

POPULATION STABILIZATION: KENYA CASE

TABLE OF CONTENT

List of Tables.....	2
Abbreviation and acronyms.....	3
1.0 introduction.....	4
2.0 Geographical location and size.....	6
2.1 locations.....	6
2.2 size.....	6
3.0 population management.....	7
4.0 Population size and structure.....	9
4.1 Population size.....	9
4.2 population structure.....	10
4.3 population growth rate.....	11
4.4 project population.....	12
4.3 population distribution and density.....	13
5.0 demographic transformation.....	15
5.1 demographic transformation and dividend.....	15
6.0 fertility trend.....	17
6.1 High fertility.....	17
6.2 high teenage fertility.....	19
6.3 Knowledge and use of contraceptives method.....	20
6.4 population momentum.....	22
7.0 morbidity and mortality.....	25
7.1 general trends in mortality.....	25
7.2 neonatal and postnatal mortality.....	26
7.3 infant mortality rates.....	27
7.4 Under five mortality.....	28
7.5 Maternal morbidity mortality.....	29
7.6 STI, HIV AND AIDS.....	30
8.0 population stability prospect.....	31
Reference.....	33

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organisation
CPR	Contraceptive Prevalence Rate
DRH	Division of Reproductive Health
EFA	Education for All
ERS&WEC	Economic Recovery Strategy for Wealth and Employment Creation
FP	Family Planning
GDP	Gross Domestic Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KFS	Kenya Fertility Survey
KIHBS	Kenya Integrated Household Budget Survey
KNBS	Kenya National Bureau of Statistics
MDGs	Millennium Development Goals
MOH	Ministry of Health
MOSPND	Ministry of State for Planning, National Development and Vision 2030
NCPD	National Council for Population and Development
NCAPD	National Coordinating Agency for Population and Development
NLC	National Leaders' Conference
NPPSD	National Population Policy for Sustainable Development
NGO	Non-government Organisation
PHC	Primary Health Care
PoA	Plan of Action
RH	Reproductive Health
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate

1.0 INTRODUCTION

Kenya was one of the one hundred and seventy nine (179) countries that participated in the International Conference on Population and Development (ICPD), in Cairo Egypt in 1994 where the issue of population stabilisation was recognised. The ICPD's POA states that early stabilization of the world population would make crucial contribution towards the achievement of sustainable development (UN, 1994 Para. 1.11). The World leaders agreed that each country adopt and implement population policies and programmes that will address among other issue the high fertility and rapid population growth in order to attain early population stabilisation. It should be noted at the outset that reduced population growth does not feature as a major objective of the POA.

In line with the ICPD Plan of Action (PoA), Kenya adopted the National Population Policy for Sustainable Development in 2000 and developed other related policies and programmes including the Adolescent Reproductive Health and Development Policy, the National Youth Policy, the National Gender and Development Policy and the National Reproductive Health Strategy. The National Population Policy for Sustainable Development is currently being revised to address continuing and emerging population challenges. Other socio-Economic measures and strategies were also put in place including the Economic Recovery for Wealth and Employment Creation that were aimed at reducing poverty and improve the wellbeing of the majority of the population.

Kenya developed recently its development blue print, Vision 2030 and its first Medium Term Development Plan for the period 2008-2012. Legal and other institutional changes were also initiated culminating to the promulgation of a new Constitution, which has a detailed Bill of Rights including Reproductive Health Rights and introduction of a devolved governance structure. The New Constitution puts gender issues at the centre of decision-making and ensures that men, women, children and the individuals are the initiator and beneficiary of all developments. It is expected that successful implementation of the Constitution, the Vision 2030 and the Revised Population Policy for National Development will spur the country to fast socio-economic development and thereby contribute to early population stabilisation.

Rapid population growth due to high fertility levels, regional disparity in population indicators, rapid urbanization and skewed population distribution still remain key population concerns for Kenya now and in the future.

It is now almost 18 years since the ICPD and there is need to review population stabilisation efforts, note the key benchmarks made and challenges experienced, and make foresight of the situation based on the available data and information.

2.0 GEOGRAPHICAL LOCATION AND SIZE

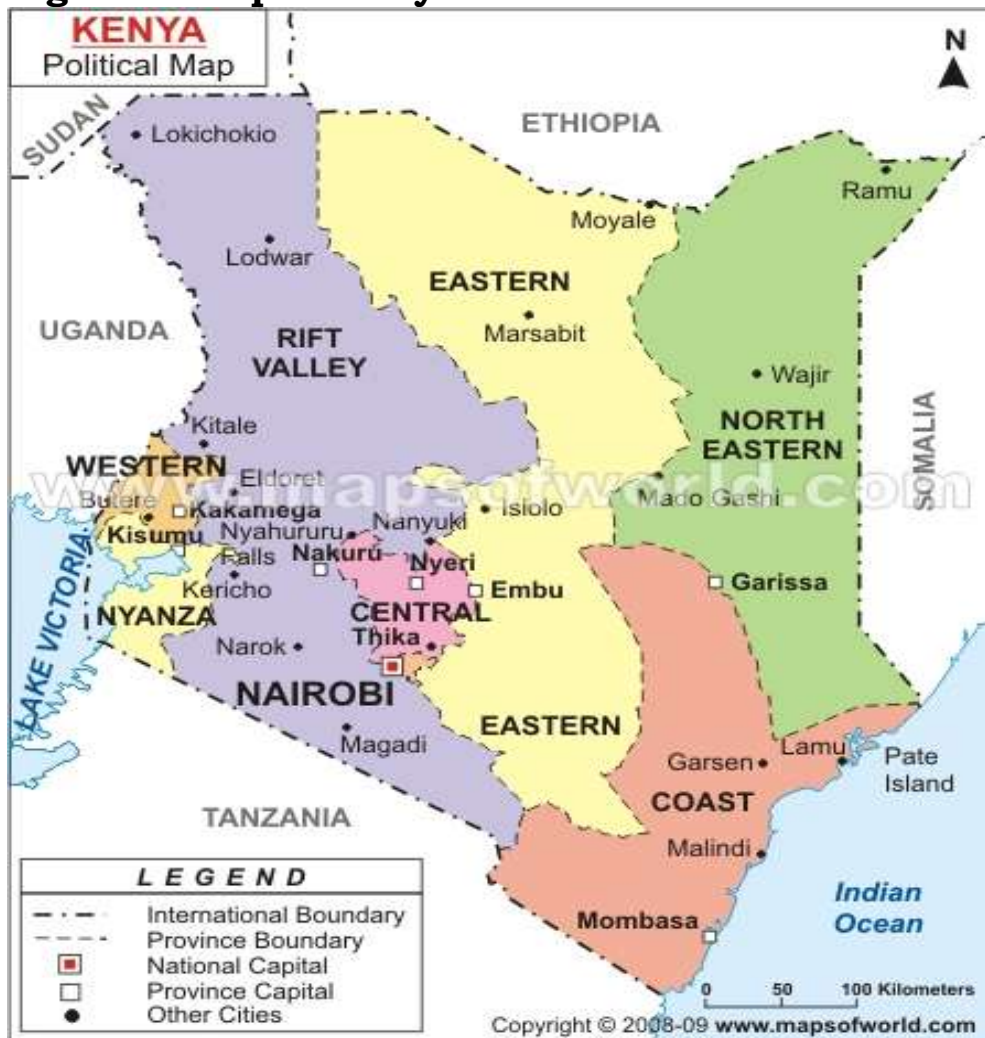
2.1: Location

Kenya borders the Indian Ocean to the east, Somalia to the northeast, Ethiopia to the north, Southern Sudan to the northwest, Uganda to the west, and Tanzania to the south. The Country is composed of eight administrative provinces. In the New Constitution which is in the process of being operationalised, the country will be composed of forty seven (47) counties and the eight administrative districts will be abolished.

2.2: Size

Kenya has a total area of 582,650 square kilometres (224,962 square miles). Land occupies about 569,140 Square Kilometres while water occupies about 11,227 square kilometres. Only about 17 percent of the land is arable for agriculture, the mainstay of the economy.

Figure 1: Map of Kenya



3.0: Population Management

Kenya has had over time, explicit and implicit population policies and strategies that have contribute to an enabling environment for addressing population and reproductive health issues. The relevant ones include:

- a) **1955:** Private Family Planning Associations formed. The Associations addressed the RH needs of the non-Africans-White settlers and the Asians
- b) **1965:** Sessional Paper No. 10 on African Socialism and Its Application to Planning in Kenya, where population issues were highlighted as challenge for development
- c) **1967:** Population Policy adopted by the Government and National Family Planning action Programme launched. The Programme emphasized on reduction of family size and spacing of children to lower the population growth rate
- d) **1982:** Government established National Council for population and Development(NCPD)
- e) **1984:** Sessional Paper No. 4 on Population Policy Guidelines
- f) **1994:** Kenya Health Policy Framework identifies **population growth management** as a strategic imperative and was reemphasized in subsequent National Health Sector Strategic Plans
- g) **1996:** National Population Advocacy and IEC Strategy developed
- h) **1997:** National Reproductive Health Strategy launched
- i) **2000:** Sessional Paper No I on National Population Policy for Sustainable Development
- j) **2003:** Adolescent Reproductive Health and Development developed

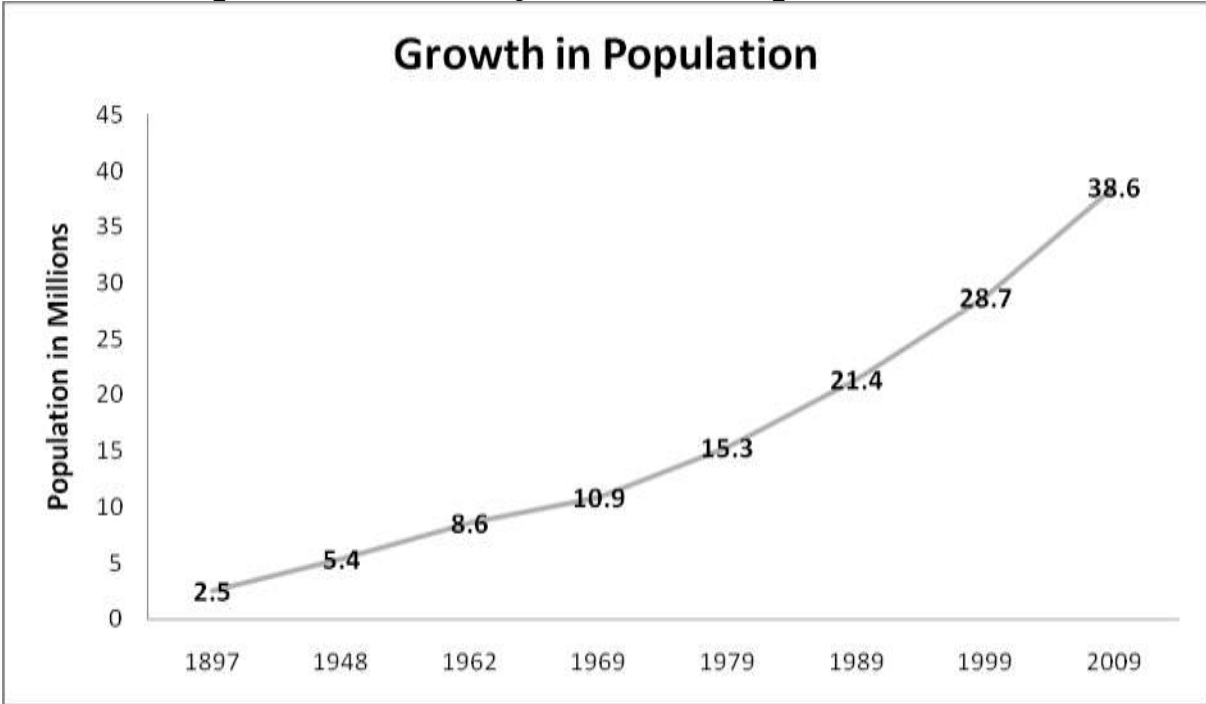
- k) 2004:** National Coordinating Agency for Population and Development established
- l) 2005/2006:** Budget line item for Family Planning established
- m) 2007:** National Reproductive Health Policy published
- n) 2007:** Population, Urbanization and Housing Section included in the Medium Term Strategic Plan of Vision 2030
- o) 2010:** New Constitution promulgated. Several Articles in the Constitution addresses Reproductive Health issues, including Family Planning.

4.0: Population Size and Structure

4.1: Population Size

The population of Kenya has continued to increase exponentially over time. The 2009 Kenya Population and housing Census enumerated a total of 38,610,097 million people, representing an increase of about 35 percent from the 1999 census. Kenya Population increased from only 8.6 million persons in 1962 to 10.9 million, 15.3 million, 21.4 million, 28.7 million and 38.6 million persons in 1969, 1979, 1989, 1999 and 2009 respectively(Figure2).

Figure 2: Population of Kenya since Independence



Source: GOK 2009 Kenya Population and Housing Census Volume 1C pp.2

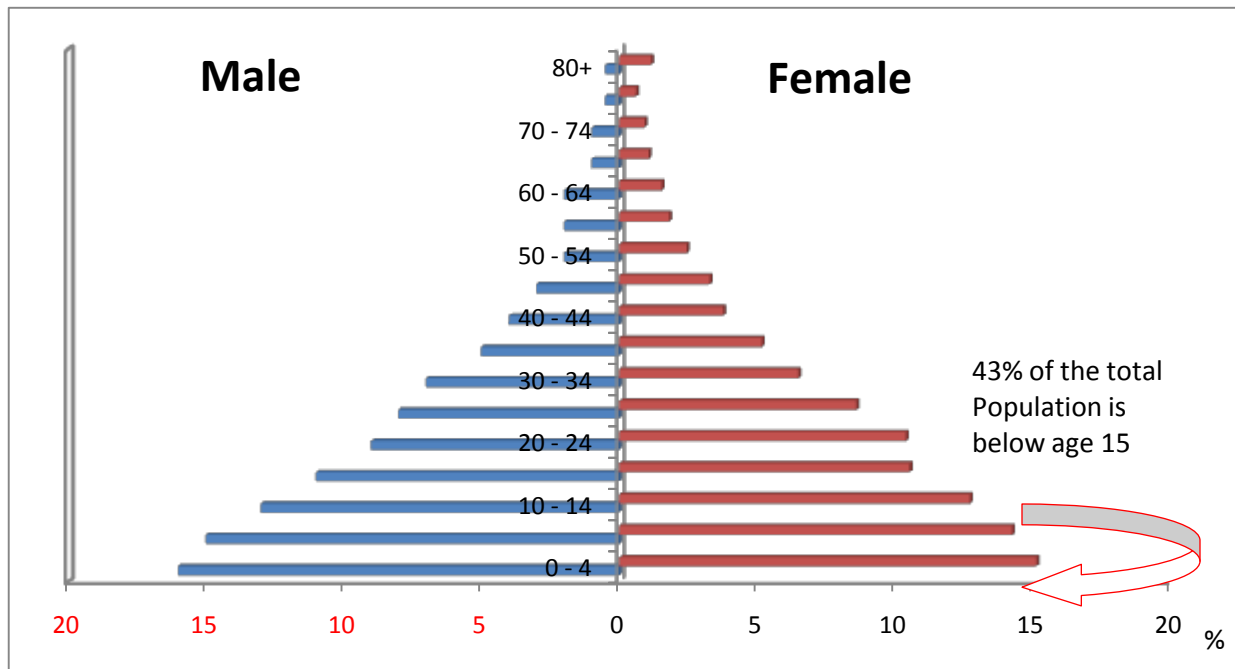
The population is growing at about one Million two hundred thousand persons per year and is currently estimated at about 41 million people. Kenya’s population has therefore doubled over the last 25 years.

The high fertility levels have had greater impact than mortality rates on population size and growth, and have been the driving force behind the rapid population growth and a youthful population structure.

4.2 Population Structure

The past and current high fertility rates coupled with improvement in child survival have resulted into a youthful population. The 2009 Kenya population and housing census revealed that about 43 percent of the total population is below age 15. Many females will soon enter their reproductive years and have children within the next decade. The 2009 Census results also revealed that female in the reproductive age (15-49) constituted about 48.3 percent of the total population. This young age structure creates a powerful momentum for future population growth.

Figure 3: Kenya Population by Sex, 2009

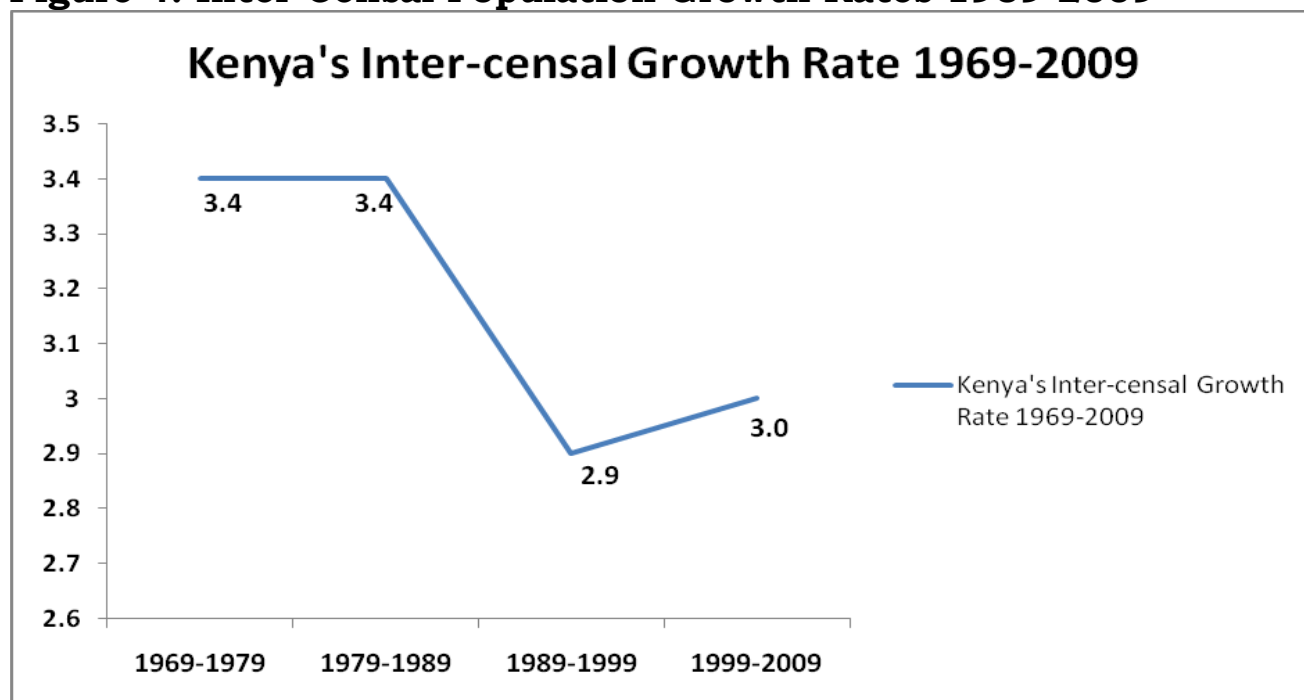


Source: Source: *GOK 2009 Kenya Population and Housing Census Volume 1C pp.23*

4.3: Population Growth Rates

The 2009 Census revealed an increase in the Inter-censal population growth rate from 2.9 in 1989-1999 to 3.0 percent in the period 1999-2009. This was the second time an increase in population growth rate is being observed. The 1962 Census results had also confirmed an increase in population growth rate which continued until it reached the peak in 1979 before it started easing off.

Figure 4: Inter-Censal Population Growth Rates 1969-2009



Source: GOK 2009 Kenya Population and Housing Census Volume 1A pp.22

A time series analysis of the census results indicates that the natural rate of population increase accelerated from only 2.5 percent per annum in 1948 to 3.3 and 3.8 per cent in 1962 and 1979 respectively. The growth rate then declined from 3.8 percent per annum in 1979 to 3.3 and 2.8 percent in 1989 and 1999 respectively, before again registering a marginal increase to 2.9 percent in 2009.

The aboved acceleration in population growth rate between 1948 and 1979 is attributed to increase in fertility levels and decline in maternal mortality , and also to improvement in health especially child nutrition and socio-economic status.The decline in the growth rate in the period

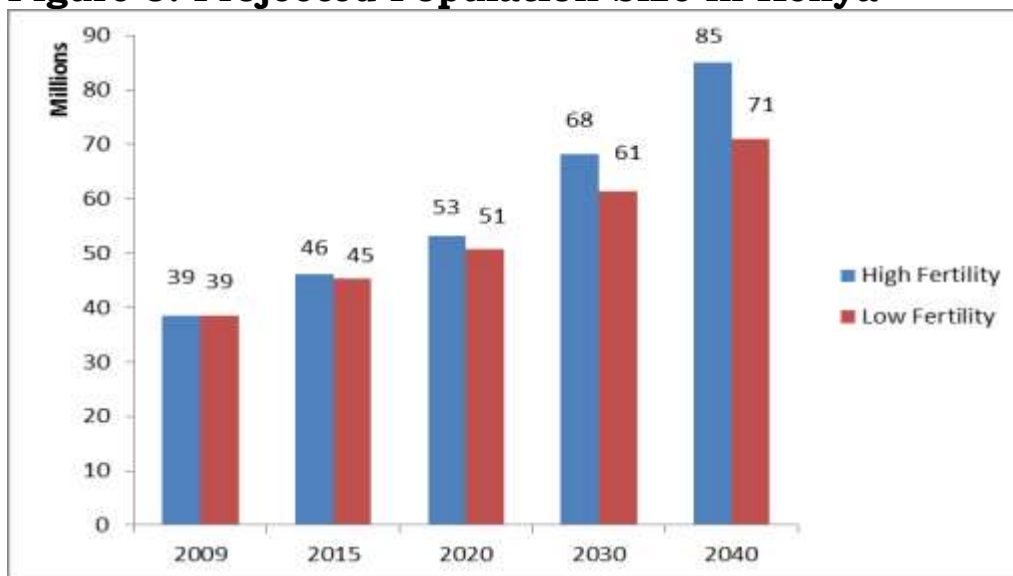
1979 to 1999 was mainly due to Kenya entering the demographic transition as fertility declined. The decline in fertility was due to the use of contraceptives. Kenya experienced a stall in fertility in the 2000s which resulted to the observed marginal increase in population growth rate as reflected by the 2009 census results.

This population growth is high considering the prevailing economic growth rates. The rapid population growth and size will therefore be the most important long-term social and economic challenge for Kenya and the realization of Vision 2030 and attainment of early population stabilization

4.4: Projected Population

The future population size of Kenya will depend on the nature of future fertility levels. Under high fertility assumptions scenarios, Kenya's population is projected to increase from 38.6 million in 2009 to 68.1 million in 2030 and 85 million in 2040 as shown in figure 5. Likewise, under low fertility scenarios, Kenya's population is projected to increase from 38.6 million in 2009 to 61.3 million in 2030 and 70.9 million in 2040 as shown in figure 5.

Figure 5: Projected Population Size in Kenya



Source: Spectrum using the 2009 Kenya Census

4.3: Population Distribution and Densities

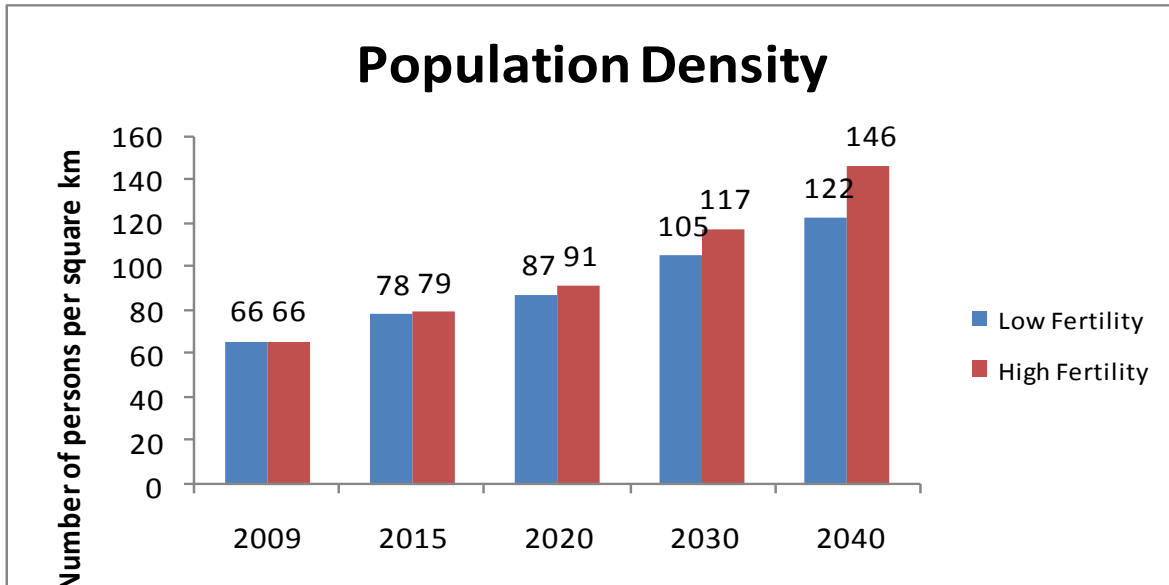
The Kenyan Population is unevenly distributed throughout the Country. The population is concentrated in mainly three clusters (i) around Lake Victoria- Western highlands, (ii) the area extending from Nairobi north to mount Kenya-Central/Eastern Highlands, and along the Coast of the Indian Ocean.

About ninety percent of Kenyans living in rural areas derive their livelihood directly from the land. Rapid population growth due to high fertility rates in the past and declining mortality has resulted in land scarcity in many areas due in part to the traditional land tenure system in which parents divide their land among their children especially the sons. Pressure on natural resources is bound to increase over time due to increasing population densities in the country. Between 1969 and 2009, population density as measured by the number of persons per square kilometre increased by more than four times from 19 persons per square kilometre in 1969 to 37 persons in 1989 and to 66 persons per square kilometre in 2009.

The national average masks the diverse regional variations on population densities considering that only 17 percent of the land is arable for agricultural activities. Nairobi, Kilindini and Mombasa which are predominantly urban have high population densities of 4, 515; 4,493 and 4,144 persons per square kilometres respectively. In the Rural areas, Kiambaa, Kikuyu, Vihiga, Emuhaya and Kisii central have high population densities of 1,342; 1,126; 1101; 1067 and 1,009 persons per kilometres respectively.

The population density is projected to increase from 66 persons per square kilometer in 2009 to 122 and 146 persons per square kilometre under low and high fertility scenarios respectively by 2040 as shown in figure 6.

Figure 6: Projected Population density in Kenya, 2009-2040



Source: Spectrum using 2009 census

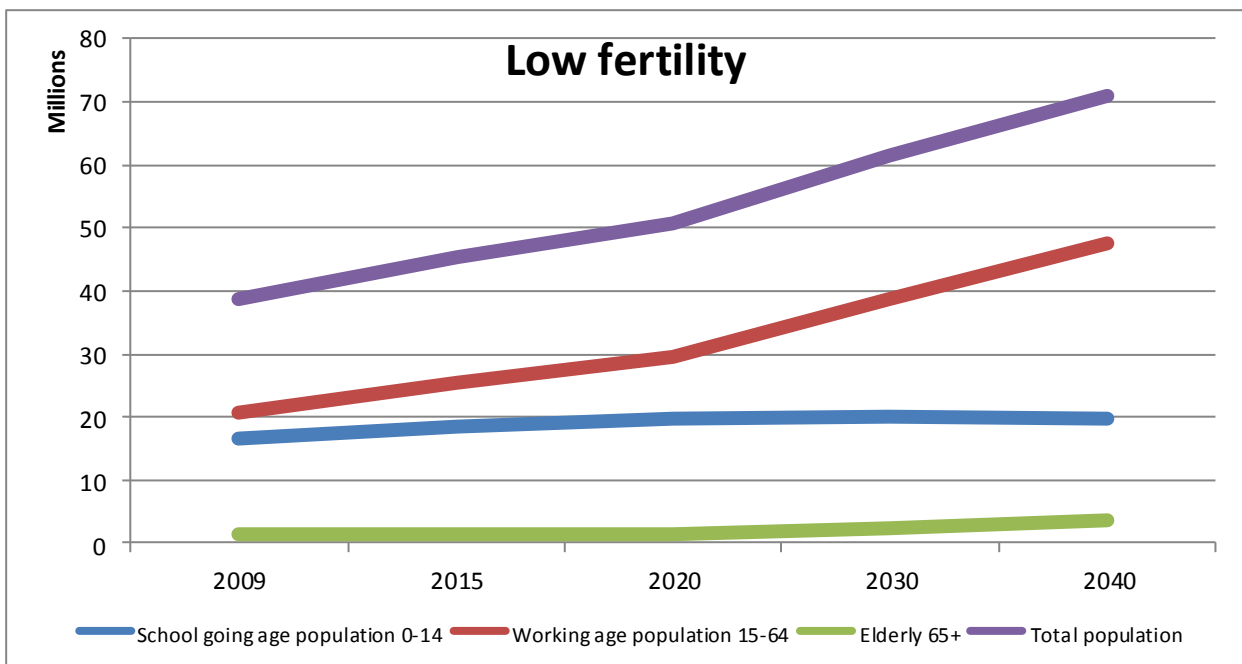
Regions with high population pressure have over time put various coping mechanisms to meet their livelihood needs. The coping mechanism includes adoption of modern agricultural technologies, intensification of agriculture activities, migration to other region and more importantly, investment in their children’s education. This has resulted into reduction of family sizes gradually and overall total fertility rates. With the ongoing education reforms and gender empowerment activities, the trend in fertility decline is bound to accelerate, and contribute to early population stabilisation.

5.0: Demographic Transformation

5.1: Demographic Transformation and Demographic Dividend

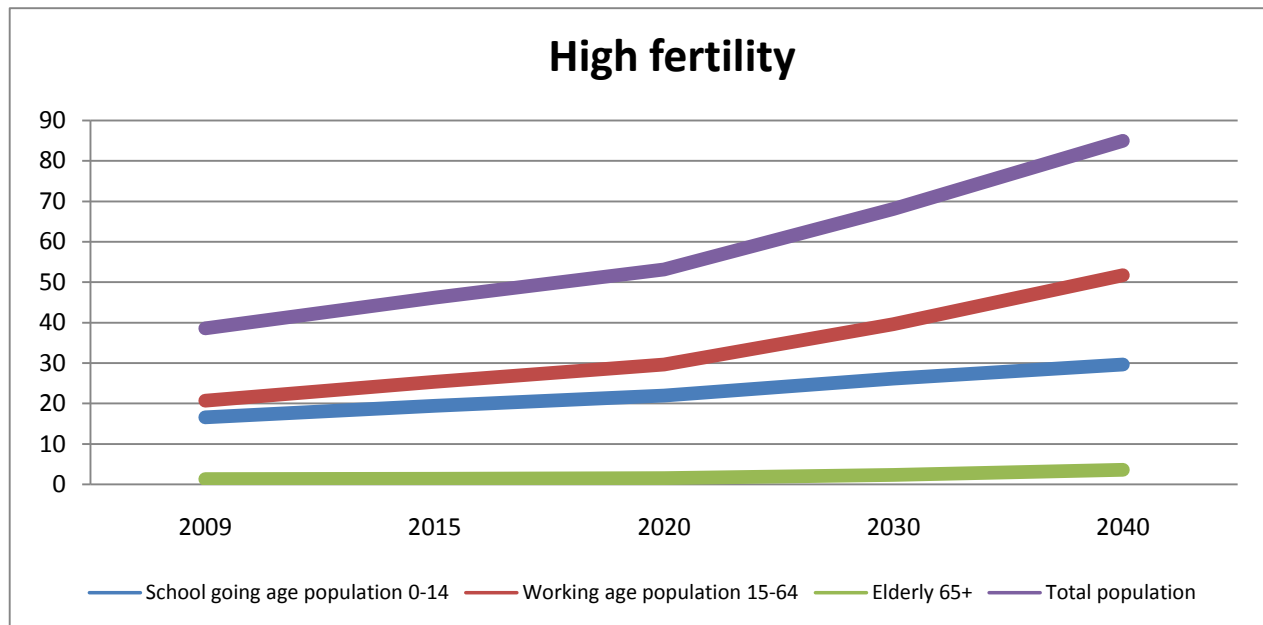
The recent decades of high fertility levels and improvements in child survival has resulted to fast growing population group of those aged 15-64 years in Kenya. This is the working age population, the labour force. The 2009 Census enumerated a total of 20,864,861 million people aged 15-64 years. This working age population is projected to increase to 25,352,395 million in 2015, to 29,619,206 million in 2020, to 38,806,046 million in 2030 and to 47,521,837 million by 2040 under low fertility scenario as reflected in figure 7a.

Figure 7a: Kenya Demographic Transformation



Source: Spectrum using 2009 census

Figure 7b: Kenya Demographic Transformation



Source: Spectrum using 2009 census

Similarly, the working age population is projected to increase to 25,352,395 million in 2015, to 29,619,206 million in 2020, to 39,627,323 million in 2030 and to 51,707,032 million by 2040 under high fertility scenario as reflected in figure 8b.

Figures 7a and 7b clearly indicate that by year 2020 the gap will widen as the proportion of the working age population will grow much faster than dependant population ages (0-14 & 64+ years). The number of people seeking employment will continue to rise. If high fertility continues, Kenya will need to create twice as many new jobs as it does today.

Reduced dependency ratios will allow greater personal savings and government spending. Kenya will therefore be in a position to gain from a **“Demographic Dividend”** provided that right enabling environment prevails.

In order for Kenya to gain from the large and expanding workforce, there is need to invest in education and technology, health care, improve the investment climate, harness new innovations, infrastructures, and build institutional capacities.

6.0: FERTILITY TRENDS

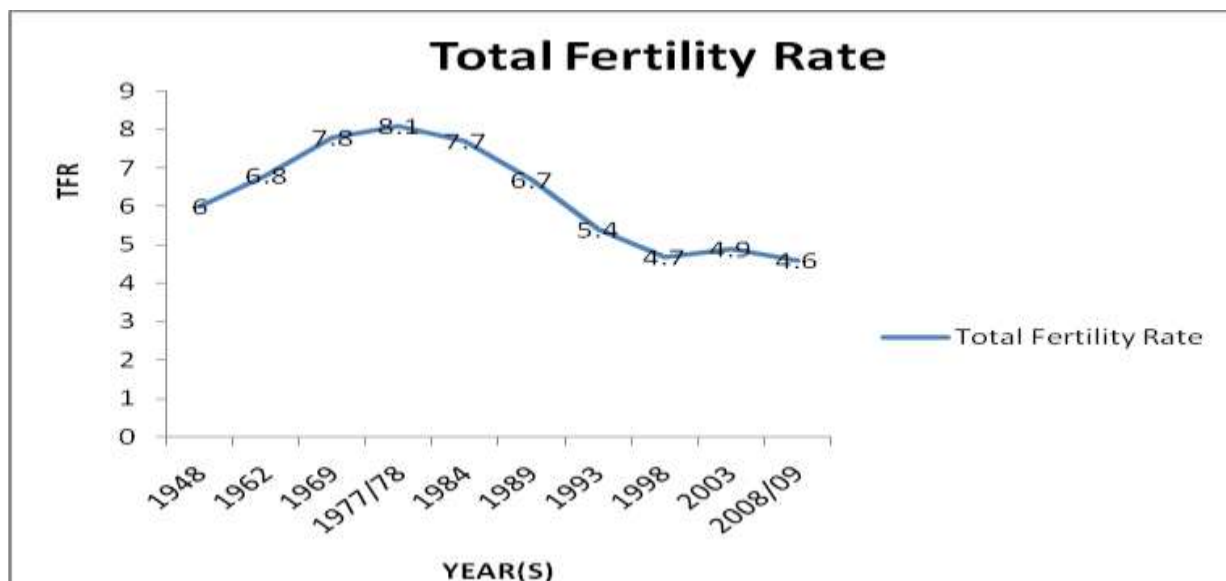
6.1: High Fertility

The rapid population growth is set to continue due to the prevailing high fertility and the population momentum. The population momentum will cause the population to increase even after fertility rates decline to the replacement level.

Kenya's Total Fertility Rate (TFR) increased to 8.1 in 1977/78 from 6.8 children per woman in 1962. The TFR then declined sharply from 8.1 children per woman in 1977/78 to 6.7 in 1989 and to 4.7 children per woman in 1998. The rapid fertility decline observed between 1978 and 1998 was as a result of substantial national and international support of the National FP Programme, including reinvigoration of the Population policy. Human and financial resources were invested in the National FP Programme.

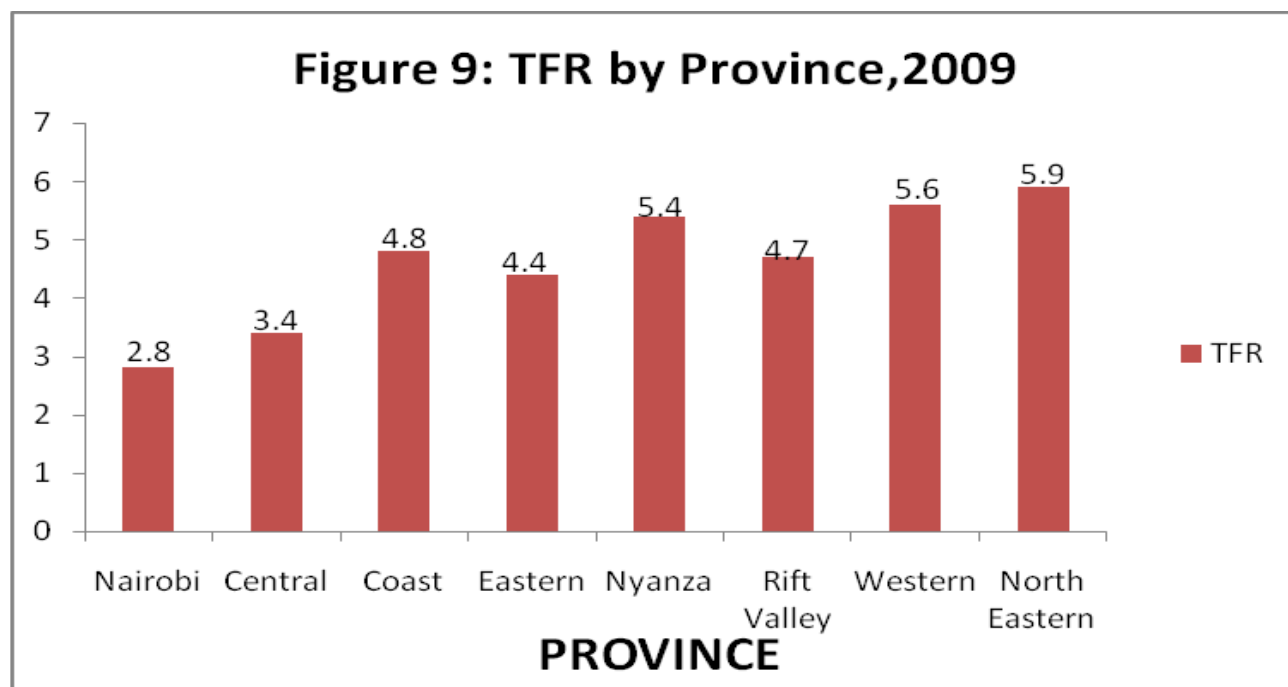
The TFR then increased marginally to 4.9 in 2003 before again declining to 4.6 children per woman in 2008/09, which is far above the fertility replacement level of 2.1 children per woman. Analysis of trends in TFR indicates that TFR declined to 2.9 in 2006-08 from 3.3 children per woman in 2000-03 periods in urban areas while in the rural areas TFR declined to 5.2 in 2006-08 from 5.4 children per woman in 2000-03 periods.

Figure 8: Kenya Fertility Trends: 1948 – 2009



Source: KNBS-KFS, KDHS, Census Reports

There are substantial differences in fertility levels by region and socio-economic group in Kenya. The TFR is higher in rural than urban areas at 5.2 and 2.9 children per woman respectively. Regionally, the TFR is highest in North Eastern province at 5.9 children per woman and lowest in Nairobi at 2.8 children per woman



Source: KNBS and ICF Macro.2010 KDHS 2008-09, Page 48

6.2: High Teenage Fertility

The 2009 Population and Housing Census revealed that about a quarter (24 %) of Kenya’s total population of 38.6 million comprise the Adolescents (aged 10-19 years).The 9.2 Million adolescent is a very huge number that has major demographic, economic and social implications.

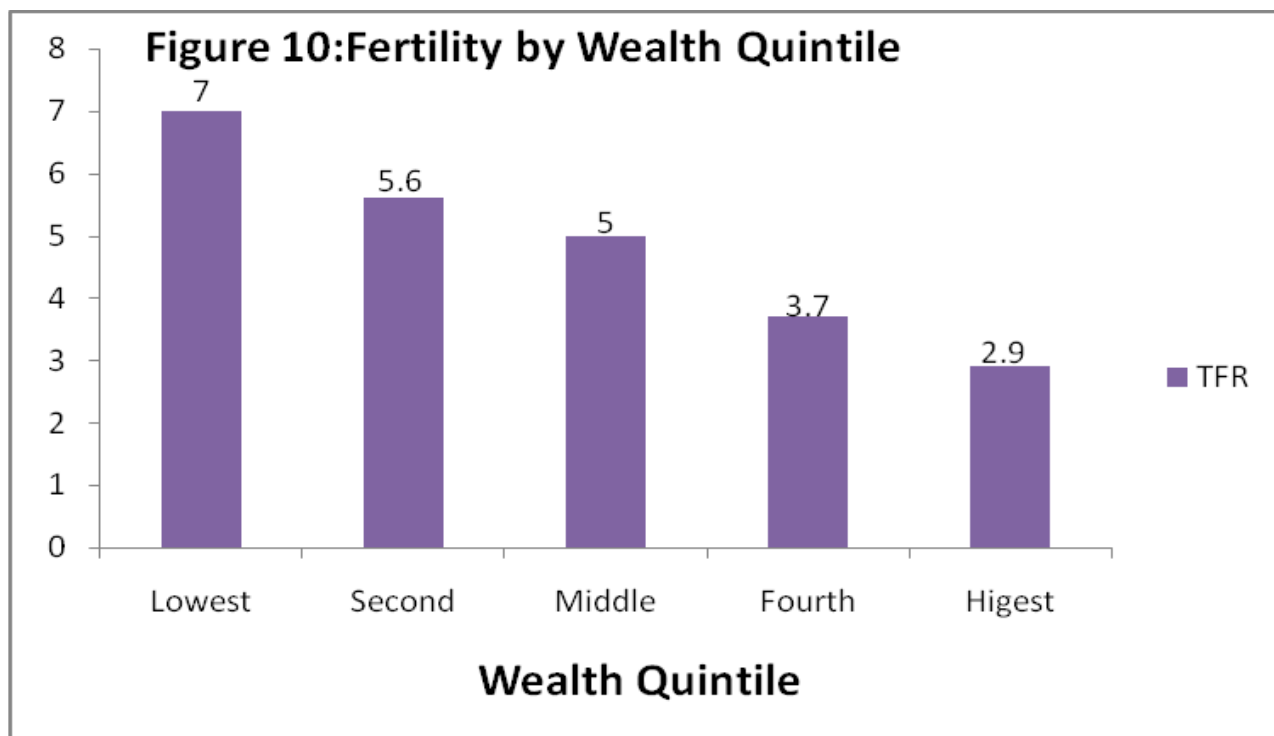
Young Kenyan women experience early sexual debut, early marriages, early child bearing and many of the pregnancies are unintended. Further, contraceptive use among the sexually active adolescents is low, resulting to high unmet need for family planning.

The 2008-09 KDHS results revealed that young women had their first birth at a median age of 19.8 years and that 18 per cent of girls aged 15-19 years had already begun childbearing. Fertility levels have remained high among the adolescents unlike the other age groups. The Age Specific Fertility Rate declined only to 103 in 2008-09 from 114 per 1,000 in 2003. The high fertility rates among the adolescents are mainly attributed to lack of access to Sexual Reproductive health information and services.

As with TFR, there are notable differentials in teenage fertility by region. Highest teenage fertility are observed in Nyanza and Coast provinces at 27 and 26 percent respectively while Central province recorded the lowest teenage fertility at 10 percent in 2008-09.

The observed differentials are due to mainly the socio-economic development status-Education and poverty levels. Expanding successful education programmes that will enroll and retain girls at least up to secondary level education will significantly contribute to reduction of teenage fertility and overall fertility. Several studies have over time indicated the correlation between education level of a woman and fertility. The 2008-09 KDHS revealed that TFR decrease by more than half from a high of 6.7 for women with no education to a low of 3.1 for women with at least some secondary education.

Notable differences are also observed by wealth quintiles. Poor women have on average about four children more than the rich women.



Source: **KNBS and ICF Macro.2010 KDHS 2008-09**, page 48

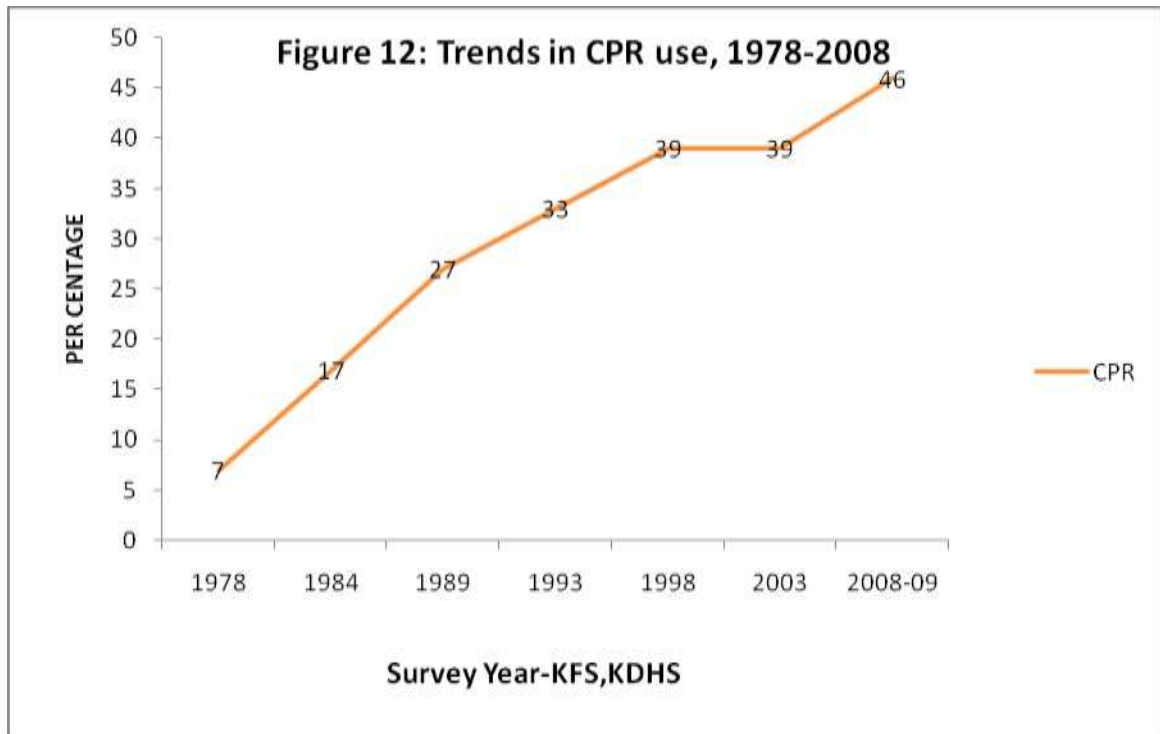
Teenagers from poorer households are more likely to begin childbearing (24%) than those from wealthier households (16 %).

The high teenage fertility has negative socio-economic outcome for both the individual, families, communities and the nation at large.

6.3: Knowledge and use of Contraceptive methods

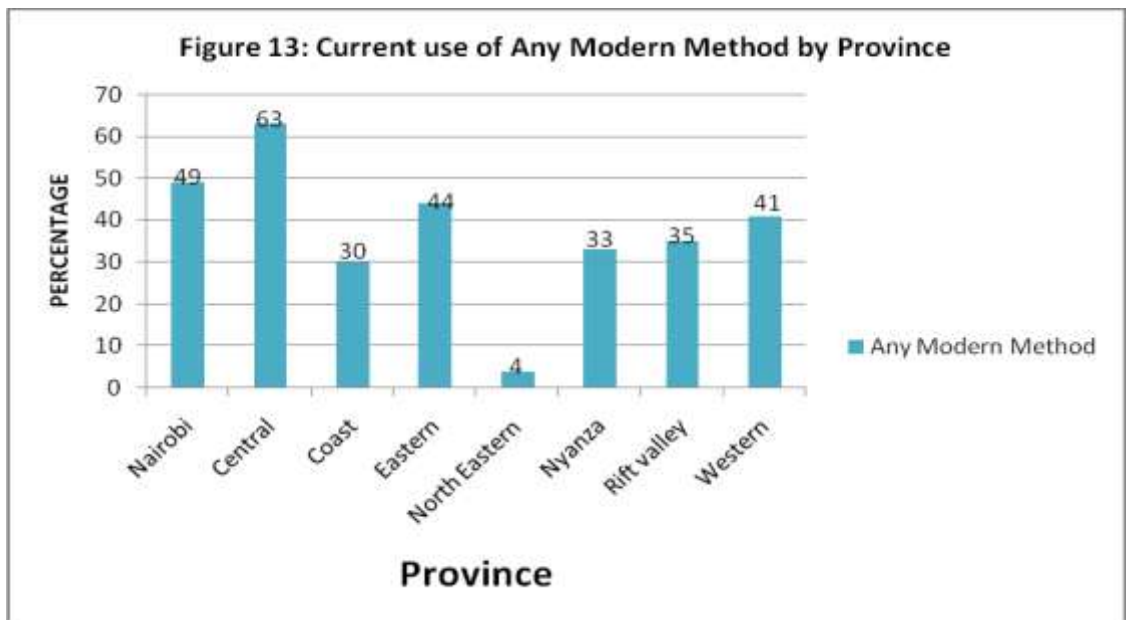
Since the National Family Planning Programme was launched in 1967, knowledge on FP methods has increased steadily and currently it is almost universal for both men and women. The drastic decline in fertility from the high of 8.1 in 1979 to 4.6 children per woman in 2008-09 has been attributed largely to the use of contraceptives.

Contraceptive use for all methods increased from 7 percent in 1978 to 39 percent in 1998, and then stalled at 39 percent up to year 2003 before again increasing to 46 percent in 2008-09 for married women aged 15-49. Use of modern method increased to 39 from 32 percent of married women in 2008-09 and 2003 respectively.



Source: KNBS and ICF Macro.2010 KDHS 2008-09, page 61

Region with high fertility have low contraceptive use. There are wide regional variations in contraceptive use from a high of about 67 percent in central province to a low of only 4 percent for currently married women aged 15-49 in Northeastern province.



Source: KNBS and ICF Macro.2010 KDHS 2008-09, page 65

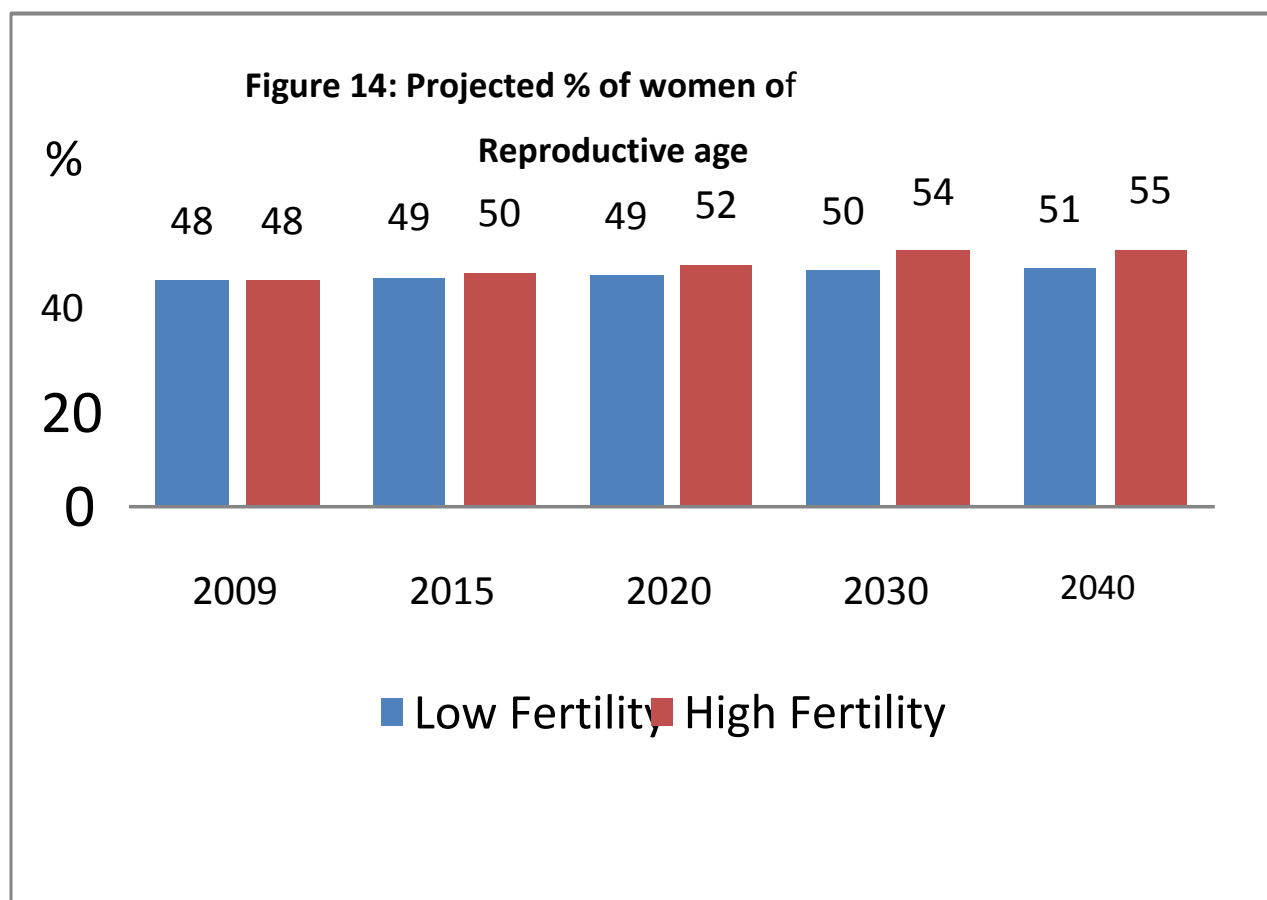
Sustaining and increasing the contraceptive use will be key in fertility reduction and early population stabilisation. Increasing access to Long Acting Lasting Methods of contraception will reduce method discontinuation and failure rates. There have been changes in method mix over time. The use of Pills, IUD, and Rhythm methods have been declining but use of injectables has increased over time.

Addressing the regional variations will increase the overall contraceptive use and contribute greatly towards fertility reduction and early population stabilisation in Kenya. The major challenge has been contraceptive commodity insecurity; social, cultural and religious beliefs and practices; coupled with over dependency on erratic donor funding for modern contraceptives.

6.4: Population Momentum

Population momentum occurs when a large proportion of women are in the childbearing years. In such a situation, the total number of births can increase even though the Total Fertility Rates falls. Rapid population growth in Kenya has increased the percentage of women of reproductive age to 48 per cent in 2009 and is projected to constitute 51 per cent and 55 per cent assuming low and high fertility scenarios respectively by 2040.

The large number of women of reproductive age implies an increasing demand for reproductive health and related services. There is therefore a need to address the issues of fertility reduction in order to reduce the population momentum.



Source: Spectrum using 2009 census

The 2008-09 KDHS revealed that three-quarters of currently married women either want no *more children* or want *to wait at least 2 years* before their next child, and that about 26% of married women have an *unmet need* for family planning(13% for spacing & 13 % for limiting).

The unmet need is highest in the rural areas and among the poor. As with other indicators, there are wide regional variations on unmet need for family planning. Nyanza and Rift valley provinces have the highest unmet need for family planning at 31.7 and 31.1 per cent respectively, followed by Western and Coast at 25.8 and 25.4 per cent respectively. Nairobi, Central and North Eastern provinces had the lowest unmet need of Family planning at 15.1, 15.6 and 16.0 per cent respectively.

This is a very significant number of women if appropriately targeted and use contraception, fertility rates will drastically drop and contribute to population stabilization.

Investing in Family Planning Programmes now will result into future savings in terms of low expenditures in the number of health care providers; health facilities and related infrastructures, among others. It will also contribute to reduced risks of maternal mortality and morbidity and fewer abortions, improved health for children, reduced burden on schools, and offer improved life options for women.

7.0: Morbidity and Mortality

7.1: General trends in Mortality

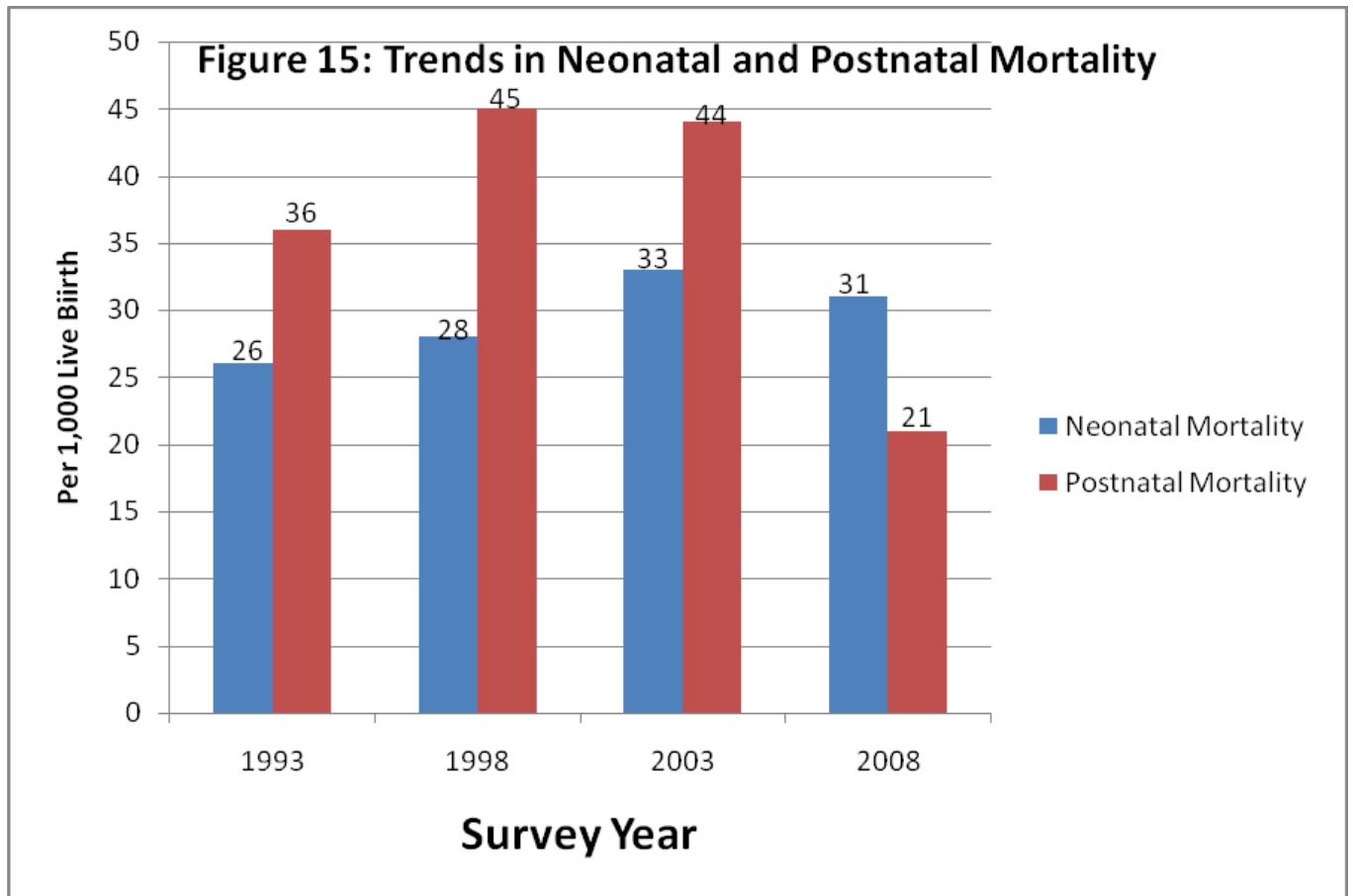
Mortality is one of the key components of population change. Kenya's mortality experience is characterized by high levels in the 1970s; a declining trend in the 1980s and early 1990s; an upsurge in late 1990s and early 2000s; and, a rapid decline in the late 200s. Crude Death Rate, Infant, child and under five Mortality rates declined rapidly. Life expectancy at birth improved to 57 years in 2009 from a low of only 35 years for both sexes in 1948. Women have a higher life expectancy of about three years than men.

Since Mid-1980s, there has been mixed trend in mortality indicators. The mixed trends observed in mid-1980s are associated with emergency and re-emergence of killer diseases such as HIV/AIDS. The leading causes of mortality in Kenya include Malaria, diseases of respiratory system, Diarrhoeal diseases, Pneumonia, anaemia, TB, HIV/AIDS, among others.

Kenya is a signatory to the UN Convention on the Rights of the Child and the African Charter on the Welfare and the Rights of the Child. Childhood mortality still remains high in Kenya despite the various intervention efforts in improving child health and survival. High levels of childhood morbidity and mortality are attributed to malaria, acute respiratory infections (ARI), diarrhoea, childhood malnutrition, measles and HIV/AIDS. Key intervention efforts include immunization, Maternal and child health and Family Planning (MCH/FP), and primary health care (PHC).

7.2: Neonatal and Postnatal Mortality

Figure 15 indicate trends in Neonatal and postnatal mortality rates for the period 1993-2008/09. The Neonatal mortality increased to 33 deaths in 2003 from 26 deaths per 1,000 live births in 1993 while postnatal mortality also increased to 45 in 1998 from 36 deaths per 1,000 live births. Postnatal mortality stalled between 1998 and 2003 before drastically declining to 21 deaths in 2008/09 from 44 deaths per 1,000 live births in 2003. Neonatal mortality declined marginally to 31 deaths in 2008/09 from 33 deaths per 1,000 live births in 2003. There has been general improvement in childhood mortality indicators including neonatal and postnatal mortality rates since 2003.



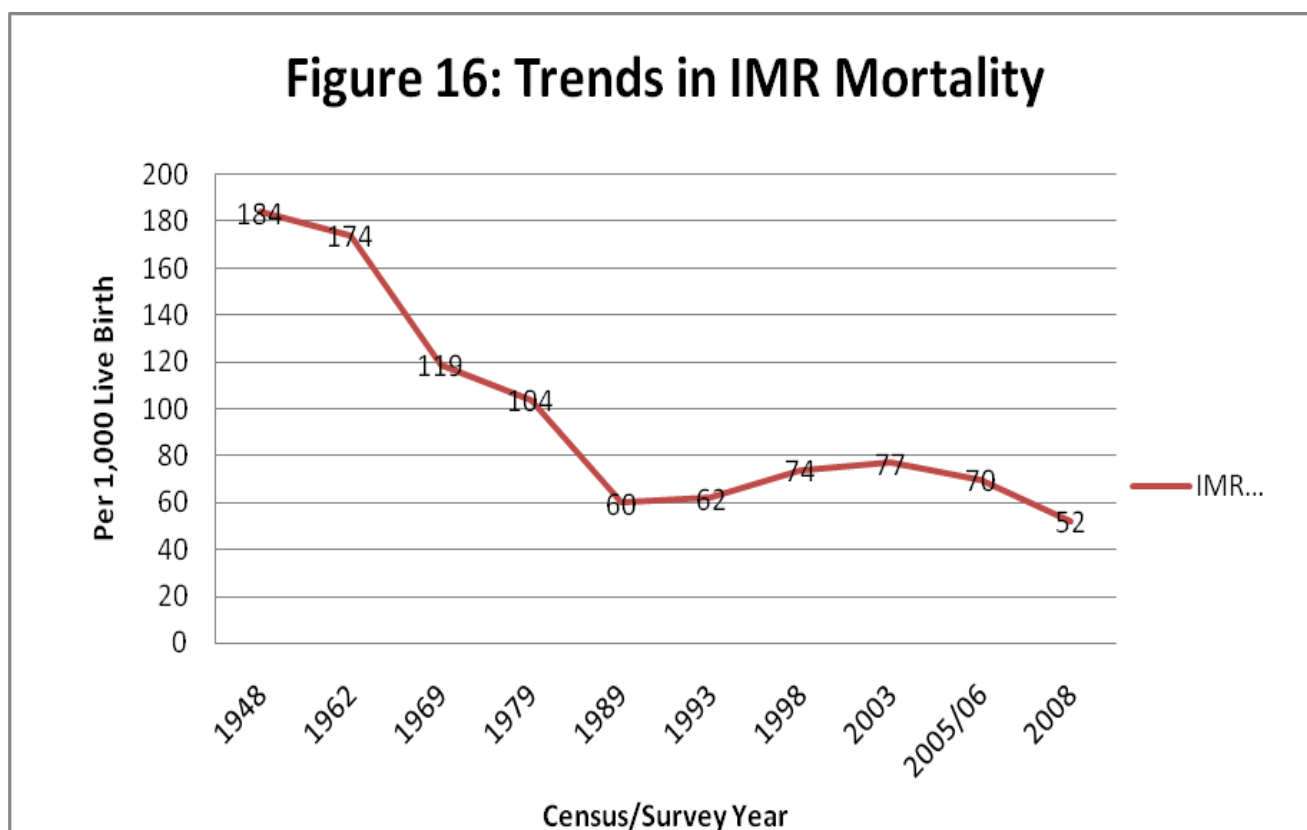
Source:KDHS

Reports

7.3: Infant Mortality Rates

Infant and under-five Mortality rates are key indicators of child health and overall development of a country. They are sensitive indicators of general public health, sanitation and nutrition status of a country. Infant and under five mortality indicators are used to measure and track MDG number 4.

Figure 16 presents trends in IMR. IMR declined rapidly to 60 deaths in 1998 from 184 deaths per 1,000 live birth in 1948. The figure also reveals that IMR increased to 77 deaths in 2003 from 60 deaths per 1,000 live birth in 1989. Recent KDHS results indicate that the IMR decline trend has been regained as it declined to 52 deaths in 2008/09 from the high of 77 deaths per 1,000 live births in 2003.



Source: Census, KDHS and KIHBS Reports

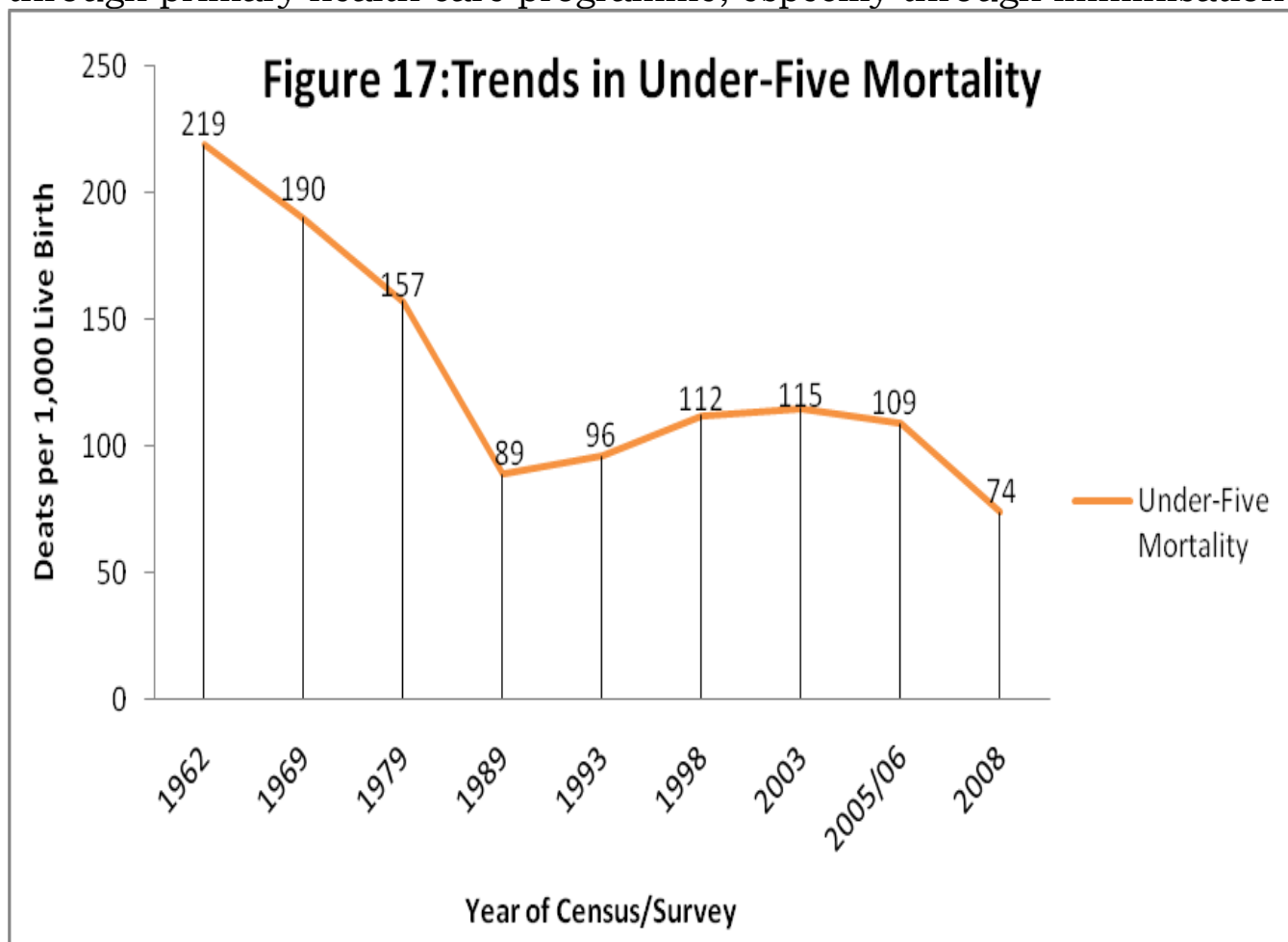
There are substantial regional differentials in IMR with Nyanza, N/Eastern and western provinces recording unacceptably high rates. The Rural areas also record high IMR than the urban areas. The Provinces with high incidence of Malaria, high poverty levels and low literacy levels records high IMR.

7.4: Under-Five Mortality

The under-five mortality rates maintained a consistent decline from a high of 219 in 1962 to a low of 89 deaths per 1,000 live birth in 1989 before starting to increase. The under-five mortality rate increased to 115 deaths in 2003 from 89 deaths per 1,000 live births in 1989. The under-five mortality is estimated to have improved to 74 deaths in 2008/09 from 115 deaths per 1,000 live births in 2003.

Analysis of under-five mortality indicate high mortality rates in rural than urban areas. Further, Coast, Eastern, N/Eastern, Nyanza and western have higher mortality rates than the other provinces.

The deterioration of childhood indicators between 1989 and 2003 has been attributed to the near collapse of health services in Kenya and re-emergence of childhood diseases that had been contained/ eliminated through primary health care programme, especially through immunisation.

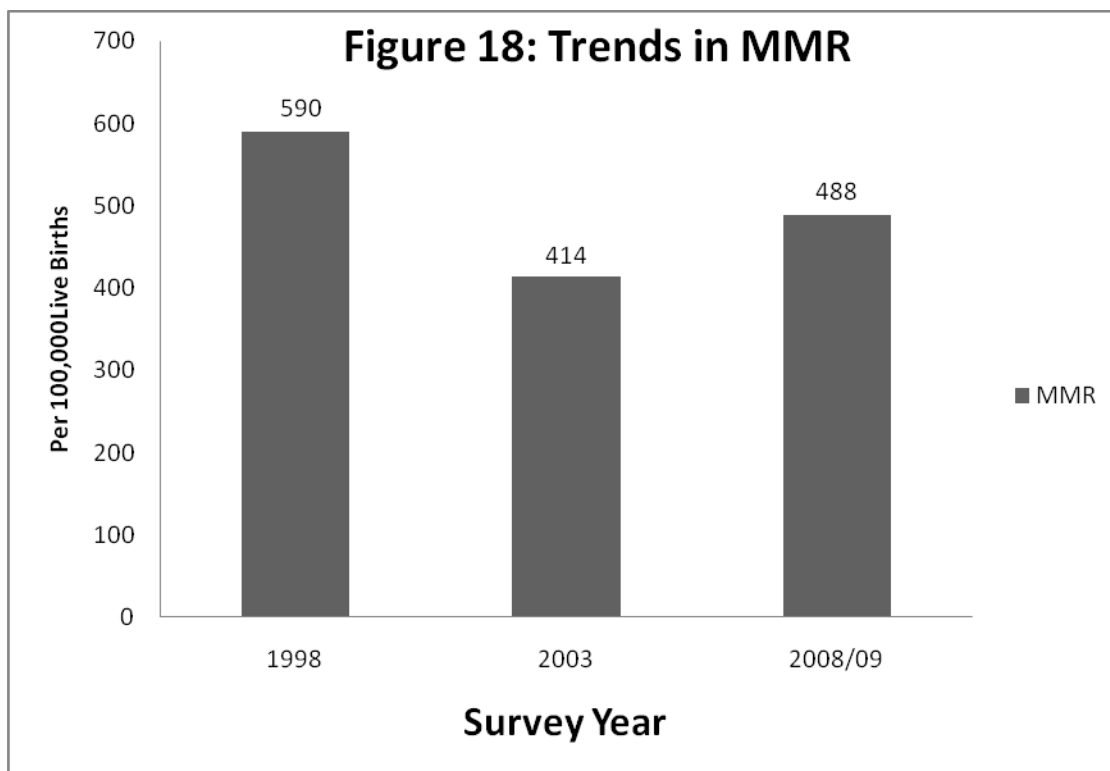


Source: KDHS and KIHBS Reports

7.5: Maternal Morbidity and Mortality

Maternal health is an important area of reproductive health. The MDG 5 targets A aim to reduce MMR by three quarters between 1990 and 2015, while Target B strives to achieve universal access to reproductive health by 2015. Trends in MMR indicate that this is one of the goals Kenya is not likely to achieve. Figure 18 shows that MMR increased to 488 in 2008/09 from 414 deaths per 100,000 live births in 2003. This was a reversal of the pattern that had been observed in the period 1998 to 2003 when MMR reduced to 414 in 2003 from 590 deaths per 100,000 live births in 1998.

It should be noted however that mortality data, and more so the maternal mortality statistics are subject to a lot of error. Various reasons have been advanced for the inadequacy of mortality data key among them being the large sampling error, and socio-cultural myths, beliefs and practices associated with death, where family members rarely report the deaths.



Source: KDHS Reports

Leading causes of maternal morbidity and mortality among Kenyan women are obstetric complications including hemorrhage, obstructed labor and unsafe abortion, with the latter causing more than a third of maternal deaths

7.6: STI, HIV/AIDS

The STI, HIV/AIDS challenges have impacted negatively in the health and economic indicators for Kenya. The HIV prevalence based on general population aged 15-49 years was estimated at 6.7 per cent in 2003, 7.4 percent in 2007 and 6.3 percent in 2008/09. There is wide regional variations in the HIV prevalence and among the various population segments. The Prevalence is high among the women than men and among the poor.

The three Sample Surveys of 2003, 2007 and 2008/09 revealed that the youth engage in risk sexual behaviour that results to STI, HIV/AIDS and unwanted pregnancies.

7.7: Expectation of Life

Change in mortality is reflected in expectation of life at birth. Expectation of life is the average number of years a newborn is expected to live under current mortality levels. Women Expectation of life measure varies with sex and is usually presented separately for men and women. In Kenya women have a higher life expectancy of about three years than men.

Life expectancy at birth improved to 57 years in 2009 from a low of only 35 years for both sexes in 1948, 49 years in 1969, 54 years in 1979 and 60 years in 1989.

8.0: Population Stabilisation Prospects

Attaining early population stabilisation for Kenya will be a challenge considering current Age-Sex structure of the population. The current population structure is broad-based with over 43 percent of the population below age 15, who will create a forceful population momentum for future population growth.

Prospects however abound of population stabilisation in Kenya depending on the concerted efforts that will be put in place to realize this goal. The prospects include the following:

- 1) **2009 census results indicate decrease in growth rates at regional levels.** Analysis of the Inter-censal growth rates between 1969 and 2009 indicate that the growth rates have reduced marginally in all provinces except the Rift valley.

Table1: Trends in Inter-censal Growth Rate by region, 1969-2009

Province	1969-1979	1979-1989	1989-1999	1999-2009
Nairobi	4.9	4.7	4.8	3.8
Central	3.4	2.8	1.8	1.6
Coast	3.5	3.1	3.1	2.9
Eastern	3.6	3.3	2.1	2.0
NorthEastern	4.2	-0.1	9.5	8.8
Nyanza	2.2	2.8	2.3	2.1
Rift Valley	3.8	4.2	3.4	3.6
Western	3.8	3.4	2.8	2.5
Kenya	3.4	3.4	2.9	3.0

Source: GOK 2009 Kenya Population and Housing Census Volume 1A pp.22

Further, population distribution by provinces for the period 1969-2009 indicates that North Eastern province's population more than doubled since 1999. Nairobi and Coast were also provinces with the highest Population increases. The observed increases are attributed to in-migration than fertility contribution.

Sustaining the reduction in growth rate will be key in population stabilisation

- 2) **Socio-economic and political development.** The social, economic and political development initiatives since 2003 have premised the country into solid development course that will contribute to population stabilisation. The key initiatives include:
- i. Vision 2030 and its Medium Term Plan-The flagship projects in all sectors of the economy will contribute to improved wellbeing of the population
 - ii. Political Reforms-The promulgation and operation the new Constitution with devolved governance structure; Bill of Rights, Reproductive Health Rights and gender concerns enshrined in the Constitution
 - iii. Health reforms-introduction of budget line item for procurement of contraceptives will address commodity insecurity. Reproductive health strategy and related policies and guidelines.
 - iv. Education and Free basic education and free secondary education tuition provides opportunities for both boys and girls to pursue education and improve their wellbeing
- 3) **Population Policy for National Development.** The Population Policy for National Development has clear goal, objectives, principles, and strategies that clearly will contribute to population stabilisation. Implementation through the proposed multisectoral approach will fasten attainment of Demographic, health and development targets.
- 4) **Development Partners' Support.** The National Population Programme has in recent time received Development Partners' support.

REFERENCES