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Evidence Brief

Addressing barriers to modern contraceptive uptake in Kenya: Evidence-informed policy options for equity and impact

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Key messages

- Persistent barriers: Cultural, religious, and gender norms continue to shape negative perceptions and restrict contraceptive use, particularly in rural and conservative communities.
- Health system weaknesses: Inadequate supply chains, poorly trained staff, and limited youth-friendly services reduce service quality and access to contraceptive methods.
- Socioeconomic and geographic disparities: Women in arid, semi-arid, and low-income urban and rural areas face additional challenges, including high costs, long distances, and inadequate infrastructure.
- Youth and adolescent gaps: Adolescent girls and young women experience stigma, confidentiality concerns, and lack of autonomy, deterring them from seeking reproductive health services.
- Policy opportunity: Targeted interventions and stronger inter-agency collaboration, led by national and county governments, can transform family planning uptake by integrating cultural gatekeepers, improving infrastructure, and institutionalising youth-responsive services.

Executive summary

Despite progress in expanding access to modern contraceptives in Kenya and Sub-Saharan Africa, uptake remains unacceptably low among women of reproductive age, particularly in rural, arid, and marginalised settings. This policy brief synthesises evidence from 17 studies conducted between 2015 and 2025 across Kenya and other Sub-Saharan African countries. It identifies key sociocultural, systemic, and structural barriers to contraceptive use and proposes actionable, context-specific policy responses. Addressing these barriers is crucial to reducing unintended pregnancies, enhancing maternal and child health outcomes, and achieving national and global development targets, including Sustainable Development Goal (SDG) 3 and SDG 5.

The brief emphasises that intersecting challenges, cultural myths and gender norms, geographic isolation, socioeconomic disparities, weak health systems, lack of youth-responsive services, and insufficient public education shape low uptake. Multi-level, inter-sectoral interventions are essential. These should prioritise community engagement, youth inclusion, health systems strengthening, infrastructure investment, and policy coordination to expand equitable access to family planning.

17

Number of studies conducted between 2015 and 2025 synthesised by this evidence brief across Kenya and other Sub-Saharan African countries.

Background

Kenya has made considerable progress in expanding access to modern contraceptives, with the contraceptive prevalence rate (CPR) for married women increasing from 53% in 2014 to 57% in 2022 [1]. This progress reflects national commitments to achieving the Vision 2030 development agenda and SDGs, particularly SDG 3 on health and well-being and SDG 5 on gender equality. The implementation of the National Family Planning Policy (2012) has played a central role by promoting voluntary, rights-based access to a wide range of family planning services, emphasising equity, informed choice, and integration with reproductive, maternal, and adolescent health services [2]. However, disparities persist, particularly among women living in rural and arid regions, and among marginalised populations such as nomadic groups and adolescents.

The consequences of low contraceptive uptake include high rates of unintended pregnancies [3], unsafe abortions [4], and elevated maternal and infant mortality rates [5]. Understanding the factors influencing modern contraceptive uptake and intervention options is essential for informing targeted and equitable interventions. This policy brief synthesises findings from 17 peer-reviewed studies conducted in Kenya and other Sub-Saharan African countries to identify barriers, facilitators, or interventions related to contraceptive use and provide evidence-based policy recommendations.

53%

Contraceptive prevalence rate for married women in 2014

57%

Contraceptive prevalence rate for married women in 2022

Methodology

This evidence brief draws on a synthesis of 17 peer-reviewed studies identified through a structured search focusing on Sub-Saharan Africa, with particular emphasis on low- and middle-income countries (LMICs). Studies were included if they examined factors influencing the uptake of modern contraceptive methods among women of reproductive age (15–49 years), specifically addressing barriers, facilitators, or interventions related to contraceptive use.

The review prioritised research from Kenya and comparable LMIC contexts within the region. Both quantitative and qualitative studies, including systematic reviews, were considered if they presented primary data or synthesised relevant evidence. To ensure the findings reflect current realities and inform actionable policy recommendations, only studies published within the past decade (2015–2025) were included. The selected studies employed diverse methodologies, such as cross-sectional surveys, mixed-methods research, and qualitative designs.

Data were extracted using a structured tool to capture information on the country, study design, population, key findings, and relevance. Findings were grouped thematically and synthesised narratively to generate evidence-informed recommendations.

Key findings

Key challenges identified

Across the 17 reviewed studies, a range of persistent challenges affecting modern contraceptive uptake was identified. To begin with, cultural and religious barriers remain highly influential. In many communities, modern contraception is perceived as taboo or incompatible with religious doctrine. Consequently, myths and misconceptions regarding side effects, infertility, or moral permissibility significantly undermine trust in contraceptive methods [6–8].

In addition, socioeconomic inequalities compound these challenges. Women from lower-income households, those with limited or no formal education, and those engaged in informal employment often face multiple access barriers. These include the inability to afford indirect costs, lack of information, and limited time to visit health facilities [9–11].

Furthermore, geographic and infrastructural challenges were commonly noted, especially for those living in arid and semi-arid lands (ASALs), remote, or pastoralist regions. The long distances to health facilities, combined with poor road networks and inadequate transport options, impede access to services [12–14].

Moreover, health system weaknesses further exacerbate the issue. Stock-outs of contraceptives, poorly trained health providers, lack of privacy, and judgmental provider attitudes reduce service quality and discourage users [15, 16]. In addition, information and knowledge gaps persist across populations. Misinformation about contraceptive side effects, distrust of modern medicine, and limited sexual and reproductive health education negatively influence uptake [20, 21]. Adolescents, in particular, face unique challenges, including social stigma, lack of autonomy, and restricted access to youth-focused services [10, 12). Services are often not youth-friendly, which limits adolescents' access to accurate information and confidential care [17–19].

In many communities, modern contraception is perceived as taboo or incompatible with religious doctrine.

Table 1. Summary of studies included

Title	Key Findings	Recommendations from the Study
Household cost of accessing contraceptive services among women in urban Ghana, Kogoziga et al.2025	Cost remains a barrier despite availability	Expand financial support and reduce out-of-pocket costs for urban poor women.
Utilization of modern contraceptives in Senegal, Endale et al.2025	Education and income improve uptake	Enhance education and community-level income generation for women.
Contraceptive use in Kinshasa slum and non-slum areas, Kabasubabo et al.2025	Urban slum residents have higher unmet need	Integrate FP services into slum-based health programs.
Contraceptive knowledge among pastoralists in Ethiopia, Beyene et al.	Lack of education and access for pastoralists	Use mobile outreach and community education in pastoralist areas.
Health facility readiness for FP, Ssanyu et al.2025	Poor readiness affects service delivery	Improve health facility readiness through staffing and supply chain management.
Pharmacy staff practices in Nigeria, Adigwe et al.	Inadequate counseling skills	Train pharmacy staff on contraceptive counseling and referral.
Role of faith leaders in FP in West Africa, Hylkema & Ilozumba	Religious leaders can influence uptake	Partner with faith leaders to promote FP within religious discourse.
FP use among adolescent girls in Tanzania, Kessy et al.2025	Stigma and autonomy are key issues	Establish youth-friendly centers and promote confidential services.
Unmet FP need in Kenyan adolescents, Damtew et al.2025	High unmet need in ASALs and among youth	Design targeted adolescent programs in ASAL regions.
FP use and barriers in Iringa, Tanzania, Ngole & Joho 2025	Cultural norms and low awareness persist	Implement culturally sensitive campaigns and community dialogues.
Postpartum FP uptake in Ethiopia, Cherie et al.2025	Missed opportunities in postpartum care	Integrate FP counseling into antenatal and postnatal care.
Barriers to FP in western Kenya, Britton et al.	Integration with maternal care is weak	Mainstream FP into maternal and child health services.
Contraceptive use in Senegal adolescents, Ba et al.2024	Peer norms and misinformation discourage use	Promote peer-led education and myth-busting campaigns.
Married couples and FP in Fentale, Ethiopia, Beyene et al.2024	Male support improves contraceptive use	Involve men in FP education and couple counseling.

Adolescent FP use in DRC, Mpunga et al.2022	Confidentiality and stigma are barriers	Create youth-only service days and ensure privacy in service delivery.
FP uptake in Ethiopia, Gobena & Kassie, 2024	Wealth and education strongly linked to use	Subsidize FP services and invest in women's education.
Client satisfaction with FP services in Ethiopia, Anne et al.2023	Poor satisfaction due to provider behavior	Improve client-provider interactions and training for respectful care.

Recommended intervention options

- First and foremost, culturally sensitive strategies must be prioritised. This entails engaging religious and community leaders in developing and disseminating accurate family planning information to help shift attitudes and debunk myths, especially in conservative and patriarchal settings [8].
- Secondly, improving access in underserved regions is another essential step. This can be achieved by expanding mobile outreach services, particularly in ASAL areas and among nomadic communities, to ensure that women receive counseling and a full method mix close to home [13, 14].
- To address the needs of young women and adolescents, youth-friendly health services must be institutionalised. This involves training providers to offer nonjudgmental, confidential care and integrating family planning into adolescent health packages [12, 9].
- Moreover, strengthening the health system is fundamental. Efforts should focus on ensuring a reliable contraceptive supply chain, building capacity in commodity forecasting, and equipping providers with up-to-date training on family planning methods to reduce stock-outs and misinformation [11, 16].
- Additionally, public education and awareness campaigns should be scaled up using mass media, community outreach, peer educators, and digital platforms. These initiatives are crucial to correct misconceptions and raise awareness about the health and economic benefits of family planning (7,21).
- Finally, male engagement must be expanded. Men's involvement in reproductive health decision-making—through couple counseling, targeted campaigns, and gender-transformative programming—can reduce opposition and increase shared decision-making, ultimately leading to improved contraceptive uptake [18, 19].

Policy recommendations

- Community-based interventions: The MoH, in collaboration with County Health Departments and the National Council for Population and Development (NCPD), should integrate religious and cultural gatekeepers in family planning advocacy efforts. This includes engaging faith leaders in behaviour change communication strategies.
- Infrastructure development: The MoH and partners should engage the Ministry of Transport and Infrastructure to prioritise investments in rural health infrastructure, particularly in ASAL areas. This includes improving transport networks, staffing, and equipping health facilities with essential commodities.
- Youth and gender inclusion: The Division of Reproductive and Maternal Health within MoH should institutionalise youth-friendly and gender-sensitive reproductive health programmes. This includes mandatory training for healthcare workers on adolescent care and gender-responsive service delivery.
- Health systems strengthening: The Kenya Medical Supplies Authority (KEMSA), in partnership with county governments, should ensure consistent procurement and distribution of contraceptive commodities. Resource allocation for forecasting and stock management must be strengthened.
- Information and education: The Ministries of Education and Health should jointly support continuous public education on contraceptive choices and benefits through school curricula, community health volunteer programmes, and media outreach.
- Male involvement: The State Department for Gender Affairs and the Ministry of Health should lead the development of programmes that address gender norms and promote male participation in shared reproductive decision-making. This should include community dialogue initiatives and couple-focused services.

Gaps in the evidence and future research needs

Several research gaps remain:

- Limited evidence on effective contraceptive models for nomadic populations
- Sparse research on adolescent reproductive needs and stigma
- Underrepresentation of urban poor communities
- Few robust evaluations of intervention effectiveness
- Inadequate analysis of the supply chain and health system logistics
- Lack of longitudinal and causal evidence
- Poor understanding of intersectionality among barriers

Future research should prioritise marginalised groups, evaluate program scalability, and integrate mixed-method approaches to inform policy and practice.

Conclusion

Findings from the 17 studies reviewed confirm that low modern contraceptive uptake is driven by complex, intersecting factors. Cultural and religious norms, gender power dynamics, socioeconomic inequalities, and geographic marginalisation continue to shape reproductive choices. Health system limitations further reduce accessibility and service quality, while stigma and lack of youth-focused interventions hinder adolescent uptake. Addressing these challenges requires multisectoral collaboration and equity-centered policy responses. Addressing these barriers is not only a public health imperative but a foundational step toward achieving equitable development and positioning Kenya to harness its demographic dividend.

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