match the skills the private sector needs, as it also expands to meet new opportunities.

15.6.2 Kenya Vision 2030

Successful implementation of the Kenya Vision 2030 that will ensure sustainable development in Kenya will be achieved through good governance founded on integrity, transparency and accountability. All these, while ensuring non-discrimination and protection of the marginalized, inclusiveness and the respect and upholding of human rights and dignity for all citizens for the attainment of equality, equity and social justice.

15.6.3 Population growth

The Government should focus on facilitating and enhancing education for all. With greater accessibility to education, young people will spend more years studying, hence become more productive, delay marriage, and consequently end up having fewer children.

Policies to address population growth and to promote social protection are vital for reducing poverty, as are national employment strategies that are formulated and implemented with full involvement of key stakeholders. Actions to expand jobs and labour productivity should focus on widening access to complementary inputs such as machinery and equipment, strengthening the business environment

in which private firms can thrive, boosting the quantity and quality of physical and institutional infrastructure, and improving working conditions.

Policy and decision makers need to recognize that continuing population growth will contribute to increased urbanization, and to develop and implement urban planning policies that take into account consumption needs and demographic trends while capitalizing on the potential economic, social and environmental benefits of urban living.

15.6.4 Accesses to Health Care Information and Services

- Form a National Health Services Commission that will be responsible for regulating matters in health, quality assurance and standards, monitoring and evaluation, strategic planning and management, inter-sectoral collaboration, enforcing the Bill of Rights and ensuring universal access to health care;
- Strengthen county health structures and ensure that each county has a referral hospital, centre of excellence, paediatric and adolescent centre, medical supplies store and a health emergency fund;
- Establish county-based affirmative action programmes to provide access to and use of services by vulnerable populations, particularly those without access to or who do not use health care due to sex, age, poverty, culture, disability, geography, language, pregnancy, social origin, etc;
- Ensure appropriate funding for the health sector in line with the needs of different counties;
- More investment should be made towards preventive and promotive health services, including lifestyle changes and effective primary level management of chronic diseases while cementing gains made in the control of communicable diseases;
- Ensure adequate human resource capacity through review of the remuneration for different cadres, and introduce additional training and incentives for personnel to work in marginalized areas;
- Ensure that legislators are fully conversant with and engaged in the budgeting cycle from the planning, implementation and review stages as part of their guidance and oversight roles; and
- Enhance and support the role of the public, civil society and non-state actors in budget tracking and monitoring including participation in public budget hearings.

Empowering women, removing financial and social barriers to accessing local accountability of health systems are all policy interventions that will enhance equal access to health services and reduce mortality.

The inadequate access to and use of skilled birth attendants and inequity by location and income are serious impediments to reducing maternal mortality. The use of contraception to space or limit births is an important factor in Kenya's high MMR. Further reducing income poverty, improving education, boosting employment and empowering women, as well as fighting HIV and AIDS, TB and malaria will all have positive effects on maternal mortality. Better maternal health will have residual effects on child health and economic well-being of individuals, families and communities.

15.6.5 Environmental Sustainability

Kenya should strive to tap into new global resources to strengthen Kenya's sustainable development. Natural resource management strategies, including reforestation that have until now often been ignored, should be given priority. Similarly, well-thought-out public-private partnerships for addressing climate change should be brought into play.

Policy and decision makers need to use existing knowledge more effectively and to prioritise research in the natural and social sciences that will provide innovative solutions to the challenges of sustainability.

15.6.6 Support Collection, Analysis, Dissemination and Use of Population and Health data

In order to gain better understanding of the policy and programme environment, there is need to contribute to undertaking of socio-demographic surveys in order to continue building the knowledge base on population dynamics, reproductive health, HIV and AIDS as well as gender equality. It will be necessary to support further analysis of modules of selected socio-demographic surveys such as the KDHS, among others. In addition, undertaking of socio-cultural, demographic and health research to support programme planning and implementation as well as policy dialogues will be added advantage.

15.7 Recommendations for UNFPA

On the basis of the challenges identified and the strategic direction for UNFPA, it is recommended that UNFPA focuses on the following three areas:

a. Universal Access to Sexual and Reproductive Health and Reproductive Rights

In line with the ICPD Programme of Action, Kenya has two policy instruments that address the issue of universal access to sexual and reproductive health:

The National Reproductive Health Policy of 2007 which aims at enhancing the reproductive health status of all Kenyans, and Article 43 of The Constitution of Kenya 2010 which provides that every person has the right to the highest standard of health, which includes the right to health care services, including reproductive health care. However, universal access to sexual and reproductive health is still being constrained by a number of factors, some economic, social and cultural. UNFPA is expected to be at the forefront in supporting the implementation of the RH Policy as well as other policies that promote attainment of reproductive health and rights within the framework of the new constitutional dispensation.

b. Improve Maternal, New Born and Child Health

In line with MDG 5, relevant policies and programmes in Kenya aim at reducing maternal deaths. However, trends in maternal mortality ratio provide clear evidence that this is one of the goals at highest risk of not being met. Uptake of maternal health care and voluntary family planning services are vital to reducing maternal deaths. This makes family planning critical in its own right. In this regard, UNFPA should support the relevant interventions that promote increased uptake of maternal health care services including family planning.

c. Support Efforts Towards a Strong Information Base

Sustainable development requires Kenya to be in a position to proactively address, rather than only react to, the population trends that will unfold over the next decades. Requisite data must inform forward-looking development policies, strategies and programmes. To measure progress in population and reproductive health and rights outcomes, and to hold associated actors accountable, a set of robust indicators must be clearly defined. The Kenyan community has not only a need, but also a right to monitor the impact of the development agenda. Development results data must be positioned to reveal the actual impacts on people, environment, economy, security, etc. in all instances, indicators must allow for impacts to be disaggregated by various characteristics including age, sex, socio-economic status and related variables, so as to track how the most vulnerable groups progress. UNFPA's role will be to enhance capacity of institutions responsible for population related data collection, analysis, dissemination and use to generate accurate and user-friendly data for integration of population issues into development planning at all levels.

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(Footnotes)

- 1 This is based on UN's definition of Eastern Africa, which encompasses 19 countries: all the Horn of Africa countries, excluding Sudan and South Sudan; and all the countries up to Zimbabwe including all the Indian Ocean islands. State parties to the UN Convention and Protocol [include Burundi, Djibouti, Eritrea (Convention only), Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Seychelles, Tanzania, Uganda, Zambia and Zimbabwe.
- 2 Excludes Comoros, Eritrea, Mauritius and Somalia.
- 3 The states are Rwanda, Seychelles and Uganda.
- 4 Excludes Burundi, Comoros, Eritrea, Ethiopia, Eritrea and Zimbabwe.
- 5 Poverty analyses construct regional baskets of goods and services. If the household cannot afford the standard food and shelter package, then it is overall poor; if it can't afford the food package, then it is food poor, and if its total spending cannot afford the food package, then it is severely poor.

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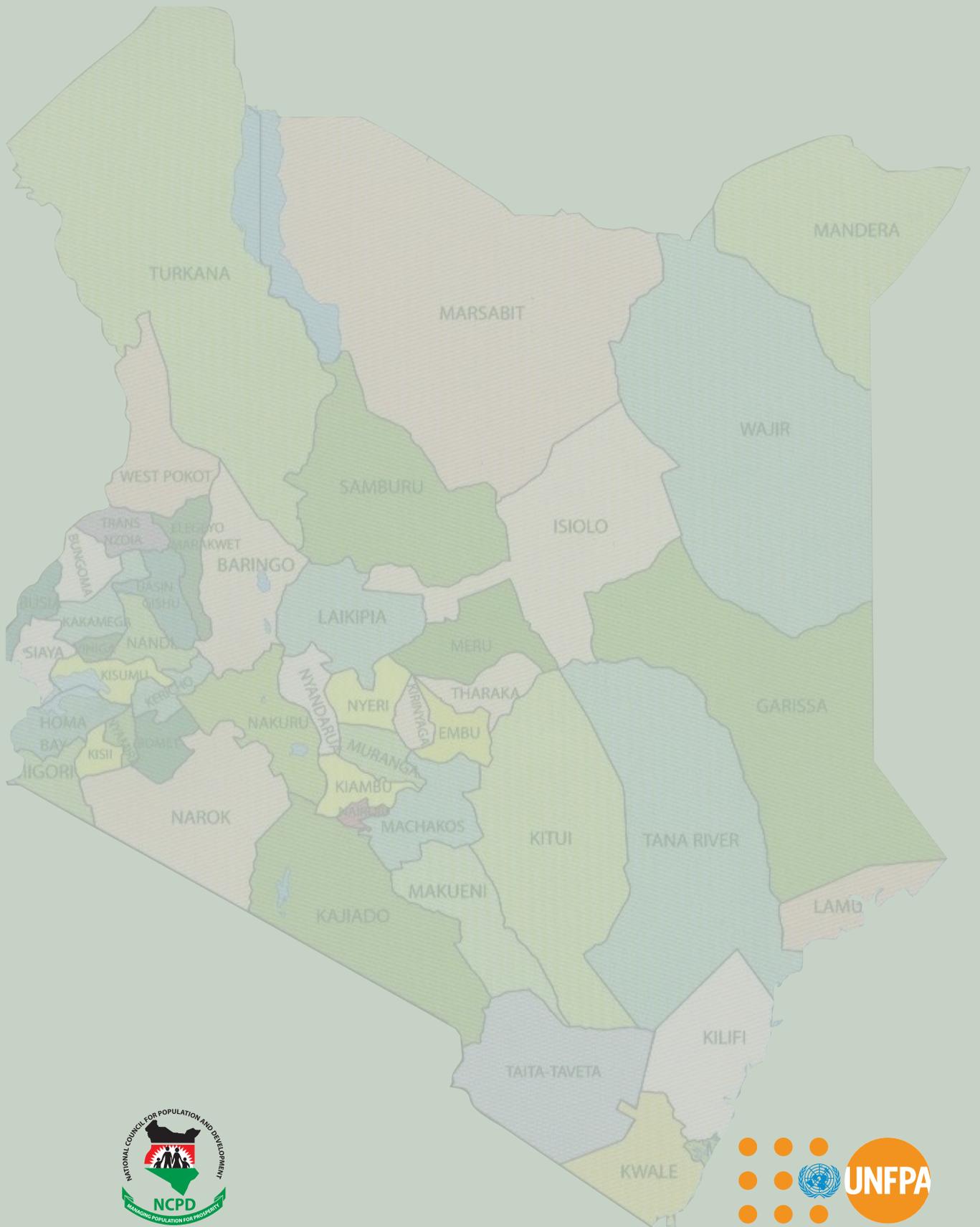
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