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POPULATION REVIEW 1970: KENYA

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Introduction

The Republic of Kenya, located astride the equator on the Indian Ocean, enjoys the distinction of being the first tropical African nation to initiate a serious government program in population analysis and family planning. Ghana, Botswana, and the Reunion Islands off the African coast recently followed suit and have positive programs underway. By contrast, most other African states remain apathetic toward their own population problems, and a few are vigorously pronatal. Perhaps the most extreme example is Kenya's island neighbor, Zanzibar, which reportedly has introduced the death penalty for illegal abortions, and banned the sale of all contraceptives.

Kenya's achievements in family planning are doubly impressive when some of the obstacles are known. The nation is over 90 per cent rural, a majority of its people living either as farmers or herdsmen. Three-fifths of the land mass is desert or semidesert, and the total productive land is estimated at only 17 per cent of the nation. Even in the fertile highlands, with the impressive agricultural wealth in coffee, tea, cereals, and pyrethrum, the land shortage is such that the densities soar to over 2,000 per square mile, exceptionally high for Africa. The diversity of the soils, the vagrancies of climates that range from tropical coastline to alpine snows, the maldistribution and underemployment of the people further compound the nation's problems. The result is that a majority of the people are trapped by their physical environment and encased in belief systems that traditionally tend to reject family limitation, family spacing, and the basic idea of reducing the birthrate.

Population Profile

The data relative to the demographic condition of Kenya falls into two main categories, the basic statistics and an evaluation of the reliability of the information. The 1962 census is the only complete information available although volume one of the August 1969 census, published in November 1970, does contain totals by age, sex, area and density, tribe or nationality, and by districts and provinces.

Basic Statistics

Total population:	10,942,705 (1969); 11,250,000 (mid-year 1970)*
Crude Birthrate:	51/1000 (1969)*
Crude Death Rate:	18/1000 (1969)*
Rate of Natural Increase:	3.3 (1962-1969)
Gross Reproduction Rate:	3.4 (1962)
Net Reproduction Rate:	2.1 (1962)

* estimate

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Immigration-Emigration:	No data for 1962, although estimated to be substantially zero. Mid-1970 expulsion of an estimated 50,000 workers plus families from Uganda creates high current migration. *Statistical Abstract*, 1968, notes resident arrivals: 113,030, resident departures: 121,709.
Age-Sex Specific Structure:	46 per cent under 15 years, 4 per cent over 60 years, dependency ratio 106. Average age of marriage for males: 24.1 years, females: 18.9.
Total Fertility Rate:	6.8 (1962); 7.1 (1969)*
Fertility Patterns:	Very little is known of fertility patterns regarding social class or rural-urban distribution. The coastal Muslim areas are reported lower. Polygamy is a minor factor compared to Tanzania where 21 per cent of the men are polygamous; no figures are available for Kenya, although the 3 per cent Moslem rate compared to Tanzania's 30 per cent indicates far less. Age patterns indicate lower fertility in early child-bearing years. Women who survive to 37-9 have an average of 7.1 children, those over 45, 8.5 children, indicating a strong tendency to continue to have children as long as possible.
Mortality Levels, Trends:	There is high child mortality between ages two and five due particularly to malaria. The trend is slowly downward due almost entirely to public health measures. Life expectancy (1962) at birth was 39.0 years (1969 estimate is 45.0 years). See Table 5, appendix.
Infant Mortality Rate:	126/1000 (1969)* as compared to 18/1000 for registered European, non-African children.
Morbidity/Cause of Death:	Rank order, 1968: pneumonia, digestive system, enteritis, meningitis, TB, heart disease, nutritional deficiencies, measles, malaria, unknown or ill-defined. *Registrar General's Report, 1968.*
Estimates of Future Trends:	At present 3.3 per cent growth rate, estimate of 22 million in 1990. Estimates for year 2000 as high as 34 million, low of 16 million if family planning programs initiated and effective. Present Nairobi (capital) growth doubles every ten years (7.1 per cent growth), other urban areas at 6.5 to 7.0 per

* estimate

cent. Outside events, such as triparte agreement (1970) to ask 10 per cent employment increase of employers, will effect trends.

Other trends: mortality down, fertility up, higher population growth in short term for 10-20 years, thereafter dependent on success of family planning. Possible rate of 3.8 to 4.0 for year 2000.

Other Factors:

Number of households: 1.50 to 1.75 million
Average size of household: African, 6.25 persons (1962)
Ideal family size: womens' ideal, 6.03 (Heisel); womens' ideal, 6.70 (Dow)

Achieved Family size: 6.8 children
Difference rural-urban: rural slightly higher

Number of females, 15-44: 2.4 million total, 2.1 married.

Urban population: 8.0 per cent

Potentially Productive Acres Per Person: 4.2 (1965), 2.6 (1980), 1.5 (1995), 1.3 (2000).

Religion (excluding traditional faiths): Roman Catholic 21.8 per cent, Protestant 36.0 per cent, Hindu-Sikh 38.3 per cent, Muslim 3.8 per cent.

Ethnic groups (mid-1969)

1. Kenya African	10,673,770
2. Non-Kenya African	59,432
3. Non-African	
a. Asian[1]	139,037
b. European	40,593
c. Arab[1]	27,886
d. Other	1,987

African Ethno-linguistic groups:
1. Central Bantu
2. Western Bantu
3. Coastal Bantu
4. Nilotic
5. Nilo-Hamitic (Kalenjin speaking)
6. Other Nilo-Hamitic
7. Western Hamitic (Rendille and Galla speaking)
8. Eastern Hamitic (Somali speaking)

	1962	1969
Tribal Population	1,642,065	2,201,632
1. Kikuyu	1,148,335	1,521,595
2. Luo	1,086,409	1,453,302
3. Luhya	933,219	1,197,712
4. Kamba	538,343	701,679
5. Kisii	439,921	554,256
6. Meru	414,887	550,520
7. Mijikenda	341,771	471,459
8. Kipsigis	181,387	203,177
9. Turkana	170,085	261,969
10. Nandi	154,079	154,906
11. Masai	121,645	90,118
12. Ogaden	109,691	130,249
13. Tugen	100,871	110,908
14. Elgeyo	983,234	1,070,288
15. All others	Total 8,365,942	Total 10,673,770

Evaluation of Data

Several factors effect the reliability of census data in Kenya. Although four enumerations were taken in 1911, 1921, 1926, and 1931, they are today of little value because Africans and Somalis in Kenya were not counted. The first census to include both Africans and non-Africans was in 1948 (estimated 5.4 million). The next census, 1962, however, makes comparisons between 1948-62 misleading because of changes in boundaries and in the degree of coverage. Figures for 1962 have been considered accurate, although preliminary figures for 1969 now suggest there was undercounting in 1962.

The August 1969 census will probably be the most accurate of the six enumerations. De facto head counting was done for the first time, post-enumeration checks done in some areas, and vigorous efforts made to train enumerators (mainly students and teachers). Several problems occurred, however, which will effect the accuracy for certain districts. Directions regarding random sampling were not followed in some areas, in others the sample obtained was too small. Response errors, particularly concerning age and marital status also occurred. The discrepancies will only effect the local figures. The national figures are considered accurate. As with 1948-62, boundary changes effect the comparability of the 1962-69 figures. Enumeration in the remote northern seminomadic areas, probably covering 50 per cent of the land area of Kenya, was exceptionally difficult, and figures are essentially guesses. Other problems, common to many developing nations, include fear of enumerators, some failure to cooperate, and confusion over relation of the census to tax assessment. The fact that district offices were responsible for the census caused some administrative confusion when the forthcoming December elections were announced, shortly before the enumeration. Senior officials tended to focus their attention on voting activities, and to disregard the enumerators. Overall, however, the census was the most exhaustive and should be considered generally reliable.

Population Distribution and Movement

Urban-rural Distribution

The general distribution of Kenya's population is reported at 8 per cent urban and 92 per cent rural (1962). The urban population is heavily concentrated in Nairobi, Mombasa, and two or three smaller trade centers. The rural population is located mainly in the southern one-third of the nation on some 17 per cent of the total land. The population density (1969 census) is 29 persons per square mile overall. A total of 930 trade centers is considered by the Ministry of Lands and Settlements to have some degree of centrality and to merit consideration as local distribution points for

education, health, markets, and social services. Some 70 centers have more than 2000 inhabitants. Migration from the rural areas to the urban centers is one of the country's continuing problems. The flow is caused mainly by the shortage of agricultural land plus the economic attractions of the city. Census projections for the rural areas are not particularly hopeful. The agrarian economy will have to support more people on less land than the present 4.3 acres per person and ostensibly do so with wages somewhat comparable to urban areas. Even with rapid economic gains and a ten-fold increase in urban employment, the rural areas will have to provide for three times the present population.[2]

Unemployment and Underemployment

Nairobi, the capital, and Mombasa, the major Kenya seaport, are the economically most active areas, employing the majority of the wage earners. Economically, socially, and politically, the unemployed and underemployed are the most serious problems in present day Kenya. Government estimates divide wage employment into three sectors, the total of which equals about 10 per cent of the population.[3]

	1967	1969
Modern Sector	600,600	627,200
Smallholdings, settlement schemes	365,600	363,400
Rural, non-agricultural activities	60,600	81,700
	1,026,800	1,072,300

Source: *Economic Survey*, 1970, p. 128

Between 1967-69 employment rose 46,000, while the total labor force rose 220,000 for the same period. The latter are mainly school-leavers. Of the 627,200 employed in the "modern" sector (firms, large farms, rural enterprises, and public employment), about 38 per cent were employed by the public sector. The breakdown by industry follows on page 6.

Although no firm figures are available, Russell estimates there are 250,000 hard-core unemployed.[4] In July 1970 there were approximately 200,000 signed up as unemployed. In addition some 60,000 overseas Kenyans, mainly in Uganda, faced prospects of losing their jobs. This essentially occurred in October 1970, with Uganda forcing most noncitizens out. At the present growth rates some 230,000 males will be added to the labor force in the year 2000. The long term employment estimates, even considering an extraordinary rate of economic growth, indicate enough employment opportunities will not be generated to provide for the oncoming labor force. Projections also suggest very serious land pressures in the Central Province and Victoria Basin areas.[5]

The problem of urban unemployment, as a direct result of the rural to urban migrations, has several consequences. High costs are incurred for housing, water and power facilities, and other amenities such as schools are severely taxed. As in other new states, crime, social upheaval, and political instability also follow rapid urbanization. Solutions planned by the government include major rural development programs, and the geographical decentralization of industry. Both programs would help alleviate the rural-urban migration and unemployment problems, although the exact costs, the explicit benefits that outweigh costs, have not been assessed.

One of the problems surrounding unemployment concerns who exactly is unemployed. During registration periods to assist the unemployed, several of the messengers and clerks in the Ministry of Economic Planning itself registered as unemployed in order to secure better jobs. The same problem arises when officials attempt to learn how many people are landless.

Internal Migration

Reports for the census year 1962 indicate some 604,000 interprovincial migrants moving to the Nairobi area, the Rift Valley, or the Coast Province. The major trends in internal migration are from the Central Province and the Victoria Basin to the farms of the Rift Valley and the plantation areas of west Kenya and the coast. These are mainly young men in rural-to-rural migrations. The major movements from rural-to-urban centers are those from the Central Province, and the western Victoria Basin areas, to Nairobi and Mombasa port. A large part of the female outflow is probably due to marriage migrations. The patterns are mainly explainable as responses to different economic opportunities. Data on fertility

Public and Private Sector Employment by Industry, 1969*

	Total	Percentage Distribution		
	Employment ('000)	Public Sector	Private Sector	Total
Agriculture and Forestry	195.0	8.4	91.6	100.0
Mining and Quarrying	2.6	-	100.0	100.0
Manufacturing and Repairs	72.7	21.4	78.6	100.0
Building and Construction	28.9	43.6	56.4	100.0
Electricity and Water	5.2	50.0	50.0	100.0
Commerce	44.2	5.4	94.6	100.0
Transport, Storage and Communications	51.8	69.1	30.9	100.0
Other Services	226.8	67.2	32.8	100.0
Total	627.2	37.9	62.1	100.0

*Provisional
Source: *Economic Survey*, 1970, p. 131

Totals by population:	1964	1969*
All Private Industry	415,886	389,600
All Public Services	173,721	237,600
Total Wage Earners	589,607	627,200

*Provisional
Source: *Economic Survey*, 1970, p. 131

and migration are not available, except there is apparently little difference between fertility in rural and urban areas. Overall, there is major movement within the high density Central and Western areas, to the Rift Valley, Nairobi, and Mombasa.[6]

Emigration

Kenya provides relatively few migrant workers to other parts of Africa, particularly in comparison to her neighboring states. The present trend is for Kenyans to return from work in other countries rather than to increasingly emigrate. This does not include non-Africans (Asians and Europeans) who are emigrating at a high rate, especially European teenage school-leavers and Asians holding British passports. In 1968 there was an excess of permanent immigrants over emigrants by some 5,400, considering all racial groups. This reversed the trend that had persisted between 1961-67 of permanent departures outnumbering permanent arrivals by up to 4,000 in a single year.[7]

A reverse in trend also occurred in the European outflow in 1968. Between 1960-67 Europeans tended to have up to 3,500 departures a year, with 1968 showing 2,500 more arrivals than departures. Most European departures were settler families; the inflow, particularly in 1968, was predominantly American commonwealth people concerned with technical or other aid. Since 1968 there has been an increased exodus of Asians, as work and trading permits become more difficult to obtain. The main emigrant tribes in the past (1948-57) have been Kamba, Taita, Kikuyu, and Baluhya.

Population and the Economy

National Economy

Kenya is overwhelmingly an agricultural nation, with farming and stock-raising the main occupations of all but 8 per cent of its population. The natural resources lie mostly in the exceptionally fertile soils in the central and western parts of the nation. Some oil is found, and further exploration is under way in several sectors. Mineral exports include cement, soda ash, and small amounts of gold, diatomite, graphite, meerschaum, gypsum, silver, and asbestos.

The scenic diversity of the country, from tropical coastline and semidesert areas to highland and alpine areas, along with the national parks and wildlife promotes a tourist industry that is the leading foreign income earner. The agricultural economy is well diversified, and industrialization is underway. The high growth in per capita output in the last five years and the relatively high savings have been supplemented by inflows of technical assistance and capital from many nations of the world.

The major agricultural items for export are coffee, tea, sisal, pyrethrum, hides, meat, and dairy products. Wattle extract and maize, forest products, and both fresh and salt water fish are also exported in modest amounts. The major trade links in Africa are with Uganda and Tanzania, partners in common trade agreements, and to a far lesser degree with Ethiopia. Overseas trade is largely with the United Kingdom, Western Europe, and the United States, although agricultural products exported to India, Pakistan, and Japan are important. Trade with Russia, Eastern Europe, and China is not significant.

Public finances have been well managed, and because the foreign exchange reserves are sound and political stability has continued, general investment confidence exists for Kenya. The balance of payments is favorable, due in part to the inflow of capital from international aid projects. The balance of trade, however, is less favorable, with Kenya importing some $140 million per year more than she exported between 1966-1969.[8] The 1968 Kenya importation of goods was $336 million with expectations to reach $560 million by 1974, mainly in raw materials for manufacturing, equipment, and machinery. Exports for 1968 were $228 million, estimated to reach $336 million by 1974.

The East African Community, a partnership of Kenya, Uganda, and Tanzania, was established in 1967, with headquarters in Arusha, Tanzania. Its main objectives are to facilitate relations in terms of customs, tariffs, research, and income tax collection. East African Corporations for railway, mail and telecommunications, airways and harbors are also in operation under the agreements. The common market created within the community attempts to remove trade restrictions between partner states, and discussions have been held with other neighboring states, particularly Ethiopia and Zambia, for inclusion in the market.

Kenya's labor problems lie in the shortage of trained technical skills and as noted, a shortage of wage-labor positions for the potential labor supply. Although the country has had a relatively long period of economic growth and the overall standard of living is on the rise, the lack of a large industrial base forces most newcomers to the labor force to find employment in agriculture or other rural employment. Temporary solutions have included the government's request that employers take on an additional 10 per cent of their staff (1970) and a computerized job-placement program.

Although the general economy looks healthy there are several danger areas. The population growth and unemployment create potential unrest for many sectors. There seems to be a growing gap between the rich African elite in the urban areas and the poor rural population. The increased pace of Africanization, particularly since early 1969, may cause serious loss of managerial and technical skills.

The nation's economic growth rate, in October 1970, is about 6.6 per cent. It is misleading because the country as a whole faces a serious problem in income distribution. Sizable wealth is held by a very few. A growing number of high school educated, unemployed individuals who are divorced from the land, make up a potentially unstable proletariat. The economy does enjoy

overseas confidence, and has a high inflow of capital. But at the same time, problems of wealth distribution persist. Whether the national leaders, who are mainly an entrenched African elite, will be able to cope with the growing economic malcontent, is a major question facing Kenya.

Population and Development

Demographic Aspects of Development

Several barriers exist for a greater portion of the population to be involved in wage earning capacities. The technological changes occurring in the nation are limited to a few urban areas. Power, transport, communications, and other infrastructural facilities do not exist for most of the nation. Industrial development, which is occurring at an impressive rate, considering East Africa as a whole, is still limited to three or four urban centers. Agricultural innovations have occurred, particularly in the central highlands, but range development, meat development, irrigation schemes, and other schemes for the improvement of the more arid regions have yet to meet with marked success, nor to support any significant wage labor.

Ecological problems continue to hinder general development and to affect the population picture. For many settled areas the necessity to protect wildlife for the tourist industry decreases usable land and places man in competition with animal. The balance between wildlife and the expanding population has not been worked out, as witnessed by the continued poaching of game, encroachment of squatters, and debates in Parliament to reallocate protected areas for human use.

Each of the Kenya Five Year Development Plans (1966-70 and 1970-74) has called attention to the impact of a high population growth on the general economy. The policy, generally stated, is that the population growth should be curtailed by family planning services. Economic officials know that the undue pressure of numbers presently exerted on Kenya resources retards the speed of development. Given present technology, population pressures accentuate the rate at which natural resources are used while simultaneously increasing the cost of their use.[9]

Several other factors are important in the relationship between Kenya's population growth and its economic development. Because of limited supplies of land and other resources, long term diminishing economic returns for the people will result, unless more capital, more trained labor, and technological innovations come into the equation. Cultivated land is currently limited to 4.3 acres per person, capital is still in short supply, and the improvement in labor skills is slow. The "back to the land" intense labor policy leads to diminishing returns, particularly when farmers have slack periods and lay off marginal laborers, thus aggravating the national unemployment situation.

Estimates in 1968 of the Kenya economic growth rate at 5.3 per cent, with population increasing at 3 per cent, gives a differential of 2.3 per cent per year. Under these conditions the income per capita would take 31 years to double. If population were to grow at 2 per cent, income would double in 21 years, at 1 per cent in 16 years. Both economic growth and population growth are now considered higher, but the income per capita changes would be about the same.

In terms of age the dependency ratio in Kenya is high; 100 adult workers support themselves plus 106 children and old people. Their work is diverted for dependents, rather than efforts that lead to capital formation. If we accept the idea that capital formation is a key to development, then the dependency figures are basic to Kenya progress. The fact that nearly 46 per cent of Kenya's population is under 15 years suggests continued high dependency for many years.

In short, population growth impinges on development by increased pressure on the land, by speeding up the consumption of nonreplaceable natural resources, by slowing the rate at which capital is accumulated, and by reducing the rate of growth of resources and equipment that can be used by the labor force.[10]

Life expectancy (Appendix, Table 4) and projected growth rates further cloud the future. The Population Council estimates for Kenya's population, projected from 1965, show overall growth under present fertility conditions, and reduced conditions.

Projected Total Population of Kenya 1965-2000
Population in Thousands

Year	Fertility Unchanged	Fertility reduced by 50% in 15 years
1965	9,100	9,100
1970	10,600	10,400
1975	12,400	11,700
1980	14,700	12,900
1985	17,500	14,100
1990	20,800	15,500
1995	25,000	17,100
2000	30,300	19,000

Source: *Family Planning in Kenya*, p. 4

The present trend in population is leading to a consuming populace of high dependency, large unemployment, and few skills. The situation will hinder the rapid development of the economy, as well as the standard of living.[11]

Social Attitudinal Factors

Social-attitudinal changes that effect the population as a whole are distinguishable by economic class. The social stratification of the colonial period was in three parts: the European managers and administrators, the Asian artisans and tradesmen, and the African unskilled labor force and farmers. Since independence in 1963 an elite class of educated Africans has moved to the top as government leaders, and in some cases managers or co-managers in private firms. The European influence is waning. Many settler families left the country after independence, and although expatriate Europeans and Americans came on development projects or commerce, the total white population is down over one-third. The Asian population continues to dominate many of the craft and commercial sectors, although pressures by leaders to promote African skilled craftsmen and entrepreneurs has somewhat reduced these numbers. The unskilled labor force is still made up almost exclusively of Africans.

Social class barriers of the colonial days in other respects remain intact. The European population, although only 40,000 in 1970, still enjoys disproportionate influence. Little social interaction occurs with non-Europeans outside business obligations, particularly for the remaining settler elements. Other European expatriate groups coalesce largely on the basis of nationality. Asians continue the old pattern of nearly total social exclusion of Africans, avoidance of Europeans, and rigid subgroup clannishness. African social mobility tends to follow occupational position and economic status. Educated Africans in government and university circles have a relatively new mobility with social networks and friendships still very much in formation. Basic social patterns tend to run along tribal lines with old schoolboy ties and approximate age groupings also important. Status in the bureaucracy also dictates general social contact. Social classes in the rural areas follow more traditional lines with family position and kinship ties of major importance. The acceptance of family planning seems to be strongest among European and educated African classes. Asian fertility is considered high, as is the case for the rural African population as a whole.

Restraints to economic development in the rural areas center around the inclination to regard any innovation with suspicion. Gradualism, chauvinistic male demands, and the belief that large families are economic necessities, promote high birthrates and hinder economic development. Women who participate in family planning programs often do so at

considerable personal sacrifice. Conflicts with husband and husband's family, ridicule, economic punishments, and loss of status are some of the costs. Strong pressures also exist for women to consult local medical practitioners or herbalists in lieu of clinics when health and child care problems arise.

Population and Society

General Cultural Conditions

The cultural availability of the educated Kenya populace to family planning innovations has been remarkably high. The initial success of the program instituted by the Ministry of Health occurred in high density areas, with women who had some education, and some exposure to government information programs. The acceptance rates, per month, in the program, however, have leveled off. This is probably because most of the more innovative women have taken advantage of the service, with the remaining bulk of the female population representing the more conservative, less educated elements.

Important factors that affect the cultural receptivity of family planning innovations for the conservative rural woman lie in the diverse economic life styles in Kenya. The majority of the population are engaged in subsistence farming which is typified by a low level of technology, labor intensive conditions, and limited, often overworked acreage. Most farm families have little capital, little or no savings, and no self-sustaining growth potential. Wealth-level mechanisms affect those families who do attain something economically. They are often obliged to spend their resources for communal purposes, including ritual feasts, religious ceremonies, and other activities which consume personal wealth. Others are expected to give inordinate time and resource to communal offices and status positions.

Social-psychological characteristics affecting family planning that would apply to much of rural Kenya include a high degree of fatalism, or the individual's feeling that he lacks the ability to control the future. In terms of achievement motivation measured as a desire for personal accomplishment, the individual would be generally apathetic. Agricultural innovativeness, assessed as the rapidity of adopting new ideas, would be low. Political knowledge is mainly limited to local institutions and vague ideas of a few national leaders. Economic knowledge centers on local prices paid and market value of crops grown, or the goods and services sought. Both educational and occupational aspirations, for one's self and one's children should depend on contact with the outside world. Aspirations tend to rise in terms of the individual's cosmopolitan experience. There would also be little sense of empathy in that older villagers have scarce capacity to identify with new aspects of their environment or see themselves in another individual's situation.

Overall, the rural villager has a short time horizon, the future is unsure, and there is a tendency to view the coming events in narrow time periods, often conceived of as cycles or repetitions of events that are known and vaguely linked to the planting and harvesting cycle. There is little knowledge of the outside world and little interest in gambling on future events. The individual in the poorer areas lives in constant insecurity, plagued throughout his life by the threat of natural disaster. The upshot of these conditions is that the probability of family planning ideas gaining widespread acceptance is low, particularly without major educational efforts.

The estimates on literacy vary in the nation. Some 35-40 per cent of the population are probably literate, with up to 70 per cent literate in the urban areas. Two high density sectors in Kenya, the Victoria Basin and the central highlands, have higher literacy than most other rural areas, and it is here that most family planning programs have been launched. The initial success has been encouraging.

In terms of socio-intellectual mobility, a large portion of the young adult male population would at some period migrate for work or to seek work, and gain a degree of understanding outside their home areas. By and large the magnetism and security of the home village, and the lack of opportunity for the uneducated or semieducated, keep travel to a minimum.

Public Health Situation

The current public health situation for urban Kenya is considered excellent by continental

African standards, although the lack of trained staff for the rural clinics makes the nation-wide health picture mixed. The physical facilities for medical treatment are considered adequate, with one hospital bed for every 715 persons (1967). The financial allocations from the government, for major medical purposes, is about 7 per cent of the total national budget, with some 0.25 per cent for family planning, maternal and child health services specifically.

Family planning services are offered as an integral part of the government health program, with about 200 clinics offering free IUD and oral contraceptives. The major medical problem lies in the gross shortage of trained personnel for both family planning and general medical practices. The ratio of doctors to the population in 1970 is about one for 10,000. However, the poor distribution of the staff—about 80 per cent of the 1,080 doctors are in private urban practices—give the rural areas an approximate ratio of one doctor for 250,000 people. The same shortage exists for nurses and other medical staff. In the nation as a whole there were some 400 KRNs/Ms (Kenya Registered Nurses or Midwives) and some 1,200 KENs/Ms (Kenya Enrolled Nurses or Midwives). About 400 medical assistants, with about four years of training, are also employed in local clinics and hospitals.

The demands on the professional time of these personnel are such, that in 1969, the average patient was seen for a period of some 53 seconds. This theoretically includes time for the patient to come into the room, to undress, to be diagnosed, to be treated, to be given medication, to dress, and to leave the room.[12] The general conclusion is that higher level medical personnel cannot under any circumstances handle family planning cases in addition to their other duties. The solution proposed is for the junior staff to be trained to handle family planning responsibilities currently carried by doctors, including loop insertion and pill distribution. The present acceptance of family planning devices is estimated at 30,000 women per year. The retention rates are not known, but probably not over 60 per cent.

Educational Profile

The Kenya government places major emphasis on education, and although there has been recent criticism of the overproduction of liberal arts graduates, in lieu of engineering and technical graduates, the nation has an impressive educational record. Three goals have been pursued by the government: (1) the production of people with sufficient skills, knowledge, and expertise to support the modern economy; (2) the provision of universal elementary education; and (3) the implanting of cultural values "for a productive society and developed personal lives."

In the decade 1960-69 the number of schools increased by 28 per cent to a total of 6,879 institutions. Pupil enrollment increased 75 per cent to 1.3 million, and the number of teachers doubled. The expenditure by the government on education rose from $16.7 million in 1963-64 to $30.8 million in 1968-69.

Specific figures for educational enrollment in 1969, and the increases between 1964-69 and 1968-69 indicate the emphasis government places on education:

	1969	Percent 1964-69	Increase 1968-69
Primary School (1-8)	1,282,297	26%	6%
Secondary School (9-14)	115,246	22%	14%

Source: *Economic Survey*, 1970, p. 171, 173

During 1969 some 6,111 primary schools operated with an average enrollment per class of 32. Secondary education has grown far faster since independence in 1963, particularly in the rural areas. In 1969 a total of 694 secondary schools was under way. School locations follow population densities. Central (171 schools) and Nyanza (127 schools) are the most numerous provinces; the Coast (42 schools) and North Eastern (one school) provinces have the fewest schools.

Trade schools have relatively small enrollments, some 3,000 students in 1969. The government is switching its emphasis to education in this sector, however, and substantial growth can be expected. Teacher training colleges had some 6,126 training to be teachers in 1969. Over 44,000 teachers were in service in 1969.

There were some 1,725 Kenya students enrolled on the three campuses of the University of East Africa in 1969-70, 1,226 in Nairobi. The three branches dissolved and became separate universities in 1970, the Nairobi branch becoming the University of Nairobi. Kenya students abroad total 901, with the United Kingdom, United States, Soviet Union, and India hosting nearly two-thirds. The number of medical students at home and abroad total approximately 250.

The 1970-74 Development Plan calls for university enrollment to double, with increased numbers of graduates in mathematics, engineering, and science. New faculties of law, agriculture, and journalism are scheduled to open by 1974. Students will increasingly receive government loans rather than grants, with repayment expected after graduation. Some pressure on students to accommodate their interests to national needs and to skills for which they will find ready employment can also be expected. As the development plan notes, "unemployed university graduates are a luxury the country cannot afford."

The population growth projections probably affect the primary school age children most directly. Currently some 60 per cent of primary age children are enrolled. The government plans an annual increase of 4 per cent. Under present population growth rates the total number of children receiving no education in 1990 will be twice the present number. If fertility were reduced by 50 per cent in the next 15 years, the government's goal of universal primary education would be possible by 1990.

Population and Polity

Legal Situation

As a result of a report submitted to the government in 1966 by the Population Council, Kenya was the first tropical African state to officially establish a family planning program. After careful consideration the government decided to "... pursue vigorously policies designed to reduce the rate of population growth through voluntary means." In 1967, under the supervision of the Ministry of Health, the program began providing information, counsel, and various contraceptives. Free clinics in government hospitals and health centers provided the services. The program continues to be presented in coordination with maternal and child health, and works in cooperation with the Family Planning Association of Kenya, and other private groups.

Although the Kenya government took decisive steps in 1967, it does not have a totally committed policy. In the early debates government leaders exercised caution and avoided taking strong stands on family planning. Tom Mboya, then Minister for Economic Planning, illustrated the feelings:

> I must also warn against those who in their enthusiasm for family planning go around preaching the scare of population explosion. This may be the problem in some countries but it is certainly not the prompting factor in Kenya.... It has never been the Government's intention to introduce birth control or family planning by compulsory or legislative measures.[13]

Earlier Mboya had pointed out that population growth could exceed economic growth, and the resulting per capita income would fall far short of the government's hopes. He further argued that the family planning programs must also assist families with infertility problems, thus avoiding "involuntary inferiority" frequently ascribed to barren women.

Family Planning Booth at the Agricultural Society of Kenya Show at Embu, Kenya. It was estimated that the Field Educators talked with approximately 4,500 men and women during the two days of the show.

Lecture on Family Planning
Embu, Kenya

Perhaps the strongest policy statement has been articulated in the 1966-70 Development Plan. "The population problem has such an impact on the future development of the country that the Government has decided to place strong emphasis on measures to promote family planning education . . . ." The plan notes that fewer children who are more widely spaced would reduce the annual cost of schooling to the family and allow more children to reach higher levels of education. Pressures on the family's housing, water, and food supplies would be diminished, and a higher standard of living would be possible.

Kenya's family planning services were first started by the Pathfinder organization in 1952. This early program and those launched by the churches and the Family Planning Association of Kenya were largely limited to the urban areas, and to the heavy population sectors of Central Province. International agencies, particularly SIDA and USAID have more recently provided the contraceptives free of charge.

No abortion laws exist in Kenya at the present time; it is neither legal nor illegal. The operation can be obtained in the urban areas, although some doctors refuse the service and others only do so with the concurrence of two other doctors that it is necessary for the mother's welfare. Indications are that professional abortions are rare. On the other hand, attempted abortions by amateur practitioneers are commonplace. The frequency with which such cases need hospital attention prompted a question in Parliament asking about the numbers admitted to government hospitals and why the government did not "legalize abortion in order to facilitate family planning." The Attorney General replied that there were 4,210 cases in 1968, and an average of 4,079 per year between 1963-67. He further stated that the increase was not significant, and there was therefore no need to amend the law.[14] Some indications are that pressures are building up to have the question debated in Parliament, although most observers feel it is too sensitive a topic, politically, and that any such debate would be side-tracked to the need for sex education or more family planning programs. Legal changes supporting abortion are improbable in the near future.

Current Political Situation

Basic political support for increased family planning came initially from the 1967 decision by government to institute a program. At that stage there was general agreement among most government leaders that the nation had a severe population problem that required immediate action. Political counterpressures, however, were quick to build up. The main arguments tended to center around six points: (1) a belief that Kenya needed greater manpower to take its rightful place of power among African states; (2) the belief, particularly during the political crisis of 1969,[15] that some tribes needed maximum growth to protect themselves against other tribes; (3) the idea that any form of family planning might lead to compulsory limitation and impinge on the individual's right of free choice; (4) the notion that the vastness of Kenya's unsettled areas could support greater population; (5) the expressed moralistic fear that contraceptives will promote promiscuity in women, a view that mainly prevails in rural areas; and (6) the belief that the military position of Kenya vis-à-vis its neighbors might be undermined by family planning. This fear incorporates the idea that with a successful Kenya program, Uganda would eventually have a larger population and with Tanzania already larger, Kenya would be dwarfed by its East African neighbors.

The major political pressures in favor of the Kenya population program have been from two general sectors. First, local institutions such as the Ministry of Health, the Family Planning Association of Kenya, churches and other locally organized agencies, and second, the foreign agencies that provide the major staff and financial backing for the program.

Although the general theory is that the national program should move ahead with vigor, in reality the government continues to vacillate. The fact that the great majority of family planning activities are initiated by foreign donors and agencies, that the training and staffing of Africans in family planning has not been given top priority, and the fact that the financial contribution from the national budget remains small, all indicate a general inaction. Although the ground work has been laid

and impressive initial steps have been taken, most professional observers state that the top echelons of government are still ambivalent about family planning. The lobbies and pressure groups that do exist are mainly the international agencies and donors, but their efforts are largely uncoordinated and they have little significant influence on government policy or planning.

Attitudes Toward Population Programs

Attitudes of government leaders toward population programs tend to be those of cautious approval. Most officials outside the Ministry of Health feel that it is that Ministry's responsibility. Agricultural officials are somewhat aware of the implications for their work, but there is reluctance to use extension workers to disseminate family planning ideas on the basis they are already overworked. Officials feel such additional attempts would dilute the extension message, confuse the farmers, and further alienate older village leaders. The Ministry of Economic Planning and Development, in drafting the 1970-74 plan, called for a substantial increase in government spending on family planning, although even here a detailed commitment is lacking.

In the Ministry of Information and Broadcasting, family planning is grouped with educational material on maternal and child health. Until 1970 broadcasting in support of family planning was avoided because the material was considered to be of "private matters." Even in the Ministry of Health, the main rationale is that the family planning program has been mounted for the sake of maternal and child health. Discussions of the demographic or economic aspects of population growth are avoided.

The general view of government officials is that family planning is a health activity that must be couched in such terms as to avoid publicity and resistance. Most middle- and lower-range officials are uninformed or misinformed about the program. The major short-run problem, the lack of administrative and paramedical personnel, is generally unrecognized.

Attitudes of religious leaders toward family planning may be assessed as Christian, Muslim, Hindu, and traditional or pagan. The Family Planning Association of Kenya (FPAK), a private association which operates in cooperation with the national program, has encouraged many of the Christian churches and missions to sponsor educational programs and clinics. The National Christian Council of Kenya has coordinated conferences and conducted research, particularly on the population implications for education and school-leavers. The general attitude of Christian churchmen and missionaries would be similar to those in the United States, the more fundamental religious groups tending to be far less sympathetic to family planning measures. Muslim leaders have cooperated with the Family Planning Association in the preparation of brochures and information aimed at that community. The activities are mainly on the coast, and one of the leading lay figures in the Mombasa Muslim community is a member of the FPAK committee. Hindu religious leaders are less involved in family planning, in spite of a relatively high growth rate for that community. Traditional religious leaders usually counsel their followers toward arch-conservative, pronatal attitudes.

The attitudes held by the general populace are in many ways better researched and documented than those of elite or religious groups. For Kenya in general, Molnos has pinpointed many of the attitudes surrounding family planning. Pronatal beliefs stem from the view that children provide a labor force and material wealth for the family, that an easy life is gained when children work for the elders, and that old age insurance is provided by many children. Traditional concepts of life carry strong notions of lineage continuity and descent. The status of a man with many children continues to be equated with wealth, power, pleasant surroundings and peace with his ancestors. Similar attitudes toward the virtue of large families derive from the fear that many children will die before adulthood, a belief founded in the high infant mortality rates of the past. There is a further desire to have a proportionate number of male and female children to support the division of labor among the sexes. Expectations of bride-wealth revenue transactions are also important. Other attitudes that tend to resist family planning are found in the humiliation to which a barren woman is subject, in her fear of being accused of witchcraft, her fear of supernatural punishments, or her fear of other social stigmas.

Special investigation of urban attitudes toward family size by Dow found that some 200 women with an average of three children wanted three more and there was little difference in the desired family size by sex. One half of both the men interviewed (152) and women had some knowledge of family planning methods, and there was widespread interest in learning more (75 per cent of the men, 90 per cent of the women). Another question indicated that only 2 per cent of the women, however, had actually practiced family planning.[16] The last finding calls the articulated attitudes into some question, and underscores that talk is easy, but practice much harder.

In his study of rural areas, Heisel noted a strong tendency to see children in an economic rather than a psychological or social context. All other considerations, such as the size of the family, risks to mother's health or fear of infant mortality, were relatively insignificant.[17] Probing attitudes surrounding the number of children desired, Heisel reports the women he interviewed desired a mean of 6.03 in the rural areas. Heisel also found that there was considerable ignorance about methods of limiting family size and that the methods known were for the most part "either objectionable or ineffective." In view of the awareness of the economic strains created by large families, Heisel thinks it may be that "in the absence of knowledge of safe and reliable contraceptives, ideas of family size tend to remain near the level of achieved fertility." Given some success in family planning education, this finding is possibly a hopeful sign about the future success of family planning measures. Dow reported 6.20 for women, and 6.6 for men. Both findings are close to the actual number of children estimated per family (7.0). On the other hand there seems to be little interest in very large families. Only 15 per cent of Heisel's sample of women reported nine or more children as ideal. There is little difference between rural and urban attitudes on number of children desired.

An interesting specific finding by Martin shows the differences in attitudes on the question "A woman has a duty to her husband and his relatives to have as many children as possible."

Positive attitudes toward family planning are usually traced to the aspirations of the parents to educate all children, to provide better material needs such as housing, food, and clothes. The need for more disposable cash and more pleasure and leisure time are also important. Many of these articulate beliefs come with education and with more confidence in the modern health services. In church-oriented families, the moral issue of the parents' responsibility to have only those children they can easily support tends to be a recurring attitude.[18]

Population Work and Research

Family Planning Programs

Family planning initiatives were first taken in Kenya in 1952 by the Pathfinder Fund. Formal services through private efforts began in 1957 with the formation of the Family Planning Association in Kenya, (FPAK). The government program, launched in 1967, is headquartered in the Ministry of Health. Its basic aim is to provide family planning education, information, equipment, supplies, and medical service through free clinics which are mainly located in existing hospitals and

	Husbands		Wives	
Response	little urban experience	much urban experience	little urban experience	much urban experience
agree	61%	53%	31%	20%
don't know	4%	3%	6%	5%
disagree	35%	44%	64%	75%
total respondents	132	241	255	108

Source: Martin, p. 5

dispensaries. The demographic targets of the program are not stated by the government beyond a desire to reduce the excessive rate of growth, while cutting down mortality. The main education thrust is to make every child a conscious choice. The Ministry of Health is adamant in stressing that the program is wholly voluntary and has no wish to encroach on religious beliefs and customs. Spacing of births is emphasized as well as methods of contraception and family limitation.

Organizationally, the Director of Medical Services in the Ministry of Health is responsible for planning of a comprehensive program. He is chairman of a working committee on family planning which serves as an advisory and coordinating group. Under this committee is the family planning section, made up of two expatriate professionals and a Kenya nurse education specialist. They are assisted by the Epidemiological section in statistical analysis and a health education section which prepares materials. Foreign donor agencies provide a number of experts and equipment.

As of mid-1970 some 200 medical facilities were offering family planning on a regular basis.[19] The key problem lay in the fact that most of the clinics are rural health centers or dispensaries which are genuinely overburdened. The number of trained personnel is inadequate, and most staff are too preoccupied with normal medical duties and health work to give family planning a high priority. An important decision was taken in 1969 to allow nurses and other paramedical personnel to begin training on inserting IUD's and dispensing other family planning services.

By 1969, some 2,600 women a month were accepting contraception after consultation, a figure that represents some fifteen-fold increase over 1967-68. In 1969 some 31,000 women were seen as first visitors, and 67,000 were seen on "revisits." During 1970 an average of 12,000 per month were visiting the clinics, with about 2,800 per month as first visitors (see Appendix, Table 2). Figures on retention rates for IUD acceptors and continuation rates for pill users were not available; estimates range from 40 to 80 per cent rejection in the first year. A majority of the clinics are operated by the government (80) or the IPPF mobile units (61). Some 40 are conducted by the Nairobi City Council, 19 by mission stations, and eight by the FPAK on a private basis. The frequency of the clinics is either weekly (99), at ten-day intervals (26), monthly (50), or on request (21). A recent study of a random sample of first visits to Family Planning clinics showed the following services being dispensed (December 1970): pill 51 per cent, IUD 29 per cent, injectibles 4 per cent, other methods 2 per cent, none 13 per cent, unknown 1 per cent.

Clinical services include consultation with patients, general examination and diagnosis, history-taking, screening, dispensing contraceptives, follow-up instructions, referral of problem cases, record keeping, and general clinic management. The contraceptive methods employed are the free distribution of pills provided by SIDA, (Ovulen and Eugynon in accordance with the Dunlop Committee reports), and the Lippes Loop. Throughout Kenya 55 per cent of the acceptors use the pill, and 45 per cent the loop, although major geographical variations occur. The Muslim-influenced coastal area, for example, has an 85 per cent use of pill and only 10 per cent use of IUD's. Therapeutic abortion is not practiced in the program, and other forms of control such as sterilization and injectables are rare. No incentives are provided to encourage participation. At the present time there is no organized opposition to the government's program. The provisional 1969 census reports, showing a higher growth rate than had been expected, has probably served to keep the family planning activities from becoming controversial and overtly political. Support, in fact, is forthcoming from the military which has several clinics on its bases.

Future plans are to increase the Kenya staff of medical and paramedical personnel in family planning schemes, and to thus alleviate the overburdened medical staff. Training, begun in mid-1970, was directed at a doctor group who will in turn act as supervisors for other personnel. Seminars are projected and a field staff of FPAK educators will join the 50 now working in rural areas. Such educators will make home visits as well as presentations at public meetings. In terms of projected financial support, the disproportionately high contribution by international agencies is

expected to be reduced with increased funds, personnel, and equipment from the Kenya government.

Demographic Research

One of the basic problems in Kenya's population program is the lack of enough trained demographic specialists. The University of Nairobi provides a second year sociology course in demography which includes techniques of population analysis. Although a thorough course, there is no direct link between those who complete the course and positions that entail the needed analysis for the Kenya government.

Other demographic activities related to family planning include the work of the Statistics Division of the Ministry of Economic Planning and Development. This office produces the *Kenya Statistical Digest*, a quarterly economic report, and other documents partially related to population. The Bureau of the Census conducts the primary analysis of the national census and provides mid-year estimates of population. Demographic work on the census data, however, is divided between several Ministries, and much of the work is carried out by expatriate officers on short-term assignments.

A registration act for births and deaths, amended in 1967, makes registration in certain areas of Kenya compulsory. It is voluntary in others. The high density Central Province has had compulsory registration since 1964, and other districts are gradually being brought into the program. There is also increased publicity on legal statutes which cover legitimacy, marriage, adoption, and divorce. This may lead to better registrations and aid future demographic research.

Indigenous Institutions

The most important local institution working on family planning is the Family Planning Association of Kenya, which operates from grants by the International Planned Parenthood Federation. FPAK operates 17 clinics in areas where government programs do not yet operate, and in urban areas on a private basis. A major information program is also offered, and branches of the association are maintained in several areas. Six area officers promote close coordination between the branches, and some 56 field educators carry family planning information to rural families.

The Association was formed in the 1950s by several doctors in Nairobi and Mombasa to help avoid unwanted pregnancies. In 1961 the Association affiliated with IPPF. In 1969 an agreement over responsibilities was reached with the Ministry of Health whereby the Association would be mainly working in the education and information fields, with the Ministry providing technical and medical services.

Other local organizations working in family planning include:

(1) Family Service Council of Kenya, a voluntary organization, which focuses on such problems as juvenile delinquency, broken homes, divorce, and marriage counseling. A school program in "family life education" is also operated in which family planning topics are taught.

(2) University of Nairobi has developed a teaching program in demography within the department of sociology and a population specialist, supported by the Population Council, is on the staff. Several conferences have been held in conjunction with the University, and surveys on knowledge, attitudes, and practices in family planning have been conducted. Medical and nursing schools also train students in family planning.

(3) Churches, usually through mission medical facilities, offer clinical services and educational programs. Some also train their own medical personnel and receive direct support from their parent mission organizations.

(4) Private organizations, which include service-oriented clubs, groups for community welfare, economists, agricultural extension groups, and school groups provide lectures on family planning. Discussions are also underway to provide family planning teaching in the schools, including the primary level.

International Agencies

The major support for the Kenya population program comes from several foreign agencies working in conjunction with the Ministry of Health. During fiscal year 1969-70 contributions from these organizations equaled $934,680.00. The Ministry of Health contributed $28,000 as a line item plus two or three times this amount in facilities and health personnel salaries. The specific contributions from the international agencies include the following, (1969-70):

(1) **British Overseas Development** provided equipment for the epidemiological section, office equipment, and ten vehicles, estimated contribution, $78,400.

(2) **Ford Foundation** provided a grant for a training and education project, supports a research survey on family planning attitudes, and keeps a population program officer for East and Central Africa. Estimated contribution, $19,600.

(3) **International Planned Parenthood Federation** makes a major financial contribution to support the FPAK, provides seven mobile teams giving family planning services and training, and finances and operates a Family Welfare Center. Contributions estimated at $368,480.

(4) **Netherlands** provided seven technical staff, including two gynecologists, and medical equipment. Estimated contribution, $126,000.

Royal Dutch Institute of Tropical Hygiene organizes and evaluates statistical data and helps train field staffs in mobile units.

(5) **Norway** provided equipment for 50 family planning clinics, valued at approximately $12,600.

(6) **Population Council** provided one medical advisor and one nurse-health educator for the Ministry of Health, plus support for university teaching staff in demography and sociology. Estimated contribution, $72,800.

(7) **SIDA** provides one advisor on administration for the Ministry of Health and supplies contraceptives for free distribution. Estimated contribution, $70,000.

(8) **USAID** provides two experts working on the population census, an expert in health education, and one audio-visual professional working with educational materials. Basic equipment for the health education unit and three vehicles are also provided. The estimated contribution is $159,600.

The total contribution by international agencies, estimated by Fendall between 1965 and early 1970 was $1,319,000. This included other contributions by The Oxford Committee for Family Relief to train midwives, the Pathfinder Fund contributions for nurse education and contraceptive pills, and contributions by the American Friends Service Committee for population consultants and advisors.

Evaluation

The major advances made in family planning lie in the clinical services, in the strides in education, and in the backing international donors continue to provide. Problems lie in the lack of trained personnel, the failure of the program to establish reliable research service, and the ambivalence of top politicians. The program's efficiency is commendable, as the growing number of participants in family planning services illustrate. Precise evaluation, however, is difficult because it is not known how many initial acceptors reject the loop or discontinue the pill. The overall commitment Kenya women have to family planning is unknown.

One of the major problems in establishing a viable family planning program has been the discoordination in the financial sector of family planning. Donor agencies have been slow to deliver contracted items, such as equipment for data processing, vehicles, and chemical supplies. Pills, far more costly than the IUD, have been preferred. The actual financial input of the Kenya government has been small, and because of lack of coordination, even these funds in the past have not been completely used. The trend has been reversed.

Conclusions

Kenya has been called the Japan of Africa, an aggressive, driving nation determined to reap the fruits of industrialization and to have for its people the benefits of the modern world. In terms of population, this nation early on took a long and sober look at its burgeoning growth rate, and began doing something about it. In just three years a major national program has reached over 100,000 women. Family planning leaders can be justly proud of this first tropical African program. It is highly rational, highly pragmatic, and, like Japan, inextricably linked to the economic development of the state.

Probing below the surface, however, the inevitable cross-pressures and difficulties in establishing such a national effort begin to emerge. In reality family planning is largely run by non-African expatriates. About 80 per cent of all contraceptives are handed out by European doctors and nurses. The organization and infrastructure of the program are indeed intact, but strong commitments from major African leaders are still lacking. The financial imbalance at which international donors support the program, a rate of 30 times that of the Kenya contribution, indicates its priority. There is a feeling that the Kenya leaders are drawing on some ancient proverb that portrays the foreigners coming with their new wares, as wise old men watch and wait and ponder the implications.

The political pressures on the family planning program spring from the basic problems of Kenya national integration. Competition between the leading tribal groups for power has characterized Kenya since independence, and particularly after the assassination of Tom Mboya in mid-July, 1969. The divisions run deep between Mboya's Luo people, the second largest tribe (1962 census) and the larger, economically dominant Kikuyu of the central highlands. The general trend, therefore, has been for politicians to cautiously ignore or soft-pedal population questions. Those who may have wished to bring family planning up as a controversy have been temporarily put off by the fact that no African politician has embraced the cause sufficiently to make him a worthwhile target.

The more meaningful criticism that the population program is still largely a paper program supported by foreign monies and basically run by "two-year visitors" has not been leveled as yet. The charge would probably reach too far into the question of foreign advisers and foreign aid. Such criticisms have been unfashionable except for the mild comments as " . . . we have more aid than we can chew . . . " or " . . . the aid bottleneck is the lack of trained personnel . . . . "

Specific organizational problems lie in the day-to-day operations of the program. A decrease in the monies appropriated by the government for family planning has been due largely to the fact that the funds available were not spent. Funds were given up at the end of the last three budget years, and the next budget subsequently reduced. The 1970 budget reverses the downward trend, up from $28,000 to $42,000.

More basically, there have been no specific targets set for the Kenya family planning program other than a general decrease in the population. There has been no research and evaluation about ideal population figures in terms of distribution. Research problems also lie in the lack of solid demographic information for some districts, and the lack of data or research on the actual clinical operations. Little is known of techniques and their effectiveness or ways to improve upon them. Data problems also exist concerning the effects of contraceptive pills, particularly in terms of attitudes and what is articulated by users to nonusers.

One possibility of major expansion of the family planning program lies in the use of injectable contraceptives. The widely-held belief that an injection is far superior to any other medicine makes the needle the most respected form of treatment for the mass rural population. The development of such injectables in Kenya has only been used in private clinics and for women with five or more children. This caution is due mainly to the uncertainty that fertility can be re-established. Other techniques such as sterilization are rarely done, often due to the unavailability of surgeons and the shortage of beds. Most surgery is done on an emergency basis and there is little time for preventive practices. Male contraceptive pills and other methods have been discussed but not tried. A further problem exists in medical staff orientation, which tends to be curative rather than preventive.

There is also a lack of interest by medical staff in serving as instructors. The shortage of counselors and advisers for educational purposes impairs the program. Personnel problems are further complicated by rapid transfer, leave-taking for long periods, and pregnancies by medical staff. Other problems in the past have stemmed from conflicts between voluntary programs and the national program, particularly regarding services to those who do not have or wish to have access to government clinics.

In a positive sense the national family planning program has shown steady progress. The number of clinics offering services has increased, and among the educated population there is a growing realization that the existing medical facilities and improved health conditions reduce infant mortality and thus reduce the need for large families. A further advantage for the Kenya program is the relatively small, Catholic population of the nation which keeps the complicated lay beliefs on birth control shared by Catholics in French-speaking African states from entering the picture. Perhaps most important, both religious and lay leaders of Kenya have commitments to improving the status of the people, and there is general realization that this cannot be accomplished without a significant decrease in fertility.

Pressures in support of the program can also be expected to come from bureaucrats and some members of Parliament, particularly those concerned with economic analysis. Here there is a growing realizaiton that the population increases seriously challenge Kenya's development. Overall, population equals the power game. For the moment there is relative peace on this front, but it would be unrealistic to expect the tranquillity to continue. As pressures go up for leaders to take strong stands on population control, so too will the political counterpressures emerge in terms of localism, tribalism, and other vested interests.

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NOTES

1. The term Asian in census terms denotes an individual from the subcontinent of India, but does not include Ceylonese, who with Chinese, Japanese, or other persons from the Far East are classified as "others." People of Arab affiliation are those with ancestry in Saudi Arabia, Yemen, Muscat, Aden, or Oman.

2. Source: *Economic Survey*, 1970, p. 128.

3. Wage employment includes self-employed farmers who work on other farms as casual laborers. Wage employment in small holding sector is only those hired by others.

4. See Russell, (1970) pp. 8-9.

5. See Etherington, pp. 54-74

6. See Map, Appendix p. iii. Also see S.H. Ominde (1968), pp. 83-196

7. *Statistical Abstract*, 1969, p. 22.

8. *Statistical Digest*, p. 12.

9. Angwenyi, pp. 1-5.

10. Angwenyi, p. 12, and Spengler, p. 311.

11. Angwenyi, p. 20.

12. J.J. Russel, speech, Kenya-American Conference on Family Planning, Nairobi, Sept. 25-6, 1970.

13. Mboya, speech, Conference on Social Welfare, September 1967.

14. Question in Parliament, no. 573, July 23, 1970. Regarding abortion, see also section 156, 159, 160 of the Penal Code, Laws of Kenya.

15. See Norman N. Miller, *Assassination and Political Unity: Kenya* [NNM-5-'69], Fieldstaff Reports, East Africa Series, Vol. VIII, No. 5, 1969.

16. Dow, part I.

17. Heisel, IDS paper. See particularly pp. 638, 639.

18. Molnos, pp. 178-194.

19. Indicates clinics reporting in government program; other private clinics exist.

Appendix

Table 1

Number of Clinics under Ministry of Health

Year	Month	National Program	Nairobi City Council	Total
1969	Jan.	85	14	99
	April	73	27	100
	July	102	28	130
	Oct.	116	33	149
1970	Jan.	133	35	168
	April	142	39	181
	July	150	39	189
	Oct.*			198

Source: Kenya Ministry of Health, Epidemiology and Medical Statistics, Report Aug. 18, 1970.

*(unofficial report)

Table 2

Attendance 1967-70. Clinic Visits and Re-visits

Year	1st Visit	Re-visit	Total
1967	1,519	7,879	9,397
1968	11,711	17,891	29,602
1969	30,303	71,967	102,270
1970 (Jan.-June)	16,743	54,149	70,892

Source: Kenya Ministry of Health, Epidemiology and Medical Statistics, Report, August 18, 1970.

Table 3

Acceptors by Education (1968 Visits)

No. Years of School	Number	%
None	2261	25.0
1-3	1149	12.7
4-7	3256	36.0
8-10	1474	16.3
11-13	117	1.3
14	27	0.3
Unstated	760	8.4
	9044	100.0

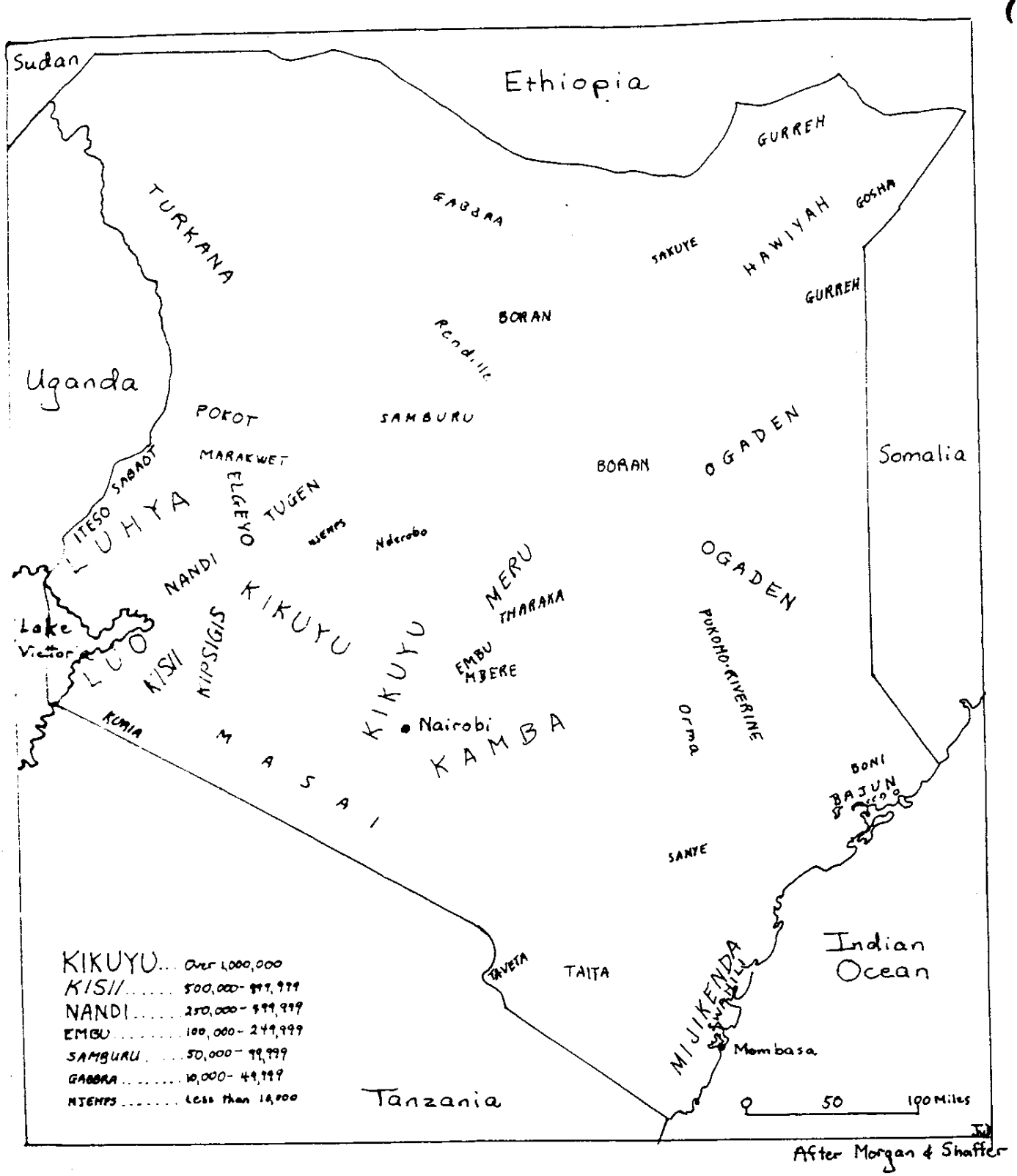
Source: Kenya Ministry of Health, Epidemiology and Medical Statistics, Report Oct. 21, 1969.

Table 4

Life Expectancy for Kenya Africans (1962)

Age	Expectancy
0	39.0
1	43.6
5	44.6
10	43.4
15	39.4
20	35.9
25	32.9
30	29.7
35	26.4
40	23.2
45	19.9
50	16.9
55	14.0
60	11.4
65	9.1
70	7.2
75	5.7
80	4.6
85	3.5

Source: Calculated from Estimates in Kenya Census, 1962, Vol. III, p. 92. Compiled by James Cramer.



Tribal distribution of Kenya