

**FACTORS INFLUENCING CONTRACEPTIVE PREFERENCE AND CHOICE
AMONG WOMEN OF REPRODUCTIVE AGE IN MSAMBWENI CONSTITUENCY,
KWALE COUNTY, KENYA**

BY

KERU, JANET WANJIKU

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DECLARATION

I hereby declare that this research project is the result of my original work and that no part has been presented for another dissertation in this university or any other University or institution of higher learning for an academic award.

Signature: _____ Date: _____

KERU, JANET WANJIKU

L50/70311/2011

This research project report has been submitted for examination with my approval as the University supervisor.

Signature: _____ Date: _____

SUPERVISOR: JOHNBOSCO KISIMBII

LECTURER, DEPARTMENT OF EXTRA MURAL STUDIES

UNIVERSITY OF NAIROBI

DEDICATION

I wish to dedicate this work to my parents- Mr & Mrs Keru; their efforts& love for education are the reasons as to why I have made it this far in education. Thanks dad and mum, you have been a pillar of faith and hope that has seen me through the difficult and weakest moments of my life.

To my siblings Alex, Lawrence, Doreen &my baby sister Matilda, the moral support you have shown me cannot pass unmentioned. May God abundantly bless you.

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ABBREVIATIONS AND ACRONYMS

ANC	-	Ante-Natal Care
AOP	-	Annual Operation plan
CPR	-	Contraceptive Prevalence rate
FGD	-	Focused Group Discussions
FP	-	Family Planning
IUCD	-	Intrauterine Contraceptive Device
KDHS	-	Kenya Demographic Health Survey
KII	-	Key Informant Interview
LAPM	-	Long acting and permanent method
NRHS	-	National Reproductive Health Strategy
TFR	-	Total Fertility Rate
USAID	-	United States Agency International Development
WHO	-	World Health Organizations
WRA	-	Women of reproductive age

ABSTRACT

The government of Kenya in collaboration with other stakeholders involved in the provision of family planning services have put in place various strategies and policies to increase uptake of family planning services. These are aimed at increasing contraceptive prevalence rate (CPR), reduction in both total fertility rate (TFR) and unmet need for family planning services. Despite the various strategies and policies, total fertility rate still remains high at 4.6 percent, while CPR and unmet need for family planning at the national level are estimated at 46 percent and 24percent, respectively. Msambweni Constituency has a low CPR of 29.5. The purpose of the study was to examine the factors influencing contraceptive preference and choices among WRA in Msambweni constituency, Kwale County-Kenya. Literature reviewed showed that demographic, social, economic and service provider factors influence the contraceptive preference and choice with spousal approval being the major determinant. To realize the objectives, a descriptive survey design was adopted. The target population constituted WRA registered as FP clients in GOK health facilities. A sample size of 372WRA and 7 service providers was identified through cluster sampling. Primary data was collected from the women using a structured questionnaire and focus group discussions while KII was used for the service providers. The data was analyzed using Frequencies, percentages and the Chi-square test statistic and presented in tables. The study established that demographic factors, social factors, economic factors and service provider' factors have a significant influence on contraceptive preference and choice among WRA. The study concludes that demographic, social, economic and service provider' factors influence contraceptive preference and choice among WRA in Msambweni constituency. It recommends community based activities should be revived and enhanced, promotion of family planning education and activities at the household level targeting the WRA and their spouses should be accorded priority. The service providers play a crucial role in the general uptake of FP and should therefore be continually trained. Lobby groups to enhance cultural change, awareness creation and counseling and integrating family planning services should be formed.

CHAPTER ONE:

INTRODUCTION

1.1 Background of the Study

1.1 Background of the study

Family planning services enabled women to postpone space and limit pregnancies. As such, the services are essential to the maternal and child health of any country and have become a target of the millennium development goals. MDG 5 target B; indicator on contraceptive prevalence and unmet FP needs, evidence suggests that these are the most resistant MDGs indicators to progress (UNFPA 2010).

There had been little effort to measure unmet family planning needs in more developed countries, where contraceptive practice was supposedly (nearly) perfect. The proportion of individuals with an unmet need for family planning i.e., who had a current unwanted pregnancy or who are fecund, are sexually active, want no more births but were not using contraceptives, was as low as 3% in two European countries and below 10% in most. However, levels of unmet need in countries with economies in transition (13% in Latvia and Lithuania and 23% in Bulgaria) surpass some of the lowest levels observed for developing countries (Klitzing, 2000).

According to Jones et al, there are 62 million women in the U.S who were in their childbearing years (15–49), they were sexually active and did not want to become pregnant, but could become pregnant if they and their partners failed to use a contraceptive method and were at risk of unintended pregnancy. The typical U.S. woman wants only two children. To achieve this goal, she had to use contraceptives for roughly three decades (Rahed et al, 2008).

In many developing countries (also termed low- and middle-income countries), official family planning programmes began during the 1960s with the aim of reducing high fertility (Seltzer, 2002). However, in recent years, various Demographic and Health Surveys (DHS) report that women in developing countries have lower desired fertility than actual fertility, i.e. women are having more children than they want. This indicates that there is still an unmet need for family

planning; there are a proportion of women of reproductive age who prefer to avoid or postpone childbearing but are not using any method of contraception. In 2000, an estimated 17% of married women (105 million) had an unmet need for family planning in the developing world (USAID, 2005), and there is considerable variation across countries, for example, 5% in Vietnam and 40% in Haiti (Khan et al, 2007).

Indeed, despite official family planning programmes being in existence for more than 40 years, the contraceptive prevalence rate (CPR) is still low in many countries. The optimum level for contraceptive prevalence is regarded as 80-85% as this level is quite consistent with replacement level fertility (approximately two children per women; Ross, no date) i.e. this level of CPR will ensure that sufficient numbers of children will be born and survive to maintain existing population levels. Although it has increased from the level seen in the 1960s (9%), according to the United Nations Population Division, the contraceptive prevalence for the developing world in 2007 was 61.7%, and there were huge variations in CPR within the developing countries; it was only 2.8% in Chad but 80% in Costa Rica, for example. There were also significant variations between regions- about 28% in Africa region and 74% in South America (United Nations, 2009). Contraceptive prevalence is part of a dynamic process, not a discrete event and therefore difficult to pin down. It is influenced by the availability and supply of contraceptives over the choice to begin and to continue to use the contraceptives over a period of time (UNFPA, 2008). In the world, FP program have been fully backed, with WHO giving directions by developing guidelines and evidence based approaches, WHO states that contraceptives use has increased from 54 % in 1990 to 63 % by the year 2007, through UNFPA to help guide the countries on the same. In Africa it has risen from 17% to 28%,Asia 57% to 67% and 62 % to 72 % in Caribbean among WRA.Many countries have adopted different types of met methods depending on their promotions by the national strategies. Female sterilizations remain the widely chosen methods, followed by IUCD (WHO, 2009).

In Africa, the population growth had forced the countries to invest a lot in FP programs; developmental partners have in their own way supported the FP programs, because of the cyclic nature and the burdens of the outcome to the country i.e. Lack of effective FP systems will lead to high fertility rate which will lead to high maternal rate then high infant mortality rate .African

countries in the Sub-Sahara have adopted mostly short term methods of family planning, North of Sahara have invested a lot in IUCD at 37 % (Alhamdu, 2011)

Kenya as a country has been slowly trying to increase its contraceptive prevalence rate with a population estimated to be 37.8 million, current growth rate of 2.9 % per annum and this is considered to be high (NRHS, 2009 -2015). To date the CPR stands at 46 % (KDHS, 2008) with injectables, pills and female sterilization being the commonly used methods (KSPA, 2010). The country has 26 % of unmet FP needs with the poorer women being the most disadvantaged. This represents a major reproductive challenge to any policy maker and the country in general (KDHS, 2008).

The Coast Province had a low contraceptive prevalence rate at 34% (KDHS 2009). At 4.8, the total fertility rate in the Coast region is slightly higher than the national average of 4.6. Msambweni constituency is part of Kwale County; it borders Taita District to the North West, Kinango District and Kwale District to the North East, Republic of Tanzania to the South and Indian Ocean to the South East.

The constituency has one district hospital, 3 health centers, 26 dispensaries, 6 private clinics and 10 community units all with the capacity to provide, promote and advocate for different types of family planning. 70 % of the population is served by the community units, which are active and this can be seen as a way through which the vital indicators and demand for services rise. The overall district indicators are below the national ones i.e. immunizations, facility delivery, utilizations of outpatient facility, CPR, and ANC attendance (AOP 6).

Statistics from (AOP 5 and 6) show that the contraceptives methods mix among the clients in the constituency is poor despite the uptake of FP doing relatively well. Msambweni has a CPR of 29.5 % from the district statistics. The method mix in the constituency is skewed towards short term with injectable taking the lion share of the methods.

1.2 Statement of the problem

Despite the increasing adoption of contraceptives use in Msambweni, statistics have shown that there is poor method mix of FP methods among WRA in the constituency. This could be directly being associated to the clients' contraceptives choice and preferences. FP methods are many; short term and long term methods with different efficacy levels, side effects hence bringing in the issue of choice and preferences to clients. Contraceptive choice is a central element of quality of reproductive rights (Diazi et al, 1999).

In Kenya, the national figures for method mix stands at 48 % for injectables, 15.5 % for pills 4 % for IUCD, 4% for condom 10.8 % for female sterilizations and traditional methods 13%. The CPR of Msambweni constituency stands at 29.5% of the modern methods (AOP 6). The methods utilizations greatly vary among WRA. Method mix statistics show 63% for injectable, 20% for condoms and 11% for pills, 2.5 % for implants, IUCD 1.57 %,0.2% sterilizations (District AOP 6 statistics) having skewedness towards short term methods.

Studies had postulated that broadening the choice of contraceptive methods increases overall contraceptive prevalence (Ross et al 2001). The provision of a wide range of contraceptives methods increases opportunity for individuals to obtain a method. Studies have further shown that contraceptives use and contraceptives methods choice among young women in countries in Sub Saharan Africa are few (Bertrand 1992, Alhamdu 2011). Researchers have primarily focused on contraceptive use and method choice among married women, leaving vulnerable unmarried young women unattached (Ayanti, 2011)

Family planning facilities that offered many different contraceptive methods are best able to meet the needs of the clients and 80 % of facilities in the country reported offering at least four types of temporary family planning methods (KPSA 2010). This is an important element in FP programs because it will help to reduce family planning unmet needs that stand at 26 %, the high rate of FP methods discontinuation which happens due to un-informed contraceptive choice.

This study is therefore intended to establish factors that affect the client's preference for one method over the other and contraceptive choice.

1.3 Purpose of the study

The purpose of this study was to determine the factors influencing contraceptive preference and choice among Women of reproductive age in Msambweni constituency, Kwale County, Kenya.

1.4 Objectives of the study

This study was guided by the following specific objectives;

- 1) To determine how demographic factors influence contraceptive preference and choice among women of reproductive age in Msambweni constituency.
- 2) To establish how social factors influence contraceptive preference and choice among women of reproductive age in Msambweni constituency.
- 3) To examine the influence of economic factors on contraceptive preference and choice among women of reproductive age in Msambweni constituency.
- 4) To assess how service provider factors influence contraceptive preference and choice among women of reproductive age in Msambweni constituency.

1.5 Research Questions/Research hypotheses

This study dealt with the following research questions and hypotheses;

1.5.1 Research questions

The study sought to answer the following questions;

- 1) What are the demographics factors that influence the contraceptive preference and choice among women of reproductive age in Msambweni constituency?
- 2) Which social factors influence the contraceptive preference and choice among women of reproductive age in Msambweni constituency?
- 3) How do economic factors influence contraceptive preference and choice among women of reproductive age in Msambweni constituency?
- 4) To what extent do health service provider' factors influence the contraceptive preference and choice among women of reproductive age in Msambweni constituency?

1.5.2 Hypotheses

This study tested the following hypotheses;

- 1) Ho: Age has no influence on the contraceptive choice and preference among women of reproductive age.
H1: Age has a great influence on the contraceptive choice and preference among women of reproductive age.
- 2) Ho: Parity does not influence the contraceptive choice and preference among women of reproductive age.
H1: Parity influences the contraceptive choice and preference among women of reproductive age.
- 3) Ho: There is no significant relationship between husbands' approval and the contraceptive choice and preference among women of reproductive age.
H1: There is a significant relationship between husbands' approval and the contraceptive choice and preference among women of reproductive age.
- 4) Ho: Education is not a factor influencing contraceptive choice and preference among women of reproductive age.
H1: Education influences contraceptive choice and preference among women of reproductive age.
- 5) Ho: Service providers' experience does not have a significant influence on the contraceptive choice and preference among women of reproductive age.
H1: Service providers' experience has a significant influence on the contraceptive choice and preference among women of reproductive age.

1.6 Significance Of The Study

Family planning programs remained one of the key areas that Kenya was trying to address, the total fertility rate of the country stands at 4.6, unmet FP needs 26%, maternal mortality rate 488/100000 all these were precursors of poorly applied FP programs.

The findings of this study will assist program managers to formulate effective strategies towards addressing the problem of family planning non-users and help to develop programs aimed at

meeting the demand of family planning through the provisions of appropriate method mix to meet the need of current users depending on their characteristics.

The findings and recommendations of this study will help to design messages on family planning targeting the rural community. The findings will also serve to enrich the literature especially on the positive influence of service providers in FP uptake and issues of contraceptive preference and choice. The study is therefore expected to form a basis for further research in the area in relation to other regions in the country.

1.7 Delimitation of this study

This study focused on factors influencing contraceptive preference and choice among Women of reproductive age in Msambweni constituency. In addition, the study only focused on WRA receiving family planning services in GoK facilities in Msambweni constituency since the overall the constituency indicators are below the national indicators.

1.8 Limitations of the study

This study was limited by the following factors;

1. Cost constraints made it difficult for the researcher to hire qualified research assistants. The community health workers in the health facilities were trained to cut down on costs.
2. The study population consisted of women with mixed literacy levels therefore the questionnaires were simplified to use Yes or No questions as opposed to five point likert scales so that clarifying it would be easy for the research assistants.

1.9 Basic Assumptions of the study

This study was informed by the following assumptions;

1. That the respondents were ready to spare their time to participate in the study and give their views without prejudice.
2. That the respondents had adequate knowledge on the subject to give meaningful responses relevant to the study.

1.10 Definition of Significant Terms as used in the study

Contraceptive Prevalence: This is the proportions of WRA or their partners who are using a contraceptive method at a given point in time.

Contraceptive Method choice: Choice among an array of contraceptives methods including the option of not using any method (Entwisle, 2008)

Family planning: A reproductive strategy that individual and/or couples employ to meet their reproductive goals and to prevent unwanted pregnancies.

Parity: Number of surviving children.

Unmet family planning: Percentage of women who do not want to get pregnant but are not using any method of modern family planning. They want to wait two or more years for their next birth.

Women of Reproductive Age (WRA): This is an indicator of reproductive health. Refers to women aged 15- 49 years; they are women of child bearing age.

Method mix: Percentage distribution of contraceptive users by method.

1.11 Organization of the Study

This study consists of Chapter one to five, preliminary pages consisting of the declaration, dedication, acknowledgements table of contents, List of tables, acronyms and abbreviations and the abstract. The appendices are listed at the end of the document and include relevant authorities given for the study to be conducted and questionnaires used for the study.

Chapter one is the introduction to the study. It presents the background of the study, statement of the problem, purpose of the study, the objectives of the study, research questions, research hypotheses, significance of the study ,Limitations and delimitations of the study, basic assumptions and the definition of significant terms as used in the study. Chapter two presents the literature review which looks at factors influencing contraceptive preference and choice among WRA which include; Demographic factors, Social factors, economic factors and service provider factors. This chapter also provides the conceptual framework of the study.

Chapter three outlines the study design, the target population, methods of data collection, validity and reliability of the research instruments and data collection procedures. The chapter also includes the ethical considerations of the study, data analysis and presentation, and the operationalization of the variables. Chapter four contains the response rate, Knowledge on family planning and the demographic, social, economic and service provider' factors influencing contraceptive preference and choice among WRA. Chapter five presents a summary of the findings and discusses the findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature related to the factors influencing contraceptive preference and choice among WRA. It focuses on assessing the extent to which demographic factors, social factors, economic factors and service provider' factors influenced contraceptive preference and choice among WRA.

2.2 Overview of contraceptive use

The prevalence of contraceptive use had increased worldwide due to the development and introduction of modern contraceptives and the establishment of organized family planning programs (D'Arcanques, 2002). Family planning services offer various economic benefits to the household, country and the world at large. First, family planning permits individuals to influence the timing and the number of births, which is likely to save lives of children. Secondly, by reducing unwanted pregnancies, family planning service can reduce injury, illness and death associated with child birth, abortions and sexually transmitted infections (STIs) including HIV/AIDS (Hawkins *et al.* 1995). Further, family planning contributes to reduction in population growth, poverty reduction and preservation of the environment as well as demand for public goods and services (Shane, 1997; Cincotta & Engelman, 1997).

Highly effective methods of birth control have been available for several decades. In spite of this, approximately one-half of pregnancies in the United States are unplanned; approximately 36% of American women of childbearing age are not using contraception (PLiskow 2000).

Contraceptive behavior in the developing world has changed remarkably over the last three decades. This revolution is driven by the behaviors of desired family size, social and economic changes. The proportion of women who had heard of at least one method of contraception was high compared to that of women who had not have heard any method (John .B et al 2002).

WHO 2011 reviewed Trends in the use of short term and long term methods of contraception in 13 developing countries in sub Saharan Africa and there was substantial increase in the use of contraception, short term methods primarily, these findings were related to the cause that most of women were using contraception to space rather than stop childbearing.

Factors which influence family planning method mix are preferred number of children, initial source of family planning information, durations of family planning use, family planning intention, provider bias and informed choice. Religious and cultural misconceptions, method availability, accessibility and acceptability are also among other factors which influence family planning method mix. Rahel.D (2008), Shows that contraceptives mix is dominated by short term methods pills and injectables, implants also contribute highly to method mix. The contribution of the IUDs and condom is very minimal while permanent family planning methods are non-existent (John .B. et al, 2009)

There is abundant information that contraceptive knowledge and awareness is high among the population, but this awareness has not translated into increased contraceptive use, with the end result being very low contraceptive prevalence. In Nigeria, this low contraceptive prevalence correlates with high levels of unplanned pregnancies and abortions, leading to increases in the maternal mortality ratios especially in the rural areas and in northern Nigeria. The current prevalence rate for contraceptive use in Nigeria is approximately 11%–13%. This rate is very low in spite of the high rate of sexual activity and widespread awareness of the various contraceptive methods among Nigerian adolescence and youths. This seems to indicate a large unmet need for contraceptive use (Monjok & Ekabua et al ,2010).

Barriers to the use of contraception are many and diverse, but include shortcomings intrinsic to contraceptive methods such as cost, inconvenience, and unacceptable side effects. Several new methods that are in development or that have recently become available may help improve user acceptability and lower barriers to contraceptive use. Contraception is least effectively practiced in those lower class families in which the husband and wife have poor communication and are characterized by a "segregated" relationship in which they "go their separate ways." Scattered and inconclusive attempts have been made to relate contraceptive behavior to other variables

such as relative dominance of husband and wife, neuroticism, degree of personality similarity between husband and wife, and personality of the wife (Rainwater 1965).

The socio-cultural, religious, family, and male-dominant factors impeding contraceptive use in African countries have all been identified, but what is lacking is the generation of political priority for family planning and safe motherhood as well as the political will and commitment to make this change on a large scale, as occurred in Indonesia (Averalo 2004, Nikula 2010).

The Kenyan government has put in place various strategies and policies to facilitate the use of family planning services as a step towards reducing the fertility rates, increasing contraceptive prevalence rate and reducing the unmet family planning needs (Ian *et al.*, 2009; and Republic of Kenya, 2008). Despite these policy measures, total fertility rate still remains high at 4.6 percent, while CPR for all methods is at 46 percent. On the other hand, the unmet needs for family planning services average at 24 percent.

The low CPR, unmet needs for family planning services, low death rate (estimated at 14.02 deaths per 1,000 women), high birth rate (estimated at 39.73 births per 1,000 population) and low infant mortality estimated at 59.26 per 1000 live births contribute towards high population growth. Standards of living tend to worsen when the rate of population growth exceeds the rate of economic growth (Feyisetan, Bamiwuye, 1998). At the household level, the high fertility rate may be contributing towards depletion of productive resources in the society, rising cost of living, ill health, poor nutrition and limited educational opportunities, ultimately trapping women in a poverty cycle.

Components of successful family planning programmes include improvements in geographic and public-private sector, access to a broad mix of contraceptive methods, availability of competent health care providers, promotion of active behavioral change through communication interventions (WHO, 2011). Delivering family planning services that address clients needs, can effectively increase the use of contraceptives. Success of the programme will depend upon how well their services are tailored to unique needs of specific groups.

Age, access to TV, number of times married ,NGO membership, working status ,number of living children and child mortality and wealth index are important determinants of

contraceptive use and method choice . There is need to establish and develop mass media programs especially television program focusing on the benefit of small family size or small number of children and giving information on available contraceptive methods. (Moustaf K. (2009)

Women and partners should be a center of focus for improving awareness of the benefits of modern contraceptive methods with the ultimate goal of helping women make informed and responsible choices about their use. Permanent family planning methods should be promoted in the provision of family planning services. Community programs also play a major role in expansion of family planning methods in rural setup.

2.3 Demographic Factors Influencing Contraceptive preference and choice among WRA

Majority of women who are adopting any of the family planning methods belong to the age group 25 to 35 years (Roumi .D. 2010). This means that the comparatively younger population is now adopting any of the contraceptive methods. Use of family planning was found to be highest among women aged between 20 – 39 years compared to those below 20 years and above 39 years. Whereas 49 percent of the women that were using contraceptives were aged 20- 29 years, 41 percent were aged between 30 - 39 years, while no woman aged 50 years and above was found to be using any form of family planning services. On the other hand, 4 percent and 6 percent of the women who were using family planning services were less than 20 years and between 40 – 49 years of age(A. Leyland, 1996).

Use of family planning was found to be high in women aged between 20-39 years compared to those below 20 years and above 39 years . Studies (Rob et al 2007, Utomo et al. 1983) show that younger age especially age group (20-29) years was more likely to be associated with use of modern contraceptive

Use of contraceptives was found to vary across marital status with married women using the services most compared to single women due to high incidences of sexual activities compared to

single women. In this case, it was revealed that use of contraceptives was aimed at helping to space children and prevent unwanted pregnancy(Meharab et al 1996).

Unmarried youth have distinct contraceptive method preferences due to unsteady partnership dynamics ,increased awareness of the risk of HIV has altered the context of contraceptive choice . Condom is the leading method among unmarried youth and this is a desirable option since it minimizes the dual risks of unintended pregnancies and STIs. Data also revealed a growing shift from condom to the pill, with increasing age and partnership stability.

The positive influence of marital status on the likelihood of using family planning services could be attributed to the fact that couples might decide to postpone raising children by resorting to use of family planning services. The value of the marginal effect simply means that a married woman is 2 percent more likely to use family planning services than a single woman(Ristya .I. 2007).

George (2007) on Lungwena (2007) Across ages, unmet need for family planning indicated higher levels among adult women compared to adolescent. In time perspective, unmet need for modern family planning was relatively high at time the women become pregnant with the first child. The level went down by the time the women conceived the last born child, but went up again by the time the women conceived current pregnancy.

Sex combinations of surviving children and womens' education were the most important significant determinants of family planning method use and method choice (Oyedokun .A. (2007). The positive influence of the number of living children on the likelihood of using family planning services could be attributed to the woman's desire for children having been satisfied. (Mahidu et al. 1998)

Women with more living children were using family planning services more compared to those with fewer children. Out of the women that were using family planning services, 36 percent had 4 – 6 children, followed by those with between 1-3 living children at 30 percent. On the other hand, 17 percent of those respondents using family planning services had between 7 – 9 living

children, while 15 percent had no living child. Women in Zimbabwe who had several children wanted to avoid further pregnancies. (Feldman and Maposhere 2003).

This reveals that the higher the number of living children, the more the desire to use family planning services. This is because those with more children might not be having desire for children as the desire has already been satisfied. The desire for more children was attributed to many factors, including a cultural perception that more children signified a source of wealth (Teresa .c. 2005). Contraceptive use was 26.2% among women with three or more surviving children compared with 19.0% of women with no surviving children (Agyei and Migadde 1995).

Injectables and IUCDs were preferred by the young or low parity women, while permanent methods were preferred by the older or high parity women. Relatively older women preferred condoms and traditional methods (Kibuuka et.al, 2009).

2.4 Social Factors Influencing Contraceptive preference and choice among WRA

Spousal communication was an important factor in contraception use. The most important determinant of the likelihood of the respondents in slums using family planning services was partners' approval. 56 percent of the women sought approval before using contraceptives, while 23 percent did not bother (Raiford et al., 2007). The remaining 21 percent of the respondents were however uncertain an indication that they were either not having a regular sexual partner whom they could seek approval from, or that they were not sexually active. The high percentage of those who sought approval from a partner clearly indicates the importance of a partner's consent in making a final decision on use of family planning services.

The wife and husbands approval of FP use positively influenced the adoption of all methods ,however ,the wife's approval was more important for the temporally methods than for the permanent methods (usually tubectomy). Partner opposition was found to cause a statistically significant increase in unmet need accounting for as much as 20 percent of unmet need reported by women and a shift in contraceptive use favoring traditional methods over modern methods (Wolff et al., 2000).

A study on correlates of consistent condom use among HIV-positive African American women living in the United States showed that women with were more likely to use condoms if they had high partner communication and reported low partner-related barriers to condom use (Raiford et al., 2007).

Individual factors that determined a person's use of services such as FP are mediated by the characteristics of the community in which the individual lives. It is important to look beyond individual factors when examining FP use or non use. (Tsui and Stephenson 2002). Diasapproval by friends, neighbors and relatives, stories from social networks proved to be more salient than medical opinions in shaping safety and perceptions. Women with strong social networks such as friends are likely to use short term methods.

Family structures, religiosity and political affiliations did not play any significant role to contraceptive use and choice, education among the youth had an association consistently (Srikanthan and Reid 2008). In terms of religious background of the woman, out of the 51 percent that were using contraceptives, 52 percent were Protestants, 35 percent Muslims while only 13 percent were Catholics. This is an indication that use of contraceptives vary across religion with Catholics using the least.

The probability of a woman using family planning services if she was a Catholic was 28 percent lower compared to others with different religious background such as Protestant and Muslims. This is because catholic faith discourages its faithful from using contraceptives as birth control measures. Faithfull are instead encouraged to rely more on observation of menstruation cycles and natural safe days of a woman. This finding clearly indicates a significance difference in the use of family planning services between Catholics and other religions.

Neeti .R. et al (2010) explored the perceptions and attitudes of Muslim women towards FP and currently available contraceptives and facilitating factors and barriers that determine adoption of contraception especially terminal methods. Being a Muslim was a crucial barrier to adoption of contraception and more so female sterilization

2.5 Economic Factors Influencing Contraceptive preference and choice among WRA

Studies showed that even after controlling the effects of other factors, education is a key factor influencing contraceptive use. majority of those using contraceptives had post primary education, while the least users of family planning had no formal education. In percentage terms, whereas 49 percent of the users of family planning services had secondary education, 28 percent had university education while only 15 percent had primary education with 6 percent reporting no formal education. Women could not convince their spouses to regularly adopt any contraception either because of illiteracy or low education levels (Hagen et al., 1999).

Damdouane (2002) realized that the women who are educated have higher chances of using contraception. Ojaka (2008) in Uganda found that numbers of women not using contraception were higher among women with primary educations than among women with no education, but the numbers decreased among women with secondary educations or higher educations.

There is a strong trend towards declining fertility and increasing utilization of contraceptives among relatively well-educated, middle-class population in Karachi- Pakistan (Hagen et al., 1999). Secondary or higher educational attainment was more likely to be associated with use of modern contraceptives in African countries; for example in Burkina Faso, higher educational attainment was more likely to be associated with use of modern contraceptives compared lower educational attainment(Rob et al. (2007).

Current users of contraceptives were more educated or had spouses who were more educated than their counterparts who were not current users. (Utomo et al., 1983) Pills, condoms and traditional methods were more common among the educated women while injectables and permanent methods were more common among uneducated women

In terms income, out of the total number of women using contraceptives, 31 percent had an average monthly income of Ksh 20,000 and above while 28 percent had an average monthly

income of between Ksh.15,000 to 20,000. On the other hand, 7 percent of users had an average monthly income of less than 5,000. Those with no income were, however, the least users of family planning services. The results thus reveal that in the absence of an income source, usage of family planning would decline. The lower the economic status of the households, the higher the non-users. (Sharma et al.(2005)

2.6 Service Provider' Factors Influencing Contraceptive preference and choice among WRA

Health services played a big role in sexual and reproductive health behaviors. In one study, results showed that increased availability and uptake of FP methods, was positively associated with the presence of a number trained FP service providers (Katende et al., 2003). Discussion of FP between clients and service providers during ANC of the first child was key to subsequent use of family planning methods and reduction of unmet need for family planning.

Use of pills, condoms, traditional methods, injectables and IUCDs was higher in women who had home visitations by welfare assistants. Studies further indicate that FP counseling and regular follow-up was accompanied by a high rate of contraceptive use and a low pregnancy incidence after delivery (Brou et al., 2009).

Kidane.G. (2008) looked at providers and client attitude/knowledge towards LAPMs and assessed the content of information exchange between the provider and the client. Clients learn little about LAPMs at the facility, due to the providers approach to the counseling and sharing information. The providers tended to focus the family planning information they gave to a client on the method asked about, without carrying discussions first on the reproductive needs of the clients. The providers have good attitudes towards LAPMs but they are concerned more on temporary family planning methods.

In Rakai, Uganda, a community randomized trial of enhanced FP efforts program showed a statistically significant higher use of hormonal contraceptives and lower pregnancy rates in the intervention arm as compared to the control arm. Investigators found that using trained volunteers and social marketing of contraceptives can improve contraceptive uptake among WRA (Lutalo et al., 2000). The quality of provider interaction and client should be improved by

retraining the providers, provider knowledge and understanding of the methods and procedures should be improved, printed materials should be made available to interested clients.

Friendliness of family planning staff had a marginal effect implying that the likelihood of respondents using family planning services was 19 percent higher if family planning staff was friendly than when they were not. The significance of this determinant could be explained by the fact that provision of certain types of family planning services requires performance of some procedures by the person administering the services.

With regard to quality of family planning services ,the probability of a woman using family planning services was 17percent higher for respondents who perceived the services to be of high quality than for those who perceived otherwise. The positive impact of quality could be attributed to the fact that in the process of making a decision on using family planning services, perceived quality of the service is given a high consideration as supported by theory whereby taste and preference is an important factor in making demand decision.

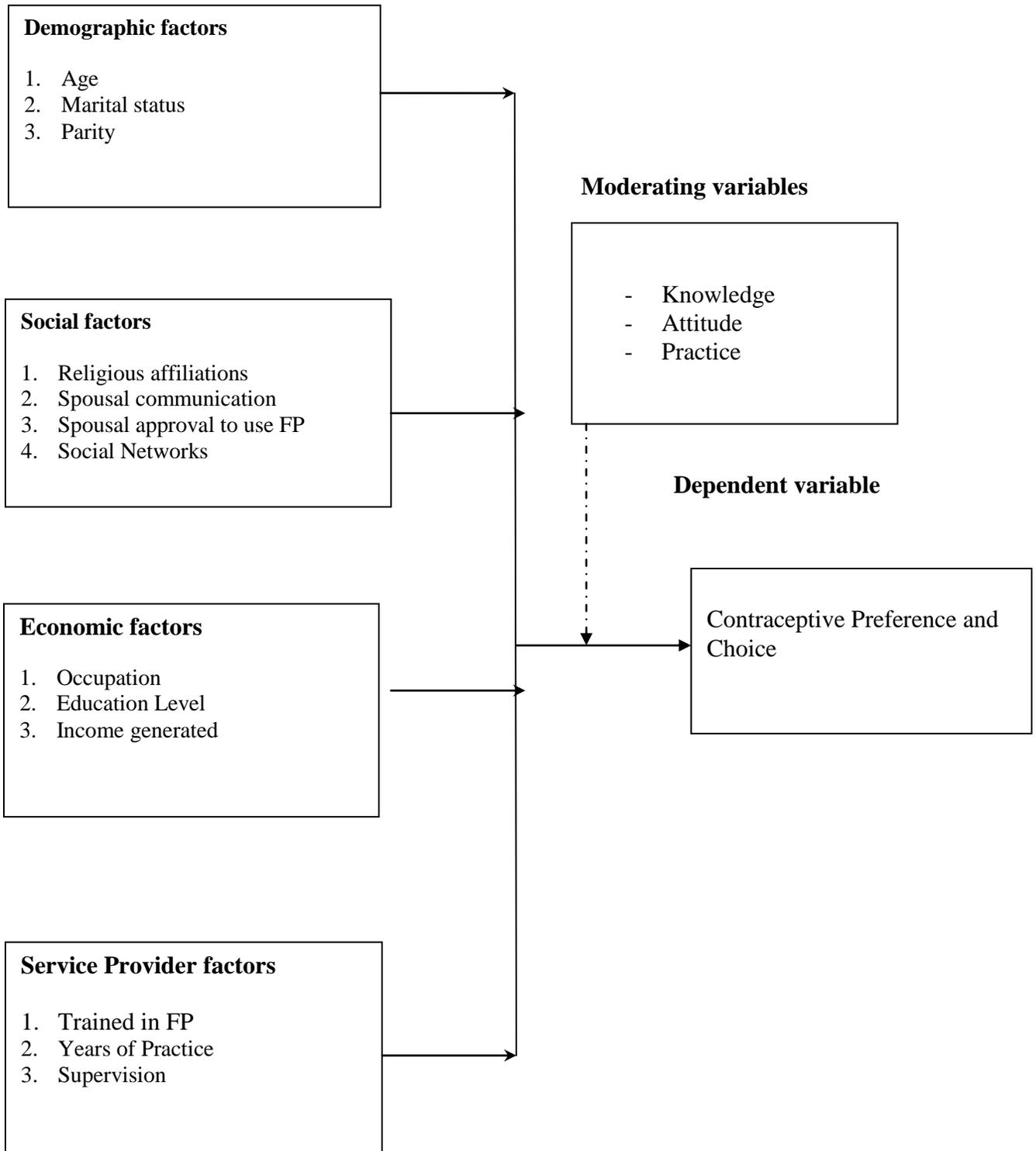
2.7 Conceptual Framework

In the conceptual framework depicted in Fig 1 below, the factors influencing contraceptive preference and choice among WRA are outlined as; Demographic factors, Economic, Social, and service provider factors.

The framework assumes that those factors directly influence contraceptive preference and choice among WRA. However, clients' knowledge, attitudes on contraception and the practice of fellow women and that of the provider may alter this relationship.

Fig 1: Conceptual Framework

Independent Variables



2.8 Literature gaps

Most of the studies have not in-depthly tackled the issues of contraceptive choice and preferences as a research issue, most of the studies have studied this as a subsidiary to the large aspect of contraceptive use and prevalence. This study will want to go deeper in matters of choice and preferences as it relates to the end users of FP methods.

The previous research focused mostly on married women, this research will have a focus on all women of reproductive age because of the changing trends in marriage concepts by the current generations and because they of their eligibility. The study will go deeper to ascertain the type of marriage relationship to contraceptives use, which has been a missing factor on the relationships.

Muslims had been in-depthly studied unlike the other denominations, this study will look at the religious groups as we know the doctrines are different and some have been critical on FP usage. Service Providers have been missing in a lot of studies and they play a crucial role by ensuring that they counsel clients, promote the usage and stock the different methods. This study will therefore try to ascertain their relevance in the preferences and method choice among the clients.

The studies have been using household survey to collect data from all WRA in the community, this study will target active WRA who are using FP methods, therefore will be facility based hence collecting reliable facts about contraceptive choice.

2.9 Summary of Literature

Literature was reviewed on the factors that influence contraceptive preference and choice among women of reproductive age. This study will deal with demographics, economic, social and service provider factors that are thought to have a great influence on the same. The proximate factors are knowledge, attitudes and practice which will lead to method choice and preferences by the FP clients.

Literatures shows that younger women will prefer short acting methods compared to older women who will prefer traditional and permanent methods. Age at marriage seems not to generate a lot; those with small parity prefer short acting methods while those with high parity

going for long and permanent methods. Level of education is critical when it comes to method choice, occupations too has an effect on the same. Social networks; being a member of community unit and self approval had an influence on short term methods, while husband approval was skewed towards permanent method but not tubectomy. Literature is very scanty on the service providers.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology that was used to conduct the research. The research design, target population, sample size, sampling procedure, data collection methods and procedure, the validity and reliability of the research instruments, ethical considerations and data analysis and presentation techniques are discussed in detail. The operational definition of variables is provided in the final section of this chapter.

3.2 Research Design

This study was conducted through the descriptive survey research design. A survey is a research design where the researcher attempts to collect data from members of a population in a bid to determine the current status of the population with regard to one or more variables (Adeyemi and Adu, 2010). The design is suitable for studies where data is intended to describe the existing conditions (Simiyu, 2009).

The researcher therefore investigated the target population through the selection of a sample to analyze and discover occurrences. The design enabled the researcher to establish how each of the independent variables either increased or decreased the probability of occurrence of the dependent variable.

3.3 Target Population

The target population consisted of 11,436 registered WRA aged 15-49 in GOK health facilities in Msambweni constituency (source: District annual work planning statistics, 2012, 52 service providers and 26 facilities (source: AOP 6 statistics,2012).

The researchers' choice of 11,436 clients was guided by the data available for registered WRA receiving family planning services. This study targeted the clients receiving FP methodology at the time of the interview so that primary data and the exact methods chosen or preferred were physically seen.

The inclusion of the service providers in this study was to enable the researcher to investigate their influence on contraceptive and preference choice among women of reproductive age because of their daily interactions with the clients.

Table 3.1: Target population

Divisions	No. of facilities	No. of registered FP clients	No. of FP service providers
Diani	7	2869	14
Msambweni	6	2535	12
Lungalunga	13	6035	26
Total	26	11436	52

3.4 Sample size and Sampling Procedure.

This study employed two approaches in determining the sample size. The approach used to determine the sample size from the WRA population was adopted from (Kothari 2004) as illustrated below;

$$n = \frac{z^2 \cdot p \cdot q \cdot N}{e^2 N - 1 + z^2 \cdot p \cdot q}$$

Where;

n- Size of the sample

Z-Value of standard variate at a given confidence level

p- Sample population

q-(1-p) and

e-Acceptable error

In this study, the researcher desired a 95% level of confidence which gave the value the value of z as ± 1.96 and an acceptable error of 0.05. The DMS statistical consulting group –Faraday (2006) states that the acceptable error is generally set at 0.05 or a 5% probability that a significance difference occurred by chance. Kothari (2004) recommends a value estimate of p at 0.5 as this gave a maximum sample value and yield the desired results. Using these values, the sample size was calculated as follows;

$$n = \frac{1.96^2 \times 0.5 \times 0.5 \times 11,439}{0.05^2 (11,439-1) + 1.96^2 \times 0.5 \times 0.5}$$

$$n = \frac{10,986.0156}{29.5554}$$

$$n = 371.71$$

$$n = 372$$

The approach used to determine the sample size from the service providers and the list of health facilities was adopted representing 10% as proposed by Mugenda & Mugenda (1999). The quoting from Gay (1983) recommends 10% of cases in descriptive studies which is representative of the total population.

Table 3.2: Sample size

Divisions	No. of facilities	of 10%	No. of FP service providers	10%
Diani	7	0.7=1	14	1.4=2
Msambweni	6	0.6=1	12	1.2=2
Lungalunga	13	1.3=2	26	2.6=3
Total	26	4	52	7

Therefore, a sample size of 372 WRA, 4 health facilities and 7 service providers was drawn using cluster sampling technique. Cluster sampling is a sampling technique used when "natural" but relatively homogeneous groupings are evident in a statistical population. The principle of cluster sampling selection procedure assigns each individual in the sample the same chance of selection. In this technique, the total population was divided into clusters and a simple random sample of the groups is selected (Williams, 1998).

The four health facilities within Msambweni constituency were the clusters; an equal number of questionnaires were distributed. The respondents will be drawn from the registered clients who

will be receiving FP services within the data collection period in each of the clusters. The population was expected to yield maximum results.

3.5 Data Collection Methods

This study used both the questionnaire and an interview guide for data collection, the questionnaire was used among the WRA and the interview guide were for the service providers. The selection of these tools was guided by the nature of data to be collected, the size and distribution of the population and the objectives of the study.

Questionnaires increased the chances of getting honest responses since they ensure anonymity of the respondent. The questionnaire used both open ended and closed ended questions. The use of open ended questions offered flexibility for the respondent to provide more details. Closed ended questions allow for quantitative analysis was done. This balance was useful for a comprehensive analysis.

Interview is a purposeful conversation in which one person asks prepared questions and another answers them (Frey & Oishi 1995). This was done to gain information on a particular topic or a particular area to be researched. The use of the interview approach was flexible, providing a large amount of detail. It is clear that the answers are solely those of the person being questioned. The intensive situation that the interview was conducted in, may in itself allow information to be gained without directly asking for it (Wimmer & Dominick 1997).

3.6 Data Collection Procedure

Once the proposal was approved by the University academic panel, the researcher started the data collection process by seeking permission from the district health management team at Msambweni Constituency.

This study used community health workers as the research assistants; they were trained on the tools and were issued with the questionnaires to administer to the WRA receiving FP services. The researcher then collected the questionnaires from the community health workers who had the responsibility of ensuring that all questionnaires were returned.

Aware of the challenges involved in interviews, the researcher made adequate preparations to maximize the chances of successful interviews. This was accomplished by informing the service providers about the study and requesting interviews with them. Copies of the interview schedule were made available to the service providers.

3.7 Validity and Reliability of Research Instruments

This section will explain the validity and reliability of research instruments.

3.7.1 Validity of Research Instruments

Validity is the accuracy and meaningfulness of inferences, which are based on the research results (O. Mugenda & A.Mugenda, 2003). According to Cooper & Schindler (2007), pretesting questionnaires helps the researcher find ways to increase participants' interest; helps in discovering question content, wording and sequencing problems before the actual study and also helps in exploring ways of improving overall quality of study.

Mugenda & Mugenda (1999) contend that the usual procedure in assessing the content validity of a measure was to use a professional or expert in a particular field. To establish the validity of the research instrument the researcher sought opinions of experts in the field of study especially the lecturers in the department of project management. This facilitated the necessary revision and modification of the research instrument thereby enhancing validity. Expert opinions were requested to comment on the representativeness and suitability of questions and give suggestions of corrections to be made to the structure of the research tools. This helped to improve the content validity of the data that was collected. Content validity was obtained by asking for the opinion of the supervisor, lecturers and other professional on whether the questionnaire was adequate.

3.7.2 Reliability of Research Instruments

According to Cooper & Schinder (2007), reliability referred to the consistency of measurement and was frequently assessed using the test–retest reliability method. Reliability was increased by including many similar items on a measure, by testing a diverse sample of individuals and by using uniform testing procedures. A number of measures were taken to ensure reliability. Themes on the interview questions were based on the objectives stated in the study.

To achieve reliability of the questionnaire, the instrument was designed with great care matching questions with objectives for the study. The questionnaire was tested in two health facilities targeting 10 WRA in a pilot study. The responses from the pilot study revealed inconsistencies in the questions within the questionnaire. Some of the questions were also left unanswered implying that they may have been too difficult for the respondents to understand. The WRA questionnaire was therefore revised to mainly include yes and no questions. In addition, the number of questions was reduced in order to reduce the time taken to respond to the questionnaire.

3.8 Data Analysis

This study sought to establish the extent to which the independent variables influence the dependent variable. It was therefore suitable to analyze data using descriptive analysis. Descriptive analysis was the study of the distribution of one variable and it provided the researcher with profiles of the study population such as their size, composition, efficiency, preferences and so on (Kothari, 2004).

In this case, data quality control and cleaning commenced in the field by the researcher ensuring that all the information on the questionnaires has been properly collected and recorded and checked for completeness of data and internal consistency. Data analysis started once all the data has been captured. Closed-ended questions were analyzed using nominal scales into mutually exclusive categories and frequencies by employing descriptive statistics using the statistical package for social sciences (SPSS V 17.0) and MS Excel. Open-ended questions were analyzed using conceptual content analysis. Analysis involved the production and interpretation of frequencies counts, tables and graphs that describe and summarize the data.

3.9 Ethical Considerations

Approval was sought from the Provincial and District ethical committee before undertaking the research. Respondents were informed that the information they would give was purely for research purposes each participant voluntarily signed an informed consent form. To achieve anonymity of the data gathered from the respondents, they were not required to reveal any information that may lead to their identification.

3.10 Operational Definition of variables

Variables referred to anything that might impact the outcome of a study. The operational definition of variables described what the variables are and how they would be measured within the context of this study.

Table 3.3: Operation definition of variables

Objective	Independent variable	Indicators	Tools for data collection	Type of analysis
To determine how demographic factors influence contraceptive preference & choice among WRA in Msambweni constituency	Demographic factors	Age of the woman Parity Marital status Number of surviving children	Questionnaire	Descriptive Means Frequencies Percentages correlation
To determine how social factors influence contraceptive preference & choice among WRA in Msambweni constituency	Social factors	Religious affiliation Self/husband approval Social/group network	Questionnaire	Descriptive Means Percentages correlation
To determine how Economic factors influence contraceptive preference & choice among WRA in Msambweni constituency	Economic factors	Education Occupation	Questionnaire	Descriptive
To determine how Service provider factors' influence contraceptive preference & choice among WRA in Msambweni constituency	Service provider factors	Age Post- basic training Religion Years of service	Interview	Descriptive Percentages correlation .

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The study investigated the factors influencing contraceptive preference and choice among WRA in Msambweni constituency, Kwale County. This was in the light of the fact that the overall constituency indicators are below the national indicators. The data is presented using frequency distribution tables and percentages. In all instances, the Chi-square statistic was calculated to test the significance in the relationship between variables. This chapter therefore presents the results of the analyses.

4.2 Response Rate

Table 4.1 shows the variation in the response rate per each targeted cluster. Although an equal number of questionnaires had been distributed in the three divisions, Lungalunga had the least number of respondents compared to Msambweni which had the most respondents.

Table 4.1: Response rate on WRA questionnaires

Division	No of questionnaires		Percentage Response
	Issued	Returned	
Diani	124	120	97
Lungalunga	124	115	93
Msambweni	124	124	100
Total	372	359	97

An overall response rate of 97% was realized. The researcher determined that this response rate would produce reliable results.

The response rate for the four divisions shows that they all had an equal response rate for the service providers as indicated in Table 4.2. The total number of targeted respondents represented populations and not samples and the researcher determined that this would be sufficiently representative.

Table 4.2: The response rate of key informants

Division	No of questionnaires		Percentage Response
	Issued	Returned	
Diani	2	2	100
Lungalunga	3	3	100
Msambweni	2	2	100
Total	7	7	100

Although there is no single recommended figure for response rate, most writers indicate that the percentage of responses would probably differ according to the type of study. Generally, 60% is rated as marginal, 70% reasonable, 80% is good while 90% would be excellent (Mundy, 2002).

4.3 Knowledge on Family Planning

Knowledge on Family Planning has been theorized as having positive influence on contraceptive preference and choice among WRA .To examine this statement; the researcher used questions to gauge the level of knowledge on FP among WRA in Msambweni Constituency.

Table 4.3: Specific method of FP Used

Methods of FP	No of respondents	Percentage Response
IUCD	18	5%
Implants	54	15%
Pills	61	17%
Tubal ligation	2	0.5%
Injectable	215	60%
Condoms	9	2.5%

According to the information presented in table 4.3, data shows that a good number of women were using at least one method of family planning in Msambweni constituency. An in-depth analysis of the findings shows that 60% of the WRA respondents were using injectable while 17% opted for pills while a minority of 0.5% went for tubal ligation.

The questions on the source of FP information was left open, however, majority of the WRA (85%) had heard about the aforementioned methods of family planning from the health clinics during morning health talks and when being counselled by the service providers. Respondents who had heard about FP from the media and friends were at 7% respectively. The media and health facilities were confirmed to be means of information exchange on FP as echoed by the WRA during the FGDs. A minority of 1% had read books and other written literature as the source of their information on FP.

Some of the advantages of FP and its effects as was shared by the respondents during the focus group discussions were prevention of unwanted pregnancies, spacing of children and time to engage in other economic activities. On asking the women of reproductive age during the FGDs about the benefits associated with the use of FP, some of them had this to say:

“We are able to engage in other businesses (to earn profit) not just rearing children. The body also gets time to regain its health” Women of reproductive Age, Kikoneni.

Some of the disadvantages that people associated with the use of family planning methods were mentioned as excessive bleeding, loss of menstrual periods and loss of weight.

4.4 Demographic Factors Influencing Contraceptive preference and choice among WRA

The demographic characteristics are analyzed based on the questionnaire set. Table 4.4 gives a summary of the demographic characteristics for all target respondents. The study focused on women of reproductive age between 15 and 49 years of age. Thus, 100% of the general respondents were women.

Table 4.4: Summary Demographic profile of respondents

	No of respondents		% Proportion
Marital status	Single /never married	80	22.3
	Married	233	65
	Separated/Divorced	46	12.8
Age	15- 24	71	19.8
	25-49	288	80.2
No. of children	1 – 2 children	19	5.3%
	3 – 6 children	104	28.9%
	Above 6 children	236	65.7%

Table 4.4 illustrates that majority of the respondents 65% were married while 12.8% had separated /divorced. Single women who had never been married at all comprised 22.3%. Use of contraceptives was found to vary across marital status with married women using the services most compared to single women due to high incidences of sexual activities compared to single women (Meharab et.al 1996).

The study sought to find out the age range for the respondents. Table 4.4 indicates that majority of the respondents 80.2% were between 25-49 years of age with 19.8% being between the age of 15-24. The study also sought to find out the distribution of children within the respondents' families and the findings are as illustrated in Table 4.4. It was evident that majority of the women of reproductive age had more than 6 children in their families as reported by 65.7% majority of the respondents. 28.9% had 3 – 6 children in their families while a minority of 5.3% had children between 1 and 2.

Although the question on number of surviving children was left open, it was reported that only 13% of the women of reproductive age had lost at least one of their children majority of who reported of birth complications having been the cause of the loss. On Further analysis whether the WRA wanted to have more children, a minority of 23% wished to have more children while

majority of them 77% did not want more children. On asking how they wished to prevent pregnancies so that they did not have any more children, some of the responses were given as follows;

1. Using modern family planning method.
2. Use of safe days.
3. Use of withdrawal method
4. Abstaining from sex.

Using the data derived from the above analysis, the research sought to test the following hypotheses;

Ho: Age does not have an influence on the contraceptive preference and choice among women of reproductive age.

H1: Age has an influence on the contraceptive preference and choice among women of reproductive age.

The Chi-square test at an alpha level of 0.05 yielded a value of 137.01 at six degrees of freedom and < 0.05 . It was however unclear as to whether the standard asymptotic calculations yielded accurate results since 50% of the cross-tabulation cells had an expected count of less than five. The exact statistic yielded a < 0.05 lending support to the Chi-square results. Based on these results, the null hypothesis was rejected and thus concluded that there is a significant relationship between age and the contraceptive choice and preference among WRA.

In order to determine the degree of relationship between age and the contraceptive choice and preference among women of reproductive age the Cramer's V Contingency Coefficient () was calculated. This yielded a value of 0.818 indicating a very strong correlation between age and the contraceptive choice and preference among women of reproductive age. Thus, WRA were 81.8% likely to prefer or choose a specific method of contraceptive based on their age.

The study also hypothesized that parity did not play an important role in determining contraceptive choice and preference for WRA in Msambweni.

The following hypotheses were tested;

Ho: Parity does not influence the contraceptive preference and choice among women of reproductive age.

H1: Parity influences the contraceptive preference and choice among women of reproductive age.

A Chi-square statistic was computed at the 0.05 level of significance to determine whether there was a correlation between parity and the contraceptive preference and choice of WRA. The test results ($X^2(1) = 0.861$) revealed that there is a significant relationship between parity and contraceptive preference and choice of WRA. The null hypothesis is therefore rejected.

4.5 Social Factors Influencing Contraceptive preference and choice among WRA

The second objective of this study was to establish the extent to which social factors influence contraceptive choice among WRA in Msambweni constituency. The researcher therefore sought to get a general view of the social factors that influence contraceptive choice by analyzing variables like religion, spousal communication, spousal approval, and method used by three close friends.

Every community has its own religion. The religion of a community has a correlation with the way of life of that particular community. The study sought to find out the respondents religious beliefs /practices and the findings were as discussed in table 4.5 below:

Table 4.5: Distribution of Respondents by Religion

Religion	Frequency	Percent
Catholic	95	26.5
Protestants	74	20.6
Muslim	185	51.5
Other	5	1.4
Total	359	100.0

Table 4.5 above indicates that 51.5% of the WRA respondents were Muslims while 1.4% did not have a religion and followed the traditional way of life. Those professing the Catholic faith

comprised 26.5% while Protestants comprised only 20.6%. The data analysis indicated that majority of the people within the area under study were basically Muslims.

The results in table 4.6 indicate that majority of the respondents 63.8% never discussed issues of family planning with their husbands and only 36.2% discussed issues of family planning with their husbands. It should be noted that majority of the WRA never preferred discussing issues of FP with their husbands. The same sentiments were echoed during the FGDs as quoted below;

“No, Family planning issues are secret and you can’t go advising other people what to do with their lives. For those of us who our spouses do not know, we fear discussing with friends in case word is let out to our spouses.” FGD in Ukunda.

Upon asking how they would rate the level of discussion on FP with their spouses, 55% of WRA rated their discussion as average while 12% rated the discussion as excellent. However, 33% rated the discussions on issues of family planning with their husbands as poor.

Table 4.6: WRA responses on Indicators of Social factors

	No of respondents	% proportion
Spousal Communication		
Yes	130	36.2%
No	229	63.8%
Husbands Knowledge on FP method being used		
Yes	229	63.8
No	130	36.2
Spousal Approval		
Yes	200	55.7%
No	159	44.3%

A majority of 63.8% of the respondents confirmed that their husbands knew the method of family planning that they were using. However, 36.2% of the respondents reported the contrary. 55.7% of WRA further reported that their spouses approved the methods they were using, and the reason for approval was mainly spacing of pregnancies while allowing the women to

undertake other economic activities in view of the hard economic times. 44.3% further reported that they spouses did not approve use of FP due their culture and other myths and misconceptions.

To examine the role of social factors on the contraceptive choice and preference of WRA, the researcher tested the following hypotheses using the Chi-square statistic at an alpha level of 0.05.

Ho: There is no significant relationship between husbands’ approval and the contraceptive preference and choice among women of reproductive age.

H1: There is a significant relationship between husbands’ approval and the contraceptive preference and choice among women of reproductive age.

The test results are summarized in the table below.

Table 5: Chi-square Results on the choice and preference on contraceptives Based on their Social factors and Backgrounds

	Chi-square value	Df	Asymp. Sig. (2 sided)	Monte Carlo Sig. (2 sided)	Cramer’s V Value
Religious affiliation	55.468	30	0.003	0.024	0.250
<i>Spousal approval</i>	48.177	20	0.383	0.378	0.209
Spousal communication	58.100	24	0.000	0.001	0.315
Husband knowledge in FP	25.434	24	0.000	0.005	0.262

In three out of four cases the results yielded a < 0.05 therefore the null hypothesis is rejected. In all cases the data sets contained cells with an expected count of less than five, therefore it was unclear as to whether the standard asymptotic calculations of the significance level had been met. The researcher therefore computed the Monte Carlo statistic at the 95% confidence interval in place of the exact statistic since the data sets were too large for the exact value to be calculated.

Mehta and Patel (1989) recommend the use of the Monte Carlo method in cases where the exact value cannot be calculated as it provides an unbiased estimate of the exact value without the

requirements of the asymptotic method. The Monte Carlo statistic lends support to the Chi-square results. The researcher therefore concluded that of all social factors computed above, spousal approval is the only factor that had a significant influence on contraceptive preference and choice among WRA.

Table 6: WRA responses on discussion with friends on FP issues

	No of respondents	% proportion
Discussion		
Yes	181	50.4%
No	178	49.6%
Method used by a friend		
Implants	12	3.3%
Pills	38	10.6%
Injectable	237	66%
Condoms	72	20.1%

On the indicator social networks, data was analyzed according to discussion with friends and parental advice on family planning. Majority of the WRA (50.4%) discussed FP methods that they used with their friends while 49.6% did not. Injectables took the lions share as the most preferred method of family planning among the top three friends of the respondents as reported by 66% of the WRA with condoms following with 20.1% of the respondents' proportion.

The pill and implants were utilized at 10.6% and 3.3% respectively. The relatively low uptake of these methods was attributed to side-effects for the pills and misconceptions for the Implants.

Table 4.9: Correlation between parental advice and family planning uptake

	Mothers' advice	Family planning uptake
Mothers' advise	1	0.689
FP Uptake	0.689	1
No. of respondents	359	359

The researcher sought to find out if the WRA had received advice from their mothers on FP. The study utilized the Pearson correlation co-efficient in establishing the relationship between the two variables. There was a positive correlation of 0.689 between WRA who received FP advice from their mothers and the subsequent uptake of FP. Similarly, it was evident that WRA had received parental advice on the same methods they were using hence the 66% of WRA using the injectables.

4.6 Economic Factors influencing contraceptive preference and choice among WRA

The third objective of this study was to examine the influence of economic factors on contraceptive preference and choice among WRA in Msambweni constituency. The researcher therefore sought to get a general view of the economic factors using the ability to generate income, educational level, and Occupation. Table 4.10 gives a summary of the responses.

Table 7: WRA responses on indicators of Economic factors

Question Number	Question	Response as a percent of the total number of Respondents.
Section D.(1)	What is your education level?	
	i. Never been to school	5.3%
	ii. Primary	67%
	iii. Secondary	23%
	iv. Tertiary	4.7%
(2)	What is your husband's education Level?	
	i. Never been to school	7%
	ii. Primary	34%
	iii. Secondary	47.5%
	iv. Tertiary	11.5%
(3)	Do you generate your own income?	
	i. Yes	57.6%
	ii. No	42.4%

The analysis of findings in Table 4.10 above indicates that majority of the WRA in Msambweni (67%) had gone to Primary school only while a significant proportion of 23% proceeded to Secondary school. It was important to note that 5.3% of the respondents had never been to school while a minority of 4.7% had gone up to tertiary level of education.

Findings on the education status for the husbands of the married respondents revealed that majority of the WRA husbands were secondary school leavers (47.5%) with 34% having gone to Primary school only. 11.5% had gone up to the tertiary level while 7% had never been to school. WRA respondents were of the opinion that there is a relationship between education and the uptake of FP. This is because education helped their spouses to dispel negative myths and misconceptions on FP.

The results of Table 4.10 show that a significant proportion of 57.6% had a source of income while 42.4% had no primary source of income and relied on their spouses. 58% of the women of reproductive age generated their own income despite being very low. During the FGD, majority of the respondents were mainly business women while a few were housewives.

The following research hypotheses were stated;

Ho: Education does not influence contraceptive preference and choice among women of reproductive age.

H1: Education has an influence on the contraceptive preference and choice among women of reproductive age.

The study utilized chi-square in testing the relationship between education and the contraceptive preference and choice for women of reproductive age.

Table 8: Testing of research hypotheses

	Education	Contraceptive preference & Choice
Chi-Square	117.521	33.662
Df	5	2
Asymp. Sig.	.010	.008

Based on the results in Table 4.11, the chi-square values on the levels of education were 117.521, at 5 degrees of freedom. The computed value is larger than the table value of the chi-square which is 11.33. The chi-square value on contraceptive preference and choice is 33.662 at 2 degrees of freedom. The null hypothesis is therefore rejected implying that education is significantly related to the contraceptive preference and choice among WRA.

4.7 Service Provider factors influencing contraceptive preference and choice among WRA

To explore the extent to which service provider factors influence contraceptive preference and choice among WRA in Msambweni constituency, the researcher used a two- fold approach by use of a KII for the service providers and asking WRA questions that would indicate clients' satisfaction.

Table 4.9: KII responses on various factors

<i>Question Number</i>	<i>Question</i>	<i>Response as a percent of the total number of Respondents.</i>
<i>Section A: Key Informants Demography</i>		
(1)	Gender	
	Male	40%
	Female	60%
(3)	Age	
	25 – 35 yrs	70%
	35 yrs and above	30%
(4)	Profession	
	Nurse	60%
	Clinical Officers	40%
	Doctors	0%
(5)	Experience	
	Below 2 years	30%
	Between 3 and 5 years	60%
	Between 6 and 10 years	10%
	Above 10 years	0%
<i>Section B: FP Mentorship</i>		
(1)	Have you received any FP supervision in the last 6 months?	
	Yes	70%
	No	30
<i>Knowledge and skills</i>		
1.	Have you received training on family planning in the past 2 years?	90% had received training while 10% had not.
2.	What tasks are you trained in or what are your competencies?	Commodity management
3.	Do you feel you have the right knowledge or skills that are needed in family planning?	Yes
4.	What method do you counsel or discuss with clients on most occasions?	injectable because of the issues of husbands approval besides the less side effects that injectable were perceived to have on women.
5.	What methods have you actually provided to your clients for the last 3 months?	injections to their clients

The analysis in Table 4.12 revealed that majority of service providers were female nurses aged between 25 to 35 years of age with a having professional experience of 3-5 years.90% of the service providers had received training on FP in the last two years of the study. It was also

apparent that injectables was the most popular method among WRA due to issues of spousal approval and the less side-effects associated with it.

The study sought to test the following research hypotheses:

Ho: Service providers' experience did not have a significant influence on the contraceptive Preference and choice among women of reproductive age.

H1: Service providers' experience had a significant influence on the contraceptive preference and choice among women of reproductive age.

Table 4.13: Chi-Square testing on Service providers' influence on contraceptive preference and choice

	<i>Chi-Square Value</i>	<i>Df</i>	<i>Asymp. Sig. (2 sided)</i>	<i>Monte Carlo Sig. (2 sided)</i>
Experience in years	12.114	4	0.228	0.675
Mentorship FP Supervision)	9.922	4	0.524	0.312
Knowledge and Skills/FP Training)	12.972	4	0.944	0.762

Table 4.13 indicates Chi-Square statistic results; it shows there was a significant relationship between service providers and contraceptive preference and choice among WRA. These results therefore suggest the relevance of service providers in general uptake of FP. They play a crucial role in counseling clients and promoting the usage of the different FP methods.

Besides the service provider factors, contraceptive preference and choice of WRA was affected by other internal and external factors. The study also sought to find out how the various aspects affected the choice of methods and an analysis of the same was made below on Table 4.14

Table 4.14: Relationship between FP preference and choice and other FP aspects

<i>Variables</i>	<i>Very great extent</i>	<i>Great extent</i>	<i>Moderate extent</i>	<i>Little extent</i>	<i>Not at all</i>
Number of surviving children	77%	6%	0%	0%	17%
Husband approval	65%	25%	0%	10%	0%
Friendliness of health care providers	0%	0%	7%	33%	60%
Quality of counselling/ approach to the various methods	35%	23%	25%	15%	3%
Waiting time	0%	0%	0%	27%	73%

Table 4.14 shows that the number of surviving children and husband approval affected family planning uptake to a very great extent as reported by 77% and 65% of WRA respectively. 35% of the respondents reported that the quality of counselling and approach to various methods influenced contraceptive choice and preference. However, it was noted that some of that aspects like Friendliness of healthcare providers and waiting time did not have a significant relationship with contraceptive preference and choice among WRA.

CHAPTER FIVE
SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND
RECOMMENDATIONS

5.1 Introduction

In this chapter, the researcher summarizes the findings of the study based on the four objectives of the study. In each case, the researcher briefly states the findings and the general implications they have towards contraceptive preference and choice among WRA in Msambweni constituency. At the end of the chapter, the researcher states recommendations and highlights areas that need further research.

5.2 Summary of Findings

The study was designed to assess the factors influencing contraceptive preference and choice among WRA in Msambweni constituency. Four factors were identified as possible factors influencing contraceptive preference and choice, namely demographic factors, social factors, economic factors and service provider factors.

The indicators of demographic factors focused on age, and parity. The chi-square statistic revealed a significant relationship between age and contraceptive preference and choice among WRA with a majority (80.2%) of the respondents being in the age bracket 25-49 years. The data analysis on parity focused on number of surviving children, the chi-square statistic revealed a weak association between the variables.

The analysis on the effect of social factors focused on the influence of social networks, spousal communication and approval. The results revealed that spousal approval had the highest positive correlation compared to other indicators. The data also revealed that 55.7% of the WRA had spousal approval for the methods they were using; the reason for approval being spacing of children. Further analysis on social networks revealed that a majority of 50.4% discussed FP

with their friends with the most preferred FP method being the injectable at 66%. The chi-square statistic results also revealed a significant relationship between maternal advice and FP uptake based on the correlation coefficient which had a value of 0.689.

To explore the effect of economic factors on contraceptive preference and choice, the researcher analyzed the ability of WRAs to generate their own income and education levels for both the WRAs and their spouses. Chi-square statistic shows a strong correlation between Education and contraceptive preference and choice. Education had a direct correlation with the attitude the WRA had on family planning. Data on the ability to generate own income also reveals a strong correlation between ability to generate income and contraceptive preference and choice for the WRA ($X = 2.12$ & $s.d = 1.14$) this finding was supported where it was established that 57.6% of the WRA were able to generate their own income.

Analysis on the effect of service provider factors focused on years of experience, FP supervision and training on FP in the last 2 years. Data shows there was a significant relationship between service providers and contraceptive preference and choice among WRA. This clearly suggests that for increased uptake of family planning services, there is need to continually train the service providers to keep them updated on FP issues in general. Friendliness of the service providers had a moderate influence thus implying that the likelihood of respondents using family planning services was higher if family planning staff was friendly than when they were not. The significance of this determinant could be explained by the fact that provision of certain types of family planning services requires performance of some procedures by the person administering the services, for example injectables, hormone releasing implants and use of IUD.

5.3 Discussions of Findings

The first objective was to determine how demographic factors influence contraceptive preference and choice among women of reproductive age in Msambweni constituency, Kwale County-Kenya. Three indicators namely age; marital status and parity were used to test the influence of demographic factors on contraceptive preference and choice. Data was obtained from questionnaire responses by WRA to test the hypothesis that age had a great influence on the

contraceptive preference and choice among WRA. The data revealed a significant relationship between age and contraceptive preference and choice among WRA with a majority (80.2 %) being between the age 25-49 years. This finding is in agreement with those of Roumi .D (2010) and A. Leyland,(1996) which cited the adoption of FP methods being high in the age-group 25-35 years as compared to the younger women below 20 years.

The study also tested the hypothesis that parity did not influence the contraceptive preference and choice among WRA. Data was obtained from questionnaires with 65.7% of the respondents having more than 6 children and a minority of 5.3% having 1-2 children. This finding is in agreement with Feldman & Maposhere (2003) which cited that women with more living children were using family planning services more compared to those with fewer children. Data on marital status shows that 65% of the respondents were married. This is in agreement with Meharab et al.(1996) which stated that married women used FP services more compared to single women due to the high incidences of sexual activities compared to single women.

The second objective was to establish how social factors influence contraceptive preference and choice among WRA in Msambweni constituency, Kwale County-Kenya. Three indicators namely religious affiliations, social networks and spousal approval and communication were used to test the influence of social factors on contraceptive preference and choice. Of all the indicators on social factors, spousal approval had the greatest positive correlation with the contraceptive preference and choice among WRA. This relationship was analyzed using questionnaire responses from WRA and the findings are in agreement with Raiford et al, (2007) and Wolff et al (2000) which state that the husbands' approval of FP positively influences adoption of FP methods.

The study also investigated WRAs perception on social networks and their influence on contraceptive preference and choice. The responses indicated that 50.4% of the WRA discussed FP with their close friends and they were more likely to use the methods their friends used thus injectables taking a lion's share at 66%. This is in agreement with Tsui and Stephenson (2002) which cited social networks being more salient than medical opinions in shaping perceptions on FP use or non-use.

The third objective was to examine the influence of economic factors on contraceptive preference and choice among WRA in Msambweni constituency, Kwale County- Kenya. The test to examine the relationship between education and the contraceptive preference and choice revealed a significant relationship between education contraceptive preference and choice among WRA. This result is similar to that of Hagen et al (1999) and Utomo et al (1983) which indicated that education is a key factor influencing contraceptive use. In general therefore, the study findings indicated that current users of contraceptives were more educated or had spouses who were more educated than their counterparts.

Data collected from questionnaires and the FGD revealed that 57.6% of the WRA generated their own income while 42.4% had no source of income and relied on their spouses. The results revealed that in the absence of an income source, usage of family planning would decline. The finding is similar with that of Sharma et al(2005) which stated that the lower the economic status of the households, the higher the non-users of FP.

The fourth objective was to assess how service provider factors influence contraceptive preference and choice among WRA in Msambweni constituency, Kwale county-Kenya. Data was analyzed from the KII and the questionnaires. 90% of service providers had received training with a majority (60%) having an experience of between 3 and 5 years. The test results revealed a significant relationship between the service providers' experience and the contraceptive preference and choice among WRA. This finding is in agreement with the views of Katende et al,(2003) that increased uptake of FP services was positively associated with the presence of trained FP service providers.

5.4 Conclusions

This study investigated the factors influencing contraceptive preference and choice among women of reproductive age in Msambweni constituency, Kwale County-Kenya. This was in relation to the fact that Msambweni constituency has continued to record a low CPR of 29.5% over the years. Various factors were considered, among them demographic factors, social factors,

economic factors and service provider factors on contraceptive preference and choice among WRA in Msambweni constituency

The study established that demographic factors, economic, and service provider factors are factors influencing contraceptive preference and choice among WRA in Msambweni constituency. The study further established that social factors have the greatest impact on contraceptive preference and choice among WRA. Notable views were also provided on the spousal approval, knowledge of family planning services, friendliness of health care providers, quality of counseling, income and their influence on contraceptive preference and choice. All explanatory variables positively influenced contraceptive preference and choice.

Utilization of family planning services has been the concern of not only the government but also other stakeholders including researchers. In this study, It has further been established that demographic factors, social factors, economic factors and service provider factors influence contraceptive preference and choice among WRA in Msambweni constituency. This means that a positive change in either of these variables will have a positive effect on contraceptive preference and choice leading to greater uptake of FP methods and generally increase in the CPR of Msambweni constituency, Kwale County.

5.5 Recommendations

In light of the research findings, contraceptive preference and choice in Kenya in general and among WRA in Msambweni constituency in particular is affected by various factors. In order to enhance the CPR and uptake of FP services, as a bold step towards meeting the challenges envisaged in the Kenya's Vision 2030 and the realization of the MDGs, the following are recommended.

The government through the Ministry of Health to revive and support family planning education at both household and community level that targets the woman and her partner. This could be undertaken through print and mass media, chiefs' *barazas*, market places as well as newsletters and posters. Additionally, the Ministry of Health should encourage the uptake of contraceptives

at household level by enhancing continuous promotion of family planning services .This could be realized by supporting family planning outreach activities by the health workers. This is expected to contribute positively towards enhancing awareness of family planning services and the benefits and side effects.

Lastly, the Ministry of Health in collaboration with other development partners involved in the provision of family planning services need to enhance large scale training of service providers in quality care, client follow up, communication skills,counselling, referral and feedback and provision of a wide choice of methods. With good customer care, clients who seek contraceptives will have confidence in the staff which in the process will attract more users while at the same time encouraging further usage on those currently using them.

Creation of advocacy groups at community level is highly recommended. This will not only articulate the rights of the clients, in this case the woman who seek contraceptives, but will lead to cultural and attitude change towards the services thereby encouraging their uptake. In the end, this is expected to contribute positively towards a reduction in the total fertility rate as well as decline in population growth rate. NGOs, CBOs, and other institutions involved in family planning need to initiate and promote targeting programmes for the uptake of the services in the rural areas.

5.6 Suggestions for Further Research

Following the findings of the study, the researcher identifies the following areas that could be explored as a basis for future research.

The scope of this study was constrained by limited time and funding, therefore the study population consisted of a small percentage of the total WRA population within Kwale County. The study was also confined to specific divisions which could be regarded as exhibiting homogenous characteristics. This did not offer much diversity in the findings. The researcher therefore suggests the need for a similar research that will focus on the general WRA population within the 6 counties in Coast region.

There is scanty literature on the role of service providers and their influence on contraceptive preference and choice. The researcher therefore suggests that further research be done to ascertain the relevance of service providers in general uptake of FP and contraceptive preference and choice among WRA.

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APPENDICES

Appendix 1: PERMISSION TO CONDUCT RESEARCH



UNIVERSITY OF NAIROBI
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SCHOOL OF CONTINUING AND DISTANCE EDUCATION
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Jubilee Insurance Building
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13TH SEPTEMBER, 2012.

TO WHOM IT MAY CONCERN

RE: DATA COLLECTION

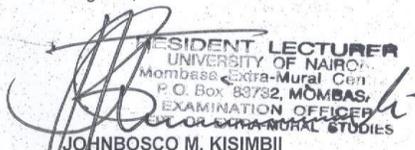
This is to introduce JANET WANJIKU KERU student Registration Number L50/70311/2011 is pursuing a **MASTERS OF ARTS COURSE IN PROJECT PLANNING AND MANAGEMENT** at the School of Continuing and Distance Education of the University of Nairobi.

As part of her course, she is required to prepare a research project. She is therefore collecting data which is related to her research topic: **FACTORS INFLUENCING CONTRACEPTIVE PREFERENCE AND CHOICE AMONG WOMEN OF REPRODUCTIVE AGE IN MSAMBWENI CONSTITUENCY, KWALE COUNTY, KENYA**

The information she is gathering is purely for academic purposes and will be treated with utmost confidentiality.

Any assistance extended to her will be highly appreciated.

Regards,


RESIDENT LECTURER
UNIVERSITY OF NAIROBI
Mombasa Extra-Mural Cen
P.O. Box 83732, MOMBASA
EXAMINATION OFFICER
DEPT. OF EXTRA-MURAL STUDIES
JOHNBOSCO M. KISIMBII
RESIDENT LECTURER
EMC. MOMBASA & ITS ENVIRONS

Appendix II: AUTHORITY TO CONDUCT RESEARCH



MINISTRY OF PUBLIC HEALTH AND SANITATION

TELEPHONE 020 2333760

E-mail dmohmsambweni@yahoo.com

When replying please quote

**DISTRICT MEDICAL OFFICER OF HEALTH
MSAMBWENI DISTRICT
P.O BOX 8 - 80404
MSAMBWENI**

REF:

DATE: 4/4/2013

ATT: Facility In charges:-
Kikoeni Health Centre
Diani Health Centre
Lunga lunga Health Centre

RE: DATA COLLECTION BY A MASTERS STUDENT IN MSAMBWENI DISTRICT

Janet Wanjiku Keru, registration number L50/70311/2011, is a student undertaking a Masters Degree in Project Planning and Management at the school of Continuing and Distance Education of University of Nairobi.

She is collecting data regarding Factors influencing contraceptive preference and choice among women of reproductive age in Kwale Constituency, Kwale County. Your facilities have been selected as her data collection centres for her project.

Please accord her necessary assistance.

MEDICAL OFFICER OF HEALTH
MSAMBWENI DISTRICT

Dr. Aggrey Okumu
For: District Medical Officer of Health

Appendix III: LETTER OF TRANSMITTAL

Janet W Keru,
P.O Box 2532-00100,
Nairobi.
Date.....

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: DATA COLLECTION

My name is Janet Wanjiku Keru a student currently pursuing a Masters Degree in Project Planning and management at the School of Continuing and Distance Education of the University of Nairobi.

I am undertaking a study to establish the Factors influencing contraceptive Preference and Choice among women of reproductive age in Msambweni constituency, Kwale County-Kenya. This is as part of the requirements for the fulfillment of the course. The findings of this study will be useful in helping to design messages on family planning targeting the rural community.

The attached questionnaire is therefore intended to seek your views on the various aspects of Family planning among WRA. Please fill it with all sincerity and honesty. The information you provide will be utilized purely for academic purposes and will be treated with utmost confidentiality.

Thank you for your cooperation.

Yours faithfully,

Janet Keru,
Student (MA. PPM) - L50/70311/2011
University of Nairobi (SCDE)
Mombasa.

APPENDIX IV: INFORMED CONSENT

Dear Sir/Madam,

You are being invited to take part in a research study being conducted by Ms. Janet Keru, a Masters student at the University of Nairobi. The purpose of the research is to explore the factors influencing contraceptive preference and choice among Women of reproductive age in Msambweni Constituency, wale county-Kenya. Before you decide to participate in this study, it is important that you understand what the research will involve. Please take the time to read the following information carefully. If you need more information, please do not hesitate to contact the researcher using the address provided below.

There are no risks or discomforts that are anticipated from your participation in the study. You may decline to answer any or all questions and you may terminate your involvement at any time you choose. If you do not want to be in the study, you may choose not to participate and leave your answers blank.

The information gathered during this study will remain confidential and only the researcher will have access to the study data and information. You will not be required to include your name on the questionnaires. Any other identifying details will not be revealed in compiling the results of the study. Information gathered will only be used for academic purposes.

By signing this consent form, I confirm that I have read and understood the information and have had the opportunity to seek clarification. I understand that my participation is voluntary and that I am free to withdraw at any time. I voluntarily agree to take part in this study.

Respondent:

Signature..... Date.....

Research Assistant:

Signature.....Date.....

Researcher:

Janet Wanjiku Keru- Mobile No. 0725454743

Student (MA.PPM)- L50/70310/2011

University of Nairobi ;Email: wanjiku.keru@gmail.com

APPENDIX V: QUESTIONNAIRE FOR THE WRA

Instructions:

Please tick (√) in the appropriate box or fill in the empty spaces. Kindly respond to all questions freely and honestly. Your response will be kept strictly confidential and your names are not required.

Section A: Knowledge on Family Planning

1. Have you ever used family planning method? ^{Yes} ^{No}

If yes, which method

Method	(Tick one)
IUCD	
Implants	
Pills	
Tubal ligations	
Injectables	
Condoms	

2. Which method are you coming for today? -----
3. If different from the above mentioned, why have you changed?-----

4. Where did you hear about the method?.....
5. Do you understand how the method works and its limitations (advantages and disadvantages)
.....
.....

Section B: Demographic Information (Tick appropriately)

1. Age in years
- 15—24
- 25- 49
2. Which is your marital status? (tick appropriately)
- Single/Never Married
- Married

Separated/Divorced

3. a) How many children do you have?

1 – 2.....

3 – 6

Above 6.....

b) How many are surviving?.....

4. Are you looking to have more children? Yes..... No.....

If no, how are you preventing pregnancy? Explain

.....
.....

Section c: Social Factors (Tick appropriately)

1. What is your religion?

Catholic.....

Protestant.....

Muslim

Other(explain).....

2. a) Do you discuss with your husband issues of family planning?

Yes.....

No.....

b) If yes, how would you rate the level of discussions with your husband about family planning?

Poor.....

Average.....

Good.....

Excellent.....

3. Does your husband know the method you are currently using?

Yes

No

If Yes, does he approve? Explain

.....
.....
If No, why?
.....
.....

Which FP method do your three close friends use for family planning ?.....

- 4 a) Do you discuss about the methods you use with your friend? Yes.....No.....
- b) If yes,have you ever advised your friends on which method to use? Yes.....No.....
- c) If yes,which one and is she using the method.....

- 6. a) Did your mother talk to you about family planning methods? Yes.....No.....
- b) If yes, which method did she advice you on?.....

Section D: Economic Factors

1. What is you education level?

- 1. Never been to school.....
- 2. Primary.....
- 3. Secondary.....
- 4. Tertiary.....

2. If married, What is your husbands' education level?

- 1. Never been to school.....
- 2. Primary.....
- 3. Secondary.....
- 4. Tertiary

3.In your view, how does the education level affect the preference and Choice of Contraception method?Expalin
.....

3. What is your current occupation? _____

4. Do you generate your own income? Yes No

Section E: Client’s satisfaction

1. Do you feel you received the information and the method you needed today?
Yes.....No.....

2. What do you think about the skills of the staff in this clinic? Explain
.....
.....Were you questions answered during the visit? Yes.....No.....

3. Were the staffs friendly during the visit? Yes.....No.....

4. Will you recommend your friend to come for family planning in this clinic?
Yes.....No.....

If yes, why?.....

If no, why?.....

6.In your opinion, how do the following aspects of Family planning services affect the choice of FP method?

	Very great extent	Great extent	Moderate extent	Little extent	Not at all
Number of surviving children					
Husband approval					
friendliness of the healthcare providers					
Quality of counseling/Approach to the various methods					
Waiting time					

5. Do you have any suggestions for improving the family planning services offered in this facility?

.....
.....

Thank you

APPENDIX VI : KII FOR SERVICE PROVIDERS

Instructions:

The purpose of this Interview is to gather Information from the Service providers relevant to the topic of study.

Please tick (✓) in the appropriate box or fill in the empty spaces. Kindly respond to all questions freely and honestly. Your response will be kept strictly confidential and your names are not required.

General Information

1. Gender: Male Female
2. What is your religion?
3. What is your age?
4. What is your profession?
5. How many years have you been practicing ?

FP mentorship

1. a.)Have you received any FP supervision in the last 6 months?
b.) If yes, when supervisors come what do they do?
2. Do you receive regular review of your job performance on FP ?
3. If Yes, what is the purpose of the performance?

Knowledge and Skills.

1. Have you received training in family planning and reproductive health in the past two years?
2. What tasks are you trained in or what are your competencies?
3. Do you feels you have the right knowledge or skills that is needed for family planning?
4. Which methods do you counsel and discuss with the clients on most occasions?

Why?

5. Which methods have you actually provided to the clients for the last three months?
6. If a client wants a service that is not provided in this facility what do you do?
7. a.)What method would you advise to Younger and old Women respectively?(tick in the table below)

Method	Advise to the younger women (15-24)	Advise to the older women (25-49)
IUCD		
Implants		

Pills		
Tubal ligations		
Injectables		
Condoms		

b.) Why?

Thank you

APPENDIX VII: FOCUS GROUP DISCUSSION GUIDE FOR WRA

Objective: To determine the factors influencing contraceptive preference and choice among Women of Reproductive age in Msambweni constituency-Kwale county, Kenya.

Sample: 372 Women of Reproductive age drawn from clients receiving FP services within the data collection period in each of the clusters.

Topic guide for the FGD

1. On average, how many people here are married?
2. What is your current occupation?
3. Have you ever used a family planning method?
4. Which method are you coming for today?
5. In your opinion, what do you think is the purpose of using a family planning method?**Probe**
 - a. Where did you hear about family planning?
 - b. Do you understand how the method works?
 - c. What benefits do people think using a family planning method has?
 - d. What disadvantages do people associate with the use of family planning methods?
6. Who decides on the family planning method you use?
 - a. For those married, does your spouse know what method you are using?
 - b. Do they approve?
 - c. Do you discuss family planning with your friends?if yes, what advice do they give?
7. Who do people consult for information about Family planning?
8. What do you think about the skills of the staff in this clinic?
 - a. Are they friendly?
 - b. What is the quality of counselling based on family planning?
 - c. What is the waiting time?
9. If someone asked for your opinion about family planning, what would you say?
10. What suggestions do you have on how to improve uptake of family planning in this community?