Sources of Family Planning

Kenya

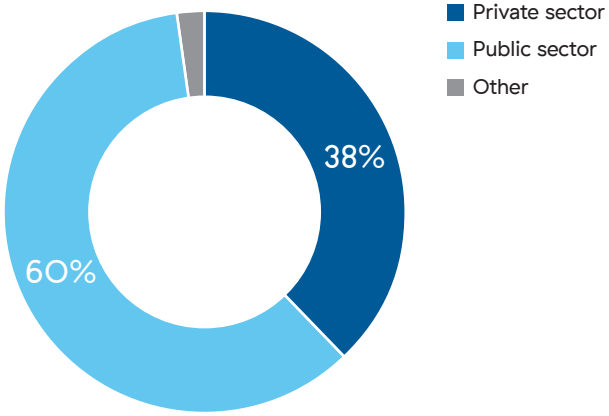
Photo: Jessica Scranton

Understanding where women acquire their family planning methods is important to increase access to modern contraception and catalyze efforts to meet Kenya's Family Planning 2020 commitments and Health Sector Strategic and Investment Plan goals. This brief presents a secondary analysis of the 2014 Kenya Demographic and Health Survey to describe where modern contraceptive users obtain their method and to examine the contribution of the private sector to family planning.

Key Findings

- More than one-third (38%) of modern contraceptive users rely on the private sector for their method.
- Kenya's modern contraceptive prevalence rate increased from 28% in 2008—09 to 39% in 2014, largely due to increased use of implants and injectables.
- Nearly two-thirds (59%) of pill users rely on the private sector.
- More than 2 in 10 of the poorest users rely on the private sector for family planning.
- Nearly half of the wealthiest users go to the public sector for family planning.

Source of modern contraceptives



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at **PrivateSectorCounts.org**.

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Modern contraceptive prevalence rate and method mix

Kenya's modern contraceptive prevalence rate (mCPR) among all women of reproductive age is 39 percent. Among married women, the mCPR is 53 percent. This brief focuses on all women, married and unmarried, to accurately portray contraceptive sources among all users. The recent growth in Kenya's mCPR, from 28 to 39 percent, is largely driven by increases in two methods: a seven-fold increase in implants (from 1 to 7 percent) and a more modest increase in Kenya's most popular method, injectables (from 15 to 19 percent). Use of both short-acting methods (SAMs) and long-acting reversible contraceptives and permanent methods (LARCs and PMs) increased from 2008–09 to 2014: SAMs from 22 to 27 percent and a substantial increase in LARCs and PMs, from 5 to 12 percent.[1]

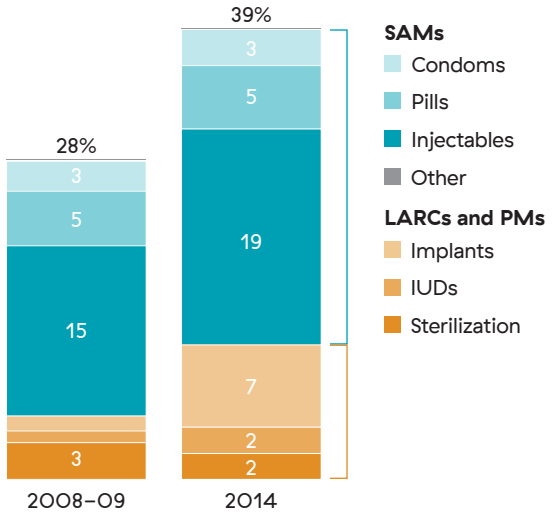
Sources for family planning methods

The public sector is the primary source of modern contraceptives in Kenya (60 percent). Yet, more than a third of users (38 percent) rely on the private sector. Two percent use other sources.[2] These source patterns are similar to those reported in 2008–09. However, as a result of Kenya's population growth and mCPR increase, the public and private sectors combined served approximately 1.9 million additional women from 2008–09 to 2014.

Private sector's contribution to method mix

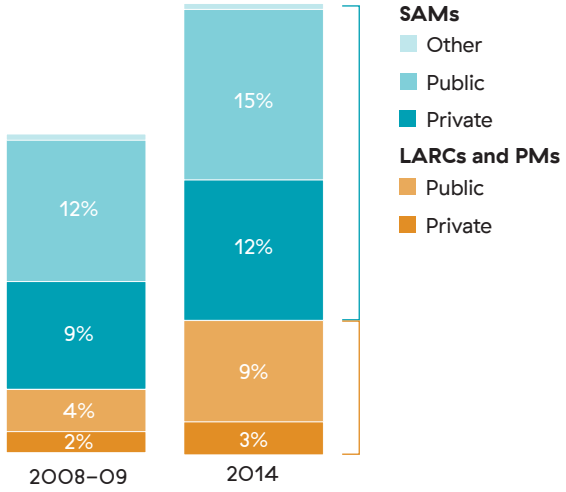
More women in Kenya rely on the private sector to obtain SAMs (12 percent) than LARCs and PMs (3 percent). Use of LARCs and PMs supplied by the public sector has increased substantially since 2008–09 (from 4 to 9 percent), while the private sector's increase in LARC and PM distribution has been more modest (2 to 3 percent). Among users of injectables, 63 percent use public sources and 37 percent use private sources. While fewer women in Kenya use pills than injectables or implants, nearly two-thirds (59 percent) rely on private sector sources for pills.

Kenya's mCPR increase is largely due to higher use of implants and injectables



Note: Numbers may not add due to rounding.

Private sector LARC and PM growth lags behind public sector increases



[1] Short-acting methods include injectables, contraceptive pills, male condoms, female condoms, and fertility-awareness methods. Long-acting reversible contraceptives and permanent methods include IUDs, implants, and male and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Survey does not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

[2] Public sector sources include hospitals, health centers, and dispensaries. Private sector sources include hospitals, clinics, and nursing or maternity homes; faith-based and nonprofit organizations such as mobile clinics, community-based distributors, and community health workers; and pharmacies, chemists, and shops. Other sources include friends, relatives, and women who did not know or report the source. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

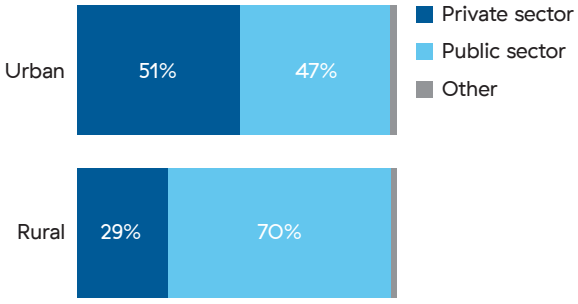
Private sector sources

Among private sector users, 55 percent obtain their method from a private hospital or clinic and 36 percent go to a pharmacy (27 percent) or shop (9 percent). In addition, 9 percent of private sector users go to a nongovernmental or faith-based organization. The two methods most commonly sought from the private sector are injectables and pills. Most private sector injectable users go to a hospital or clinic (79 percent), while private pill users typically go to pharmacies (77 percent).

Rural and urban areas

The mCPR is similar in urban (41 percent) and rural (37 percent) areas. Urban contraceptive users are nearly twice as likely to purchase their method from the private sector (51 percent) compared to rural users (29 percent). Almost half of urban users go to the public sector to obtain their method, while more than two-thirds (70 percent) of rural users rely on public sector sources.

Urban users are nearly twice as likely to use the private sector as rural users



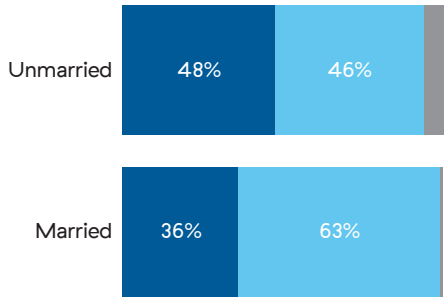
Percent of urban and rural users who obtain method from each source

Contraceptive source by marital status and age

Unmarried contraceptive users are more likely than married users to use condoms (25 percent versus 4 percent, respectively) and to rely on private sector sources for their contraceptive method (48 percent versus 36 percent, respectively). This raises questions as to whether unmarried users are seeking out SAMs such as condoms, which leads them to the private sector, or if they are seeking out the private sector for particular benefits such as privacy, where SAMs happen to be more available. Notably, 6 percent of unmarried contraceptive users obtain their method from a friend or relative.

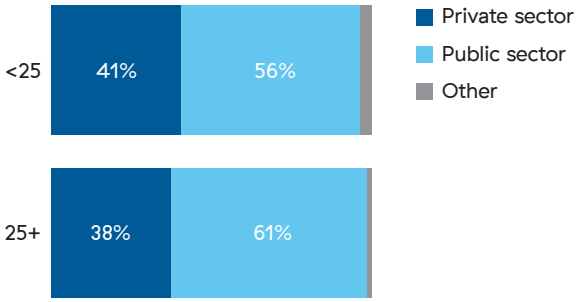
Contraceptive users younger than 25 and those 25 and older use the private sector in similar proportions (41 percent and 38 percent, respectively). Both age groups are somewhat more likely to obtain their method from the public sector (56 percent and 61 percent). The method mix is fairly similar across age categories, with injectables as the most popular contraceptive for both younger (54 percent) and older users (46 percent). Younger users are more likely to use condoms (16 percent versus 6 percent), while older users are more likely to use IUDs (7 percent versus 2 percent).

Almost half of unmarried users obtain their method from the private sector



Percent of married and unmarried users who obtain method from each source

Use of the public and private sectors are similar across age groups



Percent of younger and older users who obtain method from each source

Contraceptive source by socioeconomic status

In Kenya, the poorest women are less likely to use a modern contraceptive method than the wealthiest women (32 versus 42 percent, respectively).[3] Among the poorest modern contraceptive users, more than two in ten (24 percent) rely on private sources. Twenty-nine percent of the poorest urban and 23 percent of the poorest rural contraceptive users obtain their method from a private sector source.

Half (50 percent) of the wealthiest contraceptive users obtain their method from the private sector and nearly half (48 percent) from the public sector. The wealthiest contraceptive users rely on the private sector for SAMs (56 percent) more than they do for LARCs and PMs (35 percent), suggesting that the private sector is underused for LARCs.

More than 2 in 10 of the poorest contraceptive users in Kenya rely on the private sector

Nearly half of the wealthiest contraceptive users in Kenya go to the public sector

Implications

Kenya's private sector is an important source for all population segments and represents a critical opportunity to increase contraceptive access and choice. This sector is an important source for users of SAMs, particularly pills. Among injectable users, though, the majority obtain their method from the public sector. Understanding barriers to private sector provision of injectables would help improve private sector participation and programming, especially given that injectables are one of the two methods that has driven recent mCPR increases. Given recent growth in implant use, interventions that expand provision of implants through the private sector could also help more Kenyan women achieve their reproductive intentions.

There are also significant opportunities to better target the government's service provision efforts away from the wealthiest and toward the poorest women who are most in need of free services. This will foster a more efficient market and provide greater opportunity for the private sector to serve those segments of the population with the ability to pay for contraceptive services. This approach may also help the government to sustain growth of LARCs and reduce inequities in use by having more resources to focus on underserved populations.

[3] The poorest women are those in the lowest two wealth quintiles as defined by the Demographic and Health Survey's asset-based wealth index. The wealthiest women are those in the top two wealth quintiles.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development (USAID). The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan. This brief is made possible by the generous support of the American people through USAID. The contents are the responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

November 2018