

**SOCIO-ECONOMIC FACTORS INFLUENCING ADOPTION OF MODERN  
FAMILY PLANNING METHODS AMONG WOMEN IN BOMBOLULU,  
MOMBASA COUNTY, KENYA**

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**2013**

## DECLARATION

I hereby declare that this project is my original work and has not been presented for a degree at any other university .

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## **DEDICATION**

This work is dedicated to my wife Stella and children Collins and Stacy for their moral support and encouragement during the study.

## **ACKNOWLEDGEMENT**

I wish to express my sincere gratitude to God for the courage and strength bestowed upon me when undertaking my research. I greatly feel honoured to salute my supervisor Mr. John Bosco Kisimbii of the University of Nairobi for his moral support and proper guidance he accorded to me when carrying out my research. Indeed I also say thank you to my classmates and my lecturers at the University of Nairobi for their crucial role of supporting and encouraging me thus yielding to the success of my study. Lastly, I also thank all other persons who in one way or the other participated and supported me when doing my research. May the Almighty God bless you indeed.

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## **ABBREVIATIONS AND ACRONYMS**

UNDP	– United Nations Development Programme
NCPD	– National Council for Population and Development
FPAK	– Family Planning Association of Kenya
MCH/F	– Maternal Child Health and Family Planning
IRH/FP	– Integrated Rural Health and Family Planning Programme
PHC	- Primary Health Care
NGOs	– Non-Governmental Organizations
PSI	– Population Services International
UN	– United Nations
MOU	- Memorandum of Understanding

## **ABSTRACT**

High population growth is common in Bombolulu just as it is the case with other informal settlements. This situation has led to increase in poor living standards with the affected population lacking basic amenities such as food, water, shelter, medical care and education among others. This further creates competition for resources among the population. Population control is a key ingredient of economic development of any country. In order to realize this, then Family Planning is crucial. This was a study on the socio-economic factors that influence the adoption of modern contraceptives among women in Bombolulu, Mombasa County. It sought to establish the influence that education, poverty and cultural practices and taboos had on the adoption of modern contraceptives in Bombolulu. The study was conducted through a cross-sectional survey method and data was collected in the months of May-June 2013. This was done through the use of interview schedules and guides from 95 household heads in Bombolulu area and 5 key informants who had special knowledge on the subject matter. The study used cluster sampling. Secondary data was obtained from document analysis and multi-media sources. The data obtained was analyzed using SPSS V.17 and presented in tables, quotations and figures. The study established that low levels of education in Bombolulu had a negative impact on the adoption of modern contraceptives. It was also observed that poverty negatively impacted on the adoption of modern contraceptives in Bombolulu. The study concluded that for there to be an effective strategy on the adoption of modern family planning in Bombolulu, low education levels, poverty and cultural beliefs and taboos must be addressed first. There is an urgent need to decentralize provision of modern contraceptives in the community. Through this, access to these can be improved. It is also important to educate community members on the benefits of planned fertility to the family. Finally there is a need for studies to be conducted on the impact of county governments in the provision of modern contraceptives and the influence of early marriages on access to modern contraceptives.

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the Study

During the late 1960s and into the 1970s, the United Nations and donor countries urged developing countries to address the problem of high fertility and rapid population growth.

They noted that population numbers were increasing at very high rates. The major concern was that population dynamics, particularly in the context of persistent inequalities, would have a major influence on development processes. It would also have a major impact on the inclusive and balanced growth and outcomes in the coming decades. They also challenged the capacity of developing countries to achieve broad-based development goals (UNDP, 2003). However the global population has increased by two billion over the last 25 years, surpassing the 7 billion mark in late 2011. It is likely to increase by at least another two billion by 2050.

The planet's expanding population means that the fight for resources such as food, water, and energy will become fiercer (Shetty, 2011). The overall increased consumption could greatly exacerbate global warming. Beyond the sheer numbers, the world is faced with unprecedented diversity in demographic situations across countries and regions, as well as within countries. Such diversity is mostly found in evolving demographic structures and the changing proportions of youth and elderly groups. It is also found in different rates of fertility, morbidity and mortality, population growth, urbanization, and internal and international migration (UNDESA & UNFPA, 2012).

The countries that will see the biggest population rises are in Asia and Africa; these make up a large proportion of the developing world. In these regions there is serious health risks associated with lack of family planning. Women who have pregnancies that are too close together are unable to properly care for their children. Indeed this has a serious effect on child nutrition (Shetty, 2011).

Family planning is hailed as one of the great public health achievements of the last century. It should however be noted that over 200 million women worldwide who want to use contraceptives don't have access to them. In the developing countries, the world's poorest women and men are not empowered to decide the number of children and timing of their births, despite the fact that complications during pregnancy and childbirth are a leading cause of death for women in Africa (Global Health Program, 2012).

The benefits of voluntary family planning are that it empowers women and men to decide when to have a child and to avoid unintended pregnancies and abortions. The result is that families are healthier which translates to overall community health. Family planning programs can reduce fertility in almost all settings (Jain,1989; Bonga arts et al, 1990; Phillips et al, 1995; Freedman, 1997). It should be noted that interest in creating family planning programs arose in many countries only after declines in mortality and other aspects of development led to decreases in fertility preferences. This led to a potential demand for contraceptives in the population and a concern about fertility among government leaders. However, the immediate task for programs was not to decrease fertility preferences. It was to legitimate contraception and make it available as the solution to pre-existing problems of an unmet need. Once most programs were underway, their primary goals were usually to increase contraceptive use and decrease fertility (Freedman, 1997).

In Kenya, prior to the evolution of modern contraception, population growth was checked by traditional population control mechanisms. Some of these were polygene, long breast-feeding periods and sexual periodic abstinence (Wortham, 1993; Mbacke, 1994). It should also be noted that Africans perceived high fertility as a sign of Fecundity and prosperity (Sinding, 1991). Through these beliefs, the traditional culture and social structure made the notion of controlling fertility foreign and alien. These methods changed in the advent of modernization and urbanization. People left their traditional practices for western ideals resulting in increased population growth.

When Kenya became independent in 1963, the question of controlling population growth was brought up. By this time, the 1948 and 1962 population censuses had documented the rapid population growth (Ruto, 1998). The government was of the opinion that the rapid population growth had serious economic and social implications to Kenya's future development. It argued for a national policy and program to reduce fertility. It was at this time that the government opened the first family planning centers in Central province in 1968 (Republic of Kenya, 1967; FPAK, 1985). In the early 1980s, the government encouraged reduction in the population and budgetary allocations were made for family planning services. The Sessional Paper No. 4 of 1984 on Population Policy Guidelines spelt out the direction the government wanted to take in relation to enactment and enforcement of relevant laws on how population issues should be treated. It was here that an urgent need was recognized to provide all relevant audiences in Kenya with information about rapid population growth.

The success of all these initiatives was to be based upon establishing a coordinating body to handle matters population control. This led to the establishment of the National Council for Population and Development (NCPD). This was to act as an umbrella organization in supporting, coordinating and strengthening all matters to do with population control. However, the danger was that of over motivation of few family planning clients without ensuring the ease of availability of the services. Here it was recommended that provision of quality of services through Community-Based distribution of contraceptives be encouraged.

The 1997 draft National Population Policy for Sustainable Development calls for an increase in contraceptive prevalence rate from 33 per cent (in 1993) to 68 per cent. The government plans to do this by providing and increasing accessibility to affordable family planning services that are safe and culturally acceptable (Republic of Kenya, 1997). Indeed the Ministry of Health has remained

the implementing agency on behalf of the government since 1967. It started to provide family planning services free of charge in practically all government hospitals, health centers and clinics. It also extended its services to those that were run by the Family Planning Association of Kenya by 1968 (FPAK, 1986).

In the second Government Development Plan 1970/74, the Government made a decision to establish MCH/FP programme which took off in 1975. It was followed by the establishment of a comprehensive Integrated Rural Health and Family Planning Programme (IRH/FP). This was which aimed at promoting more cooperation with NGOs and introducing new innovative strategies, such as Primary Health Care (PHC), and demand creation (ROK, 1974).

Since inception of the various programs, Non-Governmental Organizations (NGOs) have been in the forefront in supporting the government in its endeavors to provide family planning services. In this regard, the private sector acts as a source of family planning to 41% of users. This is hampered by the fact that the private sector is critical in increasing access but it lacks the necessary skills. Among the NGO sector Population Services International (PSI) a USA based organization promotes various health interventions. This is done through the use of social marketing strategies in over 60 countries. Its Kenyan affiliate PSI/K was founded in 1990 initially as a family planning program with the goal of increasing access to contraceptives. It was to work through the social marketing of condoms and oral contraceptives but has grown to embrace other aspects of health. The Tunza Family Health Network is its first clinical services intervention (Tunza, PSI/K, 2010).

## **1.2 Statement of the problem**

Population control is a key factor in the realization of Vision 2030. This is an ambitious blueprint for rapid economic development. Indeed the Kenyan government has included family planning in its development strategy since 1965. The impact of these initiatives is that they have succeeded at

lowering the fertility rate, or the number of births per woman. Indeed, fertility declined from 8.0 births per woman in the late 1970s to 4.6 in 2009. However, most of the decline occurred between 1980 and 2000. During this period the fertility rate remained stagnant at 4.6 births per woman since 2003 (NCPD, 2012).

Kenya's experience has shown that an effective strategy to increase the use of family planning is to bring the services closer to where people live. Certainly bringing services closer to homes reduces the distance that clients need to travel. It also gives them access to trained health workers that provide a family planning method (Musembi & Kariuki, 2008). Some of these clinics offering these services may also refer them to the nearest clinic or health center for longer acting or permanent contraception.

Kenya's population stood at 38.6 million in 2009, having doubled over the previous 25 years (Kenya National Bureau of Statistics, 2009). This is a sign that the country's population has been growing at an average rate of one million per year despite various population control initiatives. According to the United Nations (UN) projections, it will reach 66 million people by 2030. The number of women who do not have access to an effective method of family planning remains unacceptably high. High population growth seems to be experienced in the country. It is certain that these initiatives have not achieved their intended objectives.

A large number of this increase in the population is found in various informal settlements in the country. Studies have shown that population growth in informal settlements tends to be specifically high. This is despite the introduction of various modern population control initiatives in these areas. Undeniably, there is a need to determine whether; education has an impact on the adoption of modern family planning methods; poverty contributes towards the adoption of modern family planning methods and whether cultural beliefs and taboos have an impact on the adoption of modern

family planning methods. If the impact of these socio-economic factors influencing the adoption of modern family planning methods among women in informal settlements are not sufficiently addressed then all population control initiatives may fail.

### **1.3 Purpose of the Study**

The purpose of this study was to examine the socio-economic factors that influence the adoption of modern family planning methods among women in Bombolulu.

### **1.4 Objectives of the Study**

The study had the following objectives

- i. To determine the extent to which level of education influences the adoption of modern family planning methods among women in Bombolulu.
- ii. To evaluate the influence of poverty on the adoption of modern family planning methods among women in Bombolulu.
- iii. To establish how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu.

### **1.5 Research Questions**

This research sought to answer the following questions:

- i. How does the level of education influence the adoption of modern family planning methods among women in Bombolulu.
- ii. How does unemployment influence the adoption of modern family planning methods among women in Bombolulu.
- iii. How does poverty influence the adoption of modern family planning methods among women in Bombolulu.

- iv. How do cultural beliefs and practices influence the adoption of modern family planning methods among women in Bombolulu.

## **1.6 Research hypothesis**

### **Hypothesis 1:**

**H<sub>0</sub>:** The level of education has no effect on the adoption of modern family planning methods among women.

**H<sub>1</sub>:** The level of education has a positive effect on the adoption of modern family planning methods among women.

### **Hypothesis 2:**

**H<sub>0</sub>:** Poverty has no effect on the adoption of modern family planning methods among women

**H<sub>1</sub>:** Poverty has a positive effect on the adoption of modern family planning methods among women.

### **Hypothesis 3:**

**H<sub>0</sub>:** Cultural beliefs and taboos have no effect on the adoption of modern family planning methods among women.

**H<sub>1</sub>:** Cultural beliefs and taboos have an effect on the adoption of modern family planning methods among women.

## **1.7 Basic Assumptions of the study**

The study had the following assumptions:

1. The study examined why majority of the women in Bombolulu have a low attitude towards modern family planning methods.

2. The study would determine the key factors that influence adoption of modern family methods among women in Bombolulu.
3. The study will enable planners and policy makers to come up with viable methods of influencing adoption of modern family planning methods among women in Bombolulu.

### **1.8 Significance of the Study**

The study is considered to be of great importance to the government and its various agencies as it will provide useful knowledge and information with regard to the adoption of modern family methods in women in Bombolulu.

NGOs and other groups providing family planning services in Bombolulu will also be able to get information on the socio-economic factors that influence the adoption of modern family methods in this area. This study enabled women in Bombolulu settlements to understand the concept of modern family planning methods and the various factors influencing their adoption in these areas.

The study was of significance to researchers and fellow students as it will not only fill the knowledge gap but it will also provide insightful information on the socio-economic factors that influence the adoption of modern family planning methods among women in Bombolulu.

### **1.9 Delimitations of the Study**

This study focused on the socio-economic factors that influence the adoption of modern family planning methods among women in Bombolulu. This study was conducted among the women who frequent the Tunza clinic of Kisimani area in Bombolulu Mombasa County. The key informants of the study were individuals with important knowledge on the field of modern family planning.

### **1.10 Limitations of the study**

The funds and other material resources to carry out a wide-ranging study were not available to the researcher. To counter this, the researcher carried out a study equivalent to the available resources as per the budget.

Poor weather conditions especially chilly weather during the month of June also adversely affected the movement of researcher when administering the questionnaires. This was overcome by the researcher working extra hours in order to beat the deadline.

The other limitation is that some respondents were illiterate hence could not understand English. To counter this problem, the researcher had to translate the questions into Swahili language which they understood.

### **1.11 Definition of significant terms**

**Education-** it is the process of training and developing people in knowledge, skills, mind and character in a structured and certified program (SIL international, 1999).

**Bombolulu area** is the place where housing units have been constructed on land that the occupants have no legal claim to. These are unplanned settlements and areas where housing is not in compliance with current planning and building regulations (United Nations, 1997)

**Poverty-** it is the lack of basic human needs such as clean and fresh water, nutrition, health care, education, clothing and shelter because of the inability to afford them (Anyangu, 2011).

**Socio-economic factors-**Socioeconomic factors are the social and economic experiences and realities that help mold one's personality, attitudes, and lifestyle. The factors can also define regions and neighborhoods (Chase, 2009).

**Traditional beliefs and taboos-** these are those beliefs that govern ethics and morality within any long standing religion or belief system (Fleischman & Moore, 2009). These refer to the practices and the way of life of the people.

### **1.11 Organization of the Study**

This study was organized in the following manner:

In chapter one the researcher presents the background of the study, outlining the problem and significance of the study. The chapter further states the objectives that guide the study in investigating the socio-economic factors influencing the adoption of modern family planning methods among women in Bombolulu.

In chapter two the researcher presents a review of literature with particular focus on the socio-economic factors that influence the adoption of modern family planning methods. The chapter also contains the conceptual framework that explains the relationship among the variables of the study.

Chapter three contains the research methodology which is the research design, location of the study, population, sampling size, data collection and data analysis procedures that were used in the study. This chapter also includes the validity and reliability of research instruments, methods of data analysis and ethical considerations. It concludes with operational definition of variables.

Chapter four gives a presentation of findings. It includes the data presentation, analysis and interpretation. This also captures the response rate, demographic characteristics and variables among others.

Chapter five presents a summary of key findings, a comparative discussion and conclusions based on research objectives and recommendations policy action and further research.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter presents a review of literature with particular attention paid to the various variables of this study. These are the socio-economic factors influencing the adoption of modern family planning among women in informal settlements. The chapter will present an in-depth analysis on education, poverty, unemployment and cultural beliefs and practices in relation to the role that they play in the adoption of modern family planning methods. Through this systematic review, it is hoped that a deeper understanding of these variables will be achieved.

#### **2.2 Education and Adoption of Modern Family Planning Methods**

Education is the act or process of imparting or acquiring general knowledge. It involves developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life (Varma & Rohini, 2008). Education is indeed a key component of modern family planning among women in informal settlements. It is worth noting that education is the cornerstone of any society. The wellbeing of a country's population is inextricably linked to its education system (Barrett, 2005). Indeed investments in the education of women yield dramatic returns in the health of women, children, and communities (Ethiopia Demographic and Health Survey, 2011). Area of residence is also a key determinant of the level of education of women in that area. In this regard women in informal settlement areas tend to have lower education levels compared to their counterparts in other areas (David & Lucile, 2011).

Women's education especially in the informal settlements is the "single most influential investment that can be made in the developing world. This is because education improves the ability of women in these areas to make important decisions on fertility (World Bank, 2009). In this regard, many governments now support women's education not only to foster economic growth, but also to promote smaller families. This has the impact of increasing modern contraceptive use and overall

child health (Lloyd, Kaufman & Hewett, 2008). Women with more schooling tend to have smaller, healthier families. It should also be noted that more education among women is associated with smaller family size. In a number of less developed and in informal settlements, women with no education have about twice the number of children as women with ten or more years of school (Diamond, Newby & Varle, 2010). The reason is that women with more education usually make a healthier transition into adulthood.

The impact of education on women is that they have their first sexual experience later, marry later, and want smaller families. They are also more likely to use contraceptives than their less educated counterparts (Diamond, Newby & Varle, 1999). The context in which education takes place is critical in shaping childbearing decisions. Fertility levels tend to decline more rapidly where schooling is wide-spread or primary school enrollment is nearly universal (Bledsoe et al, 1999). When a larger proportion of the population is brought into the educational system, even a small amount of education may be associated with fertility decline. Indeed as overall education levels rise, social norms concerning childbearing and parenting change (Hennink, 2005). In this regard, even those women without much formal education will be affected by the changing community norms regarding smaller family size (Jejeebhoy, 1995). Formal education among women increases their aspirations for their children. This pushes them to have fewer and manageable children. Schooling often increases the costs of having children (World Bank, 2010). Often, education is associated with characteristics that might lead a woman to choose fewer children. Some of these might be increased literacy skills, greater personal autonomy, and exposure to new values, ideas, and role models (Tyler & Peterson, 1991). More informed women in turn tend to have greater demand for and be better users of health services. This is also influenced by the years spent in school. Years in school might influence fertility in different ways. It has an impact of changing student values by making it more likely that a girl will marry an educated husband who desires a smaller family. It may also improve knowledge through family life education or other means (Soldan, 2004).

Almost all studies of the impact of education on fertility find that the estimated reductions in fertility rates associated with increases in education levels dwarf the effects of most other explanatory variables. Some of these variables can be those that measure the presence of family planning programs (Angeles et al, 2005). There is a positive relationship between family developmental outcomes such as children's schooling and health associated with a mother's education and beneficial effects for her children (Behrman, 1991). Programs to increase women's educational attainments might be the most effective way to stimulate reductions in fertility and improve children's lives in developing countries (Becker & Gary, 1960). Certainly, highly educated women might have more bargaining power when making contraceptive decisions within their families. Since women often wait until they have left school to begin families, staying in school longer postpones the age at first childbearing and thereby can lower the total fertility rate (Bledsoe et al, 1999).

Female education creates awareness that their reproductive and health seeking behavior show a noticeable difference than illiterate women (Diamond et al, 1999). Indeed ample research has been carried out to find out the linkages between female education and fertility. Female education empowers women through increasing their involvement in family decision making.

It also improves their autonomy and control over household resources, knowledge and awareness of the modern world and inter-spousal communication (Jejeebhoy, 1992). Female education largely affects fertility through the proximate determinants. It also improves the duration and intensity of breast-feeding among educated women compared to the illiterate women (Jain and Nag, 1986).

Another important linkage of female education and fertility works through the improved survivorship chances of their children (Gustavo et al, 2003). As such, the effect of female education works independently regardless of the socio-economic status of the household (Elo, 1990). Improved child survivorship affects both the age at marriage and fertility. It is important to note that the spread

of female education would take more than a generation to produce results. On the other hand family planning programs were designed as an action oriented strategy that would facilitate a faster decline in fertility levels. This can only be made possible once the contraceptive technology is made available in the developing countries.

### **2.3 Poverty and Adoption of Modern Family Planning Methods**

Poverty is a state of absolute or relative lack of basic necessities of life (Ighedosa, 1998). Poverty in the broadest sense implies a lack of resources for reasonable comfortable living. It has an impact on several aspects of human life (Okoro, 1998). The current situation in urban areas is that one third of all urban residents are poor. This figure represents one quarter of total poor. Indeed poverty is becoming increasingly urban (Baker 2009). From these statistics it is evident that the urban poor have low skills, low wages and are unemployed. These people mostly work in the informal sector and have no social or medical insurance (Simmons & Koenig, 1994).

It is obvious that poverty has a great impact on family planning. It is estimated that a large number of urban residents especially those in informal housing live below absolute poverty level (Ujiro, 2009). As such they cannot afford essential non-food requirements such as contraceptives and tend to get pregnant frequently. Their interval is that of less than 2 years and at extremes of ages for example less than 18 years and more than 35 years (Ighedosa, 1998; Egboh, 2000 and National Policy on Population (NPP) 2004). There is a strong relationship between poverty and inadequate reproductive health status of married women in informal housing (Igbudu, 2007 and Ighedosa, 1998). It is also noted that urban women in informal housing lack access to health information on ways to achieve satisfying and safe sex life. They have poor knowledge of planned parenthood, have inadequate access to safe, effective, affordable and acceptable methods of family planning of their choice (Ighedosa, 1998 and Makoju, 1999). This state of affairs flourishes among the urban poor due to illiteracy resulting from financial limitations or lack of

access to educational institutions or sources of basic information. There is a need by most family planning program providers to provide contraceptives to women in informal settlements that have an affordable range of choices. Certainly the lack of such choices limits poor women's basic rights and thus deteriorates family planning efforts in these areas (Okoro, 1998). Family planning is a powerful tool in combating poverty.

However, universal access to family planning is not yet a reality—particularly not among the poorest. Worldwide, 200 million women would like to delay or prevent pregnancy, but are not using effective contraception due to poverty (Sathar & Zeba 1984). Due to poverty in the informal settlements, the demand for contraceptives is expected to grow by 40 per cent in the next 15 years, but funding for it has been declining over the years (Geoffrey, 2006). Indeed, effective family planning programs targeted to meet the needs of poor populations can reduce the fertility gap between rich and poor people. It can make a powerful contribution to poverty reduction and the achievement of the Millennium Development Goals (Jain & Nag, 1986). Income has been commonly used as the measure of the overall level of social and economic development of a society. However, empirical studies of the relationship between income and fertility have reached very mixed conclusions (Egboh, 2000). At the macroeconomics level, negative relationships have typically been observed, with low fertility in the richest countries and high fertility in the poorest countries (Simmons & Koenig, 1994). This implies that the relationship between poverty and reproductive health and hence uncontrolled population are particularly evident in less developed countries. It is obvious that family planning plays a pivotal role in population growth, poverty reduction, and human development (Igbudu, 2007). There is evidence from the United Nations and other governmental and non-governmental organizations that supports this conclusion.

Failure to sustain family planning programs, in informal settlements will lead to increased population growth and poorer health for the poor in these areas (Ighedosa, 1998). However, robust

family planning services have a range of benefits, including maternal and infant survival. It also has a positive input on nutrition, educational attainment, the status of girls and women at home and in society. Conclusive family planning services also have a bearing on human immunodeficiency virus (HIV) prevention, and environmental conservation efforts (Makoju, 1999). Indeed family planning is a prerequisite for achievement of the United Nations' Millennium Development Goals. It is also important for realizing the human right of reproductive choice among women in informal settlements.

Family planning is a powerful tool in combating poverty. However, universal access to family planning is not yet a reality—particularly not among the poorest (UNFPA, 2006). The situation worldwide is that, 200 million women would like to delay or prevent pregnancy, but are not using effective contraception (Okoro, 1998). Indeed, the demand for contraceptives is expected to grow by 40 per cent in the next 15 years, but funding for it has been declining over the years (UNFPA, 2006). Effective family planning programmes targeted to meet the needs of poor populations can reduce the fertility gap between rich and poor people. This can also make a powerful contribution to poverty reduction and the achievement of the Millennium Development Goals (National Policy on population for sustainable development 2004).

#### **2.4 Cultural Beliefs & Taboos and Adoption of Modern Family Methods**

Cultural beliefs and taboos refer to the behaviors and beliefs characteristic of a particular social, ethnic, or age group (Makoju, 1999). Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe. It also has a reference on material objects and possessions acquired by a group of people in the course of generations through individual and group striving (Ighedosa, 1998). Indeed culture in its broadest sense is cultivated behavior. That is the totality of a person's learned, accumulated experience which is socially transmitted, or more briefly, and / or

behavior through social learning. It is a collective programming of the mind that distinguishes the members of one group or category of people from another.

Despite the wide range of effective contraceptive options available to women in developed countries, unintended pregnancies continue to occur in large numbers (Karra et al., 1997). In light of this it is obvious that a number of factors and barriers can affect a woman's access to, or effective use of contraception. Among these barriers are personal beliefs and values that can be shaped by both culture and religion (Toure, 1996). Fertility studies indicate that men play a major role in using family planning methods and in determining the number of children a couple should have (Campbell, 1985; Mbizvo, Adamchek, 1991 and Carlos, 1984).

Undeniably men's involvement in family planning can have a significant effect on fertility levels and trends (Karra et al., 1997). Men who believe that women are responsible for family planning and birth control are less likely to use family planning methods. In contrast, those who believe that other men in the community approve use of family planning methods and also approve men's acceptance of responsibility for family planning are more likely to use these methods (Toure, 1996). Better communication between spouses concerning their children and family planning, as well as men's higher education increase the likelihood of using contraceptive methods (Omondi-odhiambo, 1997). Men's negative attitudes towards family planning can also be the leading obstacle to the success of family planning in Africa, (Hawkins 1992). Notable examples can be found in Kenya, where changes in men's attitudes could have been partly responsible for its recent fertility transition (Omondi-Odhiambo, 1997).

Religion may also be an obstacle to effective use of modern family planning methods among many women (Adamchak & Adebayo, 1987). In some instances, higher levels of fertility have been associated with 'traditional', religious prohibitions on some forms of birth control. 'Traditional'

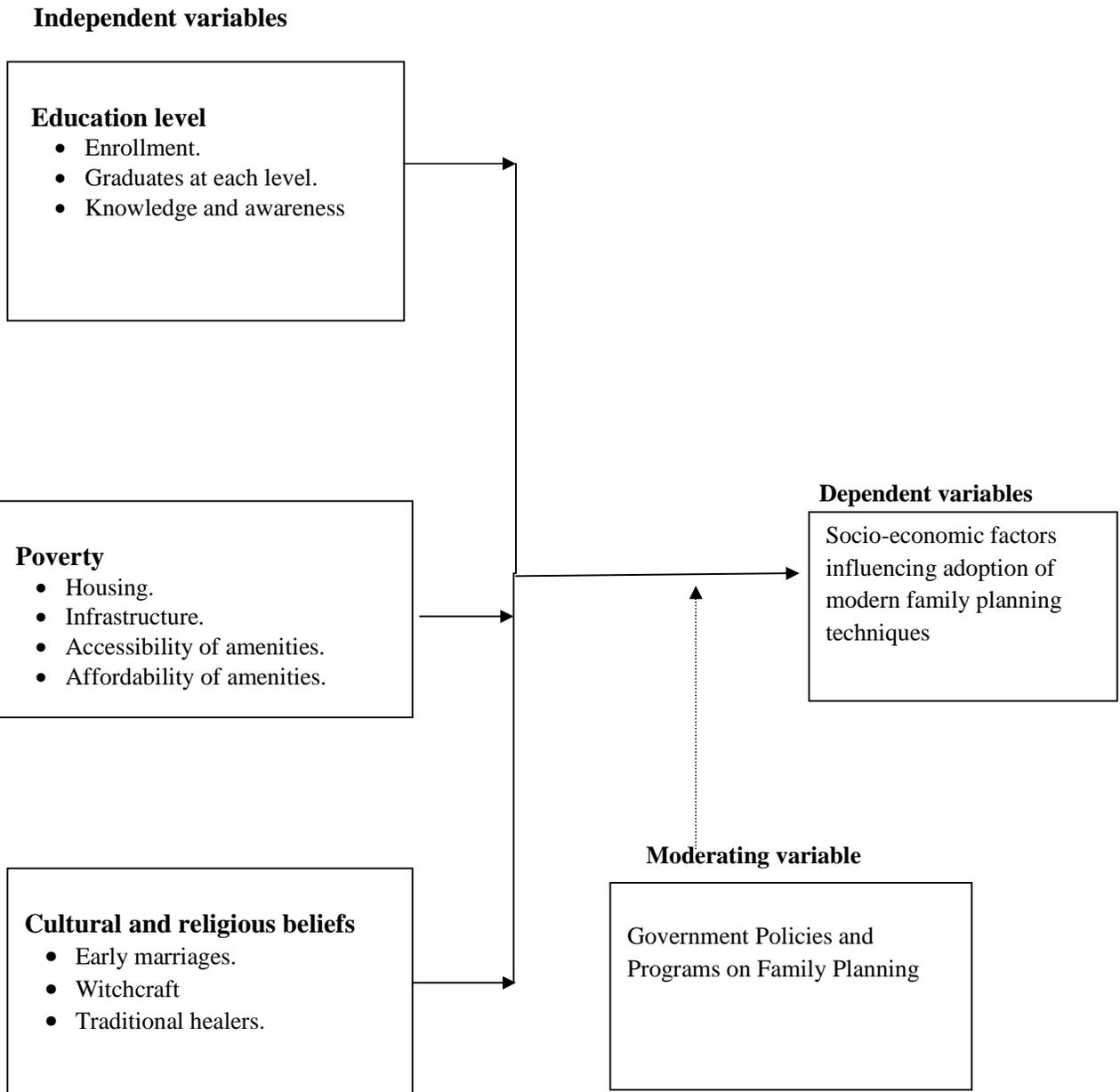
values about the importance of children and the priority of family, and 'traditional' family and gender roles reinforced by religion may also be another obstacle to effective use of contraception (Adebayo, 1988; Fisher, 1984; Olukoya, 1985; Omondi-Odhiambo, 1997; Reinecke, et al., 1997).

When a couple's most fundamental assumptions of a faith are dissimilar to those of the health care provider, medical recommendations may be made that are not in keeping with the couple's religious or cultural values (Srikanthan & Reid, 2007). Over and above religious views, the cultural values of a given population may greatly affect sexual and contraceptive behavior (Whitley and Schofield, 1986). Indeed, some religions are subdivided into denominations, adherents of which may have their own distinct interpretation of religious teachings. These differences complicate the attempt to articulate a single position for a given religion. In addition, although individuals may identify with a particular faith, they may not agree at a personal level with official teachings (Varacalli,2006). It is however important to note that whether a particular woman and her partner adhere to specific religious beliefs is a matter for discussion on an individual basis. However, higher religious attendance is linked to less favorable opinions about contraception (Varacalli,2006).

Catholic affiliation is not consistently associated with family planning opinion. Born again and fundamentalist Christians have less positive opinions about contraception, generally, whereas evangelical identity is linked to negative views on family planning policy, (Thornton & Camburn,1989). However, the values that an individual woman holds may not be in keeping with the official teachings of her religion or the cultural norms reported by other members of the same culture (Jennifer et al, 2010). These findings contribute to knowledge about the relationship between religion, culture and family planning attitudes.

## 2.5 Conceptual framework

**Figure 1: Conceptual framework**



The conceptual framework was developed through explaining and ascertaining the relationships and interconnectivity of the objectives of this study. In this study, education, poverty, cultural and religious beliefs are the independent variables. The moderating variable are the government policies and programs.

## **2.7 Explanation of variables**

### **a) Cultural beliefs and practices**

- i. Cultural beliefs and taboos refer to the behaviors and beliefs characteristic of a particular social, ethnic, or age group.
- ii. Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe

### **b) Education**

- i. Education is the act or process of imparting or acquiring general knowledge.
- ii. It involves developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life.

### **c) Poverty**

- i. It is a state of destitution in which one experiences many levels of hardship
- ii. It is the state of deficiency of the basic needs by community members.

## **2.8 Summary of Literature**

The literature has clearly indicated the socio-economic factors influencing the adoption of modern Family Planning methods among women.

The literature captures the three independent variables namely poverty, education, and cultural beliefs & taboos.

Generally what we get is the role each of these variables play in adoption of the modern Family Planning methods among women in informal settlements.

By examining the three variables, we can be able to gather adequate information in regard to the subject.

This crucial information gathered will assist the stake holders to have a better understanding of the concept of Family Planning. This will further equip them with the necessary skills in dealing with any shortcomings arising and also enable them come up with the right policies and combative measures in regard to modern Family Planning. Therefore as far as the literature gathered is concerned, Family planning forms a core ingredient of community development hence its therefore crucial to thoroughly understand it.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter examined the research design, the location of the study, population, sample size, data collection and data analysis procedures that were used during the study. It described in detail what was done and how it was done.

#### **3.2 Research design**

This study was conducted through a survey research design. A survey is a present oriented methodology used to investigate populations by selecting samples to analyze and discover occurrences (Oso & Onen, 2009). It was used to provide numeric descriptions of some part of the population. It describes and explains events as they will occur. This design was purposively selected for this study because of the economy of the method and the ability to understand the selected population from a particular part of it.

#### **3.3 Target population**

This study was carried out in Kisimani area of Bombolulu in Mombasa County. Bombolulu is found in Nyali Constituency and is 5.3 KM north of Mombasa Island. It has an approximate population of 50,000 people (with an average of 9 people per household) although its size (KM<sup>2</sup>) is not well documented. Bombolulu has five villages namely: Kisimani, Bombolulu, VoK, Mkunguni and Ziwa la Ng'ombe. The main economic activity of this area is small scale business and employment in surrounding industries and in the main town of Mombasa.

#### **3.4 Sample size and sampling procedure**

Sampling is a process used in statistical analysis in which a predetermined number of observations are taken from a larger population. It is the gathering and asking of a range of individuals the same

questions related to their characteristics, attributes, how they live or their opinions, it also involves the collection of relevant information (O' Leary, 2004).

The following formula was utilized in calculating the sample size:

$$N = \frac{Z^2 \times (p) \times (1 - p)}{d^2}$$

Where:

N= the desired sample size

Z= the standard normal deviate at the required confidence level (1.96 for 95% confidence level)

p= the proportion in the target population estimated to have characteristics being measured

d= the level of statistical significance test

Thus,

$$N = \frac{(1.96)^2 \times (0.50) \times (1 - 0.5)}{(0.05)^2} = 384$$

However, because the target population is known and is less than 10,000, the final estimate was calculated using the following formula:

### **3.5 Correction for finite population**

The ideal sample size for the research was 333 respondents. However, due to time and financial constraints, the researcher utilized a sample size of 100 respondents, 95 of who were household heads from the larger Bombolulu area and 5 purposively selected key informants.

**Table 3.1 Number of study respondents**

<b>Respondents category</b>	<b>Number</b>
<b>General respondents (household heads)</b>	<b>95</b>
<b>Key informants</b>	<b>5</b>
<b>Total number of respondents</b>	<b>100</b>

The sample of this study consisted of a total of 100 respondents, 95 of which were household heads from the larger Bombolulu area and 5 purposively selected key informants who had key knowledge on the subject matter. This study employed cluster sampling technique to select the sample. The clusters included respondents from the five villages of Bombolulu and parts of the clusters randomly selected as the sample. All members of the chosen clusters were then studied.

**Table 3.2 Sampling of general respondents**

<b>Zone</b>	<b>Respondents in each zone</b>
<b>Kisimani</b>	<b>19</b>
<b>Bombolulu</b>	<b>19</b>
<b>VOK</b>	<b>19</b>
<b>Mkunguni</b>	<b>19</b>
<b>Ziwa la Ngombe</b>	<b>19</b>
<b>Total number of respondents</b>	<b>95</b>

From each of the zones, the researcher purposively selected 15 respondents to be interviewed in the study. This particular method was favored due to the fact that the researcher used zones rather than individual members because the factual sampling frame cannot be constructed. Another reason for the selection of this method was due to pragmatic reasons like time and money spent in the course of the study.

**Table 3.3 Sampling of key informants**

<b>Key informants</b>	<b>Number</b>
Community Leaders	1
Health Ministry Employees	2
Religious leaders	1
Local NGO Representatives	1
<b>Total number of key informants</b>	<b>5</b>

Purposive sampling technique was used to sample the various key informants used in this study. The researcher purposively selected the following individuals were used in this study; 1 community leader, 2 employees of the ministry of health, 1 religious leader and 1 local NGO representative. These individuals were selected due to the fact that they were knowledgeable in issues to do with reproductive health services and family planning in the area.

### **3.6 Data collection methods**

Interview guides were used as the main tools for primary data collection from the various respondents and key informants selected for the study. The researcher then constructed an interview guide, which is a collection of items to which a respondent was expected to react to in writing. They were then administered to the various respondents and key informants in the study.

The interview guides contains basic demographic information like gender, age, marital status, socio-economic status in the form of employment and level of education among others. They also contained both open and closed ended questions. The open ended questions ask the respondents to construct answers using their own words. Without a doubt, through these, they were able to offer information and to express their opinions regarding the various variables of the study as they wished

and deemed fit. The closed ended questions restrict the respondents to choose from a range of predetermined responses that give them a range of answers from which they are able to choose from.

The interview sessions were recorded through respective appropriate answers being taken; note taking or jottings at the bottom of the interview guides that were made at the time of the interviews and typed transcripts created from such notes soon afterwards, more often that same day. Most of the interviews were conducted in both English and Swahili. On average, the interviews lasted for approximately 20-30 minutes. The researcher was also able to make good use of focus group discussions with the various purposively selected key informants which comprised of a number of meetings with local community leaders, government officials and local NGO representatives on relevant study areas. Undeniably, these techniques were instrumental in helping the researcher to deepen his understanding of the various issues under study.

Participant observation is a systematic method of data collection that relies on a researcher's ability to gather data through his or her senses; it is to notice, using a full range of appropriate senses, to see, hear, feel, taste and smell (O'Leary, 2004). Indeed, the nature of information which the researcher seeks to obtain is what will lead him to adopt this particular method of study. By using this method, the researcher saw for himself what the people and the various key informants do in the course of their duties and by doing this he will be able to bridge the gap between what the people said and what they actually did. This method allowed the researcher to gain firsthand experience without necessarily utilizing informants whose views at times could be misleading; the researcher recorded information obtained here as it occurred. Document analysis is also another method of data collection that was utilized by the researcher in the course of this study. This method involves a collection, review, interrogation, and analysis of various forms of texts on the issues and subject of family planning that the researcher use as a secondary source of research data. These include censuses, surveys, books, journals, independent inquiries and reports prepared on the issues and problems related.

Also utilized was multimedia sources in the nature of newspapers or various magazine columns/articles, current affairs, shows, news reports and internet sources on the various objectives of the study. He also used historical documents in the form of articles and various books that have been written on the various issues of the study. The purpose of this particular method was to obtain unobtrusive information that was done at the pleasure of the researcher without interrupting the research process. Through this, the researcher was able to obtain the language and words of the informants who by their nature are the authors of these documents; he was able to access data at his convenience. Overall the researcher was able to save time and expense in transcribing this data.

### **3.7 Validity and Reliability of research instruments**

This section dwells on the validity and reliability of the data collection instruments.

#### **3.7.1 Validity of the Instruments**

According to Mugenda and Mugenda (2003), validity is the measure of relevance and correctness. It is the accuracy and meaningful of influences which are based on the research results. Data collection techniques must yield information that is not only relevant to the research questions but also correct.

To yield good results in regard to this study, the researcher consulted with the supervisor and also visited the area of the study to familiarize himself with its geographical set-up. This indeed assisted him in terms of ascertaining the validity of the research instruments. This gives a confirmation that the issues raised in the questionnaires were indeed the situation on the ground as far as the socio-economic factors affecting adoption of modern family planning methods among women in Bombolulu are concerned.

#### **3.6.2 Reliability of the Instruments.**

According to Mugenda (2003), reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. The research instrument had to be subjected to

pretest reliability by initially applying it to a small sample of ten (10) respondents. The researcher had to test for reliability of the questionnaire using test retest method initially administered to a small sample of ten (10) respondents from Kisimani zone and then re-administered it to the same sample after two weeks. The scores from both were then correlated giving a Pearson correlation coefficient of 0.876. Which indicates strong positive linear relationship between the two scores and implies high instrument reliability. Before administering the questionnaire, the researcher must ensure that the questions are clear and no ambiguities. This ensures that the respondent understand the questions clearly and thus give the right answers.

### **3.8 Data Collection Procedures**

Two research instruments were used for data collection. One for the 95 household heads in the five villages and then the other for the 5 key informants. The researcher had the responsibility to formulate the questionnaires and administered them to the respondents where relevant questions concerning the study were asked. Interviews were conducted involving the household heads and the key informants hence their response/feedback were given required. The researcher had of course to seek permission in terms of approval from the relevant authorities which includes the key players like the University of Nairobi, the local community, the government, the religions fraternity, NGO representatives and the village elders among others. If this was done, then recruitment of 2 research assistants was done followed by briefing on the study objectives, data collection process and study instrument administration; pilot testing, revision of the data, collection instruments after the pilot study; Reproduction of required copies for data collection upon approval by supervisors; Administration of data collection instruments to respondents, collection of duly completed research instruments. Assessment of filled in questionnaires through serialization and coding for analysis, Data analysis and discussion and finally preparation of conclusions and recommendations.

### **3.9 Ethical considerations**

The major ethical problem anticipated in this study was the privacy and confidentiality of the various respondents selected in this study. In some instances, obtaining a valid sample may entail gaining access to specific lists and sensitive files which in itself maybe an infringement on the privacy and confidentiality of the respondents, but it was the only way that the researcher could construct a valid sampling frame and generate a representative sample. The respondents however while filling in information had the freedom to ignore the various items in the questionnaires and discussions that they may not have wished to respond to.

### **3.10 Data presentation and analysis techniques**

Data analysis is the process of bringing order, structure and meaning to the mass of information collected (O. Mugenda & A. Mugenda 2003). The data collected as per the questionnaires in this study was in the form of “Yes”, “No” or “I do not know” responses with a further segment provided for a slight explanation for each of the responses selected for each of the various closed ended questions; while in the open ended questions, a range of responses was offered for some of the questions; this was be in the form of pairing some of the problems associated with family planning and any other socio-economic or medical problems associated with this problem, providing a range of answers from “good”, “poor” to “do not know” and the request of solutions to the problems associated with the issue of family planning.

The researcher was systemically able to organize this mass of raw data that had been collected in a manner that would facilitate proper and adequate analysis. Since empirical or quantitative analysis was anticipated, the various responses in the questionnaire were assigned numerical values. This was in the form of yes taking the value of 1, no taking the value of 2 and I do not know taking the value of 3. This was done for the closed ended questions while for the open ended questions the researcher

categorized the various responses given and assigned numbers or numerical values to these. The intention was to combine the power of words with the authority of numbers as to permit quantitative analysis, the data was then converted to numerical codes that represent the attributes or measurements of variables. Coding is the conversion of data into numerical codes (O. Mugenda & A. Mugenda, 2003). The various code categories in the questionnaire were mutually exclusive and hence allowed for independent analysis of each of the responses provided. The coding process began with the preparation of a codebook that is found in the computer program used in the analysis (SPSS version 17).

The codebook is a document that describes in specific details the coding scheme to be followed (O. Mugenda & A. Mugenda, 2003). Here, the codebook describes the code assignment for each response category for each item in the questionnaire. It also indicated the variable name, its type (width), label, the values assigned for the various responses given for the particular variable, the missing values and the measurement types. The codebook was then used to transfer the information to a code sheet. This is what was used to build or create a 'data set' that was managed and utilized throughout the process of analysis; this is essential for both qualitative and quantitative data. The main reason for the researcher to adopt this approach was to save time and to increase the accuracy of the results of the analysis. The data analysis conducted involved developing summaries and looking for trends and patterns with the data. This was done with a view of analyzing the data in a systematic way in order to come up with useful conclusions and recommendations. The data was then presented in summary in form of tables, graphs, pie charts, with various verbatim discussions being included in the presentation.

## CHAPTER FOUR

### DATA ANALYSIS, PRESENTATION AND INTERPRETATION

#### 4.1 Introduction

This study investigated the socio-economic factors influencing the adoption of modern family planning methods among women in Bombolulu. The study was conducted in Kisimani area of Bombolulu. This was in light of how education, poverty and cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu . The data was collected through the use of interview guides and was analyzed using SPSS V.17. This section begins with a brief description of the study respondents and the rest of the chapter presents the results of the study.

#### 4.2 Response Rate

This section entails an analysis of the rate at which questionnaires that were handled out were returned in complete form. This is indicated in table 4.1

**Table 4.1 The response rate of Respondents**

	No. of respondents	%percentage	Valid%	Cumulative%
Returned	95	100	100	100
Not returned	0	0	0	100
<b>Total</b>	<b>95</b>	<b>100.0</b>	<b>100.0</b>	

The study had a target of 95 general respondents. All the questionnaires were returned. This formed the basis of data analysis.

**Table 4.2 Response rate of key informants**

	<b>No. of respondents</b>	<b>%percentage</b>	<b>valid%</b>	<b>cumulative%</b>
Returned	5	100	100	100
Not returned	0	0	0	100
<b>Total</b>	<b>5</b>	<b>100</b>	<b>100</b>	

As shown in table 4.2, the key informants included, 1 community leader, 2 employees of the ministry of health, 1 religious leader and 1 local NGO' representative. All their questionnaires were completed and returned thus valid for analysis.

### **4.3 Demographic characteristics of the population**

This entails age, gender, income, marital status and levels of education of the respondents.

#### **4.3.1 Gender of the respondents**

**Table 4.3 Respondent's gender**

<b>Gender</b>	<b>Number of respondents</b>	<b>Percentage</b>
Male	25	26 %
Female	70	74%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

In this study, about 26% of the respondents were male while 74% of them were female. A large number of the households in this study were female headed households. The study was on family planning and most of the respondents were female.

#### **4.3.2 Marital status**

The study sought to know marital status of the respondents and details are discussed in table

4.2

**Table 4.4 Marital status of the respondents**

Marital status	Number of respondents	Percentage
Married	55	58%
Single	10	10.5%
Divorced	20	21%
Widowed	10	10.5%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

In this study, about 58% of the respondents were married, 10.5% of them were single, while 21% of them were divorced and 10.5% of them were widowed. A large portion of household heads in the study was married as compared to those from other categories in this section.

### 4.3.3 Age

The study sought to find out the age distribution of the respondents and the findings are shown in table 4.3 below.

**Table 4.5 Age bracket**

Age bracket	x	No. of respondents(f)	fx	%Proportion
21-25 years	23	18	414	19%
26-30 years	28	20	560	21%
31-35 years	33	18	594	19%
36-40 years	38	13	494	13.7%
41-45 years	43	12	516	12.6%
46-50 years	48	8	384	8.4%
51-55 years	53	6	318	6.3%
<b>Total</b>		<b>95</b>	<b>3,280</b>	<b>100</b>

$$\bar{x} = \frac{\sum f x}{\sum f} = \frac{3,280}{95}$$

$$= 34.5$$

The average age of the respondents is 35 years. Ages were distributed in the following manner; 19% were between 31-35 years, 13.7% were in the age bracket of 36-40 years, 12.6% were between the age bracket of 41-45 years, 8.4% were between the age bracket of 46-50 years and 6.3% were in the age bracket of 51-55 years. Majority of the respondents are relatively young below the age of 40 years.

#### 4.3.4 Education

Table 4.4 below shows the levels of education among the respondents.

**Table 4.6 Level of education**

<b>Level of education</b>	<b>Number of respondents</b>	<b>Percentage</b>
Primary school	67	71%
Secondary school	15	16%
College education	13	13%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

Of the respondents in this study, about 71% of them had primary education, 16% had secondary education and 13% had college education. The study was conducted in Bombolulu which is an informal settlement and this is characteristic of such areas.

#### 4.3.5 Occupation

The respondent's occupation activities are shown in table 4.7 below

**Table 4.7 Occupation of the respondents'**

<b>Occupation</b>	<b>Number of respondents</b>	<b>Percentage</b>
Business/Self Employment	25	26%
Private employment	20	21%
Do not work	50	53%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

26% of the respondents in the study were in business or self-employment, 21% of them were in private employment and 53% did not work. This study had a large portion of the respondent's not engaged in any economic activity.

#### **4.4 Research Objectives**

The study objectives investigated were, education, poverty, and cultural practices and taboos in respect to how these influence the adoption of modern family planning methods among women in Bombolulu.

##### **4.4.1 Education and adoption of modern Family Planning methods among women in Bombolulu.**

The first objective of this study was to determine the extent to which education influences the adoption of modern contraceptives among women in Bombolulu . Here the researcher sought to establish whether formal education had an impact on adoption of modern family planning methods. The results are then presented in the below.

##### **4.4.2 Key informants and respondents opinions on education and contraceptives**

Data was collected and analyzed from the various key informants and respondents on the question of the impact of education on the adoption of modern contraceptives. The results are presented in the table below.

**Table 4.8 Understand the need for modern contraceptives**

<b>Understand</b>	<b>Number of respondents</b>	<b>Percentage</b>
Yes	35	37%
No	60	63%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

About 37% of the respondents understood the need for modern contraceptives and 63% of them did not understand the need for modern contraceptives. Indeed, many of them did not fully understand the importance of modern contraceptives. This was largely attributed to their low level of education. Responses from various key informants also reinforced this view. Majority of them noted that low education level meant that the residents did not fully appreciate the need for adoption of modern family planning methods. From the responses obtained it was noted that education plays a major role in the adoption of modern contraceptives. It is an important component in understanding the importance of modern contraceptives.

#### **4.4.3 Respondents and key informants opinions on understanding instructions**

Data was collected and analyzed from the respondents and key informants on whether the community members could fully understand the instructions on use of modern contraceptives. The results are presented in the table below.

**Table 4.9 Understand instructions on modern contraceptives**

<b>Understand instructions</b>	<b>Number of respondents</b>	<b>Percentage</b>
Yes	35	37%
No	60	63%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

About 37% did not understand the usage instructions on modern contraceptives while 63% of them understood these instructions. From the various responses and discussions held on this issue it was noted that there exists confusing instructions on how to use modern contraceptives. The education

levels of the community members serves to fuel this confusion on how to use these modern contraceptives. Several key informants noted that low education levels in the community were a key determinant in the low adoption of modern family planning methods. It was also noted that education was paramount in establishing and encouraging community members to start using modern contraceptives.

#### **4.4.4 Key informant's perceptions on education and modern contraceptives**

Data was collected and analyzed from the key informants on the impact of education on the adoption of modern contraceptives. The researcher sought to establish how education impacted on the adoption and use of modern contraceptives in the community. Most of them were of the opinion that low education levels in the community had a negative impact on the adoption of modern contraceptives. They said that low education levels were the main reason there was a high population growth in the community. A number of them were of the opinion that there should be some form of adult education introduced so as to improve the adoption of modern contraceptives by the women in Bombolulu.

#### **4.4.5 Poverty and adoption of modern Family Planning methods among women in Bombolulu**

The second objective of this study was to evaluate the influence of poverty on the adoption of modern family planning methods among women in informal settlements. The researcher sought to establish the influence that poverty has on the adoption of modern family planning among women in the community. Poverty is closely associated with women empowerment in the community. It is also linked to access to modern family planning in the community. In order to achieve this, he sought the views of both the key informants and general respondents in the study. The results are presented in the discussion below.

#### 4.4.6 Respondents and key informants opinions on unemployment and contraceptives

Data was gathered and analyzed from both the key informants and respondents on the question of whether unemployment played a major role in the adoption of modern contraceptives. The results are then presented in the table and discussion below.

**Table 4.10 State of employment and modern contraceptives**

<b>Access to contraceptives</b>	<b>Number of respondents</b>	<b>Percentage</b>
Yes	72	76%
No	23	24%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

About 76% percent of the respondents said that the status of the employment determined their access to modern contraceptives and for 23% of them it did not. This was a sign that employment and poverty was a major factor in access to modern contraceptives. Here many of the key informants were of the opinion that for one to use modern contraceptives they had to be empowered financially. This is only possible if the user of these contraceptives in engaged in some form of income generating activity. According to the key informants, for the women to get some money to attend family planning clinics, they have to ask from their spouses. In some instances this is denied to them. It is factors like these that limit women's access to modern family planning method in the community. According to the key informants, increasing women's empowerment in the community has a direct impact on increasing their access to modern contraceptives. As such poverty was a major hindrance to the access of modern family planning methods for the women in the community.

#### 4.4.7 Key informants and respondents opinions on contraceptives affordability

Data was collected and analyzed from both the key informants and respondents on the question of whether modern contraceptives were affordable. The results are then presented in the table and discussion below.

**Table 4.11 Modern contraceptives are affordable**

<b>Are affordable</b>	<b>Number of respondents</b>	<b>Percentage</b>
Yes	36	38%
No	59	62%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

About 38% of the respondents said that modern contraceptives were affordable and 62% did not think they were affordable. This was a major indicator of women Lacking empowerment in the community. If a large number of these women in the community cannot afford contraceptives it is a sign that they are not empowered. Many of the key informants said that women in the community had a low opinion of the free contraceptives offered by the government. They thought that these free contraceptives could cause permanent barrenness in women. On the issue of affordability, the key informants were of the opinion that the government could do more in knowledge spreading among community members. Knowledge will help the women to know that they can access these contraceptives for free at government hospitals.

Another issue that was observed from the discussions was that community members had to commute to the nearest government clinic. They had to ask their spouses for money and this was a cause of trouble and conflict in the homes. This was a major issue of empowerment of these women. It is such factors that cause unaffordability of modern family planning methods among women in Bombolulu.

#### **4.4.8 Respondents and key informants opinions on poverty and modern contraceptives**

Data was gathered and analyzed under the question of whether poverty had an impact on the adoption of modern contraceptives in the community. From the various focus group discussions held with the key informants and community members, it was noted that poverty was a big hinderance to the adoption of modern family planning methods in the community. Many of the key informants were of the opinion that if community members cannot afford the basic needs in life, then money for

modern contraceptives was not possible to be found. Fare to government clinics where free contraceptives are offered was also a challenge for majority of the community members. In this regard it was noted that poverty has continued to be a play a negative role in the adoption of modern family planning methods in the community.

Many of the key informants said that the government should consider providing mobile family planning clinics so as to improve access of these services in the community. Such initiatives are beneficial to the women in the community irrespective of their financial situation. It was also noted that poverty in the community limits the ability of the women to make decisions on family size and number of children. If the women cannot make these decisions then they cannot take and use modern contraceptives. Indeed for women to be actively involved in family planning then they must be empowered financially. This will greatly assist in the adoption of modern family planning methods in the community.

#### **4.5 Cultural practices and taboos**

The other objective of this study was to establish how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu . The researcher sought to find out if there were any unhealthy community practices. He sought to establish their impact on the adoption of modern family planning methods by community members. The results are presented in the discussion below.

##### **4.5.1 Respondents and key informants opinions on awareness of taboos and practices**

Data was collected and analyzed under the question of whether the respondents knew of any cultural practices and taboos. He sought to establish if they had an impact on the adoption of modern family methods by the community members. The results are presented in the table below.

**Table 4.12 Aware of cultural taboos and practices**

<b>Aware of taboos/practices</b>	<b>Number of respondents</b>	<b>Percentage</b>
Yes	90	95%
No	5	5%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

About 95% of the respondents were aware of some cultural and practices that prevent the adoption of modern contraceptives and 5% were not. Here the researcher observed that there are several cultural practices in the community that discourage women not to use modern contraceptives. Some of these are like the belief that these contraceptives can cause loss of libido in men. Many of the key informants noted that such beliefs that have been propagated by their spouses and the women believe them. The key informants noted that many negative cultural beliefs negatively affected the adoption of modern contraceptive in the community. They observed that for there to be an increase in the adoption of modern contraceptives, there has to be a paradigm shift in the thinking of community members. This can be achieved by continuous socio-civic education being provided to community members.

#### **4.5.2 Respondents and key informants opinions on role of religion**

Data was collected and analyzed under the research question of whether the religion played a major role in the adoption of modern contraceptives. Here the researcher sought to establish the impact that the respondents religious beliefs had on the adoption of modern contraceptives in the community. The results are then presented in the table and discussion below.

**Table 4.13**

<b>Religion</b>	<b>Number of respondents</b>	<b>Percentage</b>
Catholic	30	31.5%
Protestant	15	16%
Muslim	20	21%
Traditional	20	21%
Other	10	10.5%
<b>Total number of respondents</b>	<b>95</b>	<b>100%</b>

About 31% of the respondents were Catholic, 16% were Protestant, while 21% were Muslim, a further 21% had traditional beliefs and 10.5% percent belonged to religious congregations that could not fit into any of the provided choices. Their religious congregation played a major role in their lifestyle choices regarding family planning. From the various discussions with the key informants it was noted that the Catholic Church forbids its members from using modern contraceptives as a form of family planning. This church encourages its members to only use the natural methods of family planning. It was noted that indeed the Catholic Church has continually advised its members from using modern contraceptives. From the discussions it was noted that the protestant church through its various movements was liberal in the use of modern contraceptives by its members. There is no extreme position on the use of modern contraceptives by the members of this church. As for the Muslims, discussions and opinions provided were that the Qur'an does not make any explicit statements about the morality of contraception but contains statements encouraging procreation. Many were of the opinion that prophet Muhammad is reported to have said "marry and procreate". Indeed this was a major guiding point to many Muslims interviewed not to use modern contraceptives. From the various opinions provided form the Muslims, their religion was a major factor in their adoption of modern family methods.

Views from the traditional and other respondents on their religious beliefs and the adoption of modern family planning methods were varied. While some in the traditional category were of the opinion that the number of children was to be determined by nature, others were of differed. They

said that modern contraceptives could be taken but only after consultation with their spiritual leaders. From the various discussions held on the issue it was evident that religious beliefs played a major role in the adoption of modern family methods in the community. Religion was noted to be a major guiding factor in the lives of community members. It played a major role in how Muslim wives submitted to their spouses and as such they could not actively participate in family planning. They could not use modern contraceptives if their husbands were against the idea. Of the Muslims interviewed the number of children and the adoption of modern family planning was the prerogative of the man/husband. This was noted as a major factor in the adoption of modern contraceptives in the community.

#### **4.5.3 Key informants views on taboos and culture**

Data was collected from the various key informants on their opinions on the role of culture and taboos in the adoption of modern family planning methods in the community. From the various discussions held it was generally noted that culture was responsible for the failure of family planning in the community. It was noted that the culture of pride in many children was particularly a factor in the adoption of modern family planning methods in the community. In this regard many of the key informants noted that a proud father becomes the subject of envy from the impotent men and barren women. The nursing mother is elevated to a status above the ordinary woman. Hence the desire to give birth to a child, or several children, is the future dream of virtually all girls when they become of age, oblivious of the fact that every live birth increases the burden of human population.

Discussions with the key informants also noted that many community members were of the belief that large families and many children were a source of cheap labour and prestige in the society. Many community members were of the opinion that working children add to family income, and they are a kind of pension plan, looked to for support during old age. Key informants noted that this practice, which is perceived to boost agricultural production, encourages men to marry several

wives, consequently producing large numbers of children whose welfare cannot be adequately catered for.

Key informants also noted that high fertility was a consequence of major gender inequalities in reproductive costs, benefits and decision-making power within the household. It is women who undertake most of the labour involved in child care. The marriage contract entitles husbands not only to children born to their wives but also to their labour. Once bride price has been paid off, child bearing becomes relatively cost-free for the father. In this regard it was noted that another cultural practice was that of early marriage of girls in the community. This particular practice had the impact of reducing the girls 'say 'in the relationship. It was noted that when the girl is married off young she cannot effectively participate in family planning decisions in the house. As such early marriage of girls in the community was a major cultural practice that influenced the adoption of modern family planning methods in the community.

#### **4.6 Research hypothesis testing.**

The study sought to test the following research hypothesis;

H<sub>0</sub>     The level of education has no effects on adoption of modern Family Planning methods among women.

H<sub>1</sub>     The level of education has a positive effect on the adoption of modern Family Planning methods among women.

The study utilized chi-square in measuring the relationship between levels of education and adoption of modern family Planning methods among women.

**Table 4.13: Chi-square values for levels of education**

	Observed N	Expected N	Residual
None	-	-	-
Primary	67	31.67	6.28
Secondary	15	31.67	-2.96
College	13	31.67	-3.32
<b>Total</b>	<b>95</b>		

Table 4.13 above shows that majority of the respondents (67) had only attained primary education followed by (15) who had attained secondary education and finally only (13) respondents had attained college education.

**Table 4.14: Hypothesis test for the relationship between education and need for adoption of modern family planning methods.**

	Education	Need for Adoption of modern family planning methods
Chi-square	59.19	6.58
Df	2	1
Asymp.sig	0.05	0.05
Correlation	0.128	1
<b>No. of respondents</b>	<b>95</b>	<b>95</b>

Table 4.14 shows that the chi-square values on the level of education are 59.19 and 2 degrees of freedom. The computed value is greater than the table value of the chi-square which is 10.597. The chi-square value on the need for adoption of modern family planning methods among women. The computed value is also less than the table value of the chi-square which is 10.597. this means that we reject the null hypothesis and accept the alternative hypothesis that education has a positive effect on adoption of modern family planning methods among women with a higher level of education tend to have a better understanding and the need for adoption of modern family planning methods.

H<sub>0</sub> Poverty has no effect on the adoption of modern family planning methods among women.

H<sub>1</sub> Poverty has a positive effect on adoption of modern family planning methods among women.

**Table 4.15: Chi-square values for sources of income**

	<b>Observed N</b>	<b>Expected N</b>	<b>Residual</b>
Business/Self employment	25	31.67	-1.19
Private employment	20	31.67	-2.07
Do not work	50	31.67	3.26
<b>Total</b>	<b>95</b>		

Table 4.15 above shows that 25 respondents were in self employment while only 20 were privately employed. Majority (50) did not work.

**Table 4.16****Chi-square values of modern contraceptives affordability**

	<b>Observed N</b>	<b>Expected N</b>	<b>Residual</b>
Yes	36	47.5	-1.67
No.	59	47.5	-1.67
<b>Total</b>	<b>95</b>		

The chi-square values above shows that only 36 respondents who could afford contraceptives as opposed to 59 who could not afford.

**Table 4.17: Hypothesis test for the relationship between poverty and adoption of modern family planning methods among women.**

	<b>Affordability</b>	<b>Adoption of modern family planning methods</b>
Chi-square	25.28	5.56
Df	1	1
Asymp.sig	0.05	0.05
Correlation	-0.97	-1
<b>No. of respondents</b>	<b>95</b>	<b>95</b>

Table 4.17 shows that the chi-square values on the sources of income are 25.28 at 1 degree of difference. The computed value is greater than the table of the chi-square values on adoption of

modern family planning methods are 5.56 at 1 degree of freedom. The computed value is greater than the table value of the chi-square which is 5.024. This means that we reject the null hypothesis and accept the alternative hypothesis that poverty has a positive effect on adoption of modern family planning methods among women. The study utilized the pearson correlation co-efficient in establishing the relationship between the two variables. There was a negative correlation of -0.97 between poverty and adoption of modern family planning methods. This implies that poverty does not have a direct relationship to adoption of modern family planning methods among women.

### Testing of hypothesis

H<sub>0</sub> Cultural beliefs and taboos have no effect on the adoption of modern family planning methods among women.

H<sub>1</sub> Cultural beliefs and taboos have a positive effect on adoption of modern family planning methods among women.

**Table 4.18: Chi-square values for awareness on cultural beliefs and taboos.**

	<b>Observed N</b>	<b>Expected N</b>	<b>Residual</b>
Yes	90	47.5	6.17
No.	5	47.5	-6.17
<b>Total</b>	<b>95</b>		

The chi-square values above in table 4.18 shows that 90 respondents were aware of the cultural beliefs and taboos as opposed to 5 of them who were not aware of the same.

**Table 4.19 : Hypothesis test for the relationship between cultural beliefs and taboos and adoption of modern family planning methods among women.**

	<b>Cultural beliefs &amp; Taboos</b>	<b>Adoption of modern family planning methods</b>
Chi-square	76.06	6.58
Df	1	1
Asymp.sig	0.05	0.05
Correlation	-1	-1
<b>No. of respondents</b>	<b>95</b>	<b>95</b>

**Table 4.19** shows that the chi-square value on cultural practices are 76.06 at 1 degree of freedom. The computed value is greater than the table value of the chi-square values on adoption of modern family planning methods among women is at 6.58 at 1 degree of freedom.

The computed value is less than the table value of the chi-square which is 7.879. This implies that we accept the null hypothesis and reject the alternative hypothesis that cultural beliefs and taboos have a positive effect on adoption of modern family planning methods among women. Pearson correlation co-efficient shows that there is a negative relationship between cultural beliefs and taboos and adoption of modern family planning methods.

## **CHAPTER FIVE**

### **SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter has identified and interpreted the major findings of this study. Here the researcher has summarized the major findings of the study. Recommendations on how to improve on the various study objectives to do with modern family planning are also offered in this chapter.

#### **5.4 Summary of findings**

This study sought to investigate the socio-economic factors that influence the adoption of modern contraceptives among women in Bombolulu. Study findings established that education, poverty and cultural practices and taboos are socio-economic factors that influence the adoption of modern contraceptives in Kisimani- Bombolulu, Mombasa County.

The first objective was to determine the extent to which education level influences the adoption of modern family planning methods among women in Bombolulu . When asked if they understood the need for modern contraceptives, about 37% of them understood the need for modern contraceptives and 63% of respondents did not understand the need for modern contraceptives.

From the various responses provided it was noted that majority of the respondents did not fully understand the importance of modern contraceptives. This was largely attributed to their low level of education. In this regard, the key informants of the study reinforced this view. They were of the opinion that the low education levels in the community meant that many of the members did not

fully appreciate the need for modern contraceptives. They preferred old contraceptive methods (traditional methods like fertility days counting).

The second objective was to evaluate the impact of poverty on the adoption of modern family planning methods among women in Bombolulu .About 76% percent of the respondents said that the status of the employment determined their access to modern contraceptives and for 23% of them it did not. This was a sign that employment and poverty were major factors in determining access to modern contraceptives. Indeed poverty had a negative impact on the adoption of modern contraceptives among these women. Key informants held the view that financial disempowerment was a negative force in the adoption of modern contraceptives among these women.

It was also noted that attendance to free family planning clinics was also pegged on income as these women had to commute to the nearest available clinic. According to the key informants, increasing women's empowerment in the community has a direct impact on increasing their access to modern contraceptives.

The second objective was to establish how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu . About 95% of the respondents were aware of some cultural and practices that prevent the adoption of modern contraceptives and 5% were not. Majority of the respondents did not only know of these taboos but also practiced them. It was observed that many of these cultural practices and taboos limit the adoption of modern contraceptives by women in the community.

Many of the key informants noted that such beliefs that have been propagated by their spouses and the women believe them. The key informants noted that many negative cultural beliefs negatively affected the adoption of modern contraceptives in the community. They observed that for there to be an increase in the adoption of modern contraceptives, there has to be a paradigm shift in the thinking

of community members. This can be achieved by continuous socio-civic education being provided to community members.

## **5.5 Discussion of results**

From an analysis and review of the research data and additional data gathered through focus group discussions a number of issues become apparent. The study established that education, poverty and cultural practices and taboos played a vital role in the adoption of modern contraceptives among women in Bombolulu .

The first objective was to determine the extent to which education level influences the adoption of modern family planning methods among women in Bombolulu. Data analysis and an interpretation of interview responses from the key informants and respondents of the study reveal that education has an impact on the adoption of modern contraceptives among women in informal settlements in Kisimani-Bombolulu. These findings indicate that education is a significant factor in the adoption of modern contraceptives in the community.

It must therefore be taken into account when developing an appropriate modern contraceptive adoption strategy in the community. This finding is in agreement with (Radulović, 2003), (Šagrić, 1998), (Višnjić, 2007) and (Marković, 2001) who are of the same view. They postulate that education is an important component in the adoption of modern contraceptives in any community. Education enables a woman to understand the need of modern contraceptives in her life. Indeed investments in the education of women yield dramatic returns in the health of women, children, and communities (Ethiopia Demographic and Health Survey, 2011). The study noted that in the community majority of the women with no or little education estimate their knowledge in modern contraceptives as unsatisfactory. Indeed these women do not use any form of contraceptives as

protection from unwanted pregnancies. It is evident that education and the adoption of modern contraceptives are closely linked.

Education is the act or process of imparting or acquiring general knowledge. It involves developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life (Varma & Rohini, 2008). The state of knowledge about contraception, family planning, and methods for family planning in women with little education in the society is not satisfactory. Indeed the level of education in the society is a key determinant in the adoption of modern contraceptives in that society. WHO studies have shown that women in many underdeveloped countries do not have enough knowledge about contraception. This situation is largely attributed to their education levels in the community. A study by (WHO, 2006) noted that women in Tanzania know almost nothing about contraception and in Nigeria only 34% women have ever heard about contraception, while only 21% know about modern methods of contraception– the best known is a condom, then oral pills and an intra-uterus spiral. It therefore follows that for the problem of low adoption of modern contraceptives in the community to be tackled, the issue of low education levels in the community must also be dealt with.

The second objective was to evaluate the influence of poverty on the adoption of modern family planning methods among women in Bombolulu. Data analysis, interpretation of various interview responses from the various household heads and key informants reveals that poverty is a challenge. For the problem of low adoption of modern contraceptives in the community to be tackled, poverty needs to be addressed. The study reveals that the levels of poverty in the community are high and this contributes to the low adoption of modern contraceptives in the community. Indeed the study reveals that the cost of access to modern contraceptives in the community is relatively high as compared to income. Several respondents did not have any income and as such could not access modern contraceptives. Situations such as these are what have resulted in the low adoption of modern contraceptives in the community. This finding is in agreement with the views of (Igbudu,

2007 and Ighedosa, 1998). They are of the view that there is a strong relationship between poverty and inadequate reproductive health status of married women in informal housing.

These authors have observed that income has been commonly used as the measure of the overall level of social and economic development of a society. Empirical studies of the relationship between income and fertility have reached very mixed conclusions. They have observed a strong link between poverty and high fertility rate. They have observed that the lack of appropriate programs to tackle poverty in the community has increased the problem of high fertility rate. Poverty is manifest in patterns of social relationships in which individuals and groups are denied access to goods, services, activities and resources which are associated with citizenship (ILO 1996).

At the macroeconomics level, negative relationships have typically been observed, with low fertility in the richest countries and high fertility in the poorest countries (Simmons & Koenig, 1994). The relationship between poverty and reproductive health and hence uncontrolled population are particularly evident in less developed countries. Poverty is a state of absolute or relative lack of basic necessities of life (Ighedosa, 1998). It is caused by the stagnation of productive forces and production over time and government policies and development measures which only help the rural rich to get richer and increase inequality in the community. It is obvious that poverty has great impact on family planning. It is estimated that over 70% people in informal housing live below the absolute poverty level. They cannot afford essential non-food requirement such as contraception and tend to get pregnant frequently. This is usually at interval of less than 2 years and at extremes of ages for example less than 18 years and more than 35 years (Ighedosa, 1998; Egboh, 2000 and National Policy on Population (NPP) 2004).

The poor in the community lack access to health information on ways to achieve satisfying and safe sex life. They have poor knowledge of planned parenthood, have inadequate access to safe, effective, affordable and acceptable methods of family planning of their choice (Igbudu, 2007) and (Ighedosa, 1998). Solutions to poverty and programs towards poverty reduction in the

community should be given priority. This can be one sure way of tackling the problem of low adoption of modern family planning methods in the community.

The third objective of this study was to establish how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu .Data analysis, interpretation of interview responses from the key informants and respondents of the study reveal that cultural practices and taboos have a major impact in the adoption of modern contraceptives in the community. Therefore the problem of cultural practices and taboos must be taken into consideration when developing an effective strategy for the adoption of modern contraceptives in the community. This finding is in agreement with those of (Adebayo, 1988),(Fisher, 1984), (Olukoya, 1985),(Omondi-Odhiambo, 1997) and, (Reinecke, et al., 1997). They postulate that traditional' values about the importance of children and the priority of family and 'traditional' family and gender roles reinforced by religion are a major obstacle in the adoption of modern contraceptives in any community.

In this regard it should be observed that culture plays a major role in determining family size and composition in the community. The study observed that in a community with deep and major cultural practices, low adoption of modern family planning methods existed. Bombolulu like any other rural area in the country has deep rooted cultural beliefs. These cultural beliefs regarding child bearing and child sex preferences have a negative impact in the adoption of modern contraceptives in the community.

It should also be noted that religion is deeply entrenched in rural communities than in urban areas (Githu, 2007). The presence of particular denominations in certain areas has an impact on the fertility rate in that area. Christian teachings vary depending upon the denomination. Roman Catholicism teaches that the primary purpose of sexual relations is procreation within marriage. Roman Catholics are therefore forbidden to use medical or physical contraceptive methods, (Zondervan, 1998). Natural contraceptive methods such as abstinence and the rhythm method remain

permissible. Although Eastern Orthodox Christianity holds a similar view of the purpose of sexual relations, most contraceptive methods are permitted. Among conservative Protestant groups, the need to procreate reflects a literal interpretation of the Bible, yet it is common for adherents to use birth control after the family is complete (Oxford University Press, 2003).

Cultural beliefs, practices and taboos are major factors that affect the adoption of modern contraceptives in informal and rural communities. It follows therefore that for there to be an effective strategy for the adoption of modern contraceptives in Bombolulu; this factor must be adequately addressed and tackled.

#### **5.4 Conclusion**

This study investigated the socio-economic factors that influence the adoption of modern contraceptives in Bombolulu. This was in relation to the fact that in spite of various population control programs being initiated in the community, the fertility rate was still high. The study specifically sought; to determine the extent to which education influences the adoption of modern family planning methods among women in Bombolulu . It also sought to evaluate the impact of poverty on the adoption of modern family planning methods among women in Bombolulu. The study also focused on how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu .

The study established that the low levels of education in Bombolulu had a great impact on the adoption of modern contraceptives in that particular area. Majority of the population and especially the women have low education levels and this limits their understanding of the importance of modern contraceptives. It was also established that poverty negatively affects the adoption of modern contraceptives in the community. This situation limits their access to proper family planning clinics and as such curtails their access to modern contraceptives. In the absence of modern contraceptives, the women are left to rely on traditional methods which are not as effective in terms of birth control. For the issue of low adoption of modern contraceptives to be effectively tackled, the

major obstacle of poverty must be addressed. This study also established that cultural beliefs, practices and taboos had an influence in the adoption of modern contraceptives in Bombolulu. Given that the area is relatively rural, traditional beliefs, practices and taboos are the norm. These beliefs guide the people in their everyday life. They are a major factor in the low adoption of modern contraceptives in this particular Bombolulu. Indeed the issue of traditional belief and taboos must be addressed if the solution to low adoption of modern contraceptives in Bombolulu is to be found.

This means that for the issue of low adoption of modern contraceptives to be solved, the problems of low education, poverty and traditional beliefs, practices and taboos must be adequately addressed. It is against this background that the recommendations below are made.

## **5.5 Recommendations**

Despite its limitations, this study should contribute valuable knowledge to the field of family planning and adoption of modern contraceptives in general. In view of this it is hoped that this study will also influence the practice of family planning and various family planning programs in the country. Basing generalizations on the findings of this study, the researcher recommends that:

1. In line with the Constitution, County governments should strive to improve the levels of education and improve access of education to as many people in the community as possible.
2. Adult education programs should be revived and strengthened so that community members can effectively access these services.
3. County governments should devote funds towards various poverty eradication programs. They should also strive to build and improve their respective economies so as to create employment opportunities to the community members

4. Appropriate subsidy programs should be established in the various counties so as to improve access to modern contraceptives by the community members.
5. Increased sensitization programs should be initiated in the community on the benefits of modern family planning. Emphasis should be put on quality of life and not on the quantity. Through sensitization, harmful cultural practices and taboos in the community can be done away with.
6. Emphasis should be placed on enlightening the various religious leaders on the benefits of modern contraceptives for their flock. Traditional views on contraceptives by the religious leaders should be shunned and in place they should encourage their members to have small manageable families.

#### **5.6 Suggestions for further research**

This study was on the socio-economic factors influencing the adoption of modern family contraception in Bombolulu of Mombasa County. Other grey areas identified in the course of this study include:

1. Influence of County government programs on the adoption of modern contraceptives
2. Impact of early marriages among girls on the adoption of modern contraceptives.

<b>OBJECTIVES</b>	<b>VARIABLE</b>	<b>INDICATOR S</b>	<b>MEASUREMENT</b>	<b>SCALE</b>	<b>TYPE OF RESEARCH</b>	<b>DATA COLLECTION METHOD</b>
To determine the extent to which education level influences the adoption of modern family planning methods among women in Bombolulu.	<b>Independent variable:</b> education	education levels in the community	education and its impact on adoption of modern family planning methods	Nominal	Survey	Key informant guide and Questionnaires: Question 3 & 4
To evaluate the influence of poverty on the adoption of modern family planning methods among women in Bombolulu.	<b>Independent variable:</b> poverty	Poverty levels of in the community	poverty levels in the community	Nominal	Survey	Key informant Interview guide: Question 1
To establish how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu.	<b>Independent variable:</b> cultural beliefs and taboos	Types of cultural beliefs and taboos	Culture and beliefs of the community	Nominal	Survey	Key informant guide: Question 4
To investigate the socio-economic factors that influence the adoption of modern family planning methods in Bombolulu	<b>Dependent variable:</b> modern family planning methods	Socio-economic factors	socio-economic factors influencing adoption of modern family planning methods	Ordinal	Survey	Questionnaires: Question 4 & 5
To determine government policies on modern contraception	<b>Moderating variable:</b> Government policies	Types of policies	Knowledge of the existence of the government policies influencing adoption of modern contraception	Nominal	Survey	Key informant Interview guide: Question 1,2,3 & 4

**Table 3.4 Operationalization of variables**

<b>Objectives</b>	<b>Target</b>	<b>Activities</b>	<b>Resource Required</b>	<b>Actors</b>	<b>Expected Outcome</b>	<b>Time</b>
To determine the extent to which education level influences the adoption of modern family planning methods among women in Bombolulu.	Carry out a cross-sectional survey	Fill in questionnaires and key interview guides	Funds, transport ,resource persons and materials	Community members and key informants	Research project report	May-June 2013
To evaluate the influence of poverty on the adoption of modern family planning methods among women in Bombolulu.	Carry out a cross-sectional survey	Fill in questionnaires and key interview guides	Funds, transport ,resource persons and materials	Government and community members	Research project report	May-June 2013
To establish how cultural beliefs and taboos influence the adoption of modern family methods among women in Bombolulu.	Carry out a cross-sectional survey	Fill in questionnaires and key interview guides	Funds, transport ,resource persons and materials	Government, NGOs and community members	Research project report	May-June 2013
To investigate the socio-economic factors that affect the adoption of modern contraceptives in Bombolulu	Carry out a cross-sectional survey	Fill in questionnaires and key interview guides	Funds, transport ,resource persons and materials	Government, NGOs,private companies and community members	Research project report	May-June 2013
To determine the effect of government policies on modern contraceptives	Carry out a cross-sectional survey	Fill in questionnaires and key interview guides	Funds, transport ,resource persons and materials	Government, NGOs private companies and community members	Research project report	May-June 2013

**Table 3.5 work plan**

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**APPENDICES**

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**MOMBASA**

**3<sup>RD</sup> JUNE 2013**

**Appendix 1: LETTER OF TRANSMITTAL**

**SCHOOL OF CONTINUING AND DISTANCE EDUCATION**

**UNIVERSITY OF NAIROBI**

**MOMBASA CAMPUS**

Dear Sir/Madam,

I am a Master's student at the University of Nairobi, Mombasa campus; I intend to carry out a study on the socio-economic factors influencing the adoption of modern family planning methods among women in informal settlements in Bombolulu, Mombasa County. The observations and findings of the study will be treated with complete confidentiality and condition of anonymity assured where necessary.

The study is purely for academic purposes and sharing of the final report once the study is completed is guaranteed.

Thank you for your cooperation.

Yours Sincerely,

Wambugu Daniel Waweru



## SECTION ONE

### 1. Personal Data

1. Gender (please tick one)

- a) MALE  b) FEMALE

2. Marital status (please tick one)

- a) MARRIED  b) SINGLE

- c) DIVORCED  d) WIDOWED

3. Age bracket in years (please tick one)

- a) UNDER 36 YEARS  b) 36-45 YEARS

- c) 46-55 YEARS  d) 56-65 YEARS

- e) ABOVE 65 YEARS

4. Highest level of education (please tick one)

- a) PRIMARY SCHOOL CERTIFICATE

- b) SECONDARY SCHOOL CERTIFICATE

- c) DIPLOMA CERTIFICATE

- d) DEGREE CERTIFICATE

5. Occupation (please tick one)

- a) PRIVATE EMPLOYMENT

- b) NGO

- c) I DO NOT WORK

## SECTION TWO

### 2. Education

Please indicate the extent to which you agree with the following statements in reference to poverty by ticking (✓) in the boxes provided.

	YES	NO	EXPLAIN
a) Does your education level determine the life that you lead?			
b) Do you understand the need for family planning			
c) Can u properly follow instructions on family planning			
d) Is this possible due to your education level?			

## SECTION THREE

### 3. Unemployment

Please indicate the extent to which you agree with the following statements in reference to the activities by ticking (✓) in the appropriate space.

	Yes	No	Not fully	Explain
a) Are you currently employed?				
b) Does the nature of your employment permit you to access modern contraceptives?				
c) Do you think these modern contraceptives are affordable?				
d) Do modern contraceptives have an impact				



### **Appendix 3: KEY INFORMANTS INTERVIEW GUIDE**

- i. Does education level in the community have an impact on the adoption of modern contraceptives among women?
- ii. What ways can be used to increase the adoption of modern contraceptives among women in informal settlements?
- iii. How does unemployment impact the adoption of modern contraceptives among women in informal settlements?
- iv. What is the role of poverty on the adoption of modern contraceptives in the community?
- v. Are there any unhealthy cultural practices and taboos that affect the adoption of modern contraceptives among women in the community?
- vi. What is the role of religion on the adoption of modern contraceptives among community members?
- vii. Do the women in the community follow the rules and norms on the adoption of modern contraceptives as set by their families, communities and religions?