GENDER RELATIONS IN THE UTILISATION OF FAMILY PLANNING SERVICES IN NYAN'GOMA DIVISION, BONDO DISTRICT, KENYA

BY

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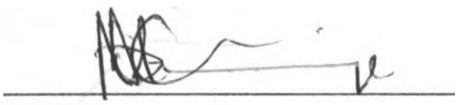
DECLARATION

This thesis is my original work and has not been submitted for a degree to any other University.



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This thesis has been submitted for examination with my approval as a University supervisor.

12/7/2002

Professor Collette Suda

Date

DEDICATION

To Robin Avigoke and Corey Wood

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TABLE OF CONTENTS

CHAPTER THREE: STUDY SITE & RESEARCH METHODOLOGY

CHAPTER FOUR: PRESENTATION OF RESEARCH FINDINGS

LIST OF TABLES

ABSTRACT

This study attempts to examine gender relations and how they influence the utilisation of family planning services in Nyang'oma sub-location in Bondo Distict, Kenya, on the shores of Lake Victoria. To date, social scientists and policy makers interested in fertility issues have devoted almost all of their attention to women, and very little to men. The researcher is aware of the historical links of 'family planning' with 'population control' and of strong arguments for and against 'population control'. She justifies the need for 'family planning', however, on the grounds that it improves maternal health and is a positive move in the long overdue emancipation of African women.

This study, therefore, aimed to find out how women in their various situations of social relations utilise family planning services. Most important decisions in the use of family planning services are made at the household level; so the household has been the level of focus and unit of analysis.

First-hand data were obtained from focus group discussions, non-participant observations, essays, narratives, key informant interviews, and a questionnaire to 100 respondents - 20 married men, 20 married women, 20 single mothers, 20 teenage girls and 20 teenage boys. Secondary data came from documentary sources.

Analyses of these data show that family planning services focus mainly on women when trying to disseminate information on family planning. Men, the

household decision-makers, are largely ignored – one reason for the failure of family planning programmes. The study showed that men and women do not make joint decisions on family planning issues: they leave nature to take its course. Women have no choice but to use family planning services secretly.

There is something of a taboo for most partners to discuss sexual issues; and this contributes largely to non-use of family planning services, especially by married women. The status, education level, household role, religious beliefs and martial status of women, all affect her access to, and use of, family planning services. Preferences for boys over girls, perceived ideal family size, and discussion about fertility related matters also affect the rate of use.

On the basis of these findings, it was concluded that, if family planning agencies want their services to be used more effectively, then they must not treat women in isolation, but consider them in conjunction with the real social situations in which they are embedded. It really must be 'family' planning.

It is, therefore, recommended that policy makers should design policies that show more concern for woman's social situations. More attention should be focussed on issues that help to empower women; so that they can then enhance their abilities to make independent reproductive decisions. There is also a need for more investigation of traditional methods of birth control and find out how they can be applied to the community, because male partners are more supportive of their use. Also, fertility treatment and counselling should be promoted to treat barrenness and lessen its associated lifelong stigma.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND INFORMATION

Issues of fertility and family planning tend to be discussed jointly in the literature, perhaps with some justification; for fertility is the most crucial demographic variable in population dynamics. The much publicised need to 'control' the generally high levels of fertility among most African nations in order to raise *per capita* income, has tended to treat family planning studies – such as contraceptive knowledge, attitudes and practices – as an integral part of fertility research. This is because fertility is perceived as the variable to be regulated and family planning is supposed to provide the means (Alando 1992). The reality, however, is considerably more complex and political.

"Family planning" arose from USA population control strategies, originally rooted in racist eugenics – designed to limit the future numbers of USA black and brown people. By 1975, a secret Kissinger Report (now in the USA National Archives) noted the need to control global population growth, so that the USA could both maintain it's share of world resources, and limit the increasing ratio of younger, more politically radical people opposed to the USA. This agenda of self-interest could not be aired publicly; so the USA used other ploys to sell this policy: environmental degradation, economic depression, maternal health and women's rights became the rationales for "family planning", aided by massive USA and United Nations (UN) funding. Within Africa, Nigeria and Kenya were targeted for special attention; and whole networks of family planning clinics and services were set up.

Condoms were subsidised and, in Africa, they became cheaper and easier to obtain than antibiotics or most medicines: it was as if the USA and Europe prioritised anti-natal policies over genuine health care for Africa.

In the 1990's, several studies – including "*More People, Less Erosion*" from Kenya's Machakos District – indicated that land resource management was the key variable for economic and environmental improvement; and that increasing population often acted as a positive catalyst in the process (Darling 1993; Tiffen & Mortimore 1994; Dowden, 1994; Oddie 1994). Later, Blum & Baker (2001) and Darling (2002) noted that capital flight of billions of US dollars per year out of Africa was the main cause of Africa's increasing poverty - not population growth. However, as African, USA and European governments and media empires stood to gain personally or politically from capital flight, it was still kept a silent issue. Many politicians bled Africa, then blamed Africa's resulting impoverishment onto a mythical 'population explosion', so shifting attention away from their secret financial activities. Today, the demographic impact of HIV/AIDS on Africa may render 'population control' redundant, under whatever guise it is practised; and the UN has already begun to shift its emphasis from 'family planning' towards caring for the increasing percentage of the world's old people.

Despite all the international chicanery, however, the whole process of promoting family planning hit on several universal values: maternal health, child-spacing, women's rights (social, legal, economic and reproductive) and other gender issues became incorporated in the majority of development

projects' documentation. This thesis assumes these values as its basic rationales for promoting family planning. Academic controversies about the impact of population on the environment or the economy lie outside its terms of reference: what matters is the wellbeing of Africa's women. For women are the custodians of Africa's future population, the guardians of its children, the carers for its old and its sick, and (in Kenya at least) the main farmers who, against all the odds, keep the alternative, traditional food economy alive.

Family planning programmes have tended to address primarily the individual mother with information on how she should limit the number of children to just those, which she can comfortably manage. However, this focus on the mother alone is not enough, since she relies on support from others: her life is embedded in gender and family relationships. This situation, then, calls for concerted efforts by family planning agencies and health authorities to involve husbands and a large network of other relatives, such as grandmothers and mothers-in-laws.

The overall situation of women and changes in gender relations are important for an adequate understanding of the use and uptake of family planning services. Women and their situation cannot be studied in isolation. The social relations between men and women are shaped partly by societal structures, cultural ideas and institutions and partly by the actions and practices of people in their daily lives; and they influence the choices that women make with regard to the use or non-use of family planning services. These gender relations are socially and culturally produced. They are also

dynamic. Silberschmidt (1991) observes that the relations between men and women and the way they manifest themselves within the household, shows gender imbalance, where men tend to be favoured in all cultures. It is within the households, then, that the various aspects of gender relations find expression.

Mbugua (1996) has raised concern over solutions and strategies that have been implemented in the past to address population growth. She argues that they have had significant gender biases in that they have focused on curtailing child bearing amongst women, often without adequate reference to their condition or their position in society. Yet women alone cannot solve 'over-population', the problem perceived by family planning agencies. It means, therefore, that women's social situations are important for an adequate understanding of the use of family planning services. This thesis aims to explore those gender issues relevant to the use of family planning services in Nyag'oma. Here, the Luo people have a patriarchal society, in which male dominance and female subordination define the locus of decision-making power, particularly when the use of family planning services is involved. This thesis, therefore, will focus on the social situations between genders and how these can be addressed for more effective uptake of family planning services.

1.1 STATEMENT OF THE PROBLEM

In sub-Saharan Africa, family planning and reproductive health care research and interventions place most emphasis on women. Social scientists and

policy makers interested in fertility have devoted almost all of their attention to women and very little to men (Anderson, 1997). This biased approach tends to ignore men and the fact that women are part of reproductive social relationships, which largely influence decisions on various issues, including the use of family planning services. The resulting belief that family planning is a woman's business is misleading (Fapohunda & Rutenberg, 1999). Logically and rationally, family planning should be the joint responsibility of husband and wife (or male and female partners). In reality, joint decision-making and responsibility is hard to achieve because of disparities in gender power relations and, sometimes, in conflicting reproductive goals. Women's powerlessness represents a barrier to the use of family planning services.

Family planning services should be provided within the gender framework, where husbands and male partners are involved, because women must rely on their support. Whilst female controlled methods are welcomed by partners of resistant men, reaching the individual mother alone is not enough, as was considered the case in the past. Women's situations and the changes in gender relations are particularly important to understanding past family planning programmes and processes. In order to explain women's use patterns, therefore, it is necessary to transcend women *per se* and to look at the relations between men and women, as well as the whole institutional framework and cultural contexts, which have formed these relations.

The gender bias in past strategies to address population growth have caused concern (Mbugua, 1996). Women have been examined in isolation and hence have been blamed for the perceived problem of 'overpopulation'. This is

wrong, as women are part of a wide network with consciously set rules for every individual in society, in which every individual has to adhere to a chain of command. So, a woman cannot decide that she has had enough children without consulting her husband and a wide range of relatives and friends.

The use or non-use of contraceptives reflects fundamental power imbalances between men and women, in which women are vulnerable owing to inequitable relationships; and this raises more important questions about the control women have over their own bodies and sexuality.

The study was designed to address the following research questions:

- How do gender relations affect the utilisation of family planning?
- Do family planning agencies focus on women alone or are men included?
- How much do men and women make joint decisions on family planning?
- To what extent does a woman's status affect her access to, and use of, family planning services?
- How do men's and women's different perceptions about children influence the use of family planning services?

1.2 OBJECTIVES OF THE STUDY:

The overall aim of this study was to investigate the effect of gender relations on the use of family planning services, specifically addressing the above research questions at the household level in Nyang'oma, so as to identify obstacles to uptake of family planning services. The objectives were to:

- determine the effect of gender relations on the use of family planning

- find out if family planning agencies focus on women alone or include both women and men
- investigate to what extent joint decisions are made on family planning
- assess how a woman's status affects her access to, and use of, family planning services
- describe men's and women's different perceptions about children and how these influence the use of family planning services.

1.3 JUSTIFICATION OF THE STUDY

Issues of reproductive health, such as maternal health and family planning, are fundamental to the rights of African women; and are as much the concern of social scientists as medical personnel. This Anthropological study was carried out to inquire into the use of family planning in a particular community, with a view to pointing out the obstacles that lead to lack of use. Once identified, these obstacles can provide much information of practical value for the improvement of services and counselling.

The focus was mainly on how men and women relate to the use of family planning services, as little attention had been paid to this before. The use of family planning should not be the responsibility of one partner; and the role of women in any society is greatly weakened, if their reproductive health is left solely up to them. This study documents some reasons why women do not use family planning services enough. The practices identified by the study may be useful to planners and other interested parties, when it comes to

drawing up health education programmes aimed at promoting appreciation of family planning services.

Many programmes, aiming to limit births, have been launched by government and non-government organisations; but most did not achieve their objectives. Failure or insignificant success of the programmes tended to correlate positively with a lack of support or acceptance by male partners. Men were the least involved (if at all) parties in the planning and implementation of these programmes. Hence the need to involve both men and women, to listen to their requirements and to address their needs (not just impose policy), in any successful future family planning programme.

This study has revealed the importance of gender analysis in the use of family planning services. For example, if women are limited in terms of economic dependence, then no significant impact will be felt. As it is, women's cultural and socio-economic environment considerably influences their own reproductive behaviour and fertility preferences. This study is policy orientated, insofar that it sought to identify specific problems in the use of family planning services. Medical practitioners can benefit from this study when disseminating ideas on the utilisation of family planning services. As Ojala (1999:19) notes: *"The major obstacles facing health administrators and planners in the world, and especially in developing countries, is the lack of data on how and by whom health services are used. The administration and planners tend to rely on such rules of thumb targets as beds per 1000 people."*

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

C20th USA politically motivated funding sponsored an extensive literature on birth control to curb the perceived 'population problem'; and it suited such a viewpoint to focus on the woman as though she were an entity divorced from any social relationship. This is too narrow a focus for analysing the complex issues of family planning. Faced with a patriarchal image, women's only option is to obey their male partners, be deferential to them, and to consult them before taking any action. This role of women *vis-à-vis* current family planning practice necessitated that this study look beyond the 'woman'.

Gender roles affect the use of family planning services due to the power imbalance between women and men. A study conducted in Switzerland (Berer, 1993) revealed that violence, threats of violence and fear of violence are familiar to most women when they ask for safer sex or need to use contraceptives. Violence is used to silence women's efforts to curb child bearing. Women are thus kept passive, and men are allowed to retain control over the decision-making process on sexual relations. This means that, in order to explain women's utilisation of family planning services, it is necessary to examine the relations between men and women, as well as the whole institutional framework supporting the inequalities of these relations.

Most family planning programmes currently make little effort to communicate directly with men or to understand their concerns (Anderson,

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1997). This neglect of men has probably exacerbated the role of those men, who take no responsibility for contraception, so burdening their female partners unfairly with the responsibility of ensuring effective contraception.

Roudi (1996) observes that men's involvement in family planning, either as users of male methods or as supportive partners of female users, has been largely ignored by family planning programmes and service providers. In addition, family planning services generally have been offered through maternal and child health care providers and clinics, which automatically excludes men. These clinic-based programmes cater mainly for mothers and children, providing services to those, who come voluntarily for medical examination and/or contraceptives; and they may not lead to a rapid increase in the number of contraceptive users because the strategy is expensive and the infrastructure poor. The introduction of community-based distribution programmes has been more effective, as they take the services to the people.

2.1 GENDER RELATIONS AND DECSION-MAKING PROCESSES

Gender relations are wrought with confluence and conflict; and the benefits and costs of bearing and bringing up children are not distributed equally. Men rarely bear the cost, so have no incentive to limit the number of children. Salway (1994) argues that neither husband nor wife should be ignored in attempts to control fertility. Little attention is given to men's cultural attitudes to fertility, even though these attitudes shift responsibility for rearing children onto women; and seriously impact on the uptake and utilisation of family planning practices.

Most decisions are made at the household level. Here, the husband and wife decide how large or small the family should be. A couple's decision to try and conceive or to avoid conception may involve consensus, compromise, coercion or co-optation of decision-making by either party (Anderson, 1997). Mothers-in-law may also come in with suggestions to their daughters-in-law and their sons about the number of children. Friends, neighbours and other relatives exert an influence, which may alter decisions made in the household. A study in Kenya's Nyanza Province revealed that social networks, in which fertility preferences and family planning are discussed, consist primarily of relatives and neighbours of the same gender, ethnicity and level of education (Bongaarts & Watkins, 1996). Such kinds of discussions may influence the choices people make on the use of family planning services.

Gachui (1975) states that women withdraw or continue in family programmes because of the influence of parent's-in-laws, friends, relatives and peers. Parents-in-laws do not favour modern family planning methods, they consider a large number of children to be the norm, and their pressure leads to poor utilisation of family planning services. Mothers-in-law consider themselves to be repositories of wisdom, pregnancies, fertility control, child births and infant care (Foster & Gallat, 1978); so they see the use of family planning services by their daughters-in-law as threatening their status and power.

Patriarchy also affects the use or non-use of family planning services: African men play an important role in most decisions on family life, including family size and family planning (Roudi, 1997). In Ghana, Oppong (cited in Were,

1991) notes the impact of power on the household; and she concludes that spouses with similar education and occupation have greater equality and more interactive decision-making. Among the Luo (where this study is based), however, Olenja (1991) observes that women have little or no control over the tangible resources, although their contribution to the sustenance of the household is substantial: their contribution, in most cases, goes unnoticed.

Other studies indicate that male attitudes of control and subjugation, especially in sexist and patriarchal cultures, disadvantage women when it comes to decision-making on issues, such as the use of family planning services (Molnos, 1968; Maleche, 1990). In Iran, women have to obtain spousal authorisation for all forms of contraception; and their husbands' opposition is the main reason for the failure to use contraception and for the spread of sexually transmitted infections. Scholars, such as Fapohunda & Rutenberg (1999) and Molnos (1968), have pointed out that the limited use of services among women results from the lack of partner support or husband disapproval. This outcome has been interpreted as the outcome of the partners infrequent verbal communication or discussion about family planning and sexual health.

Iranian women are aware that the use of family planning services minimises unplanned or unwanted pregnancies. However, they lack control over their own sexuality, because they belong to a society that has set its own unwritten rules about children. At the end of the day, they have little power and control over their own sex lives, because of certain cultural practices and the

imbalance in gender power relations in the family structure. *"Even where the woman is in control and can make a decision, this is open to negotiation"* (with her husband and relatives) (Olenja, 1991:4). "*The husband has wide-ranging authority over his wife and has the right to order her to perform work tasks, to decide when to have sexual intercourse and to prevent her from using contraceptives*" (Hankansson, 1994:522).

According to Weeks (1981), part of the reason for the non-use of modern contraceptives among women was the ambivalent attitudes arising from a conflict between the societal ideal of a large family and a personal desire for fewer children. This confusion limits the ability of the ordinary woman to use family planning services: she does not know which of the two is superior – society or family planning agencies.

The widespread belief that family planning is a woman's affair may account for the problematic lack of concern by men. Fappohunda & Rutenberg's (1999) study in western Kenya's Kakamega District, found that lack of information and conviction regarding the advantages of family planning, compounded with misconceptions about condoms and other contraceptive methods, may explain their limited use in rural areas and among persons of low education status. Other reasons given for non-use are:- misconceptions emanating from local beliefs and practices; divergent preferences for the number and composition of children; disparities among spouses about the costs and benefits of children; persistence in the beliefs and practices that promote male domination, such as naming ceremonies, pressure from parents-

in-law and polygamy; and the gender division of labour, which promotes women's reproductive roles at the expense of their productive roles.

Family planning should be perceived as the joint responsibility of husband and wife or male and female partners: the reality is that joint responsibility is hard to achieve. In sub-Saharan Africa, family planning and reproductive health care research and interventions place more emphasis on women, yet tend to ignore the cultural milieu of their social relationships, so exacerbating a widespread idea that family planning is a woman's business (Fapohunda & Rutenberg, 1999). In reality, African men, who are heads of their households in patrilineal societies, are often the key figures in domestic decision-making, particularly in fertility behaviour and preferences – and their authority is supported by tradition (Isiugo-Abanihe, 1994).

Fapohunda & Todaro (1988) argue that African family structure shapes spousal perceptions of fertility and that men and women do not necessarily have the same views about family planning and reproduction because their interests are shaped by expectations, which themselves are determined by the social structure of their households and community. A couple's family planning decisions result from a complex process (Roudi, 1996).

Men are generally perceived as obstacles to the use of family planning services. Silberschmidt (1991) argues that most men are reluctant to have their wives use modern contraceptives for fear that this would encourage their wives to "roam about", violating men's perceived sexual and genetic

'property', and leading to broken families. Male superiority and female inferiority are acting conjointly on male ideas of gender relations. Men almost invariably claim to be more knowledgeable and more powerful than women – hence the need for women to consult with them on issues regarding family planning. When men feel that their position is threatened, this has led to domestic violence. The imbalance in gender power relations quite clearly does impose certain limits on a woman's reproductive freedom; yet some wives circumvent their husbands by using family planning services covertly. "*Men's objections to family planning prompts some women to select contraceptive methods from the limited set of those that their partners cannot easily detect*" (Suda, 1999:23). Women in most cases prefer to use those forms of contraception that are less conspicuous, such as injections (Id de-provera) and NormaPlant. Only the medical practitioner knows the secret of their use; and he or she may not know the client; whereas pills or condoms run a real risk of the wrong person stumbling upon them.

There is, therefore, a great need to accommodate both men and women in reproductive health, so that women can feel free to use the optimum method available. Fapohunda & Rutenberg (1999) argue that, in order to elicit greater participation of men in reproductive health, health facilities should offer predominantly family planning and sexually transmitted diseases services; a range of methods exceeding condoms and vasectomy; and guarantee confidentiality, privacy and comfort. However, one wonders why they, like so many other family planning authors, omit to mention fertility treatment for the childless; for this, too, must be integral to 'family planning'.

2.2 THE STATUS & POSITION OF WOMEN IN THE HOUSEHOLD

Gender is part of any household economy: men and women are involved in virtually every household. It is in the household that gender-based divisions of labour exist; and gender is closely inter-linked with other dimensions of social inequality. Focussing on the relations between men and women and the way in which they manifest themselves within the household, in kinship relations and in the overall society, gender relations are asymmetrical and hierarchical, with some form of asymmetry being present in all cultures (Rosaldo, 1980; Ortner & Whitehead, 1981).

In western Kenya, agriculture is dominant and land is the main asset; but mainly men govern the access to, and ownership of, this land. Nevertheless, women provide most of the on-farm labour in peasant farming; so they receive usufruct rights for subsistence farming via their husband's lineage. Women usually involve their children in farming and household tasks, hence one need for a large number of children for these chores in marriage. Hay & Stitcher (1984) observe that the relations of patriarchal dominance in the household economy, combined with continuing practices of rural exploitation through low crop prices and high consumer good prices, all serve to confine the great majority of rural women to a life of heavy labour and limited welfare. Women's specific problems of low productivity in food farming, lack of cash to invest in modern inputs, lack of time and money to provide adequate nutrition for their children and, in most cases, an extreme workload, also relate to long-standing traditions operating at the household level.

Raikes (1990) observes that the socio-economic status of users would be expected to influence the use of family planning services. Those with a relatively high socio-economic status are motivated to reduce births to a more manageable number. A woman, who is under many traditional constraints, is less likely to use family planning services because her main concern is about the basics of life. Besides, her husband has an upper hand on everything: he manages the family farm and keeps the proceeds of cash crops for himself, whilst expecting the wife's food crops and any cash earnings will be used to meet most of the family's daily consumption needs. This social and economic dependence of wives on their husbands or partners gives men great influence in family planning decisions (Roudi, 1996).

Traditional practices, such as the payment of bride wealth, male inheritance of land, and the belief that children 'belong to' their father's lineage in patrilineal societies, all continue to limit the freedom of choice and economic dependence of women (Hay & Stitcher, 1984). A woman, therefore, cannot make her own independent decision on the number of children to whom she would like to give birth, because other factors come into play. She has to rely on her husband or partner for advice concerning her desire to use family planning services and he may not welcome the idea, in which case she has to obey her husband or partner.

Through bride wealth, the husband's lineage secures the wife's reproductive rights, leaving the wife with no traditional right to use family planning services. The transfer of bride wealth is perceived as being necessary to

create a woman's status as a wife, and to establish her as a proper adult in her new family (Hakannson, 1994). He asserts: "*It is the payment of bride wealth that provides a woman with a social network for managing social crises and economic problems*" (*ibid*:526).

Modern legal systems offer the formal possibility for inheritance of land by widows and to a woman's right to shared custody of her children in divorce. However, actual legal judgements commonly refer to the 'traditional customs of area', which routinely deny a woman the right to land or parental custody.

In a situation where there is economic dependence on men, there is a negative effect on family planning programmes and activities, because women are limited in terms of economic dependence. Omari (1988) argues that this may increase the capacity for men to influence certain decisions, including the use and non-use of modern methods of family planning. He analyses the situation in Dar-es-Salaam, where he observes that there is ongoing social control by men in both rural and urban areas. This process centres around the cultural values and norms among many ethnic groups, where men head the households and have key roles in the decision-making processes pertaining to the welfare of those family members under their control.

Omari (1988) sees women not only as a source of labour, but also as a source of reproduction of the potential labour force. Children in traditional societies were valued very much as a source of support in old age and as a source of labour. They played an essential role in the household and the agricultural/

pastoral economy; hence their contribution cannot be overlooked when family planning services aim to limit their numbers. Reproduction of labour in the form of many children is considered as an investment.

Suda's (1999) study on the fertility and status of women in Kenya's Kericho District indicates that women's cultural and socio-economic environments considerably influence their own reproductive behaviour and fertility preferences. Although children are still highly valued, changing social and economic circumstances, coupled with the high and rising cost of living, have now made children a liability rather than an asset.

Molnos (1968) observes that women in East Africa have often been considered in terms of their 'status'. Most observers have come up with the value judgement that this status was 'low'. Molnos argues that such a conclusion is wrong, because an absolute equality of the sexes is not achieved by any society. She observes that, in almost all cultures, men hold the leadership. Women play a secondary role in all institutions, which provide for the political, economic and social existence and progress in the country. Even women in executive and leading positions find themselves overwhelmed by the male majority on the same levels. This has a strong corollary to the female function of childbearing and concomitant maternal duties, hence family planning services will be used more by women in such leading positions.

Driberg (1932) points out the very clear status differences in traditional East African societies. Status is an important factor in African society and may discriminate between the sexes. For instance, in the Luo's patrilineal kinship organisation, the children born to a wife belong to her husband. This has far-reaching implications for the use of family planning services, because the man is also involved: the children belong to him and he has a greater say on the number of children required. Furthermore, a wife becomes closely identified with her husband's lineage upon payment of bride wealth: in effect, her husband's family has purchased her; so her husband has a perceived right to exert strong control over his wife.

Cory (1959) analysed polygamy among the Sukumu people in Tanzania. According to him, it was not difficult to keep peace in a polygamous household, because wives competed among themselves in work and good behaviour, and the husband benefited from this competition. The most frequent reasons for taking a second wife were the barrenness of the first wife, the desire for more children, and the need for a larger labour force. This confirms that the use of contraceptives must be heavily influenced by the husband's reproductive intentions.

In respect of the Luo in western Kenya, "*... the degree of initiative and freedom among women is greater in polygamous families than in monogamous ones*" (Ominde, 1952:29). The polygamous system offered more freedom to the woman, enabling her to make most decisions on her own for a variety of issues. However, it is important to note that the reproductive

powers of the legitimate wife belonged to her husband's family, even after her husband's death. Whenever a man died without children, widow inheritance was practised to produce children for the husband's lineage. All these customs point to the importance role of childbearing in traditional societies; and the status of a woman rose increased with the number of children she bore for her husband. A barren woman had no social prestige whatsoever.

Joekes (1994) sees the family as the basis of social organisation in all societies, generally characterised as an arrangement whereby men provide protection and support to women as mothers of their children. Family organisation may allow or even promote gender inequalities, if the woman's bargaining power is weak. This is not always the case; and there are contexts of change in which women's control over resources and independence from men has actually increased.

Feminists have always seen the conjugal family as the social structural basis of men's social control over women. Tapper (in Pollack, 1985) sees marriage as the structure, which reinforces men social control over women. It is a relational contract facilitating the material protection by men for women, in exchange for women's subservience to men, their provision of sexual services and their assumptions of responsibility for household provisioning and the care of dependants. Women, who have a greater degree of autonomy, are able to resist demands from their husbands for, say, more children.

2.3 EDUCATION LEVEL AND THE USE OF FAMILY PLANNING

The level of education links the knowledge of family planning services, so it becomes an important factor in their use. Education is seen as a key factor in the socio-economic development of both men and women. The link between education and fertility decline was not emphasised until recently, when the level of women's education and consequent knowledge of family planning services was positively correlated with declines in fertility. Less attention has been paid to the relationships between male education and fertility.

Cleland & Chidambaram (1981) describe the female education/fertility relationship in terms of differences in the tempo of childbearing at different marital duration. Four countries - Peru, Pakistan, Indonesia and Kenya – demonstrated a common pattern in their findings. In the Peruvian sample, fertility was uniform across the education level groups in the early stages of marriage but began to diverge five to nine years onwards after marriage, as the better educated groups use contraceptives to restrict family size.

Caldwell (1982) sees the introduction of universal national education as the prime mover behind fertility transition. She observes that a traditional family morality cannot survive the changes brought about by national education programmes, which promote individualistic, nationalistic values and have agendas different from those of the parents. Education also decreases the child's potential as a worker within and outside the home, making the child a future, rather than a present, worker. Education increases the cost of children, making them dependant on the household for support (Caldwell, 1980).

Handwerker (1986) challenges Caldwell's position on the effects of education on fertility. He argues that education does not always lead to a change in values in the expected direction: rather, fertility decline comes about through changes in material constraints. In his 'Resources Access Theory', he argues that women begin to reduce fertility when they have other opportunities besides childbearing for the attainment of adult status, prestige and wealth. These opportunities are more available to educated women. His data from Antigua and Barbados shows that educational attainment works through women's empowerment to decrease fertility. Women use family planning services if they have some education status, itself a form of empowerment.

Le Vine *et al* (1991) conducted a study in two towns of central Mexico on the relationship between fertility and education. They argued that there was a possibility of multiple mechanisms through which education results in lower fertility. It was observed that women with more schooling had greater aspirations for both themselves and their children, had more exposure to the media, had more egalitarian families, and had fewer expectations of returns from their children. These women communicated more with their children, as well as using more child health and antenatal services.

Bradley (1995) studied fertility decline in Maragoli, western Kenya and suggested that women's empowerment and education are linked to declining fertility. Ndege (1991) reports that educated Maragoli women are more likely than less educated women to communicate with their husbands about contraception. Education empowers women; and, once empowered, women

may influence or control social, political and economic decision-making, both within and beyond the household.

Education may make women more interested in, or capable of, using credit, banking, participating in a co-operative, and hiring labourers. Thus, they may be empowered to resist the demands of relatives to have more children, or to be more rewarded by those activities than by having many children. Co-operative participation may further expose women to information about family planning (Hammerslough, 1991; Watkins, 1993). Women involved in these ways are more likely to use family planning services.

Caldwell (1982) argues that education leads to fertility decline by inculcating western values and changing the economic value of children. Therefore, families no longer gain economically or politically by having many children, nor do they achieve high status. Children are no longer seen as future investments for parents in their old age and there is no more 'situational advantage'. Situational advantages include gender and age roles in decision-making power; and changes in these may bring about changes in fertility.

2.4 INFLUENCE OF RELIGIOUS BELIEF ON FAMILY PLANNING

Traditional pre-Christian religion among the Luo involved a complex system of beliefs and customs, inseparably interwoven with people's lives and their social organisation. Whisson (1964) contends that the question about priorities and interactions between religion and society is an almost insoluble problem. Religion is seen as a substantial manifestation of traditional

cultures, of their whole value system, and not a mere set of beliefs, precepts and prohibitions put at the choice of families and individuals.

Most of the beliefs and customs have already disappeared or are rapidly disappearing. Some isolated beliefs and attitudes concomitant of past social forms are preserved out of their original context, sometimes over many generations, in more or less disguised forms, contaminating new ones and reappearing in modern rationalisations. The discovery of the original background of such mental constructs should help in understanding and, if necessary, in overcoming them (Whisson, 1964). In Luo traditional religion, several kinds of extra-human and supernatural agencies played a part: a supreme being and/or other night gods, ancestor spirits and some third force between them. "*... the concept of a creator spirit was present in the minds of the Luo before the introduction of the Christian concept. The primary function of the personified high god, called 'Nyasae', consisted in the maintenance of good rather than in the defeat of evil.*" (Whisson, 1964:6).

According to Luo beliefs, "*at death, the shadow (tipo) leaves the body of the dying person and stays in the home for few days to ensure that the proper ceremonies are carried out ... After the ceremonies the shadow goes to the sky (polo) where it remains peacefully as a spirit (juogi) ... the pattern of the ancestors living in the sky beyond the grave, corresponded closely to that of the people living below*" (Whisson, 1964:7).

The spirits of the dead needed their descendants to perform the rites in their honour and comply with their wishes: the latter needed the spirits as advisers and helpers in important and difficult matters. However, most often the dead ancestors acted as severe censors of rule-breakers and those who neglected duties. In short, the ancestral spirits assumed functions of direct social control (Molnos, 1968).

The Luo also saw birth and death as forms of passage between two similarly organised worlds. Death was more of a passage than a real loss, so long as children were born to keep the balance of the world of the living and that of the dead. The facts of being childless and barren are intimately linked with these traditional ideas. The lack of descendants interrupts the communication between terrestrial and ancestral society causing, thus, the death of both. One may desire children to satisfy the ancestors and for fear of revenge from them. Consequently, a deliberate planning of the number of children would be a decision against one's own interest and that of the society.

Cory (1959) points out the various reasons why traditional societies practised contraceptive methods and, in extreme cases, abortion. Among the Luos, for example, abortion was carried out for socially unacceptable pregnancies, mainly for unmarried and pre-pubescent girls; and other measures were taken to prevent pregnancy in premarital sexual experiences. The Luo also practised infanticide: all babies born feet first, albino, maimed or believed to come from an incestuous union were strangled at birth (Whisson, 1964).

Molnos (1968) asserts that traditional societies generally used contraceptive methods for reasons different from those in modern family planning. This may explain the unpopularity of modern family planning services, which are viewed with considerable suspicion as compared to traditional methods.

Many of these traditional ideas have been influenced or replaced by new religious beliefs. The question arises as to which Christian ideas and values actually replaced traditional ones, and which ideas have only been outwardly accepted leaving former values and attitudes more or less unchanged. In many cases, such as the traditional preference for many children, they remain unopposed by Islamic or Christian ideas. Indeed, the tendency is for most religious belief to be a conservative reflection of a past emptier world, still echoing its divine injunctions for people to '*multiply*' (Genesis 1:28
).

Islam and Christianity are instrumental in influencing people's lives; so it would be good if their religious leaders now updated their stance to reflect today's world and to begin seriously addressing the various issues involved in family planning programmes, education and capital flight out of Africa.

2.5 PERCEPTIONS ABOUT CHILDREN AMONG THE LUO

"*The ideal in nearly all traditional African societies was to have as many children as was physically and socially possible. Children were, are still are, highly valued in Africa and variously perceived as a source of wealth and security, a status symbol and a blessing from God and the ancestors. Large*

families were desired and the value of children had much to do with their family's future expectation of them" (Suda, 1999:59). This ideal of the traditional African family has implications for the use or non-use of family planning services, since men and women still holding to this ideal will see no need to use family planning services.

Traditionally, among many Kenyan societies, children are a virtue and the desire to have children is a desire for righteousness. It is a custom, whose moral good is equally perceived to be intrinsically good. It tends to reject the use of contraceptives and induced abortions. This belief is further reflected in the attitude towards a barren or childless woman, who is usually the subject of pity and sympathy, often undergoing divorce or remarriage as a result. In many societies, including the Luo of western Kenya, children are not quite considered to be ancestors reborn, but are named after recently deceased grandparents, who visit the parents in dreams until this demand is fulfilled. The fear that a family line may come to an end because one has no male child is a deep socio-cultural imperative, which no family would defy in the name of fertility control (Ochollo-Ayayo, 1986).

Swartz (1996) asserts that the size of the family in an African context is symbolic of parenthood and of having children. He argues that if one wants to find out what children 'mean', one should look at what is made of having them and of not having them, of having many as opposed to having few, and of losing them or keeping them.

Alando (1992) has assessed the influence of marriage on one's status among the Luo, observing that a child cannot be named after a person who was never married or had no children. The elders would not invite such men to a social gathering or any important discussions. Indeed, in many Luo communities, the unmarried and childless were stigmatised. Today, such people are useful in different ways, such as looking after and teaching the young (Ocholla-Ayayo, 1976). At death, though, such people lose all their property and their names are soon forgotten. Thus a person's name only live after him/her if he/she had children; in which case they can be named after by any member of the clan. In the face of such strong cultural expectations and beliefs, people are usually very reluctant to accept contraception. According to Isiugo-Abanihe (1994:1), "... *marriage has meaning only when a child is born or in fact survives.*"

Alando (1992) also observes that divorce was not accepted in many societies and was considered as temporary separation. A family would accept a woman back after many years of separation, even when she sometimes brought with her the children sired by other men. Divorce or separation do little, therefore, to interfere with the reproductive performance of separated women, as they see no need of using family planning services.

Studies of the values placed on children in various societies point to a near universal sentiment favouring parenthood and the belief that children constitute an important, if not crucial, component of a happy and normal family life (Hoffman & Hoffman, 1973; Arnold *et al*, 1975). These studies

generally conclude that children in most societies have both economic and symbolic value. "*The value of children refers to the functions they serve or the needs they fulfil for parents.*" (Hoffman & Hoffman, 1973:20).

There are socio-economic benefits implied in the need for more children, such as their labour input at home and/or on the farm and their source of security for parents in old age. The decisions about the size of the family take these considerations into account, as well as being influenced by religious beliefs, resources, personal/marital agendas of the couple and other factors.

Ramu (1988) observes that the religious and moral values that encourage fertility are deeply entrenched in the community and are an important consideration in the couples desire to procreate. It is widely believed that procreation is a natural and moral act incumbent upon a couple once past the initial excitement of marital romance and sex. Giving birth and raising children are viewed as altruistic acts, because these entail dedication and personal sacrifice.

Fapohunda & Todaro (1988) point out the practice of polygamy as a contributory factor to a large family. "*In fact, the very institution of polygyny instils some form of competition amongst the co-wives in child-bearing.*" (Olenja, 1994:62). Competition for children among the co-wives is likely to lead to less use of family planning services. This is true of other traditional practices, including naming (which requires that ancestral names are kept alive through the children), pressure from the extended family members

(especially grand-parents and parents-in-law), and the persistence of the idea that a woman's job is to give birth to as many children as possible. The desire to have sons to inherit the homestead often encourages many men and women to postpone family planning until they have achieved the desired gender composition of children. Owing to customs and traditions, daughters will soon be married and go to live with their husbands elsewhere irrespective of their number, leaving their parents alone. Any person with many daughters and no son will consider themselves as having no children to look after them in old age, or to whom they can pass on their wealth and authority when they die. In some cases, this can force a woman to go outside her husband's family to try her luck if she can get a son. This is supported by the custom and tradition that a child obtained by a married woman belongs to her husband, irrespective of the biological father (Ocholla-Ayayo, 1986).

Olenja (1991) carried out a study of a patriarchal society in Siaya District, western Kenya. Here, it was considered essential that a son is born to the family; so families with only girls continued to have more children, defeating fertility control measures. The practice of replacing a dead child and the belief that the dead child may come again makes it difficult to stop giving birth. These beliefs, coupled with the fear of losing a child, minimise or limit the practice of contraception (Ominde *et al*, 1983; Ocholla-Ayayo, 1986). Western Kenya has maintained its traditional patterns of highly distinctive family structure and economic arrangements. These patterns have proved to be quite persistent and are the main factors that determine the use or non-use of family planning services (Odile & McNicoll, 1987).

Knowledge concerning the interaction between cultural values and population policy requires advancement, facilitating a more effective interface between family planning services and Kenyan people's values. There is a relationship between population growth, birth-rates and desired family size (Muganzi, 1988); so the use of family planning services depends upon lowering family size expectations or desires, in effect imposing change on cultural ideology.

Indeed, almost all this literature describing socio-economic factors has little real link with the uptake of family planning services: there is little evidence of the 'family' in 'family planning'. Fertility control agenda have focussed research and action on women, as women's reproductive health and social emancipation were powerful factors promoting that agenda. However, in the process, this focus on women has led to the needs of African families, men, barren women and childless couples being largely overlooked, even consciously avoided, by 'family' planning services. Field study was needed to test if both women and these groups could benefit from a more holistic approach from family planning agencies.

2.6 THEORETICAL FRAMEWORK

This study adopted a gender perspective framework, and aimed to describe, explain and predict relationships between the main variables affecting the utilisation of family planning services. This gender perspective conceptual framework is suitable for analysing the relationship between men and women, as well as the roles they perform in society. Relationships between men and women are based on the social and cultural roles of men and women in a

particular society; and these roles are socially defined, without any reference to their biological abilities. The theory differs from feminism, which views men as the main oppressors of women, but shares many of the feminist ideas of feminine consciousness (Hook, 1984).

The gender perspective is more concerned with women as agents of change and, in so doing, introduces the relational aspect, looking into the relationship between men and women insofar as they affect reproduction. The emphasis on this relational approach shows how the contribution made by men and women in reproduction affects their use of family planning services. Gender perspectives also look holistically at how gender roles and relations affect every aspect of human life, cross-cutting health, politics, economics, employment, beliefs, education and many other spheres of social activity.

The transformational approach of gender perspectives identifies all the oppressive structures, which perpetuate women's poverty and helplessness. It focuses mainly on changing the structure of gender roles and relations by seeking for those measures, which enhance sharing responsibilities, opportunities and powers between men and women. This approach also seeks to establish a sustainable mechanism for promotion of gender equality and equity; for gender roles are not static, they change over time and space, so it is feasible to change them at whatever level.

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2.7 RELEVANCE OF THE THEORY TO THE STUDY

Gender analysis studies the social construction of gender; and analysis of the relations between men and women (and how they nearly always work to the detriment of women) is one key to understanding the use of family planning services. Silberschmidt (1991) argues that all societies exhibit a gender division of labour: some tasks are allocated predominately or exclusively to women, others to men, while some may be carried out by both genders. Gender relations exist within a matrix of persistent cultural norms and values, themselves based on societies with traditional sexual divisions of labour and traditional role definitions, which 'legitimise' the relations between genders.

Based on this premise, it became crucial for this study to look at the extent to which men and women make joint decisions on family planning issues. Caldwell (1982) points out that the increasing insecurity surrounding the position and role of women is often a motive to bear many children, both for extra hands in the fields and as a source of security and support in old age. In addition to these, and to many of the other factors already noted in this chapter, is the high social prestige accorded to motherhood. This, however, has a sting in the tail; for women fear that, if they do not make themselves available for motherhood, they will risk their husbands pressing for a divorce or taking a second wife (Levine, 1979).

2.8 HYPOTHESES

- Many family planning agencies focus on women as the primary consumers of family planning services.

- It is probable that, partly as a consequence of division of labour and consequent gender relations, men and women do not make joint decisions on family planning issues.
- A woman's status affects her access to, and use of, family planning services.
- Community perceptions about the value of children influence the use of family planning services.

2.9 DEFINITION OF TERMS

Gender: The different socially and culturally defined roles and relationships existing between men and women in any society.

Gender Roles: The different male and female roles assigned respectively to men and women in a particular society as part of the process of socialisation.

Gender Relationships: The relationships between men and women derived from the social and cultural gender roles of men and women in a society.

Family Planning Agencies: The personnel and organisation providing family planning services, including community-based distributors, community health workers and health facilities. Family Planning Agencies derive from external UN initiatives and funding, hence their cultural awkwardness in a Kenyan context and the need for this study.

Joint Decisions: The result of discussions between a couple (husband and wife/ man and woman) on issues affecting them both and in which, ideally, there is some parity of decision-making. In this thesis, this term has been restricted to family planning issues.

CHAPTER THREE

STUDY SITE AND RESEARCH METHODOLOGY

3.0 STUDY SITE

This study was conducted in Nyang'oma sub-location, Nyang'oma division of Bondo district, Nyanza Province. Bondo District, carved out of Siaya District, is along the shores of Lake Victoria and covers an area of 1,069 km^2. In Nyang'oma sub-location, there are 23 villages with an average of 77 households per village. This study used the Kedahr project framework, which sampled only seven large villages (Kadero, Kanyandiri, Karateng', Duka, Wawaye and Wayendhe) in the sub-location. According to the Siaya District Development Plan of 1989, the District had a population of 66,811 in the 1989 census, and was projected to increase to 96,108 by 2001, an increase of 3.1% per annum. (The 2000 Census results are still tentative).

3.1 THE PEOPLE

The Luo, who are the majority of the inhabitants, carry out subsistence farming as their main economic activity; and their socio-economic status is low (National Survey of Kenya). Most of the crops grown are mainly for subsistence and include cassava, sorghum, sweet potatoes and maize; and most people keep indigenous cows for milk and, in some cases, for sale. A few people are engaged in small-scale fishing and gold mining.

Marriage is an important institution among the Luo. It sanctifies a union, whose ultimate purpose, according to Makila (1978) writing about the adjacent Babakusu, was to bring new lives into the world. Children born to a wife belong to her husband, his lineage and clan; so the rights of the woman

over her own children are limited. Marriage was never complete until a couple had children.

3.2 TOPOGRAPHY, CLIMATE AND SOILS

Nyang'oma division is within the Lake Victoria region. It receives an annual rainfall of about 166mm-1800mm per annum, with the maximum during the months of April and May. Short rains are often unreliable and fall between October and November. The soils are vertisols and vertic sub-groups of phaeozems and luvisols, commonly known as black cotton soil: these stiff clay soils are very fertile but difficult to cultivate by hand. The dry climate is not conducive for high population growth; and it might be expected that people would try to reduce the number of children born. However, population trends in the District show that this has not been the case; and it is useful to consider the success of high density populations in even drier areas elsewhere (Mortimore, 1989). In the Machakos District of Kenya, a six-fold increase in population led to an eleven-fold increase in farm production and much environmental improvement (Tiffen & Mortimore, 1994). More marketing outlets, allied to positive changes in land resource management (*e.g.*, intensification and diversification), have arisen all over Kenya, as population densities have risen. In high density areas "*farmers have the highest percentage incidence of cultivated land, tree crops and livestock; they have the shortest fallows, practice the most zero-grazing and have the highest milk sales; they use the most manure, fertiliser, bought seeds and pesticides*" (Darling, 1993: 13). Such changes in land management practice introduce a response elasticity not catered for by determinist Malthusian theories.

3.3 HEALTH

Health in the area is aggravated by a lack of adequate water resources and poorly distributed health facilities. The division has three health centres: the Nyang'oma mission clinic for the Catholic parish, Nango dispensary and Bondo District hospital. The dispensary often lacks drugs and the mission clinic is too expensive for most people. Bondo district hospital is 12kms from Nyang'oma and lacks adequate transport due to the poor roads. So, people resort to visiting local community health workers, drug retailers and 'injectionists' for their health needs.

3.4 STUDY POPULATION

The study aimed to identify various groups willing to be interviewed on the sensitive issue of family planning. Those knowledgeable in family planning were taken as the key informants. Among these were village elders, opinion leaders, community health workers, community based distributors, women from women groups, religious leaders, and lay men and women.

The unit of analysis for this study was the household, from which a married man, married woman, single mother, teenage boy or teenage girl was interviewed. Simple random sampling, using a ballot system, identified 100 households from the 1995 Nyang'oma Kedahr household survey project framework. In each household, either a young teenage man or woman (13–17 years), a single mother, a married woman or a married man constituted the sole respondent. Each of the five categories sampled enough respondents, as about 20% of both teenagers and adults proved to be using family planning.

3.5 METHODS OF DATA COLLECTION

Both quantitative methods and qualitative techniques were used in the data collection process, for no single method was considered to be superior and adequate, even though open-ended discussions encouraged participation of the research subjects. The complexity and sensitivity of the problem under study also called for a multi-dimensional approach to data collection. The study utilized qualitative techniques in the first phase pilot study to identify new insights, while the new findings were quantified in the second phase to help prioriorise the problems under study.

3.6 QUALITATIVE DATA COLLECTION

Qualitative data was collected using in-depth or open ended interviews with key informants, who included community based distributors, health workers, opinion leaders and hospital staff. Reproductive narratives were also obtained from selected persons in the study.

3.7 KEY INFORMANT INTERVIEWS

Discussions were held with people perceived to be knowledgeable in matters concerning the family, family planning agencies, role of women in the society, decision-making in the household, and the traditional societal set up. Those contacted were priests, nuns, teachers, elderly members of the community, women leaders and family planning personnel, including community based distributors, health workers and nurses. This category of informants was considered to be observant, reflective and articulate on issues relating to gender relations and family planning (Bernard, 1988:179).

Informal conversations were used to gather information from the key informants; and this information was intended to help focus the problem under study. The information included traditional methods of birth control, reasons for that control, modern methods of birth control and the reasons for its use and constraints, traditional perceptions and beliefs about children, role and status of women in society and decision-making in the household. Through these informants the researcher was able to obtain a good idea of people's attitude towards family planning services. This information gathered from key informants cannot be wholly regarded as correct or false but rather says something about the relationship of the speaker to the society's perception of family planning issues.

3.8 NON-PARTICIPANT OBSERVATION

Observation, although a pervasive activity in our daily life, is a primary tool of scientific enquiry. However, as a research tool, it must be planned systematically to serve a formulated research purpose, then recorded in relation to the general proposition of the inquiry (Cook *et al.* 1962). In this study, non-participant observation was used to capture the process of social interaction within the household, how men and women relate in different situations and how decisions on various matters are made. The researcher paid attention to details in daily life; some basic cultural aspects, which were either vaguely perceived or unnoticed by the informants, were captured. For instance, the researcher attended a meeting of community based distributors, which was composed of over ten women and two men. The two men were carefully listened to in the meeting, asked most questions, while the women

nodded. However, the men cared little when females asked several questions, even booing down their female colleagues. Women are particular about time keeping; and when one of them asked about coming on time, her male colleagues booed her down; yet the same woman gave serious consideration to issues raised by these males in the group. This may be a result of socialization processes, whereby women have internalised the perception of men as decision-makers and leaders.

Among the issues noted through non-participant observation, and which were later raised in focus group discussions, were:

- Most meetings called by the Chiefs were attended mainly by men (the focus group discussions confirmed this: men brought to the women at home the news of what was discussed in the chief's *baraza*).
- Those seeking family planning services were mainly women; and most *Nyamrerwas* (traditional herbalists and midwives) were women with a few men (a ratio of 1:10 respectively). This serves to strengthen the hypothesis that family planning agencies solely focused on women, leaving out the men even though they are also stakeholders.
- Women engage in a wide variety of household chores.

3.9 ESSAYS

Essay writing was employed as a means of eliciting information from secondary school Class Two students, where most consisted of the desired age group of 13 – 17 years. Although the same age limit could be found in

Class Two students, they were not used, as most of them were trying to get used to their new school environment.

The reason for using this method was to find out young people's perception of family planning services .The researcher wanted to find out if these youngsters had any knowledge regarding family planning, their views on it, and if they considered it good or bad. These young people's essay were requested because, from the key informant interviews, it emerged that the older generation saw family planning as something for the younger generation.

The teenage schoolchildren argued that the older generation had resources but the young have no resources, as they have been depleted by the older generation. For example, land is scarce or barren as a result of much subdivision. Children today need education in order to fit in the society, which was not the case at the past. Society is moving towards modernization, the emergency of incurable diseases such as AIDS, large families are no longer admirable, and the economy is in dire need of revamping. Essay writing also confirmed that society is changing rapidly due to 'Westernisation' processes.

3.10 FOCUS GROUP DISCUSSIONS

Focus group discussions were the principal method to gather qualitative data in the community. It systematically provided answers to research issues, which emerged through interviews with groups of men and women. It

speeded up data gathering and provided more community experiences and opinions than could be learned from any individual interview. Data were generated from five groups of people, who included young boys, young girls (who had never had children but were sexually active), single mothers, married women and married men. Most focus groups were organized with the assistance of the research assistant, women groups, local administration personnel and the church.

The focus groups consisted of seven to eleven participants of the same sex and more or less the same age. The participants gave qualitative data about various issues that emerged during the key informant interviews, non-participant observation, and essays. Such issues included their knowledge about the activities of family planning agencies, decision-making in family planning, the role and status of women, and perception and beliefs about children. Data was presented qualitatively by selecting anecdotes and comments from the informants. Participants in these discussions were selected on the basis of their experience in family planning issues. A field assistant facilitated each group and recorded notes of its discussions. The discussions were also tape-recorded, the tapes transcribed and then compared with the notes to produce a complete account of the session. Guidelines for the focus group discussions were in English and Dholuo.

3.11 REPRODUCTIVE NARRATIVES

Ten individual participants were selected purposively to narrate relevant experiences about their reproductive life. Reproductive narratives were

derived from barren women, and men and women with large numbers of children. The narratives revealed aspects of the community's perception of large families or lack of them, the use or failure of family planning agencies, and the status of women in society.

3.12 SURVEY METHODOLOGY

A short questionnaire was designed for youths, married men, married women and single mothers. The questionnaire was divided into four parts for each of these four sets. Only one respondent was interviewed in each household, as there were fears of respondents from the same household influencing each other's responses. Five groups of 20 (above; 45) were sampled in this way.

Altogether one hundred respondents were asked the same questions in the same sequence. The questionnaire (Appendix 1) contained both closed and open-ended questions, the latter on issues needing further elaboration or personal opinions. Selected questions gathered demographic and socio-economic information; *e.g.*: age, marital status, level of education, occupation and religious affiliation. The research instrument (questionnaire) was written in English and interpreted into Dholuo or Kiswahili whilst it was being used, as many respondents were unable to give interviews in English.

3.13 SECONDARY SOURCES

Available relevant documents, books, journals, reports, research papers and magazines provided further useful complementary data, although this could not answer all the possible questions arising from the research issues.

3.14 METHODS OF DATA ANALYSIS

Quantitative data gathered by means of standard questionnaires were analysed using the Statistical Package for the Social Sciences (SPSS computer software package). It included the use of descriptive statistics, such as means, frequencies and percentages; but it was considered that the data sub-sets were not large enough to make statistically meaningful detailed cross-tabulations.

Selective, qualitative data anecdotes and comments from key informants, focus group discussions, essays, non-participant observation and narratives were presented. The researcher tried to use the informant quote technique effectively, avoiding what Lowland (1971) deemed to be the two 'great sins of qualitative analysis'- excessive analysis in tedious jargon and lengthy informants' quotes proffering no analysis at all.

3.15 ETHICAL ISSUES

The use of standard questionnaires guaranteed confidentiality and control over the interview environment. It ensured that only the respondent answered the questions to trap individuals' perceptions. Privacy was maintained throughout, as the topic was a sensitive one and touched on private lives. The respondents were assured that whatever information they gave would not be disclosed to anyone else.

3.16 PROBLEMS ENCOUNTERED IN THE FIELD

A number of problems were encountered in the field by the researcher. Fortunately, they did not have any significant effect on the data collected, as the

researcher usually found some way of solving them. The language barrier posed a formidable problem, as the researcher had no knowledge of Dholuo. The employment of a research assistant well versed in the Dholuo language and a native of the area solved this difficulty. The researcher also tried to learn the basic words hence allaying fears from the population under study. The introduction of the researcher to notable figures in the area helped her settle down easily. It is possible, however, that some vital information was lost through the whole interpretation process. The sensitivity of the research topic meant that some respondents were not willing to talk freely. However, assurances about privacy and confidentiality helped alleviate much of this problem but, possibly, some people did not feel free enough to disclose deep, private and confidential information in just one visit.

Another problem had to do with the terrain of the area. The area consists of rough roads, which made transportation poor. Due to sparse population, great distances separated the sample households (another factor challenging the idea of 'overpopulation' – Dowden (1994) maintains that '*Africa is an empty continent*'). These distances were aggravated by the fact that the research team were dependent on bicycles - an expensive and cumbersome means of transport, as a lot of time was wasted trying to cover the research area.

CHAPTER FOUR

CHARACTERISTICS OF THE SAMPLE FINDINGS

4.0 INTRODUCTION

Several observations have been made in the field about gender relations in the use of family planning services. This chapter discusses research findings about the belief that men and women joined in marriage or in a relationship have to consult each other on various issues. Family planning issues automatically becomes an issue for consultation. The findings are used to test the following hypothesis:

- Family planning agencies focus on women alone, not men and women
- Men and women do not make joint decisions on family planning issues
- A woman's status affects her family planning service access and use
- Local community perceptions of children influence use of these services.

To test these hypotheses and assess the impact of gender relations in the use of family planning issues, both qualitative and quantitative information were gathered during the course of fieldwork.

4.1 SEX, AGE AND MARITAL STATUS

Out of the 100 householders selected to take part in the interview, 40% were male and 60% female. The higher number of women householders was explained by the groups selected (three female and two male): there was no group of men corresponding to the 20% single mothers because, when men lose their wives through death or divorce, they feel obliged to remarry. Over 80% of those interviewed fell within the reproductive age range (Table 4.1)

Table 4.1: Age of respondents

Age	(%)
15 – 24	40
25 – 34	20
35 - 44	20
45 – 54	17
Over 54	3
Total	100.0

Source: Field Data 2000 n = 100

4.2 RELIGION

The data collected revealed that most respondents were Christian (90%), followed by those who espoused traditional religion. Of the 90% Christian, 60% were Protestant and 30% were Catholic. Religion had an impact on family planning, insofar as Catholics did not embrace artificial family planning methods, as these were against church teachings, which stated that they murdered a life before it was formed. However, natural methods of family planning were acceptable; and natural methods worked to a small extent, since some customs demanded that sex is practiced, even if one was observing natural methods.

4.3 EDUCATION

The respondents' education levels were split into two categories – Primary and Secondary School (there being none with University education). Most female respondents (65%) had received some primary level education, but only 35% underwent secondary education. By comparison, 59% of male respondents had received secondary education. The level of literacy is a big factor in knowing about family planning and its use or lack of use.

4.4 OCCUPATION

Nearly three-quarters of the respondents (71.4%) were involved in farming, 14% were in business, 10% in fishing and gold mining, whilst 5% said they did nothing. All those who said they did nothing for a living were women. The researcher, however, found out that these women were the main providers in terms of food, looking after children and doing other petty things to survive. According to them, whatever they did was never paid for in terms of cash, hence the term "nothing". Although farming was prevalent, it was noted that it did not offer much in terms of cash support. The drought season was prolonged leaving the farmer with no means of income.

4.5 KNOWLEDGE OF FAMILY PLANNING AGENCIES

The first hypothesis asserts that family planning agencies do not focus on both women and men. By and large, women are the target population: the control of birth has been made to lie squarely on women, because the act of giving birth is solely within the female domain. "... *this perception is misleading because family planning should be the joint responsibility of husband and wife or male and female partners.*" (Fapohunda & Rutenberg, 1999). Over half of the female respondents (57%) admitted to having received their knowledge of family planning from pre and post-natal clinics (Table 4.2). In most cases, women are the ones charged with the responsibility of taking the children to post-natal clinics. They are also the ones, who attend the pre-natal clinics when they are expectant. Therefore, if family planning agencies use pre and post-natal clinics to teach about family planning, they lock out male clients, who should be part of the whole

exercise. Due to women's economic and social dependence on their male partners, men greatly influence family decisions. Men play an important role as heads of the household and are viewed as custodians of their lineages.

Table 4.2 : Sources of family planning information for men and women

Where knowledge acquired	% men	% women
Ante-natal or post-natal clinic	-	50.0
Community based distributors	13.6	33.3
Friends / Relatives	22.7	16.7
Media (radio and newspapers)	63.7	-
Total	100.0	100.0
Source: Field Data 2000	n = 40	n = 60

The nurse-in-charge of Nango Clinic observed that men were also targeted in family planning; but he pointed out that family planning services are integrated in post-natal and ante-natal clinic activities, which in effect omits men. Most male respondents (63.7%) acquired their knowledge of family planning from the media (mostly radio and newspapers) and also from friends and relatives (22.7%). Only a few men (13.6%) received information on family planning from hospitals or community based distributors. This was usually in a forum offering information on the use of condoms to prevent HIV-AIDS. As this is particularly virulent in this area, leaving numerous orphans as parents die young, family planning staff prioritised the campaign to fight the spread of the HIV-AIDS virus; and the issue of family planning

automatically fell into this context as a secondary consideration. *"I personally came to hear about condoms when I was admitted in the hospital. Every morning, the patients were always taught about condoms before any kind of treatment was given. The emphasis was on condom as a method to protect against sexually transmitted diseases*". (Onyango, 27 years old).

A deliberate attempt was also made to find out from the teenage where they acquired their knowledge of family planning. It emerged that most of the youth (61.0%) knew about family planning from friends, media and teachers.

Table 4.3: Source of teenage youths' information

Source of youths' knowledge	**%**
Media	29.3
Friends	29.3
School teachers	29.3
Community based distributors	7.3
Family planning health centres	2.4
Total	100.0

Source: Field Data 2000 n = 40

A few (9.7%) had acquired family planning knowledge from health centres and community based distributors; but most of these came from families where at least one of the family members was working as a community based distributor or a health worker/nurse. The youth preferred friends (29.3%) and media (29.3%), because they did not expect questions as to why they were

interested in family planning. The health centres asked questions, because they handled family planning as an issue which youths should not venture into unless they are married. Whilst teenage youths appear to know about the use of condoms, it is pertinent to note that both the Government and family planning agencies seem to assume that family planning services are for married couples, and not for single teenagers. Consequently, widespread pre-marital sexuality is practised without protection, as is evidenced by the high rates of pre-marital pregnancies. Another interpretation is that the use of condoms has encouraged pre-marital sexuality; but this cannot be assessed, because earlier quantitative baseline data is non-existent.

Other sources of family planning information were parents and places of worship. Every woman interviewed confirmed that she had heard about family planning services: this was not so for all men and male youths. One man in the focus group discussion defined family planning as "*giving birth, putting each child outside the house, if there is no space in the house*"; and one youth defined it as "*swallowing pills in order to stop giving birth*" – the imprecision possibly arising from a mistranslation. Table 4.4 shows that married women were not keen to use family planning services, perhaps because marriage was a license to give birth to as many children as possible.

4.6 USE OF FAMILY PLANNING AGENCIES

65% of married women respondents were non-users, outnumbering users (35%) of family planning services; whereas single women, who head their own households, had an opposite pattern of use (Table 4.4).

Table 4.4: Women's use and non-use of family planning methods

Use	% (married)	% (single)
Yes	35	65%
No	65	35%
Total	100	100%

Source: Field Data, 2000 n = 20 n = 20

The use or non-use of family planning services varied with one's marital status. If one is married, one is expected to bear children and so, there is no fear of what people will think about one; for in most African societies, marriage is largely in order to bear children (Ocholla-Ayayo, 1991). This provides the framework in which a married woman is seen in the society as complete for begetting children to perpetuate the family tree. A single woman is viewed with suspicion by society and, despite the high value society puts on children, she is seen as an epitome of immorality each time she conceives. She does not have anyone to lean on in case of problems so, being unhindered in her decision-making, she is motivated and free to use family planning services to compensate for that insecurity.

Attendance at pre- and post-natal clinics requires time, which a married woman rarely has, as she has to take care of her children, her husband and the in-laws. She also has to explain all her movements to her husband, which seriously inhibits her possible use of family planning. Else she may have to wait until the husband is away, so that she can steal her way to the family

planning agencies. As for single women, they have no one to report to about their intentions to visit pre and post-natal clinics. They visit when they feel like it and no husband opposes their moves.

Youths feared the local community based distributors, because these were people who knew their parents and information could reach their fathers or mothers. Despite the fact that the community based distributors issued condoms without charging for them, they preferred the village shopkeeper, who was paid ten shillings and issued these same condoms without asking even a single question

4.7 KNOWLEDGE OF CONTRACEPTIVES

All in all, we can say that knowledge of family planning is widespread in Nyang'oma amongst women of all ages, with most (76%) indicating that they knew about various methods of family planning. The most widely known methods were pills, injection, Normaplant and sterilization (Table 4.6). The widespread knowledge of family planning was as a result of pre-and post-natal clinics, media, and community based distributors. Health facilities, health workers and the community-based distributors were given the definition of family planning agencies. The research findings indicated that these agencies largely focused on women alone, so confirming the hypothesis that family planning agencies do not focus on both men and women, thereby contributing to poor utilization of family planning agencies.

Table 4.6 Most widely known methods of family planning

Method	%
Pills	30
Injection	30
Normaplant	20
Sterilization	15
Others	5
Total	100

Source: Field data, 2000 n = 100

Ndege (1991) asserts that information about knowledge of contraceptive methods is important, because the possession of knowledge and information directly affects use. The reason for this is that people use what they are familiar with and what they have information about. By asking respondents to name and describe the different ways in which couples can space child birth, a more exact picture of what people knew about contraceptive methods was identified. Traditional as well as modern methods were recorded.

4.8 TRADITIONAL FAMILY PLANNING METHODS

The cultural awkwardness of interventionist family planning methods leads to the consideration of whether traditional methods would be more appropriate. One traditional methods is in polygamy, where a husband with several wives only invites intercourse with a wife not having a small child. A mother of a small child was not involved intimately with her husband until the child was

big enough. The test was to give the child a calabash of porridge to take to the father. If the child delivered the porridge, then he or she was strong enough to have a follower. The act of sending of the child to the father was a signal that this mother was ready for the man. Another sign was a rug with menstrual blood kept above the fireplace on the roof of the house: it got smoked up but was only removed when the woman was ready to have another child. The links between beliefs about the potency of menstrual blood and this practice remain to be explored. *Nindo Ariey* was also a traditional method. A woman slept straight, with her thighs together and the man stimulated himself on her thighs in order to ejaculate his sperm. This method was most effective, as it ensured that sperm did not enter the woman's body.

Other traditional methods were almost certainly less effective. If a woman sat on a stone on the boundary of two *shambas* (farms) during her menses, it was believed that she would never conceive again but become infertile. Some women crushed *mrenda* leaves and put them in their vaginas after intercourse to avoid conception, as it was believed that the bitter sap killed sperm.

The reasons for traditional family planning were varied. Among the Luo, there is a belief that giving birth all the time was a bad omen and that it would cause the death of the husband. Sometimes, when a woman conceived frequently, her babies became emaciated and slow to grow: this was called *hero (kwashiokwor)* and such a woman was referred to as *Nguol Pono* (fear of witchcraft), because people believed that she must be bewitched to gave birth so without spacing. In such a case, if anybody died in the home, people

would say that the woman had bewitched him or her. "*A woman who had one child at the back, another one crawling and was also expectant could not do her work well nor maintain the health of those children*". (Bond, 65 years). Some say that the traditional methods just noted are becoming less and less operational, as those who practiced them die out; and that it hard to find the *mrenda* plant nowadays – but these assertions remain to be researched.

4.9 MODERN FAMILIY PLANNING METHODS

The most popular modern methods of family planning are shown in Table 4.7:

Table 4.7: Methods commonly used in family planning today

Methods	%
Pills	30
Injection	20
Condoms	20
NormaPlant	15
Sterilization	15
Total	100

Source: Field Data, 2000 n = 100

Traditional family planning used child-spacing to help the health and feeding of babies and their nursing mothers in a pro-natal society, which respected large families; whereas modern family planning is rooted in anti-natal agenda - despite a shift of emphasis to maternal health in recent decades. In the

conflict between these two worlds lies the key underlying reason for the non-utilization of modern family planning services.

4.10 IMPLICATIONS OF PERCEPTIONS AND BELIEFS ABOUT CHILDREN ON THE USE OF FAMILY PLANNING SERVICES

One hypothesis was that men and women's different perceptions and beliefs about children influence the utilization of family planning services. This was based on the assumption that in many African traditional societies, women are valued for their ability to bear children. It is considered shameful not to bear children and barrenness is a source of ridicule. African people also view large numbers of children as guarantors of social and economic security for their old age (Frank and Mc Nicolli, 1987). It is also no secret that an African man usually marries because he wants children, hence his resistance to the use of family planning services. Due to increasing economic hardships, however, women are openly admitting that circumstances may force them to have just the number for which they can cater. As one key informant put it, when asked about what she would consider as the ideal number of children; *"I think the more there are the better. Children can assist each other; but hard economic times have forced us to limit the number, as it is too expensive to maintain them"* (Dina, 34 years).

Those women respondents, who used family planning, were asked to say after what birth they first used family planning services. Most respondents (57%) first used family planning services on attaining four to six children, 28.6% after bearing seven or more children, but only 14.3% on bearing one to three

children (Table 4.8). The first child was never stopped, so no family planning was used before the first birth.

Table 4.8: First use of family planning according to children born.

Number of Children	%
None	0
One to three	14.3
Four to six	57.1
Seven or more	28.6
Total	100.0

Source: Field Data, 2000 n = 40

Most women used family planning services after giving birth to several children. Key informants noted that most women first started using family planning services after shouldering the burden of having many children. These women saw children as creations, who, once born, live to take increasing care of themselves.

In the women's focus group discussions, it was revealed that women attend to family planning services late because, at the back of their minds, they already have an idea of how many children they need and how many of these should be boys or girls. So, they first acquired that number before using family planning. If one sex is missing in the preferred number, the desire to go for the missing sex is so strong that one ended up with an unanticipated number.

Children are also perceived as a continuity of the lineage - where the future of the community dwells. In the past, children were seen as a sign of wealth; however, this has now changed because children were once used in production of food but, today, there is little land for that kind of activity. To a great extent, the cost of bringing up children has made them a burden. Today, children are not a treasure anymore, because the economy is harsh. Education is also too expensive and land has become scarce.

However, large numbers of children are viewed as wealth politically: the leaders of small tribes call on their people not to use family planning, in order to strengthen their voting power (Bondi, 65 years - reproductive narratives). In the men's focus group discussions, it emerged that many of today's children are perceived to be liabilities compared to children of the past, who were assets. Past children worked in the *shamba*, herded animals and assisted in domestic chores. Today's children seem pitiable, when compared with these assertive past children; for they do not want to be independent, even when they are employed.

Despite the fact that men saw large families as liabilities, they were not committed to introducing the issue of family planning to their wives. They feared that if they allowed their wives to have few children, their wives would never look old, making them a source of admiration and competition with other suitors. This would make men insecure all the time; and men suspected that most of their wives were using family planning services without their knowledge. Meanwhile, women were wise enough not to over-use family

planning services, lest the husbands' fears were confirmed. Men wondered why their wives took so long to conceive, as this had not been the case before.

In the women's focus group discussions, the burden of looking after children rested squarely on women, who ensured their upkeep; while the men went looking for liquor or other woman to marry. As one key informant noted, "*My husband does not help me at all. He only assisted me to feed the children when they were three; but when they reached six, he abandoned the responsibilities. He just sits around and drinks beer*" (Anyango, 26 years).

4.11 IDEAL NUMBER OF CHILDREN

All respondents were asked to say how many children they thought were ideal in a family. Ndege (1991) asserts that the desired family size, or desired completed fertility is an important indicator of the respondent's desire to use family planning services. Table 4.9 below presents findings on the responses:

Table 9: Different age groups' perceptions of the ideal number of children

Age Group (years)	n	Mean number of children desired
13-25	35	3.0
26-38	40	5.0
39-51	25	7.2

Source: Field Data, 2000.

From the table, the mean ideal number of children increases with age from 3.0 children among women aged 13-25 years, to 7.2 among women aged 39

to 51 years. In the focus group discussions of teenage girls, it emerged that most girls preferred two to four children in marriage. They gave various reasons for this preference, such as being able to pay school fees easily, to feed the children well, to teach them good manners, to afford expensive things for them and to have someone, who can care for them in old age. These girls were already aware of the problems of large families and, if this trend picks up, it means a decline in fertility rate in future. It is also a sign of the younger generation use family planning services more compared to the older generation.

However, when teenage boys in the focus group discussions were asked the same question, most considered five to six children as the ideal number. They were quick to add that, if the preferred sex, *i.e.* a boy, was not born, then the wife would go on giving birth until a boy was born. The wife would only be allowed to use contraceptives when the desired number of children and the desired sex combination was met. These findings concur with Rono (1994), who notes that family size preferences, as well as child sex preferences, play a big role in determining contraception. A son is preferred, because he will stay with the parents while the girl will go away to join another family on marriage. An 80 year-old key informant observed that during their time, people preferred boys to girls and one did not mind having many boys and a few girls or none at all: "*Girls are like the wild beast who will go away one day. Boys are the pillars of the home and will dwell within the compound and continue the family tree*". Other reasons for son preference is that a person without a son is not considered socially to be a man. A boy ensures

continuity and, in case of land disputes or theft, he will defend the family (Ndege *et al*, 1993).

Sex preference is important in determining the use of family planning services. A couple that has certain sex preference may not wish to use family planning services, unless they have achieved the desired sex combination. If the young generation still harbours such feelings, it means family planning services will be under-utilized for as long as one feels that one has not got the ideal family size.

Women, men and teenagers were questioned to sample society's feelings about barrenness. Most male respondents (59.1%) sympathized with the barren but said that, to counter this problem, they would marry another wife or consider divorce. Most female respondents confirmed this, saying that they knew incidences where men had divorced or remarried, just because their women were barren.

A barren woman is a worried person, it was revealed. She feels despised by the community and people keep reminding her of her failure to give birth. One key informant, who did not give birth immediately after marriage, echoed this: "*My mother-in-law despised me and was always talking ill of me. She used to complain to her son about my condition. People had already started talking, but God opened my womb after five years*" (Dina, 34 years). In one narrative, a barren woman confirmed that infertility becomes a real problem when one shares the homestead with one's co-wives. The co-wives

jeered at her and kept referring to her condition every time there was a quarrel. Rhoda Adhiambo Ochieng, 63 years old, was such a wife with no child: "*I got married when I was only seventeen years. Before I had lived with my paternal grandmother after the death of my mother. I was only 8 years old, my sister 5 years and my little brother was six months. Then I was in nursery school but after the death of my mother, I dropped out of school because my father did not believe in educating girls. I was the oldest and was looking after the other two children in my grandmother's house. However, my little brother died soon after due to stomach ache and diarrhoea. After I got married, I discovered that I could not conceive. I took traditional herbs for a long time without success. My husband took me to hospital but they were of no help. I tried all I could until I left everything to God.*

"*Six years into marriage my husband decided that we had done the much we could. He married the second and later the third wife. My co-wives have children and these children have been the cause of constant pain in my heart. They keep referring to my barrenness in every small thing I do. My mother-in-law and her sons do not like me and they show this openly. They feel that the place of their brother is with a no-body. The wives insult me, declaring that I am of no use. The goodness of a child is realized in old age. It is now that I feel the most pain of failing to have a child. In this world, without a child, nobody sees anything that you do. When I call out to a child to come, she or he says she/he is coming but does not make a move. Children of today have no respect for anybody but I have no ill feelings for anybody's child.*"

What emerged from this harrowing narrative is that children are intrinsically valued, hence the constant pain in a barren person, exacerbated by the negative attitudes and frequent cruel reminders from others. Barren women desperately sought cures from four sources; herbalists, hospitals, their friends and God. Social research remains to substantiate the impression that barrenness is always blamed on the woman in African society; and more medical research is needed to cross-check these social perceptions against the realities of male infertility, the spreading of venereal disease (causing female infertility) by male partners, and other similar factors.

Family planning clinics could play a more holistic role in 'family' planning, if they were not tied to population control agenda. Clearly, the perceived needs here are for fertility treatment for the 'barren' (including checking the fertility status of the husband), for education about infertility to the rest of society, and for psychological counselling. Until these needs of African society are addressed, 'family planning' will remain a euphemism for western anti-natal beliefs driving only one way through Africa's pro-natal culture. As yet, 'family planning' offers no hope to the barren woman. Even as family planning avoided issues of female genital mutilation in the past, so also they may not be heeding the voice of stigmatised, barren women today.

This chapter has highlighted much of the traditional background on fertility issues; and it is now time to explore the interface between this background and decision-making in regard to today's family planning services.

CHAPTER FIVE

DECISION MAKING BETWEEN SPOUSES ON THE USE OF FAMILY PLANNING SERVICES

5.0 INTRODUCTION.

Discussions between husband and wife or male and female partners about family planning are taken as a measure of whether men and women make joint decisions regarding family planning services or not (Table 5.0). Discussion does not necessarily lead to joint decisions but it does influence decisions made by both spouses on the use of family planning services. Roudi (1996) notes that a couple's family planning decisions derive from complex processes. Communication is the most important variable associated with family planning practice.

Table: 5.0 Discussion with husband or partner

Women who discuss	%
Yes	28.6
No	71.4
Total	100.0

Source: Field Data, 2000 n = *40*

The study indicated that nearly three-quarters of the women did not discuss with their husbands or partners about the use of family planning services, leaving only just over a quarter, who did. The main reason why they did not discuss family planning was because their husbands or male partners were opposed to its use; and the women were afraid that telling them would

interfere with their plans to use it. "*He is very difficult and I suspect that he would not be likely to support my adventure into the family planning world. In fact, I fear to discuss it with any one else, lest my husband hears about it*" (Anyango 29 years). Other women are scared of even mentioning family planning to their husbands. "*It remains for me on my own to arrange how to go about it*" (Akeyo, 30 years). Women fear that once they raise the issue, they will be suspected of being unfaithful.

Most women did not see 'family planning' as an issue to be discussed with their husbands. "*There is nothing to be discussed about family planning. This can only be done with fellow women but not with a man. I only discuss with my husband when tradition demands it: for instance, when my father-in-law died, my husband had to sleep with me as his first wife before sleeping with anybody else*" (Akinyi, 33years)

Information from key informant interviews and focus group discussions also revealed that only a few people discuss family planning with their spouses. This is because men tend to restrain their wives; and this has led to secrecy and silence. The men think that once a woman is left free to use family planning services, she will have sexual relations with other men. However, men use condoms very secretively, because condoms have been dubbed as toys to prevent diseases. Seemingly, men only use condoms with women other than their own wives; for, most women revealed, their partners did not use condoms. "O*ur machine to dispense condoms here is never used by*

anybody openly. However, when we put condoms in, men come at night to collect them" (Male Nurse-in-charge, Nango Clinic).

In married women's focus group discussion, it was revealed that determined women access family Planning services without necessarily letting their husbands know. They pin-pointed various factors that give a woman the determination. Age was considered as one of the factors: it was argued that a young person will tend to shy away from contraceptives and only seeks services after bearing several children. Education on the other hand was seen as a tool to impart knowledge and help one to decide when the next child should be expected.

Table 5.1: Use of family planning by number of children

Ideal no of children	%
None	0
1st - 3rd	14.3
4th - 6th	57.1
7th and above	28.6
Total	100.0

Source: Field Data, 2000 n = 7

According to table 5.2, just over half the married women respondents (57.1%) used family planning services after having four to six children; and 28.6% married women used the services after seven or more births. The lower percentage of the latter reflects the fact that fewer women have seven or more

children: it does not imply that the percentage of women with this number of children use the services less! Only 13% considered the use of family planning services after one to two children; and none used any kind of family planning methods to prevent the arrival of the first child.

This leads up to the issue of how many children are ideal in a family. One possible explanation is that most people will use family planning services, if they felt that they have acquired the desired number of children. Women already involved in some kind of occupation, tend to use family planning services so as to have more time to attend to their jobs. In rare cases, understanding men introduce their wives to Family Planning services in order to create space between children.

Most single women respondents started using family planning services immediately after having their first or second child. Most married respondents with four or more children are current users of family planning services, in contrast to single women, who become users with one or more children.

5.1 JOINT DECISION-MAKING BETWEEN MEN AND WOMEN

"I will not draw one common line for everybody, for this is circumstantial; but sitting down and discussing with one's partner is not very effective, especially in the traditional set up, where it is a strange phenomenon" (Allando, 55 years male key informant).

Indeed, a significant number (71.4%) do not discuss with their spouses about the use of family planning services. Thus, in the words of the key informant above, they qualify to be placed 'in the traditional set-up'. Only 28.6% admit to holding discussions with their spouses. Such discussions are most commonly associated with the social élite influenced by Western thinking.

Molnos, (1968) asserts that attempts should be made to improve communication between husband and wife in matters of sex behaviour, conception, contraceptive methods, childbearing and the desired number of children. She observes that in societies dominated by men and masculine values, the motives and attitudes held by men should be carefully considered when promoting family planning services. She asserts that women discuss problems of childbearing and family planning amongst themselves, and are less used to discussing them with their husbands.

This concurs with the finding that 85.7% of the married women respondents, who used family planning services, discussed family planning with persons other than their own husbands. This finding is consistent with Raikes' (1990) observation that women discussed family planning with other people such as friends, while the issue was not generally taken up with husbands and mothers-in-laws. Only a small proportion (14.3%) could not trust anybody with whom to hold discussions. The reasons for this secrecy were varied: some were using contraceptives without the knowledge of their husbands and feared that a second party would end up leaking the information to their husbands; whilst others felt that matters pertaining to sex were best treated as

private. There are cases where women seek family planning services without telling their husbands. "*Women do this secretly because men are arrogant and do not care to discuss petty issues with women*" (Fridah, 26 years).

In focus group discussions, though, men aired their fears of modern family planning services, and suspected that they dispensed chemical of an unknown constitution, which caused persistent illnesses for women, such as headaches, uncontrollable blood flows and fatigue. Besides, they were proud of many children as, *inter alia*, this demonstrated their virility.

Some husbands do not live at home, but stay away at their work places; and for that reason, their wives decided to use family planning services to counteract the unexpected arrival of their husbands. In the focus group discussions, some women indicated that they were weary of the problems undergone in pregnancy and after birth, such as ailments during childbirth and problems with house girls. They stated that, in most cases, husbands left the responsibility of bringing up their children solely to their wives. Polygamy was one explanation for this attitude, as men had always gone on marrying other wives, despite the fact that they could barely support the first wife and her children. So, under such conditions, women had no alternative but to secretly go for family planning services. In the women's focus group discussions, women claimed that they chose methods that men could not easily identify, such as injection or NormaPlant. Yet, women also casually mention family planning services, just to find out if the husbands will co-operate. The man's response determines whether or not he is told of the use.

75% of single women respondents said that their status gives them self-determination regarding the use of family planning services. One key informant was more explicit about this self-determination: "*Women, with no husbands, find solace in family planning services, because they need to satisfy their sexual desires and at the same time satisfy the community by not being pregnant. The community will hold her in high regard, if she is seen not to engage in activities that will lead to conception*" (Liondo, 45 years).

Half the respondents (50%) arrived at their decision about family planning through consultation with friends, and community based distributors (Table 5.2). What the table does not show, but what appears to be true from anecdotal data, is that in cases where a women consults with her friends, there is a greater use of family planning services.

Table 5.2: Persons consulted by respondents

PERSON	%
Church leader or school teacher	30
Community Based Distributor	30
Friends	20
Other persons	10
Nobody	10
Total	100

Source: Field data, 2000 n = 100

The adage "*Birds of a feather flock together*" applies to friends, who tend to imitate each other. When those women not using family planing services were asked whom they would consult if they wanted to be users, 75% said that they would go to female users, who are their friends or relatives. Only 25% preferred to be attended to by a doctor.

Women felt insecure discussing with their male partners. Failure to consult their men may lie with the fact that they perceived their men as tending to be opposed to the idea of family planning. The male focus group discussions highlighted some of their various practical reasons for not using family planning services. Their wives work hard and do not eat a well-balanced diet due to economic hardship; so the pills are often too powerful for them, causing serious side effects. This then affects their husbands, who have to shoulder the burden of caring for their ailing wives. Men also feared the use of the coil, as it could disappear up into the uterus, leading to an unnecessary, difficult and sometimes dangerous operation. They also pointed out that planning families was useless, because God can take them away through death; so that responsibility should be left to God.

Men believed that women could not be trusted to use contraceptives, because most would be unfaithful. "*Women cheat and you are left waiting for them. They can pretend that they are in their monthly periods and go out to another man*" (Onyango, 35 years). About whether they used condoms with their wives to prevent a pregnancy, most admitted that they only used condoms with a girl friend, whom they do not trust. Condoms are used for *"safari"*.

One sleeps with girl friends all the time, but with one's wife only once a week. Condoms are only used to prevent sexually transmitted diseases, not as a family planning method.

However, all the men agreed that women should be allowed to use the natural methods of family planning. To them the natural methods, such as counting safe and unsafe days, separating beds or withdrawal had none of the side effects common in artificial methods. Despite the preference for the natural methods, men alleged that these could not work effectively today, because there are too many attractive temptations for sex, such as a nicely perfumed woman to a man, or a well-dressed man to a woman. Men agreed that prostitution was at its peak, despite the HIV/AIDs menace. A popular belief is that "*A bull dies with grass in it's mouth*": *i.e.,* people will carry on practising sex in spite of the HIV/AIDS danger, even as a bull keeps on grazing before its imminent slaughter. Also, some traditional practices of the Luo community are not conducive for the natural method because of the unpredictable and immediate occurrence of ritual coitus, regardless of timing in the woman's menstrual cycle. Such rituals occur when a mother-in-law or any other close relative dies, when children are named, at planting or harvesting rituals, or when someone returns after a prolonged absence. For all these various reasons, the natural method was ruled out as a practical method of family planning.

5.2 OTHER DISCUSSIONS ABOUT USE OF FAMILY PLANNING

The key informant interviews and men's focus group discussions revealed that when men were in beer parlours with their peers, they discussed about various family planning methods and their side effects. These discussions were unreliable, because their friends often boasted about their permanent methods, whilst actually cheating on them.

In the women's focus group discussions, it emerged that even if women genuinely saw the need to use family planning services, they feared doing it, unless they got the husbands' permission to do so (*c.f.* Table 5.0, above: 68). Male discussants echoed this, when they admitted that they would beat up their wives, if they found out that they were using any form of family planning service secretly: this could lead to divorce or to the husband marrying another wife. Also, if a man takes the initiative in making family planning suggestions to his wife, she gets suspicious that her husband may be intending to marry another wife.

One key informant revealed that she was using pills without her husband's knowledge. The pills were kept outside in a tin buried underground near a pepper plant. Every evening, her eldest daughter was sent to go and pick a pepper for her mother: she picks one pepper and carries one tablet back to her mother; so her father does not know. The process is risky: the community based distributor gives the pills to a shopkeeper, from whom she collects them, lest the husband sees her with a community based contraceptive distributor. Her husband pesters her about why she does not get pregnant

these days; and she has no answer to his questions. Such situations are discouraging. "*Inability to discuss family planning by couples can be seen as being detrimental to the adoption of family planning services, because neither party gets the forum to influence the other in the importance of family planning, which could lead to this utilisation*" (Esipisu, 1992).

What seems to be the case is that that men and women do not make joint decision on family planning issues: only 35% of married women respondents were users of family planning services and 65% did not use anything at all. Raikes (1990) observes that most women know that they cannot even approach their men on this issue for two reasons. Firstly, sex is often a very secretive and important part of their lives; and men are too urgent to make time to co-operate on planning contraception. Secondly, the high rate of alcoholism throughout the district also makes planning and co-operation extremely difficult.

Esipisu's (1992) study in Kakamega District (western Kenya) on socio-cultural factors constraining adoption of modern family planning services noted that some women made their own decisions, if their husbands refused to respect their views on family size preferences and fertility regulation. In focus group discussions, teenage girls stated that life today is expensive and, because of that, they would seek family planning services with or without their future husband's permission. Most teenage boys in the focus group discussions agreed that life was too expensive to allow for uncontrolled births: they saw that things had changed and that the past proverb "*children*

are wealth" no longer applies. They maintained, however, that a woman should listen to her husband's decision on every matter; for a women cannot make decisions, because she loses her respectable position when she moves from her parent's home to join her husband's. The teenage boys concurred that a woman's status is reduced by tradition, because she is always expected to come after the head of the household, who is in this case the man.

There are, therefore, two sets of opposing forces driving the uptake or non-uptake of family planning services. Gender power relationships biased in favour of men lead to large family size expectations; whereas increasing costs of living and education are powerful incentives to use family planning. The determination of which set of forces tips the balance may rely on yet another important influence – education.

5.3: EDUCATION & THE USE OF FAMILY PLANNING SERVICES

Educational attainment is a predisposing factor in the use of family planning services, because it links to a wider exposure to ideas and knowledge, and the more someone is educated the greater their aspirations in life than those who are not educated. The assumption is that the educational status of a woman affects her access to, and use of, family planning services.

Educational attainment was measured in two categories - primary school and secondary school (no university-educated people were in the sample). Most female respondents (65%) had received only primary education, the rest (35%) also had secondary education. 59% of male respondents had received

only primary education and the rest (41%) had also received secondary education (Table 5.3).

Table 5.3: Education level of respondents

Educational level	% men	% women
Primary	59	65
Secondary	41	35
Total	100	100

Source: Field Data, 2000 n = 40 n = 60

Key informant interviews and questionnaire answers explain the discrepancy between men's and women's education: they note that some girls got married young or became pregnant and had to drop out of school; whereas men married later than women and continued with their studies, even if they were responsible for pregnancies. In the focus group discussions, it also emerged that parents emphasised boys' education the expense of girls' education: this was because girls would go away to settle with their husbands, whereas boys would always remain to take care of the home. Thus boys were more of an asset and parents could easily invest in them. So, where parents could not raise school fees for all the children, the choice was usually for boys to be educated. The issue here, though, is whether a woman's educational status was a positive influence on her decision about using family planning services and on her ability to negotiate that decision successfully.

In the focus group discussions, it was agreed that education enlightens an individual woman, making her use all available means to give birth to only those children she is able to support. The educated, they said, think faster and will use family planning services earlier as compared to the uneducated. The uneducated may use family planning services, but they only think about it after wasting precious time, and already have many children, perhaps eight or more. Most of the uneducated, it was argued, socialize within the family and comfort one another through sexual intercourse, hence more children. The questionnaire answers tend to confirm these impressions: 65% of women respondents believed that education positively influenced their decision on the use of family planning services; whereas 35% of the women did not think education influenced their decision in any way.

This finding concurs with those of LeVine *et al* (1991) and Caldwel (1982). LeVine *et al.* (1991) studied the relationship between fertility and education in two towns in central Mexico. They observed that women with more schooling have greater aspirations for both themselves and their children, more exposure to the media, more egalitarian families, fewer expectations of returns from children, and were more likely to use child health and parental services. Watkins (1993) argues that education empowers women to resist the demands of relatives to have more children. Caldwell (1982) argues that education leads to fertility decline by inculcating Western values and changing the economic value of children. Therefore, families no longer gain economically or politically by having many children, nor do they achieve high status.

Information on the women's accessibility to family planning services showed that pre-and post-natal clinics were the most popular sources of information. 57% of women indicated that they acquired information on family planning from their attendance of pre- and post-natal clinics, while 29% from community based distributors and 14% from friends and relatives. However, 88% of teenagers obtain their information from media, schoolteachers and friends. The role of family planning clinics as disseminators of information seems set to diminish in future years; and increasing use of the media may reach both men and women. However, with the change in international funding emphases, the future of family planning media initiatives may decrease, rather than increase; and Africa may, once again, be left with a half-completed Western policy agenda.

The drastic fall in primary school education over the last decade (c.95% to c.75%) has reinforced the old gender power relations. Yet Kenya's demographic transition to lower birth rates has persisted, which suggests that much family planning usage levels depend on economic conditions despite gender power relations. Poor primary commodity prices, a sharp dip in tourist income and the silent bleeding of capital flight from Kenya ($1.2 billion p.a.) have all contributed to this economic austerity. A total clamp down on secret capital flight could release government funds for education, greater support for farmers, and attention to urban poverty and crime-rates affecting Kenya's tourist industry. In turn, the findings from this study indicate that improved education and living standards would have a positive impact on the status of women, and thus on the use of family planning services.

5.4 TYPES OF CONTRACEPTIVES COMMONLY USED

The field data shows that 71% of married women users favoured pills, whilst single women users preferred the injection. In the married women's focus group discussion, it was agreed that married women mostly used pills, because these are easily obtainable from community based distributors. The married woman does not need to worry about her husband wondering where she has gone; for she can pretend that she is on her way to collect firewood or water and acquire her supply. This is not so with the injection: a woman has to make a long journey to the health centre and this may make her husband suspicious, especially as she is also supposed to take a bath and change into clean clothes. If her husband has not allowed the use of contraceptives, then pills are more reliable. Given the chance, the married women's focus group argued, injection was better, as it does not involve a long process and lasts for about three months. Also, only qualified medical personnel can administer it; and these personnel usually do not know the client, so the secret of use remains in the hospital records. This is not so with the pills, which have to be carried around or buried away from her husband's prying eyes; and one can easily forget where they are buried or to take them on time.

In the single women's focus group discussion, injection was the most preferred method; for this ensured the greatest privacy – the matter rested with the nurse at a distant health centre. This was not the case with community based distributors, who may first start wondering about whom they were seeing and later leak the information to the rest of the village.

Teenage boy discussants preferred to use condoms above all other methods, because they were easily acquired: the shopkeeper was the best supplier but one could also get them from the clinic, from community based distributors, and from dispensing machines in health centres, especially at night away from prying eyes. A condom was multi-purpose, protecting one from sexually transmitted infection and preventing pregnancies. However, teenage boys never used condoms with their girlfriends: they used the 'safe days' of natural methods, because there was no pleasure in sex with a condom. The condom was just an instrument to be used with an unknown partner. The paradox is that condoms are for males, who have less desire for family planning; whereas female contraceptives are more difficult to obtain and administer, even though females are much more concerned about family planning.

Asked about from where they got the condoms, most boys said that they bought their supply from the shop. The shopkeeper is respected in the village, as he does not entertain gossips in his business. No one, apart from the shopkeeper, knows that he had purchased condoms. Also, the shop condoms are considered to be of a superior quality. Those given free by the clinic and the community based distributors, are of poor quality and can easily burst; and there are also rumours that they are laced with the deadly HIV virus. Other methods used by teenagers included sterilisation, Normaplant, coil and traditional methods, though all to a lesser degree.

Female respondents not using family planning services gave various reasons for their decisions (below; Table 5.4).

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Female respondents not using family planning services gave various reasons for their decisions (below; Table 5.4).

Table 5.4: Reasons why women do not use contraceptives

Reason	%
Adverse side effects or complications	40.9
Undisclosed confidential reasons	18.2
Not enough children yet	9.1
Too young	9.1
Husband disapproves	4.5
Does not stay with husband	4.5
Failure of previous contraception	4.5
Doctor refused	4.5
Never though about it	4.5
Total	100.0

Source: Field Data, 2000. n = 22

The largest category of non-users was fearful of side effects and complications: these side effects included obesity, heart problems, body pains, frequent bleeding and nausea. Women used painkillers from the market to treat them, or stopped using the method altogether. These side effects raise concerns for the future use of contraceptives. Ocholla-Ayayo (1991) notes that contraceptive side effects are considered to signify future permanent effects, leading to barrenness. This explains the high rates of discontinuation. Also, one must question whether, as with so much other western research, most contraceptive techniques were developed for, and tested on, Caucasian women, with little respect for the different physiological requirements of most women in tropical Africa.

5.4 RELIGION AND FAMILY PLANNING

Table 5.5 (below) shows that the majority of the respondents were Protestant (52%), while 24% were Catholics, 4% Muslims and 20% belonged to what is classified as others, which included traditional and recent religions like Roho, Injili, Nomiya, Legion and Soul Winning.

Table 5.5 RELIGIOUS STATUS

Religion	%
Protestant	52
Catholic	24
Others	20
Islam	4
Total	100.0

Source: Field Data, 2000 n = 100

In the literature, religion was recorded as a key influence on people's behaviour. It can also be hypothesized that religious status impacts on family planning usage in a positive or a negative sense. The basic premise here is that the major religions see the main purpose of sexual intercourse as the propagation of legitimate offspring, as expressed in the Bible "*Be fruitful, and multiply, and replenish the earth, and subdue it;*" (Genesis ch.1 v.28). This can impact negatively on the use of family planning services, as is reflected in respondents' answers, which point out that creation is the work of God and human beings should not interfere with God's work of conception and child-bearing. "*I will have the number of children, that God gives*" (Onyango, 28

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years). "*I will have many children, because God who gives can take some and leave others*" (Caroline, 34 years).

The traditional religious point of view contends that birth and death are forms of passage between two similarly organized worlds. According to this belief, physical death could not be considered as a simple landmark between existence and non-existence. Death was more of a passage than a real loss, so long as children were born to keep the balance between the world of the living and that of the dead. The lack of descendants interrupts the communication between the terrestrial and ancestral society, thus the definite death of both (Whisson, 1964). So both sets of religious belief appear to promote fertility, not family planning.

During discussions, it became clear that religion was perceived as a woman's domain: the discussants observed that on Sundays men go to the beer parlour, while women attend church. To women, church was a place to tell God of all your problems and also to meet other women for socialization purposes. The few men, who went to church, were either leaders or else were looking for leadership positions. Many men attended church services only when they were ill, just to receive prayers for their healing; and others have come only in response to the Catholic Church's refusal to bury those who do not attend church. Accordingly, the rest of this section will focus mostly on women's religious affiliation and its impact on family planning practices.

Being involved in church activities was taken as an indication of one's commitment to religion. Some female respondents, especially Catholic Christians, gave their religious beliefs as the reason why they were not in touch with the current modern family planning services. One key Catholic informant said that modern contraception had no place in the Ten Commandments, because it meant that a life is murdered after conception (Fr. Lusi, 45 years). However, the church had no problem with natural methods of contraception. Female respondents practising natural methods said that they worked to a certain extent but often failed, because men were not always willing to co-operate, sometimes came home drunk and imposed sex on their powerless wives, and some customs discouraged the natural method (above; 70, 72). As a result, many Catholic women continued getting pregnant; and Catholic Church teaching hindered successful usage of family planning services.

Protestant Christians encouraged the use of family planning services; and most of their respondents practised family planning. However, not all respondents conform to their religion's expectations: some Protestants do not use family planning services (especially if the man opposes the idea of family planning), and some Catholics approve of family planning. One key informant described human beings as different individuals, influenced by different friends and partners (who may be unable to practice self-control), hence the diversity of behaviour in spite of religious belief (Sr. Frida, 32 years).

5.5 ROLE OF LUO WOMEN & FAMILY PLANNING SERVICES

In the Luo community, men hold the functional leadership; and female participation is concentrated on the low and middle ranks of institutional hierarchies, and the low and middle levels of *per capita* income groups and of educational attainment. This situation is to a great extent the corollary of the female function of childbearing and accompanying maternal duties (Molnos, 1968). Women's role functions in the family and household generally make it practically and psychologically difficult for the female population to occupy social positions identical to those held by men.

Dalsgaard (2000) studied Luo women of childbearing age. She contends that men and women are perceived as fundamentally different: they are expected to fulfil different roles and, in any decision making process, men are considered more active and important, and women more passive. This field study found that polygamy is still widely practised. African polygamy appeared to some early observers as a means used by men to enslave women and keep them for their own pleasure (Molnos, 1968). One male key informant narrated how he married, then six years later he married a second wife, because he had to stay in different places. He took a third wife because he wanted many children, which his first and second wives had not borne him. He also wanted to '*silence the wives, as one wife is problematic*'. He paid a lot of bride wealth for his wives, and people respected him for that (Ochieng, 50 years).

What emerged during this narrative is that children born to a wife belonged to her husband: her reproductive powers are transferred to the husband and his lineage. When a husband decided to take many wives, competition for the husband became the norm; so, if what the husband needs is many children, the women compete to give the man those children. In this case, rarely do the women take the initiative to use family planning services, as they are preoccupied with the idea of pleasing their husband. Whyte and Kariuki (1991) contend that polygamy promotes fertility, insofar that co-wives consciously, or not, competed with one another to beget children. Through the children, they may claim their husband's attention and resources, so that it is disadvantageous to limit the number of children, if your co-wife does not. Ominde (1952) asserts that bride wealth symbolised the social status as a married woman: in communities where it is paid to the woman's parents, it is a condition that she gives birth to sustain the lineage. Childbearing is virtually inseparable from marriage (Ocholla-Ayayo, 1991:23). A woman often gives birth without worry, as she knows that her social status will increase as she bears her husband more children.

A barren woman has no social prestige whatsoever, as Rhoda Adhiambo (63 years old) narrated (above; 61). Her life was very difficult and her heart was full of pain, because her mother-in-law, brothers-in-law, co-wives and their children, all consider her a no-body and often insult her about her infertility. This behaviour epitomises the strongly pro-natal element of Luo culture, scarcely the most appropriate milieu for the successful implementation of family planning services.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 INTRODUCTION

Study findings are summarised with respect to the stated objectives and hypotheses and, based on these findings, various recommendations are made.

6.1 SUMMARY OF THE FINDINGS

The first study objective was to determine whether family planning agencies - such as community based distributors, health centres and health workers - focus on women alone or on both men and women and how this impacts on the use of family planning services. The hypothesis relating to this objective was that family planning agencies focus on women alone, hence a negative impact on men in the use of family planning services. The study's qualitative and quantitative data results confirmed that family planning agencies target women in their campaigns. Most information on family planning is sourced through pre- and post-natal clinics, which are a preserve of women. Even if a woman has received this information, it does not mean that it trickles down to her husband or partner. A woman may use the information or ignore it altogether, depending on how she relates to her husband or partner. She may bring up the issue, in which case the husband may utilise it or not, or ban this topic for discussion in his house. From the results, it is concluded that family planning agencies' focus on women alone, without any direct positive impact on men, may be a major reason for non-utilisation of family planning services.

The second study objective was to investigate the extent to which men and women make joint decisions on family planning issues. The hypothesis relating to this objective was that men and women do not make joint decisions on family planning issues, and that this silence influences the patterns of using family planning services. The fieldwork results showed that men and women do not make joint decisions regarding the use of family planning services: that they rarely ever discuss family planning issues and, for this reason, women used these services secretly or did not use them at all. The implications are that most of the population does not use family planning services, despite having the information. Where there was discussion about family planning services between spouses, this enhanced the uptake of the services by those concerned.

The third study objective was to assess how a woman's status affects her access to, and use of, family planning services. The hypothesis relating to this objective was that the status of a woman - including her educational level, her role in the household, religious belief and marital status - affects her access to, and use of, family planning services. Research findings indicated that men bear a large share of the lineage family-based responsibilities, hence more influence on use or non-use of family planning powers. Also, women do not have much say on the ideal number of children, because Luo custom dictates the responsibilities of women, what is expected of them in terms of childbearing, and that children born all belong to the husband's lineage. The educational status of a woman affected her pattern of family planning service use: women with secondary education could more easily access information,

read manuscripts on family planning and access the media than their counterparts having only primary education. These latter mainly clung to traditions, hence non-use of family planning services.

Religious affiliation affected the use pattern of family planning in Nyang'oma community differently. The Protestant church played a great role in creating awareness on family planning: it had recruited both male and female community based distributors, who helped to reach clients; and it had also provided bicycles to community based distributors. Catholic women were more likely to be a non-user of family planning services, as artificial forms of contraceptives were denounced by their Church, as they were seen as killing life after it had begun. However, the natural methods advocated by the church had a high failure rate, because of most women's social and cultural circumstances.

The marital status of a woman affected her use of family planning services: if she is married, custom demands that she informs her husband about this use; and this may not go down well with men, who have been blamed for the failure in the usage of family planning services. If a husband prevents his wife from using contraceptives, she has no forum to oppose him; so she may end up using the services secretly. A single woman has greater freedom to choose from a wide range of methods. The role of women in procreation largely determines their use or non-use of family planning services: procreation is seen as their main role and sole responsibility; and the use of family planning services is in denial of all this.

The fourth study objective was to describe how men's and women's different perception and beliefs about children influence their use of family planning services. The hypothesis, which related to this objective, was that man's and women's different perceptions and beliefs about children would influence their use or non-use of family planning services. The study noted that the desired number of children and their sex determine contraceptive use. In most cases, couple will use family planning services, if that feel that the ideal number of children has been achieved and the desired sex combination. Therefore, family size preferences as well as child sex preferences play a big role in determining the uptake of family planning services. Women and men share neither the same fertility preferences nor the same attitudes towards family planning. Barren women are cruelly stigmatised, yet 'family planning' clinics fail to provide them with access to fertility treatment or to psychological counselling.

6.2 RECOMMENDATIONS

The following recommendations are made in the light of this study's findings:

- Family Planning agencies should pay more attention to men, so as to influence men's attitude more positively towards family planning. The ratio of male to female community-based distributors in the study area is about 1:15; so training of more male distributors would help to redress this imbalance and change the belief that 'family planning is a woman's affair'. Today, it is shameful for a man to be a *Nyamrerwa* (health worker); for these, in traditional culture, were women and they

handled health matters, such as health issues, tending the sick, midwifery and family planning.

- More attention should be focused on issues that help empower women; so that they can enhance their abilities to discuss family planning issues with their husbands. Society should no longer rely on traditional beliefs about boys being the preferred sex; and women should become more involved in the decision-making on issues that affect their lives. The most effective means of bringing about such change are the encouragement of girl-child education and equality of job opportunity for women (not equal jobs and unequal pay). The drop in school attendance from about 95% to 75% over the last decade bodes ill for the future of girls' education, as they are the most likely to suffer. Official education funding must increase via proper restraint of capital flight.
- Links need to be established between the patriarchal family structure and family planning. This study had neither the time nor the resources to investigate this; but it would be a worthwhile topic of future research.
- Traditional methods of birth control need investigating for effectiveness and possible modifications to suit both traditional and modern societies.
- The urgent humanitarian need for researchers and agencies to look at the issue of infertility must be addressed: barren women (and/or their husbands) should have easy access to fertility treatment and/or to psychological counselling. This would mean a radical re-orientation of Africa's family planning services genuinely to address the perceived family planning needs of African women and men, rather than dancing to the tune of external, interventionist agenda.

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