DETERMINANTS OF CONTRACEPTIVE USE AMONG THE YOUTH IN KENYA

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This project is submitted in partial fulfillment of a Master of Arts Degree in Population Studies at the Population Studies and Research Institute (PSRI), University of Nairobi

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DECLARATION

This Research Project is my original work and has not been presented for a Degree award in any other Institution.

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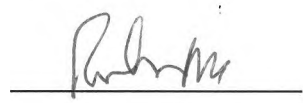
1. **DR. MURUNGARU KIMANI**		21/11/06
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DEDICATION

This work is lovingly dedicated to my son, Ryan, for filling my life with joy and for giving me so much to yearn and long to achieve in life. I also dedicate it to my lovely wife, Jedi, for her support, love and care she accorded me throughout the time I was undertaking my Masters Studies. Indeed she is a gifted and caring encourager companion and friend.

God bless you.

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ABSTRACT

This study set out to establish the factors that influence contraceptive use among the youth in Kenya and recommend possible ways through which contraceptive use among the youth can be promoted to achieve the intended goals of controlling fertility in Kenya.

The study uses the 2003 Kenya Demographic and Health Survey (KDHS) data. The study analyses 2132 female respondents aged 15 to 24 years. The statistical tool used to analyze the data include percentages and cross-tabulation at the bivariate level, while logistic regression was used to demonstrate the presence of statistical association between ever use of contraception and selected intervening, socio-economic, socio-cultural and demographic factors.

The key findings of the study as presented in chapter four show that most of the variables used in the study affects contraceptive use among the youth in Kenya. However, some variables are not significant in influencing contraceptive ever use among the youth. Three models are used in the analysis, where the first model controls for both demographic and intervening variables while the second model controls for intervening variables only. In the third model, all variables for the study are included and the results obtained are not different from the results obtained when some variables are controlled for in the first and second models. This show that demographic variables and intervening variables do not influence the way socio-economic and socio-cultural variables affect contraceptive use among the youth.

Also in the multivariate analysis finding show that Demographic factors and socio-economic factors are significant whereas intervening and socio-cultural factors are not significant in influencing contraceptive use among the youth.

The principal policy implication is to design communication strategies that will reach the less privileged, rural and illiterate people who are by far the majority in Kenya and who are les contraceptive users as compared to other groups. It is recommended that school based dissemination of family planning information in the context of family life education should be revamped.

In Kenya, family planning services are available in many hospitals, clinics, and dispensaries. However these services are available only to married women because the unmarried women fear from seeking for these services directly from these clinics. Sexually active unmarried young people are therefore disadvantaged as far as access to family planning services is concerned. This lack of access promotes their inadequate use of family planning methods. Although contraceptives use among unmarried young people has been highly criticized, the government officials NGO's, community leaders, church leaders and parents need to provide alternative solutions since knowledge and skills without access to services are worthless (Bandura, 1992). Family planning services should be made widely available and accessible to the young people.

The findings underscore the need for further studies in understanding further specific factors affecting contraceptive use among different socio-cultural groups among the youth. For instance what factors affect contraceptive use among the poor young people in Kenya? The studies should further identity strategies and interventions that can help increase contraceptive use within the different socio-cultural groups.

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ABBREVIATIONS

CEB: - Children Ever Born

CBC: - central Bureau of Statistics

CPAK: - Conference of Population Association of Kenya

DHS: - Demographic Health Survey

GOK: - Government of Kenya

HIV/AIDS: - Human Immuno-deficiency syndrome

KDHS: - Kenya Demographic and Health Survey

KENPOP: Kenya Population Journal

MDG: - Millennium Development Goals

NARC: - national Rainbow Coalition

NCPD: - National Council of Population and Development

NASSEP: - National Sample Survey Evaluation Programme.

SPSS: - Statistical Package for Social Scientists

TFR: - Total Fertility Rate

UN: - United Nations

WB: - World Bank

CHAPTER ONE: INTRODUCTION

1.0 Background Information

Increased urbanization, modernization and education together with exposure to western lifestyles, appear to have led to a decline in traditional values and in particular to the reduction of the importance of virginity at marriage. Previously in African societies, sexual health information concerning for example the giving and receiving of sexual pressure, sexual taboos, rites and cleansing procedures was transmitted in conjunction with formal rituals such as circumcisions or initiation. Nowadays, however the influence of such traditional structures have weakened, thus reducing the sources of social support and resource for adolescents with sexual health questions leading to increasing sexual health problems. Sexual activity thus seems to be increasingly occurring before marriage, leading to an increase in unwanted pregnancies and their associated risks. Although there is increased sexual activity in Kenya and in sub-Saharan Africa in general, the problems associated with sexual activity can be reduced by contraception.

Reducing fertility rates in developing countries is believed to lead to reduced infant mortality improved maternal and child healthy and enhanced quality of life, particularly for women, (World Bank, 1993). One of the millennium development goals is to improve maternal health and reduce deaths due to maternal causes and among the actions suggested in meeting this goal in the International Conference on Population development (ICPD) programme of

action was the provision of information on reproductive health services including family planning services. According to Bongaarts, 1984, no other indicator of reproductive behaviour predicts a population's fertility better than contraception preference.

Macrae et al., 2001, supports the view that contraceptives are used by most Kenyan women either to delay their first birth or space births, or stop child bearing altogether. The pill, injection and female sterilization are the most popular modern methods whereas post-partum abstinence is the most popular traditional method. Complications of abortion performed under unsafe conditions are among the main causes of maternal deaths (Adefuye et al., 2003; Jain et al., 2004) and appropriate management as recommended in the programme of action will reduce deaths related to this cause. However, prevention of unplanned pregnancies is a more logical action to be taken to decrease women's reliance on unsafe abortion. In summary fertility rates among the youth in Kenya appear to have remained high despite decline experienced among other age groups. This is partly due to high sexuality among youths. There is evidence from many studies world wide which show that youths become sexually active early and have multiple sexual partners. Further evidence based on 1998 KDHS reveals that 44% of women aged 15-19 years had sexual encounters and nearly 80% of young people had sexual intercourse by the age of 17 years.

Studies carried out in Kenya show that Kenya's fertility transition is attributable to increase in contraception adoption (Omwanda, 1996) and so by implication increased and stable fertility among the youth is attributable to lack of effective contraceptive use. Indeed the evidence show that youths are poor contraceptors, (Gage, 1998; Gardner, 1993; Kiragu and Zabin, 1995). This may be as a result of several factors including lack of knowledge of, and access to contraceptive technology, youth risk taking and experimentation behaviours, individual variables like lack of self-efficacy and self-confidence, economic hardships, and socio-cultural environment of the youth.

1.1 Problem Statement

Several studies carried out in Kenya have highlighted the need to study sexual behaviour, (Ajayi et al., 1991; Toroitich-Ruto, 1997; Bauni and Obonyo, 2000; Long Field et al., 2004). These studies have mainly concentrated on the determinants of sexual behaviour and linked them to contraceptive behaviour, fertility or knowledge of HIV/AIDS. While some of these studies have indicated that sexual activity begins early in Kenya and is sporadic (Njue et al., 2004), they have not investigated the determinants of contraceptive use among the youth aged 15-24 years in Kenya. Most studies have only concentrated at the factors determining adolescent contraceptive use, i.e. only those aged between 15 and 19

years. Since the age at marriage in Kenya has increased there is a need to include the 20-24 age group when studying contraceptive use among the youths.

Since most studies carried out in this field have been focusing on adolescents, i.e. only those aged between 15 and 19 years, it therefore implies that only a few married cases are captured since at this age most people have not been married instead it is the time most young people are preparing to get married. This study therefore attempts to fill this gap in knowledge.

1.2 Objectives of the Study

1.2.1 General Objective of the Study

The general objective of the study is to identify the socio-economic, socio-cultural, demographic and intervening factors influencing contraceptive use among the youth in Kenya.

1.2.2 Specific Objectives of the Study

i. To establish the demographic factors influencing contraceptive use among the youth in Kenya.

ii. To establish the socio-economic factors influencing contraceptive use among the youth in Kenya.

iii. To establish the socio-cultural factors influencing contraceptive use among the youth in Kenya.

iv. To establish how intervening factors affect socio-economic, socio-cultural and demographic factors in influencing contraceptive use among the youth in Kenya.

1.3 Justification of the Study

The study seeks to examine the determinants of contraceptive use among young women in Kenya. The increasing fertility trend in Kenya today is a major concern for health planners and programmers. The information will help in designing interventions aimed at reducing fertility and related problems of unwanted and mistimed pregnancies in Kenya and sub-Saharan Africa in general.

The study will also inform reproductive health providers about the exact determinants that affect contraceptive use among youths and hence enable them to take appropriate initiatives in remedying the abnormality.

The study also seeks to enrich the existing knowledge and enable researchers to have a better understanding of the determinants of contraceptive use among the youth in Kenya.

1.4 Scope and Limitations of the Study

The study uses secondary data for women (married and unmarried) aged 15-24 years, obtained from the Kenya demographic and health survey (KDHS), 2003. This data set was collected from the whole country including North Eastern province that has always been left out in most studies.

In this study, the effect of abortion on contraceptive use has not been examined since it is considered illegal in Kenya and therefore the data available is insufficient in both 1998 and 2003 KDHS data sets.

Lastly the non-numeric response cases are excluded from the analysis due to computation reasons; however it is my view that their small proportion would not significantly alter the results.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

According to the Population Council, 1997, although teenage fertility is not increasing in Kenya, what is increasing is the percentage of births to unmarried teenagers. A study conducted in Brazil found that despite near universal knowledge of contraceptive methods, 20% of all births were to teenagers in the year preceding the 1996 survey compared with 12%, 10 years earlier. Another study quoted by population council of Kenya report indicates that 50% of child bearing in Kenya before the age of 20 involves a premarital conception (Bledsoe and Cohen, 1993).

The United Nations publications indicate that adolescents comprise about 20% of the world's population and most of them are found in the developing world. The growing numbers of young women in sub-Saharan Africa is as a result of past high fertility in this region. According to internet sources, about 15 million babies are born to adolescent mothers each year. Results from Demographic and Health Surveys (DHSs) from Asia, Africa and Latin America show that about 8 in every 10 of these babies born in the developing countries are born to teenage mothers. In Dominican Republic, fertility rate for 15-19 year–old had increased from 91 births per 1000 to 112 per 1000 between 1989 and 1996 (Maguuni et al., 2000).

According to the study carried out in Kenya and Nigeria on influences of adolescents' sexuality, young people know more about and have favorable

altitude towards abortion than modern contraception (Barker and Rich, 1992). Another study carried out in Nigeria indicated that among 1,800 never married women age 14-25, of those who had experienced sexual relations, half of the students and two-thirds of non students had been pregnant and nearly all had ended their pregnancies with abortion (Nicholas et al., 1986).

2.1 Contraceptive Use among the Youth

Few unmarried couples use contraceptives before their first sexual intercourse. A study in Latin America and Caribbean revealed that among young women 15-24 years, only less than 43 percent used contraceptives before first sexual intercourse. Premarital sexual activity therefore results in unintended pregnancies. A study in Zimbabwe showed that out of 200 16 deliveries in Harare Maternity Hospital had become pregnant within 3 months of starting sexual activity. Common reasons given by young people for non-use of contraceptive are that they do not expect to get pregnant and lack of knowledge about contraception.

Even when young people can name contraceptives, they might not know where to get them or how to use them. In Kenya and Nigeria, students had heard about contraceptives but incorrectly cited dangerous side effects (Population Report, 1995). Results from a study carried out in Kenya by National Council for Population and Development (NCPD) in 1997 showed that adolescents wanted

to be taught about family planning and how a woman gets pregnant (NCPD, 1997).

A study carried out in South Africa showed that young people face high levels of unwanted pregnancy and HIV/AIDS. The South Africa government has cited the high incidence of unwanted pregnancy among the youth as one of the major challenges facing the country. More than one third of women nationally have their first pregnancies occur outside marriage, and most of them were either unwanted or unplanned. Evidence from 1990s suggested that many young women become pregnant intentionally, to demonstrate their fertility, and return to school after the birth of their child. However more recent studies have found women often want to avoid pregnancy at an early age.

In many countries, sex discussion is a taboo even among married couples. In such culture, it would be harder for young people to discuss sex matters and some people believe that planning sex activity spoils the fan while others believe that use of contraceptives encourages promiscuity. Such attitudes may not prevent sexual activities but increases vulnerability to STI and unwanted pregnancies. Young women may also not have skills to negotiate for safe sex especially when involved with old men and when sexual intercourse is forced or unwanted. It is widely asserted that increased gender equality is a prerequisite for achieving improvements in female reproductive health. The program of action adopted at the 1994 international conference on population and

development claimed that improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in their area of sexuality and reproduction. For instance, in Nepal, the low social status of women has been identified as a hindrance to progress towards national health and population policy target.

HIV/AIDS is a threat to young people. Out of the population infected with HIV, about 25% are below 25 years and many contracted HIV before age 20. A study in Zimbabwe showed that 30% of pregnant girls aged 15-19 years were HIV positive. Young people may also not use condoms consistently and are likely to have first sexual intercourse without condoms. Young people once they are sexually active are also likely to change sexual partners often transmitting STIs even more. Young people are embarrassed to discuss STIs and are more likely to buy drugs over the counter or from the street other than going for complete medical check ups. Incomplete treatment only masks the symptoms and may lead to infertility in future. Infertility is fragile for women in culture, where children are primary means to social status.

In developing countries, poverty forces girls to prostitution. Teenage prostitution is a double tragedy for younger people who are not able to negotiate for safe sex especially from older men who are infected with HIV and STIs. STIs' pathogens move easily and penetrate mucous membrane of young women than

for older women and are therefore more vulnerable to infections like gonorrhea, Chlamydia, and *papilloma* virus, which causes cancer.

Young people suffer from physical and emotional trauma through sexual abuse and incest. It may not be possible to know the magnitude of the problem because most sexual assaults go unreported as it happens at home, among relatives and acquaintances of neighbours, however, sexual abuse in childhood may lead to early onset of consensual sexual activity. A study on this showed that among 93% of young people who were pregnant, before age 17, two thirds reported having been sexually abused as children (Pop Report, 1995).

2.2 Determinants of Contraceptive Use among the Youth.

Adolescence is a transitory stage of development whereby the individual acquire adult characteristics roles including reproductive roles. As girls progress through the teenage stage, more and more of them are initiated to sexual activities and reproduction. Kenyan data showed that in 1998, the proportion of girls who were mothers or pregnant with first child increased from 3.3% among those aged 15 years to 44.9% among the nineteen year olds. A study by Kiragu, 1991, show that among Kenyan adolescents, an increase of one year was associated with 45 and 21 percent rise in sexual activity among females and males respectively. However, the study found no significant association between age and contraceptive use.

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Onsongo, 1991, found that women who are married as expected have the highest contraceptive use rates as compared to those who are divorced, separated or single. Single women have the lowest contraceptive rates although the difference between their rates and that of the divorced/separated was negligible.

Ojakaa, 1986, shows that married women have the highest levels of contraceptive use. The minority are the widowed. The researcher concluded that the currently married women contributes the majority in contraceptive use because they are at greater risk of conception by virtue of having a husband and being aware of this greater risk, they may avoid being contraceptive non-users. In addition family planning in Kenya mainly focuses on married women.

In Kenya it is a common belief that the issue of family planning is mainly a concern for those who are married and those with families. The introduction of family planning methods especially when done indiscriminately has been a controversial issue in the country, where one school of thought supports the adoption of family planning by anybody who is sexually active (including school girls), the other school of thought opposes the advocacy of the methods to everybody. The church in Kenya is very concerned and opposes the introduction of the methods to the youth or to those who have no family to plan for. The fact is that the youth form about 50 percent of our population and about 35 percent of the births are by children mothers.

In sub-Saharan Africa, the married adolescents are likely not to use modern methods of family planning as they may be under pressure to have children quickly, (Magnani et al., 2000). Age at marriage has been increasing over the last few decades, but a substantial proportion of girls still marry in their teens. Among the newly married, the motivation to engage in contraception may be suppressed by the society's pressure on the young wife to give birth and prove her womanhood (Mensch et al., 1998). Furthermore, those who marry early are likely to come from societies with high fertility norms hence the married adolescents may not engage in contraception even after the realization of a birth. They are also likely to be people of low educational aspirations and achievement; hence they may have low levels of reproductive and contraceptive knowledge. They are also likely to come from low socio- economic background and so they may lack the necessary finances to procure contraceptive services.

Analyses of DHS data in sub-Saharan Africa indicate that married adolescents are less likely to use contraception than unmarried adolescents. In the early 1990s in Nigeria, for example, 11 percent of sexually active unmarried adolescents and only 1 percent of married sexually active ones were using contraceptive. Married adolescents use contraceptive more to space births than to delay age at entry into sexual union. On the other hand, unmarried sexually active adolescents are likely to be attending school so they are more highly motivated to delay child bearing in order to attain educational goals (Caldwell, et

al., 1998). Their higher educational attainment relative to the married is likely to ensure they have more knowledge on reproduction and contraceptive.

In a Senegalese study, four percent of adolescent women and seven percent of adolescent men surveyed have ever visited a family planning clinic. Reasons cited for non-use of services include unmarried status (among women), embarrassment, cost, and poor reception by clinic staff, lack of knowledge about sexuality, concern about the efficacy and side effects of contraceptives, and contradictory social perceptions around premarital sex and contraceptive use, (Nare C. et al., 1997).

Religious adolescents regardless of religious denomination are at least likely to experience early sexual initiation (Moore and Rosenthal, 1993). Besides acquisition of religious values, a religious adolescent is likely to associate with other religious youths hence peer group works to reinforce the values. Strict religious prescription may explain the great variations in the rate of unmarried adolescent pregnancies in Asia and Africa.

Religious instructions prohibiting premarital sex may not be helpful to adolescents who have already initiated sex: it might well serve to push the adolescents further away from religious values into more premarital sex. Jorgenson, (1993) further argues that religious adolescents who become sexually active are less likely to use contraceptive because to employ contraception in a premeditated manner would be admitting to themselves and their partners that

they are planning something wrong within the context of their religious value system.

Most major religious denominations in Kenya teach against premarital sex and some of them are against the whole idea of contraceptive use. The Catholic Church is on record for burning condoms in public (Mulindi, 2000). Such strong disapproval of premarital sex and contraceptive use may translate into late age at sexual debut but low level of contraceptive use among sexually active adolescents.

In contrast to wide spread thinking in the 1970s, the efficacy of mass media exposure for promoting family planning is increasingly getting widely accepted today. Recent findings suggest that exposure to family planning messages on radio, television and the print media is strongly associated with contraceptive behaviour (Westoff and et al, 1993). Adolescents today are exposed to a wide range of sexual behaviors on television, movies and videos and of importance is the fact that sex act in the mass media is explicit (and usually takes place between unmarried partners) hence teenagers know what sex is and how it is enacted at increasingly earlier ages (Moore et al., 1993). This eroticism on its own may increase the youth's desire to experiment with sexual behaviors.

The models shown in most films do not encourage the female youths to be assertive since female models are passive victims; they do not get out of their problems through their own efforts but by attracting the man with their look or

sex (Moore et al., 1993). In addition, mass media rarely portrays planning for sex or the consequences of sex, and the idea of contraception is simply ignored. According to Peggy et al., 1989, media messages are overwhelmingly exploitative, provocative, permissive and unsafe towards practicing safer sex by using contraceptives. On the other hand, mass media may make people aspire for higher status and goods whose acquisition may entail postponement of reproduction and fertility regulation (Freedman, 1979).

Rural or urban type of place of residence also has been found out to have a significant effect on contraceptive use among the youth. There are various avenues through which type of place of residence may influence a youth's contraceptive behaviour, including access to mass media channels, socio-economic endowment of their parents, and parental supervision. Urban residence may be associated with higher levels of exposure to mass media, which implies that urban youths are likely to have more knowledge about contraception, and are likely to hold norms that favour delay of entry into parenthood.

On the other hand, the sexual behaviours portrayed on the television and print media may encourage initiation of sexual activity (Moore et al., 1993), but their effects may be cancelled out by housing constraints and consequent lack of privacy in urban areas (Kiragu, 1991). In addition, urban areas are associated with higher socio-economic endowment, which is associated with contraceptive

use. Again, since urban residence is associated with low TFR in Kenya (NCPD, CBS and MI, 1998), adolescents in urban areas are more likely to be inclined to use contraceptive in future. These adolescents are also more likely than their rural counterparts to have higher rates of sexual activities because they may date working class men who presumably have their own dwelling units and who may also facilitate contraception (Kiragu, 1991).

Several studies have shown that age at first intercourse is declining, suggesting that today's young adults are becoming sexually active at younger ages (Pop. Reports, 1992, Kane et al., 1993, Kiragu, 1995). Other studies (McCanley et al., 1995; Kiragu et al., 1995 have shown that few of them use contraceptives which results in situations such as dropping out of schools, early marriage and contracting sexually transmitted diseases. The school has been associated with reproductive and contraceptive behaviour of adolescents; school may be source of information on sex through peer networks, and from teachers and school books including family life education books. On the other hand, type of school may offer opportunity for sexual experience. A study on Kenya showed that girls in mixed schools and day schools were more likely to be more sexually active than girls from single stream and boarding schools (Adebayo, 1996). The school environment may indirectly encourage sexual activities especially among female adolescents.

There is an extensively positive association between female education and contraceptive use (Caldwell, 1982). This is further evidenced by the demographic and health surveys conducted by Macro International since the late 1980s. DHS data reveal that contraceptive prevalence rates are lowest in Sub-Saharan Africa, apart from Zimbabwe, Kenya and Botswana which are said to have reached moderate prevalence levels. Indeed lowest levels of female educational attainment are found in Sub-Saharan Africa and North Africa where a large proportion of women have never attended school and lack basic literacy skills. These low educational standards could thus explain the low contraceptive prevalence rates as revealed above.

In Asia and Latin America where favourable education attainments are found, contraceptive use is reported as moderate to high with prevalence rates ranging from 48% in Indonesia to 65% in Thailand (Castro et al., 1995). However in some areas of Latin America, namely Bolivia, Guatemala and El-Salvado, contraceptive prevalence rates are below 33%. These three regions are reported to be far from reaching the goal of universal literacy.

The influence of education on fertility and contraceptive use is assumed to have been derived from various dimensions of the educational experience. Schooling provides literacy skills, enables pupils to a wide range of information and also simulates cognitive development. Schools are also important agents of socialization with a crucial role in shaping attitudes, opinions and values.

Exposure to new ideas and alternative lifestyles might lead a person to question traditional norms, and practices. In addition to promoting cognitive and attitudinal change education opens up economic opportunities and provides a vehicle for social mobility. All those educational assets have a pervasive influence on women's lives shaping both production and reproductive roles (Kesarda et al., 1989; Eiseman, 1987; Devnrus, 1992).

Currently, schooling status of the adolescents also has an influence in adolescent's contraceptive behaviour. Adolescents who are currently attending school are likely to have more motivation to avoid pregnancy compared with those who are not attending school since pregnancy may act as a barrier to attainment of educational goals. Moreover, peer group norms among such adolescents are likely to be supportive of contraceptive use hence such adolescents are likely to have more knowledge of contraceptive technology and to use contraceptive compared with those not attending school.

Schooling remove adolescents from their homes, provides them with information that often contradicts parental instructional, and allows young people of both sex to interact without family supervision (Caldwell et al., 1998). The longer the duration between puberty and marriage, the higher the likelihood of engaging in pre-marital sex. Education offers younger people with the opportunity to loosen parental control (Caldwell, et al., 1998) hence it may be associated with pre-marital sex among adolescents. On the other hand, education

increases one's knowledge of the means of controlling fertility largely as a result of access to many communication channels. These factors way increase the likelihood of contraceptive use among unmarried adolescents to delay child bearing.

Education may also increase one's self- efficacy in making decision on sexual activity and reproduction. More educated young girls are more likely to have confidence to acquire contraceptive and, more importantly, to discuss contraceptive with their partners all of which are associated with contraceptive use. In addition, education gives the woman the power in decision-making, which leads to effective contraceptive use.

In the contemporary world, contraceptive use of individuals tends to vary with income. In a comparative study carried out by Manlook, (1982), there was a very negligible difference in the level of contraceptive use between the working and the nonworking women in Costa Rica, Jordan and the republic of South Korea. She found that in the Philippines and the Panama the use of contraception among working women was 14 percent and 17 percent respectively, high than among non-working women. However in Peru she found out that women who were employed used contraception at the rate of 20% lower than the unemployed women. Taha and Abdelhany (1981) conducted a study in Egypt and found that the contraceptive use rate of women classified as in top white collar group was higher than those of women classified as blue collar group. Even the

contraceptive use of the low white collar group was lower than that of the blue collar workers, farmers and services. This was attributed partially to the difference in childlessness among occupational groups and partially to defective data.

Empirical evidence indicates that effective contraception is less likely to occur when the individual desires a pregnancy, lacks cognitive development required in making complex decisions, has low educational and occupational aspirations, lacks accurate knowledge about human sexuality and facts relating to contraception, is unable or unwilling to plan for sexual encounter that may be sporadic and unexpected, and finally, if the male adolescent believes that contraception is the females responsibility , and the female believe that it is the males responsibility (Jorgensen, 1993).

Religion has generally been found to be negatively related to premarital sexual behavior and contraceptive use. Religions persons regardless of denomination are less likely to be sexually active (Devaney et al., 1981, Sparier, 1976).This is not surprising as sexual values encourage conservatism and restraint as are promulgated by most religious.

Casterline, Peres and Biddlecom, (1997) developed a framework to explain the unmet need for contraception. According to their framework, unmet need is an artifact of survey measurement, fertility preferences or contraceptive practice inaccurately measured, or it can be a result of certain obstacles to the use of

contraceptives among women who would otherwise wish to do so. The second set of the framework posits that certain factors serve as obstacles to the use of contraceptives for women who apparently should be using them in order to reach their reproductive goals.

2.3 Summary of Literature Review

In summary contraceptive use among the youth seems to be affected by many factors as emulated from the literature review. These ranges from demographic factors to socio-economic factors and socio-cultural factors. Therefore the study aims at examining these factors to determine which ones influence contraceptive use among the youth in Kenya the most.

2.4 Conceptual Framework

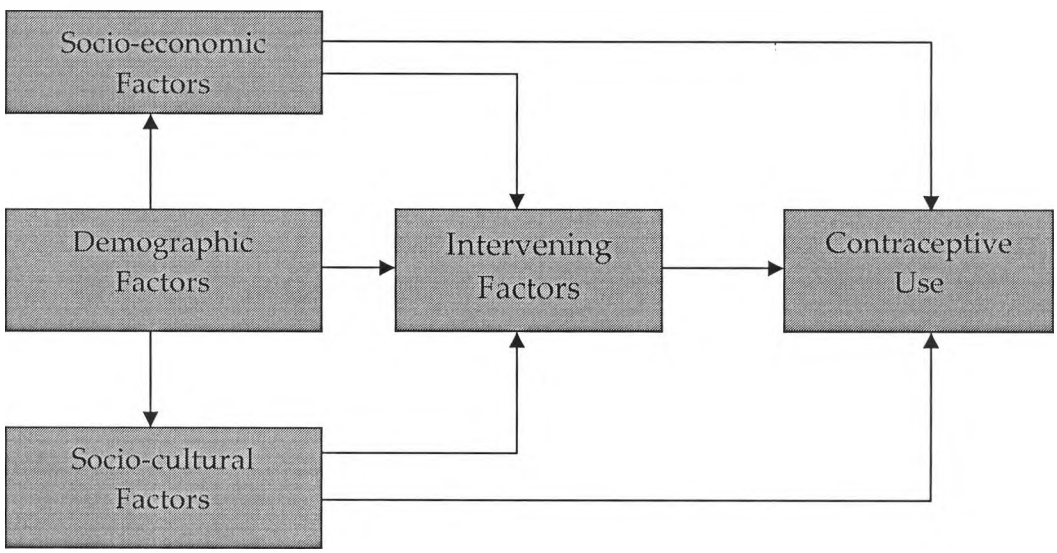
Casterline et al., 1997, developed a framework, to explain the unmet need among women. According to this framework unmet need is an artifact of survey measurement, fertility preferences and contraceptive practice inaccurately measured, or it can be a result of certain obstacles to the use of contraceptives among women who would otherwise wish to do so. The second set of the framework posits that certain factors serve as obstacles to the use of contraceptives for women who apparently should be using them in order to

reach their reproductive goals. The framework has been modified in order to suit this particular study.

According to this study background and intervening factors have been used to serve as the obstacles that prevent young people from using contraceptives. The background factors may act directly to influence contraceptive use or they may act through intervening factors to do the same. This study will analyse the direct effect and the indirect effect (acting through intervening factor) of the background factors in influencing contraceptive ever use among the youth in Kenya. The study will also control for intervening and demographic factors to assess their influence on contraceptive use.

Figure 1: Conceptual Framework

Background factors **Intervening Factors** **Dependent Variable**



SOURCE: Casterline, Perez and Biddlecom, 1997 (Modified).

2.4.1 Conceptual Statement

Although contraceptive use is directly influenced by intervening factors, it is also affected, promoted or modified by socio-economic, socio-cultural and demographic characteristics existing in a society.

2.4.2 Conceptual Hypotheses

i. Socio-economic factors are likely to influence contraceptive use among the youth.

ii. Socio-cultural factors are likely to influence contraceptive use among the youth.

iii. Demographic factors are likely to influence contraceptive use among the youth.

iv. Intervening factors are likely to influence demographic, socio-economic and cultural factors in influencing contraceptive use among the youth.

2.4.3 Definition of Concepts

Demographic Factors: It refers to age and marital status

Social-Cultural Factors: This includes religion and ethnicity.

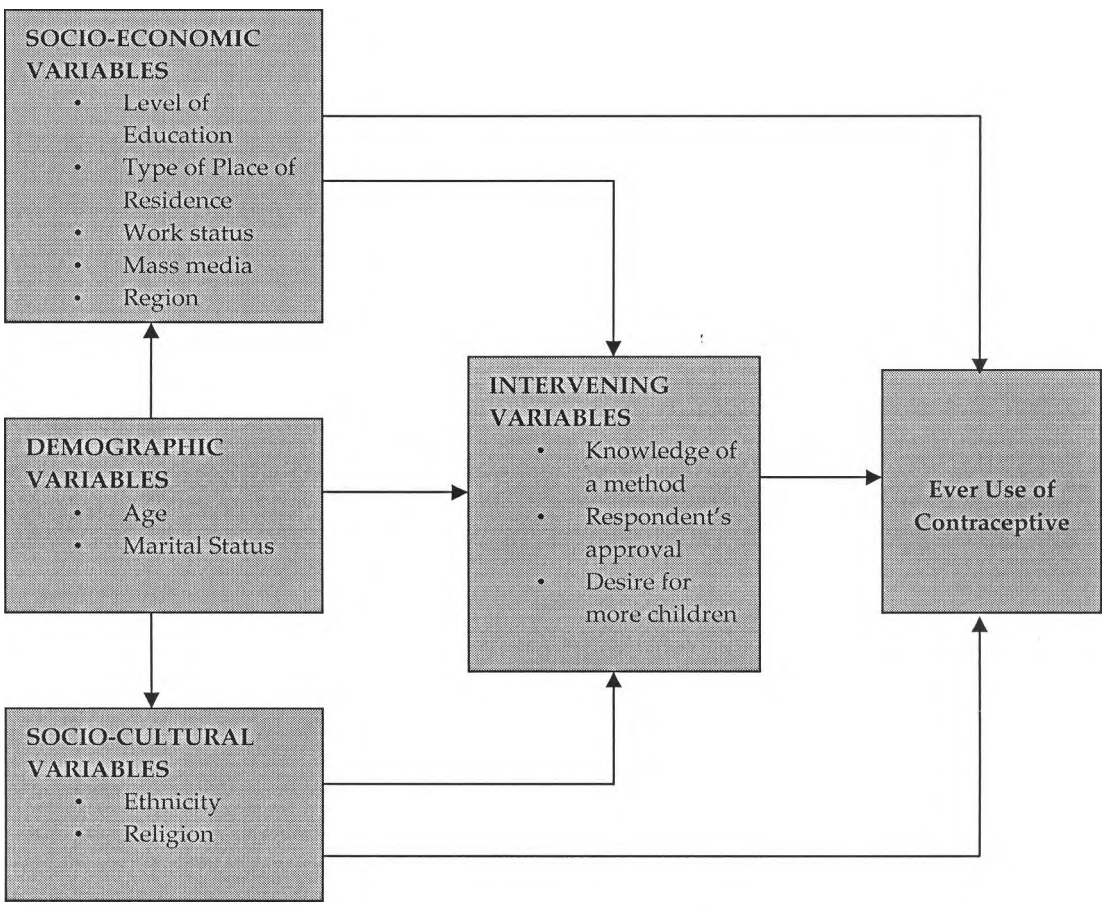
Social-Economic Factors: This refers to region of residence, type of place of residence, level of education, current working status and mass media exposure.

Intervening Factors: This refers to those factors through which other factors act to influence contraceptive use. The include knowledge of a contraceptive method, approval of contraceptive use and desire for more children.

Youth: This term has numerous definitions by different scholars. According to the population council, a youth is a person who is at the age of between 10 and 24 years. This is the period or stage between childhood and adulthood. For the purpose of this study a youth refers to somebody who is between the age of 15 and 24.

2.5 Operational Framework

Figure 2: Operational Framework for determinants of youth contraceptive use.



2.5.1 Operational Hypotheses

i. There is a significant positive association between age and contraceptive use among the youth.

ii. There is a significant positive association between marital status and contraceptive use among the youth.

iii. There is a significant association between ethnicity and contraceptive use among the youth.

iv. There is a significant association between religious affiliations and contraceptive use among the youth.

v. There is a significant positive association between level of education and contraceptive use among the youth.

vi. There is a significant association between region of residence and contraceptive use among the youth.

vii. There is a significant association between type of place of residence and contraceptive use among the youth.

viii. There is a significant positive association between exposure to mass media and contraceptive use among the youth.

ix. There is a significant positive association between current working status and contraceptive use among the youth.

x. There is a significant association between a woman's desire for more children and contraceptive use among the youth.

xi. There is a significant association between a woman's approval for contraceptive use and contraceptive use among the youth.

xii. There is a significant positive association between knowledge of a contraceptive method and contraceptive use among the youth.

2.6 Definition of Operational Variables

2.6.1 Dependent Variable

Ever use of Contraceptive: This refers to whether somebody has ever used a contraceptive method or not.

2.6.2 Independent Variables

Age: A demographic variable that refers to how old the respondent was at the time of the survey. In this study, youths have been categorised into two age cohorts; 15-19 and 20-24.

Marital status: This refers to whether a youth is married or not married. In this study the variable has been categorized as ever married and never married.

Religion: This refers to a particular system of religious affiliation where one is affiliated. This study has categorised them into the following four categories: Catholics, Protestants, Muslims and other religion/no religion.

Ethnicity: This includes the various ethnic communities in Kenya. These are:, Kamba, Kalenjin, Kikuyu, Kisii, Luyia, Meru, Mijikenda/Swahili and other tribe.

Level of education: education is defined as the transmission of ideas, knowledge or values through the formal system. The variable can be defined as the level of schooling a youth has had and can be classified into three categories: no education, primary, and secondary plus education.

Region of residence: This refers to the province in which the youth lives. It includes all the eight provinces in Kenya. These are: Nairobi, central, Eastern, Coast, Western, Nyanza, Rift Valley and North Eastern.

Type of place of residence: This refers to either rural or urban area of residence of the youth.

Work status: This refers to the current working status of the sampled population. This variable has been categorized as either working or not working.

Mass media exposure: This refers to the exposure to radio, television or the print media. This variable has been categorized into either exposed or not exposed.

Knowledge of any method: As the name suggests it refers to whether the respondent has any prior information of any contraceptive method.

Respondent's approval of contraceptive use: This refers to whether the respondent approves the use of contraception or not.

Desire for more children: It refers to the woman's future fertility preference and it has been categorised as whether the respondent wants a child or not.

2.6.4 Summary of Operational Variables

The operational definitions of variables are summarized by the table below.

Table 1: Summary of variables employed to establish the determinants of contraceptive use among the youth

Variable	Variable Type	Recoded Categories
Ever use of contraception	Dependent	0 = Never used 1 = Ever used
Knowledge of a method	Independent	0 = Don't know a method 1 = Knows a method
Desire for more children	Independent	0 = Don't desire more children 1 = Desires more children
Respondent's approval of contraceptive use	Independent	0 = Don't approve 1 = Approves
Age	Independent	1 = 15-19 (Early Youth) 2 = 20-24 (Late Youth)
Marital status	Independent	0 = Never married 1 = Ever married
Religion	Independent	1 = Roman catholic 2 = Protestant 3 = Muslim 4 = No religion/other
Ethnicity	Independent	1 = Kikuyu, 2 = Luhyia, 3 = Meru, 4 = Kamba 5 = Kisii, 6 = Kalenjin 7 = Mijikenda/Swahili,

		8 = Other tribes.
Region of residence	Independent	1 = Nairobi, 2 = Central, 3 = Coast, 4 = Eastern, 5 = Nyanza, 6 = Rift Valley, 7 = Western, 8 = North Eastern.
Education Level	Independent	1 = None, 2 = Primary, 3 = Secondary, 4 = Higher
Type of place of residence	Independent	1 = Urban, 2 = Rural
Mass media exposure	Independent	0 = Not exposed, 1 = Exposed
Current working status	Independent	0 = Not working, 1 = Working

CHAPTER THREE: DATA AND METHODOLOGY

3.0 Introduction

The chapter discusses the sources of data for this study and its analytical methods. It is divided into two sub-sections. The first section examines issues relating to data sources, data quality, and the study population while the section two presents the variables used in the study. Finally section three presents the analytical methods.

3.1 Data Source

The study uses data drawn from the 2003 Kenya Demographic and Health Survey (KDHS).

3.2 Sample Design

A representative probability sample of about 10,000 households was selected for the KDHS sample. This sample was constructed to allow for separate estimates for key indicators for each of the eight provinces in Kenya, as well as for urban and rural areas separately given the difficulties in traveling and interviewing in the sparsely populated and largely nomadic areas in the North eastern province, a smaller number of households was selected in this province while urban areas were over sampled.

The survey utilized a two-stage sample design. The first stage involved selecting sample points ("clusters") from a national master sample maintained by

CBS (the fourth national sample survey and evaluation programme (NASSEP IV). The list of enumeration areas covered in the 1999 population census constituted the frame for the NASSEP IV sample selection and thus for the KDHS sample as well. A total of 400 clusters, 129 urban and 271 rural, were selected from the master frame. The second stage of selection involved the systematic sampling of households from a list of all households that had been prepared for the NASSEP IV in 2002. The household listing was updated in May and June 2003 in 50 selected clusters in the largest cities because of the high rate of change in structures and household occupancy in the urban areas.

All women who were 15-24 years who were either usual residents of the households in the sample or visitors present in the household on the night before the survey were eligible to be interviewed in the survey. In addition, in every second household selected for the survey all mean age 15-54 were eligible to be interviewed if they were either permanent residents or visitors present in the household on the night before the survey.

3.3 The Study Population

For this particular study, the study population is 2132 women aged 15-24 who reported to have had sex by the time of the interview.

3.4 Data Analysis Methods

3.4.1 Descriptive Statistics

In order to understand the characteristics of the population, percentages were used to describe the distribution of the variables.

3.4.2 Cross-Tabulation

At the bivariate level, Cross-tabulations were used to test the association between the dependent and independent variables. Cross tabulation is a form of contingency distribution in which two nominal scale variables are cross-classified. Cross tabulations show the frequency distributions according to each category of the two variables of interest; hence they are useful in comparative analysis. This is a simple analytical method although it has the limitation that it does not control for the effect of other variables and thus further analysis is necessary.

3.4.3 Logistic Regression

In this study, logistic regression will be used since the dependent variable (contraceptive use) is dichotomous. It is either ever use or never use. Logistic regression uses the concept of maximum likelihood and results are analysed using the iteration method. The odds ratios obtained from this analysis estimate the relationship of each independent variable to the outcome (dependent)

variable, while simultaneously taking into account all other variables in the regression model.

The logistic regression model is specified as: -

$$P(X) = 1 / (1 + Exp - (\beta_0 + \beta_1 X_1 + \text{--------} + \beta_p X_p)$$

Where,

P(X) = The probability of an event occurring

B = Coefficients estimated

X = Independent variables

The implication of this equation is that the probability, PX, of the occurrence of the dependent variable depends on the independent variables X_1, X_2 ------ X_p (age, region of residence, marital status, religion e.t.c).

Logistic regression is used to analyse data where the dependent variable takes values either 0 or 1. Such data is generated by yes/no responses. The odds ratios generated permit direct observation of the relative importance of each independent variable in predicting the likelihood of the outcome, for instance, contraceptive use compared with the reference category. A negative value of β_i means the independent variable reduces the likelihood of making the observation. Odds ratio is the probability of having the observation to not having it then computed by exponentiating β_i.

CHAPTER FOUR: DETERMINANTS OF CONTRACEPTIVE USE AMONG THE YOUTH IN KENYA

4.0 Introduction

This chapter entails the analysis of the factors that influence the use of contraceptives among the youth in Kenya. The analysis is based on 2132 women aged 15-24 years old who were exposed to sexual activity by the time of the survey. The relationships between various independent variables and the dependent variable are analyzed using the methodologies, described in chapter three above. From the results, appropriate inferences or interpretations are made to explain the relationship between the dependent and independent variables.

This chapter is arranged by first showing the frequency distribution to assess the nature of distribution of cases in each variable in order to facilitate meaningful bivariate and multivariate analysis. This is followed by showing the association between the dependent variable and the independent variable.

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4.1 Description of Variables.

Table 2 below shows the percentage distribution of the various variables used in the analysis.

Table 2: Percentage distribution of variables

Variable	Percentage
Dependent Variable	
Ever use of contraceptive method:	
Never used a method	53.6
Ever used a method	46.4
Intervening Variables	
Knowledge of a method:	
Knows	94.4
Don't know	5.6
Desire for more children:	
Desires	57.9
Don't desire	42.1
Respondent's approval of contraceptive use:	
Approves	74.9
Don't approve	25.1
Demographic Variable	
Age:	
15-19 years	35.1
20-24 years	64.9
Marital status:	
Never married	35.5
Ever married	64.5
Socio-economic Variable	
Highest Educational level:	
No education/Pre-school	10.9
Primary	63.6
Secondary	21.7
Higher	3.8
Region of Residence:	
Nairobi	15.2
Central	12.8
Coast	10.0
Eastern	12.1
Nyanza	16.6
Rift Valley	15.6
Western	13.1
North Eastern	4.5
Type of place residence:	
Urban	35.1
Rural	64.9
Respondent currently working:	
No	50.8
Yes	49.2

Socio-cultural Variable	
Mass media exposure:	
Not exposed	12.6
Exposed	87.4
Religion:	
Roman Catholic	25.5
Protestant/Other Christians	60.9
Muslim	11.0
Other religion/No religion	2.5
Ethnicity:	
Kikuyu	20.5
Luhyia	16.7
Meru	5.2
Kamba	10.1
Kisii	7.0
Kalenjin	7.3
Mijikenda/Swahili	6.0
Other tribes	27.2
N	**2132**

Table 2 above show that 46.4% of the young population has ever used a contraceptive method while 53.6% has never used a contraceptive method although they have had sex encounters. Those aged between 15 and 19 years constituted of about 35% while those aged between age 20 and 24 years constituted of about 65% of the sample.

As expected the table also show that slightly more than 94% of the respondents reported to have knowledge of at least one method of contraceptive use while less than 6% reported not knowing any method. About 58% of the respondents reported to have a desire for more children while a lesser proportion of about 42% reported not to have a desire for more children. Also as expected about three quarters of the respondents reported to approve the use of contraception as opposed to about one quarter who disapproves their use.

Most of the women are married with only about 35% having not been ever married while 64.5% have ever been married. This is expected because these are the ages when most marriages occur. About 15% of the sampled population lives in Nairobi while 12.8%, 10%, 12.1%, 16.6%, 13.1% and 4.5% live in central, in coast, Eastern, Nyanza, western and North Eastern Provinces respectively.

Kikuyu tribe represents the highest proportion of the sampled youth, 20.5%, followed by Luhyia with 16.7%, Kalenjin 7.3, Kisii 7.0%, Mijikenda/Swahili, 6.0%, Meru 5.2% Kamba 10.1% and other tribes represent 27.2%. This is consistent with the national distribution of the Kenyan population according to tribe where Kikuyus have the largest proportion and the Somalis have the lowest proportion. On respondent's religious affiliations, Roman Catholics represent 25.5% protestant/other Christian 60.9%, Muslim 11.0% and those in other religion/No religion are the least with only 2.5%.

Most of the respondents are literate with only about 11% with no education. The proportion of the young people with primary level of education is about 64% while those with secondary represented about 46% and those with higher are 3.8%. This is expected because the proportion of the population with a higher level of education is expected to decrease with an increase in level. Of the total sampled population, about 35% are living in the urban areas while the majority, 65% are living in the rural areas. This is expected because majority of the Kenyan population lives in rural areas. Almost half of the sampled

population is currently working while the other half is not currently working. This is 49.2% who were currently working and 50.8% who are not working.

Those who are exposed family planning messages through the mass media are about 87% of the sampled population while about 13% are not exposed.

4.2 Relationship Between Ever Use of Contraception and the Independent Variables.

The relationship between the ever use of contraceptive method and each independent variable is analysed using cross tabulation between independent variables and the dependent variable. Table 3 below summarizes the results of the relationship.

Table 3: Percentage distribution of variables on contraceptive use.

Variable	Ever Used (%)	Never Used (%)
Intervening Variables		
Knowledge of a method:		
Knows	49.2	50.8
Don't know	0	100
Desire for more children:		
Desires	46.7	53.3
Don't desire	46.0	54.0
Respondent's approval of Contraceptive Use:		
Approves	45.3	54.7
Don't approve	49.5	50.5
Demographic Variables		
Age:		
15-19 years	33.2	66.8
20-24 years	53.5	46.5

Marital status:		
Never married	42.3	57.7
Ever married	48.7	51.3
Socio-cultural Variables		
Religion:		
Roman Catholic	49.4	50.6
Prot./other Christian	50.7	49.3
Muslim	19.1	80.9
Other Religion./ no Religion	29.6	70.4
Ethnicity:		
Kikuyu	62.5	37.5
Luhyia	51.5	48.5
Meru	52.3	47.7
Kamba	55.6	44.4
Kisii	51.0	49.0
Kalenjin	46.5	53.5
Mijikenda/Swahili	26.6	73.4
Other tribes	29.7	70.3
Socio-cultural Variables		
Level of education:		
None/Pre-school	11.2	88.8
Primary	45.8	54.2
Secondary	62.2	37.8
Higher	67.5	32.5
Region of Residence:		
Nairobi	54.5	45.5
Central	68.0	32.0
Coast	32.2	67.8
Eastern	54.1	45.9
Nyanza	34.6	65.4
Rift Valley	45.0	55.0
Western	51.8	48.2
North Eastern	1.0	99.0
Type of place residence:		
Urban	52.1	47.9
Rural	43.3	56.7
Current working status:		
No	41.5	58.5
Yes	51.5	48.5
Mass media exposure:		
Not exposed	17.9	82.1
Exposed	50.5	49.5

As shown in table 3 above, about half of the young people who know of a contraceptive method have never used any contraceptive method. This is contrary to expectations because it is expected that contraceptive use should be universal. It is expected that once somebody knows of any method that person should be contracepting. As expected for those who don't know any method none has ever used a contraceptive. The proportion of contraceptive ever users among those who desires more children is about 47 percent while the proportion drops by one percent among those who do not desire more children. However this is contrary to expectation because this proportion is expected to be higher among those who do not desire a pregnancy and lower among those who desire a pregnancy. The same reversal scenario is observed where by a slightly higher proportion of women who do not approve contraceptive use actually ever used as compared to those who approve their use. This is not expected because contraceptive use is supposed to be higher among those who approve their use and lower among those who do not approve their use.

For age there is an increasing effect on contraceptive use. Those women in age group 15-19 years have a lower proportion of contraceptive use among them as compared to those in age group 20-24 years. This is expected because of factors like knowledge of contraception and school status which might bar women in the lower age group from using contraceptives. For marital status, the ever married women have a large proportion of contraceptive ever users as

compared to the never married women who do not have sex often like most married women. Even when they have it, most of them do not use any contraceptive method due to the fact that most of them are not married and have not experienced their share of the problems associated with unsafe sexual activities.

Contraceptive ever use according to religion shows that Muslims have the least proportion of contraceptive users while protestants and Roman Catholics have each a proportion of half those who have ever used contraceptives. This is expected because the Muslims have never acknowledged the use of contraceptives as a way of controlling child birth. They believe that they were created to multiply and fill the earth. According to ethnicity, Kikuyu tribe emerges to have the highest proportion of women who have ever used while the Swahili & Mijikenda tribe has the least proportion. This is expected due to the different levels of socio-economic development.

The level of education shows an increasing effect on contraceptive use where by the proportion of contraceptive ever users increases with an increase in the level of education. The proportions which have ever used are 11.2%, 45.8%, 62.2% and 67.5% for those with no education/preschool, primary, secondary and higher categories respectively. This is expected because education increases the knowledge and exposure of an individual to family planning methods. As expected, type of place of residence shows that more women in urban areas have

ever used contraceptives as compared to their counterparts in the rural areas. According to region of residence contraceptive ever use was highest in Central province followed by Nairobi while North Eastern province has the least proportion of contraceptive ever users. This is expected because of different levels of socio-economic development in the different regions within Kenya. Those who are currently working have the highest proportion of contraceptive ever uses as compared to those who were not working. This is expected due to the pressure of work for those who are working hence decreased desire for pregnancy. Mass media exposure as expected shows that those who exposed have a proportion of about 50 percent ever uses against a proportion of about 18 percent for those who are exposed.

4.3 Effect of Independent Variables on Contraceptive Use among the Youth.

Table 4 below summarizes the logistic regression results for ever use of contraception among the youth and the various background and proximate characteristics affecting it.

Table 4: Differentials in independent variables and Contraceptive Use.

Variable	Model 1	Model 2	Model 3
	Exp (β)	Exp (β)	Exp (β)
Level of Education:			
No education/preschool	0.199***	0.160***	0.206***
Primary	0.497***	0.435***	0.438***
Secondary	0.905	0.850	0.855
Higher (Ref)	1.000	1.000	1.000
Type of place of residence:			
Urban	1.437***	1.443***	1.423***
Rural (Ref)	1.000***	1.000	1.000
Work Status:			
Not working	0.712***	0.767***	0.771**
Working (Ref)	1.000	1.000	1.000
Mass Media Exposure:			
Not Exposed	0.523***	0.498***	0.536***
Exposed (Ref)	1.000	1.000	1.000
Region:			
Nairobi (Ref)	1.000	1.000	1.000
Central	2.430***	2.442***	2.455***
Coast	0.949	0.962	0.956
Eastern	2.031***	2.010***	2.024***
Nyanza	0.561***	0.568**	0.551***
Rift Valley	1.183	1.068	1.144
Western	1.288	1.287	1.288
North Eastern	0.057***	0.052***	0.083**
Ethnicity:			
Kikuyu	1.246	1.339	1.292
Luhyia	1.272	1.382	1.325
Meru	0.879	1.096	1.047
Kamba	1.180	1.224	1.179
Kisii	1.920***	2.036***	2.022***
Kalenjin	1.127	1.180	1.142
Mijikenda/Swahili	0.815	0.797	0.707
Other tribes (Ref)	1.000	1.000	1.000
Religion:			
Roman Catholic	1.114	1.322	1.131
Protestant/other Christian	1.155	1.300	1.118
Muslim	1.173	1.186	1.087
Others/No Religion (Ref)	1.000	1.000	1.000
Age:			
15-19	-	0.625***	0.640***
20-24 (Ref)	-	1.000	1.000***
Marital status:			
Never married	-	0.476***	0.486***
Ever married (Ref)	-	1.000	1.000
Knowledge of a method:			
Don't know a method	-	-	0.002
Knows a method (Ref)	-	-	1.000

Approval of use:			
Disapproves	-	-	1.089
Approves (Ref)	-	-	1.000
Desire for more children:			
Don't desire	-	-	0.925
Desires (Ref)	-	-	1.000
-2 Log Likelihood	**2588.508**	**2497.429**	**2467.274**
Chi-square:	**355.943**	**447.017**	**477.172**
R^2	**.154**	**.189**	**.201**
Significance:	**.000**	**.000**	**.000**

Ref = Reference category
****significance at P<0.01, ** significance at P<0.05, * significance at P<0.1*

The primary goal of this study was to establish the determinants of contraceptive use among the youth. As shown in table 4 above the first model of multivariate analysis involves the socio-economic and socio-cultural factors while controlling for demographic and intervening variables. Model two introduced the demographic factors into the analysis while controlling for intervening variables and the last model is the full model which includes all the variables in the analysis. The exponentiated Betas for the three different models are not any different from each other. This shows that Demographic factors and intervening factors do not affect the way the other factors influence contraceptive use among the youth in Kenya.

4.3.1 Demographic Variables and Contraceptive Use.

As shown in table 4, age is a statistically significant variable in influencing contraceptive use among the youth with those aged 15 – 19 years less likely to use contraceptives compared to older women. This is expected because young

women are less likely to be exposed as compared to older women. Marital status is also statistically significant in influencing contraceptive use among the youth. Never married women are less likely to use contraceptives as compared to married women. This is expected because of the need for married women to space between children and the general need for family planning among married women.

4.3.2 Socio-economic Variables and Contraceptive Use

As shown in table 4 above, all the five socio-economic variables used in the model have a significant association with contraceptive use. Level of education shows statistically significant associations with contraceptive use where by an increase in the level of education is associated with an increase in the likelihood of using contraceptives. Those with no education are less likely to use contraceptives as compared to those with higher levels of education.

Women living in urban areas have a higher likelihood of using contraceptives as compared to those living in rural areas. This is expected because those in urban areas are more exposed and are socio-economically more developed. The table also shows that those who are currently not working are les likely to use contraceptives as compare to those who are currently working. This is expected because those who are working are less likely to desire a pregnancy than those who are not working. Exposure to mass media has a positive

association with contraceptive use. Those who are not exposed to family planning message through the mass media are 0.5 times less likely to use contraceptives as compared to those who are exposed. Region of residence shows a significant effect on contraceptive use with central province having the highest likelihood and North Eastern the lowest likelihood as compared to Nairobi province.

4.3.3 Socio-cultural Variables and Contraceptive Use.

Two social-cultural variables are used in this study; ethnicity and religion of residence. However the two variables are not statistically significant in influencing contraceptive use. On ethnicity, apart from the Kisiis all the other tribes have an equal likelihood of using contraceptives. Kisiis are twice more likely to contracept compared to all the other tribes in Kenya. Religion also shows an approximately equal likelihood of contraceptive use among the four different religious categories

4.3.4 Intervening Variables and Contraceptive Use.

Knowledge of a contraceptive method, approval of use of contraceptive method and desire for more children are the three intervening variables used in this study. However all these variables are not statistically significant in influencing contraceptive use. As expected the likelihood of using contraceptives without the knowledge of a contraceptive method is approximately nil as

compared to having knowledge of a method. Contrary to expectation, the likelihood of using contraception for those who do not approve use of contraception is about 1.1 as compared to those who approves. This is slightly higher than for those who approves their use Also contrary to expectation the likelihood of using contraception for those who do not desire more children is slightly less than the likelihood for those who desires more children.

4.4 Summary of the Determinants of Contraceptive Use among the Youth

The study has established that contraceptive use among the youth in Kenya is determined mainly by demographic factors and socio-economic factors. The effect of intervening and socio-cultural factors on contraceptive use is not significant. This is contrary to previous studies which have shown that the other factors act through the intervening factors to influence contraceptive use

The demographic variables which have been found to influence contraceptive use are age and marital status while the socio-economic variables include type of place of residence, region of residence, level of education, current working status and mass media exposure. The socio-cultural variables used in the analysis but were not significant include ethnicity and religious affiliations. For intervening variables, knowledge of a contraceptive method, approval of contraceptive use and desire for more children were used in the regression but turned out to be insignificant.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The primary purpose of the study was to establish the major factors determining contraceptive use among the youth with the aim of filling the existing gaps that existed from previous studies concerning contraceptive use among the youth in Kenya. The findings of the study are summarized below.

5.1 Summary of the Findings

The key findings of the study as presented in chapter four shows that most of the variables used in the analysis affects contraceptive use among the youth in Kenya. However, some variables are not significant in influencing contraceptive use. Three models where used in the analysis. The first model controlled for both demographic and intervening variables while the second model controlled for intervening variables only. In the final model, all the variables for this study were included and the results obtained are not very much different from the results obtained when the variables were controlled for. This shows that demographic variables and intervening variables does not affect the way the other variables influence contraceptive use among the youth.

In the multivariate analysis finding shows that Demographic factors and socio-economic factors are significant whereas intervening and socio-cultural factors are not significant in influencing contraceptive use. The results show that

an increase in age increases the levels of contraceptive use and that married young people are more likely to use contraceptives than unmarried ones. Also an increase in level of education increases the level of contraceptive use. People living in urban areas are more likely to use contraceptives than those who are living in the rural areas. Working status increases the use of contraceptives where by contraceptive use is high among those who are employed than among those who are not employed. Mass media exposure to family planning messages through radio, television and print media doubles the probability of using contraceptives.

Different regions of residence have different levels of contraceptive use but those regions which are more developed have higher probabilities of contraceptive use than those that are less developed. The same way different tribes have different probabilities of contraceptive use and more developed tribes have higher probabilities of using as compared to those tribes that are less developed.

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Intervening variables are not significant in influencing contraceptive use among the youth in Kenya because the likelihood of contraceptive use does not change with all without the inclusion of these variables in the analysis. The inclusion of these variables in the analysis is not statistically significant.

5.2 Discussions

Contraceptive use among the youth in Kenya is mainly affected by both demographic and socio-economic variables. However socio-cultural and intervening variables do not necessarily influence contraceptive use although to some extent they have some impact. These results conform to the existing literature on the topic. Among the socio-economic factors, level of education, type of place of residence, current working status, and mass media exposure are the main variables that are found to determine contraceptive use among the youth in Kenya. Region of residence also determines the probability of using but not as much because results obtained for some regions were not statistically significant.

The two variables used as socio-cultural factors in the study did not show any significance in determining contraceptive use among the youth. Contrary to the existing literature, religion does not show any differences in contraceptive use among the different religious affiliations. The Roman Catholics and the Muslims are known to be against the use of contraceptives as away of controlling child birth and prevention of HIV/AIDS. However this is not depicted from the results obtained on this study. This implies that young people do not necessarily follow what they are told in church hence the results.

Demographic variables have a great effect in the use of contraceptives among the youth in Kenya. Age has a positive effect in the use of contraceptives

with older age group being more likely to use than the young age group. Likewise marital status has a positive effect on contraceptive use with the married ones more likely to use than the unmarried ones.

None of the intervening variables affect the use of contraceptives among the youth. Those who don't know any method can not use contraception while those who have knowledge of any method have at least ever used a contraceptive. There is no difference in the proportion of those who approves the use of contraceptives and those who do not approve them. There is an equal chance of contraceptive use between the two groups. Likewise there are also equal proportions between those who desires and those who do not desire for more children.

5.3 Implications

The primary objective of the study was to investigate the determinants influencing contraceptive use among the Kenyan youth. From the results obtained above, the following implications have been made by the study:

5.3.1 Policy Implications

The principal policy challenge is to design communication strategies that will reach the less privileged, rural and illiterate people who are by far the majority in Kenya. It is recommended that school based dissemination of family

planning information in the context of family life education should be revamped The youth should be educated on the need to use contraceptives to protect themselves from unwanted pregnancies and other ill effects of unprotected sexual activity. This can be done through increased mass media campaigns.

In Kenya, family planning services are available in many hospitals, clinics, and dispensaries. However these services are not friendly to young people who fear from seeking such services publicly. Sexually active young people are therefore disadvantaged as far as access to family planning services is concerned. This lack of access promotes their inadequate use of family planning methods. Although contraceptives use among unmarried young people has been highly criticized, the government officials NGO's, community leaders, church leaders and parents need to provide alternative solutions since knowledge and skills without access to services are worthless (Bandura, 1992). Family planning services should be made widely available and accessible to the young people.

The young people in Kenya form the backbone of economic development and hence for both policy makers and planners, reproductive health issues of young people should form a core value for any planning since its incorporation in planning will ensures that all the relevant policies are achieved.

5.3.2 Implications for Further Research.

The findings underscore the need for further studies in understanding on how the different identified factors affect contraceptive use among the youth. For instance how does education affect the use of contraception? Is it the level of education or the content of education that affects the use? Further studies should identity strategies and interventions that can help increase contraceptive use among sexually active young people in Kenya.

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