National Council for Population and Development

POLICY BRIEF

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FAMILY PLANNING USE AND DISCONTINUATION AMONG WOMEN AGED 15-24 YEARS IN KENYA.

Overview

The 15–24-year old cohort of young women constitutes 5 million of the Kenyan population[1]. Addressing the reproductive health (RH) goals of adolescents and young women aged 15-24 years is a priority because improved RH status of young women leads to lower fertility and improved maternal and child morbidity and mortality indicators. It frees up resources for increased investments in their health, education, and economic productivity, as well as that of their children and they, enjoy better quality of life and longer life expectancy. The women aged 15-24 pose high potential for unintended pregnancy through incorrect and intermittent use of contraception. Correct and consistent use of family planning (FP) is a game-changer in preventing unintended pregnancies, which pose risks of poor pregnancy outcomes, especially for teenage girls[2]. Providing client-centered care, expanding the method mix, especially with long-acting reversible contraception (LARC), which is more effective than short-acting methods (SAM), and training health workers to provide high-quality counseling are recommendations to enhance contraceptive continuation and switching for the cohort.

Background

The International Conference on Population and Development (ICPD) of 1994 thrust enhanced access to reproductive health (RH) to the forefront in the process of development. Reproductive health is about the use of effective contraception and quality maternal and child health care and is a key pillar of human capital (health, education, and productivity). Ending the unmet need for FP and preventable maternal deaths are transformative result areas for the Government of Kenya in implementing the country's commitments of ICPD after 25 years (ICPD25) and in achieving Universal Health Coverage (UHC) by 2030. This policy brief presents FP use among women aged 15-24 in Kenya from 2012 to 2014 using KDHS 2014 FP calendar data and recommends actions toward enhanced, correct and consistent use of contraception. The data is available from the Choices and Challenges tool developed by Population Reference Bureau (PRB) and is visualized innovatively using Sankey Diagrams that show contraceptive use/non-use, continuation, switching/discontinuation, and pregnancy[3].

Influence of family planning and reproductive health on youth well-being and potential

KDHS 2014 revealed unintended pregnancy rates of 47% among 15-19-year-olds and 37% for the 20-24 age group[4]. The majority of these young women are supposed to be in school or college pursuing education and skills development hence their future economic participation is adversely affected.

Unintended pregnancies among girls aged 15-19 have a much higher risk of poor health outcomes such as unsafe abortion, miscarriages, stillbirths, and complications during births that may result in infant and/or maternal mortality.

Despite the many interventions to improve youth reproductive health, the median age at first birth has continued to decline[4]. Women aged 15-19 in Kenya contribute 31% of maternal mortality and have a much higher rate of 464/100000 against a national average of 355/100000[1]. Thirty-five percent of pregnancies among them result in abortion. If modern contraception was fully provided alongside quality healthcare for all pregnant adolescents and their newborn babies, unintended pregnancies will decrease by 73% annually, abortions by 74% and the high adolescent maternal mortality would drop by 76% to 110/100000[5].

Family planning use data and trends among youth

Kenya had attained a remarkable Contraceptive Prevalence Rate (CPR) of 58% for married women and a Total Fertility Rate (TFR) of 3.9 in 2014.

KDHS 2014 also showed that 50% and 70% of sexually active 15–19 and 20-24 year-olds respectively were using contraception.

The 15-19 group had a high unmet need for FP at 23% while the rate for 20-24 was 19% against Kenya's 18%[4]. Use of LARC (Implants and IUD) among women aged 15–24 years increased fourfold from 2008/09 to 2014 while the uptake of Implants more than doubled to 21% in 2014 from 10% in 2008/09[6]. However, the cohort had the highest rates of discontinuation while still in need of contraception among all age groups. Age and method of contraception were identified as the two significant determinants of discontinuation[7].

Influence of contraceptive use dynamics and method mix in family planning use

The use of more effective methods of contraception is associated with greater fertility declines than use of less effective ones. Women aged 15-24 are mostly lower compliance SAM users hence have higher rates of unintended pregnancies, and for the unmarried, sexual activity may be sporadic. Method mix is the percentage distribution of total contraceptive use across different methods. A limited method mix does not encourage switching and may raise discontinuation rates and hence unintended pregnancies.

KDHS 2014 data highlighted sizeable modern method mix shares for the 15–24 age group among all users of reproductive age; 24% injectable, 18% implants, 15% pill, and 8% of IUD. It also revealed the shifting popularity of injectables to implants[4] but provider bias and peer influence may influence youth to use SAM such as pills, condoms, and injectables which have higher discontinuation rates as they demand high user adherence. LARC is 99% effective if used correctly but may not be accessible to youth in spite of being recommended for even unmarried and nulliparous (without children) youth.

Role of Kenya's youth in national development- Demographic Dividend

Family planning also enhances gender equality and women empowerment through enabling better educational and economic attainment hence improved social status[8]. Kenya's demographic window is expected to open in 2038, and strategic investments in FP are accelerators toward achieving the Demographic dividend (DD), which is expected to be realized by 2050. The DD is projected as a five-fold economic growth, but to realize it, Kenya must achieve lower birth and death rates as a result of strategic investments in FP[9].

The high contraceptive use momentum that could be generated by the young women aged 15-24 could result in the requisite fertility declines and an age structure with a lower dependency ratio (lower numbers of young and older persons dependent on the working age population) which accelerates economic development. The annual population growth rate target of 2% by 2030, Vision 2030, and Sustainable Development Goals (SDGs) could also be achieved if the women delayed their first births.

Kenya's family planning commitments and goals

There is a robust legal and policy framework enshrining the right of every woman to safe, effective, affordable, and acceptable contraception services. The FP Costed Implementation Plan (FPCIP) 2021-2024 goal is to reduce unmet need from 18% to 9% by 2024 while the National Adolescent Sexual and Reproductive Health policy (ASRHP), 2015 guides on enhancing the status of sexual and reproductive health for adolescents[11].

Kenya Targets
CPR 2030 -70%
TFR 2030 - 3.0
FP2030
Commitment 2 - Reduce unmet need from 14% to 10% by 2030
Commitment 5- Reduce adolescent pregnancy from 14% to 10% by 2025

Key Findings 2012-2014 - Choices & Challenges Tool

FP Use ↑17%-29%
LARC use ↑87%
SAM ↑70%
Modern Method users ↑83%
Discontinuation 35% - Side effects leading reason
Non-Users average 66%
Pregnancies 11% annually

Method Performance
SAM 80% share of modern method mix
Implants ↑27%
IUD ↓25%
Injectable ↓37%
Pill ↓33%

Family Planning Use (All Women Aged 15-24 Years) 2012-2014

Use of contraception for women is normally dynamic and the findings in the Sankeys reflect this.

Figure 1 shows use of FP by women aged 15-24 increased from 17% in 2012 to 29% in 2014. There was a notable increase in uptake of both LARC and SAM and a corresponding decline in non-users in 2013 and 2014.

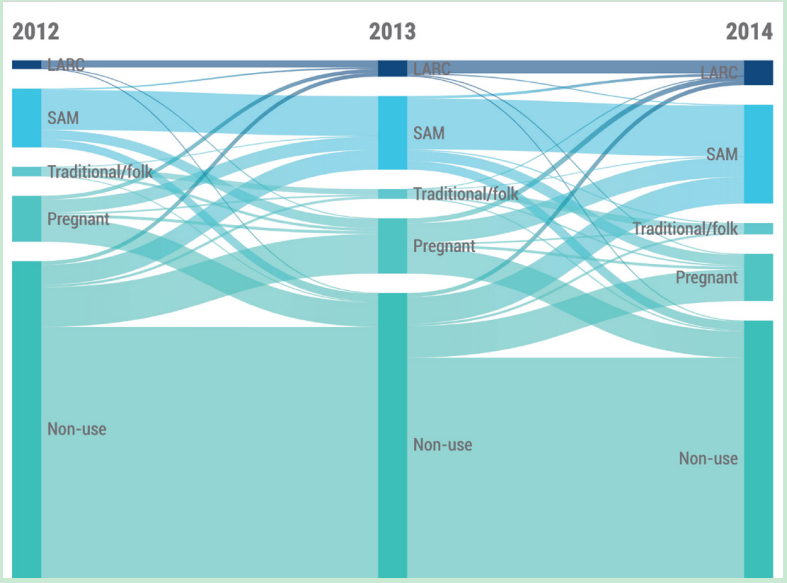

Figure 1: Distrubution of all women aged 15-24 by contraceptive use status, 2012-2014.

LARC: Long-acting reversible contraceptives (IUD and Implants).
SAM: Short-acting modern methods(injectable,pill,other modern).
Other modern: Male and female condom, emergency contraception, diaphragm, foam or jelly, amenorrhea, lactational.
N/A : Some samples are under the display threshold and do not appear.

Source: Choices and Challenges

Non-Use of FP

An average 66% of the women were non-users and an overall decline of 18% in non-users was shown from 2012 to 2014. About 12% of them fell pregnant in each year in 2013 and 2014. Most of the non-users who initiated contraception chose SAM and especially injectable.

Use of modern methods (LARC & SAM)

LARC share in the modern method mix increased by 54% from 13% to 20% from 2012 to 2014. The uptake of SAM rose by about 30% between 2012 and 2014 but its share declined from 87% in 2012 to 80% in 2014. Use of the different methods is shown in figure 2.

Family Planning Use by Specific Methods

The Sankey diagram shows users of various methods from 2012 to 2014. An average 65% users in both 2012 and 2013 continued with their current methods.

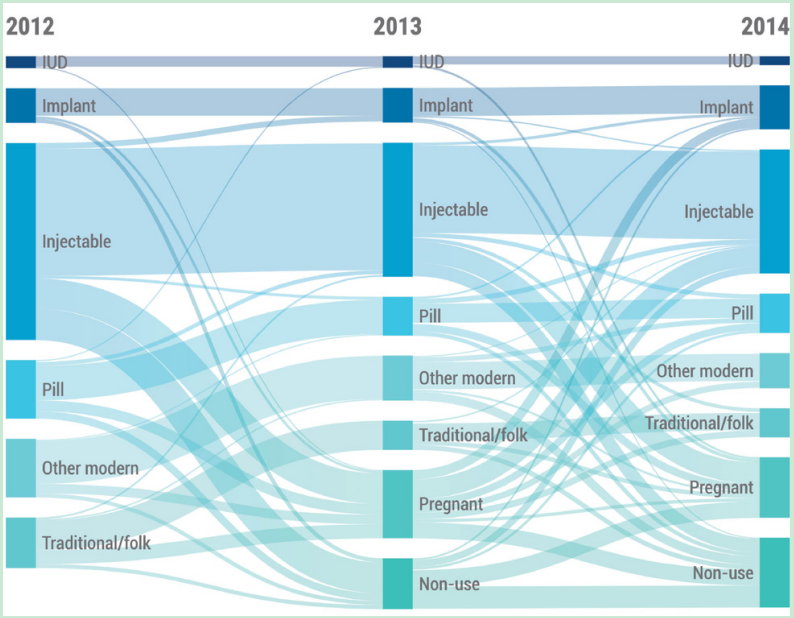

Figure 2: Distribution of women family planning users aged 15-24, 2012-2014

All FP Users	**N 2012=1137**	**N 2013=1469**	**N 2014=1995**
Modern FP Users	**N 2012= 997**	**N 2013=1326**	**N 2014=1827**

Source: Choices and Challenges

Injectable

The injectable was clearly the most popular method with a 50% share of the method mix in 2012 and 64% of users continuing on to 2013 and into 2014. Some 15% of users experienced method failure and became pregnant each year in 2013 and 2014 while a small proportion switched to implants and the pill. An average of 10% of its users stopped use and became nonusers in the period.

Implants and IUD

Use of the implant doubled from 8% to 16%. Eighty percent of users continued from 2012 into 2014 with about 8% experiencing method failure annually in 2013 and 2014. The IUD was the least popular at about 4% with an average of 75% users continuing each year and a few experiencing method failure and falling pregnant.

Pill

The pill had 14% share of the method mix in 2012 which reduced to 5% in 2014. The continuation rate was about 58% with some 22% falling pregnant, 9% switching to IUD and injectable while 11% became non-users. In 2013, 53% of pill users continued into 2014 while 20% fell pregnant. Eighteen percent users switched to implant and injectable while 10% became nonusers.

Discontinuation of FP and Leading Reasons

Among women who were no longer using family planning in 2013, 46% of pregnant women and 49% of non-users reported having discontinued their mostrecent method while still in need of preventing pregnancy.

For 2014 non-users, 54% of pregnant women and 38% of non-users reported having discontinued their most recent method while still in need. The injectable and pill had the highest discontinuations at about 30% including method failure while Implant had about 20%. Switching was mostly from SAM to LARC in both 2012 and 2013. The leading reason for discontinuation was side effects/health concerns and this was evident in the modern hormonal methods of Injectable, Implants, and pills in that order.

DISCONTINUED WHILE STILL IN NEED

2013	2014
46%	**54%**
49%	**38%**

Pregnancies

There was an average of 11% of pregnancies among women across the period. About 80% of the pregnancies were contributed by non-use of FP while method failure contributed the rest.

SAM contributed about 75% of the pregnancies resulting from method failure with the injectable and pill being the greatest individual contributors. About 50% of those pregnant in 2012 and 2013 became non-users.

Policy Implications

Results showed low use of FP at below 30% hence high unmet need and 40% unintended pregnancies. The women are mostly single and want to avoid pregnancy as they progress with education.

This presents an opportunity for harnessing demand for FP and thereby raising and achieving the CPR and mCPR 2030 targets as well as accelerating the achievement of the demographic dividend and Vision 2030. This increasing demand needs a constant supply.

If the 35% of the women who discontinued did not switch to more effective contraception, the impact on fertility may have been big. Negative outcomes from unintended pregnancies may roll back the great progress attained in maternal and child health indicators. Most discontinuations were attributed to side effects and health concerns, and this raises concern about whether clients made an informed choice. Discontinuation should ideally be driven by the desire to get pregnant or to switch to a more effective method.

To address the high discontinuation rates for short-acting methods, service providers may need to promote LARC in cases where women need to delay pregnancy for long periods. LARCS are provider-dependent methods and the government may need more service providers skilled in insertions and removals. Increased use of implants might enhance retention of users and reduce discontinuations among the cohort.

Policy Recommendations.

The following actions that will elevate attention and resources to assist youth to attain their reproductive goals of preventing, delaying or spacing pregnancies are recommended.

1. Provide client-centered care in recognition of youth's diverse reproductive health needs

FP programs should be cognizant that youth are not a homogeneous group and have varying and unique reproductive health needs to prevent, delay, or space pregnancies e.g. married/unmarried and rural/urban youth.

2. Train and support providers to offer high-quality, supportive contraceptive counseling to youth

Service providers, including private ones, should be given regular refresher training focusing on youth cognitive development and needs, be equipped for LARC insertion/removal, and be encouraged to provide non-judgmental, high-quality counseling that addresses the facts, myths, and misconceptions about FP as well as abstinence, dual protection and management of side effects.This will ensure youth make informed choices and use contraception consistently and correctly. Follow-up should be consistent and integrated with digital interventions and social media.

3. Support youth to access to the full complement of family planning methods regardless of age, marital status, and parity.

Policy frameworks that positively address barriers and restrictions based on age, marital status and parity should be fully implemented to promote contraceptive use and continuation among youth.

Broadening the method mix, including LARC, will allow youth to initiate suitable methods and switch if unacceptable side effects are experienced hence discouraging discontinuation.

Emergency contraception should be availed in humanitarian situations and during pandemics such as COVID-19 when youth may not easily access health facilities.

Conclusion.

For Kenya to achieve transformative results in ending the unmet need for family planning and preventable maternal deaths and also achieve the targets of FP 2030, Vision 2030, DD, and SDGs, it has to sustain the current gains in contraceptive prevalence rate (CPR) by using evidence-based approaches to promote the retention of youth users and encourage new users.

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