FAMILY PLANNING AND WOMEN'S UNMET NEEDS IN KIBERA SLUMS, NAIROBI

BY

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ABSTRACT

Unmet need for family planning is a core concept in international population discourse. The main aim of this study was to explore women's unmet needs in family planning methods in Kibera slums, Nairobi. Specifically the study sought to:- determine the knowledge, attitude and practice (KAP) of family planning amongst women in Kibera; determine the proportion of women accessing and utilizing family planning methods and establish the barriers to access and use of family planning methods that women face.

The study was guided by Westoff and Ochoa's (1991) model for the determination of unmet need for family planning amongst women in reproductive age. The model served as a conceptual framework for understanding the level of women's unmet needs in family planning methods based on the limiters, spacers and none usage. A non-probability sampling procedure was used to identify 100 women within four sampled villages of Kibera. Structured questionnaire complemented with key informant interviews, focus group discussions and case narratives were used as the main data collection instruments. Quantitative data were analyzed using Statistical Package for Social Sciences (SPSS) and qualitative data analyzed thematically.

The study found out existence of a high level of unmet needs in family planning methods amongst women resulting from low level of knowledge, attitude and practice of family planning methods. The study found out that majority of women experiences political, economic, socio-cultural and technological barriers to access and utilization of family planning methods. Therefore this study recommends that family planning methods should be both age and gender sensitive and responsive to the people's knowledge, attitude and practice levels. For efficient and effective family planning programming, both men and women must be fully involved. In addition, the study recommends that family planning methods should be designed to overcome women's barriers to access and utilization of family planning methods.

DECLARATION

This research project is my original work and has not been presented for a degree in any University.

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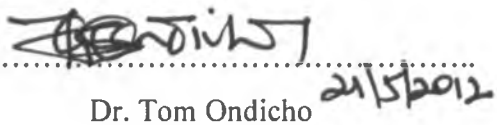
This research project has been submitted with my approval as the university supervisor.



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Dr. Tom Ondicho 21/5/2012

DEDICATION

To wife and children

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Anti Natal Care
CBD	Community Based Distributors
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Surveys
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immuno Deficiency Virus
IPPF	International Planned Parenthood Federation
IAGAS	Institute of Anthropology, Gender and African Studies
IUCD	Intra-Uterine Contraceptive Device
KDHS	Kenya Demographic and Health Surveys
KAP	Knowledge, Attitude and Practice
KIIs	Key Informant Interviews
KNBS	Kenya National Bureau of Statistics
LAM	Lactational Amenorrhea Method
MOH	Ministry of Health
MSF	Medical Sans Frontiers
NGO	Non-Governmental Organization
STDs	Sexually Transmitted Diseases
SPSS	Statistical Package for the Social Science
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USA	United States of America
USCB	United States Census Bureau
U5MR	Under-five Mortality Rate
WB	World Bank
WHO	World Health Organization

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CHAPTER ONE
INTRODUCTION AND PROBLEM STATEMENT

1.1 Introduction

Family planning refers to the planning of; when to have children, when to use birth control and other techniques to implement such plans for spacing and limiting births (WHO, 1995). Therefore, family Planning is an organized plan to prevent unwanted pregnancy and infertility. It also refers to the management and prevention of sexually transmitted diseases (STD's) as well as pre-conception. Thus with proper knowledge of family planning, infant and maternal mortalities due to abortion will most likely be reduced. Family planning can be categorized into two i.e. natural and artificial.

Family planning services are most usually applied to a female-male couple who wish to limit the number of children they have and/or control the timing of pregnancy (also known as 'limiters' and 'spacers' respectively). The techniques commonly used in family planning services include sexuality education, prevention and management of sexually transmitted infections (STIs), pre-conception counseling and infertility management. Family planning services may encompass sterilization as well as abortion (Mischell, 2007). Family planning methods include; male and female sterilization, male and female condoms, hormonal implants, injections, vaginal ring, patch, combine oral contraceptive pills, progestagen only pill, or estrogen free pill, Copper Intrauterine device (IUD) , Intrauterine Device (IUD) with hormone, Diaphragm, natural methods, lactational amenorrhea or breast feeding Methods.

All these family planning techniques are geared towards controlling the population growth. Family planning is related to population growth. The world's population hit a seven billion mark in 2011 (United States Census Bureau, 2011). This population is unevenly distributed between and within the seven continents of the world. This is even more so the case in Africa, which is the second most populated continent. Just like elsewhere in the world, this high and unevenly distributed population exerts great pressure on the already meager resources, particularly in the provision of sexual and reproductive health services (SRH). This is an indication that even at the

global level; family planning services have not fully met the needs, especially of women. Kenya provides a good example of one of the developing countries caught up in a vicious cycle of poverty resulting from rapid population growth against diminishing resources. Efforts to improve living standards and alleviate poverty are overwhelmed by the need to provide basic health services and jobs for the growing number of people.

In order to manage population growth and demographic explosions, the government of Kenya has designed family planning services and offers these services through a range of health institutions. These family planning services benefits people at all levels starting from individual, family, community, national through to global levels. Access to family planning methods is a human right that enlarges women's health options. Family planning aims to enhance quality of life by reducing infant mortality, improving maternal health and alleviating pressure on the government to meet social and economic needs. However, family planning services in Kenya, like other developing countries have not fully met the needs especially of women.

1.2 Problem Statement

The central problem for this study was the high level of women's unmet needs in family planning services in Kibera. The existing literature and practice confirms that women's needs in access and utilization of family planning methods are not fully met due to political, socio-cultural and economic barriers.

According to Ross and Winfrey (2002) more than 100 million women in less developed countries prefer to avoid a pregnancy but are not using any form of family planning methods. Demographers and health specialists refer to these women as having an "unmet need" for family planning, a concept that has influenced the development of family planning programs for decades now.

A report by the United Nations Population Fund (UNFPA, 2009) reveals a range of obstacles that inhibit women from accessing and utilizing family planning methods. These obstacles are political, socio-cultural, economic and technological. Women face access and utilization

obstacles to family planning methods which are further compounded by the low levels of knowledge, attitude and practice (KAP) of family planning methods.

There is a significant lag between knowledge, attitude and practice on the use of family planning methods. As such, up to 100, 000 maternal deaths during pregnancy each year occur in Kenya which could be avoided. Further, women also face political, socio- cultural, technical and structural challenges in accessing and utilizing family planning services. These barriers to access and utilization of family planning services constitute the women's unmet needs in family planning.

The Kenya Demographic and Health Survey (2008) show a 47 per cent contraceptive prevalence rate (CPR). One in every four women in Kenya experience unmet needs for family planning services for spacing and limiting births (KDHS, 2008). This is an indication that greater efforts are needed to understand and address the causes of women's unmet needs in family planning. This is a clear indication that women's family planning needs have not been adequately met alongside their sexual and reproductive health rights, especially for those women within the informal settlements and urban slums.

Resulting from the high level of women's unmet needs for family planning services, this study was designed to probe further and find out the knowledge, attitude and practice levels among women to family planning services; the number of women accessing and utilizing family planning methods, and the barriers they face in utilizing the family planning services in Kibera slums in order to expose the state of affairs that needs to be changed with regard to family planning services.

This study will seek to explore family planning and women's unmet needs in Kibera slums. Meeting the unmet need for contraception in Kenya would avert not only unintended pregnancies, but also unsafe abortions and maternal and child deaths (Smith et al, 2009). It would slow the rapid rate of population growth of which more than half are attributed to unwanted fertility or bedroom accidents (Kekovole, 1998; USAID, 2009). Many Kenyan women would like to postpone their next pregnancy or even stop bearing children but for various

reason they are not using any method of family planning. This is because the family planning programs have not fully met the needs of women. This underscores the primary objective of this research.

1.3 Research Objectives

1.3.1 Overall Objective

To explore and analyze women's unmet needs in family planning in the slums Kibera, Nairobi.

1.3.2 Specific Objectives

Specifically the study sought to:

- To describe the knowledge, attitude and practice (KAP) of family planning amongst women in Kibera slums;
- To determine the level of women accessing and utilizing family planning methods in Kibera slums-Nairobi through survey method; and
- To establish the barriers women face in accessing and utilizing family planning methods amongst women in Kibera slums.

1.4 Research Questions

The research questions arising from the above objectives are:

- What are the levels of knowledge, attitude, and practice (KAP) of family planning amongst women in Kibera slums?
- What percentage of women are accessing and utilizing family planning methods in Kibera slums?
- What are the barriers to access and utilization of family planning methods amongst women in Kibera slums?

1.5 Study Justification

Family planning is a very important component of sexual and reproductive health (SRH) discourse within the development field and academic realm. Family planning programs influence sustainable development due to the intricate relationship between family planning and population growth. A general survey of the literature on women's unmet needs for family planning indicates that there has been no major field research within Kibera slums on this topic. This research therefore fills the gap in literature and improves our understanding on family planning.

Therefore, the study findings are expected to contribute to reviewing strategies and designing gender sensitive family planning programs for addressing women's unmet needs in family planning. The information documented in this report may be used for further follow- up on the magnitude and determinants of unmet need for family planning in Kibera Slums.

Further, this study is justified by its timeliness in Kenya, the country is under new constitutional dispensation with sexual and reproductive health rights (SRH) entrenched as human rights under chapter four (Constitution of Kenya, 2010). The country is also implementing vision 2030 where family planning is a core determinant to sustainable development. Therefore family planning programs receive the much needed response with a view to address the women's unmet needs. The findings and empirical information from this study will be of great use to researchers, practitioners, policy makers and implementers of family planning programs.

According to National Coordinating Agency for Population and Development (NCAPD) publication of June 2010, fulfilling the unmet need for family planning will help Kenya achieve vision 2030 (NCAPD, 2010). It is hoped that the study findings will provide very useful background information and deep insights for attainment of vision 2030and smooth implementation of the constitution with regard to its provisions on sexual and reproductive health rights.

1.6 Scope and Limitation

Scope is a description of the boundary of the research in terms of content, sample size, and geographical and theoretical coverage. Scope is also referred to as the delimitations of the study. On the other hand, limitations refer to hindrances or anticipated constraints or potential weaknesses of the study imposed by the research methodology. The study limitations consider the weaknesses or shortcomings of the research methodology and potential sources of bias.

The delimitation of this study was women's unmet needs for family planning methods. In terms of geographical location, the scope of the study was Kibera slums, Nairobi. The research was limited to a sample size of 100 women either married and or are in active union in Kibera slums. The study design emphasized on women unmet needs, even though men are also affected by the unmet needs in family planning. The calculations of the total women's unmet needs were limited to the categories of women of (18 and 49) years.

1.7 Definition of key terms

Unwanted pregnancy: In this study, unwanted pregnancy will refer to any pregnancy that was not intended which occur by error to a girl when the girl didn't want any child or to a woman after the woman already had the desired number of children and she doesn't want to have any more children.

Mistimed pregnancy: In this study, mistimed pregnancy refers to a pregnancy, which has occurred without intention of the woman or the couples at specific time, but wants to be pregnant and have a child sometime in the future.

Unintended pregnancy: In this study, unintended pregnancy refers to both unwanted and mistimed pregnancies. While intended pregnancy will refer to pregnancy that is wanted and planned for using family planning methods.

Knowledge of contraception methods: Refers to level of knowledge of woman on family planning methods. It will also refer to a woman's awareness of at least one method of contraception. While attitude on contraception method refers to a woman's attitude to access and utilization of family planning method.

Fecund: All women (married or in union) who are neither pregnant nor postpartum amenorrheic, and who either do not want any more children (want to limit family size), or who wish to postpone the birth of a child for at least two years or do not know when or if they want another child (want to space births), but are not using any contraceptive method.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Introduction

This chapter presents a review of literature related to family planning and women's unmet needs. The literature has been reviewed across the following areas: Knowledge, attitude and practices of family planning; access and utilization of family planning methods and barriers to access and utilization of family planning. Finally, the chapter presents the conceptual framework and assumptions that guided the study. The chapter summarizes the main points emerging from the literature reviewed on women's unmet needs in family planning.

2.2 Situation of the world population

Family planning methods is directly related to population growth. Countries with low contraceptive prevalence rate (CPR) are more likely to experience high population growth rate (McKelvey, 2000). According to United States Census Bureau (2011) Asia is the most-populated of the earth's continent, accounting for over 60 percent of the world population i.e. 4,140,336,501 people. The world's two most-populated countries are China and India, accounting for about 37 percent of the world's population. Africa is the second most populated continent, with around 994,527,534 people or 14.6 percent of the world's population.

The third continent is Europe, which has 738,523,843 people who make up 10.8 percent of the world's population, while North America is fourth with a population of 528,720,588 people and they constitute 7.6 percent of the world population. South America is the fifth most populated continent with a population of 385,742,554 people or 5.7 percent and Oceania has 36,102,071 people or 0.5 percent of the world's population. Antarctica is the least-populated region, with about 4,490 inhabitants or 0.1 percent which varies. See Table 2.1 for more details on World's population by continent as at 31st October 2011. Oceania and Antarctica are not permanently inhabited by any fixed population. Antarctica has a small, fluctuating international population,

based mainly in polar science stations. This population tends to rise in the summer months and decrease significantly in winter, as visiting researchers return to their home countries.

Table 2.1: World's Population by continent

Continent Name	%age Pop.	Density (in hab./km^2)	Population (2011)	Most populous country	Most populous city
Asia	60.7%	86.7	4,140,336,501	People's Republic of China (1,341,403,687)	Tokyo (37,730,064)
Africa	14.6%	32.7	994,527,534	Nigeria (152,217,341)	Cairo (19,439,541)
Europe	10.8%	70	738,523,843	Russia (142,905,200)	Moscow (14,837,510)
North America	7.6%	22.9	528,720,588	United States of America (308,745,538)	Mexico City (21,163,226)
South America	5.7%	21.4	385,742,554	Brazil (190,732,694)	São Paulo (19,672,582)
Oceania	0.5%	4.25	36,102,071	Australia (22,612,355)	Sydney (4,575,532)
Antarctica	0.1%	0	4,490 (varies)	Ross Dependency (1,480)	McMurdo Station (955)

Source: http://en.wikipedia.org/wiki/World_population#cite_note-USCBcite-0

A rapid population growth is a burden on the resources of many developing countries. This rapid population growth is as a result of low level of knowledge, attitude and practice of family planning. The unregulated fertility, compromises socio-economic development and political stability of these countries. Many countries consider limiting population growth as an important component of their overall developmental goal to improve living standards and the quality of life of the people.

Family planning strategies are now enhanced by the availability of effective modern contraceptive methods since the beginning of 1960s with a view to controlling births. Many international institutions and organisations such as the World Health Organisation (WHO), World Bank (WB), United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) have strongly advocated for family planning as a means to space children and limit family size.

In the developing countries, 76 million women still experience unintended pregnancies each year with 19 million resorting to unsafe abortions. Many of these abortions are done by quacks and performed under unsafe conditions (WHO, 2000). According to Rosen and Conly (1998), the sub-Saharan Africa population has doubled in 25 years since the mid-1970s even after taking into account declining birth rates and rising deaths resulting from AIDS. This is partly because large families are still the norm in Africa. According to the World population structure, 60 per cent of the sexually active population are youth who are about to enter their reproductive years (World Bank, 2009).

Between the mid-1960s and 1990, the percentage of couples in the developing world using contraception went up from an average of 9% to 53% (World Health Organization (WHO), 2001). Disparities still occur between developed and developing countries. Developing countries suffer from scarcity of resources and information, falling donor support. Estimates of maternal mortality indicates that every year, about 515,000 women die from causes related to pregnancy and childbirth, a rate of over 1,400 maternal deaths each day, and a little short of one death every minute Another estimated 62,000,000 acute morbidities per year occur during pregnancy, childbirth or in the postpartum period worldwide, and these estimates might well be twice as high (WHO, 2001).

Many low-income countries are caught in a vicious cycle of poverty; efforts to improve living standards and alleviate poverty are overwhelmed by the need to provide basic services and jobs for the growing number of people. Government resources are stretched thin even to provide minimal level of education, health care including family planning, housing, water and sanitation. In order to manage the rapid population growth and demographic explosions, the government designed family planning services. However, these family planning services have not fully met the needs especially of women. Family planning services benefit people at all levels starting from the individual, family, community, national to global levels and to enhance the quality of life by reducing infant mortality, improving maternal health and alleviating pressure on governments to meet social and economic needs. Access to family planning methods is a human right that enlarges women's health options.

According to the United Nations Population Fund (UNFPA, 2009) at least 200 million women worldwide want to use safe and effective family planning methods but are unable to do so because of the low knowledge, attitude and practice, limited access and utilization of family planning services and disapproval by husbands and communities (UNFPA, 2009). In the Sub Saharan Africa, more than half of women give birth by age 20, a proportion that has remained substantially unchanged over the years. This early marriage shortens the span between the generations and also contributes to greater population momentum and a high rate of population growth.

In Kenya for instance, the level of women's unmet needs in family planning stands at 65%. This is relatively high even though there seem to be some progress made during the last 30 years on family planning. Initially, people were opposed to modern family planning due to cultural and traditional beliefs and practices; today the uptake of family planning methods has increased even though the needs have not been fully met especially for women in informal settlements. Women within the informal settlements such as Kibera slums constitute the greatest proportion with unmet needs. This is an indication of unmet needs in family planning methods.

According to the National population census of 2009, Kenya has a population 38 million people. The level of unmet needs still remain relatively high in Kenya with one in four women experiencing unmet needs in family planning (KDHS, 2008). Couples have been able to benefit from family planning services however more than 120 million people worldwide are still without access to family planning services. Rosen and Conly (1998) observe that the need for voluntary family planning is growing fast, but the unmet needs in family planning remains. It is estimated that the 'unmet need' will grow by 40 per cent during the next 15 years. Family planning services have helped millions of couples avoid unwanted pregnancies and thus have contributed significantly to reducing fertility rates (UNFPA, 2009).

At the national level, between 1977 and 1998, Kenya registered a rapid increase in contraceptive use and a substantial decline in fertility i.e. from an average of 8.1 children per woman in 1977 to 4.7 in 1998. The contraceptive prevalence rate (CPR) for modern methods increased during this period from 7 per cent in 1977 to 30 per cent in 1998 (Population Reference Bureau, 2009).

After 1998, however, the increase in contraceptive use and decline in fertility lost momentum. This is because family planning begun to lose ground as an international development priority with more focus being put on HIV and AIDS. Between 1998 and 2003, there was little change in the contraceptive prevalence rate, the total fertility rate increased from 4.7 in 1998 to 4.9 in 2003. Since family planning programmes were integrated with HIV and AIDS programs (KNBS, 2004). According to the Kenya Demographic Health Survey, contraceptive use has registered a significant increase to 46 percent from 39 percent in 2003 (KDHS, 2008, KNBS and ICF Macro, 2010). From 2003 the fertility rate declined from 4.9 to 4.6 births per woman between 2008-2009 (UNFPA, 2009).

According to the Kenya National Bureau of Statistics report 2010 (KNBS, 2010), one in four currently married women in Kenya has an unmet need for family planning. This rate of unmet need for family planning has not diminished in more than a decade in Kenya. This unfulfilled need for family planning has caused 43 per cent of unintended births among women aged 15–49 years. One harmful outcome of unintended pregnancy is abortion. In Kenya, each year, an estimated 316,560 abortions—both spontaneous and induced—occur; that is 46 abortions for every 1,000 women of reproductive age per year. (Guttmacher Institute, 2008). Some of the reasons that contribute to women's unmet needs in family planning include; fertility-related issues i.e. desire to become pregnant, infrequent sex, infertility or menopause; opposition to use on the part of the woman, her partner or others, or perceived religious prohibition; lack of knowledge about a method or the source of a method; method-related health concerns such as fear of side effects, cost, inconvenience, lack of access (Westoff, 2002).

The level of unmet need is not static. It is always changing, depending on the interplay between fertility desire and contraceptive use. Thus the level of unmet need in family planning methods keeps on changing (Sita, 2003; Devakumar, 2011). The unmet needs for family planning services increases, as more women want to control their fertility, and it falls, as more use contraception. This study will seek to explore family planning and women's unmet needs in Kibera slums. Meeting the unmet need for contraception in Kenya would avert not only unintended pregnancies, but also unsafe abortions and maternal and child deaths (Smith et al., 2009). It

would slow the rapid rate of population growth in Kenya, more than half of which is attributed to unwanted fertility (Kekovole, 1998; USAID, 2009).

2.3 Knowledge, attitude and practice on family planning

Contraceptive knowledge is a precondition for use of family planning services. Bongarts and Westoff (2000) stated that the low level of knowledge of family planning methods contributes to the low attitude and practice of family planning. Women who have adequate knowledge of family planning are more likely to have positive attitude towards contraception. Low contraception prevalence rate and the effectiveness which may lead to unintended pregnancies and induced abortion. According to Kenya Demographic and Health Survey (2008) about 85% of couples who stops using contraceptives will become pregnant within one year, this is an indication of a high fertility rate. Thus, even the least effective form of contraception is considerably better than using nothing. There are a number of family planning methods available to the couples. These methods can be divided based on several criteria such as natural/artificial, traditional/modern, temporary/permanent, male/female and oral/injectables/IUCDs.

Natural family planning means abstinence from sexual intercourse during fertile period to prevent pregnancy. This includes the rhythm method (the calendar method), mucus method, basal body temperature method or a combination of these methods. This method has no systemic or long-term side-effects. However, these methods are based on the timing of the women's fertile period, which can be highly unpredictable, even if their cycles are regular. The timing is even less predictable for women with irregular menstrual cycles. The fertile period occurred during a broad range of days in the menstrual cycle. On every day between day 6 and 21, women have at minimum a 10% probability of being in their fertile period. Only about 30% of women had their fertile period entirely within the days of the menstrual cycle identified by the clinical guidelines, which is between day 10 and 17 and only 10 percent of women ovulate exactly 14 days before the next menses. Most women reach their fertile period earlier and others much later (Stan Becker, 1999).

In Malaysia, abstinence during fertile period is the third most popular contraceptive methods used among all ethnic groups (Rohani et al, 1988). Some couples find that abstinence during the fertile period is difficult to practice consistently as it produce undesirable tension in their relationship. Other traditional methods include coitus interrupts or male withdrawal, which is one the oldest method of contraception. The husband withdraws the penis just before ejaculation to ensure that all sperms are deposited outside the vagina. It is a simple method, moderately effective, widely acceptable by well-adjusted and motivated couples and does not require any professional supervision. It is the commonest traditional method used among all three ethnic groups in Malaysia (ibid).

Lactational amenorrhea method (LAM) is a contraceptive method that relies on, or uses, the state of infertility which results from exclusive breastfeeding. Other criteria necessary are that the woman is still having lactational amenorrhea and up to six months post-partum. When these criteria are met, LAM can be more than 98% effective in preventing pregnancy (Hight-Laukaran V *et al*, 1996). As presently defined, the method is effective for a maximum of six months, yet a large proportion of women remain protected from pregnancy beyond this time. Only about 5% (3-10%) of breastfeeding women have been known to conceive during amenorrhea during the first year postpartum.

Barrier methods of contraception prevent sperm in the ejaculate from entering either the vagina or the cervical by either mechanical or chemical means, or both. It includes male condoms, female condoms, diaphragms and cervical caps. It creates a barrier that prevents sperm from reaching the ovum. Male condoms are one of the most commonly used contraceptives. It is one of the oldest methods used to prevent pregnancy and sexual transmission of diseases. They were initially made from animal skins but most modern condoms are made from latex or polyurethrane. Use of condoms is advocated as an effective primary prevention for HIV/AIDS in the fight to control of the current epidemic.

Spermicides can be used as a primary birth control method or as an adjunct to the barrier methods. They are chemical barriers that kill or inactivate sperm in the vagina before they can move in to the upper genital tract. The spermicides are surfactants – surface – active compounds

that can destroy sperm – cell membranes. These barrier methods are safe and fairly effective if used consistently and correctly. It also can be used as a backup method in cases of failure by the barrier methods.

Hormonal methods are the most popular family planning methods used worldwide. There are several types of hormonal contraception available. These include oral contraceptive pills, which include combined oral contraceptive pills, progestogen only pills and post coital contraceptive pills, injectables and implants

The first oral contraceptive, Enovid was marketed in the USA in 1960. Since then, many different steroidal contraceptives have been developed, progressively containing lower doses of estrogen and progestogen/progestin. More than 200 million women have used these preparations worldwide since 1960. The oral contraceptive pill is the best – known modern method and the commonest family planning method used in Kenya (FHOK, 2011). By 1965, the pill had become the most popular birth control method used in the United States.

Combined oral contraceptive pills contain two hormones, an estrogen and a progestin that come in packets of either 21 or 28 pills. The 21 pills pack contains only active pills and requires women to take a seven days break in between packs. The 28- pills pack contains 21 active pills and 7 inactive or hormone free pills. There are three types of combined pills, which are monophasic pill, where the hormone content is constant in all 21 active pills, biphasic pills and triphasic pills, where the ratio of estrogen to progestin varies among the active pills. Progestogen only pills contain only progestin and no estrogen. They are especially suitable for women who are breastfeeding since this type of pills does not affect milk supply and quality.

The Kenya Demographic, Maternal and Child Health Survey (2008) reported that 84% of currently married women have heard of at least one family planning method and slightly less than 80% reported knowing a modern method and oral contraceptive pill was the most widely known modern method at more than 75% of currently married women (FHOK, 2010).

Post-coital contraceptive pills are intended for emergency use and must be taken within 72 hours of a single episode of unprotected coitus and repeated exactly 12 hours later to prevent pregnancy. This method is indicated in a woman who is exposed to unexpected and / or unprotected sexual intercourse such as cases of rape. Worldwide, this emergency post-coital contraception has been used extensively for over two decades. The options currently available include progestin alone (levonorgestrel, 750 mcg (Prostinor), an estrogen –progestin combination, which comprises of combination of 100 mcg ethinyl oestradiol and 500 mcg levonorgestrel, which is called yuzpe regimen. The pregnancy rate in these treated women varies from 1 % to 4 %, depending on the stage in the cycle when coitus occurred and also depends on the timing of the pill used. A recent analysis of the timing of pill use suggests an inverse linear relationship between efficacy and the time from intercourse to treatment. The earlier the pills were used, the more effective they were during the 72 hours period studied. Delaying the first dose by 12 hours increased the odds of pregnancy by almost 50 % (Hans Vemer , 2008).

Injectable forms of hormonal contraception are considered safe, very effective, simple to use and easy to administer. Injectable contraceptives are among the most effective reversible contraceptive available, with a failure rate less than one percent after a year of use. It is particularly suited to the needs of young women, providing very high efficacy rate and less complication. The disadvantages include irregular bleeding, weight gain and delayed return to fertility. Injectable contraceptives work in several ways to prevent pregnancy. The primary action is the inhibition of ovulation. Besides that, it also increases the viscosity or thickness of the cervical mucus, making it less permeable to sperm penetration to the uterine cavity (Hans Vemer , 2008).

Another type of hormonal contraception is the contraceptive implant. It is an effective, long acting, reversible, low dose progestogen-only product, suitable for use in family planning programs along with other currently available contraceptive preparations and devices. It offers long term contraception and is an alternative to the irreversible methods of contraception. Implant is inserted subdermally in the first seven days of menstrual cycle and once in place it requires no further attention by the user. However, it must be inserted or removed by a specially trained health professional. The mode of actions includes inhibitions of ovulation, suppression of

endometrium and increase the viscosity or thickness of the cervical mucus. The effectiveness of this method is comparable to combined oral contraceptive pills and intrauterine device. Amenorrhea is common after insertion of implants, reported by 20% of users at any time in the first two years (Hans Vemer , 2008).

Intrauterine contraceptive devices (IUCDs) are small plastic devices that come in different sizes and shapes and have a life span ranging from one to five years. It prevents pregnancy primarily by preventing fertilization. Fertilization is prevented by a foreign body sterile inflammatory reaction in the endometrium that prevents sperm from reaching the fallopian tubes. In the past, there were objections to IUCDs as it believed to function primarily as an abortifacient, preventing implantation of the fertilized egg. The IUCD is inserted in to the uterus through the cervix by a trained health professional at any time convenient to the user, normally within the first seven days after normal menses, or within the first seven days post abortion, or six to eight weeks post-delivery, or within five days of unprotected sexual intercourse (Takkar et al, 2005).

Sterilization is a permanent contraceptive option available to couples that have decided to end bearing child. Female sterilization involves occlusion or transaction of the fallopian tubes, commonly referred to as 'tubal ligation'. Male sterilization is performed by vasectomy. In many developed countries, this remains the most popular method in couples over 35 years. Female sterilization is the most common birth control method at 30% worldwide for married couples, followed by intrauterine devices at 20% and contraceptive pills at 14% (Hamilton, 1997). Despite calls for increased involvement of men in contraception, only the traditional methods of withdrawal and condoms are available (Takkar et al, 2005).

2.3.1 Knowledge about family planning methods

Contraceptive knowledge is a precondition for use of family planning services. Bongarts and Westoff (2000) stated that low level of contraceptive knowledge results into low contraception prevalence rate and the effectiveness which may lead to unintended pregnancies and induced abortion. The level of knowledge about family planning is low in many developing countries. In a study of seven African countries, Burundi, Ghana, Liberia, Mali, Niger, Senegal, and Uganda

less than 40% of married women were able to name any family planning method spontaneously. Some of the contributing factors to this low level of knowledge amongst women include: ignorance and misconception of family planning services, high level of illiteracy, lack of access to relevant information. In most cases women are not exposed to public forums.

In Nigeria, for example, only 44% of married women recognized any family planning method (DHS, 1990). In all surveyed countries except Mali, Niger, Senegal, and Togo, awareness of modern methods exceeds awareness of traditional methods often by a wide margin. In Pakistan, 77% of married women recognized a modern method compared with 26% who recognized a traditional method and in Mexico 93% and 72%, respectively. Among all surveyed countries oral contraceptives and female sterilization are most widely recognized, followed by injections and IUCD. Male sterilization is least known method of family planning in the world (DHS, 1990).

According to the Demographic Health Survey (1990) misconceptions about modern contraception lead to low approval of family planning methods thus resulting in unmet needs. Thus, the low level of knowledge on family planning methods is a key contributing factor to women's unmet needs in family planning. The Demographic Health Survey (1990) distinguish between the unmet needs for "limiting" births among women who want no more children, and the unmet need for "spacing" among those who want to delay their next birth by at least two years. Women who want to either postpone or avoid childbearing but are not using contraceptives are more likely to be young, poor, living in the urban slums, particularly in remote regions of the country, poorly educated, and less likely to have discussed family planning with their husbands or partners than women who use contraception.

The Demographic Health Survey (1990), shows that unmet need for family planning is high among young women (18–29 years of age), that is, women in the more fertile age group. The 18-49 cohort of women, have high levels of unintended pregnancies. The unmarried, sexually active adolescents have difficulty accessing contraceptive services; therefore they suffer the most unmet needs. As a result nearly half (47 percent) of births among Kenyan adolescents are unintended, but wanted later or not at all (KNBS and ICF Macro, 2010). Younger women are also more likely than older women to have an unmet need for spacing because they are more apt

to want more children. Amongst older women, most unmet needs are for limiting births because these women have had as many children as they want, and often more. Unmet need for limiting births rises with age and peaks among women over age 40. Therefore, once there is no knowledge of, or a dislike for contraception, or the use is inconsistent among sexually active women, the result will be an unintended pregnancy (Bongarts and Westoff, 2000).

2.3.2 Attitude towards family planning methods.

According to Bongarts and Bruce (1995) about 85 per cent of women desire to know more about contraceptive methods indicating a positive attitude. However, family planning services have not reached them. Furthermore income levels, have direct bearing on the levels of women's unmet needs. The lower the income, the higher the unmet need. This suggests that lack of income and other factors associated with poverty, are barriers to obtaining contraceptives.

Women living in rural areas of Kenya have higher levels of unmet need for family planning compared with those living in urban areas 27 per cent versus 20 per cent. Urban women have greater access to family planning clinics and services (Family Health Options Kenya (FHOK), 2008). They also want fewer children than rural women and have a greater interest in avoiding pregnancy. Higher unmet need in rural areas of Kenya reflects the more limited availability and acceptability of family planning among women in these areas (ibid).

2.4 Access and utilization of family planning methods

According to United Nations Population Fund (UNFPA, 1998) an estimated 570 million couples Worldwide were using contraception. In developing countries the percentage of married couples using contraception has increased from less than 10 per cent in the 1960s to 55 percent in 1998 and still continues. For a 15 percent increase in contraceptive prevalence results in approximately one less birth per women on average. According to the World Health Organization (1998,) North America has the highest rate of modern contraceptive use at 67 per cent, while Africa has the lowest contraceptive use at 15 per cent. Amongst the developing world, Asia, including China,

has the highest rate of contraceptive use an estimated 83 percent of married women of reproductive age (UN, 1994)

A study conducted in Kenya by the Population Council of Kenya (2008) at different times show a variation in contraceptive use and contraceptive prevalence rates between urban and rural ranging from 2 per cent in rural to 35.5 per-cent in urban areas. The ever-used rate is 17 per-cent for all contraceptives, 14 per cent for modern and 6 per cent for traditional methods. The most commonly used modern method among currently married women is the pill followed by injectables. Married women in urban areas are nine times more likely than their rural counterparts to use a modern method of family planning due to accessibility. The Contraceptive Prevalence Rate (CPR) for married women who are currently using a method of family planning is 8 per cent in Kenya (KDHS, 2008). The CPR for modern methods stands at 6 percent while only 2 per-cent of currently married women are using traditional methods.

2.5 Physical barriers to family planning methods

There is a gap between the number of women who want two children and the actual number of children they have. This is a strong indication that many women who wish to limit their family size, face difficulty in doing so. This is due to the physical barriers to access to the family planning methods. The physical barriers include distance and lack of facilities.

The Demographic Health Survey (DHS, 1990) categorized the physical barriers to family planning methods according to the demographic barriers, socio-economic barriers and cultural barriers to women's access and utilization of family planning methods. These are further explained here below:-

2.5.1 Demographic factors

According to Westoff (1998) demographic factors constitute barriers to family planning methods. These demographic variables among others include age, number of children surviving, desired number of children. Age play a very important role in choosing family planning methods

to use. Women with ages above 40 years may use female sterilization as a method for family planning, while women below age 20 are likely to use pills for birth control.

2.5.2 Socio-economic and cultural factors

Socio-economic and cultural factors are a barrier to access and utilization of family planning methods. Within the traditional African society, family planning was mainly natural with polygamy practiced. The cultural and customary practices did not allow a man to have sexual intercourse with a lactating mother, thus lactational amenorrhea method (LAM) was preferred. Their sexual desires were satisfied with other women in the polygamous marriage. This influenced the use of family planning methods for birth control and spacing. Things have changed over time and family planning services necessary even for polygamous families.

Breast feeding mothers were expected to space their births until such a time that the child stops breast feeding is when the mother could get pregnant again. This culture has so far changed yet the people have not changed their perception. The resistance to change from the old tradition is a contributing factor to the high level of women's unmet needs in family planning. Among the socio-economic factors that affect contraceptive use and unmet needs to family planning method include: place of residence, religion or fatalistic reasons, work status/occupation, education, husband or relatives disapproval, lack of knowledge about contraceptive methods, actual or perceived fear of side effects are considered to be important (Westoff, 2001). Women who have easy access to family planning methods due to place of residence are less likely to suffer high levels of unmet needs.

2.5.3 Difficulties with access to methods and quality of services

In most countries, unmet need is greatest among women who that have least access to family planning programs i.e. rural and urban poor women have problems accessing the family planning services. Further, women with little education have low level of knowledge on family planning services hence greater levels of unmet needs. According to the Demographic Health Survey

(1990) 44 countries reported that 57 per cent of women cited lack of access to family planning method as the main reason for not using contraception.

The difficulty with access to quality family planning methods is higher amongst women who have never used contraceptive methods than among those who have tried contraception. Lack of access to people's preferred family planning method and service is a formidable obstacle. Satisfying people's various contraceptive needs requires a range of contraceptive methods. Thus, the more contraceptive methods are available in a country, the lower the level of unmet need.

2.5.4 Health concerns and side effects

Many countries covered under the Demographic Health Surveys (1990) indicated that majority of women suffer from high level of unmet needs due to concerns about health and contraceptive side effects. These concerns come from a variety of sources, including women's own experiences in using contraception, experience of friends and the rumors that often result as these experiences are told and retold throughout the communities which further influence the levels of unmet needs.

2.5.5 Lack of information

Women who are aware of many contraceptive methods know where they can be obtained. They also understand the side effects associated with the family planning method and they know how to use the methods. These category of women with adequate information are less likely to have unmet need. Further, women who have the information and lack money for the family planning services also suffer from the unmet needs.

Analysis of Demographic Health Survey data (1990) from 44 countries showed that for each additional contraceptive method that is widely available in a country, contraceptive prevalence increases by an average of 3.3 per cent. More than half of this increase comes from meeting unmet need. In addition to lack of preferred methods various other costs limit family planning.

Many potential clients do not use contraception because of monetary, psychological, physical and time related costs constraints (Bongarts and Bruce, 1995).

The more contraceptive methods that women know, the lower their level of unmet need and vice versa, as findings from the Demographic Health Survey of 1990 illustrate. In the Dominica Republic, for example, among women who know three methods or fewer, unmet need is more than twice as high at 35 percent as among women who know six methods or more which stand at 14 percent. Lack of awareness of any contraceptive method is most likely to explain unmet need in countries with little contraceptive use, as in Sub-Saharan Africa. This is because, if a woman does not know about contraception then, she also does not know about lack of availability or side effects (UNFPA, 1994). On knowledge of availability and how to use contraception, women must not only know about the existence of contraception itself, but also what services are offered, where and when.

2.5.6 Opposition from spouse husbands, families and communities

According to Schuller et al (1994) many women do not use contraception because their husbands are opposed. Only one- third of women use contraceptive with their spouse, husbands, family and community approval. According to the Kenya Demographic Health Survey (2008), women with unmet need are less likely to be contraceptive users because of their husband's disapproval. In Botswana only 47 percent of women with unmet need think that their husbands approve of family planning compared with 22 percent of contraceptive users. In Pakistan the difference is even more striking 32 percent compared with 83 percent.

According to Bongarts and Bruce (1995) lack of support from extended families and community leaders also discourages some women from using contraception. In Kenya, mothers in- law prevent some women from using contraception because they think it would weaken the control of the husband's family or that their daughters in- law should not expect anything different from their own experiences. In Bangladesh, Nigeria, Pakistan, and Senegal, religious opposition is one of the main reasons that women gave in the Demographic Health Survey of 1990.

2.5.7 Little perceived risk of pregnancy

When a woman believes that she is unlikely to become pregnant she is unlikely to be interested in contraception. Women with unmet need for limiting birth are much more likely than potential spacers to think that they face little risk of pregnancy-probably because most women with unmet need for limiting are older. Among limiters who do not intend to use contraception, for example, 32 percent think that they are at risk of becoming pregnancy compared with only 15 percent among spacers (Bongarts and Bruce, 1995)

Knowledge, attitude and practice on how to access and use family planning services are key factors to addressing women's unmet needs in family planning. When women are empowered with the right knowledge they will have a positive attitude towards family planning and they will implement the best practices on family planning hence they will be able to address the unmet needs of family planning.

2.6 Conceptual framework

This project was guided by the conceptual framework developed by Westoff and Ochoa in 1991 titled Framework for determination of unmet need for family planning among currently married/union women in reproductive age (figure 2.1). The model was developed to ascertain the level of women's unmet needs in family planning.

The basic tenets of this conceptual framework is that women who are currently married or are in union have unmet needs for using family planning methods for either limiting birth, spacing birth or are not using any family planning method.

The framework postulates that women who become pregnant have the likelihood that the pregnancy was intended or unintended due to method failure, mistiming or completely unwanted. On the other hand, women who are not pregnant are either fecund or infecund. Thus this conceptual framework guided the study in establishing the total unmet needs of women in Kibera slums Nairobi.

2.6.1 Model for determination of unmet need for family planning

The model by Westoff and Ochoa (1991) captures key objectives of this study namely: to assess the level of knowledge attitude and practice; to determine the level of unmet needs in family planning; and to establish the barriers to access and utilization of family planning methods by women in Kibera slums.

In order to establish the total unmet needs of women the research targeted women who are currently married or are in union both pregnant or amenorrheic and not pregnant. The study established the level of unmet needs based on the limiters, spacers and none usage of family planning methods amongst women in Kibera slums. This model captures the variables that this study used for analysis.

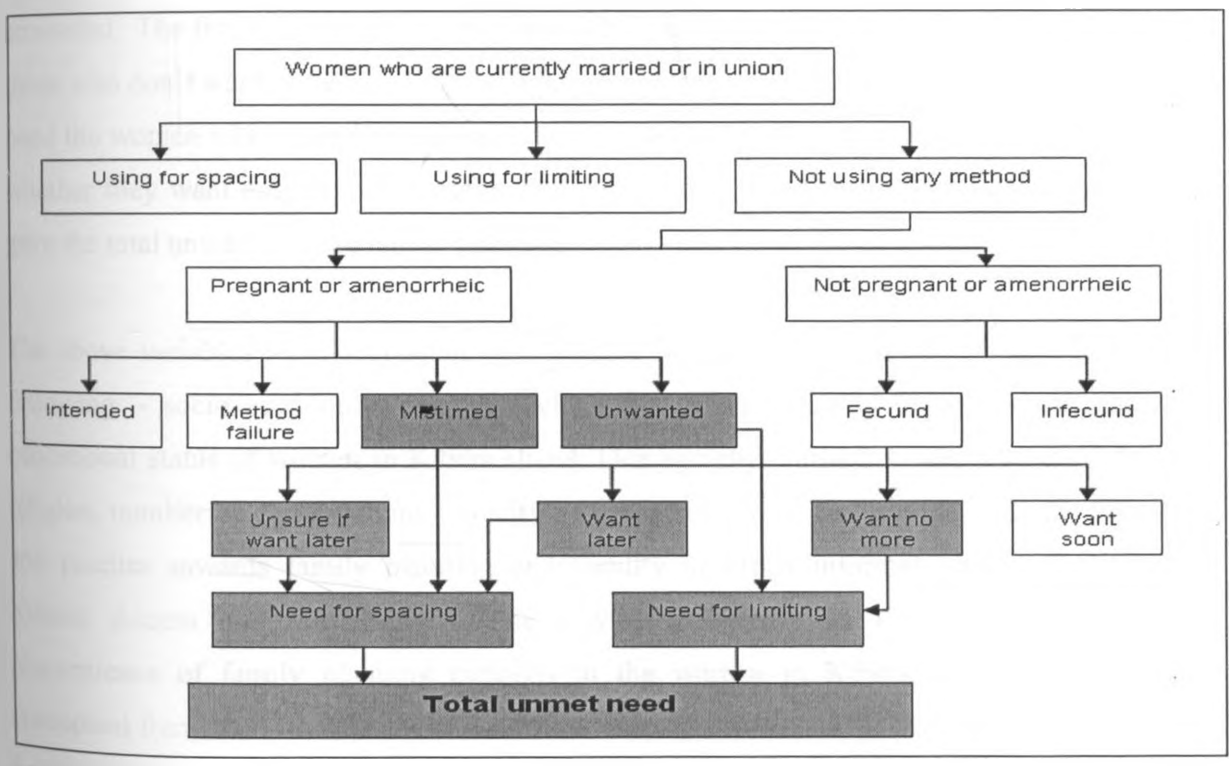


Figure 2.6: Framework for determination of unmet need for family planning among currently married/union women in reproductive age. Source: Westoff and Ochoa (1991).

2.6.2 Relevance of the conceptual framework to this study

The above model was applied within the conceptual framework that women's unmet needs are with regard to spacing birth and limiting birth. The model was used to determine the total unmet needs of women in family planning. The model captures both dependent and independent variables. The dependent variables in this study was the proportion of women currently married or are in union and are using family planning method for spacing or limiting birth as well as women who are not using any family planning method but willing to use.

Those women currently married or are in union and not using any family planning method were clustered as pregnant or not pregnant. Further the 'not pregnant' women were to be categorized as fecund and infecund while the pregnant women were categorized as those who intended to be pregnant, those who became pregnant because of method failure, pregnancies mistimed and unwanted. The fecund women were further categorized as those who want to give birth soon and those who don't want more thus they need family planning method that limits birth. On the other hand the women who had mistimed and unwanted pregnancy were categorized as those not sure whether they want another pregnancy or not sure of another. The sum total of these variables gave the total unmet needs in family planning.

The above variables were dependent on a number of independent variables which include the following: - socio economic variables such as the monthly family income, occupation, and educational status of women in Kibera slums; Demographic variables: age, sex, marital status, religion, number of children, and ethnicity of urban residence; Knowledge, attitude, behaviour and practice towards family planning and fertility of urban informal settlement women of Kibera; Access and availability of the service to women in Kibera and Acceptability /convenience of family planning methods to the women in Kibera. This study used this conceptual framework to assess and determine women's unmet needs in family planning within Kibera slums.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology and context in which this study was carried out. Having reviewed the relevant literature to the present study in chapter two, the aim of chapter three is to describe the study setting and research methodology. The chapter is organized as follows. The first section presents a brief description of the general profile of Kibera the study area. Secondly, the methods of data collection including primary and secondary data gathered and analyzed for the achievement of the objectives of the study. The research methodology entails subsections on survey technique, questionnaire design, and sampling. Thirdly, the chapter presents the study limitations and methods used for data analysis and presentation.

3.2 Research Site

The research area selected for this study was Kibera slums in Nairobi, Kenya. Kibera, one of the biggest and famous slums in Africa, is located approximately seven kilometres to the Southwestern part of Nairobi, Kenya's capital city. Generally, the whole of Kibera is an informal settlement covering approximately 250 hectares of land divided into thirteen villages namely: Lindi, Kisumu Ndogo, Soweto, Makina, Kianda, Mashimoni, Siranga, Undugu, Gatuikira, Laini Saba and the newly founded Raila village. Kibera slums are located within Nairobi County, formerly Nairobi province.

Nairobi city is the capital of Kenya and a business hub of East Africa. The name "Nairobi" comes from the Maasai phrase *Enkare Nyirobi*, which translates to "the place of cool waters". However, it is popularly known as the "Green City in the Sun" and is surrounded by several expanding villa suburbs. Nairobi city was founded in 1899 as a simple rail depot on the railway linking Mombasa to Uganda. The town quickly grew to become the capital of British East Africa in 1907 and eventually the capital of a free Kenyan republic in 1963. During Kenya's colonial period, Nairobi city became a centre for the colony's coffee, tea and sisal industry. Nairobi city

lies on Nairobi River, in the South of the nation, and has an elevation of 1795 m above sea-level. Nairobi is the most populous city in East Africa, with a current estimated population of about 3 million. According to the 2009 national population census, Nairobi's administrative area contains 3,138,295 inhabitants who live within 696 km^2. According to the National Population Census report, the population of Kibera was 170, 070 people living in 131, 901 households (KNBS, 2010). Of these, 48% were male and 52% were female which indicate a slight overall majority of female population. With an average population density of 2,000 people per hectare, Kibera is an overcrowded area with approximately 95% of the residents living below the poverty line of one US dollar or less a day.

The living conditions in the Kibera slums are pathetic with more than 8 people occupying a small room measuring approximately 10 by 10 feet. Most of the houses are made of mud and roofed with either corrugated iron sheets or covered with polythene paper. With no properly functioning sewerage, electricity and running tap water, the environment is unhygienic thus exacerbating the spread of upper respiratory infections and other infectious diseases. Most of the social problems that are often associated with urbanization such as high crime rates are also prevalent. A majority of the women in Kibera are directly dependent on men in general and husbands in particular for their survival. However, a few live by themselves, some with young children and engage in a whole range of activities including prostitution as a survival strategy.

3.3 Justification of Research Site

The decision to select Kibera as the research site was largely influenced by the following factors: One, Kibera slums is a cosmopolitan area that provided unique setting. Being located within Nairobi city, the administrative capital of Kenya, it is served with a whole range of health facilities ranging from those run by NGOs, the government to those run by the local communities. This means that health services including family planning are presumably easily accessible to a majority of women and men in the slums as compared to those women in the rural areas. In spite of this accessibility, many people in Kibera continue to face numerous health related challenges because they cannot either afford the exorbitant cost for medical services

including family planning or because of ignorance about the availability of such services. The site therefore provides a suitable site for study on women's unmet family planning needs.

In Nairobi family planning is increasingly becoming acceptable especially among women keen to delay or space child birth. The demand for family services among slum women has more than tripled in the last decade owing to the ever rising cost of living. As a consequence, of that it is feared that the demand for family planning needs has by far outstripped the supply of such services. The site provides an extremely good site where such issues are not only a priority but can easily produce results that can be generalized to other similar areas.

Apart from the above considerations, that is, the apparent presence of many health services and personnel in Nairobi and the increasing demand for family planning services, convenience also contributed to the choice of Kibera as the research site. The proximity of Kibera slums to the researcher was a justification for the research site. Doing the study elsewhere would have caused financial strains and could have probably put the research to other disadvantages like language barriers. In Kibera almost every one can either speak in English or Kiswahili which made it easier for the researcher to interview many people from diverse backgrounds thus giving the study useful insights.

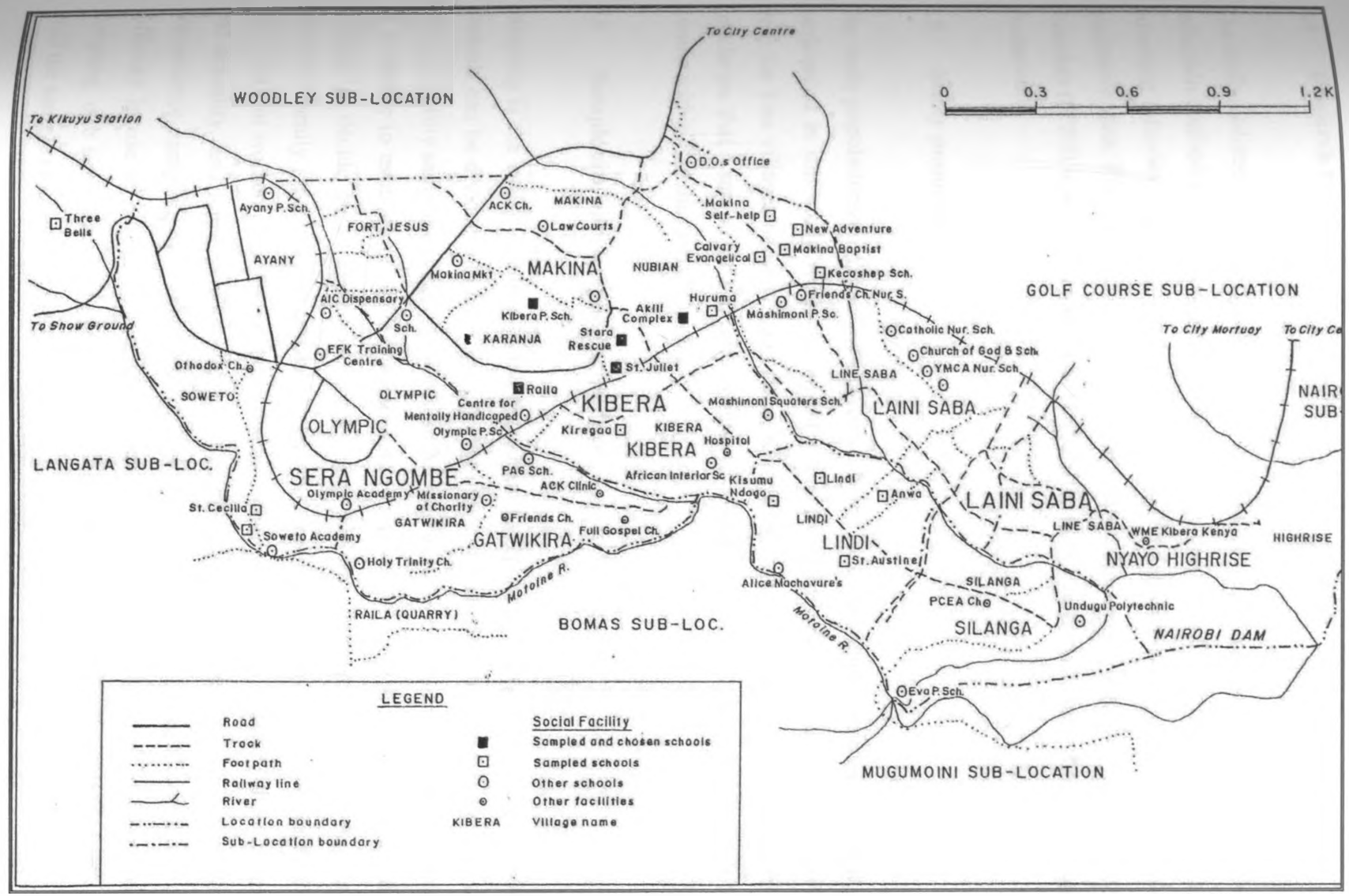


Figure 3.1: Map showing the villages of Kibera Slums, Nairobi Kenya

Source: University of Nairobi, Cartography Department

3.4 Research Design

The study utilized exploratory research design featuring both quantitative and qualitative data collection methods. Field survey questionnaires were used to collect quantitative data while key informant interviews, focus group discussions (FGDs) and case narratives were used to collect qualitative data. Further, quantitative data was analyzed using the statistical package for social scientists (SPSS) to establish the trends and relationships, while qualitative data will be analyzed thematically.

3.5 Study population

The study populations comprised of all women living in Kibera slums, Nairobi. The women who participated in this study were conveniently selected from women aged between 18-49 years from the four villages namely: Laini Saba, Kianda, Soweto and Makina villages. It is from this population that a sample of 100 respondents was drawn. The unit of analysis was the individual woman within Kibera slums Nairobi.

3.6 Sample size and sampling procedure

Sampling is the use of a subset of the population to represent the whole population. Sampling methods can be divided into two types: probability and non-probability sampling. It is claimed that probability sampling is best if the researcher wishes to describe accurately the characteristics of a sample to estimate population parameters (Kalton, 1983). For this research, it was rather difficult to decide on an appropriate sampling procedure. This was because, women's unmet needs for family planning does not stand alone but are dependent on many other factors. Again, most African women often do not freely discuss openly matters that relates to their reproduction and sexuality, and more so with men who are strangers. Due to the prevailing circumstances convenience sampling was considered the most suitable sampling procedure because of the difficulty in use of other sampling techniques. Selltiz et al. (1959), state that in convenience sampling, one simply reaches out and takes the cases that fall to hand, continuing the process until the sample reaches a designated size.

Probability sampling or random sampling is a technique where all the sample population has an equal chance of being selected. Sudman (1976) while discussing sampling techniques in social research explains that there is no uniform standard of quality that always can be reached by every sample. He further explains that the quality of the sample depends entirely on how the information is going to be used. Non probability sampling is a technique where the chances of selection of all the sample population are unknown. The most obvious disadvantage is that it is the least reliable design since the probability that an element or person will be chosen is not known and the researcher cannot claim that his/her sample is representative of the larger population. This of course limits the researcher's ability to generalize his/her findings beyond the specific sample studied. Bailey (1959) further adds that it is not easy to estimate the degree of departure from representation or sampling error.

3.7 Data Collection Methods

The data used in this study were collected between August and September 2011. With prior knowledge that the research site was mainly residential and the assumption that most women were either businesswomen, employed or housewives, researcher had to go round the estate at 11am after the women had settled. The study largely utilized survey method for data collection where a questionnaire was used as the principle data collection instrument. Supplementary information was obtained through key informants. Focus group discussions and case narrative interviews were used to obtain more information from respondents.

3.7.1 Questionnaire

The main instrument used in the data collection was a scheduled structured questionnaire. The questionnaire was constructed to include both closed and open ended questions. The questionnaire was divided into four sections. The first section was designed to obtain demographic and socio-economic characteristics of the respondent. The second section was designated to obtain data on the reproductive history of the respondents. Section three was designed to obtain data about the respondent's knowledge and practice of family methods while

section four was designed to obtain data attitude and barriers to access of family planning services. Since most of the respondents could not read and write the questionnaire was personally administered to the respondents through the researcher.

The questionnaire was drawn up in English and administered in Kiswahili (see appendix1). The interviewer had to read out questions and wait for a response which was given verbally by the interviewee before recording down on the questionnaire. This was done to ensure that respondents never consulted anybody before giving answers and that the sensitive questions were never avoided. Face to face interview gave the researcher a chance to rephrase or explain questions that were not understood and make probes where necessary. The observation method used helped the researcher to assess the barriers to access and use of family planning methods the respondents explained during the interview. Each interview took between 25-40 minutes to complete.

3.7.2 Case narratives

The researcher used case narratives to capture data on women's experiences with family planning services. From each of the four villages one woman was selected to give their story of the experiences with family planning programmes. A case narrative interview guide was used to document the women's experiences with family planning services (see Appendix 2). Case narrative method collected qualitative data on the knowledge, attitudes and practice of women on family services.

On knowledge about family planning services, narrators were asked about their understanding of family planning services. Further, they were asked about their knowledge of the various family planning methods locally available within Kibera slums. The narrators were asked how they learnt about family planning services and if they knew some of the benefits or disadvantages of family planning. The general perception and attitude of women towards family planning were also gauged. Finally the narrators were given a chance to explain the barriers encountered in the access and utilization of family planning methods.

3.7.3 Focus group discussion

Four Focus Group Discussions (FGDs) were carried out with 8 women from each of the four villages. A focus group discussion guide was used (see Appendix 3).The community knowledge; attitude and practice of family planning services were gauged using FGDs. The FGDs complimented the data collected using the questionnaires.

3.7.4 Key Informant Interviews

Key informant interviews were carried out with three professionals purposively selected. A reproductive health expert drawn from Medical Sans Frontiers a Non-Governmental Organization operating in Kibera, one government official drawn from the Ministry of Medical services division of reproductive health and gender and reproductive health expert from African Population Health and Research Centre. The key informant's interviews generated additional information that gave the researcher deeper insights on the knowledge, attitude and accessibility versus utilization of the family planning methods in among women in Kibera slums. A key informant interview guide was used (see Appendix 4).

3.7.5 Secondary data

Secondary data was collected through a literature search of pre-existing data and information. In order to establish a framework for the present study an extensive literature research was carried out at the Institute of Anthropology, Gender and African Studies, Medical School and Jomo Kenyatta Memorial Libraries at the University of Nairobi including textbooks, periodicals and journals, and articles on family planning and reproductive health and other databases on the internet. Additional data was collected from reports published by public and private organizations including community-based organisations (CBOs) and Non-Governmental Organizations (NGOs) working in the study site.

3.8 Data processing and analysis

Both qualitative and quantitative data were collected in this study. Quantitative data were processed and analyzed using computer software. The data processing begun after ensuring completeness of each research instrument used. Quantitative data was entered into the computer using EPI Data version 3.1 and exported to Statistical Package for Social Sciences (SPSS) version 17 for further statistical analysis.

The quantitative data collected from survey questionnaires were analyzed to establish trends and relationships between variables of the study. During the analysis, frequencies of different variables were determined.

The processed and analyzed data were presented in frequency tables and graphs. The qualitative data were subjected to content and thematic analysis since they could not be analyzed quantitatively. Most of the qualitative data has been used as supplementary information for the present study.

3.9 Problems encountered in the field

Although every attempt was made to design and carry out the best possible research, there were some limitations, as with all other research. The main limitations of the study were budget and time constraints.

It was impossible to conduct in-depth interviews to establish all the variables for measuring women's unmet needs in family planning in the particular study area. The researcher also faced a difficulty in finding an appropriate sampling frame for the general residents in the slum, such as the postcode address file or the Electoral Register do not exist and consequently convenience sampling technique was employed.

However, by utilizing convenience sampling, two weaknesses were recognized: selected respondents were often friends and therefore they had the more or less similar viewpoints about the issues under investigation. Thus, many potential respondents who were not identified by others were omitted from the study. It is not clear how much their views would have agreed or differed with those interviewed.

Finally, as the general residents, the respondents were restricted to a total of 100 respondents. Thus, it was difficult to regard it as entirely representative of the local residents in the slums. In order to obtain a purely accurate picture of the local residents' KAPs, the sample size should have been larger.

CHAPTER FOUR
PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the results of the study on women's unmet needs in family planning in Kibera Slums, Nairobi. The chapter is arranged along the specific study objectives. The first section presents the demographic and socio-economic characteristics of the respondents.

The second section presents the data on knowledge attitude and practice (KAP) of family planning amongst women in Kibera slums. The third section gives the statistics of women accessing and utilizing family planning services in Kibera.

The fourth section presents data on the barriers to access and utilization of family planning services amongst women in Kibera that contributes to women's total unmet needs in family planning.

4.2 Characteristics of Respondents

4.2.1 Age

Age of respondents was defined to be a very important variable in this study. According to the Kenya law, people below the age of 18 years are considered to be children and hence cannot theoretically consume any family planning methods. Table 4.2.1 shows the age distribution of the respondents. A total of 100 women aged between 18-49 years from Laini Saba, Kianda, Soweto and Makina villages were involved in this study.

From table 4.2.1 the mean age of the respondents was found to be 20 years. This is an indication that most women are married at early age. Thus, the type of family planning method for women should be age specific. Since most women in Kibera are young, the need for 'spacers' and 'limiters' family planning methods are very important. The selected socio-demographic variables of the study population are summarized in Tables 4.2.1 to 4.2.10

Table 4.2.1: Respondents Age

No.	Variables	Frequency N=100	Percent (%)
Age (Years)	18-22 years	57	57%
	23-27 years	26	26%
	32-35 years	10	10%
	Above 36 years	7	7%
Totals		**100**	**100%**

Source: Researcher (2011)

4.2.2 Marital Status

Marital status was considered an important variable for this study because issues of sexuality and family planning involve adults. Table 4.2.2 indicates that all the respondents interviewed were in active sexual union. 29% of the respondents were single women not married but were in active union, 27% were widowed, 23% were separated, 12% married and 9% were divorced. The focus group discussions, found out that there is a high level of sexual activity in Kibera amongst the youthful population. The group explained that many women are nowadays single but they engage in sexual union with men who are not necessarily their marital spouses. The singles use family planning methods but not with the intention of planning a family but rather of birth control.

Table 4.2.2: Respondents marital status

No.	Marital Status	Frequency N=100	Percent (%age)
1.	Married	12	12%
2.	Single	29	29%
3.	Separated	23	23%
4.	Divorced	9	9%
5.	Widowed	27	27%
Totals		100	100%

Source: Researcher, 2011

4.2.3 Religion

Religion was a very important variable for this study because some religions and rigid while others are liberal in supporting use of family planning methods. The study established that

religion influences family planning methods that women use. Further, the study found out that Muslim women don't use any family planning methods because of their religious beliefs. For Muslims, traditional methods of family planning are applicable. There is no use of modern family planning methods such as condoms, pills or injectables. Similarly, some sections of Catholics are opposed to condom use.

Other religions are silent about family planning methods, but in a subtle way they allow minimal use of family planning methods. This scenario increases women's unmet needs in family planning. It was also noted during focus group discussions that majority of respondents desire to have more information about family planning services even though fertility issues are considered by them that it is the domain of ''God''. Table 4.2.3 presents the distribution of the respondents per their religious affiliations. 35% of the respondents were Muslims, 48% Protestants, 12% were of African Traditional Religion and 5% Catholics.

Table 4.2.3: Respondents Religion

No.	Religion	Frequency N=100	Percent (%age)
1.	Catholic	5	5%
2.	Protestants	48	48%
3.	Traditional	12	12%
4.	Islam	35	35%
Totals		**100**	**100%**

Source: Researcher, 2011

4.2.4 Respondents ethnicity

On the ethnic background of the respondents, the survey questionnaire obtained 6 major ethnic groups staying within the four sampled villages of Kibera slums. Knowing the ethnic background is important because already in the literature review section, it has been explained that ethnicity is a contributing factor to the cultural barriers to women's unmet needs.

Different tribal groups differ from one another in language, culture, beliefs, myths and customs with regard to family planning methods. These opinions and perceptions influence knowledge,

attitude and practice of family planning. For instance, among the Luo tribe, women who use contraceptives are seen to be promiscuous. Among the Abagusii tribe, for example, men are the sole decision makers with regard to the number of children to be born. This will definitely affect the need for family planning method for spacing children. Table 4.2.4 shows the frequency distribution of the various ethnic groups who participated in the study.

Table 4.2.4: Respondents Ethnic background

No.	Ethic background	Frequency N=100	Percent (%age)
1.	Agikuyu	17	17%
2.	Luo	23	23%
3.	Abaluyia	15	15%
4.	Kalenjin	10	10%
5.	Nubian	24	24%
6.	Akamba	10	10%
7.	Ameru	1	1%
Totals		**100**	**100%**

Source: Researcher, 2011

4.2.5 Educational Background

On educational status, 78% of the respondents indicated that they were able to read and write and had attended primary/elementary education. Majority of the women interviewed indicated that they were forced to drop out of school because their parents could not pay their school fees especially that they were girls. Girls are not given equal opportunity for education compared to the boys. 7% of the respondents had attended secondary/high school education, 5% had tertiary/higher education. The study found out that the level of education has a direct influence on the women's unmet needs in family planning. There is a high incidence of unmet needs in family planning amongst women with low level education compared to those with higher education.

Table 4.2.5: Respondents Educational Status

No	Education Status	Frequency N=100	Percent (%age)
1.	Can't read and write/Illiterate	8	8%
2.	Primary/Elementary School (1-8)	78	78%
3.	Secondary/High School (9-12)	7	7%
4.	Tertiary/Higher education	5	5%
5.	University Education	16	16%
Totals		**100**	**100%**

Source: Researcher, 2011

4.3 Socio-Economic Status

On employment, 60% of the women in Kibera are house wives, 20% daily laborers/casual workers whom you find sitting on stones waiting for any casual work of household cleaning on a per day payment, 15% of women interviewed worked as house maids, 3% local drink sellers and 2% government employees. Table 4.3.1 shows the respondents employment.

Table 4.3.1: Employment

No.	Respondents Occupation	Frequency N=100	Percent (%)
1.	House Wife	60	60%
2.	House Maid	15	15%
3.	Local drink seller	3	3%
4.	Daily labourer	20	20%
5.	Government Employee	2	2%
Totals		**100**	**100%**

Source: Researcher, 2011

Table 4.3.2 presents the income distribution from the information gathered from the respondents. From both formal and informal employment, the study found out that the average monthly households income in Kibera slums is Kshs. 3,500. The income bracket of Kshs. 0-4,000 stood at 52%, showing that only 48% of the households earn more than Kshs. 4,001 and above. This income is inclusive of the husbands and the wife's income. Generally, majority of the population in Kibera slums live below the poverty line i.e. less than a dollar a day.

Table 4.3.2: **Income Distribution**

No.	Household monthly income	Frequency N=100	Percent (%)
1.	0-1,000	8%	8
2.	1,001-2,000	15%	15
3.	2,001-3,000	17%	17
4.	3,001-4,000	12%	12
5.	4,001-5,000	13%	13
6.	5,001-6,000	7%	7
7.	6,001-7,000	9%	9
8.	7,001-8,000	8%	8
9.	8,001-9,000	6%	6
10.	9,001-10,000	3%	3
11.	Above 10,000	2%	2
Totals		**100**	**100%**

Source: Researcher, 2011

4.3.3 Family Size

On family size, the average family size of the respondents in Kibera is 4 per household. 59% of the respondents indicate that they have at least four children (Table 4.3.3). Majority of the children are girls with 65% respondents indicating that they have girl child, while 35% are boy child. During the focus group discussions, many women explained that they were forced by their husbands to give birth to boy child, that's why they ended up with many children in search of a boy child. Boy child is still regarded more important than girl child as heir apparent. This is a case of strong patriarchal system which is still dominant in Kibera.

Table 4.3.3: **Respondents family size**

No	Variables	Frequency N=100	Valid Percent (%age)
1.	Family Size		
2.	1-4	59	59%
3.	5-9	40	40%
4.	10 and above	1	1%
Totals		**100**	**100%**
No	**Variables**	**Frequency N=100**	**Valid Percent (%age)**
1.	Number of Female Children	65	65%
2.	Number of Male Children	35	35%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4 Reproductive characteristics

4.4.1 Age at first marriage

Age at first marriage was a very important variable for this study. Although women of ages 18-49 years were sampled for this study. The study found out that the age at first marriage was as early as 16 years and as late as 35 years with a median age at marriage of 18 years. The study also found out that the age at first marriage determines the type of family planning method women use i.e. the limiters and spacers. The study found out there is still low knowledge amongst women of family planning methods especially those young women who were married before being exposed to family planning services. Table 4.4.1 below shows the distribution of respondents as per their age at first marriage.

Tables 4.4.1: Age at first marriage

No.	Age at first marriage (Years)	Frequency N=100	Percentage (%)
1.	10-14 years	0	0
2.	15-19 years	23	23%
3.	20-24 years	58	58%
4.	25 Years and above	19	19%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4.2: Age at first delivery

Amongst the 100 women interviewed, although the focus was for respondents aged 18-49, the study found out that age at first delivery in Kibera ranged from 16 years to 25 years. This is an indication of early sexual debut amongst women in Kibera. Women in the age group 15-19 years in Kibera are 4.6 times more likely to give birth than women in the age group of 20-24 years. Table 4.4.2 shows the distribution of respondents according to age at first delivery. This is a pointer that family planning methods should be designed to meet the needs of adolescents.

Table 4.4.2: **Age at first delivery**

No.	Age at first delivery	Frequency N=100	Percentage (%)
1.	<14 years	15	15%
2.	15-19 years	29	29%
3.	20-24 years	40	40%
4.	25 years and above	16	16%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4.3: Number of children alive

The number of children born alive was used as a determinant factor of women unmet needs in family planning. Women who reported have given birth to many children explained that they wanted to have fewer children but were unable to control the birth. This was as a result of the unmet needs in family planning. 40% of the women interviewed gave birth to more than 6 children. This is a clear indication that women in Kibera still suffer high levels of unmet needs in family planning. Table 4.4.3 shows the distribution of women and the number of children alive.

Table 4.4.3: **Number of children alive**

No.	No.of children alive	Frequency N=100	Percentage (%)
1.	1-2	15	15%
2.	3-4	11	11%
3.	4 -5	34	34%
4.	6 and above	40	40%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4.4: Number of desired children

More than 78% of the women indicated that they desire to give birth in future but not immediately. Majority desired on average 3-4 children especially if they are both girls and boys. The average expected time before the birth of the next child in the urban area was 2 years. Table 4.4.4 shows the distribution of number of desired children and the expected time before next birth.

Table 4.4.4: **Number of desired children for those who don't have**

No.	No. of desired children for those who don't have	Frequency N=100	Percentage (%)
1.	2	23	23%
2.	3	56	56%
3.	4	21	21%
Totals		**100**	**100%**
	Expected time before next birth	**Frequency N=100**	**Percentage (%)**
1.	< 2yrs	56	56%
2.	2-3	34	34%
3.	4-5	7	7%
4.	6 and above	3	3%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4.5: Aware of Family Planning methods

60% of women in Kibera are aware of family planning methods, 28% are not aware while 12% don't know completely what family planning methods are. Access and utilization of the family planning methods still remains low. Table 4.4.5 shows the distribution of respondent's awareness levels of family planning methods.

Table 4.4.5: **Aware of Family Planning methods**

No.	Aware of Family Planning methods	Frequency N=100	Percentage (%)
1.	Yes	60	60%
2.	No	28	28%
3.	Don't Know	12	12%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4.6: Current pregnancy

The study found out that 72% of the respondents were pregnant, whereas 28% were not pregnant. On further probing, 47% of the pregnant women indicated that their pregnancies were mistimed, while 25% indicated that they got an unwanted pregnancy. Only 10% of the women had intended pregnancy. Table 4.4.7 shows the percentage distribution of respondents who had

mistimed and unwanted pregnancy yet they did not avoid the pregnancy. 27% of the pregnancy could not be avoided due to family planning method failure.

Table 4.4.6: Current pregnancy

No.	Current pregnancy	Frequency N=100	Percentage (%)
1.	Yes	72	72%
2.	No	28	28%
Totals		**100**	**100%**
No.	**If pregnant how was the pregnancy**	**Frequency N=100**	**Percentage (%)**
1.	Intended	10	10%
2.	Mistimed	47	45%
3.	Unwanted	25	23%
4.	Not Applicable	28	28%
Totals		**100**	**100%**

Source: Researcher, 2011

4.4.7: Reasons for not avoiding pregnancy

The study found out that 72% of pregnant women would like to avoid pregnancy but are not doing so because of a number of reasons. Some of the reasons highlighted by the respondents include: Husband/partner disapproval of family planning methods which was reported by 30% of the respondents, followed by religious prohibition which accounted for 26%.

Poor access to family planning services in Kibera, contraceptive failure, little perceived risk of pregnancy were highlighted by 8% of the respondents each while 28% were non response due to lack of knowledge on family planning methods. Table 4.4.7 presents the findings.

Table 4.4.7: **Reasons for not avoiding pregnancy**

No.	Reasons for not avoiding pregnancy when you didn't want to	Frequency N=100	Percentage (%)
1.	Poor access to family planning	8	8%
2.	Husband/partner disapproval	30	30%
3.	Contraceptive failure	8	8%
4.	Little perceived risk of pregnancy	8	8%
5.	Religion prohibition	26	26%
6.	No response	28	28%
Totals		**100**	**100%**
No.	**If pregnant due to family planning method failure which method used**	**Frequency N=100**	**Percentage (%)**
1.	Pills	26	26%
2.	IUCD	10	10%
3.	Condoms	36	36%
4.	No Response	28	28%
Totals		**100**	**100%**

Source: Researcher, 2011

4.5 Knowledge, attitude and practice of contraception

4.5.1 Awareness of contraception

The study found out that more than 85% of respondents knew about family planning methods. However, only 35% were using family planning methods. This is an indication poor attitude and practice of contraception. Further, the study found out that most women don't use any contraception or family planning methods due to a variety of reasons. The main barrier to use of family planning methods by the women was the husbands or partners disapproval. Table 4.5.1 presents the findings of knowledge, attitude and practice of family planning.

Table 4.5.1: **Comparison of knowledge and attitude towards contraception**

No.	Variables	Frequency N=100	Percentage (%)
1	**Ever heard of contraception**		
	Yes	85	85%
	No	15	15%
Totals		**100**	**100%**
2.	**Knowledge of at least one method of contraception**		
	Yes	35	35%
	No	65	65%
Totals		**100**	**100%**
3.	**Desire to know more about contraception**		
	Yes	90	90%
	No	10	10%
Totals		**100**	**100%**
4.	**Intention to use contraception**		
	Yes	68	68%
	No	22	22%
	Not decided	10	10%
Totals		**100**	**100%**
5.	**Discussed contraception with husband**		
	Yes	10	10%
	No	90	90%
Totals		**100**	**100%**
6.	**Husband/Partner attitude**		
	Approve	10	10%
	Disapprove	90	90%
Totals		**100**	**100%**
7.	**Respondent approve using contraception**		
	Approve	60	60%
	Disapprove	30	30%
	Don't Know	10	10%
Totals		**100**	**100%**

Source: Researcher, 2011

4.6 Practice of Contraception

The study found out that only 35% of the respondents were using a form of contraception. 65% of them have never practiced family planning. For the contraceptive users, the average age of

starting to use contraception was found to be 15 years. For the respondents who ever used contraception methods, safe period/billings, condoms, IUCD, injectables and pills were the most preferred family planning methods by the women. In contrast, spermicides, sterilization and Norplant were the least used methods. Women opt to use pills and condoms because of their affordability and availability over the counters in shops, pharmacies or chemists. One respondent said that with Kshs. 20 she is able to buy Femi plan pills that can last her one month. Table 4.6.1 shows the statistics of contraception practice and most preferred family planning methods in Kibera.

Table 4.6.1: Women practicing family planning services and reason for none-use

No.	Variables	Frequency N=100	Percentage (%)
1.	**Contraceptive Practice**		
	Current User	35	35%
	Non User	65	65%
Totals		**100**	**100%**
2.	**Unmet Need**	**Frequency N=35**	**Percentage (%)**
	To space	27	27%
	To limit	8	8%
3.	**Age at start of using contraception**	**Frequency N=100**	**Percentage (%)**
	18-24	30	30%
	25-29	15	15%
	30-34	15	15%
	35-39	10	10%
	40-49	3	3%
Totals		**100**	**100%**
4.	**Reason for use of contraception**	**Frequency N=100**	**Percentage (%)**
	To space	65	65%
	To limit	35	35%
Totals		**100**	**100%**

Source: Researcher, 2011

The study found out that 30% of respondents were using oral pills, 27% were using injectables, 15% were using condoms, 12% were using IUCD, 10% were using natural methods, 2% were using spermicidal and implant respectively while 1% were using female/male sterilization methods respectively. Table 4.6.2 and figure 4.1 shows the contraception method used by the respondents.

Table 4.6.2: **Types of contraception method used**

No.	Types of contraception method used	Frequency N=100	Percentage (%)
1.	Pills	30	30%
2.	Injectable	27	27%
3.	Natural Family planning methods/Billing	10	10%
4.	Male sterilization	1	1%
5.	Female sterilization	1	1%
6.	IUCD	12	12%
7.	Spermicidal	2	2%
8.	Condoms	15	15%
9.	Implant (Norplant)	2	2%
Totals		**100**	**100%**

Source: Researcher, 2011

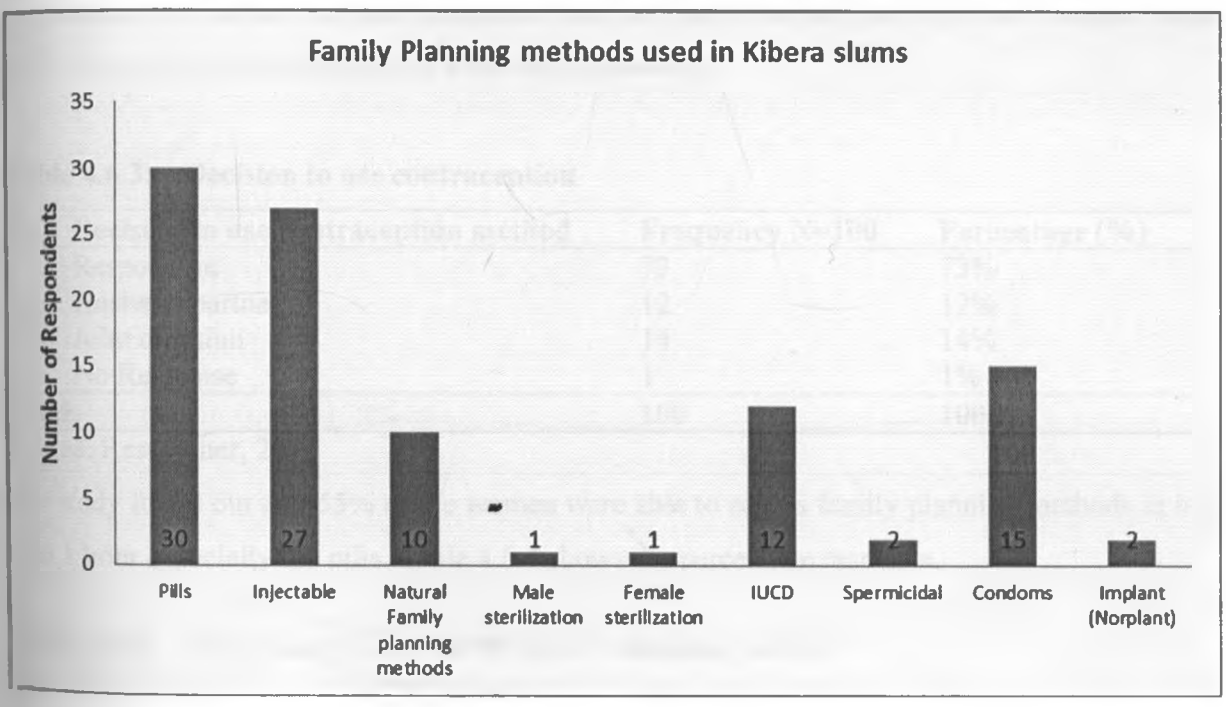


Figure 4.1: Family planning methods used by respondents

Reasons for non-use of contraception: Various reasons were given during the interviews for not using contraception amongst women. It was found out that 50 % of women desired to have more children therefore they don't use contraception for fear that contraceptives will stop them from having children. Ideally, contraceptives don't stop them from having children. 40% of respondents mentioned that they don't use contraception because of their husbands/partners

disapproval of contraception use. 10% of the respondents feared the side effect of contraception and/or they had health concerns.

Reasons for discontinuing contraception: Among the respondents who discontinued use of contraception, 71% mentioned that they desire to have more children while 26% had fears of side effects and health concerns. The study also established that the level of education influences the level of women's unmet needs in family planning. Illiterate women are more likely to have high level of unmet needs, compared to the literate women.

The study found out that of the users of contraception, 73% of them decided by themselves to use family planning methods, 14% were joint decisions while 12% was decision by the husband or partner. This means that the decision to use contraception still lies with the women. Table 4.6.3 shows the responses gathered from the respondents.

Table 4.6.3: Decision to use contraception

No.	Decision to use contraception method	Frequency N=100	Percentage (%)
1.	Respondent	73	73%
2.	Husband/partner	12	12%
3.	Joint decision	14	14%
4.	No Response	1	1%
Totals		**100**	**100%**

Source: Researcher, 2011

The study found out that 55% of the women were able to access family planning methods in less than 1 hour especially the pills. Table 4.6.4 shows the percentage response.

Table 4.6.4: Time taken to access the family planning method

No.	Time taken to access the method	Frequency N=100	Percentage (%)
1.	Less than 1 hour	55	55%
2.	1-4 hours	37	27%
3.	More than 5 hours	18	18%
Totals		**100**	**100%**

Source: Researcher, 2011

Table 4.6.5 shows some of the reasons why the respondents don't use contraceptives. The desire to have more children and fear that some family planning methods cause cancer and HIV were the main reasons with 27% respondents respectively citing the fears.

Table 4.6.5: Reason for not using contraception

No.	Reason for not using contraception	Frequency N=100	Percentage (%)
1.	No desire to use	26	26%
2.	Husband/partner opposition	5	5%
3.	Health concern and fear of side effects	15	15%
4.	Desire for more children	27	27%
5.	Others (some methods causes cancer & HIV)	27	27%
Totals		**100**	**100%**

Source: Researcher, 2011

Table 4.6.6: Reason for discontinuation of family planning method

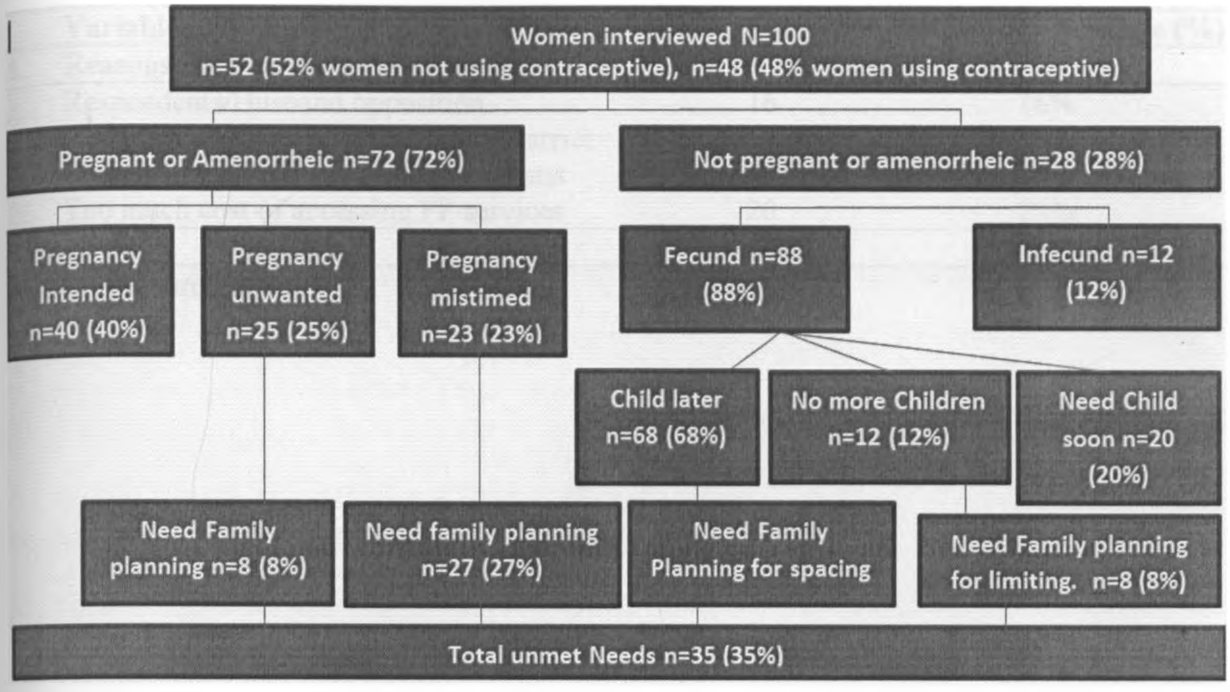
No.	Reason for discontinuation of a method	Frequency N=100	Percentage (%)
1.	Desire to have more children	71	71%
2.	Health concern and fear of side effects	15	15%
3.	Religious prohibition	13	13%
4.	Others	1	1%
Totals		**100**	**100%**

Source: Researcher, 2011

The unmet need: The study established that unmet need to space births among women currently married was 55% (spacers). On the other hand, unmet need to limit birth was found to be 45% (limiters). The unmet need to space among currently pregnant and post-partum amenorrheic women was found to be 2% women and unmet need to limit births was 1%. On average, the total women's unmet need was found to be 35%, which constitute 27% for spacing and 8% for limiting births. This calculation is arrived at using the conceptual model that guided this study.

Total women's unmet needs in family planning =	(Unmet need for limiting birth + Unmet need for spacing birth.)

Figure 4.7: Unmet need for family planning among currently married women in Kibera



4.7 Barriers to women's access to family planning methods

This section presents results of some of the barriers or reasons for non-use of contraception among women. Out of all the respondents interviewed during the study, 54% of women cited religious and cultural beliefs as the main barrier to use of family planning methods. 20% of the women indicated high cost of family planning services. While, 16% of the women indicated that they did not use contraception due to husband and respondent opposition. 10% of the respondents indicated that they did not use contraception due to health problems and side effects. Table 4.8 below summarizes the identified reasons preventing women from accessing family planning services.

Table 4.7.1: **Percentage distribution of reasons for not using family planning methods**

	Variables	Frequency N=100	Percentage (%)
1.	**Reasons for non-use of contraception**		
	Respondents/Husband opposition	16	16%
	Religious, Cultural and Traditional barrier	54	54%
	Fear of side effects and health problems	10	10%
	Too much cost of accessing FP services	20	20%
Totals		**100**	**100%**

Source: Researcher, 2011

CHAPTER FIVE
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion of findings

During the Focus Group Discussions women expressed their opinion that men and religious groups are a barrier to effective implementation of the family planning methods. Men have low knowledge on contraceptive methods compared to female. The study found out that family planning services were not accessible to women due to political and socio-economic barriers.

5.2 Barriers to access and utilization of family planning methods

Even though the majority of respondents have heard about family planning methods, the contraceptive prevalence rate is relatively low amongst women in Kibera. This could be attributed due to different reasons: desire to have more children, poor family planning outreach activities, scarcity of family planning services, cultural and religious taboos and inadequate information on contraception are some of the factors that contribute to the low level of knowledge, attitude and practice.

Women who use contraceptives, use them for spacing and limiting birth. Majority of women use family planning methods for spacing. Some of the barriers to use of family planning include failures of the contraceptives. An understanding of the reasons why people do not like to use family planning methods is critical in designing programs that could improve the quality of the service. Because not all users may need family planning services, an effort was made to identify those women who wanted to space or limit their fertility without using any form of contraception during the survey. This is important because it helps to estimate the contraceptive demand in the future and to select target groups for family planning programme intervention.

Age is an important factor when total unmet need is divided into need for spacing and need for limiting. Otherwise its importance becomes negligible. Hence age is an important determinant of overall unmet need for family planning. On the other hand, family planning unmet need for

spacing concentrated around the relatively younger age groups and declines towards the oldest age groups. As expected, only a small proportion of spacers were found in the last childbearing age group. Women with large numbers of surviving children have a greater unmet need for family planning than those women with fewer children .On the other hands women with a larger ideal family size have a lower need for family planning services in Kibera slums areas. The finding suggests that women prefer to go for their ideal number of children before accepting a family planning method especially in the urban area. Women with three or more living children are 3 times more likely than women with fewer children to have unmet need in Kibera.

This study shows that there are statistically significant associations between knowledge, attitude and practice to family planning. Involvement of men in family planning programmes is key in meeting the women's unmet needs in family planning. These results agree with the result of bivariate analysis. The other variables: ethnicity, religion, occupation, education, number of living children, and desired children had no statistically significant association with unmet need. Hence the following factors are identified as affecting unmet need for family planning among the study population in Kenya, family size, knowledge of contraception, husband's attitude, discussion with husband and place of residence.

Literacy levels are a key determinant factor for use of family planning methods. An assessment of the magnitude and determinants of unmet need for family planning among currently married, pregnant, and post- partum amenorrheic women in Kibera slum were carried out. 8% of the study population indicated that they have no education, which is lower than the Kenya Demographic Health Survey (KDHS 2009) result of 15% literacy rate. The study found a significant difference in reproductive characteristics amongst women in Kibera slums.

5.3 Level of access and utilization of family planning methods

Level of awareness about contraceptive methods in Kibera is high but the number of women using family planning method is very low indicating a high level of women's unmet needs. Women are more likely to have heard of contraception than men. Women who have no knowledge of contraception are more likely than women who do have knowledge to have unmet

need. This could be explained by dissemination of information through different ways. In this study the contraceptive prevalence rate was found to be 48%, which is lower compared with national CPR of 53% (KDHS, 2008). This might be due to low level of awareness and knowledge of the community about contraception. This can be increased through promoting easy access of family planning services through; Community Based Distributor (CBD) of contraception, increased non-governmental and private organizations participation in the education and provision of family planning services.

5.4 Conclusion

In summary, there is a high level of women's unmet needs in family planning within Kibera slums. 65% of women interviewed had never used contraception in their lifetime. The reasons for non-use of family planning methods include; low level of knowledge, attitude and practice of family planning, opposition by husband or partner to use contraception, health related problems and fear of side effects and desire to have more children were some of the reasons for non-use of family planning methods among women.

5.5 Recommendations

Based on the study findings the following are recommended:-

- Maximizing access to good quality family planning services to women. Improving the quality of family planning services and making contraceptives easier to obtain and use will help meet the need of many women.
- Family planning programs should advocate for reduction or minimization of risk of side effects associated with contraceptive methods compared to health problems and maternal health incurred by unwanted pregnancies.
- Future family planning programmes should be gender sensitive, and also focus on men as well as women while encouraging communication between couples and involving men more in family planning are key, while most couples agree on reproductive matters,

husbands who oppose contraception or worry about its side effects often prevent their wives from using it.

- There is need for integration of family planning services with maternal and child services so that the currently pregnant and post-partum amenorrheic women with unmet are supported with the necessary family planning methods to control birth before they become pregnant again unless they start using contraceptives
- It is recommended that family planning methods should be age friendly because the younger women need spacing, while the older women prefer limiting. This indicates that the family planning service has to take into account these needs and to provide methods that suit the needs of the target groups.
- Further research is needed to identify the extent of unmet need of different population groups, including unmarried women and the rural population.

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APPENDIX 1: SURVEY QUESTIONNAIRE

Good Morning/Good Afternoon, my name is Seith Odiwuor Abeka, a student of Gender and Development at the University of Nairobi. I am conducting a study on family planning and unmet needs among women in Kibera slums. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. I am interested in knowledge attitude and practices, the access and utilization of family planning methods by women in this village and the barriers to access and utilization of family planning methods faced by women in this village.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. Your name will not be written in this form to preserve your anonymity and will never be used in connection with any of the information you tell me. You are at liberty to terminate your participation at any time but I would urge you to create some time because of the value of your input. We would appreciate your help in responding to this survey questions .The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, No----------

Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Thank you for your cooperation.

Interviewer's name: .....

Result (1) completed, Result (2) respondents not available, Result (3) Respondent refused

001 –Interviewer code ----------/----------/Name----------

002 –Name of the Village in Kibera of the respondent---------- Nearest facility:.....

003 – Date of interview:---------/---------/------Start time: ..... End Time: .....

004 – Checked by supervisor. (1) Yes (2.) No

Signature---------- day----------month----------year.

Note: This questionnaire will be administered to women between the ages of 18 and 49 years. Family Planning Method Users or Defaulters, Never Users are asked. You Should Circle among the multiple choices the right answers or write the code.

Part I: Demographic and socioeconomic characteristics of the respondent				
Qn.	Questions	Choice of answer (Responses/Variables)	Code	Skip rule
100	Age of respondent:	(1.) 18-22yrs (2.) 23 – 27yrs (3.) 27-31yrs (4.) 32-35yrs (5.) Above 36 yrs		
101	Marital status	(1.) Currently Married (2.) Single (3.) Separated (4.) divorced (5.) Widowed (6.) Others specify.....		
102	Husband's occupation	(1.)Unskilled (2.) Mid-level (3.) Professional (4.) Others specify.....		
103	Respondent's Occupation	(1.) House wife (2.) Farmer (3.) student (4.) Mass organization employee (5.) Government employee (6.) Local drink seller (7.) Daily laborer (8.) House maid (9.) Merchant (10.) Job less [family defendant]		If no income go to Qn. 105

		(11.) Others specify…….		
104	Monthly income. What is your monthly income	Kshs……..		
105	If you compare you monthly income with your neighborhood, where you put your economic status?	(1.) Very poor (2.) Poor (3.) Medium (4.) Sufficient (5.) Rich (6.) Others specify……		
106	Religion	(1.)Catholic (2.) Protestant (3.) Pentecostal (4.) Anglican (5.) Traditional (6.) Islam (7.) Others specify……		
107	Ethnic origin	Kikuyu Luo Luhyia Kalenjin Nubian Kamba Others specify……..		
108	Educational status	(1.)Do not write and read [illiterate] (2.) Read and write (3.) Elementary school [1-6] (4.) Junior high school 7-10] (5.) Preparatory school [10-12] (6.) Higher education (7.) Others specify		

109	How many children do you have?	(1.)Males …… (2.) Females…… (3.) Total…….		
Part II Reproductive History				
201	At what age were you first married?			
202	Have you ever been pregnant?	(1.) Yes (2.) No		If No go to Q 205
203	How many pregnancies have you had?	…enter number		
204	How old were you when you first got pregnant?	…enter age in years		
205	How many live children do you have?	…enter the number		
206	How old were you when you first child was born?	…enter age in year		
207	If you could go back to the time you do not have children and could choose exactly the number of children to have in your whole life, how many Children could that be?	…enter the number		
208	How many children would you like to have in your life? [For those who do not have children]	…enter the number		
209	Are you aware of family planning methods	(1.)Yes (2.) No (3.) Don't know		

210	If the answer was yes, is the pregnancy?	1 Intended 2 Mistimed 3 Unwanted 4 No response		 215 213 213
211	Are you currently amenorrheic?	(1.) Yes (2.) No (3.) Do not know		 223
212	If the answer was yes, is the pregnancy?	(1.) Intended (2.) Mistimed (3.) Unwanted (4.) No response		215
213	If you have been pregnant when you do not want to, what was the reason you could not avoid becoming pregnant?	(1.) Lack of awareness of Contraception method? (2.) Poor access to contraception method (3.) Husband or partner disapproval (4.) Relative disapproval (5.) Contraceptive failure (6.) Little perceived risk of pregnancy (7.) Religion prohibition (8.) Culture prohibition (9.) other specify…….		
214	If it was due to contraceptive method failure, what was the method used?	(1.) Pill (2.) IUCD (3.) Injectable (4.) Implant [Norplant] (5.) Condom (6.) Female sterilization (7.) Male sterilization		

		(8.) Spermicidal[foam, injectable] (9.) Natural methods[abstinence,] (10.) Others specify…		
215	Which family planning services are you aware of?	(1.) Male Condom (2.) Billings method (3.) IUCD (4.) Oral contraceptive pills (5.) Injectable (6.) Withdrawal method (7.) Implants (8.) Bilateral tubal ligation (9.) Female condom (10.) Others specify		
216	After the child you are expecting now, would you like to have another child or would you prefer not to have any more children?	(1.) Have child (2.) No more (3.) Undecided (4) Don't know		
217	If you preferred to have another child, how long would you like to wait before the birth of another child?	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		Go to 220 Go to 222
218	After the birth of the child you are expecting now, do you think that you will use any method to delay or avoid pregnancy at any time in the future? [For pregnant. Women]	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		Go to 222
219	Do you intend to use family	(1.) Yes		

	planning in the future to delay or avoid pregnancy? [For post-partum amenorrheic women]	(2.) No (3.) Not decided (4.) Do not know		
220	If the answer were yes, would you like to use method to space or limit pregnancy?	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		
221	Which method do you prefer to use?	(1.) Pill (2.) IUCD (3.) injectable (4.) implant [Norplant] (5.) condom (6.) Female sterilization (7.) Male sterilization (8.) Spermicidal [foaming tab. jelly] (9.) Natural method [periodic abstinence, withdrawal] (10.) Other specify…		
222	If, you were not going to use any method to delay or avoid pregnancy at any time in the future would you tell me the main reason?	(1.) Not aware of contraception (2.) Fear of side effect (3.) Fear of infertility (4.) Unacceptable in my culture (5.) Medical problem (6.) Preferred method is not available (7.) Desire to have more children (8.) Husband or partner disapproval		

		(9.) Religion prohibition (10.) Little perceived risk of pregnancy (11.) Other specify…		
223	If you are not pregnant or amenorrheic would you like to have another child or not to have another child?	(1.) Have child (2.) No more child (3.) I cannot give birth (4.) Undecided (5.) Don't know		
224	If you like to have a child how long would you like to wait from now before the birth of another child?	(1.)….enter month if less than 2 years (2.) 2 to 3 year (3.) 3 to 4 year (4.) More than 4 year (5.) Do not know		
Part III Practice of contraceptive Methods				
300				
301	Please tell me to which group you belong regarding contraceptive practice?	1. Current user 2. Ever used 3. Non user 4. Other specify…		Go to 309
302	If you have ever used contraceptive method, how old were you when you first started to use?	… enter age in year		
303	How many living children did you have at that time?	…enter number of children		
304	What was the method you used then?	(1.) Pill (2.) IUCD		

		(3.) Injectable (4.) Implant [Norplant] (5.) Condom (6.) Female sterilization (7.) Male sterilization (8.) Spermicidal [foaming tabs, jelly] (9.) Natural method [periodic abstinence, withdrawal] (10.) Other specify…		
305	What was the main reason that you stopped using contraceptive method?	(1.) Fear of side effect (2.) Fear of infertility (3.) Medical problem (4.) Preferred method is not available (5.) Desire to have more children (6.) Little perceived risk of pregnancy (7.) Unacceptable in my culture (8.) Religion prohibition (9.) Other specify…		
306	Do you intend to use any method to delay or avoid pregnancy at any time in the future?	(1.) Yes (2.) No (3.) Not decided (4.) Do not know		
307	Tell me about rumors you hear concerning contraceptive methods?			
308	Who talks about these rumors?	(1.) Current users (2.) Previous user/defaulters (3.) Non users		

		(4.) Do not know (5.) Other specify….		
309	If you are currently using the contraceptive method for what purpose?	(1.) Spacing birth (2.) Limiting birth (3.) Do not know (4.) Other specify…		
310	What type of contraceptive method do you use currently?			
311	Would you say that using contraception is mainly your decision, or your husband or partner decision, or did you both decide together?	1 Mainly respondent 2 Mainly husband or partner 3 Joint decision 4 No response		
312	For how long have you been on this present contraceptive method without interruption?	…enter the period in Month		
313	Are you practicing the same method currently?	1 Yes 2 No		
314	Time taken to travel to the source of contraceptive methods?	…..write time in Minutes		
315	If you were not using any contraceptive method to delay or avoid pregnancy, would you tell me the main reason?	1 Respondent opposed 2 Husband or partner opposed 3 Relative opposed 4 Knows no method 5 Knows no source		

		6 Health concern 7 Fear of side effect 8 Lack of access or too far 9 Little perceived risk of pregnancy 10 Too much cost 11 Inconvenient to use 12 Other specify… 13 to have more child		
316	Do you intend to use any method to delay or avoid pregnancy at any time in the future?	1 Yes 2 No 3 Not decided 4 Do not know		Go to 317 Go to 318 Go to 318
317	If, yes which method would you prefer to use?			
318	You will use the contraceptive method for what purpose?	(1.) Spacing (2.) Limiting birth [no more child] (3.) Do not know		
319	After how long you want to use contraceptive method?➨	(1.) ……Write in month if less than 2 year (2.) 2 to 3 year (3.) 3 to 4 year (4.) More than four year (5.) Do not know		
320	If you were not going to use a family planning method to delay or avoid pregnancy in the future would you tell me the main reason?	(1.) Respondent opposed (2.) Husband or partner opposed (3.) Relative oppose (4.) Desire for more children (5.) Religion prohibition (6.) Culture prohibition		

		(7.) Knows no method (8.) knows no source (9.) Health concern (10.) Fear of side effect (11.) Lack of access or too far (12.) Little perceived risk of pregnancy (13.) Other specify…		
Part IV attitude towards contraception methods				
401	Would you like to know more about contraceptive methods?	(1.) Yes (2.) No		Go to 404
402	Do you yourself approve or disapprove of couples using methods of family planning?	(1.) Approve (2.) Disapprove (3.) Do not know		
403	If no why?	(1.) Respondent refusal (2.) Husband or partner refusal (3.) Family disapproval (4.) Religion prohibition (5.) Culture do not allow (6.) Fear of side effect (7.) Medical problem (8.) Other specify. (9.) desire to have more children		
404	Have you discussed contraception with your husband or partner within the last one-year?	(1.) Yes (2.) No (3.) Do not know		Go to 406
405	If the answer is yes, how	(1) Only 1 time		

	many times have you discussed?	(2) Discussed some time (3) Discussed often (4) I cannot remember		
406	What is your husband's or partner's attitude towards contraceptive methods?	(1) Approve (2) Disapprove (3) Do not know		
Part V knowledge about contraception methods				
501	Have you ever heard of family planning methods?	(1.) Yes (2.) No		
502	Do you know any way or methods that women and men can use to delay or avoid pregnancy?	(1.) Yes (2.) No		Go to 509
503	If yes, is it possible to obtain this method?	(1.) Yes (2.) No		
504	Where is the main place that you or other women are able to get modern contraceptives from?	(1.) Hospital (2.) Health center (3.) Health station (4.) Community health post (5.) FGAE clinic (6.) Private clinic (7.) Pharmacy /drug vender (8.) Shop (9.) Do not know (10.0 Other specify…		
505	Which advantage of contraceptive methods do you know?	(1.) To avoid unwanted pregnancy (2.) To delay mistimed pregnancy (3.) Regulation of period		

		(4.) Limit family size (5.) Prevention of STIs (6.) Other specify…		
506	How do you think oral contraceptive Pills should be taken to prevent unintended pregnancy?	(1.)On pills daily from one menstrual cycle to the next (2.) One pill every other day (3.) One pill following sexual intercourse (4.) Do not know (5.) Other specify… (6.) Do not know		
507	How do you think injectable Contraceptive should be taken to prevent unintended pregnancy?	(1.) One injection ever three month during menstruation (2.) One injection every 6 month (3.) One injection following sexual intercourse (4.) Do not know (5.) Other specify… (6.) Do not know		
508	Suppose we compare using the pill and pregnancy, do you think using pill is more harmful to women's health than pregnancy, equally harmful, or less harmful?	(1.) Pill is more harmful (2.) Equally harmful (3.) Pill less harmful (4.) Neither harmful (5.) Do not know		
509	How do you think is the best way that, currently married women in the reproductive age should prevent unwanted or mistimed pregnancy?	(1.) Use modern contraceptive (2.) Use natural methods [periodic abstinence. withdrawal] (3.) Do not know (4.) Other specify…		

510	Source of information for family planning?	(1.) Health workers (2.) Radio (3.0 TV (4.) News papers (5.) Posters. leaf lets (6.) Friends (7.) Other specify…		
511	Do you have radio and TV in your house?	(1.) Radio only (2.) TV only (3.) Both radio and TV (4.) None		
Any other comments or inputs to the study:- END OF THE INTERVIEW I THANK YOU VERY MUCH FOR YOU PARTICIPATION				

APPENDIX 2: CASE NARRATIVE INTERVIEW GUIDE

Good Morning/Good Afternoon, my name is Seith Odiwuor Abeka, a student of Gender and Development at the University of Nairobi. I am conducting a study on family planning and unmet needs among women in Kibera slums. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. I am interested in knowledge attitude and practices, the access and utilization of family planning methods by women in this village and the barriers to access and utilization of family planning methods faced by women in this village.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. Your name will not be written in this form to preserve your anonymity and will never be used in connection with any of the information you tell me. You are at liberty to terminate your participation at any time but I would urge you to create some time because of the value of your input. We would appreciate your help in responding to this survey questions .The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, No---------- Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Thank you for your cooperation.

- What is your understanding of family planning methods?
- What are some of the common family planning methods you are familiar with and are locally available around this village?
- How did you learn about the above mentioned family planning methods?
- What is your assessment of the benefits of the family planning methods that you have used and those you have learnt and/or heard about?
- What is the general perception of women's attitude toward family planning methods in Kibera slums?
- How would rate the use and access if family planning methods in Kibera slums?
- What has been your experience in using the family planning methods?
- If you have encountered certain obstacles in access and utilization of family methods, please explain these barriers.

APPENDIX 3: FOCUS GROUP DISCUSSION GUIDE

Good Morning/Good Afternoon, my name is Seith Odiwuor Abeka, a student of Gender and Development at the University of Nairobi. I am conducting a study on family planning and unmet needs among women in Kibera slums. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. I am interested in knowledge attitude and practices, the access and utilization of family planning methods by women in this village and the barriers to access and utilization of family planning methods faced by women in this village.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. Your name will not be written in this form to preserve your anonymity and will never be used in connection with any of the information you tell me. You are at liberty to terminate your participation at any time but I would urge you to create some time because of the value of your input. We would appreciate your help in responding to this survey questions. The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, no----------

Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Thank you for your cooperation.

- Please tell me about the family planning services you are familiar with and where they are offered
- What are some of the family planning methods that you have learnt about?
- What is the community's attitude among women in this community?
- How are women in reproductive health age affected by these family planning methods in this community?
- Do we have cases of women affected by unwanted and mistimed pregnancies in this community?
- Are women aware of the avoidance of unwanted and mistimed pregnancies?

- Why are women in this community not actively using family planning methods?

Summary of FGDs amongst women within the four villages of Kibera

		Laini Saba	Makina	Kianda	Soweto	
Issue for discussion		Currently married women in reproductive age (15-49)	Currently married men in reproductive age (25-49)			Religious leaders
Knowledge of contraception	Yes	++++++++	++++++++	+++++++	+++++++	+++++++
	No	--	--	+	+	+
				--	--	--
Contraceptive method known	Pills	++++++++	++++++++	+++++++	+++++++	+++++++
	Condom	++++++++	++++++++	+++++++	+++++++	+++++++
	Norplant	++++++++	++++++++	+++++++	+++++++	+++++++
	Tubal	++++++++	++++++++	+++++++	+++++++	+++++++
	litigation	+++++++	+++++++	+++++++	+++++++	+++++++
	Vasectomy	++++++	++++++	++++++	++++++	++++++
	Spermicidal	++++	++++	++++	++++	++++
	Natural	+++	+++	+++	+++	+++
	methods	++++	++++	++++	++++	++++
Family planning methods provided	Available	++++++	+++++++	+++++++	+++++++	+++++++
	Affordable	++++++++	++++++++	+++++++	+++++++	+++++++
	Accessible	+++++++	+++++++	+++++++	+++++++	+++++++
	Useful	+++++++	+++++++	+++++++	+++++++	+++++++
The best family size	0-2	++++++++	++++++++	+++++++	+++++++	+++++++
	2-4	++++++	++++++	++++++	++++++	++++++
	5-8	++++	++++	++++	++++	++++
Method to achieve	Modern	++++++	++++++	++++++	++++++	++++++
	Natural	++++	++++	++++	++++	++++
Problems regarding large	Poor maternal	++++++++	++++++++	+++++++	+++++++	+++++++

		Laini Saba	Makina	Kianda	Soweto	
Issue for discussion		Currently married women in reproductive age (15-49)	Currently married men in reproductive age (25-49)			Religious leaders
family size	child health Shortage of food Poor economy Jobless	 +++++++ +++++++ +++++++	 +++++++ +++++++ +++++++	 +++++++ +++++++ +++++++	+++++++ +++++++ +++++++	+++++++ +++++++ +++++++
Women in reproductive age affected by unwanted/mistimes pregnancies	Abortion Family break Maternal health School drop out	++++++ ++++++ ++++++ +++++	++++++ ++++++ ++++++ +++++	++++++ ++++++ ++++++ +++++	++++++ ++++++ ++++++ +++++	++++++ ++++++ ++++++ +++++
Why people don't use family planning methods	Low awareness Culture and religious matters Inaccessible	+++++ +	+++++	+++++	+++++	+++++
Opinion of community	Approves Disapprove	+++++ +	+++++	+++++	+++++	+++++
Traditional methods practiced	Breast feeding Abstinence	+++++ ++	+++++	+++++	+++++	+++++

		Laini Saba	Makina	Kianda	Soweto	
Issue for discussion		Currently married women in reproductive age (15-49)	Currently married men in reproductive age (25-49)			Religious leaders
	Withdrawal					
How commonly practiced	Widely Not widely	+ + + + + + +	+ +	+ +	+ +	+ +
Contraceptive method practiced	Modern Natural	+ + + + + +	+ + + + +	+ + + + +	+ + + + +	+ + + + +
Community awareness on avoid ability of unwanted and mistimed pregnancies through use of family planning	There is awareness No awareness	+ + + + + +	+ + + + +	+ + + + +	+ + + + +	+ + + + +
Men opinion to ward family planning	Approve Disapprove	+++++ +	+++++	+++++	+++++	+++++
Usefulness of information passed through mass media	Useful Not useful	+ + ++ + -	+ + ++ +	+ + ++ +	+ + ++ +	+ + ++ +
Do people discuss on family planning issues	Yes No	+++++ ++	+++++	+++++	+++++	+++++

		Laini Saba	Makina	Kianda	Soweto	
Issue for discussion		Currently married women in reproductive age (15-49)	Currently married men in reproductive age (25-49)			Religious leaders
Major obstacles to alleviate the problem	Low awareness Too much cost Culture and religious matter Inaccessible	+++ + ++ ++	+++	+++	+++	+++

Legend: ++++++ Indicates majority of participants/respondents +++++ Average +++ Some, ++ few, + very low knowledge, -- nobody

APPENDIX 4: KEY INFORMANT INTERVIEW GUIDE

Good Morning/Good Afternoon, my name is Seith Odiwuor Abeka, a student of Gender and Development at the University of Nairobi. I am conducting a study on family planning and unmet needs among women in Kibera slums. You have been chosen to partake in this study by being a resident on this village which has been sample and by virtue of being in the reproductive age bracket defined in this study. I am interested in knowledge attitude and practices, the access and utilization of family planning methods by women in this village and the barriers to access and utilization of family planning methods faced by women in this village.

I am going to ask you some questions that are not difficult to answer. Please feel free to respond to any questions you find comfortable. Your name will not be written in this form to preserve your anonymity and will never be used in connection with any of the information you tell me. You are at liberty to terminate your participation at any time but I would urge you to create some time because of the value of your input. We would appreciate your help in responding to this survey questions .The interview will take about 30 minutes. Would you be willing to participate [indicate by ticking the appropriate responses]? Yes-------, no----------

Signature of the interviewer certifying that the informed consent has been verbally by respondents----------

Thank you for your cooperation.

- What is the level of family planning services to the slum community?
- What is the level; of family method knowledge among these women in Kibera slums?
- What are the attitudes and practices associated with family planning methods amongst women in reproductive health age in the slums?
- What is the general prevalence of the contraceptive use among the slum women?
- What are some of the barriers women in the slum face in accessing and utilizing family planning methods in the slums?

APPENDIX 5: CURRICULUM VITAE

Personal Details:			
Name	Mr. Seith Odiwuor Abeka		
Marital Status	Married		
Nationality	Kenyan		
Occupation	Consultant/Researcher		
Name of Organization	TAABCO Research and Development Consultants		
Religion	Christian - SDA		
Contact Address	P.O. Box 75898 00200 Nairobi Kenya E-Mail: seithabeka@gmail.com		
Languages	Reading	Writing	Speaking
English	Excellent	Excellent	Excellent
Kiswahili	Excellent	Excellent	Good
Luo	Excellent	Excellent	Excellent
French	Fair	Fair	Fair

Education Background

Date	Institution	Qualification
2009-2011	University of Nairobi – Institute of Anthropology, Gender and African Studies (IAGAS)	Master of Arts in Gender and Development Studies
1998-2002	University of Nairobi - Faculty of Arts	Bachelor of Arts 2nd Class Upper division in Economics and Mathematics
1993-1996	Ambira High School	KCSE mean grade B

Work Experience

2005 to date	TAABCO Research and Development Consultants
2002-2005	Centre for the Study of Adolescents

Skills and Computer literacy

	Competent in use of Statistical Package for Social Scientists (SPSS) Proficient in Database management software's i.e. Epi-Info, Epi-data, Stata, Competent in Computer use and programming using C++
Hobbies	Safari Rally Motorsports Adventuring Research and Policy Analysis
Referees	Dr.Agnes Abuom, Executive Director-TAABCO Research and Development Consultants, P.O. Box 10488-00100 Nairobi, E-mail: taabco@taabco.com Dr. Odhiambo Sule, University of Nairobi, P.O. Box 30197 Nairobi Kenya. Dr. Charles Owuor Olungah ,University of Nairobi, P.O. Box 30197 Nairobi Kenya

APPENDIX 6: WORKPLAN

The plan of action of the research study is as shown below:

Activity	Timeframe
Developing of a research topic and research proposal	November 2010-March 2011
Inception report writing (enhanced proposal) and defending the proposal	April 2011
Development of conceptual and methodological framework	April 2011
Development of research questions and data collection instruments and testing	April 2011
Refining the research proposal	May – August 2011
Final defense of the Research Proposal and submission to the panelists	August – September 2011
Field Work for Data collection	August - November 2011
Data analysis	October – November 2011
Drafting of Research Study report	November 2011
Draft final report	November 2011
Stakeholders workshop for dissemination	November 2011
Dissemination of research results, including publications in journals	November 2011