AN INVESTIGATION OF FACTORS INFLUENCING ACCEPTANCE
CHOICE AND USE OF MODERN CONTRACEPTIVE METHODS BY
WOMEN IN LURAMBI DIVISION IN KAKAMEGA DISTRICT

BY

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DECLARATION

This Thesis is my original work and has not been presented for a degree in any other University.

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This work is dedicated to my dear loving parents. My Mother Sellah Indimuli and My father Shadrack Indimuli Murundu.

Above all, thanks to God whom I have been depending on throughout the course of study.
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Above all, thanks to God Almighty for Grace, Strength and Sustenance throughout the course of study.
ABSTRACT

This was a survey research into factors influencing acceptance, choice and use of modern contraceptive methods by women. The major objectives of this study were to (1.) Establish the extent of acceptability and use of modern contraceptives by the respondents. (2.) Determine the social, economic and cultural factors influencing acceptance, choice and use of modern contraceptive methods. (3.) Determine the respondents knowledge, attitude and practise towards use of modern contraceptive methods. (4.) Identify perceived side effects of modern contraceptives used by the respondents. (5.) Identify beliefs, misconceptions and rumours held by the respondents about the use of modern contraceptives. (6.) Identify the problems encountered by the respondents as regards information, education and communication (IEC) and accessibility to modern contraceptive methods and services.

The data for this study were collected using an interview schedule which was administered by the researcher to a sample of 100 women residing in Lurambi division Kakamega District from December, 1994 to April 1995. The analysed data were presented in frequency distributions, percentages, and Pearson Product Moment Correlation Coefficient.

The results showed that the most represented age-group was 25-29 years. Most of the women (76%) were currently married. The most represented income group was between Ksh. 4,001-6,000, while 'O' level with additional period of training was the educational level most represented. Fifty seven respondents (57%) were gainfully
employed. Most of the respondents were protestants. Sixty seven (67%) women had used a modern method of contraceptive before, while only half the women (50%) were current users of modern contraceptives.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Many people tend to believe that the practise of family planning is a new phenomenon, yet family planning has been with us for generations now. This is probably because until recently, family planning or birth control was not being given the publicity it deserves.

However, the idea of family planning has been received with mixed feelings all over the world. According to Oucho (1988), the initial response to the Family Planning idea may be either positive or negative. Usually, the initial attitude is irrationally prejudiced until it is moulded by knowledge or informed judgement. However, in some communities, its reception has rather been low-keyed probably owing to the beliefs and values of those communities.

In the United States for example, the first family Planning Clinic was opened in 1916 by a nurse, Mrs. Margaret Sanger (Hagenfeldt, 1988), whereas in Britain, the first two birth control clinics were opened in 1921 (Law, 1973). The organization of Family planning services in Britain owes its origin to the pioneer work of Marie Stopes and others (Barnes, 1976).
In Latin America for example, Viel (1988) points out that not all Latin American Governments support Family Planning. The traditional opposition of armed forces to Family Planning has been a strong factor in the reluctance of the Latin American Governments to support it. Contrary to this, Governments in Asia have been pioneers in fertility regulation and since the early 1970's most countries in Asia have adopted policies to reduce their levels of fertility (Concepcion, 1988). In India for instance, the Government adopted a national Family Planning Policy 40 years ago (Visaria and Visaria, 1992); whereas in Thailand, Concepcion (1988) notes that the Government’s population program has adapted a policy to reduce the size of the family to no more than two children.

The need for a population policy was felt in most Middle East countries, where the family institution was regarded to be sacred. Hathout (1988) found out that, Islam permits contraception as long as it does not entail the radical separation of marriage from its procreative function. Family planning is not a new phenomenon in African society. It has always been with us. The most usual form of traditional contraception was abstinence.

However, according to Sai and Newman (1988), during the early 1970's it was argued that Family Planning was a veiled attempt by the white race to eliminate or keep down the number of non-white races. This probably could be one of the reasons why in African countries South of Sahara, about 90% of fertile couples do not practise any form of modern contraception (Germain, 1987).
Raising standards of living in poor nations will first and foremost require planning of family sizes so that the available resources can reasonably support them. According to Mugenda and Mugenda (1992), it is for this reason that over the last three decades, the Government and Non-Governmental organizations have embarked on Family Planning Programs in Kenya. The Kenyan Government recognized the importance of Family Planning in 1966 and officially adopted a Family Planning Policy in 1967 (Mutie, 1989).

1.2 PROBLEM STATEMENT.

The provision of Family Planning services remains one of the most important reproductive health issues in Kenya today. Kenya was the first country in sub-saharan Africa to adopt a family planning policy and since then, there have been several programs which have been set up with mixed success (Mutie, 1989). For about three decades, Kenya has had family planning programs which have been managed by the Government and various Non-Governmental organisations. During this period, numerous research studies in various aspects of family planning services have been conducted with the overall objective of increasing the number of new acceptors of family planning methods (Miller et. al, 1992). Despite these efforts, Kenya continues to experience a high population growth rate at 3.6% per annum, (KDHS, 1989; Mwangi et. al, 1992). This growth rate is one of the fastest in the world. If this trend continues, Kenya will have a population of about 33.2 million by the year 2000 (Mwangi et. al, 1992).
Recent studies (KDHS, 1989; Mugenda and Mugenda, 1992; KDHS, 1993) indicate that the level of awareness of family planning methods stands between 90%-96% (for women aged between 15-49). Although this is encouraging development, the KDHS (1993) findings indicate that only 26% of women surveyed are currently using modern contraceptive methods. This is a slight improvement from the 18% observed in the 1989 KDHS. The above figures show a big gap between awareness and usage of modern contraceptive methods hence, need for further research in this area. Results from the KDHS 1993, show that, the vast majority of women want either to space their next birth or limit child bearing. These can be considered to be potentially in need of family planning services.

A better understanding of the factors influencing women's choice and use of contraceptive methods is needed so that administrators and policy makers can determine the most appropriate type and balance of methods to be made available in family planning programs (WHO, 1980). Barnes (1976) and WHO (1980), explain that, a woman’s choice of a contraceptive method is complex and preferences may be only lightly held and readily subject to modification.

So, despite concerted and expensive efforts by the Government of Kenya, contraceptive use still remains low at 26% (KDHS, 1993), yet studies by Mugenda and Mugenda (1992), and KDHS (1993), indicate that the level of the awareness of Family Planning has gone up to between 90%-96%. According to the KDHS (1993), of the currently married women, 97% know of a method of Family Planning but, only 33% are
currently using a method for contraception. Oniang'o and Rogo (1989), and Kaseje and Otieno (1989) draw similar conclusions that, although many women continue to use or claim to use traditional and less effective methods of contraception, the beliefs, rumours and misconceptions about contraceptives as well as fears of side effects and uncertainty about how the husband would react to the idea of Family Planning, make women reluctant to use modern contraceptives. Germain (1987) and KDHS (1993) point out that many women who do not desire another pregnancy are not using contraceptives. Thus, there exists a disparity between knowledge, attitude and practice of Family Planning.

In spite of the growth of the economy, the problems associated with a rapidly growing population have seriously complicated the country's economic and social plans. A slowdown in the current rate of population growth is absolutely necessary if Kenya is to hope to make headway with its development plans (ROK, 1988). The proposed study is therefore aimed at investigating the factors that influence the acceptance, choice and use of modern contraceptive methods by the women.

Several studies (KDHS, 1989; Maillard, 1985; Oniang'o and Rogo 1989; Kaseje and Otieno, 1989; Mugenda and Mugenda 1992; KDHS 1993) investigating factors associated with the choice and use of contraceptives have been conducted, but few have investigated why women choose specific methods. Kahley and Gillaspy (1976) in their study found out that income levels, education, parity and age were associated with the individual's contraceptive choice.
Although more than half the world population are men, family planning has mainly been left to women. For some strange reasons, men have been alienated from family planning by design and fate as most family planning programs are female oriented (ROK, 1988). Men are critical to the success of family planning programs, increasing acceptance and effective use of both male and female methods of contraception. Muindi (1992) points out that the biggest role men have in family planning is to support their wives in their endeavour to use various family planning methods by psychological, material and personal understanding. Currently within family planning programs male involvement is often viewed negatively and men’s opposition or indifference to family planning is often identified as a major constraint to program development and implementation (IPPF, 1984). If men were motivated to use effectively the few male oriented family planning methods, then the same goal of limiting family size could be achieved (ROK, 1988).

1.3 PURPOSE OF STUDY

The purpose of this study was to investigate the determinants of acceptance, choice and use of modern contraceptive methods by women in Lurambi Division of Kakamega District.
1.4 **OBJECTIVES OF THE STUDY**

The study was designed to:

a) Establish the extent of acceptability and use of modern contraceptive methods by the respondents.

b) Determine the social, economic and cultural factors influencing acceptance, choice and use of modern contraceptive methods.

c) Determine the respondents’ knowledge, attitude and practice towards use of modern contraceptive methods.

d) Identify perceived side effects of modern contraceptives used by the respondents.

e) Identify beliefs, misconceptions and rumours held by the respondents about the use of modern contraceptives.

f) Identify the problems encountered by the respondents as regards Information Education and Communication (IEC) and accessibility to modern contraceptive methods and services.

1.5 **SIGNIFICANCE OF STUDY**

The findings of this study serve as contributions to home-economics education in the following ways: Since Home Economics is primarily concerned with strengthening family life as well as, helping families and individuals cope with change and use available technology to enrich their lives; knowledge of the latest Family
Planning technologies and devices will help the women plan their families more effectively. This in turn will result in better maternal and child health hence lower Maternal and Child Mortality rates in the country. It also adds to general knowledge by the women in knowing about the various methods available; their advantages and disadvantages, and being able to choose a method confidently.

1.5 LIMITATION OF THE STUDY

Another major contribution of this study is that it has highlighted the factors that influence women in choice and use of modern contraceptives. These factors included income, number of children alive, educational level, age, rumours/beliefs, spread of HIV/AIDS, knowledge of family planning and various sources of information on Family Planning sector could adopt these factors and put them into use in improving the existing and future family planning programs.

1.6 DEFINITION OF TERMS

The study also identified the socio-economic and demographic profile of the respondents. Therefore, all campaigns to promote use of modern contraceptives should be directed at this target group. The government through the Ministry of Health, The Family Planning Association of Kenya, The Family Planning Private Sector and other Non-governmental Organisations should co-operate in developing appropriate marketing strategies for the modern contraceptives for this target group.
The study assessed and confirmed the fact that although a majority of the women were aware of family planning, half of them preferred to use natural methods of family planning. This adds further strength to the purpose of this study and also calls for further research in the area of factors hindering use of modern contraceptives.

1.6 LIMITATION OF THE STUDY

Since the study was limited to a sample of the population within Kakamega District, any implications and generalizations of the study findings to other areas in the district and in Kenya can only be done with caution since contraceptive choice priorities of Kenyans differ from one area to another.

1.7 DEFINITION OF TERMS

Contraceptive

The Longman Dictionary of contemporary English defines a contraceptive as a drug, object, or method used as a means of preventing an act of sex from resulting in a woman becoming pregnant. In this study, contraceptives will refer to the various drugs (pills), objects (IUDs, Barrier Methods) and other methods (sterilization both male and female) of contraception employed.
Contraception

This refers to the act or practice of preventing sexual intercourse from resulting in the birth of a child, and/or the methods for doing this. In this study, the term will be used as defined above.

Family Planning

Family Planning is defined in various ways but simply, it is the spacing and number of children. The Longman Dictionary of Contemporary English defines Family Planning as the controlling of the number of children born in a family and the time of their birth by the use of any of the various contraceptive methods. In this study, the term will be used as defined above.

Modern Contraceptives

The term is used to refer to all those artificial methods of contraception including oral contraceptives, IUDs, injections, implants, male and female barrier methods, and both male and female sterilization.
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 AN OVERVIEW

In the contemporary world, Family Planning is usually associated with the use of contraception to limit family size (Lema, 1988). According to Kigondu (1988), contraceptive technology is what is really new and not the whole idea of Family Planning. However, due to urbanization and the adoption of a western way of life, traditional birth control measures are no longer practised on a large scale.

Family Planning is an essential component of any broad-based development strategy that seeks to improve the quality of life for both individuals and communities (Maine, 1982). To stress this further, Germain (1987) explains that there is need not only to strengthen Family Planning Programs but also, make them accessible and acceptable for all women and girls in need. Family Planning is a basic human right and Governments should be encouraged to translate this right into realistic policies and programs which meet the needs of their people (Inayatullah, 1988). With increasing development the idea of Family Planning and Fertility regulation becomes more acceptable and Family Planning Programs serve mainly as catalysts. Mugenda and Mugenda (1992) and Concepcion (1988) as well as results from the KDHS (1993) indicate that the gap between awareness, and usage of Family Planning Service is big;
hence the need for Information Education and Communication (IEC) programs to create more awareness on contraceptive use and clear the public's misconceptions of the new contraceptives.

Literature will be reviewed under the following sub topics:

(a) Family Planning in Kenya
(b) The Role of Women in Family Planning
(c) The Role of Men in Family Planning
(d) Aids and Family Planning
(e) Modern Contraceptive Methods
(f) Factors influencing Acceptance, choice and Use of Modern Contraceptive Methods
(g) Conclusion

2.2 FAMILY PLANNING IN KENYA

The Government of Kenya recognized the importance of Family Planning in 1966 and officially adopted a Family Planning Policy in 1967. Since then, Miller et. al. (1992) note that several Family Planning programs have been administered by the government of Kenya, through the Ministry of Health; and these have been integrated with Maternal and Child Health (MCH) services. Although this led to program expansion and increase in visits to the Family Planning Clinics, Oniang'o and Rogo (1989) explain that, the impact on reducing population growth remained low mainly due to shortage of qualified staff, poor rural coverage and non-expansion of the Family
Planning Service infrastructure, hence need for change in the approach to the whole idea. It is the need for change that necessitates the need for new solutions and make recommen
dations.

The growth of the Family Planning movement in Kenya owes a great deal to the efforts of Volunteer Physicians and lay persons. According to Kigondu (1988), contraceptive services and supplies have been available in Kenya since the early 1950's for Africans and even earlier for the white minority. Dr. S. N. Mwathi pioneered the delivery of these services in Kenya for the Africans in 1950's (Oucho,1988). However, these were received with mixed feelings amongst some African communities who believed that one's wealth was determined by the number of wives and children one had (Oucho, 1988; Oniang'o and Rogo, 1989; Kaseje and Otieno, 1989).

Modern contraceptive techniques have been available in Kenya through private practitioners for many years. Kigondu (1988) explains that voluntary Family Planning efforts by individuals and Family Planning associations started in Nairobi and Mombasa in 1955, mainly to make people aware of Family Planning and provide them with modern contraceptive methods. In 1960, the Nairobi and Mombasa Associations were merged into the Family Planning Association of Kenya. This became an affiliate member of the International Planned Parent-hood Federation in 1962 (Kigondu, 1988). Kigondu further explains that the main aim of the Family Planning Association of Kenya was to help those who needed the Family Planning Services.
The high rate of population growth and its effect on economic development prompted the Kenya Government to invite a population advisory mission to study the situation and make recommendations in 1966. This culminated in the formation of the National Family Planning Program in 1967 (Mott and Mott, 1980; Mutie, 1989; Mwangi et. al., 1992). However, instead of achieving the target, a significant increase occurred that raised the annual growth rate to about 3.8% in 1979 (Mott and Mott, 1980; Mutie, 1989; Oniang'o and Rogo, 1989; Mwangi et. al., 1992). At this stage, the Government decided to form the National Council for Population and Development (NCPD). It was formed in 1982 and was expected to co-ordinate the activities and non-governmental organizations involved in the Integrated Rural Health Family Planning Programs. It was also to formulate population policies and strategies, and to co-ordinate growth rate.

The Family Planning Policy of Kenya Government is aimed at enhancing the health of the mother and child in order to reduce fertility rate. This has not changed since the 1960's and 1970's as is observed by (Kigondu, 1988; Mutie et. al., 1992; Mwangi et. al., 1992). According to Mutie (1989), Maternal and Child Health and Family Planning services are offered by the Government of Kenya; Non-Governmental Organizations and Private practitioners free of charge or at a small fee. The extent of the government's involvement in the Family Planning Program has increased tremendously since the establishment of the National Council for Population and Development (NCPD) in 1982. The practise of contraception has gone up more than 40%-50% since 1984 (i.e. from 17% to 27%). Fertility rate has declined from 6.7 % in 1989 to 5.4 % in 1993 (KDHS 1993; Mugenda, 1992). There are now approximately 1,700 Family
Planning clinics and Community Based Distribution points excluding outreach clinics (Mugenda and Mugenda, 1992). This is an improvement from 1,200 clinics in 1989 (Mutie, 1989; Maneno and Mwanzia, 1991). Despite the impressive performance documented above, there is considerable unmet demand for Family Planning services in Kenya (Githinji, 1992). The Government's short term objective is to close this demand gap; a fact that is reiterated by Mugenda and Mugenda (1992) and the KDHS (1993).

2.3 THE ROLE OF WOMEN IN FAMILY PLANNING

Although women world-wide are voicing their concerns about Family Planning and trying to fight for their rights of freedom of contraception choice; they are not getting the necessary support financially and morally from the society (Norsigian, 1987). Also, arguing in favour of the above thought, Maillard (1985) lays emphasis on the role of women first as individuals and secondly as being with sexual prerogatives of their own. They cannot be relegated to the reproductive function alone although this is a function that is physiologically suited to them. Women are thus entitled to a fully-fledged status as individuals and social beings in society.

Both Sai and Newman (1988) and Maillard (1985) agree that Family Planning helps the woman to have children when she wants them and when it is deemed appropriate; Family Planning then helps to restore the health of the woman. Maine (1982) points out that, given a choice, women can avoid high-risk pregnancies. Family Planning thus makes a substantial contribution to maternal health (Githinji, 1992).
Control over reproduction is a basic right for all women. Early entry into reproduction and marriage, and high fertility without access to medical services, endanger Third World Women's health and their lives, and curtail their opportunities for education, employment and social and political participation (Germain, 1987). In addition, Germain (1987) points out that, millions of women who want to limit or space births do not use modern contraceptives because they fear the technology; find services unavailable, inaccessible, or unacceptable. They are also restrained by partners, family, or the community; or they lack information. Both Maine (1982) and Germain (1987) agree that if these women were able to put their wishes into practice and prevent unwanted births; many unnecessary infant and maternal deaths could be avoided.

The status of women is of great concern to Africa. Sai and Newman (1988) point out that in some African countries, fewer than 20% of the school children are girls, yet female education is directly related to women's control over their fertility. Women's use of contraceptives increases with their access to education. Recent studies (Mugenda and Mugenda, 1992; and KDHS, 1993) indicate that between 80-82% of the women under study had some form of formal education. In Bangladesh, the Government recognizes that high status of women favours planned parenthood, and therefore, encourages women's education, training, employment and participation in public affairs (Concepcion, 1988). Sai and Newman (1988) reiterate the fact that small family sizes greatly improve women's capacity to realize their potential and participate in national development.
Although modern contraceptives are available in many parts of the world, many people are not using an effective method of contraception; and in some countries, many women do not know of a source to obtain Family Planning Services (Maine, 1982). The KDHS (1993) results indicate that, 93.5% women in Kenya know of a source of Family Planning Service, but only 26% of the women under study are currently using an effective method of contraception yet, 46% of the women want no more children. Of all women, only 9% have been sterilized.

According to Adamson and Adamson (1993), an estimated 300 million couples in the developing world do not want more children but they are not using any effective means of contraception. They further suggest that, if women had the power to make their own decisions on family planning, family sizes would be greatly reduced.

2.4 THE ROLE OF MEN IN FAMILY PLANNING

For a long time, men have not been actively involved in modern Family Planning. Although more than half the world population are men, Family Planning is mainly the concern of women. For some strange circumstances, men have been alienated from Family Planning by design and fate as most Family Planning programs are female oriented (ROK, 1988). There are only two modern contraceptives for men as opposed to more than ten for women. Men feel alienated because there is no forum for them to articulate the issue (Muindi, 1992). Khasiani and Muganzi (1989) point out that men's perception of Family Planning is that, contraceptives are a women's affair and
some men do not like Family Planning because it was first introduced to women.

Men have a responsibility to ensure that women's contraceptive decision-making rights are respected, and have a right themselves to participate in this decision making (IPPF, 1984). Family Planning should be accepted as a philosophy of life for men in the modern world (Muindi, 1992). Male attitudes towards contraception are bound to have a significant effect on success or failure of Family Planning Programs. Certainly, male attitudes have changed due to the increased cost of living and the realization that investing in children means forfeiting other comforts of life (Muindi, 1922).

In the current economic recession, families throughout the world are experiencing increasing financial difficulties, hence men are especially sensitive to the economic advantages of Family Planning (IPPF, 1984). Family Planning will have tremendous impact on lives of families once men are meaningfully involved in their activities. It is no longer tenable for Family Planners and other agents of social change to go assuming that men are ignorant about their families' quality of life (ROK, 1988).

In certain countries and cultures, men have the right to make decisions about fertility, and they can deny women access to Family Planning services for various reasons (Sai and Newman, 1988). As husbands and Family heads, men should be involved in Family Planning decisions and since reproduction cannot take place without them; on biological grounds men have a responsibility to be involved in the Family Planning decision making (IPPF, 1984). Men are critical to the success of Family
Planning Programs, in increasing acceptance, and effective use of both male and female methods of contraception. The knowledge of contraceptives among men is equally high but the patterns of use are low (KDHS, 1989; KDHS, 1993).

Since fertility performance is held in high esteem by men, any attempt to hamper this propensity would be portrayed as a problem (ROK, 1988). Family Planning Programs therefore have to be seen to have potential to enhance the positive aspects of this subtle concern. The biggest role that men have in Family Planning is to support their wives in their endeavour to use various Family Planning methods by psychological, material and personal understanding (Muindi, 1992). Currently within Family Planning Programs, male involvement is often viewed negatively and men's opposition or indifference to Family Planning is often identified as a major constraint to program development and implementation (IPPF, 1984). If men were motivated to use effectively the few male oriented Family Planning methods, then the same goal of limiting family size could be achieved (ROK, 1988).

2.5 AIDS AND FAMILY PLANNING

Aids is like a misery-seeking missile, spreading fastest where health care and education is poor. Dossier (1988) points out that it is becoming a disease of disadvantage of women and children, as well as of men, targeting the most vulnerable third world communities. A steep increase in the number of Aids cases is being observed throughout the world. Of the 6 million HIV-infected people, it is estimated that
10-30% will develop AIDS during the next 5 years (WHO, 1990).

Doomsday theorists have predicted that AIDS will result in the massive depopulation of heavily affected areas (Dossier, 1988). A report by MOH (1993) agrees with the above fact that AIDS will have a significant impact on population size. However, it will still grow by over 30% by the year 2005. Currently the issue of declining population due to AIDS is one of extreme political sensitivity. At present, the level of uncertainty attached to population forecasts vis-a-vis AIDS is great (Dossier, 1988).

In contrast to most health problems which affect either the very young or the elderly, AIDS strikes mainly those in the age group 20-49 years (WHO, 1990). AIDS also affects mothers and children. In some areas, the increase in infant mortality from HIV infection may offset the progress being made in Maternal and Child Health Programs (WHO, 1990; MOH, 1993).
supplies of safe, effective and acceptable contraceptives (WHO, 1990).

Non-barrier Contraceptives such as the IUD have no protective effect against HIV transmission. When carefully and consistently used, condoms offer effective protection against transmission of HIV and other STD's (WHO, 1990; PCC, 1991).

The global menace of AIDS cannot be overstated. As the number of AIDS cases rises steeply over the next years, the economic, social, political, and cultural effects will be dramatic. In the developing world, the additional burden of AIDS on already strained health resources will be enormous (WHO, 1990). In order to reduce the rate of spread of AIDS, Collier and Donnelly (1991) suggest that, people everywhere, whatever their cultural or religious perspective, must face the challenge posed by HIV. It is a challenge that requires each of us to reconsider our traditions, morals and values and to respond positively to the pandemic.

2.6 MODERN CONTRACEPTIVE METHODS

The search for ways and means of preventing unwanted pregnancy started thousands of years ago and is still going on (Law, 1973; Barnes, 1970; Maillard, 1985). Religious attitudes and cultural practices have impeded progress in this field and still continue to do so (Mott and Mott, 1980; Macklin, 1988; Kaseje and Otieno, 1989; Caldwell et.al, 1992). In Sub-Saharan Africa, Germain (1987) points out that contraceptive use is exceedingly low and modern contraceptives are mainly suited to
women and do not allow men to share the side effects and risks of contraception. Due to the present economic hardship more and more couples are realizing that it is advisable to have smaller families, and this can only be achieved by use of reliable contraceptive methods (Law, 1973; Maillard, 1985; Mwangi et. al, 1992). Law (1973), Barnes (1976), and Maillard (1985) all agree that the perfect method of Family Planning has not yet been discovered and so we should make the best use of those that are available to us. There is need to know the basic facts about the advantages, disadvantages and potential efficiency of methods available on the market (PCC, 1991).

Combined oral contraceptives are available in many countries and there are an estimated 65 million women who use them world wide (Hagenfeldt, 1988; PCC, 1991). The pills contain varying doses of synthetic hormones that suppress ovulation, thicken mucus to block passage of sperms and thin the endometrial lining (Law, 1973; Barnes, 1976). The pill is quite effective with one out of one hundred becoming pregnant. It reduces menstrual cramping, pelvic infections, ovarian and uterine cancer amongst many other advantages (PCC, 1991; Barnes, 1976). However, it is contraindicated for older women, who risk suffering cardiovascular disease.

Several studies carried out (Indonesia DHS, 1987, Mc Ginn et. al, 1989, Hagenfeldt 1988, Zimbabwe DHS, 1989) found out that the pill was more popular among contraceptive users than the other methods. In the KHDS (1993) of the 28% currently married women using modern contraceptives, 10% were presently using the pill. The survey also reports that 95% of the women under study were aware of the pill
as a method of contraception. In a similar study carried out by Mugenda and Mugenda (1992) of the 92% of new clients who chose a Family Planning method, 40% chose the pill. However, the use of the pill has not been that successful without any obstacles. The church in Kenya especially the Catholic Church has been known to strongly oppose the use of the pill. Those who use the pill or favour use of the pill do so primarily because they recognize that it is a highly effective method (Ogawa and Retherford, 1991; Ajayi et. al 1991).

The use of Intra-uterine Devices (IUD's) goes back to the 1950's when they were first developed in Japan (Barnes, 1976). According to Hutchings et. al (1985) and Treiman and Liskin (1989), IUD's have been used throughout the world for almost three decades; and millions of women have found them very effective, safe and convenient. There are about 8 types of plastic-based IUD's that release copper e.g. The copper T 380A, TCU-220C, Nova T, MLCU-375 and LNG-20 and others. These mostly have either copper or hormones added to a plastic frame and is released into the body (Barnes, 1976; Treiman and liskin, 1989). Side effects include severe bleeding, abdominal cramps, risk of infertility and ectopic pregnancy (Barnes 1976, Maine 1982, Hagenfeldt 1988). But contrary to the above perceived side effects, Treiman and Liskin (1989) argue that all - plastic IUD's do not increase the risk of ectopic pregnancy. In fact, these IUD's provide some protection against them.
Several studies indicate that levels of IUD use have gone up (Hagenfeldt, 1988; Mahran, 1988; Treiman and Liskin, 1989). Although this may be true for the developed countries, in Sub-Saharan Africa, levels of IUD use are generally the lowest in the world (Treiman and Liskin, 1989). In Kenya for example, results from the KDHS (1993) indicate that overall, only 4% of women aged 15-49 years were current users. In support of the above figures, Mugenda and Mugenda (1992) in their study found out that only 16% of women surveyed were currently using IUD's for contraception. This in fact shows a drop in use of IUD's.

Two long-acting injectables are widely available depot-medrogestrone acetate (DMPA; trade name Depo-provera) and norethindrone enauthate (NET EN; trade name Noristerat). Both are highly effective, reversible methods (Hagenfeldt, 1988; Mahran, 1988). Although injectables have proved popular, Liskin and Blackburn (1987) point out that, controversies about DMPA causing cancer in the long run have limited their availability in some areas. These injections are given every three months. Failure rates are less than 1-2% (Mahran, 1988). The injections are administered in the first week of menstrual cycle to ensure that the woman is not already pregnant at the time of injection. The injectables are however contraindicated for women with breast or genital cancer, abnormal uterine bleeding and those who are pregnant (WHO, 1982; PCC, 1991).
Injectables are currently the only widely used long-acting hormonal contraceptive. An estimated 6.5 million women are using them (Liskin and Blackburn, 1987). In Kenya, several studies indicate that use of injectables is quite popular despite some of it's negative effects (Khasiani & Muganzi, 1989; KDHS, 1989; Mugenda and Mugenda 1992). Results from KDHS (1993) indicate that overall, 7% of all contraceptors were using injectables while 14% of the married women were using injectables. This compares favourably with results from other countries (Liskin and Blackburn, 1987; London et.al, 1985).

Contraceptive implants are available as Nor plant which is a set of six capsules that are inserted under the skin of a woman's upper arm. The implants consist of flexible non-biodegradable tubes filled with levonnorgestrel, a synthetic hormone of the progestin family. The hormone is slowly released at a constant rate for several years (Mahran, 1988; PCC, 1991). Developed by the population council, Nor plant has been tested in more than 44,000 women in 31 countries including Thailand, Indonesia, Egypt, Kenya and Zambia (Lubis et. al 1993; Satayapan et. al, 1983; Shaaban et. al, 1983; Kalule et. al, 1989; Whittaker et. al 1989). There is no evidence of serious side effects and the method is effective upto 5 years. The advantages of this method are that it is highly effective, requires no further action until the implants are removed and has no oestrogen side effects (Mahran, 1988). However, Lubis et. al (1983) and Shaaban et. al (1983) do explain that its main disadvantages are that the implants must be inserted and removed by well trained health professionals, they change bleeding patterns, and that they are initially more expensive than short-term methods. The method is not yet quite
popular as it is still rather new. The contraceptive had been introduced in Kenya as early as 1987, but by 1989 54% of the users had already discontinued use citing different reasons ranging from medical-religious-personal (Kalule et. al, 1989). Results from the KDHS (1993) did not report any users or acceptors of Nor plant, proving that the method is not yet popular with women in Kenya, although 14% of the women had heard of the method.

The diaphragm and cervical caps are the most widely used Barrier Methods. Others include vaginal rings, creams, foams, foaming tablets and jellies. These are inserted into the Vagina to cover the cervix, forming a barrier between the uterine opening and the sperms (Law, 1973, Liskin and Blackburn, 1987; Mahran, 1988). However, according to Barnes (1976), they must be properly fitted as they have a relatively high failure rate that is, about ten to thirty pregnancies per one hundred women. Law (1973) points out that barrier methods have no long-term effects, a fact that is reiterated by Mahran (1988), Hagenfeldt (1988), as well as Liskin and Blackburn (1987). In Kenya, use of Barrier Methods is rather high. Results from the KDHS (1993) indicate that 43% women overall aged between 15-49 years were using at least one of the barrier methods available.

Tubal Ligation is a surgical method of female sterilization. The fallopian tubes are blocked to prevent sperms from reaching and fertilizing the egg. The tubes are tied, clipped or cauterized. Failure can occur if the tubes grow back (PCC, 1991; Barnes, 1976). Viel (1988) explains that surgical sterilization has become a simple procedure,
which can be performed outside hospital and with local anaesthesia. According to Hagenfeldt (1988), there is evidence that demand for it is increasing. It is particularly popular in Great Britain and the United States accounting for 21% and 33%, respectively, of all contraceptive use. In Kenya for example, results from the KHDS (1993) indicate that 88% of the women have heard of the method although only 6% of the married women have used the method. This may be partly due to the fact that it is a permanent and almost irreversible method hence the method is more popular amongst the older women (KDHS, 1993; Mugenda and Mugenda, 1992; and Oniang'o and Rogo, 1989).

According to Hagenfeldt (1988), Sterilization raises ethical questions because it requires surgery and is irreversible and this has led to some religions and cultural groups being opposed to contraceptive drugs and devices (Viel, 1988). As a method of contraception, female sterilization has very minor side effects which include pain and discomfort which soon disappear (PCC, 1991).

Vasectomy is a surgical method of male sterilization, done under local anaesthesia. Through an incision made in the scrotum tubes are cut and tied or clipped or cauterized (Mahran, 1988). There are an estimated 45 million male users worldwide with largest numbers in China and India (PCC, 1991). In Kenya results from KDHS (1989) indicate that only 1% of the male have been sterilized, and only 35% of the men knew about the method. It is a highly effective, safe and simple procedure with little long-term medical follow-up. It has no long term effects. It is appropriate for men who
want no more children (PCC, 1991). The method is not immediately effective for the first twelve weeks (PCC, 1991). Sterilization is forbidden on religious grounds in some countries, is a criminal offence in a few, or allowed only on medical grounds in others. Spousal consent is required in some countries as a matter of law (Sai and Newman, 1988).

The condom is still one of the commonest methods in use today (PCC, 1991). It is mostly used for contraception but can also be used for protection against AIDS and Sexually Transmitted Diseases (Law, 1973; PCC, 1991). There are an estimated 45-50 million users world-wide. Use is increasing in many countries in response to spread of Aids (Gordon, 1992; PCC, 1991). They are mostly made of latex (thin rubber). They are placed over an erect penis before sexual intercourse and prevent sperms from entering the vagina (PCC, 1991). Typical use results in five to twenty pregnancies per one hundred users. A new condom must be used with every act to ensure effectiveness. Failure results from irregular or improper use and breakage during use (Law, 1973; Barnes, 1976; PCC, 1991). Sale or distribution outside pharmacies or to unmarried minors is restricted in some countries (PCC, 1991). Results from the KDHS (1989) indicate that only 3.2% of the men were using condoms yet 81.5% knew of the condom as a method of contraception. But with the spread of Aids and other sexually transmitted diseases, use is now increasing tremendously (Gordon, 1992).
2.7 FACTORS INFLUENCING ACCEPTANCE CHOICE AND USE OF MODERN CONTRACEPTIVES

2.7.1 Religious and Cultural Factors

Some religions and cultural groups are opposed to contraceptive drugs and devices, thus, raising the issue of the role of religion in a pluralistic world (Macklin, 1988). Although a religion may impose on its adherents duties and prohibitions, these are morally neutral to others. Viel (1988), for example, explains that the Roman Catholic and Mormon prohibition of contraception has no ethical relevance for adherents of other religious faiths. Catholic teaching still influences governments very strongly, even when the church has been separated from the state (Viel, 1988). Contrary to this, findings from the KDHS (1989) indicated that Religion was not a major obstacle in the practice of contraception as it accounted for only 1% of the non-users. In a study carried out by Mugenda and Mugenda (1992), 95% of all respondents were christians while 3% were Muslims indicating that religion is not really a major obstacle to contracepting. Hathout (1988) reiterates the above fact and points out that, Islam permits contraception as long as it does not entail radical separation of marriage from its procreative function. Any contraceptive methods are acceptable to Muslim scholars as long as they do not lead to abortion. This observation is contrary to the Catholic Church's belief which has a more restrictive view on methods accommodating only "natural contraception" (Viel, 1988). Other churches according to Hathout (1988), seem to be more flexible, and to them the issue is not critical. In Kenya for example, it is the Catholic Church which is known to strongly and openly oppose the use or promotion of
modem contraceptive methods, especially the pill.

Traditionally, a woman got married to give birth to children, hence, a barren woman was treated as an outcast (Oniang'o and Rogo, 1989). Caldwell et. al (1992) acknowledge the fact that, African Traditional Society and Religion stressed the importance of ancestry and descent through children. Both Mott and Mott (1980) and Oniang'o and Rogo (1989), draw a similar conclusion that tribal loyalties and the value placed on children and women (by many rural families in Kenya) continue to dampen national efforts to reduce population growth. Further findings by Kaseje and Otieno (1989), indicate that the preference for sons over daughters, pressures from men and in-laws and male dominance in sexual relations force women to have more pregnancies than they otherwise would. Mott and Mott (1980) reiterate the fact that, the prestige value of children is very important to rural Kenyans. Having many children is seen as enlarging a family's chance for marring into other familial networks and thus enhancing its political and economic strengths.

In some communities such as those in Western, Nyanza and Coast provinces, Khasiani and Muganzi (1989), and Oniang'o and Rogo (1989) point out that polygamy is still culturally accepted although the practice is declining. This practise of polygamy has adverse effects on Family Planning because, a woman with many sons inherits most of the family property, and this leads to competition among co-wives to have more children. If women are to improve their status, Sai and Newman (1988) suggest that, they must control their fertility. But this is made difficult in some cultures
and communities where only men have the right to make decisions about fertility. In some communities, women cannot practise Family Planning without consent of their husbands, for example, results from the KDHS (1989) indicate that 12% of the women could not practise any form of contraception because of disapproval by the husband. According to Kaseje and Otieno (1989) talking to the husband tended to block rather than encourage use of Family Planning. This was due to the fact that traditionally, children came from God. Also, since so many children died, there was need to have so many of them so that others would survive. Therefore, the issue of whether or not to have children and how many to have was not an issue for discussion.

2.7.2 Misconceptions and Rumours about Family Planning

Rumours and misinformation are widespread in many countries, and they seem to be major barriers to contraceptive use (Liskin and Rutledge, 1984; Schuler et. al, 1985; Tucker, 1986). For example, Grubb and Pill Survey Group (1987) report that in a survey among women aged 18 to 45 years in eight Developing Countries, between 20 and 50 percent thought that oral contraceptives caused sterility and birth defects. While many believed these false notions, only 25 to 35 percent were aware of the possible adverse cardiovascular effects of oral contraceptives.

Oniang'o and Rogo (1989) indicate that rumours about contraceptives heard by women adversely affect contraceptive use. A 1977 Dominican Republic Study for example, found out that unfavourable rumours led to discontinuation of a variety of effective methods. Women who had side effects were more likely to discontinue use of
modern contraceptives after hearing unfavourable rumours (Porter, 1984). In a similar observation, Kaseje and Otieno (1989) found out that the hindrances the women experienced were predominantly fears and uncertainties about use of modern contraceptives. Some of the fears and uncertainties mentioned include; fear of husband’s reaction to the idea of Family Planning; fear of side effects; fear of clinic staff; fear of getting pregnant; fear of relatives and friends and fear of being able to manage the method.

According to May et. al (1990) rumours which sometimes are spread deliberately by opponents of Family Planning may also discourage potential users. For example, Liskin and Blackburn (1987), argue that Depo-provera (DMPA) is unsafe because it causes cancer. On the other hand, supporters of DMPA point out that epidemiological and clinical studies provide no clear proof of increased risk of cancer or other harmful effects among DMPA users. According to Treiman and Liskin (1989) further research is helping lift a cloud that has hung over the IUD for many years. Research in the past has shown that use of IUD increases the risk of Pelvic Inflammatory Disease (PID) and subsequently infertility. Newer studies and analyses show that there appears to be virtually no increased risk of fertility in women using copper IUD’S. Similarly, evidence shows that copper and all plastic IUDs do not increase risk of ectopic pregnancies. Infact, IUDs provide some protection against them.
Although many women think that use of the pill causes infertility, on the contrary, use of oral contraceptives does not have permanent effect on fertility (PCC, 1991). However, women may not ovulate or conceive for several months following discontinuation. Bearing this in mind, Lettenmaier and Gallen (1990) suggest that the Family Planning provider should make sure that each client has correct information and can make informed choices about having children and using contraceptives.

2.7.3 Socio-Economic and Demographic Factors

Acceptability of use of any method of modern contraception depends upon many varying factors like age of couple, marital status, size of family desired, educational status of couple and income level (Barnes, 1976). These factors either directly or indirectly influence a couple's acceptance or non-use of modern contraceptive methods. For example, findings from the KDHS (1993) indicate that the desire to limit births increases rapidly with age; by the time women reach their late twenties, almost half have had all the children they want or have already been sterilized. Three-quarters of the women in their late thirties and early forties want no more children. Mugenda and Mugenda (1992) do agree with the above observations. They found out that the average age of contraceptive users was 28 years. Whereas this may sound encouraging, Germain (1987) explains that in many countries, the young and unmarried are excluded from Family Planning Programs as a matter of policy, or because of value of service providers. According to Oniang'o and Rogo (1989), the proportion of women desiring pregnancy reduces as the number of children alive increases. Ayiemba and Oucho
(1989), reiterate this by indicating that the desire for an additional child is due mostly to the need to realize the desired number of children, obtaining sex balance; fear of high infant and child mortality and desire of husband for more children amongst many other reasons. Oniang'o and Rogo (1989) make an observation that no woman with only girls is willing to adopt a permanent method of contraception. Khasiani and Muganzi (1989) reiterate the fact that in communities where large family size is still the norm, women must compete to bring forth more children especially in polygamous homes.

According to Ayiemba and Ocho (1989) well educated couples prefer fewer children as opposed to the desires of illiterate couples. This may be because couples are increasingly becoming aware of changing environmental conditions namely rising costs of living and increasing education costs and health care e.t.c. This observation gives foundation to findings from the KDHS (1993) in which large differentials in use of modern contraceptive methods were found for educational groups. Fifteen percent of the married women had no formal education, 23% had some primary schooling and 45% had some secondary education. Mugenda and Mugenda (1992) found out that the more education one had, the more one tended to use modern contraceptive methods because they understood better how the methods work. Hundreds of studies in recent years have shown that the education of girls is strongly associated with the use of Family Planning Services among other things. Empowering women with at least basic education and literacy is one of the most important single elements in the development process hence, educating women is one of the most important steps towards women gaining more control over their own lives and that of their families (Adamson and Adamson, 1993).
The prestige value of children is important to rural Kenyans. Having many children is seen as improving the family's economic strengths (Mott and Mott, 1980). Both May et. al (1990) and Oniang'o and Rogo (1989) draw a similar conclusion that children are seen as an economic asset as they provide cheap labour on the farm and "social security" in old age. Even in low income countries (excluding India and China), where the average total fertility rate was 4.6 in 1990, women are having two children fewer on average than women in Kenya (Mwangi et. al, 1992). On the contrary, educated women and those in paid employment seem to go for contraception when the burden of caring for many children appears overwhelming or when they are unable to make ends meet (Oniang'o and Rogo, 1989).

2.7.4 Information, Education and Communication

For people to practise Family Planning successfully, they need to recognize that Family Planning can benefit them and their families; know how to practise Family Planning correctly and know where to obtain services or supplies (Gallen and Lettenmaier, 1987). Today, more and more people throughout the world have access to radio, television, and audio and videotapes (Gilluly and Moore, 1986). As a result, many Family Planning Programs can now reach large audiences through the mass media at the same time that they reach the individual through service providers. Coeytaux et. al (1987), suggest that more attention to counselling can encourage more clients to start using Family Planning.
Although modern contraceptives are now available in many third world countries, there is still a great unmet need for Family Planning services. Many women are not using any effective contraceptive method because they do not know of any place to get Family Planning services (Maine, 1982). For those who know of a place, they may be denied the services because of age, marital status or Government policy (Germain, 1987). Recent studies by Mugenda and Mugenda (1992), and KDHS (1993) however indicate that the level of awareness of Family Planning methods in Kenya has reached the 90% mark. About 96% of the women aged between 15-49 years have heard of at least one method of Family Planning and also know where and how to obtain the method. But only 26% of the Kenyan women are practising modern Family Planning methods. This shows a big gap between awareness and usage of Family Planning services hence the need for information, education and communication to reduce this gap. Ayiemba and Oucho (1989), suggest that Family Planning Private Sector (FPPS) should co-operate with other Family Planning Promoters in developing appropriate models for information, education and communication.

Ensuring informed choice is an ethical and legal obligation in some countries (Lettenmaier and Gallen, 1990). Informed choice is especially important for the Family Planning Client who should know about the various methods available; their advantages and disadvantages, and be able to choose one they feel confident and comfortable to use (Gallen and Lattenmaier, 1987). According to Ayiemba and Oucho (1989), it is generally agreed that the desire for children requires effective dialogue between husband and wife. Contrary to this, findings by Khasiani and Muganzi (1989), indicate that in
some communities, contracepting was believed to be a female responsibility. In a similar observation, Muindi (1992), argues that men's perception of Family Planning is that contraceptives are a women's affair. If men are better informed, this will give them an opportunity to be the best judges of their families.

2.7.5 Access to Family Planning Services

Access to Family Planning can be constrained by limiting the methods available, by provider prejudices or by religious bias (Concepcion, 1988). Millions of women in developing countries still do not have easy access to Family Planning services a fact that has serious health consequences (Maine, 1982). According to Kaseje and Otieno (1989), time and expense to travel to the Family Planning site, having services available at a time of day when women can get away from their family duties, and many other factors may influence utilization of contraceptive services. An example of what can happen when women have access to Family Planning services can be seen in Chile. The Government and Private Agencies provided contraceptives since 1965. By 1982, the proportion of women using contraceptives had increased from 3% to 20% (Maine, 1982). In Kenya, the use of contraceptives has gone up from 27% in 1989 to 33% in 1993 for married women (KDHS, 1993). Majority of the married women are in need of Family Planning services yet, Government sources for Family Planning account for only 68% of the total outlets. Germain (1987), suggests that there is need not only to strengthen Family Planning Programs but also, make them accessible and acceptable for all women and girls in need. Sai and Newman (1988), argue that, in some countries and
cultures, men have the right to make decisions about fertility, and they can deny women access to Family Planning services for various reasons. For example, findings from the KDHS (1989) indicate that 12% of the women were not using contraceptives because of disapproval by the husband. The right of access to Family Planning services follows from a basic right to make decisions about reproductive behaviour (Adamson and Adamson, 1993). According to Germain (1987), in Sub-Saharan Africa, contraceptive use is very low and maternal and child mortality high. Family Planning services in some countries are virtually non-existent. Maine (1982) draws a similar conclusion that even though modern contraceptives are now available in most third world countries, there is still a great unmet need for Family Planning services as women are still having pregnancies too close together. Oniang’o and Rogo (1989) in their study confirm that even in places where contraceptive services are available, women often do not have a choice in the matter. Most of the Family Planning Programs do not even reach out to rural areas where health personnel are scarce. Ayiemba and Oucho (1989) found out that 68.9% of the variance noted in reasons for stopping contraception was attributed to transportation costs to the Family Planning delivery points. Some of the clinics are just not within easy reach of the clients.
A clear understanding of the factors influencing women's acceptance, choice and use of contraceptive methods is needed so that Administrators and policy makers can determine the most appropriate types of Family Planning Programs to implement in the society. Since the provision of Family Planning Programs services remains one of the most important reproductive health issues in Kenya today; the purpose of this study is thus to investigate the factors that influence acceptance, choice and use of modern contraceptive methods especially by women. When so much could be achieved by the meeting of an existing demand, and at such a relatively small cost, the time has surely come for a major renewal of the effort to ensure that all couples, and especially all women have the information, the means, the support and the right to decide for themselves how many children they will have and when they will have them (Adamson and Adamson, 1993).
CHAPTER THREE

METHODOLOGY

3.1 RESEARCH DESIGN

Descriptive survey research design was used because it allows for extensive data collection on a large population within a short time. It also allows for study of social conditions and determines relationships that exist between people and variables under study. This investigation was carried out using an interview schedule which was designed to meet the objectives of the study.

3.2 STUDY LOCATION

The study was carried out in Lurumi division of Kakamega District. Kakamega District is one of the four districts making up Western province. Kakamega District has a total population of 1,463,525 and a density of 624 persons per square kilometer. It has an approximate area measuring 2,963 square kilometers. The district has ten administrative divisions, 33 locations and 128 sub-locations. The divisions are Butere, Mumias, Khwisero, Ikolomani, Shinyalu, Lugari, Navakholo, Matete, Kabras and Lurambi.
The study was isolated to Lurambi division. Lurambi Division has a population of 113,855 and density of 1629 persons per square kilometer. According to the 1989 population census, there were 35,810 households. The division has four locations and 18 sub-locations. The locations are Bunyala, North Butsotso, South Butsotso and Municipality.

During the sampling procedure, only one location in Lurambi division was diagnosed. Municipality location was chosen purposefully for convenience of accessibility due to inadequate time and funds.

Municipality location has three sub-locations. These are Shirere, Township and Sichirai. Two sub-locations were randomly selected from the three for this study. These were Township and Shirere.

3.3 SAMPLE SIZE AND SELECTION

The target group was all women aged between 15 - 49 years residing in Shirere and Township sub-locations, who practise family planning. This included both the married and unmarried women. The total number of households for the two areas was established from the 1989 population census. These were Shirere 4,672 households and Township 3,466 households. A list of past and current users of modern family planning methods was obtained from various family planning clinics and community based
distributors in these two areas. This formed the sampling frame. Shirere had 540 names which represented 540 households while Township had 602 names which represented 602 households. A proportional sample was selected from each sub-area and a sample size of 100 households (50 per sub-area) was obtained. This represented approximately 10% of the total number of households in the sampling frame.

3.4 SAMPLING TECHNIQUE

Systematic random sampling was used to obtain a representative study sample. This is a method whereby every \( nth \) case in the sampling frame is selected for inclusion in the sample. Every \( nth \) case was selected for both areas until a total of 100 households was obtained. To obtain the interval at which to pick the \( nth \) case, the sample size required for each area was divided by the total number of households in each area.

3.5 INSTRUMENT FOR DATA COLLECTION

An interview schedule was administered to the respondents by the researcher. It consisted of some closed-ended questions to provide for more structured responses and some open-ended questions to provide in-depth information to the study in order to enhance formulation of useful recommendations to the study. An interview schedule was chosen because it allowed probing through which the researcher could get more in-depth information. The respondents were also asked by the researcher to clarify or expand on responses given. The interview schedules were selected because they yield
3.7 DATA ANALYSIS PROCEDURES

This study assumed a quantitative and qualitative perspective and descriptive statistics were used. Data were analysed by computer using the statistical package for social sciences (SPSS-X). Descriptive statistics were computed and included, percentages and frequencies which were presented and explained using tables. Pearson Product - Moment Correlation Coefficient was computed to determine the direction and strength of relationship between dependent and independent variables under study. The Correlation Coefficient was considered significant at the alpha level $P \leq 0.05$. 

1. Establish the research questions and hypotheses.
2. Determine the sample size and selection criteria.
3. Determine the appropriate statistical analysis.
4. Identify the variables and their relationship.
5. Identify the data collection methods and tools.
6. Analyse the data using appropriate statistical techniques.
7. Interpret the results and draw conclusions.
8. Present the findings in a clear and concise manner.
CHAPTER FOUR

RESULTS, INTERPRETATIONS AND DISCUSSION

4.1 Introduction

The purpose of this study was to investigate factors that influence acceptance, choice and use of modern contraceptive methods by women. It specifically focused on women aged between 15 - 49 years residing in Shirere and Township locations of Lurambi Division - Kakamega District. The study had six specific objectives namely:

1. Establish the extent of acceptability, choice and use of modern contraceptive methods by the respondents,

2. Determine the social, economic and cultural factors influencing acceptance, choice and use of modern contraceptive methods,

3. Determine the respondents knowledge, attitude and practise towards use of modern contraceptive methods,

4. Identify perceived side effects of modern contraceptives used by the respondents,

5. Identify beliefs, misconceptions and rumours, held by the respondents about the use of modern contraceptives,
6. Identify the problems encountered by the respondents as regards Information Education and Communication (IEC) and accessibility to modern contraceptive methods and services.

The results were reported using frequencies and percentages. Pearson Product - Moment Correlation was used to test the relationship between the independent and the dependent variables. The results discussed in the chapter are therefore grouped under the following sub topics:-

1. Socio-economic and Demographic profile of respondents and their contraceptive choice preferences,

2. Socio-economic and Demographic factors influencing acceptance, choice and use of modern contraceptives,

3. Factors influencing acceptance, choice and use of modern contraceptives,

4. Knowledge, practice and attitude of the respondents towards use of modern contraceptives,

5. Relationship between variables was examined by determining Pearson Product-moment Correlation coefficients,
4.2 Socio-economic and Demographic Profile of respondents and their contraceptive choice preferences.

4.2.1 Age of Respondents

Table 1 shows the distribution of respondents according to their ages. The results show that forty respondents (40%) were aged between 25-29 years. Twenty one (21%) aged between 20-24, and nineteen respondents (19%) aged between 30-34 years. This could be due to the fact that most Kenyan women on average get married between 20-30 years of age hence the need to start planning their families. The least represented age brackets were 45-49 years (4%) and 15-19 years which was not represented.

Table 1: Respondents Age

<table>
<thead>
<tr>
<th>AGE Group (Years)</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 19</td>
<td>0</td>
</tr>
<tr>
<td>20 - 24</td>
<td>21</td>
</tr>
<tr>
<td>25 - 29</td>
<td>40</td>
</tr>
<tr>
<td>30 - 34</td>
<td>19</td>
</tr>
<tr>
<td>35 - 39</td>
<td>6</td>
</tr>
<tr>
<td>40 - 44</td>
<td>10</td>
</tr>
<tr>
<td>45 - 49</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
4.2.2 Marital Status

In Table 2, results show that seventy-six respondents (76%) were currently married. This could be explained by the observation that most respondents were aged between 20-30 years, an age category at which most Kenyan women are considered to be adults hence get married. Fourteen respondents (14%) were single while five (5%) were either divorced or separated. Only five (5%) were widowed.

Table 2: Respondents' Marital Status

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Not been in school</td>
<td>21</td>
</tr>
<tr>
<td>High school &amp; below</td>
<td>14</td>
</tr>
<tr>
<td>Never married</td>
<td>14</td>
</tr>
<tr>
<td>Currently married</td>
<td>76</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>
"O" level with additional period of training was the most represented level of education by forty-two respondents (42%) followed by "O" level and below which had thirty-four respondents (34%). Only ten of the respondents (10%) had attained "A" level education while those who had attained "A" level with college training were six (6%). The least represented level of education was University degree where only three respondents (3%) reported having a University degree, while five (5%) reported having no formal education at all. Table 3 shows the educational level of respondents.

Table 3: Respondents' Educational level

<table>
<thead>
<tr>
<th>EDUCATIONAL LEVEL</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Not been to school</td>
<td>5</td>
</tr>
<tr>
<td>&quot;O&quot; level and below</td>
<td>34</td>
</tr>
<tr>
<td>&quot;O&quot; level plus college training</td>
<td>42</td>
</tr>
<tr>
<td>&quot;A&quot; level only</td>
<td>10</td>
</tr>
<tr>
<td>&quot;A&quot; level plus college training</td>
<td>6</td>
</tr>
<tr>
<td>University degree</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>
4.2.4 Respondents Employment Status

Results in Table 4 below show the respondents' employment status which was categorised into three groups for discussion purposes.

Table 4: Respondents Employment Status

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Employed</td>
<td>57</td>
</tr>
<tr>
<td>Self-employed</td>
<td>22</td>
</tr>
<tr>
<td>Not-employed</td>
<td>21</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Fifty-seven respondents (57%) were gainfully employed, twenty-two respondents (22%) were self-employed in some form of business which gave them income at the end of the month and twenty-one respondents (21%) were not employed at all.
4.2.5 Respondents Income

Table 5 shows the distribution of respondents according to their income levels. Thirteen respondents (13%) reported a monthly income of Ksh. 2,000 and below, twenty-three respondents (23%) earned between Ksh. 2,001 to Ksh. 4,000 and forty respondents (40%) reported a monthly income of Kshs. 4,001 and 6,000 while fifteen respondents (15%) said they earn Ksh. 6,001 and 8,000. Only nine respondents (9%) reported an income of Ksh. 8,001 and above per month.

Table 5: Respondents' Income per month in Kenya Shillings.

<table>
<thead>
<tr>
<th>INCOME PER MONTH</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100</td>
</tr>
<tr>
<td>Kshs 2,000 and below</td>
<td>13</td>
</tr>
<tr>
<td>Kshs 2,001 - 4,000</td>
<td>23</td>
</tr>
<tr>
<td>Kshs 4,001 - 6,000</td>
<td>40</td>
</tr>
<tr>
<td>Kshs 6,001 - 8,000</td>
<td>15</td>
</tr>
<tr>
<td>Kshs 8,001 and above</td>
<td>9</td>
</tr>
</tbody>
</table>
4.2.6 Respondents Religious Preferences

Results showed that eighty respondents (80%) were protestants, fourteen (14%) were catholics, while six (6%) were muslims. This is characteristic of Kakamega district where most people are protestants.

Table 6: Respondents' Religion

<table>
<thead>
<tr>
<th>RELIGION</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Catholic</td>
<td>14</td>
</tr>
<tr>
<td>Protestant</td>
<td>80</td>
</tr>
<tr>
<td>Muslim</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

4.3 Contraceptive Choice Preferences

One of the main objectives of this study was to establish the extent of acceptability, choice and use of modern contraceptives by the respondents. This is because, it is possible to want to use a certain type of contraceptive, yet not be able to do so due to various reasons.
4.3.1. Ever Users of Modern Contraceptives

Table 7: Percentage of ever users of modern contraceptives.

<table>
<thead>
<tr>
<th>Have you ever used any modern method of contraceptive before</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Yes</td>
<td>67</td>
</tr>
<tr>
<td>No</td>
<td>33</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

Results in table 7 above show that sixty-seven respondents (67%) had used a modern method of contraception, while thirty-three (33%) reported that they had never used a modern method of contraception before. Further analysis was done to establish the actual methods which had been used by the respondents.
Table 8 below shows the type of contraceptives ever used by the respondents.

### Table 8: Percentage of ever users of specific modern contraceptive methods

<table>
<thead>
<tr>
<th>METHOD</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Pill (oral)</td>
<td>33</td>
</tr>
<tr>
<td>IUD (coil)</td>
<td>22</td>
</tr>
<tr>
<td>Injection</td>
<td>7</td>
</tr>
<tr>
<td>Sterilization (T.L)</td>
<td>3</td>
</tr>
<tr>
<td>Norplant (Implant)</td>
<td>1</td>
</tr>
<tr>
<td>Barrier (foam, jellies, Diaphragm, Condom)</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>*67</td>
</tr>
</tbody>
</table>

* n = 67 - Only those who had ever used a modern method of contraceptive reported below.

Out of the sixty seven respondents who reported having ever used any modern method of contraceptive before, thirty three respondents (49.3%) reported having ever used the pill, twenty-two (32.8%) had ever used the IUD, seven (10.4%) had ever used the injection, three (4.5%) had been sterilized while only one respondent had used Norplant (implant) and another one respondent had used a barrier method.
4.3.2 Current contraceptive users.

Out of the fifty respondents who reported that they were currently using a method of contraception, twenty-one respondents (42%) were using the pill, fifteen (30%) were using the IUD while six (12%) were using the injection. This again illustrates the popularity of the pill among contraceptive users.

However, a half of the respondents (50%) reported that they were using natural methods of contraception. This may be influenced by various factors. Some respondents preferred natural methods of contraception because of fear of side effects and rumours they had heard about modern contraceptives. These findings are similar to those of Oniang'o and Rogo (1989), Porter (1984) and Mugenda and Mugenda (1992), who found that unfavourable rumours adversely affect contraceptive use leading to discontinuation of a variety of effective methods. Religion may also have had a strong influence as we see that the church especially the Catholic church has a more restrictive view on contraceptives accommodating only natural contraception. Religion, coupled with strong cultural biases towards having many children for prestigious as well as economic purposes are some of the factors that promote use of natural methods of Family Planning.
Table 9: Percentage of current users of specific modern contraceptives.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Pill (oral)</td>
<td>21</td>
</tr>
<tr>
<td>IUD (coil)</td>
<td>15</td>
</tr>
<tr>
<td>Injection</td>
<td>6</td>
</tr>
<tr>
<td>Sterilization (T.L)</td>
<td>4</td>
</tr>
<tr>
<td>Norplant implant</td>
<td>2</td>
</tr>
<tr>
<td>Barrier (foam, jellies, Diaphragm, condom)</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>*50</td>
</tr>
</tbody>
</table>

*n=50 - only users of modern contraceptives reported

4.4 Socio-economic and Demographic factors influencing Acceptance, Choice and Use of modern contraceptives.

Table 10 shows the results for the socio-economic and demographic factors influencing the respondents choice and use of modern contraceptive methods. The results indicate that income, number of children alive, education level and age were the most significant factors influencing acceptance, choice and use of modern contraceptive methods. Income positively influenced the use of modern contraceptives. The data show that ninety five respondents (95%) attributed choice of contraceptive method to income. These respondents wanted to have the number of children that they could comfortably support given their income. This may be due to the fact that in the current economic situation, most families in Kenya are experiencing increasing financial difficulties, hence the need for smaller families that are easier to manage.
Table 10: Factors influencing use of modern contraceptives.

<table>
<thead>
<tr>
<th>Factors influencing use</th>
<th>Yes</th>
<th>No</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Age</td>
<td>81</td>
<td>81</td>
<td>19</td>
</tr>
<tr>
<td>Educational level</td>
<td>84</td>
<td>84</td>
<td>16</td>
</tr>
<tr>
<td>Religion</td>
<td>12</td>
<td>12</td>
<td>88</td>
</tr>
<tr>
<td>Income</td>
<td>95</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>Number of children alive</td>
<td>87</td>
<td>87</td>
<td>13</td>
</tr>
<tr>
<td>Misconceptions on modern contraceptives</td>
<td>71</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>66</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>Counselling on Family Planning</td>
<td>65</td>
<td>65</td>
<td>35</td>
</tr>
</tbody>
</table>

*Multiple responses were allowed

Eighty-seven respondents (87%) reported that they could not adopt a more permanent method of contraception either because of the number of children they had, or the sex of their children. Those who had one or two children wanted more children. This may be due to the fact that culturally, having many children was seen as a prestigious value. Those women who had girls only tended to want more children in the hope of getting boys.

Education positively influenced the use of modern contraceptives. Eighty-four respondents (84%) indicated that the amount of education they had helped them quite a
lot when it came to choosing and using contraceptive methods. These results are similar to those of Mugenda and Mugenda (1992) in which the more education one had, the more one tended to use modern contraceptive methods because they understood better how the methods work.

Age was considered by eighty-one respondents (81%) as a main factor positively influencing the decision to use modern contraceptives. They said that the age at which one decides to start using modern contraceptives is an individual decision. Results also indicate that seventy one (71%) of the respondents’, choice and use of modern contraceptives was influenced by rumours, beliefs and/or misconceptions that they had heard about the modern contraceptives.

In Kenya like elsewhere in the world, AIDS is a menace as it strikes mainly those in the age group 20-49 years (WHO, 1990). Sixty-six respondents (66%) said that the disease AIDS/HIV and other STDs had made them more receptive to the idea of their partners using condoms. This is not consistent with the finding that only one respondent (1%) reported use of any barrier methods including the condom. This may be due to the fact that, condoms are a male oriented method and women may find it difficult to convince their partners to use them much as they appreciate their importance.

Counselling about family planning methods did emerge as a factor positively influencing the decision to use modern contraceptives. Sixty-five respondents (65%)
who were counselled said that the counselling did have an influence on whether or not they did finally agree to use a modern method of contraception. More attention to counselling can encourage more clients to start using family planning.

Suprisingly, only twelve respondents (12%) attributed religion to influencing choice and use of method of contraception. These results are similar to those of KDHS (1989) in which religion was not a major obstacle in the practice of contraception as it accounted for only 1% of the non users.

Specific factors influencing Acceptance, Choice and Use of Modern contraceptives.

4.5 Cultural and Religious Factors

It is commonly assumed that Women or couples who know about modern contraceptive methods do not use them because of cultural, social and religious influence. When asked whether their churches encourage or discourage use of modern contraceptives, results in Table 11 show that thirty-one respondents (31%) agreed that their churches did encourage them to plan their families, thirty-eight respondents (38%) said their churches did not encourage them to plan their families; whereas thirty-one respondents (31%) did not know what the church's stand was on this issue.
Table 11: The church's Views on Use of modern contraceptives as reported by the respondents.

<table>
<thead>
<tr>
<th>Encouragement to use contraceptives</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
<tr>
<td>Encourage</td>
<td>31</td>
</tr>
<tr>
<td>Discourage</td>
<td>38</td>
</tr>
<tr>
<td>Do not know</td>
<td>31</td>
</tr>
</tbody>
</table>

The respondents were further asked which methods of contraception their churches encouraged them to use. Results in table 12 below show that most of the respondents (70%) indicated that their churches advocated for use of Natural methods of family planning; thirteen respondents (13%) said that their churches did not encourage use of any particular method; whereas seventeen respondents (17%) did not know whether their churches advocated for use of any methods of contraception. The category for modern methods of contraception did not have any representation. This may be due to the fact that some religious and cultural groups are opposed to contraceptive drugs and devices.
Despite social and cultural constraints hindering modern contraceptive use, results in Table 13 show that most respondents (49%) indicated that the community in general was supportive towards the idea of use of modern contraceptives to plan their families. However, twenty-eight respondents (28%) reported lack of support from some members of the community; whereas twenty-three respondents (23%) did not know the community's stand on this issue.
Table 13: The community's Views on use of modern contraceptives as reported by the respondents.

<table>
<thead>
<tr>
<th>Community's Views on use of contraceptives</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Approve</td>
<td>49</td>
</tr>
<tr>
<td>Disapprove</td>
<td>28</td>
</tr>
<tr>
<td>Do not know</td>
<td>23</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

When asked specifically whether the community supported married/single/unmarried women to use modern methods of contraception, results in table 14 show that most respondents (70%) agreed that married women should be allowed to use modern contraceptives as this would help them to plan and space their families. Twenty-four (42%) respondents did not agree with the idea of married women using modern contraceptives as this would make them become unfaithful to their husbands as there was no risk of getting pregnant. Six respondents (6%) were non-committal to the idea.

Results in table 14 further show that sixty-six respondents (66%) disapproved the idea of single/unmarried women using modern contraceptives as this would promote a lot of promiscuity in society. However, thirty respondents (30%) did feel that single/unmarried women should be given a choice to use modern contraceptives so as to avoid many unwanted pregnancies which may lead to abortions. Only four respondents
(4%) were non commital.

Table 14: Results showing the Respondents views on the use of Contraceptives by married and single women

<table>
<thead>
<tr>
<th>Use of modern contraceptive</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>Don't know</th>
<th>%</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>70</td>
<td>70</td>
<td>24</td>
<td>24</td>
<td>6</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Single</td>
<td>30</td>
<td>30</td>
<td>66</td>
<td>66</td>
<td>4</td>
<td>4</td>
<td>100</td>
</tr>
</tbody>
</table>

4.6 Beliefs Misconceptions and Rumours about Family Planning

The researcher asked the respondents to state some of the rumours/beliefs/fears that they associated with the use of modern contraceptives, as this would be useful information in dispelling the fears and uncertainties associated with modern contraceptives.

In general, it was believed that the pill causes infertility, a belief that was expressed by most of the respondents (90%). Eighty two respondents (82%) also expressed fears that use of pills would make one give birth to deformed babies. The respondents also said that when taken over a long period of time, the pills formed into a small lump in the stomach blocking the fallopian tubes. The other fears associated with the pill were the normal side effects experienced which include; headaches, nausea and...
Seventy one respondents (71%) believed the injection causes infertility, backache, irregular bleeding while a few respondents (2%) reported temporary paralysis of the feet after the injection had been administered.

Most respondents (87%) reported that the IUD if not properly fitted can perforate the uterus which in turn causes infections of the uterus. This can result in infertility. Whereas this might be true, it does not commonly happen. Other fears associated with use of the IUD are that it causes heavy bleeding. Also, one can conceive while it is still in place and when this happens the baby will be born with the IUD implanted on its body.

Sterilization or Tubal Ligation is not so popular method as it is permanent and not reversible. The only fears expressed by 33% of the respondents were that one loses her sexual desires after the operation has been carried out and this could bring about problems in the home, especially with the husband.

Barrier methods were thought of as not being 100% effective especially the condom. Sixty-two respondents (62%) believed that the condom if not properly used can burst or it can get lost inside the woman's body during intercourse.

While many of the respondents believe in most of these notions, the hindrances the women experience are predominantly fears and uncertainties about use of modern
contraceptives. Very few women are aware of the actual possible adverse effects of modern contraceptives.

It is the responsibility therefore of family planning providers to make sure that each client has correct information and can make informed choices about using contraceptives. Rumours and misinformation are widespread in many countries and they seem to be major barriers to contraceptive use (Tucker, 1986).

Results in table 15 below show that seventy-six respondents (76%) believed these rumours/beliefs have some truth in them; seventy-three respondents (73%) believed that these rumours/beliefs pass on some important information about modern contraceptive methods; while sixty-two respondents (62%) said that given an opportunity; they would pass on some of this information to a friend who wants to adopt a modern method of family planning. The above results thus confirm that unfavourable rumours/beliefs if widespread easily lead to discontinuation of a variety of effective methods. These results are supported by Oniang'o and Rogo (1989) who indicate that rumours about contraceptives heard by women adversely affect modern contraceptive use and that women who have had side effects are more likely to discontinue use of modern contraceptives after hearing unfavourable rumours.
Table 15: Respondents' opinions on rumours/beliefs about modern contraceptive methods.

<table>
<thead>
<tr>
<th>Respondents' opinion</th>
<th>Yes N</th>
<th>Yes %</th>
<th>No N</th>
<th>No %</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rumours/beliefs influenced choice and use</td>
<td>71</td>
<td>71</td>
<td>29</td>
<td>29</td>
<td>100</td>
</tr>
<tr>
<td>Rumours/beliefs have some truth in them</td>
<td>76</td>
<td>76</td>
<td>24</td>
<td>24</td>
<td>100</td>
</tr>
<tr>
<td>Rumours/beliefs pass important information</td>
<td>73</td>
<td>73</td>
<td>27</td>
<td>27</td>
<td>100</td>
</tr>
<tr>
<td>Would pass on rumours/beliefs to a friend</td>
<td>62</td>
<td>62</td>
<td>38</td>
<td>38</td>
<td>100</td>
</tr>
</tbody>
</table>

4.7 Information, Education and Communication (IEC)

All the respondents (100%) said that they had heard of family planning and could name some family planning methods. However, when asked whether they were ever counselled before choosing a method of contraception, sixty-five respondents (65%) said they had been counselled before making a choice on what contraceptive method to use while thirty-five respondents (35%) were not counselled at all (see Table 16).
Asked whether they had ever conceived while using any modern method of contraception, eleven respondents (11%) reported they had while eighty-nine (89%) had not. This proves that modern contraceptive methods are not 100% effective, a fact that is reiterated by Maillard (1985).

Regarding proper and adequate marketing of family planning in the community, forty respondents (40%) agreed that this had been well done whereas sixty respondents (60%) reported that there was need for more marketing strategies and more information was needed especially on side effects to be expected during use and what to do if and when they occurred.

Table 16: Information, Education and Communication. Factors influencing choice and use of modern contraceptives.

<table>
<thead>
<tr>
<th>Factors Influencing Choice and Use</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever heard of family planning</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Can name some methods</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Ever been counselled about family planning</td>
<td>65</td>
<td>35</td>
<td>100</td>
</tr>
<tr>
<td>Ever conceived while using a modern method of contraception</td>
<td>11</td>
<td>89</td>
<td>100</td>
</tr>
<tr>
<td>If family planning has been well marketed</td>
<td>40</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

*Multiple responses were allowed.*
Table 17: Sources of Information influencing knowledge on family planning.

<table>
<thead>
<tr>
<th>Factors Influencing Information/knowledge</th>
<th>Yes N</th>
<th>%</th>
<th>No N</th>
<th>%</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>20</td>
<td>20</td>
<td>80</td>
<td>80</td>
<td>100</td>
</tr>
<tr>
<td>Television</td>
<td>59</td>
<td>59</td>
<td>41</td>
<td>41</td>
<td>100</td>
</tr>
<tr>
<td>Newspapers</td>
<td>27</td>
<td>27</td>
<td>63</td>
<td>63</td>
<td>100</td>
</tr>
<tr>
<td>Friends/Relatives</td>
<td>22</td>
<td>22</td>
<td>88</td>
<td>88</td>
<td>100</td>
</tr>
<tr>
<td>Husband</td>
<td>94</td>
<td>94</td>
<td>6</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>23</td>
<td>23</td>
<td>77</td>
<td>77</td>
<td>100</td>
</tr>
<tr>
<td>CBD</td>
<td>85</td>
<td>85</td>
<td>15</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Chief's Barazas</td>
<td>90</td>
<td>90</td>
<td>10</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Church</td>
<td>92</td>
<td>92</td>
<td>8</td>
<td>8</td>
<td>100</td>
</tr>
</tbody>
</table>

* Multiple responses were allowed.

It is apparent from the results in table 17 above that friends and relatives are the most popular channel through which the respondents hear/learn about family planning as this was reported by eighty-eight respondents (88%). This was followed by radio which was reported by eighty respondents (80%). The least represented categories were Chief's Barazas which had eight respondents (8%) while only six respondents (6%) heard about Family Planning from their husbands.
The respondents were also asked who first introduced them to start using the contraceptives. Results in table 18 show forty-five respondents (45%) were first introduced to contraceptive use by friends. These results show that friends have a role to play in influencing choice and use of modern Contraceptives hence, the need for right and proper information. In support of this opinion, Gallan and Lattenmaier, (1987) agree that informed choice is necessary for one to be able to choose a method they feel confident and comfortable to use. Twenty three respondents (23%) said that the choice to use specific Modern Contraceptives was self decision; while seventeen respondents (17%) were advised to start using modern contraceptives by the Family Planning Clinic/Doctor. However, only six respondents (6%) were influenced by CBDs Table 18 shows the results.

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Friends</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Relatives</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>CBDs</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Self - Decision</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
4.8 ACCESS TO FAMILY PLANNING SERVICES

Family Planning Services in some countries are virtually non-existent (Maine 1982), hence the need to introduce more Family Planning Service outlets. Mugenda and Mugenda (1992) for instance indicate that there are approximately 1,700 Family Planning Clinics in Kenya today. The respondents were asked how they obtain their contraceptives. The results reported in table 19 are based on fifty respondents only, who are the current Users of Modern Contraceptives.

Results from table 19 show that thirty three respondents (66%) obtain their contraceptives from the Family Planning Clinic, fifteen respondents (30%) obtain their contraceptives from Community Based Distributors, while only two respondents (4%) obtain their contraceptives from private doctors. The chemist and friends did not have any representation. This may be because Family Planning Services are offered free of charge in most Government hospitals and clinics.
Table 19: Sources of contraceptive supply for current users

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* N</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>33</td>
</tr>
<tr>
<td>CBD</td>
<td>15</td>
</tr>
<tr>
<td>Private doctor</td>
<td>2</td>
</tr>
<tr>
<td>Chemists</td>
<td>0</td>
</tr>
<tr>
<td>Friends</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50</td>
</tr>
</tbody>
</table>

*n = 50 Results based on only current users of Modern Methods.

4.9 ATTITUDE AND PRACTISE TOWARDS FAMILY PLANNING

This section discusses objective four of the study. A series of questions relating to contraceptive use were asked and they responded by either agreeing (Yes) or disagreeing (No).

As Table 20 shows, ninety four respondents (94%) agreed that they wanted to continue using the method of contraception they were currently using while only six respondents (6%) wanted to stop. This was because of the side effects they were experiencing with these methods.
Asked whether they had ever experienced any side effects with the methods they used before or were currently using, fifty-seven respondents (57%) said they had experienced side effects while forty-three respondents (43%) had never experienced any side effects. This may be one of the reasons why of the 67% ever users (see Table 7), only 50% are current users (see Table 9). These findings are similar to findings by Porter (1984) where women who had side effects were more likely to discontinue use of modern contraceptives.

Respondents were asked whether they wanted to have any or more children. Only sixteen (16%) wanted to have more children while eighty four (84%) did not want any/more children yet; a majority of those who did not want any or more children were not using an effective method of contraception. Results in Table 9 show that only 50% of the respondents were users of modern methods of contraception which are thought to be more effective than the natural methods of family planning. This finding is similar to that of Adamson and Adamson (1993) where, an estimated 300 million couples in the developing world do not want more children but they are not using any effective means of contraception.

Asked whether use of modern contraceptives should be encouraged, seventy-two respondents (72%) agreed while only eighteen respondents (18%) disagreed citing promotion of promiscuity in society. Those who agreed to the idea said that use of modern contraceptives would help couples to plan their families and get children that they are able to take care of especially financially.
Results in Table 20 further show that ninety respondents (90%) agreed that mothers should be allowed to space the births of their children as this would give their bodies time to recover from one pregnancy before the next. Only ten (10%) respondents disagreed with this idea saying that mothers should give birth to the number of children they want as quickly as possible and forget about the whole idea of giving birth.

The respondents were asked whether or not they had ever discussed with their husbands the number of children to have. The sample was reduced to 86 as those who have never been married did not answer. Only thirty-six respondents (41.9%) said they had ever discussed with their husbands how many children to have. This may be because culturally, children come from God therefore, the issue of whether or not to have children and how many to have is not an issue for discussion. These findings are similar to those of Kaseje and Otieno (1989) where talking to the husband tended to block rather than encourage use of family planning.

Respondents who were currently married or had ever been married before were asked if their husbands approved the method of contraception they used before or were currently using. All the eighty-six respondents (100%) said that their husbands did/had approved the methods they were currently using or had used earlier. This then proves that husbands are no longer a negative factor in the use of modern contraceptives. The biggest role men have in Family Planning is to support their wives in their endeavours to use various modern Contraceptives (Muindi, 1992).
### Table 20: Attitude of Respondents towards Use of Modern Contraceptives

<table>
<thead>
<tr>
<th>Information</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers should be allowed to space births</td>
<td>90</td>
<td>90</td>
<td>10</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Use of modern contraceptives to be encouraged</td>
<td>72</td>
<td>72</td>
<td>18</td>
<td>18</td>
<td>100</td>
</tr>
<tr>
<td>Continue/Stop current method of contraception</td>
<td>94</td>
<td>94</td>
<td>6</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Experienced side effects with method of contraception</td>
<td>57</td>
<td>57</td>
<td>43</td>
<td>43</td>
<td>100</td>
</tr>
<tr>
<td>Want any/more children</td>
<td>16</td>
<td>16</td>
<td>84</td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td>Ever discussed with husband number of children to have</td>
<td>36</td>
<td>41.9</td>
<td>50</td>
<td>58.1</td>
<td>86</td>
</tr>
<tr>
<td>Husband approve method of contraception</td>
<td>86</td>
<td>86</td>
<td>0</td>
<td>0</td>
<td>86</td>
</tr>
</tbody>
</table>

*\( n = 86 \) - THOSE NEVER MARRIED DID NOT ANSWER

The respondents were asked how many children they had alive. Table 21 shows that twenty-seven respondents (27%) had more than four children alive. This might be the reason why results in Table 20 indicate that 74% of the respondents did not want any more children. Twenty-three respondents (23%) had three children; followed by...
seventeen respondents (17%) with four children, sixteen respondents (16%) had two
children, thirteen respondents (13%) had one child and only four respondents (4%) did
not have any children alive.

Table 21: Percentage of Number of Children Alive.

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
</tr>
<tr>
<td>One</td>
<td>13</td>
</tr>
<tr>
<td>Two</td>
<td>16</td>
</tr>
<tr>
<td>Three</td>
<td>23</td>
</tr>
<tr>
<td>Four</td>
<td>17</td>
</tr>
<tr>
<td>More than four</td>
<td>27</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 22 shows the results of number of children desired by the respondents. Sixty-eight respondents (68%) would like to have only two children, while twenty-two
respondents (22%) would like to have three children. Only two respondents (2%) would
like to have one child. These results indicate a desire for smaller family sizes by the
respondents mainly due to the present economic hardships in bringing up a large family.

Category-none did not have any representation. This may be due to the prestigious value
placed on children by Kenyans.
### Table 22: Percentage of Number of Children Desired by the Respondents

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>One</td>
<td>2</td>
</tr>
<tr>
<td>Two</td>
<td>68</td>
</tr>
<tr>
<td>Three</td>
<td>22</td>
</tr>
<tr>
<td>Four</td>
<td>5</td>
</tr>
<tr>
<td>More than four</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The respondents were asked by how many years they would like to delay their first or next pregnancy. Results in Table 23 show that sixty-seven respondents (67%) want to delay their next or first pregnancy by at least three years yet only fifty respondents (50%) use an effective method of contraception (see Table 9). Eight respondents (8%) did not want to delay their pregnancy at all while none of the respondents wanted to wait for more than four years.
Table 23: Number of years by which the respondents desire to delay the first or next pregnancy.

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
</tr>
<tr>
<td>One</td>
<td>14</td>
</tr>
<tr>
<td>Two</td>
<td>6</td>
</tr>
<tr>
<td>Three</td>
<td>67</td>
</tr>
<tr>
<td>Four</td>
<td>15</td>
</tr>
<tr>
<td>More than four</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

The respondents were also asked why they chose to use particular methods of contraception. Results in Table 24 indicate that forty respondents (40%) chose to use specific contraceptive methods for contraception purposes. This was more of a self decision made out of the desire to space the births of their children. Twenty-seven respondents (27%) were advised by a doctor to adopt a method of contraception because their health could not allow them to have more children. Thirty-three respondents (33%) preferred to use natural methods of family planning due to various reasons. Some of the reasons given were; the husbands preferred wives to use natural methods, some of the respondents had discontinued use of modern contraceptives after experiencing serious
side effects while, some respondents were afraid to use modern contraceptives.

Table 24: Reasons for choosing method of contraception.

<table>
<thead>
<tr>
<th>Reason for Choosing Method</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Contraception</td>
<td>40</td>
</tr>
<tr>
<td>Advised by doctor/clinic</td>
<td>27</td>
</tr>
<tr>
<td>Prefer Natural family planning</td>
<td>33</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

4.10 Relationship Between the Independent and the Dependent Variables

Pearson Product-Moment Correlation Coefficient was run with the aim of establishing the relationship between the independent and the dependent variables. The independent variable was current users of Modern Contraceptives; while, the dependent variables considered were age, marital status, educational level, number of children alive, rumours or beliefs, attitude to contraceptives use, desire for more children, religion and delay of next pregnancy. The correlation coefficient was considered significant at the alpha level P < or =.05. For discussion purposes the results were divided into the following correlation categories:
4.10.1 a) Relationship between contraceptive use and socio-economic and demographic variables

From table 25, results show that the current use of contraceptives correlated positively with number of children alive \( (r=0.308, p=0.031) \) and desire for more children \( (r=0.259, p=0.005) \). This indicates that respondents who highly considered these factors in choice and use of contraceptives had some satisfaction with the method of contraception they chose to use. This could be because they did not have to go by the mass society's belief in having many children as a sign of prestige; but selected a method of contraception based on how many children they had or according to their desire for more children.
Results in table 25 show a positive relationship between Number of children alive and attitude towards contraceptive use \( (r = 0.307, p = 0.001) \), and number of children alive and desire for more children \( (r = 0.307, p = 0.02) \). Finding suggests that the less children one has alive the less likely she is to use contraceptives to limit births because of the desire to have more children. Traditionally, a woman got married to give birth to children and having many children was seen as enlarging a family's chances for marrying into other familial networks and thus enhancing its political and economical strengths. African Traditional Society and Religion stressed the importance of ancestry and descent through children.

The results also indicate a weak but significant positive relationship between Rumours/ beliefs and desire for more children \( (r = 0.278, p = 0.002) \). This means that the more rumours were spread about modern contraceptives, the more the women discontinued using the modern contraceptives. Rumours and misinformation are wide spread in many countries and they seem to be major barriers to contraceptives use. Oniang'o and Rogo (1989) also agree with the above findings and indicate that rumours heard about contraceptives adversely affect contraceptive use.

Attitude towards use of modern contraceptives showed a positive relationship with desire for more children \( (r = 0.204, p = 0.02) \) and delay of next pregnancy \( (r = 0.211, p = 0.02) \). This denotes that the attitude the respondents had towards use of modern contraceptives positively influenced the desire for more children and delay of next
pregnancy. The desire for an additional child is due mostly to the need to realize the
desired number of children; obtaining sex balance and fear of high infant and child
mortality amongst many other reasons greatly hamper the campaign for effective Family
Planning. There is also a weak but significant association between Attitude and Religion
($r=0.173,p=0.04$). This may be due to the strong and strict stand that the church has against
use of modern contraceptives. The Catholic church has more restrictive view on methods
of contraception accommodating only "Natural Contraception".
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Current Users</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age</td>
<td>0.008</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Marital Status</td>
<td>0.498</td>
<td>0.187*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Educational Levels</td>
<td>0.568</td>
<td>0.241*</td>
<td>0.492</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. No. of Children Alive</td>
<td>0.308**</td>
<td>0.720</td>
<td>0.465</td>
<td>0.143</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Rumours/Beliefs</td>
<td>0.417</td>
<td>0.254*</td>
<td>0.235*</td>
<td>0.380</td>
<td>0.154</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Attitude to use</td>
<td>0.590</td>
<td>0.055</td>
<td>0.474</td>
<td>0.440</td>
<td>0.307**</td>
<td>0.446</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Desire more children</td>
<td>0.255*</td>
<td>0.139</td>
<td>0.355</td>
<td>0.540</td>
<td>0.206*</td>
<td>0.278*</td>
<td>0.204*</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Religion</td>
<td>0.331</td>
<td>0.038</td>
<td>0.394</td>
<td>0.563</td>
<td>0.286*</td>
<td>0.168*</td>
<td>0.173*</td>
<td>0.426</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10. Delay of Pregnancy</td>
<td>0.142</td>
<td>0.909</td>
<td>0.010</td>
<td>0.409</td>
<td>0.480</td>
<td>0.473</td>
<td>0.211*</td>
<td>0.355</td>
<td>0.192*</td>
<td>1</td>
</tr>
</tbody>
</table>

**P < 0.001  * P < 0.05
CHAPTER FIVE
SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.1 PREAMBLE

5.1.1 PURPOSE OF THE STUDY

The purpose of this study was to investigate factors that influence acceptance, choice and use of modern contraceptive methods by women in Lurambi division in Kakamega District.

5.1.2 RESEARCH OBJECTIVES

The study sought to achieve the following research objectives:

1. Establish the extent of acceptability, choice and use of modern contraceptive methods by the respondents.

2. Determine the social, economic and cultural factors influencing acceptance, choice and use of modern contraceptive methods.

3. Determine the respondents knowledge, attitudes and practise towards use of modern contraceptive methods.

4. Identify perceived side effects of modern contraceptives used by the respondents.

5. Identify beliefs, misconceptions and rumours and held by the respondents about the use of modern contraceptives.
6. Identify the problems encountered by the respondents as regards information, education and communication (IEC) and accessibility to modern contraceptive methods and services.

5.1.3 PROCEDURE

The study using a sample of 100 women aged between 15-49 years was conducted in Lurambi Division in Kakamega District starting December 1994 to April 1995. The information pertaining to the research objectives was determined using an interview schedule. The data were analysed using frequencies, percentages, and Pearson Product - moment correlation coefficient.

5.2 RESULTS

Socio-economic and demographic profile of respondents

The socio-economic and demographic profile of respondents identified by the study were: age, marital status, occupation, education level, income and religion. Majority of the respondents were aged between 25-29 years; seventy six (76%) were currently married. Most of the respondents forty two (42%) had attained 'O' Levels plus some college training and forty (40%) earned between Ksh. 4,001-6,000. The study also found that 57% of the respondents were gainfully employed. Most of the respondents (80%) were protestants.
5.2.2 Contraceptive Preferences

The study found that 50% of the women were current users of modern contraceptive methods. Out of these twenty one respondents (42%) reported that they were using the pill, fifteen (30%) were using the IUD, six (12%) were using the injection, four (8%) had tubal ligation done, two (4%) were using Norplant capsules while another two (4%) were using barrier methods. A half of the respondents (50%) reported that they were using natural methods of family planning. On whether they had ever used modern methods of contraception before, it was found that sixty seven women had used a modern method of contraception before.

5.2.3 Factors influencing choice and use of modern contraceptives

Socio-economic and demographic factors influencing choice, and use of modern contraceptives by the women were addressed by the study. The most significant factors turned out to be income, number of children alive, education level age, rumours/beliefs/misconceptions about contraceptives and the spread of HIV/AIDS and other STD's. Factors including counselling on family planning importance, attitude by respondents to various contraceptives and religion had lower influences on the women's choice and use of modern contraceptives.
On cultural and religious factors, the study found that the church encouraged use of natural methods of family planning as this was reported by 70% of respondents. Despite social and cultural constraints hindering modern contraceptive use, 49% of the respondents reported that the community was supportive towards the idea of use of modern contraceptives.

The study also found that knowledge about family planning was a most influential factor when it came to choice and use of modern contraceptives. Marketing of family planning and whether the respondents had ever conceived while using a modern method of contraception were less significant.

On sources of information influencing knowledge on family planning the most important factors influencing the women were: friends/relatives, radio, family planning clinic and newspapers. The other factors like television, CBDs, chiefs barazas, church and the husband had lower influence on the women's knowledge of family planning.

The respondents were asked some questions pertaining to attitude towards use of modern contraceptives to which they were to answer either yes (agree) or no (disagree). Since majority of the respondents answered yes to the questions it can then be assumed that there is a positive attitude by the respondents towards use of modern contraceptives. Seventy two percent of the respondents agreed that use of modern contraceptives should be encouraged while 94% of the respondents wanted to continue with the method of contraception they were using.
Pearson product-moment correlation coefficient analysis showed significant positive relationship between current use of contraceptives and number of children alive \((r = .308, p = .001)\) and desire for more children \((r = .259, p = .005)\) socio-economic and demographic variables showed significant positive relationships with information education and communication variables. Desire for more children was influenced by rumours and beliefs \((r = .278, p = .002)\) and attitude towards use of contraceptives \((r = .173, p = .043)\).

The study also highlighted some misconceptions rumours and beliefs about family planning associated with contraceptive use. It was agreed in general that the pill causes infertility, blocks the tubes, forms lumps in the stomach and if taken, babies born are deformed. The injection was also believed to cause infertility, heavy bleeding, irregular periods and backache. The IUD can cause infection which leads to infertility. The barrier methods are not very effective as failure rates are very high. Tubal ligation was not popular as it is a permanent method. While most of the respondents believe in these notions, the hindrances the women experience are predominantly fears and uncertainties about use of modern contraceptives. Very few women are aware of the actual possible adverse effects of modern contraceptives.
5.3 RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

1. Administration and Policy makers in the Family Planning sector need to address themselves to the socio-economic and demographic factors, contraceptive preferences, cultural and religious factors and IEC factors influencing use of modern contraceptives by women, and their implications to the campaign for family planning. A better understanding of these factors will help the administrators and policy makers determine the most appropriate type and balance of methods to be made available in Family Planning Programs and strengthen the existing and future programs.

2. Since the gap between awareness and usage of Family Planning is big, there is need for Information, Education and Communication programs to bridge this gap. The family planning private sector should co-operate with other family planning promoters in developing appropriate models for Information Education and Communication.

3. As the perfect method of contraception has not yet been discovered, we should make the best use of those that are available to us. There is need to know the basic facts about the advantages, disadvantages and potential efficiency of methods available on the Market. This is a challenge to the manufacturers of Modern Contraceptives and those who provide the services to make available, and public this information.

4. Currently, the issue of declining population due to AIDS is only one of extreme political sensitivity. In order to reduce the rate of spread of AIDS, the Ministry of Health, Family Planning Association of Kenya and other organisations should come out
strongly to educate the people and inform them that; whatever their cultural or religious perspective, they must face the challenges posed by HIV/AIDS. It is a challenge that requires each one of us to reconsider our traditions, morals and values and to respond positively to the pandemic. If contraception is desired, one should be provided with information, advice and supplies of safe, effective and acceptable contraceptives.

5. The Government should liaise with the church, the people and other organisations related to Family Planning when making decisions about Family Planning or implementing new programs or policies about family planning. If the church and the people are part of the decision-making process then they will not object to new policies or programs when they are implemented in the community. This will go a long way in improving and strengthening the existing and future Family Planning Programs.

5.4 CONCLUSIONS

The following conclusions have been made:

1. Most respondents (76%) were currently married and the age category most represented was between 25-29 years. Most respondents had 'O' levels plus some college training while majority of them were employed earning a salary between Ksh.4,001 - 6,000. The above group thus forms a target population that can be educated on the importance and advantages of modern methods of contraception hence, be used as a group to promote the marketing of modern contraceptives.

2. The socio-economic and demographic factors that influence women in choosing and using modern contraceptive included: Income, number of children alive, educational
level, age, rumours/beliefs about modern contraceptives and the spread of HIV/AIDS. The factors can be used by the ministry of Health and Family Planning Association of Kenya, in their campaign efforts towards population decrease through family planning; by using modern methods of contraception which are more effective than natural methods.

3. On cultural and religious aspects, the church was found to be more influential as it advocated for natural methods of family planning. In an effort to promote modern methods of contraception, the government through the Ministry of Health, the Family Planning Association of Kenya, NGOs concerned with Family Planning and the Family Planning Private Sector should get together with the church leaders and inform them of the importance and advantages of using modern methods of contraception especially in achieving the goal of having smaller but healthier and well cared for families. This would help church leaders not to have a negative attitude towards modern contraceptive methods.

4. Friends and relatives were the most popular channel through which the women heard/learnt about family planning. If the women are thus equipped with the proper and right information they can be used by the family planning sector as a means to market modern contraceptives to their fellow women.

5. There is need to inform the women about the side effects to be expected when some methods are used. Quite a number of women discontinued use of modern contraceptives after experiencing side effects.
6. There is need for the family planning sector to convince women that use of modern contraceptives does not necessarily lead to promiscuity in society. Modern contraceptives can also be beneficial especially in averting unwanted pregnancies which lead to abortions and these are dangerous to one's health.

7. Appropriate information, education and communication programs are needed so as to dispel the fears, uncertainties, rumours, beliefs and misconceptions associated with modern contraceptives. These misconceptions are widespread and they seem to be major barriers to contraceptive use.

8. There was a significant positive correlation between contraceptive use and number of children alive and desire for more children. Desire for more children was also influenced by society. More IEC programs are therefore needed to wipe out these uncertainties, and false notions about having many children as a prestigious value and for economic gains.

5.5 SUGGESTIONS FOR FURTHER RESEARCH

From the findings of this study it is recommended that:

1. Further research be carried out on the same topic using larger samples.

2. A similar study to the current one be carried out using men.

3. A comparative study be done on the same topic to compare the views of women vs men.

4. A comparative study be carried out to compare the views of rural versus Urban women on the same topic.
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INSTRUMENT: INTERVIEW SCHEDULE

An investigation of Factors influencing Acceptance, Choice, and Use of Modern Contraceptive methods by women in Lurambi Division in Kakamega District.

SECTION A: Respondent's Profile

1. Name of respondent (OPTIONAL) __________________________

2. Name of Village/Estate: _________________________________

3. Age: 15 - 19 years ______________________
   20 - 24 " ______________________
   25 - 29 " ______________________
   30 - 34 " ______________________
   35 - 39 " ______________________
   40 - 44 " ______________________
   45 - 49 " ______________________

4. Marital Status: __________ Never Married
   __________ Currently married
   __________ Widowed
   __________ Divorced
   __________ Separated

5. Age at first Marriage: ________ years
   (NOT APPLICABLE IF NEVER MARRIED)

6. How many children do you have alive?
   _____ One
   _____ Two
   _____ Three
   _____ Four
   _____ more than 4 (specify exact number)
   How many are Boys ________
   How many are girls ________
7. a) Are you: Employed
   Self-employed
   Not employed

   b) Is your spouse: Employed
   Self-employed
   Not employed

8. Have you had any previous schooling?
   Yes    No
   If yes, How Many years of schooling?
   Primary  _________ years
   Secondary _________ years
   College   _________ years
   University _________ years
   Others (specify) _________ years

9. What is your religion?
   Catholic  _________
   Protestant _________
   Muslim    _________
   Others (specify) _________

Section B
Knowledge, Attitudes and Practice Towards Family Planning

(A) Knowledge

10. Have you ever heard of family planning?
    yes ______ no______

11. If yes, what do you understand by the term family planning?
    ______________________
    ______________________

12. Can you name some methods of family planning?
    yes ______ no______
(B) Attitude

13. How many children would you like to have?
   ____ 1
   ____ 2
   ____ 3
   ____ 4
   ____ More than four (specify)
   ____ None

14. How many children does your husband/spouse want to have?
   ____ 1
   ____ 2
   ____ 3
   ____ 4
   ____ More than 4 (Specify how many)
   ____ I don't know

15. a) Do you think that mothers should be allowed to space the births of their children?
   yes _______ no______

   b) If yes, by how many years?
   ____ 1
   ____ 2
   ____ 3
   ____ 4
   ____ More than 4 (specify how many years)
   If not why? ____________________________

16. What in your opinion is the ideal number of children a couple should have these days?
   ____ 1
   ____ 2
   ____ 3
   ____ 4
   ____ More than 4 (specify exact number)
17. Have you ever discussed with your husband/spouse the number of children you want in your family?
   yes _____ no _____

18. (a) Does your husband have more than one wife?
   yes _____ no _____
   (b) If yes, how many wives? _____
      (NOT APPLICABLE IF NEVER MARRIED)

19. (a) Would you like to continue/stop the method of contraception you are currently using?
    continue______ stop_______
    (b) If yes/no why? ______________________________________________________
       (NOT APPLICABLE IF RESPONDENT IS NOT CURRENTLY USING A MODERN METHOD)

20. (a) Have you experienced any serious side effects with the method of contraception you used before or you are currently using?
    yes ______ no_______
    (b) If yes, name the side effects experienced. ______________________________________
       (NOT APPLICABLE IF RESPONDENT HAS NEVER USED A MODERN METHOD).

21. Does your husband/spouse approve of the method of contraception that you are currently using?
    yes_____ no_______ I don't know_______
    (NOT APPLICABLE IF NOT CURRENTLY USING A METHOD)

22. (a) Do you think that the use of modern contraceptive methods should be encouraged?
    yes______ no______
    (b) If yes/no why? __________________________________________________________
C. PRACTISE

23. At what age did you first start using contraceptives?
   15-19 _____
   20-24 _____
   25-29 _____
   30-34 _____
   35-39 _____
   40-44 _____
   45-49 _____

24. What method of contraception are you currently using?
   _____ None
   _____ Pill
   _____ IUD
   _____ Injection
   _____ Sterilization
   _____ Norplant
   _____ Barrier methods (foam, jelly, diaphragm)
   _____ Natural
   _____ Any Other (specify)

25. Why did you choose the particular method you are using now (used before) and not any other?
   _____ For contraception purposes
   _____ For health reasons
   _____ Advised by husband
   _____ Any other reason (specify)

26. Has the spread of HIV/AIDS and other Sexually Transmitted Diseases made you/or your spouse more receptive to the use of condoms?
   yes _____ no _____

27. When did you last give birth to a child?
   _____ 1 year ago
   _____ 2 years ago
   _____ 3 years ago
   _____ 4 years ago
   _____ More than four years specify exact Years
   _____ I do not have any children
28. Do you want to give birth to any/more children?
   yes______ no_______ I don't know______

29. By how many more years would you like to delay your next pregnancy?
   ____ None
   ____ 1
   ____ 2
   ____ 3
   ____ 4
   ____ More than 4 (specify exact number)

30. How often do you attend the family planning clinic?
   ____ I do not attend clinic
   ____ Once a month
   ____ Once every three months
   ____ Once every six months
   ____ Once a year
   ____ Any other time (specify how long)

Factors Influencing Acceptance, Choice and Use of Modern Contraception Methods.

1. Cultural and Religious Factors

31. (a) Does your church encourage or discourage the use of modern contraceptives?
   Encourage______ Discourage______ I don't know______

   (b) If it encourages/discourages, what are some of the reasons given for use or non-use?

32. Does your church have any counselling sessions especially for the youth on the use and misuse of modern contraceptives?
   yes______ no_______ I don't know______

33. Which methods of contraception does your church advocate for?
   ____ None
   ____ Natural
   ____ Traditional
   ____ Modern
   ____ Any other (specify which one)
34. (a) Does the community you live in approve or disapprove use of modern contraceptives
   ____ Approve
   ____ Disapprove
   ____ I don’t know

   (b) If they approve/disapprove, why?

35. (a) Does your community support married women to practice modern methods of contraception?
   yes_____ no_____
   (b) If yes/no why?

36. (a) Does your community support single/unmarried women to practice modern methods of contraception?
   yes_____ no_____
   (b) If yes/No why?

37. (a) Has the religion/community you belong to in any way influenced you to choose the method of contraception you are currently using?
   yes_____ no_____
   (b) If yes, how?

2. Misconceptions and beliefs about family planning

38. What are some of the rumours/beliefs/fears that are associated with the use of modern contraceptives in your community?
   Pill: ________________________________
   IUD: ________________________________
   Injections and Implants: ________________
   Sterilization: ________________________
39. Have these rumours/beliefs in any way influenced your choice of contraceptive methods?
   yes  no

40. Do you believe that these rumours/beliefs have some truth in them?
   yes  no

41. Do these rumours/beliefs pass on any important information about modern contraceptives?
   yes  no  I don't know

42. Would you pass on some of these rumours/beliefs to a friend who wants to adopt a method of family planning?
   yes  no

3. Socio-Economic and Demographic Factors

43. Do you think that one's age can dictate the type of contraceptive method to use?
   yes  no  I don't know

44.(a) At what age do you think one should be allowed to start using contraceptives?
   15-19
   20-24
   25-29
   30-34
   35-39
   40-44
   45-49
   Any other age (specify age)

   (b) Reasons for age given:

45. (a) Do you think that one's age at marriage would influence the number of children that one may choose to have?
   yes  no  I don't know

   (b) If yes, how
46. Does the level of education you have in any way help you when it comes to choosing and using contraceptives?
   yes   no

47. What is your approximate income per month?
   _____ K.Sh 2,000 and below
   _____ Between K.Sh 2,001 - 4,000
   _____ Between K.Sh 4,001 - 6,000
   _____ Between K.Sh 6,001 - 8,000
   _____ K.Sh 8,001 and above

48. Has your income in any way:
   (a) Had an influence on the number of children you have decided to have?
      yes   no
   (b) Had an influence on the method of contraception that you have chosen?
      yes   no

49. With the amount of income that you get per month, are you satisfied with the number of children that you currently have?
   yes   no   I don't know
   (Not applicable if respondent has no children)

4. Information, Education and Communication as a Factor

50. Through what means do you learn/hear Family Planning?
    _____ Radio
    _____ T.V
    _____ Newspaper
    _____ Friend
    _____ Clinic
    _____ Provider (CBD)
    _____ Any other (specify means)

51. Who first introduced you to start using contraceptives?
    _____ Friend
    _____ Doctor
    _____ Relative
    _____ Provider
    _____ Any other (specify means)
52. What is the general attitude of the family planning providers in your clinic/community?
   friendly_________ not friendly_________

53. Have you ever been counselled by the provider on the advantages and disadvantages of the various contraceptive methods available before choosing one?
   yes_______ no_______

54. If yes, does the counselling in any way have any influence on the method of contraception that you chose in the end?
   yes_______ no_______

55. Does your clinic provide a wide range of contraceptive methods from which you can choose?
   yes_______ no_______

56. Have you ever conceived while using any particular method of contraception?
   yes_______ no_______

57. If yes, was it because:
   ____ Method was ineffective
   ____ Did not follow instructions
   ____ Stopped method for a while then resumed
   ____ Any other reasons (specify)

58. (a) Do you think Family planning has adequately been marketed in your community?
   yes_______ no_______

   (b) If no, what measures do you think the organisations concerned with Family Planning in your area could adopt to improve on their services?

5. Access to Family Planning Services as a Factor

59. How do you obtain your contraceptive services?
   ____ Family Planning Clinic
   ____ Provider (CBD)
   ____ Private Doctor
   ____ Chemist
   ____ Friend
   ____ Any other method (specify)
60. How regular is/was the supply of the particular contraceptive method that you used before or using now?
regular______ irregular______

61. Have you ever been turned away from the Family Planning Clinic because the particular method you want to use was not available?
yes______ no______

62. How far is the nearest Family Planning Clinic from your home?
____ Between 100mts-500mts
____ 1/2 km-1 km
____ 1-2 kms
____ 2-3 km
____ More than 3Kms

63. How long do you have to wait at the clinic before you are attended to?
____ 5mins - 30mins
____ 1/2 hr - 1 hr
____ More than 1hr (specify how long)
____ I don't attend clinic

64. (a) Does your clinic provide any other services apart from Family Planning Services?
yes______ no______

(b) If yes, which are these other services?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

65. Have you ever been denied family planning services because of:
your age
________ yes ______ no

your educational level
________ yes ______ no

your economic status
________ yes ______ no

your religion
________ yes ______ no

your marital status
________ yes ______ no

your health condition
________ yes ______ no