MONGOLIA AND KENYA:
A COMPARATIVE OVERVIEW OF DEMOGRAPHIC LANDSCAPES

Muchira Muraguri,
Economist/Demographer
UNV, Population Teaching and Research Center,
National University of Mongolia

This comparative overview is a brief cast into the demographic landscape of both Kenya and Mongolia. The motivation for it was sheer curiosity that I had in trying to understand what differences and similarities may be there between the two countries.

Interesting similarities and differences have emerged. The paper has examined the following issues: population policy development; fertility and mortality rates; life expectancy; abortion; Hiv/Aids; migration; population size; history of censuses; population growth rates; population distribution and family planning.

This review has shown that there are more differences than similarlities. Similarlities mainly exist only in mortality and fertility trends. In each case the trend is towards a decline in both demographic processes. Some similarities also exist in population distribution where both countries have very sparse population densities. This is because both countries have a wide expanse of land which is arid, semi-desert and desert. Differences exist in all other areas which include contraceptive prevalence with Mongolia having a much higher prevalence 60% vs. 39% for Kenya(1998); HIV/AIDS, an area in which Mongolia has not been affected as much as Kenya. Only a few cases have been reported in Mongolia compared with about 2m Hiv positive cases in Kenya in a population of 30 m. Unlike Kenya which adopted a population policy much earlier (1967), Mongolia did not adopt one until 1996. The main and compelling reason for the early adoption in the former case was the high population growth rates which were absent in Mongolia. It is also clear from this overview that unlike Kenya, Mongolia has not had a history of very high population growth rates. It also has had over the years much lower fertility and mortality levels. Abortion has not yet been legalized in Kenya as is the case in Mongolia. What is surprising is the fact that it does not appear to have been as much a debatable issue as is the case in most Christian societies such as Kenya. Marked differences exist in the types of contraceptive methods used by women in the two countries. The average Mongolian is also leaving longer than his Kenyan counterpart.

Comparative analysis often brings forth lessons for researchers, policy makers as well as program managers. It is true to say that many countries have taken cue form others in many fields of development. Population management is no exception. Mongolia and Kenya are not only geographically far apart, one being found in the North-Eastern corner of the continent of Asia while the other is to be found on the east coast of Africa but also socially and historically different. This comparative overview is largely driven by curiosity. However Kenya is a case study in population management in Africa having managed to lower its population growth rate from a high of four per cent inter-censally in the late seventies to early 80's to about two per

cent t per today. It has also a compulsive case on maternal child health and family planning.

1.0. Kenya bisected almost into two halves by the equator, enjoys a warm and tropical climate contrasted with the cold and dry continental climate characterized by four seasons, summer, autumn, spring and an extremely cold winter found in Mongolia. Kenya attained her independence from the British in 1963 while Mongolia became a nation state and independent in 1921 and was thereafter under the communist yoke until 1991.

2.0. The two countries have very different population sizes. While Mongolia has 2.6 times Kenya's land surface, Kenya has contrastingly 12 times its population. Mongolia has an estimated 2.5m people while Kenya has an estimated 30m.

3.0. The demographic change historically is equally and markedly different. The first recorded population census in Kenya was in 1948 when only the African population was counted. Thereafter censuses have been conducted in 1962, 1969, 1979, 1989 and in 1999. Kenya is one of the few countries in sub-saharan Africa to have consistently conducted reliable and regular population censuses. This scenario is contrasted with that of Mongolia where there has been a longer history of population censuses. The first census dates back to 1918, two years before Kenya became a colony of the British. Thereafter censuses have been conducted regularly as in Kenya. This has provided both countries with a reliable census database for analysis.

4.0. Perhaps one of the most glaring contrasts in the demographic landscapes is found in the character of the respective population growth rates of the two countries. According to historians, the population of Mongolia was declining for 300 years until the beginning of the 20th Century. The rate of growth was slow until the 1950's. Some of the reasons attributed to this slow growth include the economic instability that was experienced in Mongolia between the revolution of 1911 and the advent of the Second World War, unusually high mortality, out –migration of people during the revolution, internal conflict and loss of lives during the political repressions in the 1930's. Between 1918 and 1928 the population increased by 100,000 persons. In 1930 the growth rate was only one percent. During this period no records exist in the case of Kenya. Available figures show that the population growth rate in Mongolia was 2.8% between 1963-69 compared with 3.2% for Kenya between 1962-69. Between 1969-79 it grew by 2.9 per cent compared with 3.8 percent for Kenya between 1969-79.In the decade 1979-89, the growth rate in Mongolia declined to 2.5 per cent while that of Kenya declined to 3.34 per cent. In the last decade the growth rate declined even further in Mongolia to 1.4% (1989-2000) while in Kenya it declined to 2.7%. It is clear that the population growth rates in Mongolia have over time been consistently lower than in Kenya. In the late 1970's and early 1980's, Kenya had the highest growth rates in the world reputedly at 4% p.a. While the growth rate was consistently above 3% for two decades, 1962-89 that of Mongolia was consistently below 3% inter-census. While this growth rate started declining in the early to mid-Seventies, it did not start in Kenya until the late 1980's.

5.0. There appears to be insufficient published time series data on total fertility rates (TFR) in Mongolia and that on crude birth rates appear to cover only a short period. However, available figures show that in 1989 and 1999 the crude birth rate (CBR) was 36.5 and 20.4 per one thousand respectively. The fertility rate figures for Kenya are high. Between 1962 and 1969 the total fertility rate (TFR) was already a high of 7.6 children per woman. The 1970's and 1980's saw a rapid increase that reached 8.0 in 1979 before declining to 6.7 in 1989 and 5.4 a decade later. Certainly these levels were some of the highest in the world at the time. The major causal factors were social-cultural norms that positively identified with the desire for large families, low contraceptive prevalence, absence and poor distribution of reproductive health services, lack of knowledge on contraception and to some extent the high infant mortality found in some of the traditional societies.

6.0. From the time of the first population census in Kenya (1948), the level of both infant and child mortality has been high as was the case in most developing countries. Throughout the 1960's infant mortality was above 100. The under five mortality had reached 192 in 1969 before declining to 157 in 1979.By 1993 it had declined further to 96.As a result of the Hiv/Aids scourge however, there was a rise in overall morality and the under five mortality rose to 106 between 1993 and 1998. As shown by extant data, mortality in Mongolia was high for a long period particularly before the 1970's. However current figures show a decline. In 1970 the crude death rate was 12.5/1000. This declined to 8.5 in 1990 and eventually to 6.6 in 1998.The level of infant mortality in Mongolia stood at 65 per1000 live births in the five years preceding the 1998 Reproductive Health Survey whereas that of children under-five was 81. While the trend has been one of decline in both countries save the late surge in Kenya as a result of the Hiv/Aids in the 1990's, the levels in Mongolia have consistently been lower compared to those in Kenya. Indeed they are currently still lower. The difference over time has not been very large however.

As in Kenya and other developing countries, mortality is higher in rural than in urban areas in both countries.

7.0. Population policy development is very crucial in any country that seeks to make progress in population management. This is one area where Mongolia has lagged behind Kenya. Whereas Kenya was the first country in sub-sahara Africa to adopt a population policy in 1967, Mongolia did not do so until 1996. Whereas there is no space here to delve into the reasons why, it is clear that the very rapid population growth rate in Kenya spurred the process towards the adoption of a population policy that formed the basis for addressing the then emerging problems. The other main difference on the other hand, is that whereas Kenya has an anti-natalist policy, Mongolia has a pro-natalist one which is meant to increase the slow population growth rate.

8.0. Migration is a phenomenon that is of concern to both countries. Urban migration is of particular concern because of its consequences in the recipient towns and cities. In Kenya the urban population growth rate, which averaged 7.4% in the 1980's, has currently slowed down to 4.6%. Whereas internal migration was controlled previously in Mongolia, but now deregulated, the case for Kenya has never been of great concern. Internal population migration in Kenya has been evident in cases where population has moved from the high population density and usually rich agricultural areas to the towns and in

such of other areas for agricultural settlement, which are usually marginal. In the dry areas of Kenya the population density is often as low as 5 persons/sq/km. but reaches a high of 1500 in the agriculturally productive regions in central, western and parts of south-west. This phenomenon is seen also in Mongolia where almost one- third of the population is concentrated in the capital city of Ulaan Baatar with a density of 161 persons per sq.km (2000). However the regional population distribution is much lower in Mongolia with some regions having less than one person per sq/km such as the eastern and southern region. Mongolia is certainly one of the most sparsely populated countries in the world.

9.0. The impact of high prevalence of HIV/Aids in Kenya has tended to lower the life expectancy in the last decade because of increased infant mortality. This index has declined from 61 and 59 years for women and men respectively in the mid-1990's in Kenya, to the current 49.9 and 48.7 years respectively. The average Mongolian is leaving longer than his Kenyan counterpart. In 1998 the life expectancy in Mongolia was 64.1 and 62.5 for women and men respectively and is rising.

10.0. Family planning knowledge and use is one of the key factors affecting the population dynamics in any country. According to findings of two reproductive and health surveys done in both countries in 1998, there are significant differences in both the levels of "ever use" and "current use" of family planning methods. Whereas the level of ever use of a family planning method stood at 84%, that in Kenya was 64%. Whereas the level of current use stood at 60% in Mongolia that of Kenya was only 39 % though knowledge about contraceptive methods was virtually universal in both countries. Differences exist also in the methods used to control fertility as revealed in these surveys. Whereas the Intra-Uterine Devise (IUD), is by far the most commonly used (32%) in Mongolia, followed by periodic abstinence while other methods are virtually insignificant, the injection ranks as the most widely used (12%) in Kenya followed by the pill and female sterilization. Contraception use is higher in urban than in rural populations in both countries. It is important to note that whereas abortion is legal in Mongolia it is illegal in Kenya and is not likely to be legalized in the near future. Whereas it is not considered a method of contraception in both countries, it is an important factor to take note of in fertility management.

11.0. AIDS has become one of the most serious public health concerns all over the world. Sub-saharan Africa is one of those regions that has been seriously affected and afflicted. Kenya finds itself as one of those countries with high prevalence. In some of the sentinel sites prevalence levels of 15-20% of the population tested have been found. In 2002, about 2.2m persons are estimated to be HIV positive in Kenya. Whereas it is difficult to generalize the prevalence for the whole population, it is however estimated to be around 10%. Obviously there are great variations between regions. Mongolia on the other hand has not been seriously affected. The institutional development to counter the spread of this scourge in Kenya is advanced with a multiplicity of local and international NGO's involved in all aspects of the national program. According to the 1998 Mongolia Reproductive Health Survey, the first national program against HIV and AIDS was established in 1987 and in 1992 the National AIDS Committee was created under the leadership of the Prime Minister. However there have been very few reported cases of HIV/AIDS but a

fairly high prevalence of other STD's. Knowledge of HIV/AIDS is very high in both countries but misconceptions about the transmission and the character of the disease are common in both cases. This knowledge is characterized in both countries by differences in regions, levels of education, exposure to media as well as area of residence.

12.0. It is no doubt that this overview which was meant to give insights into the comparative demographic landscapes of the two countries, has shown that interesting differences exist that may be of curiosity to some readers and may be a basis for further reading. This discourse is however not sufficient for drawing lessons because no deeper analysis was intended and therefore afforded here.

Bibliography:

1. "Kenya Population Policy for Sustainable Development" –Republic of Kenya, Government Printer- 2000

2. National Report- "Reproductive Health Survey, 1988"; National Statistical Office/UNFPA, August 1999

3. "Kenya Demographic and Health Survey, 1998",- National Council for Population and Develoment/ DHS- Macro International Inc., Maryland/Central Bureau of Statistics, Sept.1998

4. "The Main Results", 2000 Population and Housing Census- National Statistical Office, Ulaan Baatar, Mongolia, July 2001