

DECLARATION
**DETERMINANTS OF CONTRACEPTIVE USE IN MERU
DISTRICT**

BY

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**PROJECT SUBMITTED IN PART FULFILMENT FOR POST-
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DECLARATION

This research work is my own work and has not been presented for a degree in any other university.



.....
KAGWIRIA KIOGA MUTWIRI

This research project has been submitted for examination with our approval as the university supervisors.



.....
DR. J. KEKOVOLE



.....
DR. Z. MUGANZI

DEDICATION

This project is dedicated to my loving husband, Joshua Mutwiri Mutea and my father M.M. Kioga for their moral support. And to Mwenda I say aim higher.

ABSTRACT

The main objective of this study is to analyze the major demographic, socio-economic and socio-cultural factors that determine contraceptive use in Meru district. The objective is based on the fact that Kenya launched its Family Planning Programme two decades ago, but still contraceptive use is very low.

In an effort to determine the factors responsible for this situation this study selected Meru District since its contraceptive prevalence has been slightly higher than most of the other districts in Kenya, so as to attempt and find out the factors that are responsible for this situation.

The study has therefore looked at the relationship between contraceptive use and socio-economic, socio-cultural and demographic factors.

The study has further used the cross-tabulation method which is best for its comparative purposes and came up with percentage distribution and histogram distribution of various variables. The study also found out that education, place of residence, age of mother, marital status, number of children living and religion are the major indicators of contraceptive use.

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ORGANIZATION OF THE STUDY

The presentation of this study is given in four chapters. Chapter one covers the study's general and background information, problem statement, objectives of the study, scope and limitations of the study, justification, literature review, conceptual and operational framework and conceptual hypotheses.

Chapter two covers the definitions of various principal concepts and research methodology which include, sources of data, reliability and quality of data, methods of data analysis, application of the cross-tabulation method and the limitations of the cross-tabulation methods.

Chapter three covers the presentation of the results findings while chapter four covers the summary and recommendations for policy makers.

CHAPTER ONE

GENERAL BACKGROUND, OBJECTIVE, LITERATURE REVIEW AND FRAMEWORK

1.1 GENERAL INTRODUCTION

Sub-saharan Africa is a region of extremely high fertility and very low contraceptive prevalence, with few exceptions. National fertility rates are six or more births per woman.

Kenya is currently among the nations with the highest fertility, not only in Africa but in the entire world. It is one of the few countries estimated to have a crude birth rate of above 50, while the annual rate of population growth is estimated to be more than 3.5 percent per year, with a doubling time of less than 20 years. However, the contraceptive prevalence is much higher than in most of Sub-saharan Africa although fertility has yet to fall substantially.

Kenya's first population census of 1948 recorded a population of 5.4 million people, revealing that there was a rapid population increase problem. On this realization the Government highlighted the concern about the population growth and its impact on the resources and the rate of economic development in sessional paper No. 10 of 1965.

In 1969, the population had doubled to 10.9 million and had reached an estimated figure of 22 million by 1989 Ouchó (1989). This realization of the high rate of population growth prompted the Government to pursue policies and programmes designed to reduce the rate of population growth. Family planning was officially launched in 1967 and Kenya became the first country in Sub-saharan Africa to officially adopt family planning programme aimed at reducing fertility and thereafter population growth rate.

The use of family planning services was voluntary and individual customs and values were fully respected (Kenya Republic of 1967).

Family planning was integrated with maternal and child health (MCH). By the end of 1979, the goal of reducing fertility and thereafter population growth rate had not been achieved.

The 1979 census indicated that instead of a decline in the population growth, there was a considerable increase, as the growth was found to be 3.8% per annum. Kimani (1982) found out that the level of contraceptive use in Kenya in 1979 was insufficient to achieve a demographic goal of 3.0% annual growth rate as the Government had anticipated earlier.

In 1982 the Government of Kenya established the National Council for Population and Development (NCPD) to co-ordinate activities of the Ministries and Non-Governmental Organizations involved in

Due to large population growth in Meru, people have encroached on forests resulting in the destruction of forests areas which serve as habitat for wildlife (Meru Development Plan 1989 - 1993).

According to the 1969 and 1979 censuses, the population of Meru district increased from 596,506 in 1969 to 830,179 in 1979, giving an intercensal increase of 3.36% per annum. Also from the District Development Plan (1983-1988), the projected district population for the year 1988 was estimated as 1,214,950. This was based on the assumption that the levels of mortality of the country would continue declining whereas that of fertility would remain constant between 1980-1990. However, it has been observed that there has been a marked decline over the period in the level of fertility as well.

The 1979 census put 386,606 people in the district within the 15-59 age bracket, the rest of the population consisted of children aged 0-14 years, those aged 60 years and about and the disabled in age 15-59 age group. This of course gives a dependency ratio of 115%. In other words, for every 100 able bodied persons in their prime age there were 115 dependents. Further analysis indicates that those under 15 years numbered 403,990 or 48.70% of the total population.

The census also indicated that there are more females than males in the economically productive and reproductive ages, recorded at

fertility and mortality.

Looking at the population distribution among the divisions, Nithi had the highest population (142,288) people, followed by Tigania (140,651), north Imenti (107,396), south Imenti (103,543), central Imenti (91,038), Igembe (90,807), Ntonyiri (80,790), Tharaka (50,277) and Timau (23,389) (District Development Plan 1989 - 1993, pg. 15).

There are four urban centers in the district which serves as the main delivery points. These include Meru, which is the district headquarters with a population of 72,049 and a density of 563 persons per sq km, Mana, Chuka, Nkubu and Chogoria.

Demographically the district has not experienced a major migration in or out in recent years, however there has been some movement of people from rural to urban areas and from high potential coffee and tea areas with high population pressures to the less productive areas with lower population density.

Medical services are offered free of charge in the district government hospitals and dispensaries, including the various methods of modern contraceptives. According to 1979 census, Meru district had a total of 104 health facilities where modern contraceptives could be offered. However, a few of the non-governmental organizations provide information on natural family

planning as well as the modern methods, but use of contraceptives has been relatively low (Kenya Demographic and Health Survey, 1989).

1.3 STATEMENT OF THE PROBLEM

The Government of Kenya officially launched the programme of family planning in 1967 and has continued to offer free services while a lot has been disseminated. However, there has been no significant improvement in the use of contraceptives.

According to the Kenya Contraceptive Prevalence Survey (KCPS, 1984), 17% of the couples practised modern methods of contraceptives as of 1984. The Kenya Demographic Health Survey (KDHS, 1989), indicated that about 93.3% of all Meru women know at least one contraceptive method, yet only 36.3% of all women are using family planning services.

This shows that the contraceptive prevalence is very low in the district. This study therefore sets out to determine the factors which contribute to the low use of contraceptives within the district.

1.4 OBJECTIVES OF THE STUDY

1.4.1 BROAD OBJECTIVE

The major objective of the study is to analyse the demographic, socio-economic and socio-cultural factors that influence the use of contraceptives in Meru district and suggest appropriate recommendations to planners and policy makers.

1.4.2 SPECIFIC OBJECTIVES

- (i) Find out the effect of age at marriage on contraceptive use.
- (ii) Examine the relationship between contraceptive use and the level of education.
- (iii) Determine whether family size affects contraceptive use.
- (iv) Find out which socio-cultural factors influence contraceptive use.
- (v) Find out if marital status and place of residence have any effects on contraceptive use.

1.5 JUSTIFICATION OF THE STUDY

Although family planning activities were introduced in the country, more than two decades ago (1967), and the Government and non-governmental organizations have continued to offer free services a lot of information has been disseminated on family planning methods. The Kenyan women know at least one contraceptive method while 27% of currently married Kenyan women were using a contraceptive method by 1989 (KDHS).

There's therefore need to examine the factors that come into play in determining contraceptive use in order to formulate appropriate policies and strategies to raise the level of contraceptive use.

Literature available also shows that studies in contraceptive use have mainly been comparative in nature Peble and Blacker (1982), Lafihan and Maneclin (1985) carried out studies on determinants of contraceptive use dealing with Latin America and Asian countries using world fertility data. Ikamari (1985), Ojaka (1985) also carried out studies on the same in Kenya. However, some studies on the determinants of contraceptive use in Meru district have been done. This study will therefore add some knowledge to what is already known about determinants of contraceptive use in Kenya and give some specific knowledge on the districts contraceptive use.

1.6 SCOPE AND LIMITATION OF THE STUDY SCOPE

This study utilises data from the Kenya Demographic and Health Survey (KDHS), which was conducted by the National Council for Population and Development between December 1988 and May 1989.

The study collected information on fertility, family planning and maternal and child health. However, although the study was national in coverage, it excluded the north eastern province and four northern districts of the country and others in the eastern province.

1.6.1 LIMITATIONS

- (i) The limitation of the study are that the study uses secondary data collected with a different objective not intended for this particular study.
- (ii) The study includes women who are not married and not having

children, infertile and those still in school, but are aged (15-49 years). This group of women is not exposed to the risk of pregnancy so do not need any contraceptives.

- (iii) The study (KDHS 1989) only interviewed about of Meru women of reproductive age. This sample may not be representative of women in the district. More so this study is limited by time and financial status hence may not be able to look at the influence of contraceptive use on fertility within women of reproductive age in the district.

1.7 LITERATURE REVIEW

African countries are poor and have high fertility and rapid population growth, until recently very few have had policies or programmes directed at reducing fertility.

A study by Mauldin (1965) showed that by the early 1960's, the majority of people in developing countries, although not yet conforming to the small family ideal, no longer had a preference for very large families.

Currently the policy of African Governments on fertility control very much depends on family planning programmes adopted. Coale (1974) argues that people will use contraceptive when they perceive advantages from reduced fertility and when they possess knowledge of effective techniques of fertility control.

According to population reports on fertility and family planning surveys (1986) knowledge of family planning is wide spread in many countries, one of the factors which influence fertility in a society is the population of fecund woman who are protected from the risk of pregnancy. The higher the proportion, the lower the fertility level is expected to be (Kimani, 1982).

1.7.1 DETERMINANTS OF CONTRACEPTIVE USE

1.7.1a AGE OF THE MOTHER

Freedman and Berelson (1967) have documented that acceptors tend to be generally older than the average woman. The percentage of ever user increases to the high thirties for women aged 25-39 before it declines to around 30% for women over 40 years (KCPS, 1984).

Older women aged 40 - 44 are less likely to use family planning than younger women, as women stop using contraceptives as they grow older. Age determines the degree of exposure to knowledge of contraceptive use depending on the relationship with other factors for example place of residence, education attainments and one's cultural values of reproduction (Oucho J. 1989).

1.7.1b LEVEL OF EDUCATION

Most evidence available for most countries indicate that, modern couples have rates of contraceptive practice significantly above average, for example the more educated.

In Guatamala and Panama, exposure to family planning communications has been identified to have played a key role in the use of contraceptive even when controlling for education (Bertrand J. et al, 1982).

According to the Kenya Contraceptive Prevalence Survey (1984). Variation in knowledge of contraceptives varied with the level of education, women with higher level of education attained, are more likely to know at least one family planning method.

Evidence from Kenya, shows that women with fewer years of education (i.e.) Primary education, have higher fertility than women with no education A.B.C. Ocholla-Ayayo (1991).

Education, particularly female education has been demonstrated to have a significant effect on fertility in many countries (Caldwell, 1980). This is because education brings a new set of values, aspirations and outlooks on life as well as skills for taking advantages to new opportunities. A rise in the level of female education eventually leads to a decline in fertility in the short run although in the long run it might lead to abandonment of traditional practices which have fertility suppressing effects such as prolonged breast feeding, post partum abstinence and polygyny practices hence increasing fertility.

Henry Mosley et al (1982) have argued that among older educated women, the decline in breast feeding and post partum amenorrhea is usually compensated for by higher levels of contraceptive practice so that education is being associated with lower fertility.

In Kenya for example, because the vast majority of educated women are only 1% education and since most of the women are young and sexually active, the net effect at least in the short-run is a substantial rise in current marital fertility by education.

According to the Kenya Demographic and Health Survey (1989), which is the major source of data for this study, the percentage of women using contraceptives increases with the level of education, as increasing education is generally associated with a tendency to delay marriage and child bearing. Increasing education is also

associated with a higher probability of employment in the modern sector, which can lead to changing values about family size. However, the availability of family planning through nearby clinics, narrows the educational differences in contraceptive use, as the less educated women experience a relatively greater increase in contraceptive use than do more educated. Nevertheless education is still positively related to contraceptive use rate even when there's a clinic near-by. This reflects a greater awareness of contraceptive methods by more highly educated women or a greater receptivity to new technologies.

This is evidenced by Julie Davon et al (1987), who asserts that as the average educational level of women of child bearing age increased, in Malaysia, the contribution of the contraception usage also increased.

1.7.1c FAMILY SIZE

NUMBER OF SURVIVING CHILDREN

Studies have shown that family size is positively related to the willingness to use contraception among the women. Couples who prefer small families on both ideal and actual levels of child bearing are most likely to be able to accumulate knowledge about fertility regulating practices which will enable them achieve their family size goals (Amy Ona Tsui 1978).

Other studies have shown that, the number of additional children desired may affect contraceptive use. Freedman et al (1981) has documented that, in Indonesia exposed women who wanted no more children used contraception more than those who wanted more children.

Results from the Kenya Demographic and Health Survey (1989) indicates that younger women are starting to contracept at lower parities than older women. According to the survey, 19% of women aged 20 - 24 years started using contraceptives after their first child, compared to only 4% of the women aged 45 - 49. Early use of contraceptives, may lead to achieved desired fertility, leading to low population growth rate in Kenya in future.

According to studies carried out in Meru (Chogoria Community Health Survey) the total fertility rate for eastern province was 8 while that of Chogoria proved to be much lower. This is basically due to the contraceptive prevalence rate which was much higher. Parity increased steadily with age averaging about 8 births. While contraceptive use was found to be highest among women with four or more living children.

Desired family size is therefore, related to level of education. Currently married women with no education like to have an average of seven children whereas the educated women have an average of five children or 5.8 KCPS (1984).

Contraceptive use has been found to increase among women with at least one child and to be more common with women who have more children than the non-users (Bogota 1964 - 1974).

1.7.1d RELIGION

Other variables that determine contraceptive use include religion. Differences according to religious beliefs are not of great interest. This is because religiosity is a problematic factor to measure accurately. However, religion has been traditionally regarded as an important force in non-use of modern contraceptives especially among the Catholics and Moslems whose religious doctrines oppose contraception.

1.7.1e CURRENTLY WORKING WOMEN

Researchers have found out that wives employment status may affect contraceptive use. Caldwell (1986B) has documented that there exists a positive relationship between occupational status and contraceptive use in Ghana.

Working women may not want more children, this is because they don't have time to cater for them and would also require a higher income, they also may not require some assurance of security from their children as they benefit financially from their jobs and are given retirement benefits (Schultz, Kangi, 1978).

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The educated and employed also prefer to have few children who they can give better food, clothing and education (Schultz, 1979).

Husbands employment status has been found to be related to contraceptive use. Freedman, et al (1981), using a multi-classification analysis has documented that husbands employment status is positively related to the use of contraceptives among the exposed women in Indonesia.

Obtaining access to contraceptives methods involves purchase cost as well as information and travel costs. The purchase cost is from private sources, although they are obtained free of charge from public hospitals and clinics. But the cost of travelling to the family planning clinics also exists and are mostly viewed as enormous by the rural population.

Freedman and Barelson (1976), Mauldin (1979), Pebbley and Brackett (1982) argued that a clear consistent and positive relationship exists between the availability of a range of contraceptive methods and contraceptive prevalence rates.

Studies have indicated a strong positive correlation between family planning messages and contraceptive use (Guatamala Contraceptive Prevalence Survey). However, no amount of effort to enhance family planning knowledge and practice levels will be of any consequences without the widespread availability of contraception either through

national programmes or commercial sources, as family planning often calls for a high degree of availability.

Accessibility affects the contraceptive use as it removes the distance barrier encouraging people to continue the different methods available for longer periods. The rate of use decreases with increase in travel time to source.

1.7.1f MARITAL STATUS

Forrest and Fordyce (1988) have documented that all of the net rise in the use of the most effective methods occur among married women.

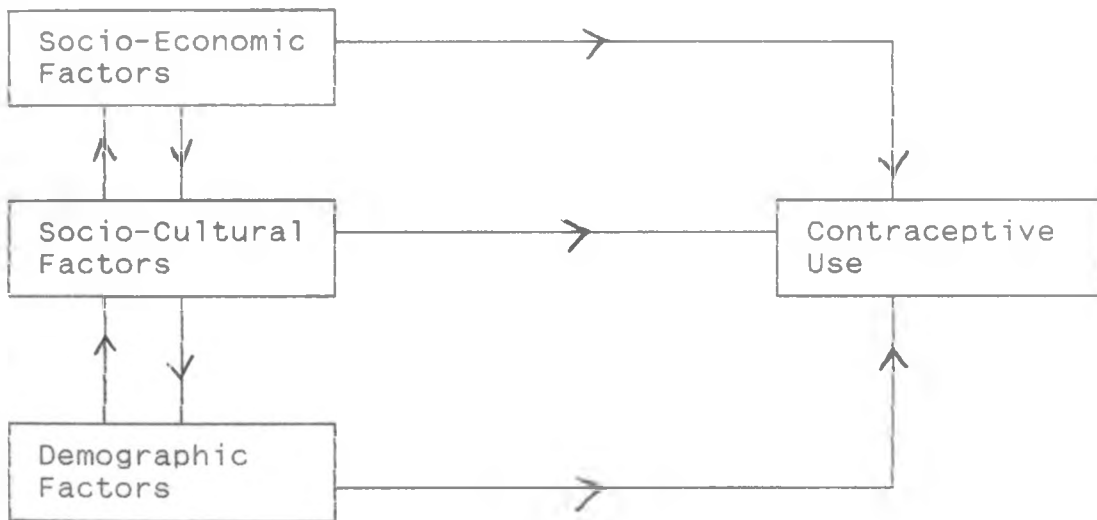
Among unmarried women at risk of unintended pregnancy, the proportion using the most effective methods is stable.

1.8 THEORETICAL FRAMEWORK

In Africa two thirds of women know of at least one method of family planning world wide. Oral contraceptives are the best known method followed by voluntary sterilization and IUD.

1.8.1 CONCEPTUAL FRAMEWORK

Figure 1: Conceptual Framework For Understanding The Determinants Of Contraceptive Use

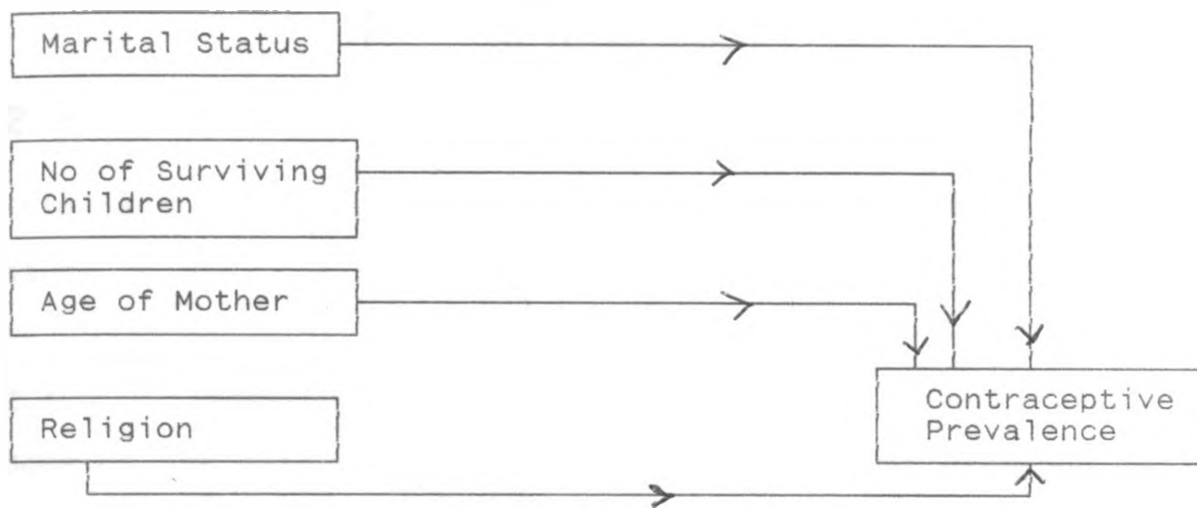


1. The socio-economic variables include the following, educational level, occupation and place of residence.
2. Socio-cultural factors, these are religion and ethnicity.
3. Demographic variables, are factors such as age, marital status and number of living children variables.

The above variables have been converted into an operational framework in order to simplify the conceptual model into a more understandable frame work.

1.8.2 OPERATIONAL MODEL

Figure 2: Operational Framework For Understanding Determinants Of Contraceptive Use



1.8.3 CONCEPTUAL HYPOTHESIS

This study assumes that:

1. Demographic factors play a major role in determining contraceptive use.
2. A woman's socio-economic status may influence her contraceptive use.
3. The socio-cultural factors of a place may affect the contraceptive use of women.

CHAPTER TWO

DEFINATION OF PRINCIPAL CONCEPTS AND REASEARCH METHODOLOGY

2.1 DEFINITION OF PRINCIPAL CONCEPTS

This section attempts to define the variables used in the present study.

2.1.1 DEMOGRAPHIC FACTORS

Some of the demographic factors that this study examines include the following, marital status, age of mother, number of surviving children, ideal number of children and contraceptive use.

(i) Marital Status

This variable is defined in terms of whether one is legitimately living with the husband or not. For this study it will be measured in terms of, married, never married, divorced, widowed, not living together, living together but not married.

(ii) Age of Mother

This refers to women respondents of reproductive age. That is 15 - 49 age group. It will be examined in terms of which age group has contributed most of the use of non-use of contraception.

(iii) Number of Surviving Children

This variable refers to the number of surviving children as

given by the respondents. For this study, this will be measured in terms of which number (parity) influences contraceptive use.

(iv) **Ideal Number of Children**

This refers to the number of children that women of reproductive age consider as reasonable and ideal to the society where they live in. It will therefore be measured in terms of the number given by respondents as acceptable.

(v) **Contraceptive Use**

Contraceptive use refers to measures which are taken in order to prevent conception. The means used to prevent or delay conception are referred to as contraceptive methods. In this study, this will be measured in terms of ever use and current use among reproductive women.

2.1.2 SOCIO-ECONOMIC FACTORS

Some of the socio-economic factors included in this study are:
Education level and place of residence.

(i) **Education Level**

This is defined as the highest level of education attained. It is examined in terms of no education, primary level and secondary level plus education.

2.1.3 SOCIO-CULTURAL FACTORS

Only one socio-cultural factor is included in the study:

(i) Religion

This variable refers to the denomination that each of the respondent's belong to. This is either Catholic, Protestant, Muslim and no religion.

2.2 RESEARCH METHODOLOGY

2.2.1 Source of Data

This study has used secondary data mainly drawn from the Kenya Demographic and Health Survey (KDHS) conducted in 1989 by the National Council for Population and Development (NCPD) in collaboration with the Central Bureau of Statistics (CBS) and Institute of Research Development (IRD).

The sample for the KDHS was based on the National Sample Survey and Evaluation Programme (NASSEP) master sample maintained by CBS. The NASSEP master sample is a two sample design stratified by urban-rural residence and within the rural stratum by individual districts. A total of 34 districts were included in the survey, Meru district being one of them.

The KDHS sample was national in coverage but excluded north eastern province. The survey covered 7,150 women aged 15 - 49 and about 1,116 husbands of the women selected from a sample

covering 95% of the population.

The KDHS used three questionnaires to collect data. These included, the household questionnaire, woman's questionnaire and husbands questionnaire. However, this study will focus on data collected using the woman's questionnaire which consisted of seven sections. The first section collected information on the respondent's background such as age, residence, educational level, household amenities, religion etc. The second section collected information on the respondents reproductive behaviour. The third section collected information on the respondents knowledge and use of family planning methods, preferences and attitudes towards family planning. The fourth section collected information on the respondents breast-feeding habits and general child health care. The fifth section collected information on respondent's reproductive intentions and family size while the sixth dealt with the fertility preferences. The last section dealt with the husbands background and woman's work.

The study has also sought data from other secondary sources: goverment publications, population reports, magazines and has borrowed alot from the District Contraceptive Prevalence Survey conducted by Population Studies and Research Institute (PSRI).

2.2.2 RELIABILITY AND QUALITY OF DATA

Since this study will use secondary data from KDHS, it is not free from the various errors found in surveys. However, since the survey was national in coverage apart from excluding districts in the north eastern province, Isiolo, Samburu, Marsabit and Turkana which only account for about 5% of Kenya's population; it is comprehensive in nature.

The survey also collected socio-economic and demographic information from women aged 15 - 49. The survey, therefore contains all the variables required for this study. The study was also carried out by qualified personnel.

KDHS therefore turns-out to be the most recent and reliable data for the present study, as the questionnaires were even translated into local languages for better understanding.

2.2.3 METHOD OF DATA ANALYSIS

Various methods have been applied to show the relationship between demographic, socio-economic and social-cultural variables and contraceptive use. However, for this study the cross-tabulation method has been will be used to analyze the relationship and show

the distribution of ever-users. Frequency Histogram has been used to show the distribution on each variable used in relation to ever-use of any method.

The cross-tabulation method has been used in this study because of lack of resources and also due to it's appropriateness for comparative purposes. The method is simple to compute and understand and will be easier to show the relationship between various socio-economic, social-cultural and demographic variables with contraceptive use.

2.2.4 APPLICATION OF THE CROSS-TABULATION METHOD

This study will be concerned with women aged 15-49 years who were exposed to the risk of pregnancy and contraceptive use.

The demographic, socio-economic and social-cultural indicators selected for this study are respondent's age, of the women, marital status, number of surviving children, ideal number of children, education level residence (urban or rural) and religion. However, respondent's current working status and ethnicity have not been examined due to lack of adequate data.

The following tables have been used in the analysis:

1. Ever-use of contraceptive by age of mother.
2. Current contraceptive use by age of mother.

3. Ever-use of contraceptive by marital status.
4. Current contraceptive use by marital status.
5. Ever-use of contraceptive by surviving children.
6. Current use of contraceptive by surviving children.
7. Ever-use of contraceptive by ideal number of children.
8. Current use of contraceptive by ideal number of children.
9. Ever use of contraceptive by level of education.
10. Current contraceptive use by level of education.
11. Ever-use of contraceptive by religion.
12. Current contraceptive use by religion.

2.2.5 LIMITATIONS OF CROSS-TABULATION METHOD

Cross-tabulation method has various limitations.

- (i) The method only indicates the association between dependent variables (example contraceptive use) and variables like (education or place of residence), but doesn't show the extent or by how much these variables influence the contraceptive use.
- (ii) Cross-tabulation also doesn't indicate which of the variables has a stronger influence than the other on the independent variable.

CHAPTER THREE

FINDINGS

3.1 INTRODUCTION

This chapter deals with the presentation and analysis of data collected from the KDHS (which is the major source of data), and also the interpretation of information on how each of the following variables, {age of mother, marital status, number of surviving children, total number ever born (parity), level of education attained, place of residence and religion} affect contraceptive use.

Cross-tabulation method has been used to show the relationship between the socio-economic, socio-cultural and demographic variables and contraceptive use. Contraceptive use has been examined among currently married women aged 15 - 49, who reported they were currently using a method or had ever used a method.

3.1.1 DISCUSSIONS OF FINDINGS

Contraceptive Use and Age of Mother

Table 1 below shows data on the percentage distribution of women 5 year age groups and ever use of any method.

Table 1: Contraceptive Use Of Any Method By Age Group Of Women

Age Group	Never Use	Use Only Tradition	Use Only Modern Method	Total Cases	%
15-19	76.7	16.4	6.8	76	100
20-24	46.5	14.0	39.5	45	100
25-29	37.7	7.5	54.7	55	100
30-34	37.5	0.0	62.5	42	100
35-39	35.7	7.1	57.2	44	100
40-44	35.5	12.9	51.6	32	100
45-49	48.1	18.5	33.4	28	100

The table 1 above shows that 76.7% of the respondents in 15-19 age group never use any method. This is probably because most of them are not married and could be in school hence not within the bracket that is exposed to the risk of getting pregnant.

The table also indicates that with an increase in age, there's a rise in the use of contraception. It is also shown that, the 30-34 age group portray a high percentage use of modern methods than traditional methods. This could be due to the level of education, as the higher educated women prefer the modern methods because they are effective.

The table also shows that as women grow older, modern methods are more preferred than the traditional methods, as portrayed by the upward trend in the per cent of women using contraceptive from age

group 20-24 to age group 35-39. This is probably because at higher ages women want to control their births and hence require effective methods which they can be sure of.

From the table above one can therefore conclude that age is closely associated with contraceptive use.

Table 2 above shows that majority of women across age groups 15-49 were not using a modern method. This could be due to the problems associated with the modern methods such as pains, high discharge, prolonged and heavy periods, as well as the socio-cultural believes which progate the idea that family planning methods are bad because they lead to infertility.

Table 2: Percentage Distribution of Age, 5 Year Group by Current Contraceptive Method

Age Group	Not Using	Pill	IUD	Injection	Diaphram	Condom
15-19	90.4	1.4	0.0	0.0	0.0	0.0
20-24	67.4	16.3	4.7	0.0	2.3	2.3
25-29	67.9	22.6	5.7	3.8	0.0	0.0
30-34	57.5	12.5	5.0	12.5	0.0	2.5
35-39	54.8	7.1	19.0	4.8	0.0	0.0
40-44	61.3	6.5	6.5	6.5	3.2	0.0
45-49	85.2	3.7	0.0	0.0	3.7	0.0

Age Group	Female Sterilization	Periodic Abstinence	Other	Total Cases	%
15-19	0.0	6.8	1.4	76	001
20-24	0.0	4.7	2.3	45	001
25-29	0.0	0.0	0.0	55	001
30-34	2.5	7.0	0.0	42	001
35-39	14.3	0.0	0.0	44	001
40-44	12.9	3.2	0.0	32	001
45-49	7.4	0.0	0.0	28	001

It is also worth noting that female sterilization has a percentage of up to 14.3%, this could be due to the improved service delivery methods within the district and especially around Chogoria area. Female sterilization is common especially among the older women because it's mostly used for controlling fertility while the pill is common among the younger women for spacing their births.

3.1.2 Contraceptive Use and Current Marital Status

Table 3 shows data on the percentage distribution of current marital status by ever-use of any method.

Table 3 shows that about 54.5% of all married women were using modern methods. This could probably be due to the fact that they are exposed to the risk of conception and need an effective method that they can rely on, either for spacing or control of fertility.

Table 3: Percentage Distribution of Respondents by Current Marital Status and Ever Use of Any Method

	NEVER USED	USED ONLY TRADITIONAL METHODS	USED ONLY MODERN METHODS	TOTAL	
				CASES	%
NEVER MARRIED	68.3	17.3	14.4	109	100
MARRIED	38.0	7.5	54.5	196	100
OTHERS	30	9.0	62	18	100

Women grouped as others included those either living together, divorced, widowed or single. 62% of the other respondents were using only modern contraceptives, while 9% and 30% were using only

traditional methods and not using any method respectively. This shows a large percentage of this group use effective methods of contraception probably because most of them are in unstable unions hence they have to be sure of their spouses before getting children.

It is also shown that 68.3% of the never married women, never use contraception. This could be due to the fact that most of them are young and still in school (i.e. 15-19 and 20-24 age groups).

Finally, the table also shows that the modern method are most preferred than the traditional methods; possible because modern methods of contraception are more safer than traditional method.

The table above indicates that 84.6% of the never married women were not using any contraceptive method while 63.1% of the married were also not using a method.

Table 4: Percentage Distribution of respondents by Current Marital Status and Current Contraceptive Method

	NOT USING	PILL	I.U.D	INJECTION	DIAPHRAGM	CONDOMS
NEVER MARRIED	84.6	3.8	1.9	0.0	0.0	1.0
MARRIED	63.1	12.8	8.0	5.9	1.6	0.5
OTHERS	72	13	0.0	0.0	0.0	0.0

Table 4 CONT'D

	FEMALE STERILIZATION	PERIODIC ABSTINENCE	OTHER	TOTAL	
				CASES	%
NEVER MARRIED	1.0	5.8	1.9	109	100
MARRIED	5.9	2.1	0.0	196	100
OTHERS	6.25	8.32	0.0	1	100

Among the respondents classified as others, the most preferred method is the pill (13%), followed by periodic abstinence (8.3%) and female sterilization (6.25%). This might be due to the fact that most of these women are not in stable unions and hence cannot use permanent methods of contraception.

Table 5 shows that 78.7% of the respondents with no children never used any method. This could be because they are yet to prove their fertility and many of them are still in the age group that is still in school (15-19). However, a number of them 19.7% were using traditional methods. The table also shows that 58.1% of respondents with one child never use contraception. This is probably because they would need another child. Contraceptive use is lowest among women with less than two children. However, the use of modern methods goes up with the increase of the number of children. This could be because women require an effective contraceptive

method for both spacing and controlling their fertility. Although contraceptive use starts declining at the sixth parity and about.

Table 5: Percentage Distribution of Respondents by Number of Living Children and Ever-Use of Any Method

LIVING CHILDREN	NEVER USED	USED ONLY TRADITIONS	USED MODERN	TOTAL CASES	%
0	78.9	19.7	1.3	80	100
1	58.1	9.7	32.3	32	100
2	36.4	6.1	57.6	35	100
3	45.2	3.2	51.6	32	100
4	35.3	5.9	58.8	36	100
5	28.6	8.6	62.9	37	100
6	26.1	21.7	52.2	24	100
10	66.7	0.0	33.3	3	100

Its worthy noting that modern methods are the most preferred among women respondents with more than two living children.

Table 6: Percentage Distribution of Respondents by Number of Living Children and Current Contraceptive Method

LIVING CHILDREN	NOT USING	PILL	I.U.D	INJECTION	DIAPHRAGM	CONDOM
0	90.8	0.0	0.0	0.0	0.0	0.0
1	77.4	9.7	3.2	0.0	0.0	3.2
2	57.6	27.3	9.1	0.0	3.0	0.0
3	71.0	22.6	3.2	3.2	0.0	0.0
4	52.9	14.7	14.7	8.8	0.0	0.0
5	60.0	11.4	8.6	8.6	0.0	2.9
6	69.9	4.3	4.3	8.7	4.3	0.0
10	100.0	0.0	0.0	0.0	0.0	0.0

TABLE 6 CONT'D

LIVING CHILDREN	FEMALE STERILIZATION	PERIODIC ABSTINENCE	OTHER	TOTAL CASES	%
0	0.0	6.6	2.6	80	100
1	0.0	6.5	0.0	32	100
2	0.0	3.0	0.0	35	100
3	0.0	0.0	0.0	32	100
4	8.8	0.0	0.0	36	100
5	5.7	2.9	0.0	37	100
6	4.3	4.3	0.0	24	100
10	0.0	0.0	0.0	3	100

The table 6 above shows that 90.85 of all women respondents with no children never use contraceptive methods, probably because, they need not to use anything as most of them are young and not within the risk of getting pregnant while others use periodic abstinence, 6.6%.

The table also indicates that the pill is the most preferred method by women with up to six children probably because they would like to space their births. Women with 0-3 children least use contraceptive methods because many have high values for ideal family size considering their actual fertility levels.

Female sterilization is also common among women with four children and more probably because they have attained their ideal family size.

We can therefore, conclude from the table 6 that the number of living children influence one's choice of contraceptive methods.

Table 7 above shows that most of the respondents of parity zero (78.4%) have never used any contraceptive method, while 20.3% have used traditional methods.

The table also shows that respondents with two children and above prefer using modern methods, probably because they want to control fertility.

3.1.3 TOTAL CHILDREN EVER BORN BY CONTRACEPTIVE USE
Table 7: Percentage Distribution of Respondents by Total Children Ever Born and Ever Use of any Method

PARITY	NEVER USED	USED ONLY TRADITION	USED MODERN METHODS	TOTAL CASES	%
0	78.4	20.3	1.4	77	100
1	61.3	6.5	32.3	32	100
2	35.5	6.5	58.1	32	100
3	40.7	0.0	59.3	28	100
4	40.0	8.0	52.0	26	100
5	20.6	8.8	70.6	36	100
6	32.0	12.0	56.0	26	100
10	50.0	10.0	40.0	10	100

Table 8 shows that 90.5% of the women of parity zero were not using any method while 6.8% used periodic abstinence. The table also indicates that

the pill is the only common method among respondents of parity one and above probably for purposes of spacing their births. Although after parity seven the respondents stop using any method, probably because they are old and need no more children so no need of spacing births. Those of parity ten too use I.U.D. as a method of contraception (10%) although many of them don't use any method at all.

Table 8: Percentage Distribution of Respondents by Total Children Ever Born and Current Contraceptive Method

PARITY	NOT USING	PILL	I.U.D	INJECTION	DIAPHRAGM
0	90.5	0.0	0.0	0.0	0.0
1	77.4	9.7	3.2	0.0	0.0
2	54.8	29.0	9.7	0.0	3.2
3	66.7	25.9	3.7	3.7	0.0
4	60.0	12.0	16.0	4.0	0.0
5	52.9	8.8	11.8	11.8	0.0
6	64.0	16.0	4.0	12.0	0.0
10	80.0	0.0	10.0	0.0	0.0

PARITY	CONDOM	FEMALE STERILIZATION	PERIODIC ABSTINENCE	OTHERS	TOTAL CASES	%
0	0.0	0.0	6.8	2.7	77	100
1	3.2	0.0	6.5	0.0	32	100
2	0.0	0.0	3.2	0.0	32	100
3	0.0	0.0	0.0	0.0	28	100
4	0.0	8.0	0.0	0.0	26	100
5	2.9	8.8	2.9	0.0	36	100
6	0.0	0.0	4.0	0.0	26	100
10	0.0	0.0	10.0	0.0	10	100

3.1.4 CONTRACEPTIVE USE AND EDUCATION LEVEL ATTAINED

Table 9 shows that as the level of education increase the percentage of those who have never used any contraceptive method decreases. The table also shows that 55.8% of respondents with no education do not use contraceptive methods as compared to 51.6% of respondents with primary education. This refutes

many scholars' views that primary level women have a higher fertility than those with no education and instead show a fertility which is slightly lower than those that are not educated.

Table 9: Percentage Distribution of Respondents by Educational Level and Ever Use of Any Method

	NEVER USED	USED ONLY TRADITION	USED ONLY MODERN METHOD	TOTAL	
				CASE	%
NO EDUCATION	55.8	11.7	32.5	81	100
PRIMARY EDUCATION	51.6	9.2	39.1	193	100
SECONDARY EDUCATION	25.5	17.0	57.4	49	100

Another observation that can be made from the table is that traditional methods are not widely used even by respondents with no education. This is probably because users of modern methods would like to be sure of using an effective method to limit their births.

Women with secondary education portary the highest propensity of using modern methods (57.4%). This is probably because educated women prefer to have fewer children whom they can give quality life. These findings are similar to observations made by Schultz (1979).

Table 10: Percentage Distribution of Respondents by Educational Level and

Current Contraceptive Method Used

	NOT USING	PILL	I.U.D.	INJECTION	DIAPHRAGM
NO EDUCATION	84.4	6.5	0.0	3.9	0.0
PRIMARY EDUCATION	71.2	9.8	6.0	3.3	1.1
SECONDARY EDUCATION	48.9	17.0	12.8	4.3	2.1

TABLE 10 CONT'D

	CONDOM	FEMALE STERILIZATION	PERIODIC ABSTINENCE	OTHERS	TOTAL CASES	%
NO EDUCATION	0.0	3.9	1.3	0.0	81	100
PRIMARY EDUCATION	1.1	3.3	3.3	1.1	193	100
SECONDARY EDUCATION	0.0	6.4	8.5	0.0	49	100

Table 10 shows most of the respondents do not use contraceptive methods. The KCPS (1984) has also revealed similar information, probably because these women are not sure of which method to use.

Generally contraceptive use tends to increase with the level of education as evidenced by the percentage of women with secondary education who are not using a contraceptive method (48.9%).

3.1.5 CONTRACEPTIVE USE BY RELIGION

Table 11: Percentage Distribution of Respondents by Religion and Ever Use of any Method

	NEVER USED	USED TRADITIONAL METHODS	USED MODERN METHOD	TOTAL CASES	%
CATHOLIC	54.0	15.9	30.1	118	100
PROTESTANTS	44.3	8.3	42.4	201	100
MUSLIM	100.0	0.0	0.0	3	100
NO RELIGION	100.0	0.0	0.0	1	100

Table 11 shows that all the respondents who are Muslims never use contraception. This could be due to the number of respondents as well as their cultural values (religion). The catholic respondents too have a high percentage of those who have never used any contraceptive method (54.0%).

Religious values and beliefs may influence contraceptive use by either increasing or decreasing the rate of use. This is shown by the high percentage use of modern methods by respondents who are protestants (47.4%) as compared to the catholics (30.1%) whose doctrine does not advocate any modern family planning methods.

Traditional methods are widely used by respondents who are catholics.

Table 12: Percentage Distribution of Respondents by Religion and Current Contraceptive Method Used

	NOT USING	PILL	I.U.D.	INJECTION	DIAPHRAGM
CATHOLIC	78.8	8.8	0.9	0.9	0.0
PROTESTANTS	65.6	10.9	8.3	5.2	1.6
MUSLIMS	100.0	0.0	0.0	0.0	0.0
NO RELIGION	100.0	0.0	0.0	0.0	0.0

TABLE 12. CONT'D

	CONDOMS	FEMALE STERILIZA TION	PERIODIC ABSTINENCE	OTHERS	TOTAL	
					CASES	%
CATHOLIC	0.9	4.4	3.5	1.8	118	100
PROTESTANTS	0.5	4.2	3.6	0.0	201	100
MUSLIMS	0.0	0.0	0.0	0.0	3	100
NO RELIGION	0.0	0.0	0.6	0.0	1	100

CHAPTER FOUR

4.0 SUMMARY AND RECOMMENDATIONS

4.1 SUMMARY

The knowledge of contraceptive methods and levels of their use within a population to a larger extent determines the level of fertility regulation in a country. The main objective of this study was to analyse the major demographic, socio-economic and social-cultural factors that influence the use of contraceptives in Meru District and suggest appropriate recommendations to planners and policy makers.

The objective was based on the observation that although the family planning programmes have been in place during the last two decades, the level of contraceptive use is still very low. This prompted to need to examine the factors that come into play in determining the contraceptive use so as to formulate appropriate policies and strategies to raise the level of contraceptives use in Meru district.

The realization of policy endeavours to further the reduction of population growth lies in ascertaining contraceptive use among eligible women. One of the factors which influence fertility in a society is the population of fecund women who are protected from the risk of pregnancy. The higher the

proportion the lower the fertility levels. The study found out that education is positively related to contraceptive use. There's a greater awareness of contraception by more highly educated women as they are more receptive to new technology.

The study has also revealed that current marital status influences contraceptive use. Married women have the highest percentage of contraceptive users as compared to the others.

Age of the mother also apparently is correlated with contraceptive use as portrayed by women aged 25 - 39.

The findings related to the number of living children show that contraceptive use increases with an increase in the number of living or surviving children, such that women with about five surviving children have the highest propensity to use modern methods of contraception.

Couples are likely to practice contraception when they do not want to have more children. Findings related to the total children ever born and use of contraceptive indicate that women of parity five and above use modern methods of contraceptive than those of lower parity.

The study also confirms the hypothesis that socio-cultural factors, where religion is a factor influence contraceptive use.

The other findings made by the study is that female sterilization a commonly used method of contraception. This could probably be due to the fact that women who use sterilization method are usually those who have achieved their ideal number of children, hence may want to stop giving birth to more children.

4.2 RECOMMENDATIONS

To be able to achieve a high level of contraceptive use in both Meru district and Kenya as a whole the following recommendations are made:

- It has been documented that education is positively related to contraceptive use. There's therefore, need to give the education of women a higher priority.
- It is also important to introduce population education especially to the rural women, in order to encourage the use of modern contraceptive methods which are not accepted culturally.

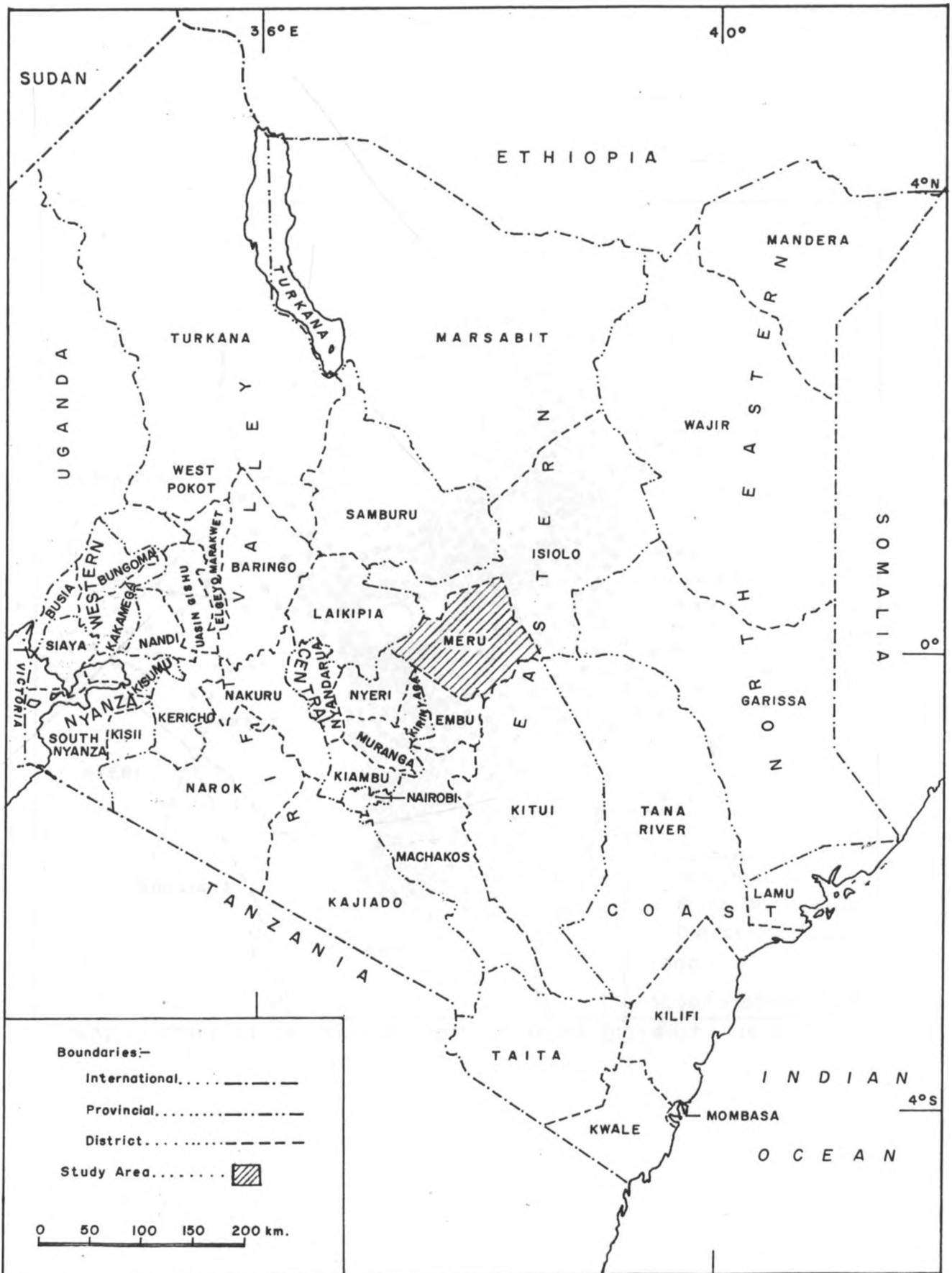
- There's need to improve the socio-economic conditions of the rural areas in order to provide them with various family planning services available in the urban areas in order to improve on contraceptive use.
- Family planning counselling should start in the hospital immediately after child birth, this takes care of the ignorant mothers who are very far away from the service providing clinics.
- Breast feeding for at least 12 months or longer durations should be promoted and equal emphasis given to its nutritional value for the first six months.
- There's need to involve males in the family planning campaigns and programmes as they control most women's fertility. Husband's objection has been given as one of the reasons for non-use of contraceptives.
- Finally information programmes should cover all forms of available contraceptive methods in order to dispel in accurate rumours about side effects and safety. Community based agents should be used in order to avoid duplication of services and reduce suspicion among women.

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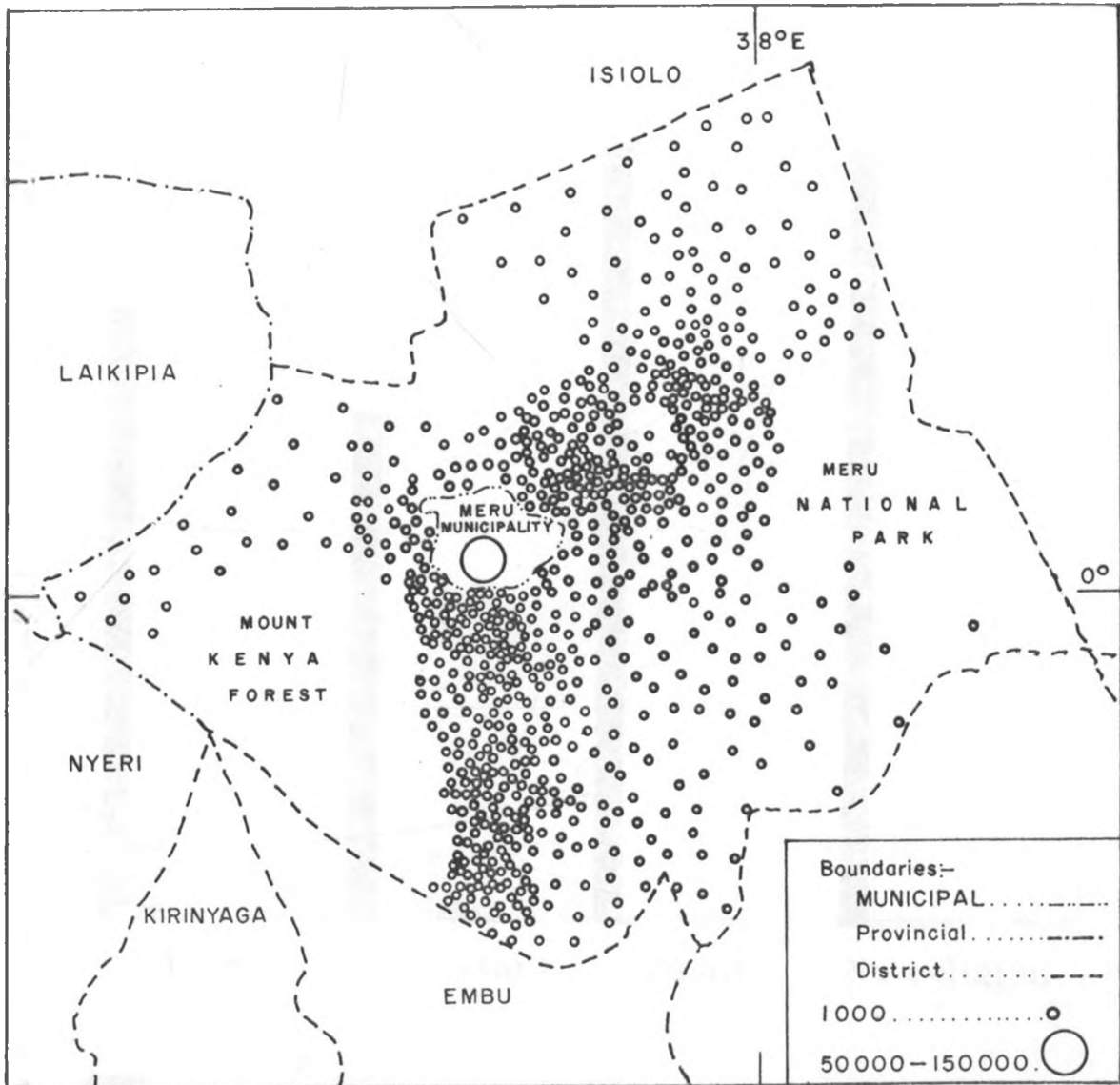
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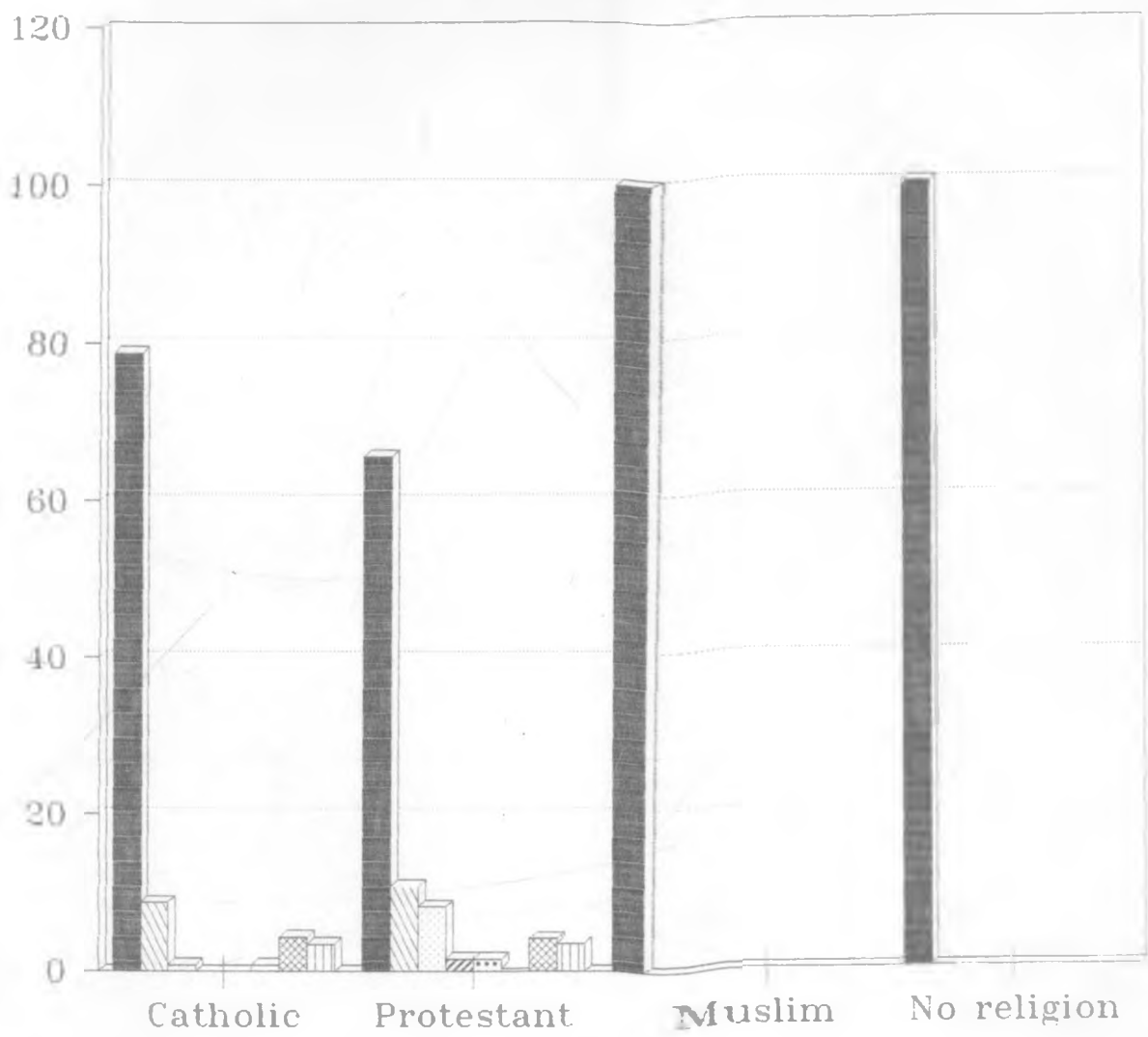


MAP I : LOCATION OF STUDY AREA



MAP 2: POPULATION DISTRIBUTION OF MERU DISTRICT — 1979

Religion by Current contraceptive me Meru District



- Not usi
- Pill
- IUD
- Inj
- Diap
- Condom
- FemSte
- PerAbs