PERCEPTION ON USE OF CONTRACEPTIVES AMONG HOUSEHOLDS' HEADS IN LOW-INCOME FAMILIES IN KURESOI NORTH SUB-COUNTY, NAKURU COUNTY, KENYA

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DECLARATION AND RECOMMENDATION

Declaration

This is my original work and has not been presented for an award of a degree in this or any other University.

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Recommendation

This work has been submitted for examination with our approval as University supervisors;

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DEDICATION

I would like to dedicate this work to my siblings and cousins for their encouragement during my studies. Their boundless love, support and prayers were with me throughout this period. May this work be an inspiration for you to work hard and reach greater heights in your endeavours.

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ABSTRACT

Family planning is widely acknowledged as an important intervention towards achieving Sustainable Development Goal 3 (SDG 3) as it has proven to reduce maternal and child mortality. Family planning has also been found to promote gender equality as well as educational and economic empowerment for women and men. Despite the enormous benefits of family planning services, the uptake of these services among men in Kuresoi North Sub-county still remains low in. The aim of this study was to investigate the perception on the use of contraceptives among households' heads in low-income households of Kuresoi North Sub-County in Nakuru County, Kenya. The study was carried out in Kamara and Sirikwa wards in Kuresoi North Sub County. The study used planned behaviour and social radical feminism theories. It employed cross-sectional survey research design. The study population was 251 households' heads in low income households. Simple random sampling procedure was used to obtain a sample size of 143 respondents. Data was collected using interview schedule and semi-structured questionnaires. The data was analyzed using qualitative and quantitative methods of data analysis. Findings of the study were presented using quotes, narratives, pie-charts, bar graphs and frequency tables. From the study findings, 75% of the respondents obtained information on the use contraceptives through social workers in health care facilities and friends. The findings indicated that 65% of respondents used condoms, making it most popular contraceptive among various types of contraceptives available. About 70% of respondents agreed that partners in stable relationships preferred to know their HIV status, and this would determine their use or non-use of a condom. The use of long term contraceptives such as hormonal contraceptives exposed women to sexually transmitted diseases. From the findings concludes that having knowledge of contraceptives and their benefits does not necessarily lead to favourable perception towards their use. This study recommends that policy makers should deal with the attitudes and perception on the use of contraceptives based on gender differences. This will improve the use of contraceptives in low income households.

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LIST OF ABBREVIATION AND ACRONYMS

AIDs	Acquired Immunodeficiency Syndrome
APHRC	African Population Health Research Centre
ECA	Economic Commission for Africa
CoK	Constitution of Kenya
CPR	Contraceptive Prevalence Rate
FP2020	Family Planning 2020
FSH	Follicle Stimulating Hormone
GnRH	Gonadotropin-Releasing Hormone
HIV	Human Immunodeficiency Virus
ICF	International Classification of Functioning
ICPD	International Conference on Population and Development
IUD	Intrauterine Device
KDHS	Kenya Demographic Health Survey
KNBS	Kenya Bureau of Statistic
LH	Luteinizing Hormone
MCM	Modern Contraceptive Method
SDGs	Sustainable Development Goals
NCPD	National Coordinating agency for Population and Development
NGOs	Non-Governmental Organizations
PAHO	Pan American Health Organization
PBC	Perceived Behavioral Control
SNs	Subjective Norms
SPSS	Statistical Packages Social Sciences
TFR	Total Fertility Rate

TPB Theory of Planned Behavior

TRA Theory of Reasoned Action

U.S. United States

USAID United States Agencies for International Development

UNFP United Nations Population Fund

WHO World Health Organization

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

The global population has been on rise as a result of decline in mortality and high fertility. According to the Economic Commission for Africa (ECA, 2016) there are about 7.3 billion people in the world, 1.2 billion people in Africa and 46 million people in Kenya. Kenya has been ranked number 7 in Africa contributing to 3.3 per cent of her population. According to Kenya National Bureau of Statistics (KNBS, 2010), there are substantial differences in fertility across the country with 5.2 and 2.9 children per woman in rural and urban areas respectively.

International societies and national governments have regarded rapid population growth rate as a challenge to natural resources and economic development of a country United Nation Population Fund (UNFP, 2011). In Kenya, especially in the larger Kuresoi constituency, high population has added pressure on land and other resources, as a result of cultural aspect, religion and lack of knowhow on family planning (Kuresoi North, 2012). Kenya is among the first countries in Sub-Sahara Africa to rally for family planning, the idea of birth control has been slowly accepted making the population to continue growing rapidly (Mulama, 2009). Adoption of family planning methods has been considered as the most effective way of reducing population growth (Greene, 2000).

In Kenya, family planning programmes are disseminated through private medical practitioners in the 1950s to 1960s targeting women as their primary clients. The services in Kenya is only offered as part of child health and maternal packages where women are the main clients, Kenya National Bureau of Statistics & ICF Macro (KNBS & ICF Macro, 2010). Most family planning programs, rarely favor participation of men in their planning and decision making process. However, meeting the needs of men for contraceptives would prevent not only early and unintended pregnancies but also lower maternal mortality, reduce chances of unsafe abortion and slow population growth. It is thought that more than a half of the population in Kenya is ascribed to unwanted pregnancy leading to high population growth (National Council for Population and Development, 2012).

Kenya, being a predominantly patriarchal society, men are the key decision makers on matters of child-rearing, sex, contraception and child spacing (Mburugu & Adams, 2004). In the African traditional setting, men hold higher status than women when it comes to access and

control socio-economic resources like land, livestock and money among others which are the main determinants of family size (Mburugu & Adams, 2004).

Despite the 1994 International Conference on Population and Development in Cairo advocating for the need to engage men in family planning programmes and the need to acknowledge their role in reproductive health, there is still low contraceptive acceptance among men (UNFP, 2009). This is due to limited communication among couples, information and education on the involvement of men in family planning. Men in the patriarchal society, especially those who practice agriculture value large families as this is related to unremunerated labour for agriculture (Mburugu & Adams, 2004).

In Kenya there is low uptake of family planning methods among men as result of misconception and attitude of health workers who perceive women as the main consumers of family planning methods as opposed to male counter parts (UNFP, 2009). Some of the negative myths and misconceptions include; women become frigid in bed, causes death, only used by unfaithful partners they cause infertility among others. In Kenya family planning services are offered at Child and Maternal health clinics where it viewed as "women's places". Also most advertisements on family planning portray women as the main users making men to shy away from seeking information the types and use of contraceptives. This makes them hostile to their spouses who intend to engage them in family planning business (Musalia, 2008).

The Sustainable Development Goals (SDGs) advocate for no poverty, good health and wellbeing for people and gender equality which, would only be achieved through creating and bringing about family planning for men and women (Dodd & Cassels, 2006). Wealth has been considered as a major factor that directly influences health. For instance, women living in poverty are five times more likely to experience an unplanned birth than affluent women because they can't afford contraceptives. Indeed, the overall poverty within a country shoots up health vulnerability and reduces life expectancy (Hosseinpoor, Victora, Bergen, Barros & Boerma, 2011). The use of contraceptives has been related with reducing fertility and as a way of escaping poverty-fertility trap in developing countries (Hosseinpoor et al., 2011).

World Health Organization (2012) advocated for state governments and non-governmental organizations to develop strategies to increase men's participation and involvement in reproductive health. Men's participation and involvement in contraceptive use is crucial in patriarchal societies where men are the main decision makers and the leaders in their families and societies. However, there is scanty information on how to include men fully in reproductive

health programmes but their participation may have various socio-economic benefits. Perception of men on use of contraceptive influences their contraception and that of their spouse (WHO, 2012). This prompted the need to find out the perceptions on contraceptive use among households' heads in low-income families in Kuresoi North.

1.2 Statement of the Problem

Although globally the level of contraceptive use is considered low compared to contraceptive awareness, certain societies have recorded higher prevalence of contraceptive use than others. The WHO in 2011 reported the general prevalence of contraceptive use to be higher in countries in Latin America, at an estimated 63%, than in countries in Africa at an estimated 30%, with the rate of nonuse highest in sub-Saharan African countries. The rate of contraceptive use among the Kenyan population was reported at approximately 17% (Izugbara et al, 2018). According to the Kenya Demographic and Health Survey (KDHS, 2014) Kenya has the lowest level of contact of contraceptive nonusers (20%). These studies reveal that men and women are aware of the existence of contraceptive methods and the benefits accruing from using contraceptives. However, this awareness is not reflected in the actual utilization of these methods, thereby leading to increase in the incidence of sexually transmitted diseases and unsafe abortions resulting from unwanted pregnancies creating a gap of investigation. Thus, this study, therefore, intended to investigate the perception on contraceptive use among households' heads in low-income households in Kuresoi-North Sub County.

1.3 Purpose of the Study

The purpose of this study was to investigate the perception of households' heads in low-income families on contraceptive use in Kuresoi-North sub-county, Nakuru County.

1.4 Specific Objectives

The following objectives guided the study:

i. To establish how the perception of households' heads in low income families affect the choice of contraceptive they use in Kuresoi North Sub County.
ii. To determine how the perception of households' heads in low income families affect their frequencies of use of contraceptive in Kuresoi North Sub County.
iii. To analyse how the economic status of households' heads in low income families affect their perception on the use of contraceptives in Kuresoi North Sub County.
iv. To examine how marital status of households' heads in low income families affect their perception on the use of contraceptives in Kuresoi North Sub County.

1.5 Research Question

In pursuing the objectives of the Study, the following research questions were employed:

i) Does the perception of households' heads in low income families affect the type of contraceptives they use in Kuresoi North Sub County?

ii) Does the perception of households' heads in low income families affect their frequency of use of contraceptives in Kuresoi North Sub County?

iii) How does economic status of households' heads in low income families affect their perception on the use of contraceptives in Kuresoi North Sub County?

iv) Does marital status of households' heads in low income families affect their perception on the use of contraceptives in Kuresoi North Sub County?

1.6 Justification of the Study

The research findings and recommendations of this study are expected to help stakeholders in the health sector to improve the uptake and implementation of family planning programmes and projects based on the strength of the evidence of information collected from this research. It will also enable them to develop strategies for implementing family planning programmes targeting household heads in rural areas. The research findings are expected to assist stakeholders in the health sector to overcome socio-cultural challenges in integration of use of contraceptive among households' heads in different cultural backgrounds. It is also hoped that the results will help policy makers restructure the activities and organization of family planning projects in order to ensure equitable participation and sharing of information on contraceptive use at all stages of reproductive life of both men and women.

1.7 Scope of the Study

The study was conducted in Kuresoi North Sub County of Nakuru County. This is because it has several initiatives targeting mostly household's heads on contraceptive use by the ministry of health in the county and USAID APHIAplus II as a way of controlling population and sexually transmitted diseases. The targeted households' heads were of age of 18 years and above since they are considered adults and are sexually active and independent to make their own decision concerning use of contraceptives. Households' head's perception on the use of contraceptives which may be positive or negative may affect the use of contraceptives among them and their sexual partners. The use of contraceptives has been regarded as a main strategy for escaping poverty-fertility trap.

1.8 Limitations of the Study

i). Findings from this study may not be generalized to all sub-counties in the country given that different households' heads have different characteristics and perceptions on the use of contraceptives.

ii). The study was sensitive in terms of privacy but the respondents were assured that that the information provided was to be handled with great privacy and assured that the purpose of the study was for academic purpose only.

1.9 Assumptions of the Study

In this study, the researcher made the following assumption;

i) That the respondents gave the right information concerning the use of contraceptives.

ii) The records on contraceptive use in the health facilities were up to date.

1.10 Definition of Operational Terms

Age: It refers to a whole duration of a being (Cambridge University Press, 2017). In this study it entails the length of time that a person has lived.

Adult(s): According to the Constitution of Kenya, it refers to a person of eighteen (18) years of age and above. In this study, it refers to a sexually active person of 18 years and above.

Attitude: It refers to an affective feeling of liking or disliking towards an object that has an influence on behavior (Kaufman, 2017). In the study it's being used as affective feelings of liking or disliking towards contraceptives that has an influence on its use.

Contraceptive use: In this study it refers to any of various methods intended to prevent a woman becoming pregnant (Cambridge University Press, 2017). In this study it includes all available modern methods that households' heads deploy to prevent their partners from becoming pregnant.

Contraceptive: According to Martin (2016) it refers to a device, agents or drug that prevents a woman from becoming pregnant. In this study it includes all modern devices or drugs that households' heads use to prevent woman from becoming pregnant.

Frequency: It refers to the number of times that an event occurs within a given period of time (Martin, 2016). In this study it refers to how often households' heads use modern contraceptives.

Household: Refers to all the people in a family or a group who live together in a house (Martin, 2016). In this study it includes all members of family living together in same house.

Household Head: According to Urban dictionary (2017) an individual in one family setting who provides actual support and maintenance to one or more individuals who are related to him or her through adoption, blood, or marriage. In this study it refers to men and women who have authority to exercise family control and to support the dependent members is founded upon a moral or legal obligation or duty.

Level of Income: Refers to amount of monetary or other returns, either earned, unearned or accruing over a given period of time (Martin, 2016). Its application in this study it involve all amount of monetary or other returns which are either earned or accruing over a given period of time.

Low Income: Refer to the state of not having or earning much money (Cambridge University Press, 2017). In this study it includes all households that live in less than a dollar a day.

Married Couples: According to University Press (2017) it refers to a relationship that results from a contract by which a man and a woman, who have the capacity to enter into such an agreement, mutually promise to live together in the relationship of husband and wife in law for life or until the legal termination of the relationship in this study, it refers to any individual in a sexual relationship.

Men: Refers to an adult male humans (Urban Dictionary, 2017). In this study it refers to all men who are above 18 year and are sexually active.

Patriarchy: It refers to a system of society in which the father or eldest male is the head of the family and descent is reckoned through the male line (Cambridge University Press, 2017). In this study it refers to a society whereby the father or mother is the head of the family and has overwhelming power over family members in the household.

Perception: Refers to a belief or opinion, often held by many people and based on how things seem (Cambridge University Press, 2017). In this study it refers to the way in which contraceptives are regarded, understood and interpreted by heads of households.

Types of Contraceptive: It refers to various devices, agents and drugs that prevent women from becoming pregnant (Cambridge University Press, 2017). In this study it include the agents, devices and even drugs that households' heads use to prevent women from becoming pregnant.

Women's Places: Is an area where only women are allowed, thus providing a place where they do not have to interact with men. Historically and globally, many cultures had, may still have, some form of female seclusion. According to this study, it refers to what the society considers as a place for women where men are discouraged to go.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This section reviews existing literature on contraceptive use among households' heads in low income households. Specifically, on the situation of contraceptives use in Kenya, types of contraceptives, frequency of contraceptive use among households' heads in low income household, financial implications on contraceptive use and the effect of marital status on contraceptive use. Similarly, it relates the theoretical framework and its rationale to the study.

2.2 Situation of Contraceptives Use in Kenya.

It is estimated that nearly 100 million married women across the world intend to avoid pregnancy whereas they are not using any method of family planning. This demonstrates the deficit in need for family planning across the world (Ezeh, Mberu & Jacques, 2009). In Kenya, the situation is almost the same with 43 per cent of unmet need for family planning. This makes more women to undergo unsafe abortion due unplanned and unintended pregnancies African Population Health Research Centre (APHRC, 2013). Over the last 25 years, Kenya's population has doubled with about 41 million people and is expected to grow more than that if it will not be managed (Zirada et al., 2015).

According to United Nations projection (2007), over the next 33 years Kenya's population will grow by 3000 people per day, 1 million per year, meaning in 2050 it will reach 85 million. Although some progress has been made, the fertility rates in Kenya are still high with approximately one million children being born every year. Today, Kenya's population stands at 46 million people and is expected to triple in 2100 with 160 million people if mortality and fertility rates remain constant (Adagala, 2014; APHRC, 2013). The population of Kenya can be described as "very young" as at least two-third of the population comprises people of 30 years and below and above 60 years make only 15 per cent. This is due to continuous growth in fertility in Kenya resulting in large youthful population. The government of Kenya has acknowledged that population control is a strategy in achieving sustainable socio-economic development (KNBS-ICF Macro, 2010). With 3 per cent annual population growth rate the Republic of Kenya (RoK) has incorporated family planning in all development policies since independence (KNBS-ICF Macro, 2010).

Kenya was the first country in Africa to come up with a National Family Planning Programme in 1967 on family planning. However, in 1990s this programme began stalling and has since

stagnated due to reduced political will and diversion of resources to HIV/AIDS (KNBS-ICF Macro, 2010). Besides this, the government has come up with strategies, programmes and population policies as an effort to manage the population growth rates. In fact, Kenya has acceded to global and regional agreements which include the Maputo protocol, the Abuja Declaration, the International Conference on Population and Development of 1994 and The Family Planning 2020 (FP2020) as way forward to manage population growth. (KNBS-ICF Macro, 2010)

Women in most parts of the world want to have small families but there is unmet need for family planning (Rozina, Uzma & Haleema, 2008). Despite the government of Kenya investing a lot on family planning, its access and use is still low among rural women and men in low income households. This is attributed to the fact that men don't use family planning or as decision maker they do not advocate their wives to use them. Even if it's a dream of every woman to have a small family, men aren't willing to use male family planning methods or allow their spouses to do so (Burke & Ambasa-Shisanya, 2011).

Men's involvement in use of family planning has been low. The argument behind this is that; they aren't interested in it and further they would damage the quality of women's services and increase competition of already scarce resources (Withers et al., 2015). However, both the 1995 Fourth World Conference on Women in Beijing and the 1994 International Conference on Population and Development in Cairo have supported the inclusion of men in reproductive health services. Insisting for the need for men be involved in constructive roles and be incorporated in the broader reproductive health agenda. There is need to consider men's perspectives on use of contraceptive not only as spouses, but as individuals with different desires of their own and distinct reproductive histories (Adelekan, Omoregie & Edoni, 2014). Neglecting to provide them with services and information about family planning negatively affects family and women's health (Adelekan, Omoregie & Edoni, 2014).

2.3 Existing Types of Contraceptives

This section discusses various contraceptives methods available for men and women and perceptions around them. They are grouped according to their mode of application

2.3.1 Hormonal Methods of Contraception

They include implants, intrauterine methods (IUD), the pill, injectable birth control, vaginal rings, the patch and vaccine for contraception (National Center for Biotechnology Information, 2010). Most of these contraceptives have between 1-5% failure rates, thus considered as the

most effective ways for birth control (Department of Health and Human Services Report, 2012). According to National Center for Biotechnology Information (2010), hormonal methods of contraception either work by preventing fertilized egg from attaching itself on uterus walls, make it hard for sperm to enter fallopian tube or they alter the normal ovulation cycles to prevent pregnancy. All hormonal methods are reversible in nature. Their side effects include vaginal bleeding, lack of consistency, some have poor reversibility, some can't be used by patients with cervical cancer among other disorders, spotting and weight gain among other complications (U.S. Food & Drug Administration, 2015).

According to Gueye, Speizer, Corroon and Okigbo (2015) many women and couples with unmet need for either spacing or limiting births do not practice contraception because they lack adequate knowledge of the social, economic and health benefits of contraceptives, do not know which methods are available or appropriate for them, or do not know where to obtain these methods. Others are discouraged from using these methods because they believe that their partner, family, community or religion is opposed to contraception. According to a study in Mali, many women feared that the pill and the injectable could cause permanent infertility (Ochako et al, 2015).

A qualitative study in Kenya among sexually active women aged 15–25 demonstrated that many women had misconceptions about the side effects of modern contraceptives (e.g., that they cause infertility or can harm a woman's uterus), but few had experienced or knew someone who had experienced an actual side effect (e.g., weight gain) (Gueye, Speizer, Corroon & Okigbo, 2015). For instance, in a study that was carried out in Kenya some respondents reported that the pill "can accumulate into a life-threatening mass in the stomach, can cause blood to flow out of the nose and mouth, and can cause delivery of children with two heads and no skin". Ochako et al (2015) noted that myths and misconceptions about methods can spread through informal communication via social networks and lead to continued negative perceptions.

2.3.2 Barrier Methods of Conception

They include male condoms, female condoms, sponges, spermicides, diaphragms and cervical caps (U.S. Food & Drug Administration, 2015). According to Meyer Laboratories Inc. (2012) most of these contraceptives they have more than 99% effective rates in prevention of pregnancy when used appropriately. Mara and Head (2015) note that contraceptives like female and male condoms provide dual protection in HIV/AIDs and pregnancy protection when used

as described. Despite male and female condoms being readily available, easy to use, cheap they are not completely accepted more so among married couples as are related with spousal infidelity and reduction in sexual pleasure (Mathew & Bantwal, 2012). According to Gueye, Speizer, Corroon and Okigbo, (2015) diaphragms, cervical caps, spermicides and sponges has been related with myths on side effects and fear of health problems leading to their nonuse or discontinuation among its users.

2.3.3 Sterilization Methods of Contraception

They are permanent methods of contraceptives that either prevents a man from releasing sperm or prevent a female from getting pregnant. Some of these methods are reversible while others are permanent (National Library of Medicine, 2013). According to Meyer Laboratories Inc. (2012) they include tubal ligation, vasectomy and sterilization implants, whereby tubal ligation and sterilization implants are permanents methods and vasectomy is a reversible method of contraception. Vasectomy works by blocking the path between testes and urethra thus making hard for sperms to get through (Anish, Sreelakshmi, Akhila, Anadu & Afsar, 2013). On the other hand, tubal ligation is a procedure cut of the path between uterus and ovaries preventing the egg and sperm from reaching each other (National Library of Medicine, 2013). Finally, sterilization implants is nonsurgical procedure which blocks the fallopian tubes (Conceptus, 2012). They are have more than 99.9% accuracy in prevention of pregnancy.

According to Ohn-Mar, Sandheep, Husayni and Zuhri (2019) on study on medical students noted that most of them favored vasectomy over female sterilization and very few would recommend it to people they were close to. According to Otovwe and Okandeji-Barry study (2018) sterilization methods more so vasectomy is perceived as form of castration, worst option as form of male contraception and encourages promiscuity reflecting poor perception towards it. In addition, the study showed that having good knowledge of sterilization methods of contraception does not really translate into good perception towards them as the respondents despite their good knowledge of them they still exhibited poor perception towards them.

2.4 Use of Contraceptives among Household's Heads

There is growing recognition of joint responsibility between women and men in reproductive health as it has been realized that men have a significant role to play (Shahjahan et al., 2013). There is growing evidence that engaging men in family planning enhances spousal communication, increases men's knowledge and de-stigmatizes the use of family planning (Stover & Ross, 2010). Use of contraceptives is an integral part in the prevention of unwanted

pregnancies, reduction of unsafe abortions and in some instances prevention of sexually transmitted diseases (Stover & Ross, 2010; Tsui, McDonald-Mosley & Burke, 2010).

Use of family planning has been related with promotion of gender equity, greater education and as empowerment strategies for women that every man would wish for his wife (Yue, O'Donnel & Sparks, 2010). A number of small-scale programs that have targeted men in reproductive health have discovered that involving men in family planning has a positive result (Blake & Babalola, 2002). However, beside the need to engage men in family planning issues, there is still lack of rationale for this, thus need for development and scaling up of evidence-based interventions of male involvement in family planning interventions (Tsui, McDonald-Mosley & Burke, 2010).

Participation of men in family planning issues, more so in patriarchal society is vital as men play a crucial role in influencing and determining family fertility (Justice & Jacob, 2014). Despite men's vital role in family planning, their participation has remained low. As are many myths and misconceptions revolving around use of contraceptives. Furthermore, mainstreamed research which has neglected the crucial role of men in family planning thus reinforcing the notion that family planning is a woman's business (Ditekemana et al., 2012; Magadi & Curtis, 2003).

This has led the International non-governmental organisations and governments to come up with numerous policies and programs that emphasis on the need for engaging men in contraception related programs and projects. Some of them include International Conference on Population and Development in Cairo of 1994 which emphasize on the importance of involving men in sexual and reproductive health (Pan American Health organization-PAHO, 2002; Stephenson, Baschieri, Clements, Hennink & Madise, 2007).

According to Blacker, Opiyo, Jasseh, Sloggett and Ssekamatte-Sswbuliba (2005), it has been observed that, men in agrarian economies prefer to have more children than in other economies to provide labour, as a source of prestige and for economic gain. This means that men in agrarian economies may not use contraceptives as they need more children. As men are the main decision makers in patriarchal societies, their perceptions on use of contraceptives is believed to deter utilization of contraceptive and family planning in general at family level (Justice & Jacob, 2014). According to a study in Kenya, men's decision making power has the ability for women to comply and submit to these decisions. Thus husband's approval on contraceptive use is vital (Babalola, Folda & Babayaro, 2008).

2.5 Economic Implication of Contraceptives Use in Kenya

Low economic growth and wealth has been associated with health, actual poverty levels and inequalities more so in developing countries increase the vulnerabilities in health and reduce life expectancy (Boerma, Bryce, Kinfu, Axelson & Victora, 2008). Use of contraceptive is not only important for individual reproductive health but as far as in reducing fertility and escaping from poverty-fertility trap in developing countries (Hosseinpoor et al., 2011).

According to large scale survey, the level of wealth in different countries marked differences in family planning coverage, maternal and child health (Boerma et al., 2008; Hosseinpoor et al., 2011). For instance, women in more affluence families use modern contraceptive much more than women in low income households. This shows the disparities in the access to and use of contraceptives which are associated with wealth gradient (Gillespie, Ahmend, Tsui & Radloff, 2007; Gakidou & Vayena, 2007).

In sub-Saharan Africa, the significance of the inequity in meeting the needs for family planning has been marked with limited specific studies confirm how wealth affect the use of contraceptives (Creanga, Gillespie, Karklins & Tsui, 2011; Ortayli & Malarcher, 2010). Nonetheless, the research on how wealth affects the use of contraceptives in Africa is scant (Elfstrom & Stephenson, 2012). In countries like Burkina Faso, Egypt and Mali community wealth factor has been recorded to have an impact on health services but not in Kenya and Mozambique. However, the relationship between wealth and contraceptive behaviour has not been explicitly investigated (Elfstrom & Stephenson, 2012).

2.6 Implication of Marital Status on the Use of Contraceptives

At least one in ten married or in-union women in most regions of the world have an unmet need for family planning**.** Globally, in 2015, 12 per cent of married or in-union women were estimated to have an unmet need for family planning; that is, they wanted to stop or delay childbearing but were not using any method of contraception (Bongaarts, 2012). The level is much higher, 22 per cent, in the least developed countries. Many of the latter countries are in sub-Saharan Africa, which is also the region where unmet need are high (24 per cent), double the world average in 2014 (Bongaarts, 2014). In general, unmet need is high where contraceptive prevalence is low. Unmet need in 2015 was highest (above 20 per cent) in the regions of Eastern Africa, Middle Africa, Western Africa, and Melanesia, Micronesia and Polynesia. Unmet need was lowest in Eastern Asia, Northern Europe, Western Europe and Northern America (Bradley, 2012). Given that survey data on unmet need for family planning

are limited, especially for countries in Europe and Eastern Asia, the median estimates presented for 2015 have relatively wide 80 per cent uncertainty intervals (Bradley & John, 2014).

According to a study that was done by Mosha, Ruben and Kakoko (2013) in Tanzania, men and women who frequently have been exposed to family planning messages on mass media are more likely to discuss it with their spouses. This explains the importance of exposing couples to family planning messages regularly as it shapes their attitude towards family planning (Mosha, Ruben & Kakoko, 2013). For instance in Mali, men and women who have been exposed to family planning campaigns are linked with developing a positive attitude towards contraception besides the fact that Islam opposes family planning (Mosha, Ruben & Kakoko, 2013). Different strategies have been employed to revise negative cultural attitudes toward the use of contraceptives. Although, contraceptives have been associated with causing of barrenness, bleeding and death among other myths and misconception.

Several studies in Africa have suggested that, family planning programs in Africa have failed because they failed to account for power relations in the families and the nature of patriarchal systems in different societies (Srikanthan & Reid, 2008). For instance in Nigeria, men have shown low interest in adoption of family planning due to socio-economic and demographic factors (Adagala, 2014). However, these studies failed to take into account how culture, traditional and gender roles affect men's participation, how they influence their attitudes and its consequences on use of contraceptives (Srikanthan & Reid, 2008). According to Zulu et al, (2011) attitudinal resistance of men is a major barrier to family planning. Zulu et al, (2011) further notes that men's attitudes and willingness to family planning is little known because of their low participation in family planning which has been under-investigated. According to a study in Senegal, men are very conservative on fertility issues (Becker, 1996). Becker (1996) suggests that, in order for couples to agree on contraceptive use, they should freely discuss and perceive the attitude of each other fairly.

Sources of family planning information have been determined to influence the perceptions of men on use of contraceptives. For instance, according to a study done in Kenya married men were aware of many modern contraceptives but were highly stigmatized on their use (Ochako et al., 2017). Some of the arguments behind limited support of men on contraceptive use is that, they believe that they have adverse effect on general health and on the couple's sexuality. Indeed married men don't use majority of contraceptives methods despite their availability because they hold certain attitudes towards them, due to mythical influences and and misconceptions (UNFP, 2009).

2.7 Theoretical Framework

This study was informed by two theories; the theory of planned behaviour and the radical feminist theory.

2.7.1 The Theory of Planned Behavior

This theory was developed by Icek Ajzen from the Theory of Reasoned Action. The theory views human behaviour as being influenced by internal and external factors (Ajzen, 1988; Fishbein & Ajzen, 1975; Ajzen, 1991). Its argument is that, human behaviour can only be explained by behavioral intention. These behavioral intentions are influenced by subjective norms (these are external factors that influence one's behavioral intention like level of education, age, marital status and culture, among others) and specific behaviour attitude (the internal factors that influence one on use of contraceptives such as personal attitude, perception and temperaments among others). That is, the intention of a behaviour is influenced by social norms and how as an individual perceive it (Montano et al., 1997). That's, the perception of an individual on others' behaviour determines whether or not to comply with others.

Regarding to this study, in order for households' heads to use the available contraceptives the subjective norms and specific attitude should support it. That is, for households' heads to adopt contraception behaviour they need to get adequate information about contraceptives, there is need for better alternatives methods and finally the society should upheld the use of contraceptives. As there are many myths and misconception on use of contraceptives (UNFP, 2009). This theory is further complimented by radical feminist theory.

2.7.2 Radical Feminist Theory

The pioneers of and the primary players in this theory include Ti-Grace, Kathie Sarachild, Atkinson Shulamith Firestone, Judith Brown and Carol Hanisch (Evans, 2002). The philosophy behind this theory is that; patriarchy is the root cause of women's oppression and marginalization. That is, because of patriarchy, women are viewed as "others" as it gives men status in the society. It asserts that men gain benefits from oppressing women. It further argues that, men use the available social systems and other methods to suppress and dominate women (Atkinson, 2000). According to this theory, eliminating patriarchy will not only liberate women but everyone from an unjust society to achieve the overall goal of gender equality (Evans, 2002).

With regard to this study, in a patriarchal society like in Kuresoi North men have an overwhelming power over their women whereby they use available systems and other methods

to enforce their power over women. On issues of reproductive health, men dominate decision making regarding family size, contraception behaviour of their spouses, children spacing, when and how to have sex and when and whether to use contraceptives or not. With this, perception of men on contraceptive directly affect their contraception behaviour and that of women. Thus, there was need to find out the perceptions on the use of contraceptive among households'heads as a strategy to improve the acceptance and uptake of contraceptives in managing population growth.

2.8 Conceptual Framework

A conceptual frame work indicates the relationship between the independent variable-low income household characteristics and how they affect the dependent variable-perceptions of households' heads on use of contraceptives. Married men believes that use of contraceptives is a women affair. On the other hand, single men may tend to use contraceptives as a way to protect themselves from sexually transmitted diseases and unwanted pregnancies, thus having positive perception on its use.

The level of income of the household may affect the cost of transport, purchasing power and sourcing of information on contraceptives from different sources. Households with low income may have negative perception towards the use of contraceptives due to lack of financial power and constraint of accessing contraceptives while household with high income may have positive perception due to availability of resources. The government policy on contraceptive use especially on subsidizing contraceptives may affect the perception of men on its use. Most cultures and religious beliefs affect the utilization of contraceptive in one way or the other hence the study only selected households' heads in low income families in order to control the intervening variable as the population was homogenous. The theory of planned behaviour concerns with this study as external and internal factors such as level of education, age, marital status, attitude and the positive perception towards use of contraceptives among households' heads have affected choice and utility of various types of contraceptives. This study disagrees with the theory of radical feminist theory as women are the main users of contraceptive and they make independent decision concerning use and choice of contraceptive contradicting with the patriarchal system where men dominate in decision making. The use of the contraceptive depended on the economic status, marital status and type of contraceptive used thus affecting the perception and frequency of use. Figure 1 shows the relationships between the variables.

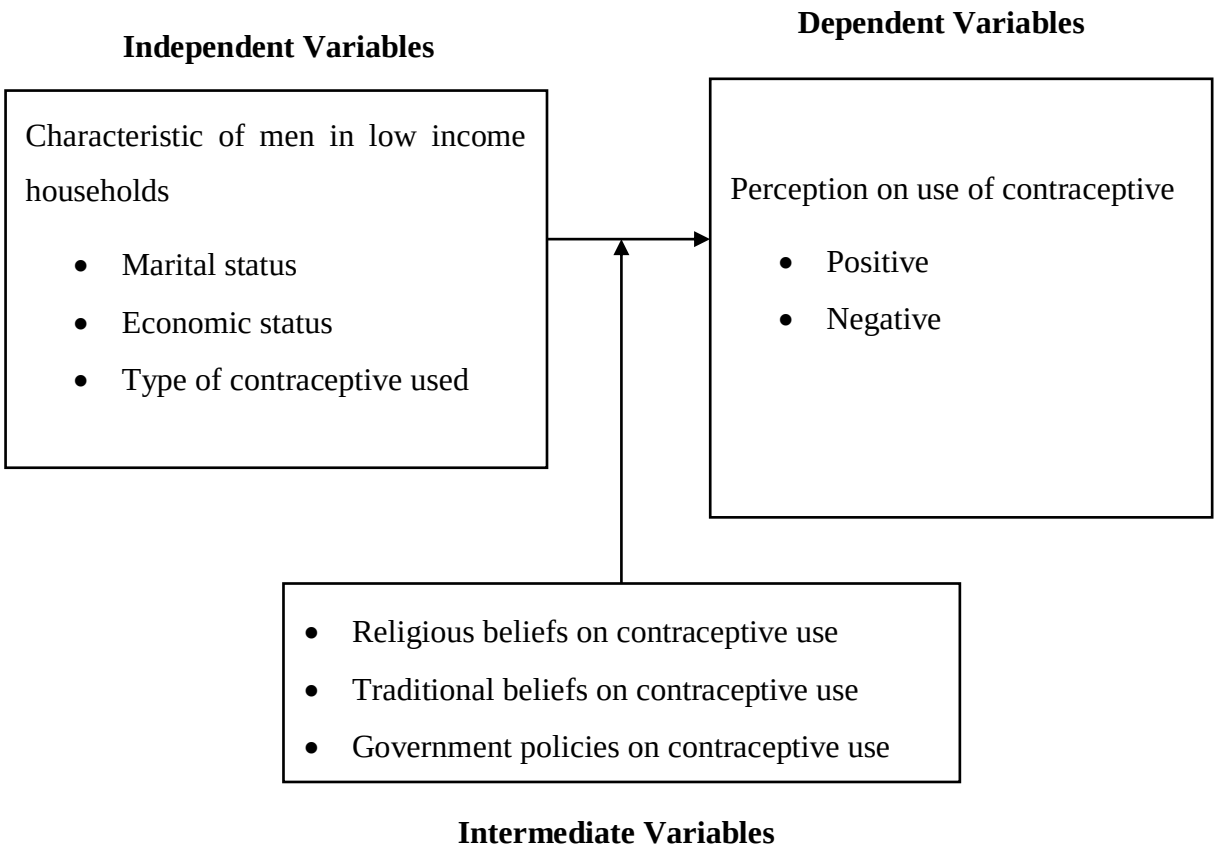

Figure 1: Relationship between Independent, Dependent and Intermediate Variable.
Source: Own Conceptual Frame Work

CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter presents the procedures that were used to collect and analyze data. It also highlights the research design, study area, population, sampling procedures and sample size, instrumentation, data collection procedures and data analysis.

3.2 Research Design

A research design, according to Kothari (2011), constitutes the blueprint for the collection, measurement and analysis of data. A cross-sectional survey research design was used for this study. Survey research is a non-experimental research method that uses questionnaires or interviews to gather information (Orodho, 2004). Survey research provides the researcher with information on characteristics, opinions, attitudes, emotions, or knowledge of a population by studying a sample of that particular population (Creswell, 2014). Survey research design was the best approach for conducting this study because of the advantages it provides. First, survey research is very flexible; it allows a researcher to study a variety of research questions that require description, explanation, and the relation of situations or variables (Kothari, 2011). Secondly, survey research allows a researcher to generalize the findings of the study to a population, especially if the sample is selected randomly and is representative of all the sub-groups within the population. Survey research is efficient as it can save a researcher a huge amount of time and money. A researcher can collect a large amount of data at low cost. This is especially true for cross-sectional surveys (Kothari, 2011). The study used this design to elicit information on perceptions on contraceptives use among households' heads in low-income households.

3.3 Study Area

The study was carried out in Sirikwa and Kamara Wards of Kuresoi North Sub-county in Nakuru County. The rationale for choosing these wards was that: there have been several initiatives targeting mostly households' heads on contraceptive use by the Ministry of Health in the county and USAID's APHIAplus II as a way of controlling population growth and sexually transmitted diseases. The sub county was also ideal for this study because the society is cosmopolitan. The ideal setting for the study was one that was directly related to the researcher's interest (Singleton, Straits & Strait, 1993). The map of Kuresoi North Sub-County where the study was carried out is indicated in figure 2.

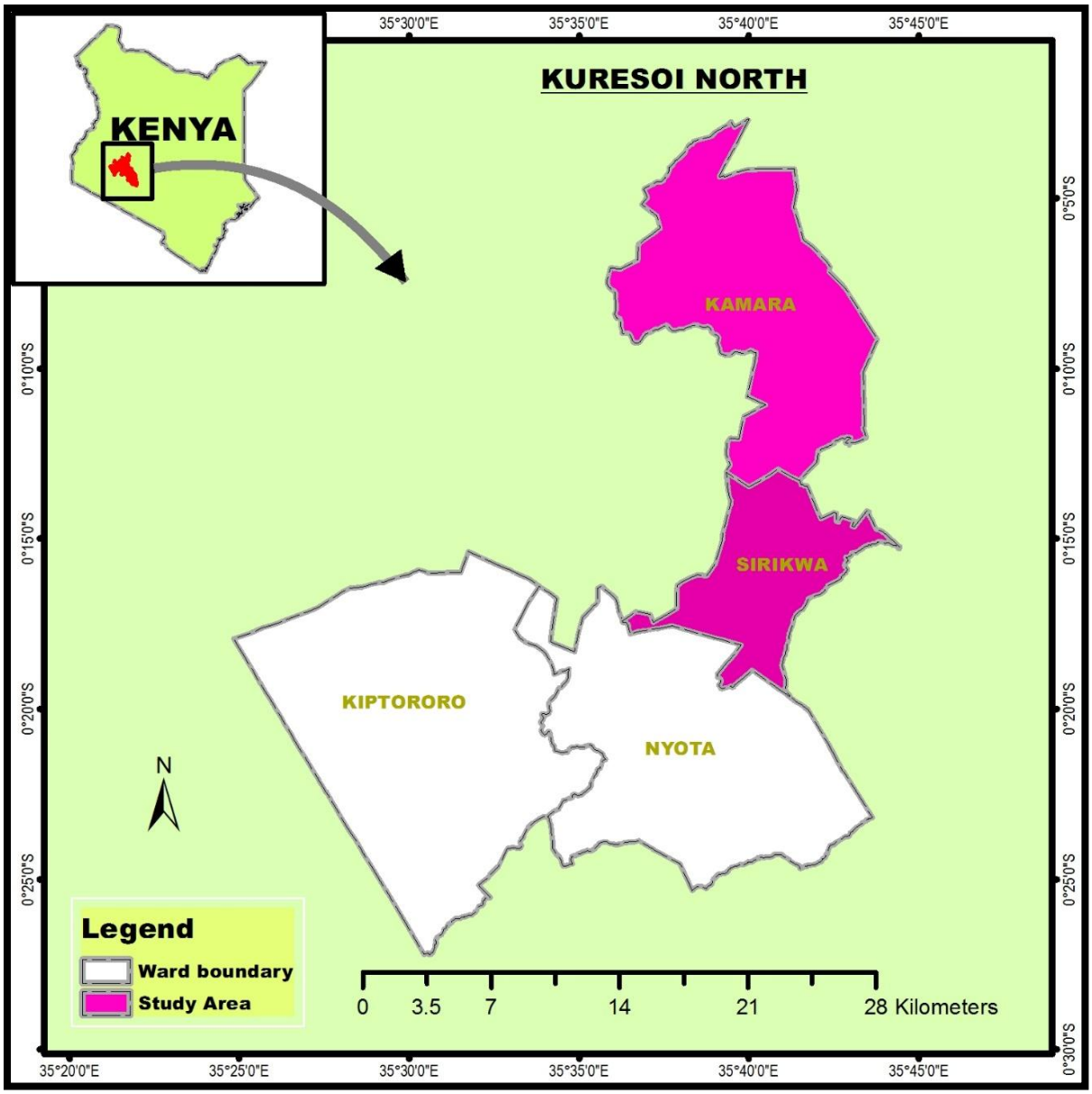

Figure 2: Map of the Study Area.

Source: Geography Department, Egerton University.

3.4 Population of the Study

The target population comprised of households' heads of 18 years of age and above in low income families in Sirikwa and Kamara Wards of Kuresoi North Sub-county in Nakuru County. The accessible population was individuals who resided in the two administrative wards during the time of study.

The target population and accessible population are shown in Table 1.

Table 1: Target and Accessible Population

Administrative wards	Target population of households' heads	Accessible population of households' heads
Sirikwa	231	134
Kamara	303	117
Totals	534	251

Source: Kuresoi North Sub-County Planning Document (2017).

From Table 1, the sub-county has five hundred and thirty four (534) households' heads in low income families. Of these, two hundred and fifty one (251) households' heads who resided in these wards were sampled to participate in the study.

3.5 Sampling Procedures and Sample Size

The sample size for the study was determined using a formulae according to Mugenda and Mugenda (2003) who recommended the following formula that was develop by Krejcie and Morgan (1970)

$$S=\frac{X^2NP\,(1-P)}{D^2(N-1)+X^2P(1-P)}$$

Where S = required sample size, N = the given population size, P = population proportion assumed to be 0.5 as this yields the minimum possible sample size required, D = the degree of occurrence with the highest occurrence and X^2 =the table value of Chi-square for one degree of freedom. Inserting the required information into the formula where N=251, P= 0.5, D= 0.05 and $X^2 = 3.841^2$ gives:

$$S=\frac{3.841^2 \times 251 \times 0.5(1-0.5)}{0.05^2(251-1)+3.841^2\times 0.5(1-0.5)}$$

= 130.382195 =130 households' heads.

Simple random sampling using the lottery technique was used to select the participants (household's heads in low income families) from a list of household's heads in the study area. According to Mutai (2000), this procedure is applied to ensure that the sample selection is independent of human judgment; and that the chance of selection for each member of the population would be non-zero. In doing this, the researcher wrote the names of all households' heads in low income families in the study area participating in the study on slips of paper. The slips of paper with the names of the respondents were inserted in a box then mixed thoroughly and were drawn (without looking). The required number of slips for the sample were drawn one after the other without replacement. In doing so, the researcher made sure that in successive drawings each of the remaining elements of the population had the same chance of being selected. Thirteen key informants who comprised 10 per cent of the study sample size were involved to verify the information gathered from the respondents using purposive sampling procedure.

3.6 Instrumentation

Data was collected using interview schedule for key informants and questionnaires for households' heads in low income families which were developed by the researcher. The test items were designed according to the research objectives.

3.6.1 Interview Schedule for Key Informants

The purpose of the interview schedule was to verify information that was gathered through the questionnaires. The interview schedule was administered to key informants who included religious leaders, public health officers, nurse in-charge, village elder, and Red-Cross social worker. They comprised ten per cent of the study sample size (13) who were purposively sampled in order to examine the in-depth issues surrounding use of contraceptive by households' heads in Kuresoi North sub-county. The interview schedule had open ended questions so as to solicit in-depth information concerning use of contraceptive among households' heads in low income households in Kuresoi North sub-county. According to Creswell, Hanson, Plano and Morales (2007), interview schedules have the ability to collect in-depth information from respondents who are well conversant with the subject matter under investigation.

3.6.2 Questionnaire for Respondents

The study used semi structured questionnaires which were administered to the selected 130 household's heads in low income families. The questionnaires were appropriate for the

respondents as they saved time and cost of administering them. According to Creswell, Hanson, Plano and Morales (2007), a questionnaires is a self-report instrument used for collecting information needed. A questionnaires assures a high response rate and minimum of bias, providing necessary explanations and giving the benefit of personal contact (Mugenda & Mugenda, 2003). Another advantage of the questionnaires is that data processing and analysis is cheaper.

The questionnaire comprised closed ended question items developed by the researcher in a likert rating scale. The major items in the likert scale included those representing the level of agreement, that is, strongly disagree (1), disagree (2), undecided (3), agree (4) and strongly agree (5) as well as those representing the extent, that is, very low (1), low (2), moderate (3), high/much (4) and very high/much (5). The questionnaire was structured to capture different types of information such as; demographic information, types of contraceptives used by households' heads, frequency of utilization of contraceptives by households' heads, financial implications of contraceptive use and effects of marital status of households' heads on contraceptive use.

3.7 Pre-testing of Instruments

Before the actual data collection, the researcher conducted a pre-testing of research instruments in the neighboring Kuresoi South Sub-County. Pilot study area was chosen due to similarity with the main study area to prevent the hallow effect during the main data collection. The researcher used 10 percent of the sampled population for pre-testing which is the minimum number of cases required for conducting statistical analysis (Mugenda and Mugenda, 2003). Therefore the pre-testing participants was household's heads who were supplied with contraceptives by health social workers. The sample was not included in the final study population. Simple random sampling were used to select the participants to ensure equal representation these households' heads. The purpose of pre-testing was to enable the researcher to ascertain the reliability and validity research instruments.

3.7.1 Validity of Instruments

Validity, according to Bryman (2004), is the extent to which a test measures what it is supposed to measure. The focus will be on face validity and content validity. According to Mugenda and Mugenda (2003), internal validity is concerned with the extent to which a study establishes a factor or variable that actually caused the effect. It is the extent to which extraneous variables have been controlled. External validity of the instrument indicates the appropriateness, meaningfulness and applicability of inferences to the target population (Creswell et al., 2007).

All assessments of validity are subjective opinions based on the judgment of the researcher (Orodho, 2003). Appropriate and relevant items were constructed in-order to capture all the research objectives to ensure valid and reliable data. Validity is established by expert judgment (Orodho, 2003). Therefore, the instruments were reviewed by the study supervisors and other educational experts from the Institute of Gender, Women and Development Studies of Egerton University. Validation of instruments was carried out to improve their effectiveness for collecting relevant data.

3.7.2 Reliability of the Instruments

According to Mugenda and Mugenda (2003), a measuring instrument is reliable if it produces the same results or data after repeated trials. An instrument is reliable when it can measure a variable accurately and consistently and obtain the same results under the same conditions over time (Orodho, 2003). From the theory of measurement, each response to an item reflects the true score for the intended construct and to some extent some random error (Kothari & Gaurav, 2014). A reliable measure minimizes the measurement error and the relationship between the true score and the observed score to be strong. The pre-testing enabled the researcher to assess the clarity of the test items so that those items found to be inadequate or vague would be modified to improve the quality of the research instrument, thus increasing its reliability. The instruments were tested for reliability by using cronbach alpha coefficient to determine the internal consistency of the items. From the pilot test results a reliability coefficient of α=0.819 was obtained. This was an indication that the instruments attained a reliability coefficient above the required threshold which is 0.7 and were therefore considered suitable to give consistent results from various respondents.

3.8 Data Collection Procedures

Before data collection, a research permit was sought from the National Commission for Science, Technology & Innovation (NACOSTI), to enable the researcher carry out the study. The researcher visited the health social workers, nurse in-charge, village elder, Red Cross social worker, public health worker and religious leaders who were also included in the study sample to familiarize himself with the study area and inform the respondents about the intension of the study. The health social workers provided an introductory note for the researcher to introduce himself to respondents. The researcher visited households' heads in low income households supplied with contraceptives before the commencement of the study for introduction and explanation of the purpose of the study. Modalities for collecting the required

data was discussed and agreed upon before the researcher embarked on the study. A set of questionnaires and interview schedules was administered to the respondents.

In order to ensure a high level of response, the researcher visited all the respondents and the instruments administered by the researcher personally. The researcher explained how to fill the questionnaires to the respondents. The purpose of administering the questionnaires and interview schedules in person was to avoid chances of misinterpretation of the items due to illiteracy as well as to solve problems of time and cost of travelling back to collect them. The instruments were then organized and then scored ready for analysis. Respondents was assured of confidentiality of their participation.

3.9 Ethical Concerns

According to guidelines for conducting research using human subjects, it is important to ensure that participants' protection is guaranteed. For this study, the required authorization letter was sought from Egerton University Ethical committee prior to conducting the research. As mandated by the Institutional Review Board (IRB), the protection of participants from safety, privacy, and welfare risks was ensured. The purpose of the research was introduced and adequate information provided about the study objectives. In particular, informed consent was sought from the participants with adequate information about (a) anonymity of participants; (b) voluntary nature of participation; (c) confidentiality of survey responses; (d) encouragement of participation; (e) freedom to stop participation at any time without explanation; and (f) contact information for the researcher. This enabled the participants to seek more information or voice any concerns. All through the study, the researcher ensured that participants understood clearly about their protection, the minimal risks for participating in the study, and that all results would be kept confidential and anonymous. Further, all the demographic data that was collected during the study were not included impersonally identifying information such as name and address in order to guarantee participants' anonymity and confidentiality. Consequently, the raw data, survey information, and subsequent statistical analysis related to the study were kept in safe custody with passwords on the SPSS templates which were burned on discs to ensure safe custody.

3.10 Data Analysis

Before the actual data analysis, questionnaires were checked to determine their completeness. The instruments were coded to facilitate analysis. The specific objectives stated in chapter one used descriptive statistical analysis. Data from interview schedules was analyzed qualitatively using Content Analysis and results presented in form of quotes and narratives. Data from the

questionnaires was analyzed quantitatively using descriptive statistics, frequencies, percentages, means and standard deviation with the help of the Statistical Packages for Social Sciences (SPSS) computer programme version 22. This provided an opportunity to increase the understanding of the perception of households' heads in low income households on the use of contraceptives.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction.

In this chapter, results and discussion are presented. The purpose of the study was to investigate the perception on the use of contraceptives among households' heads in low-income families in Kuresoi North Sub County in Nakuru County in Kenya. Data was collected from one hundred and thirty respondents and thirteen key informants. All the instruments were answered, as were self-administered by the researcher. This represents 100% level of response rate.

The study findings presented and discussed in this chapter were based on the four objectives listed below:-

i) To establish how the perception of households' heads in low income families affect the choice of contraceptive they use in Kuresoi North Sub County.
ii) To determine how the perception of households' heads in low income families affect their frequencies of use of contraceptive in Kuresoi North Sub County.
iii) To find out how economic status of households' heads in low income families affect their perception on the use of contraceptives in Kuresoi North Sub County.
iv) To examine how marital status of households' heads in low income families affect their perception on the use of contraceptives in Kuresoi North Sub County.

4.2 Socio-Demographic Characteristics of the Respondents

The subjects for the study comprised 130 respondents simple random sampled using lottery technique. The study gathered information on the respondents' personal characteristics, these personal characteristics encompassed age, marital status, monthly income, types of employment, size of household, level of education and religion. The analysis results are as shown in table 2 below.

Table 2: Background Information.

	Frequency	Percent
Age		
18-27yrs	33	25.0
28-37yrs	39	30.0
38-47yrs	33	25.0
48-57yrs	25	20.0
Marital Status		
Single	39	30.0
Married	91	70.0
Monthly Income		
Ksh 0-5000	71	55.0
Ksh 5001-10001	39	30.0
Ksh10002-20002	7	5.0
Ksh 20003-30003	13	10.0
Type of Employment		
Formal Employment	13	10.0
Informal employment	32	25.0
Self-Employment	85	65.0
Size of Household		
0-2	52	40.0
3-5	52	40.0
6-8	26	20.0
Level of Education		
Non-formal	13	10.0
Primary	33	25.0
Secondary	58	45.0
Tertiary college	19	15.0
University	7	5.0
Religion		
Catholic	65	50.0
Protestant	52	40.0
None	13	10.0

Source: Field Data (2018).

4.2.1 Age of the Respondents

From table 2 above it was noted that 55 % respondents were of age between 18 years and 37 years. This age bracket indicated that the respondents were sexually active and were either using contraceptives for prevention of sexually transmitted infectious and unplanned pregnancies. Respondent of age 47 years and above reported that they were not using contraceptives as most of their sexual partners had reached menopause. According to a study carried out by Okech, Wawire and Mburu (2011) in Kenya, family planning was found to be highest among users aged between 20 - 39 years compared to those below 20 years and above 39 years. Whereas 49 percent of the users that were using contraceptives were aged 20- 29 years, 41 percent were aged between 30 - 39 years, while no user aged 50 years and above were

not found using any form of contraceptives. The current study concurs with Okech, Wawire and Mburu (2011) study which indicated that age plays a major role in use of contraceptives.

4.2.2 Marital Status of the Respondents

From table 2 above 70% of married respondents reported using contraceptives compared to 30% who were single during the time of the study. Married respondents reported that they used contraceptives for birth spacing and to get desired number of children that they can sustain without straining. On the other hand, single respondent recorded low use of contraceptives as they reported that they did not engage in coitus regularly like married respondents. According to Jones, Mosher and Daniels (2012) a much higher proportion of married women than of never-married women use a contraceptive method (77% vs. 42%) was noted, largely because married women are more likely to be sexually active. But even among those at risk of unintended pregnancy, contraceptive use was higher among married women than among never-married women (93% vs. 83%) concurring with the current study. According to Wang (2017) Eastern and Southern African countries have shown increase in contraceptives prevalence among never-married women. Whereby, the greatest increase in use of contraceptives among never-married women occurred in Malawi, Kenya, Lesotho, and Tanzania, ranging from 11% points in Malawi to 20% points in Lesotho, disagreeing with the current study.

4.2.3 Monthly Income of the Respondents

According table 2 above, 85% of respondents had less than Ksh 10,000 monthly income which was affecting the choice of contraceptives they used, access to information on contraceptives and access to the contraceptives as their income only facilitated their physiological needs. Frost, Darroch and Remez (2008) observed that the proportion of pregnancies in the United States that are unintended was 49%, and among low-income families, this proportion was even higher with 62%. This observation corroborates the findings in the current study.

4.2.4 Type of Employment of the Respondents

Table 2 above indicates that 10% of the respondents reported that they had formal employment, 25% reported they were in informal employment while 65% reported that they were self-employed. The type of employment/ occupation affected the reproductive behaviour of respondents positively and negatively. Formally employed respondents reported using contraceptives frequently and going for expensive and more effective contraceptives. The informal and self-employed respondents reported low and irregular use of contraceptives with others reporting use of natural and herbal contraceptives. According to Blackstone (2017) the

desire for career development increases the likelihood for the use of contraceptives more so for those in formal the sector. Frost, Darroch and Remez (2008) noted that because of inconsistence in income, self and informal employment affect their choice of contraceptives one want to use and limit contraceptive information access affirming the current study.

4.2.5 Size of Household of the Respondents

From table 2 above, 80% of the respondent reported that they had a household size of 0-5 members. This size of household tended to have been affected by use of contraceptives among respondents. According to Jayaraman, Mishra and Arnold (2009), white women were reported to have fewer number of children and an older mean age at first birth than Hispanic and black women and that men and women with low levels of education were likely to have high mean numbers of children. Aldashev and Platteau (2014) noted that the size of household is influenced by religion, income, age, land size, personal preference, old age security, occupation and age at first marriage indicating other factors that influence the size of households.

4.2.6 Level of Education of the Respondents

According to table 2, 90% of the respondents reported that they attained primary level of education. This means they were able to read and write. From the study results, the higher the in level of education among the respondents improved the use of contraceptives, that is, it increased the frequency of use and the choice of contraceptives they used. According Gubhaju's (2006) survey which assessed the choices made by women, it emphasized that the education levels of the wife and the husband influenced which method a couple used. For instance, higher level of education among women was associated with use of hormonal methods and condoms. While, a higher level of education among men was strongly associated with the use of condoms and reliance on male sterilization concurring with the current study. According to descriptive data from the 2006 Nepal DHS, use of contraceptives was higher with couples with high education levels concurring with the current study (Dahal, Padmadas & Hinde, 2008).

4.2.7 Religion of the Respondents

As shown in the table 2, 50% the respondents reported that they were Catholics, 40% reported that they were Protestants while 10% of the respondents they did not disclose their religion. Based on these findings, religion affected perception of the respondents towards use of contraceptives. Some of the respondents reported that the decision to use contraceptives was affected by the doctrines taught by religious leaders based on the faith. The respondents still felt fear of being punished by God, to be accused by others, or some felt a frustration caused

by a contradiction between religious rules and their practices. Another issue was that the religious texts were interpreted differently, and in order to deal with this contradiction, some of the participants sought advice among the religious leaders and actively tried to interpret religious texts. No matter the decisions one made, religious beliefs affected individual attitudes and decision-making processes in a way that complicated the decisions being made. The community under study is a small and intimate community and most people know one another. Religious peer influence and fear of disapproval among peers due to decisions based on wrong interpretations were factors that influenced how people talked about and related to contraceptives. However, the ambivalent relationship caused by a conflicting interest between religious beliefs and socio-economic needs, first of all seemed to cause conflict within the individual.

According to Yihunie et al., (2013), the Current Use of Contraceptive (CUC) varied significantly among users across all categories of association between ethnicity and religion thereby justifying their predictor effect on CUC. For instance, the prevalence of CUC among users of Hausa, Fulani and Kanuri ethnic origin who were Muslim was quite expected. The possible reason for this, was the religion and cultural beliefs of most of these users that God has placed Children in the womb of a women and until they are given birth to, you do not stop. Also, Islam permits polygamy and as such most of these women believed that they could gain much of their husband's attention when they are often pregnant for him. This explains the findings in Ethiopia that women who had polygamous marriage were by half less likely to use modern contraceptive methods than women in monogamous marriage (Yihunie et al., 2013) affirming the current study.

4.3 Perception on the Choice of Contraceptives

The first objective of this study intended to establish whether the perception of households' heads in low income families affected the use of contraceptives. To achieve this, the study gathered information on the types of contraceptives households' heads used, why they used it and who introduced them to contraceptives. This is summarized below

4.3.1 Types of Contraceptives Used.

From figure 3, 55% of respondents reported that they used condoms, 30% hormonal contraceptives and 15% they were not using any form of contraceptives during the time of study. Condoms were most used form of contraceptives in the study as they are cheap, easy to use, effective and sometimes given free by the government and USAID. Most of the health workers recommended these form of contraceptives to those who visited clinics to receive

contraception. This was because the method was readily available, easy to use and effective in prevention of sexually transmitted diseases and unwanted pregnancies. The majority of the respondents that used other methods of contraceptives seemed to have good knowledge about its use and their effects as indicated in the figure 3.

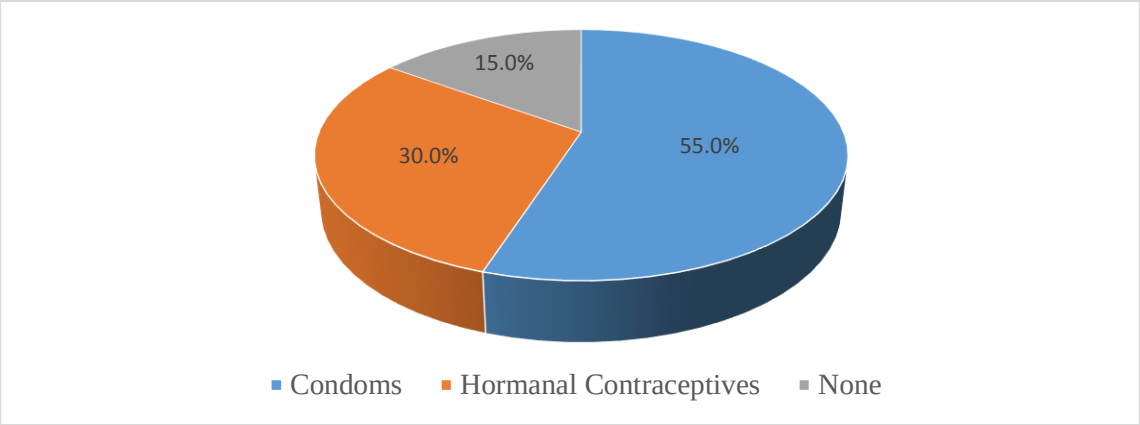

Figure 3: Types of Contraceptives Commonly Used .
Source: Field Data (2018).

Weinberger (2014) affirm that in Kenya, condoms (35%), pills (33%), injection (19%), and intrauterine contraceptive devices (IUDs) (4%) are the most commonly used contraceptive methods, concurring with the current study. According to Nelson et al., (2018) in Kenya most majority of contraceptive users (68%) had experience with oral contraceptive, while fewer had experience with other forms: 15% injection, 4% implant, 7% patch, 7% vaginal ring, 13% IUD. 17% of users had undergone a permanent contraception procedure or had been told they were unable to conceive disagreeing with the current study which indicated that condoms were most used type of contraceptives.

4.3.2 Reasons of the Choice of Contraceptives.

From the study results, different respondents seemed to have different perceived reasons for contraception as indicated in figure 4. 40% of the respondents reported that they preferred use of condoms as it had no side effects, 20% reliable, 20% cost effective, 15% readily available while 5% they were just using it. Most of the respondents were of the view that hormonal contraceptives have mild to severe health effects depending on the body makeup of a person discouraging some from using them. Respondents reported similar fears based on the use of injectable contraceptives, the contraceptive pill, and implants. Respondents indicated that using such contraceptives could lead to weight gain, increase in blood pressure, infertility, protruding belly, nausea, mood swings, persistent bleeding or spotting, retention of blood in the body, dark marks on the skin, decreased sexual pleasure, backache and headache.

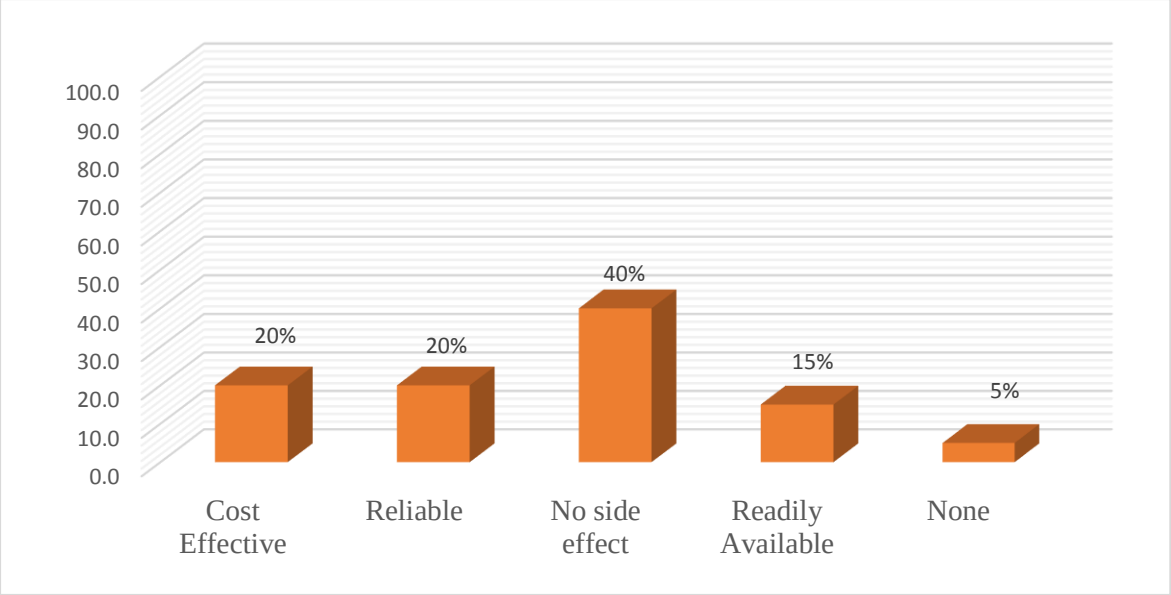

Figure 4: Reasons for the Choice of Contraceptives.
Source: Field Data (2018).

From the interview schedule the respondents outlined that, although the use of contraceptives depended on the availability of the contraceptives, their effectiveness, their cost and the ease of use, their level of side effect determined whether they would using them or not. The theory of planned behaviour argues that unfavourable perceptions towards a behaviour in question negatively impact on the actual performance of the behaviour (Ajzen, 1991). The perceptions and beliefs about the likely outcomes of using hormonal contraceptives could possibly produce unfavourable attitudes towards their use, which in turn might lower their use. The perceived health effects and cognitive beliefs about using hormonal contraceptives might have contributed to their low use by the participants in the study.

According to Kenya National Bureau of Statistics (KNBS) and ICF Macro (2009) survey across all age groups, perceived and actual side effects of contraceptive methods emerge as a primary barrier to use of contraceptives. For instance in Kenya it was noted that married women reported they did not intend to use contraception in the future most commonly citing fear of side effects and health concerns on different types of contraceptives to affirm the current study (KNBS & ICF Macro, 2009).

4.3.3 Cost of Contraceptives.

This study found that cost of acquiring contraceptive services and contraceptive related influenced decision-making processes about contraceptive use. From the study results, the respondents reported that they spent on contraceptives as indicated in the figure 5 below.

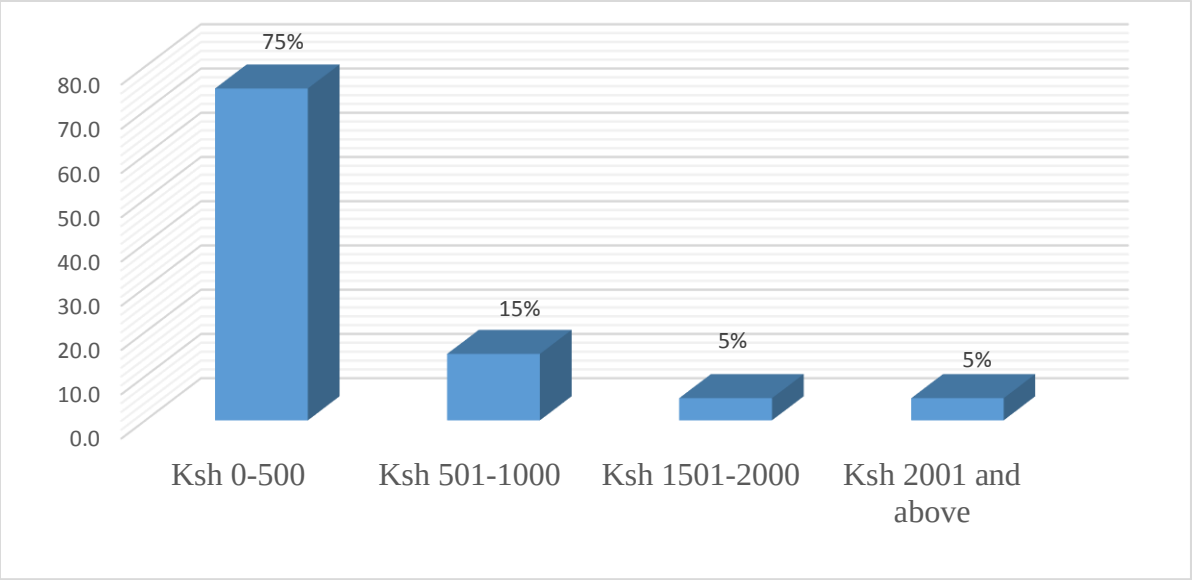

Figure 5: The Cost of Contraceptives.

Source: Field Data (2018).

From figure 5 above, 75% of the respondents reported that they spent less Ksh 500 on contraceptives, 15% spent between Ksh 501- 1000, 5% spent between Ksh1501-2000 while 5% spent Ksh 2001. This has been attribute by government and USAID provision of free and subsidized contraceptives in the study area. According to the interview schedule, respondents reported that, the ministry of health in the country was providing subsidized contraceptives in all public health centers making clients to spend less on contraceptives. From content analysis extraction respondents reported that:

Text Box 1: Content Analysis Extraction on Cost of Contraceptives.

"*Although the government is providing subsidized and free contraceptives some of them are considered of poor quality and ineffective. For instance, when it comes to condoms, the most trustable condoms are the most expensive ones, so somebody like me who does not trust the free ones will go and buy the most affordable ones, but we still think that the most expensive ones would still be better to have, so the issue of money.*"

Wafula, Obare and Bellows (2014) reported that, the government of Kenya do provide free and subsidized contraceptives thus one doesn't have to spend a lot of money on them concurring with the current study.

4.3.4 Source of Information on Contraceptives

From the study results, 45% of respondents reported that they were introduced to contraceptives friends, 30% by medical doctor, 15% by social workers while 10% got from

other sources as indicated in figure 6. This phenomenon can be said be to out of peer interactions and as patients went for medical services they were enlightened on different contraceptives. The key informants reported a lot of information on contraceptive is disbursed through posters and pamphlets; and the mass media like the internet, radio, and TV programmes.

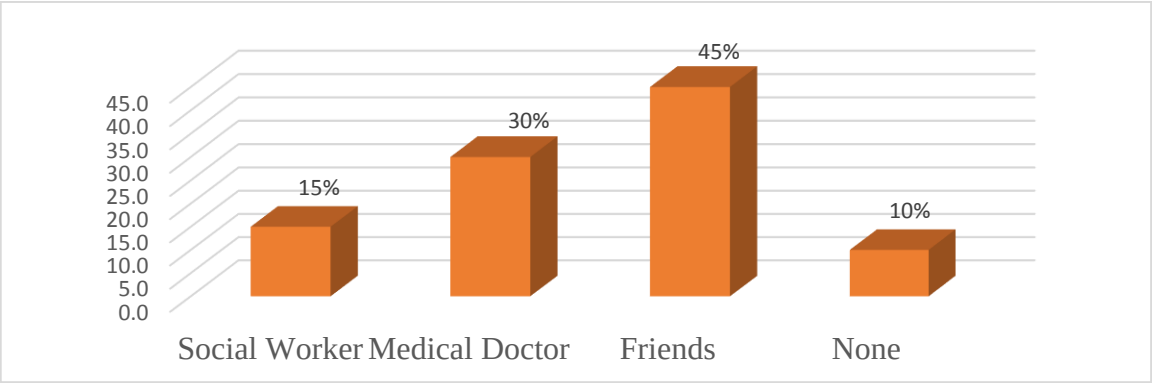

Figure 6: Source of Information on Contraceptives.
Source: Field Data (2018).

From the key informants, respondents acquired the knowledge from multiple sources. As the majority of the respondents were introduced to contraceptives by their friends, their attitude was shaped by the information given by friends on different types of contraceptives affecting their use. Parents were rarely mentioned as sources of knowledge of contraceptive use, yet they were perceived as more knowledgeable on the topic. The theory of planned behaviour argues that improper evaluation of outcomes of behaviour may possibly change attitudes towards the behaviour, and this could negatively influence actual practice (Ajzen, 1988; Fishbein & Ajzen, 1975; Ajzen, 1991). The implication of this theoretical assumption to the findings of this study is that the respondents might be lacking sufficient and accurate information about contraceptive use, which could help them evaluate the cost and benefits of using them. According to Wafula, Obare and Bellows (2014) peers and partners has been documented to affect contraceptive demand, perception, attitude and uptake in Kenya. Wafula, Obare and Bellows (2014) noted that myths and misconceptions that contraceptive users hold about potential side effects and negative outcome of contraceptive use, are heard from peers and partners, concurring with the current study.

4.3.5 Reasons for the Use of Contraceptives

The perceived benefits of contraceptives among the respondents shaped the types and the choices of contraceptives they used. Different types of contraceptives has been related with prevention of sexually transmitted diseases and unwanted pregnancies, improve a woman's

facial appearance by removing acne and can help to decrease menstrual cramps benefits (ESHRE Capri Workshop Group (2014). From figure 7, 55% of the respondents reported that they used contraceptives to control pregnancy, 30% to prevent sexually transmitted infection, 5% to control pregnancy and prevent sexually transmitted infection while 10% had other reasons for the use of contraceptives.

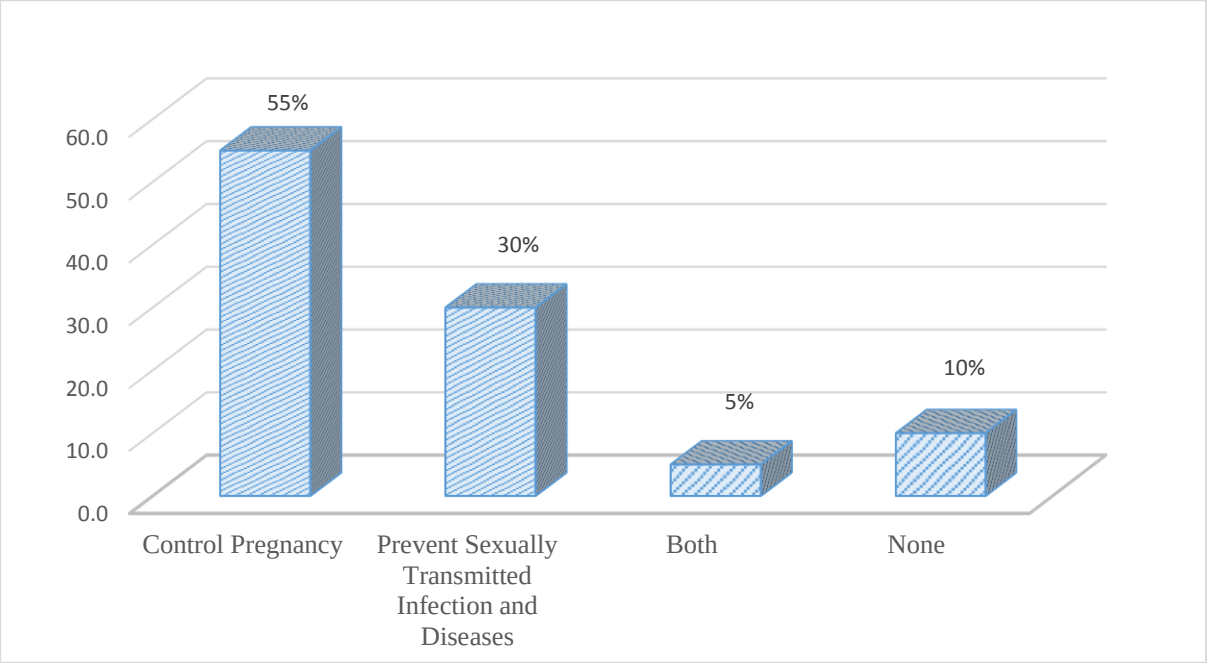

Figure 7: Reasons for the Use of Contraceptives.
Source: Field Data (2018).

From figure 7 above, majority of the respondents reported using contraceptives to prevent them from unwanted pregnancy. According to the interview schedule reported, the primary role of use of contraceptives is to provide protection against unwanted pregnancies though others like male condoms offer dual protection against sexuality transmitted diseases and unwanted pregnancies. According to ESHRE Capri Workshop Group study (2014), contraceptives offer broad protection and prevention against unwanted pregnancy and sexually transmitted diseases concurring with the current study.

4.4 Frequency of Use of Contraceptives

The second objective of this study was to determine whether the perception of household's heads in low income families affected their frequency of use of contraceptives. To attain this, the study examined the frequency of use of contraceptive among the respondents, the type of contraceptives they preferred most, reasons for such preference and the period they had used contraceptives

4.4.1 Frequencies of Use of Contraceptives among Respondents

From the study results, the respondents reported that they used contraceptives shown in figure 8:

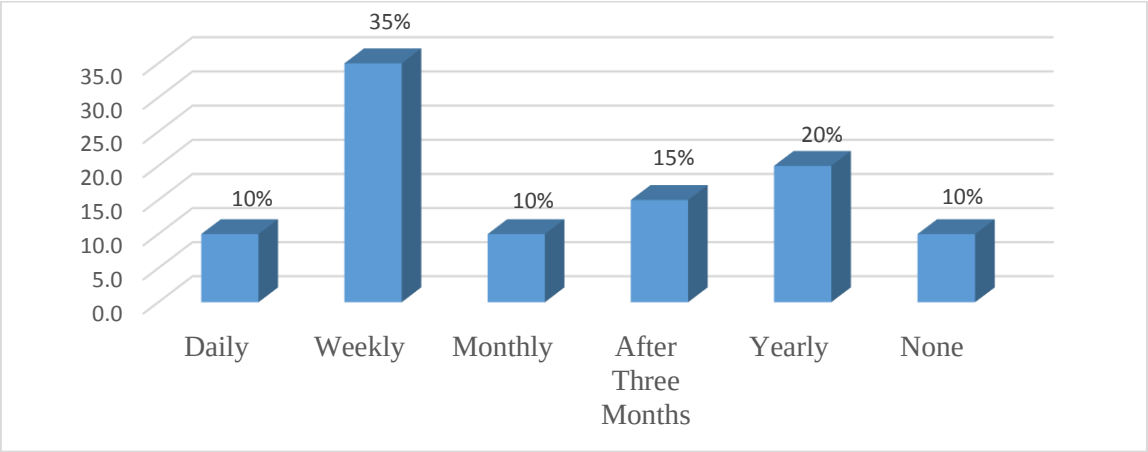

Figure 8: Frequency of Use of Contraceptive.
Source: Field Data (2018).

According to figure 8, 35% of the respondents reported that they were using contraceptives weekly, 20% of the respondents used them yearly, 15% of the respondents used them in every three months, 10% of the respondents reported that they used them daily, 10% of the respondents reported that they used them monthly and 10% of the respondents reported that they were not using any form of contraceptives as at the time of the study. 35% of the respondents reported that they were using contraceptives weekly, meaning that they were using short term contraceptives which were readily available, cheap and had no side effects. This was reaffirmed by interview schedule respondents who said that:

Text Box 2: Interview Schedule Respondents' Response on Frequency of Use of Contraceptive.

"*The frequency of use of contraceptives is determined by the type of contraceptive that one is using. Most contraceptive users prefer to use short term contraceptives which is related with being cheap, effective and available with low levels of side effects increasing their rate of use*."

According to Ettarh and Kyobutungi (2012), the use of short term contraceptives increases the frequency of use of contraceptives among sexual partners to affirm with the current study.

4.4.2 Preference of Contraceptives among the Respondents

From the study results, respondents reported that they had varied preferences on contraceptives as indicted in figure 9 below:

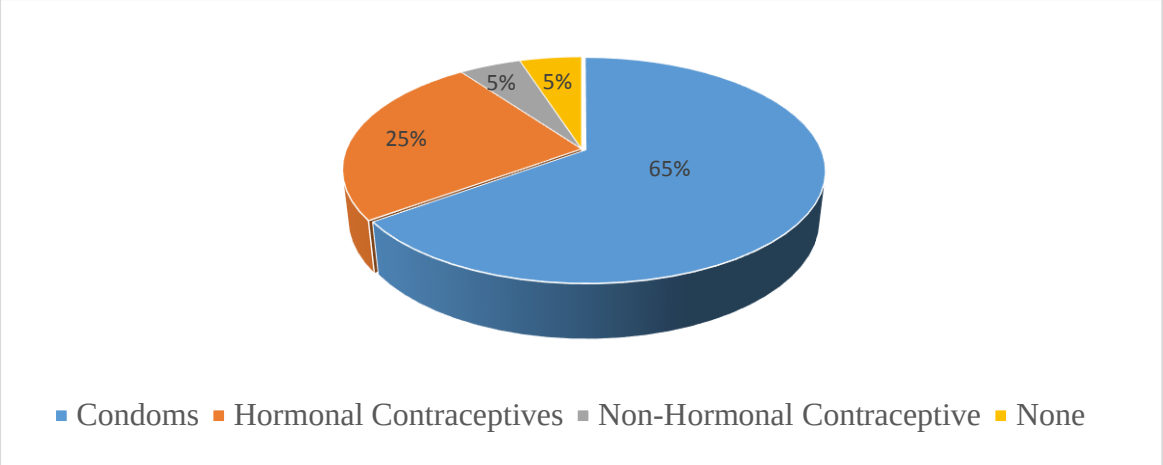

Figure 9: Contraceptives Preferences among the Respondents.
Source: Field Data (2018).

According to figure 9, 65% of the respondents preferred to use condoms as a form of contraceptives, 25% hormonal contraceptives, 5% non-hormonal contraceptives while 5% did not prefer any form of contraceptives. Condoms were most preferred type of contraceptives among the respondents as they were readily available, had no side effect and are reliable. From the interview schedule, it was reported that, because condoms have low to zero side effects, readily available and reliable, they are the most preferred type of contraceptives among their users. Afolabi et al., (2015) noted that in Kenya, condoms were the most used and preferred type of contraceptives with sterilization methods and intrauterine contraceptive devices (IUDs) the least used and preferred types of contraceptives. This view corresponds with the current study. In a study conducted by Thapa, Pokharel and Shrestha (2018) in Nepal majority (35.6%) of the respondents preferred Injection Depo-Provera followed by female sterilization (18.5%); abstinence (0.7%). Male sterilization was found to be the least (2.2%) preferred method of contraception. This shows how regions and societies dynamics in the use of contraceptives.

4.4.3 Reasons for Preference of Contraceptives among Respondents

From the study results, respondents reported that they had different tastes and preferences on contraceptives. This is as shown in figure 10 below.

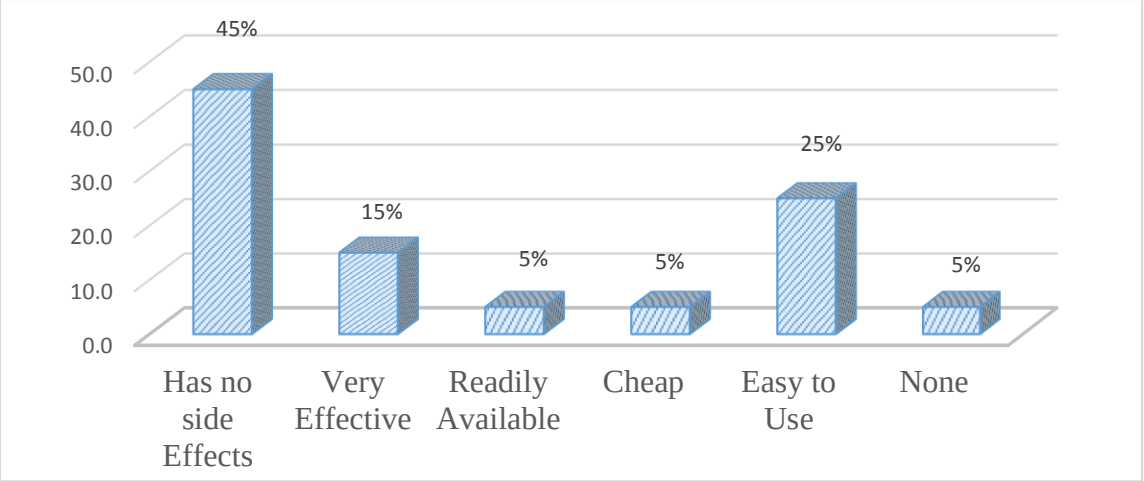

Figure 10: Reasons for the Preference of Contraceptives.
Source: Field Data (2018).

From figure 10 above, 45% of respondents reported that they preferred the type of contraceptives of their choice because they did not have side effects, 25% of the respondents reported that they were easy to use, 15% of the respondents reported that they were very effective, 5% of the respondents reported that they were readily available, 5% of the respondents reported that they were cheap and 5% of the respondents reported that they were not using any form of contraceptives. From the interview schedule respondents outlined that, clients only prefer contraceptives that are cheap, have no side effects, easy to use, they are effective and readily available. For instance, male condoms are most preferred type of contraceptives because they have low to zero side effects to a lot of its users, they are readily available, easy to use, effective and are cheap According to the respondents, the use of contraceptives was affected by the ease of use, availability, side effects and their level of effectiveness. Afolabi et al., (2015) noted that contraceptive users in US and Europe stopped using them when they related its use with adverse side effects, they were less effective and unavailable concurring with the current study.

4.4.4 Period of Use of Contraceptives among Respondents

The period of use of contraceptives among respondents indicated in figure 11 below:

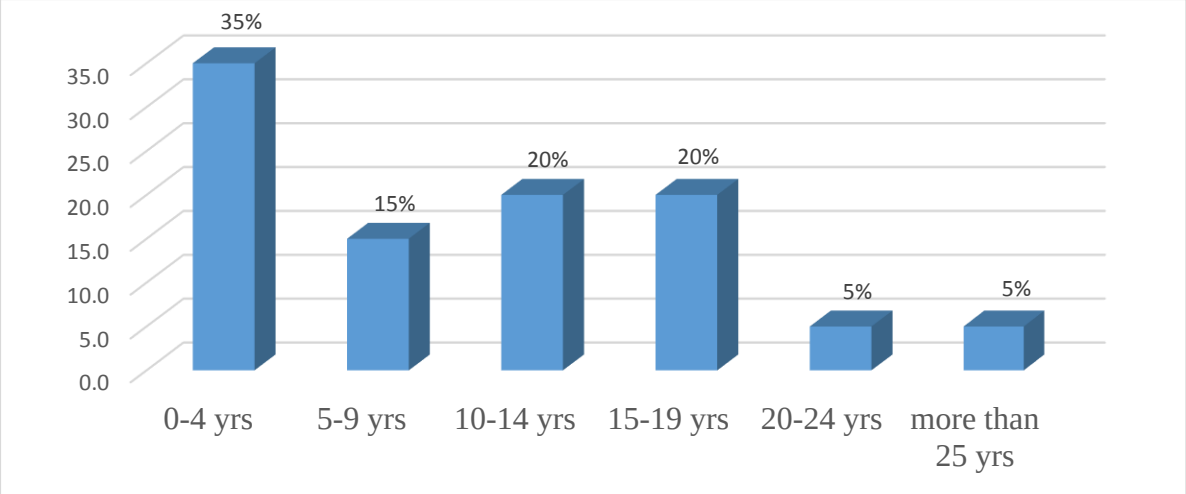

Figure 11: Period of Use of Contraceptives among Respondents.
Source: Field Data (2018).

According to figure 11, 35% of respondents reported that they had used contraceptives between 0-4 years, 15% between 5-9 years, 20% between 10-14 years, 20% between 15-19 years, 5% between 20-24 years while 5% of the respondents had used for a period of more than 25 years. Majority (50%) of the respondents reported to have used contraceptives for a period of 0-9 years as some were young and for married respondents they reported that they were in early stages of using contraceptives as they wanted to space their children.

For those who had 10-19 years' experience they showed long term commitment for its use as they had planned to have a suitable number of children due to economic constraints. While those who had 5-9 years of experience were in their reproductive phase of marriage thus low use of contraceptives. From the interview schedule respondents reported that:

Text Box 3: Response from Interview Schedule Respondents' on Effect of Age on Use of Contraceptives.

"*Age and persuasion by sexual partners on use of contraceptives is a significant factor, as it may encourage or discourage its use. Majority of young couple tend not to use contraceptives as they want children while those in average age tend to use contraceptives frequently because they want to space their children or they didn't want more children.*"

According Lakew et al., (2013), use of contraceptives among young couple tend to be low compared to those who have been married for more than 10 years as they are in time when they want to have children. Unlike those who were married couples between 10-19 years, couples who have been married for more than 20 years reported low in use of contraceptives concurring with the current study.

4.5 Effects of Economic Status on Use of Contraceptives among Households Heads

The third objective of this study was to determine whether the economic status of respondents in low income families affected their perception on the use of contraceptives. To achieve this, the study analyzed; how much money respondents spent on contraceptives, their take on level of income on the use of contraceptives and the availability of subsidized contraceptives near the households.

4.5.1 Spending on Contraceptives among Respondents

According to the study results, respondents reported that they spent differently on contraceptives as indicated in figure 12 below.

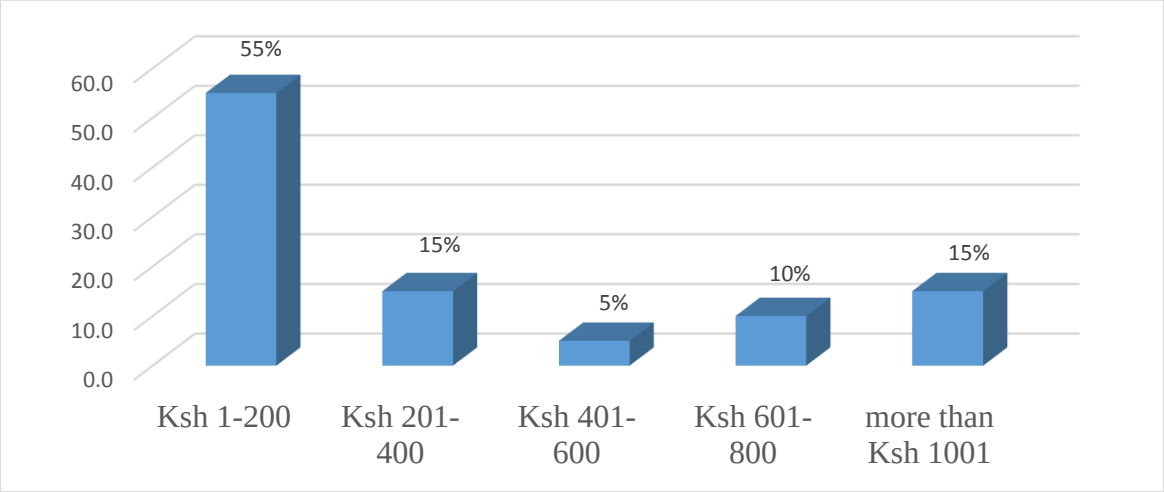

Figure 12: Spending on Contraceptives among Respondents.
Source: Field Data (2018).

From the figure 12, 55% of respondents reported that they spent between Ksh 1-200, 10% of respondents reported that they spent Ksh 201-400, 5% of respondents reported that they spent 401-600, 10% of respondents reported that they spent Ksh 601-800 while 15% of respondents reported that they spent more than Ksh 1001. Majority 55% of the respondents reported that they spent less on then Ksh 200 on contraceptives as the government was providing subsidized methods of contraceptives. From the interview schedule, respondents reported that:

Text Box 4: Interview Schedule Respondents' Response on Contraceptives Spending among Respondents.

"*Most contraceptives are available in public health facilities, we offer free contraceptives to all. The only thing one has to do is to pay Ksh 100 which act as consultancy fee to make sure that contraceptives are accessible to all besides their level of income.*"

The theory of planned behaviour argues that, because the perceived behavioral control is a person's expectancy that performance of the behavior is within his/her control, this translates that, with the availability of subsidized contraceptives it increases the use of contraceptives among respondents (Ajzen, 1988). Watt et al., (2015) accord that the republic of Kenya has adopted Voucher Schemes in health sectors, where subsidies trickle-down from government and donors to underprivileged populations and the government is also providing subsidized contraceptives in all government hospitals.

4.5.2 Level of Income of Respondents

From the study results, respondents reported different reaction on the effects of level of income on use of contraceptives as shown in figure 13.

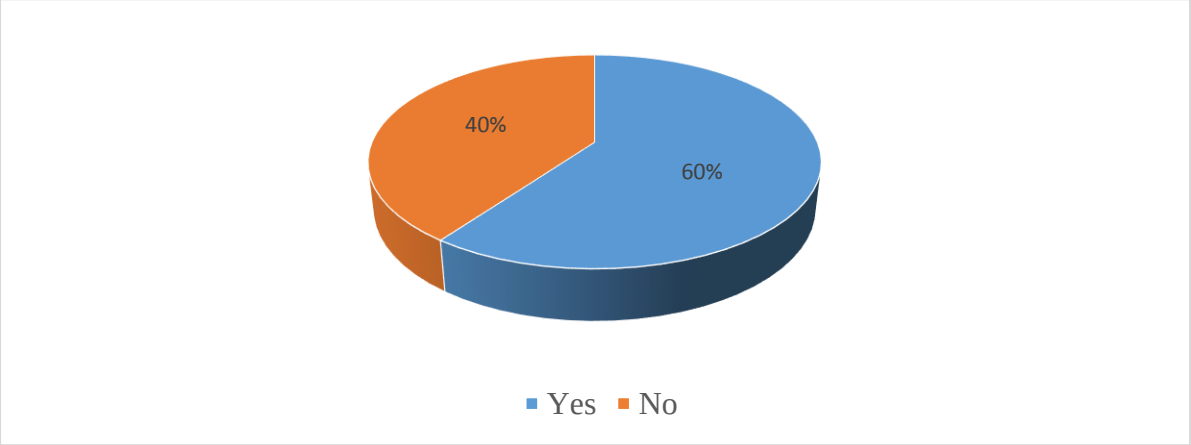

Figure 13: Level of Income of Respondents.
Source: Field Data (2018).

From figure 13, 60% of the respondents reported that the level of income affected the use of contraceptive while 40% of the respondents reported that it did not affect the use of contraceptives. For the respondents who reported that the level of income affected the use of contraceptives they cited that even though there were subsidized contraceptives the cost related affected its use. This was reaffirmed by interview schedule respondents who reported that:

Text Box 5: Narrative from Interview Schedule Respondents' on Effects of Income on Use of Contraceptives.

"*Public health centers around here they provide subsidized contraceptives but other cost related challenges affect negatively on its access more so the individual from low income households.*"

According to Wafula, Obare and Bellows (2014) even if the Republic of Kenya is providing cheap and subsidized contraceptives, there are other expenses like transportations that one has

to endure in accessing these services and sometimes the contraceptives are stock out, concurring with the current study.

4.5.3 Availability of Subsidized Contraceptives

According to the study results, the availability of subsidized contraceptives affected the use of contraceptives as indicated in figure below.

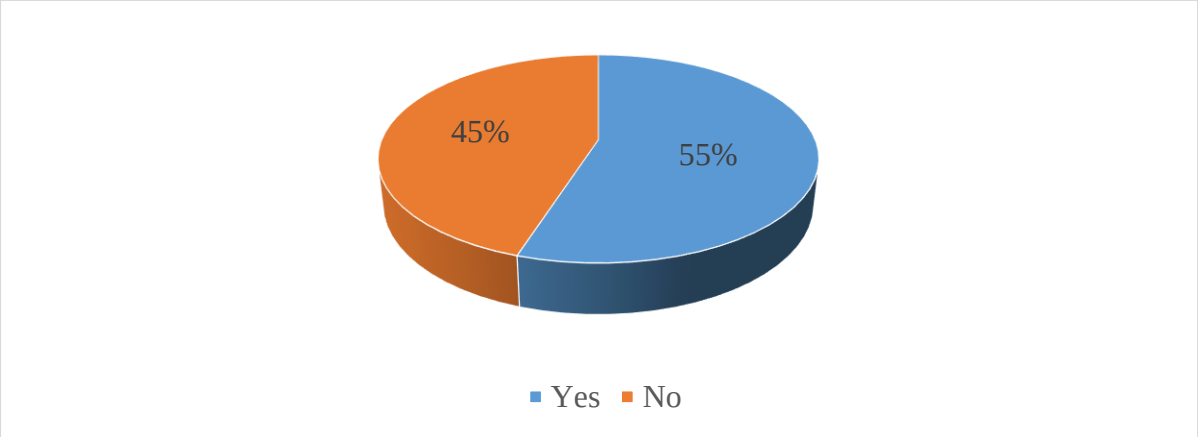

Figure 14: Availability of Subsidized Contraceptives.
Source: Field Data (2018).

According to figure 14, it was noted that 55% of the respondents reported that the health facilities near their households provided subsidized contraceptives while 45% of the respondents reported that they were not aware of subsidized contraceptives. Lack of information on the cost of contraceptives and negative attitudes was reported among respondent shaping their assumption that there were no subsidized contraceptives near their households. According to some interview schedules respondents reported that:

Text Box 6: Interview Schedule Respondents' Response on Availability of Subsidized Contraceptives

"*Although the health facilities around provide subsidized contraceptives, users complain that they are often out of stock.*"

Sangi-Haghpeykar, Ali, Posner and Poindexter (2014) affirm that the availability and adequate information and access to the health centers among clients, healthcare and attitude are important factors which affect the assumption on services provided and the cost of the services.

4.6 Effects of Marital Status on the Use of Contraceptives

The study sought to examine whether marital status of households heads in low income families affected their perception on the use of contraceptives.

4.6.1 Effect of Marital Status on Use of Contraceptives

From the study results, respondents reported that the marital status affected the use of contraceptives (see figure 15).

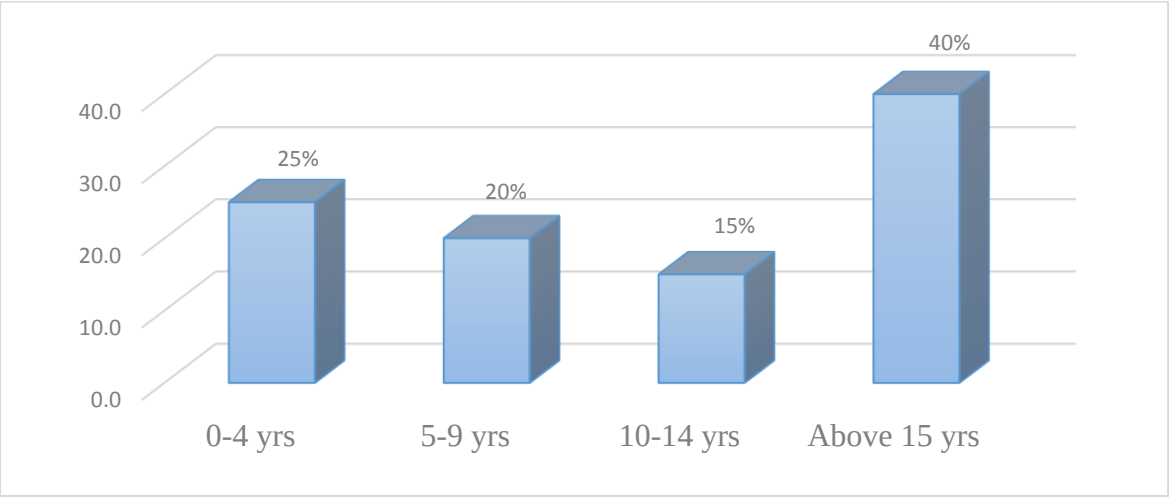

Figure 15: Effect of Marital Status on Use of Contraceptives.
Source: Field Data (2018).

According to figure 15, 25% of the respondents reported to have been married for a period of 0-4 years, 20% of the respondents reported to have been married for a period of between 5-9 years, 15% of the respondents reported to have been married for a period of between 10-14 years and 40% of the respondents reported to have been married for more than 15 years. From the study results, respondents reported that the marital status affected the use of contraceptives with married individuals using them frequently unlike unmarried individuals being they are in stable relationships. According to the interview schedule respondents reported that the society encourages the use of contraceptives among the married respondents increasing their use. It also highly discouraged the use of contraceptives among unmarried individuals as their use was related to encourage promiscuity thus affecting negatively on its use among them.

From another interview schedule it was reported that:

Text Box 7: Narrative from Interview Schedule Respondents' on Effects of Marital Status on Use of Contraceptives.

"*If a woman wants to use contraceptives, the husband need to be involved in the issue in some way, whether it was to give permission or to assist in various ways. For instance, some female patients reports that their husbands help them to read what the health worker has written and remember when the next appointment is. When couples cannot reach an agreement, we have found that these discussions usually end in wives following their husbands' decisions.*"

According to Asiimwe, Ndugga, Mushomi and Ntozi (2014) the use of contraceptives is low among young marriages as they want children and high among older marriages as they do not want more children. This assertion affirms the findings of the current study.

4.6.2 Effect of Number of Sexual Partner on the Use of Contraceptives

From the study results, respondents reported that the number of sexual partners affected the use of contraceptives as indicated below.

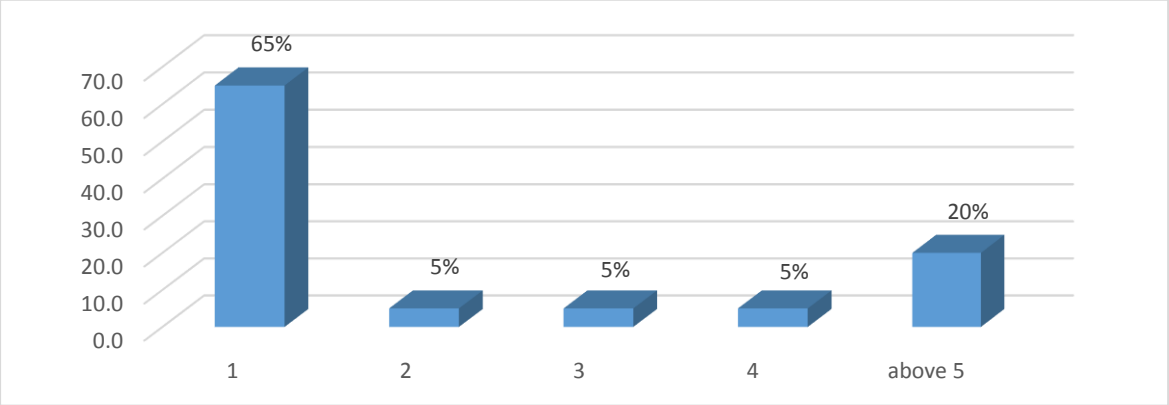

Figure 16: Effect of Number of Sexual Partner on Use of Contraceptives.
Source: Field Data (2018).

From figure 16, 65% of the respondents reported that they had one sexual partner, 5% of the respondents reported that they had two sexual partners, 5% of the respondents reported that they had three sexual partners, 5% of the respondents reported that they had four sexual partners and 20% of the respondents reported that they had more than four sexual partners. According to the respondents, the choice of contraceptives and frequency of its use was positively affected by an increase in number of sexual partners. From the interview schedule respondents reported that:

Text Box 8: Response from Interview Schedule Respondents' on Effects of Number of Sexual Partners on Use of Contraceptives.

"*When an individual has multiple sexual partners, more so when they aren't married tend to use contraceptives frequently to prevent him from sexually transmitted diseases and unwanted pregnancies.*"

According to Raine et al., (2010), the number of sexual partner determined which type and how regular one uses contraceptives, concurring with the current study. For instance, Raine et al, (2010) noted that participants who had several sexual partners used condoms regularly for prevention of sexually transmitted diseases and unwanted pregnancies.

4.6.3 Perception of Use of Contraceptives among the Households Heads

The respondents gave mixed responses concerning their perception on the use of contraceptives. The Likert scale varied from SA-Strongly Agree, A- Agree, N-Neutral, D-Disagree and SD-Strongly Disagree. The results are discussed as indicated in table 3 below.

Table 3: Perception of Use of Contraceptives among Respondents in Low Income Families.

Statement	S A	A	N	D	S D	Mean	Standard Deviation	Ranking
The use of contraceptives is important for a healthy family	(78) 60%	(19) 15%	(7) 5%	(0) 0%	(26) 20%	3.9500	1.60509	1
Contraceptives are used on unmarried sexual partners	(26) 20%	(26) 20%	(13) 10%	(26) 20%	(39) 30%	2.8000	1.57614	7
Contraceptives are used on married sexual partners	(26) 20%	(26) 20%	(19) 15%	(39) 30%	(20) 15%	3.0000	1.41421	6
Contraceptives have side effects	(52) 40%	(33) 25%	(13) 10%	(19) 15%	(13) 10%	3.7000	1.41793	3
Contraceptives are expensive	(13) 10%	(19) 15%	(26) 20%	(46) 35%	(26) 20%	2.6000	1.27321	8
Contraceptives lower libido on both women and men	(46) 35%	(26) 20%	(7) 5%	(32) 25%	(19) 15%	3.3500	1.56525	4
Use of contraceptives is time wasting	(7) 5%	(13) 10%	(7) 5%	(32) 25%	(71) 55%	1.8500	1.22582	9
Contraceptives make the body to slim or enlarger	(26) 20%	(39) 30%	(20) 15%	(19) 15%	(26) 20%	3.1500	1.46089	5
Men's contraceptives are not common	(46) 35%	(58) 45%	(0) 0%	(13) 10%	(13) 10%	3.8500	1.30888	2

Source: Field Data (2018).

From table 3 above it was noted that, 75% of the respondents reported that they agreed that the use of contraceptives methods is important for a healthy family, 80% of the respondents reported that the contraceptives for men are not common, 65% of the respondents reported that the contraceptives have side effects and 55% of the respondents reported that the contraceptives lower libido on both women and men. 80% of the respondents reported that they disagreed that the use of contraceptives is time wasting, 55% of the respondents reported that they disagreed

that the use of contraceptives are expensive and 45% of the respondents reported that they disagreed that the contraceptives are used by unmarried sexual partners this affected the use of contraceptives.

From the study result respondent's reports, it can be deduced that the respondents perceived that the use of contraceptives is important besides some of them having some side effects. According to the interview schedules respondents reported that although men understood the importance of use of contraceptives, fear of side effects and unavailability hindered their use of contraceptives. Kabagenyi et al., (2014) note that the side effects, dissatisfaction with male contraceptives, contraceptives seen as female domain and fear of partner sexual promiscuity affect the perception on use of contraceptives among men.

Most of the respondents were of the opinion that the society imposes beliefs about sexual activity which stigmatizes contraceptive users. Some of the interview schedule respondents reported that:

Text Box 9: Extraction from Interview Schedule Respondents' on Stigmatization on Use of Contraceptives.

"If an individual is not married he can't just walk to a shop and say I want contraceptives, you are considered very weird and immoral. So if an individual wants to go to a shop and buy something like a condom, he has to negotiate and think about how he will approach the issues. It is not as simple as going and buying Hedex (painkiller) and sweets".

4.6.4 Perception of Use of Contraceptives among Respondents

The respondents gave varied responses concerning the perception on use of contraceptives. The Likert scale varied from SA-Strongly Agree, A- Agree, N-Neutral, D-Disagree and SD-Strongly Disagree. The results are discussed as shown in table 4 below

Table 4: Perception of Use of Contraceptives among Respondents in Low Income Families.

Statement	S A	A	N	D	S D	Mean	Standard Deviation	Ranking
The use of contraceptives should be women affair	(32) 25%	(13) 10%	(13) 10%	(42) 40%	(20) 15%	2.9000	1.48324	3
Contraceptives should only be used by unmarried couple	(7) 5%	(13) 10%	(0) 0%	(58) 45%	(42) 40%	1.9500	1.14593	7
Contraceptives should only be used after the woman gives birth	(39) 30%	(26) 20%	(7) 5%	(45) 35%	(13) 10%	3.2500	1.48235	1
Church discourage the use of contraceptives	(19) 15%	(20) 15%	(7) 5%	(39) 30%	(45) 35%	2.4500	1.50350	5
Married couples should not discuss issues on contraceptives	(13) 10%	(7) 5%	(6) 5%	(52) 40%	(52) 40%	2.0500	1.27630	6
Use of contraceptives is seen as promiscuity	(19) 15%	(13) 10%	(13) 10%	(65) 50%	(20) 15%	2.6000	1.31389	4
Men should decide when to use contraceptive	(39) 30%	(26) 20%	(7) 5%	(39) 30%	(19) 15%	3.2000	1.54238	2

Source: Field Data (2018).

From the study results, 50% of respondents disagreed that contraceptives should only be used after the woman gives birth, 50% disagreed that men should decide when to use contraceptives, 55% agreed that the use of contraceptives should be a women affair and 65% agreed that the use of contraceptives is seen as promiscuity. 85% of respondent disagreed that: Contraceptives should only be used by unmarried couple, 80% disagreed that married couples should not discuss issues on contraceptives while 65% disagreed that Church discourages the use of contraceptives. From the study results respondents report it can be deduced that the respondents

understood the importance of use of contraceptives and they felt the rationale of taking part in use and decision making on contraceptives. According to the interview schedule respondents reported that, even if men do not take contraceptives, majority want to be involved in decision making regarding its use. Indeed men are very comfortable when they are aware that their partners are using.

Kabagenyi et al., (2014) found that in Uganda some men regarded communication on family planning as inappropriate and distractive, with women's utilization of family planning services regarded to cause them to become unfaithful. It also found out that some religion and culture discouraged its use and the type of marital status influenced its uptake. The respondents were of the opinion that the motive of accessing the male condom, either to use with the wife or with other women, may determine how a person takes the judgement from others. The following extract from interview schedule illustrate some of these findings:

Text Box 10: Extract from Interview Schedules Respondents' on Effects of Marital Status on Contraceptives Access.

"The reason why one will use contraceptive when he is married or unmarried depends why he is buying it (condom) for example if you are buying to use it with your wife, it will be more acceptable in the community unlike if you go with your wife and buy the condom. It is more problematic like if you are alone, or with a girl that you are not in any formal relationship and you buy a condom, that will be more problematic, the community will view that as immoral and not acceptable".

The opinions raised by the respondents suggests that perceptions of others about when the contraceptive should be accessed and used may impact on actual use, even if a person is motivated to protect against the risk of pregnancy and/or STIs. This relates to the argument in the theory of planned behaviour that approval or disapproval of behaviour by others may impact on behavioral outcomes (Ajzen, 1991).

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study set out to examine the Perception on the use of contraceptives among households' heads in low-income families in Kuresoi North sub-county, Nakuru County, Kenya. This chapter cores summary of findings, conclusions, recommendations and areas for further research.

5.2 Summary.

Based on the objectives and the analysis of the results obtained from the study, the following key findings were established:

5.2.1 Effects of Perception of Households' Heads in Low Income Families on the Choice of Contraceptives.

According to study results, the perception of households' heads on the type of contraceptives they were using was affected by the availability of contraceptives, availability, cost, side effects and the effectiveness. Although men were perceived as less vulnerable than women when it came to the negotiation of safer sex. There were views from the respondents that women play a role in influencing contraceptive use. They asserted that that men would be easily convinced by women into engaging in unprotected sex. The arguments made by respondents in the study seem to suggest that the perceptions of risk and approach to contraceptive use are gendered. These gender differences determined their intentions to prevent the risk of pregnancy and/or STIs. This in turn affected their choices of methods of contraception especially by men, since their choice was mostly limited to condom use.

The sources of information on contraceptives had an effect on the perception of respondents on the choice of contraceptives they used. It was noted that, 40% of the respondents learnt about contraceptives from friends, 30% from medical doctor, 15% social worker and 10% from other sources. This means that, majority of the respondents learnt about contraceptives from friends affecting their perception based on what other informed them about the cost of contraceptives. This caused condoms and hormonal contraceptives to be highly used among the respondents as they were perceived as being cheap.

According to the study results 55% of the respondents reported that they used contraceptives to prevent pregnancies, 30% to prevent sexually transmitted diseases, 5% both and 10% were not using any contraceptive. This translates that, men were more comfortable with using

contraceptives that prevented pregnancies alone compared to others that either prevented from sexually translated diseases or both. Meaning that households' heads feared unplanned pregnancies more than getting infected with sexually transmitted diseases. This increased the frequency and uptake of condoms and hormonal contraceptives among unmarried and respondents who had multiple sexual partners.

5.2.2 Effects of the Perception of Households' Heads in Low Income Families on Frequency of Use of Contraceptives

From the study results, the frequency of the use of contraceptives among the respondents was based on the need to prevent the risk of pregnancy and STIs. The frequency of use was also determined by the fact that whether the sexual partner is infected by STIs. The respondents reported that the use of contraceptive was affected by the cost and availability. Female's sexual partners also affected the frequency on use of contraceptives by proposing to their male sexual partners to use contraceptive throughout sexual activity. This was based on the relationship type whether legally or illicit and also the number of sexual partners one have. From interview schedule, this is what respondents had to say:

Text Box 11: Narrative from Interview Schedule on Effects of Peer Influence on Use of Contraceptives.

"*We have learnt from our peers that one of the reasons why people don't use condoms frequently is that the sexual satisfaction is different when you have a condom and when you don't have. Because the girlfriend is afraid of getting pregnancy what they tend to do at times, although they may insist to use the condoms the male at one point decides to withdraw it (take out the condom during sexual activity) without the ladies' awareness"*.

Form the responses of the respondents indicated that; the use of contraceptives depended on its level of awareness among the users. The effects of the contraceptive also determined the frequency of use. The respondents noted that when contraceptive have low levels of side effect the more they used them and the longer the effect the less they used them.

5.2.3 Effects of Economic Status of Households' Heads in Low Income Families on their Perception on the Use of Contraceptive

The economic status of respondents had a significant effects on contraceptive use. 90% of respondents reported that the cost of contraceptives was between Kshs0-1000, 70% reported that they spent between Kshs 0-400 every month on contraceptives with 60% agreeing that the cost of contraceptives affected their contraception behaviours. Low income parents were

reported to have inability to freely talk about contraceptive use with their children and among themselves as sexual partners (husband and wife).The reason behind this is that their energies and debates surround the physiological needs and sex was treated as a secondary issue. Low income households were reported to have less information on use of contraceptives as they didn't access many sources of information and couldn't afford Kshs100 that was charged by public health care centers as consultancy fee. They could also afford transport to go and access contraceptives and seemed to relate to their expectations about their children's sexual behaviours, and discussing such issues was geared towards helping their children focus on their education and careers.

5.2.4 Effects of Marital Status of Households Heads in Low Income Families on their Perception on the Use of Contraceptives

From the study results, sexual behaviours of unmarried and married respondents who used contraceptives were either seen as moral right or immoral based on the circumstance in which the contraceptive was used. Contraceptive use was linked to promiscuity when the respondent acquired the contraceptive if he was unmarried or went with another partner who was not officially his wife. Comments from the interview schedules indicated that contraceptive use was not stigmatized but their use was an indication of sexual behaviour which in itself was considered a humiliating practice.

The perception that sexual activity is a shameful act may not only compromise young people's rights to contraceptive access and use but also interfere with their rational decision making processes to prevent the risk of pregnancy and/or STIs. In this study, more than 75% of the respondents were married. The length of time the married respondents were married had some effects on utilization of contraceptives from the responses. It can be noted that the newly married couples had a low usage of contraceptives as they were looking forward to sire a child; those who were married for a long period of time and had children had a high need of using contraceptives. It was also noted that the unmarried respondents had high utilization of contraceptives to protect them from unwanted pregnancies and or sexually transmitted diseases. The use of contraceptives among unmarried individuals was related by married respondents as encouraging promiscuity in the society. This was supported by responds from among the key informants.

5.3 Conclusion

The study came up with a number of key findings on perception on the use of contraceptives among households' heads in low-income families in Kuresoi North Sub-County, Nakuru County, Kenya. Each finding is hereby summarized under the corresponding objective.

From the study findings, it can be concluded that the perception of respondents affected the choice of contraceptives they used. Because of condoms being perceived to have low to zero side effects, cheap, available and effective making it most used type of contraceptives across all age group. Indeed, 40% of the respondents perceived that condoms had no side effects, 75% it was cheap while 85% perceived that it offered broad prevention against unwanted pregnancy and sexually transmitted infections. 65% of the respondents reported that they had used contraceptives for more than 5 years, meaning that they had develop trust with the type of contraceptive they were using. In fact 80% of interview schedule reported that most of condom users expressed 'feel free' feeling on ease of use and to show how much they trusted it.

It can also be concluded that the perception of respondents affected the frequency of use of contraceptives. 70% of respondents reported that they used contraceptives regularly, meaning that they used short term contraceptives which they perceived were effective, cheap reliable, available, has low to zero side effects and easy to use. For instance 65% of respondents reported that they preferred condoms because they perceived that they didn't have side effect and were effective. Multiple sexual behaviour among respondents was also found to encourage the frequency of use of contraceptives. As was the need to prevent unwanted pregnancy and sexually transmitted infections. It was also noted that the frequency of use of contraceptives was influenced by its source of information, the health status of the sexual partner either infected with STIS or not, type of contraceptives their sexual partner are using and the need for sexual satisfaction.

The study further concluded that the level of income of the respondents had an effect on perception on the use of contraceptives. 60% of the respondent reported that their level of income affected the choice of contraceptives they used, type of information on contraceptives they accessed and how frequent they used them. 85% of the respondents had a monthly income of between Ksh 0-10,000. Thus the income obtained by respondents was mostly used for physiological needs and not on contraceptives. This made most respondent to rely heavily on subsidized and free contraceptives which was often out of stock.

Finally, the study concludes that it was examined that the marital status of respondents in low income households affected their perception on the use of contraceptives. They perceived that, it was important for the married sexual partners to use contraceptives, as it led to a healthy family but they highly discouraged its use among unmarried as they regarded it to promote promiscuity. The perception that sexual activity is a shameful act may not only compromise young people's rights to contraceptive access and use but also interfere with their rational decision making processes to prevent the risk of unwanted pregnancy and/or STIs infection.

5.4 Recommendations

On the basis of the findings and conclusions already discussed, the following recommendations were made;

i. The ministry of health and local non-governmental organizations dealing with reproductive health should conduct trainings and workshops to create awareness on the use of contraceptives. Specifically on types of contraceptives that are available for men and women.
ii. The national government and county government should budget for acquisition of more contraceptives in order to increase the uptake of the contraceptives. As most of free and subsidized contraceptives are usually out of stock.
iii. Government and non-governmental organization need to come up with free contraceptives to increase the uptake of contraceptives.
iv. There is need of the government, non-governmental organization, religious leaders and the family should conduct counselling sessions together with health workers to eliminate cultural and peer influence on the utilization of conventional contraceptives.
v. Policy makers should formulate policies that encourage utilization of contraceptives among men.

5.5 Suggestions for Further Studies

Due to limited scope and time, the study could not have exhausted all the aspects of the topic; hence the study recommend on the following areas for further research:

i. There is need for a similar study at county and national level to determine to what extent the perception of men affects the use of contraceptives.
ii. Further research should be conducted to find out to the role of peers on use of contraceptives.

iii. There is need for further study to determine the effectiveness of policies on use of family planning.

iv. Further studies should be conducted on how socio-economic factors affect the utilization of contraceptives among married and unmarried individuals.

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APPENDICES

Appendix A: Questionnaire for Households' Heads Respondent

My Name is Joseph Macharia, a Master of Arts student at Egerton University. I have cleared my course work and am currently embarking on a research project. This questionnaire has been prepared for the sole purpose of getting feedback from you in relation to a survey that is conducted on, perception on the use of contraceptives among Households' Heads in low income families in Kuresoi North Sub-county, Nakuru County Kenya. You are requested to place an X in the provided box after the question. This may take less than 25 minutes to complete. Please provide responses that show personal and independent opinions on issues being asked. This is purely academic research, and thus your confidentiality is guaranteed. Your participation in this study should be completely voluntary. You may refuse to participate or leave the survey at any time without penalty or any negative consequences. Your responses will be kept confidential.

Instructions

Kindly do not write your name

Tick where appropriate

Section A: Background Information

1. What is your age?
   18-27yrs ( ) 28-37yrs ( ) 38-47yrs ( ) 48-57 yrs ( ) above 58 yrs ( )
2. What is your marital status?
   Single ( ) married ( ) others ( )
3. What is your average monthly income?
   Ksh 0-5000 ( ) Ksh 5001- 10001 ( ) Ksh10002- 20002( ) Ksh 20003-30003( )
4. What is your current occupation?
   Formal employment ( ) Informal ( ) Self-employment ( )
5. What is the size of your household?
   0-2 ( ) 3-5 ( ) 6-8 ( ) 9 and above ( )
6. What is your highest level of education?
   Non-Formal ( ) Primary ( ) Secondary ( ) Tertiary Colleges ( ) University ( )
7. Which religion do you belong to?
   Muslim ( ) Catholics ( ) Protestant ( ) Hindus ( ) Others specify **……**

Section B: Types of Contraceptives Available

8. Which type of contraceptive do you use?

   Condoms ( ) Hormonal contraceptive ( ) Vasectomy ( ) Vaccine ( ) Non-Hormonal contraceptive ( ) Natural Methods ( ) Others specify……..

9. Why do you use the above contraceptive? Cost effective ( ) reliable ( ) no side effect ( ) readily available ( ) others specify…….

10. How much does the contraceptive cost?

    Ksh 0-500 ( ) Ksh 501-1000 ( ) Ksh 1001-1500 ( ) Ksh 1501-2000 ( ) 2001 and above ( )

11. Who introduced you to the contraceptive?

    Social worker ( ) Medical Doctor ( ) Friends ( ) Wife ( )

    Others specify……

12. Why do you use the contraceptive?

    Control pregnancy ( ) control sexually transmitted infections ( ) both ( )

    Others specify ……..

Section C: Effects of Frequencies of Use of Contraceptive

13. How frequent do you use contraceptives?

    Daily ( ) weekly ( ) monthly ( ) after three months ( ) after six months ( ) yearly ( )

14. Which contraceptive do you prefer most?

    Condoms ( ) Hormonal contraceptive ( ) Vasectomy ( ) Pills for men ( )

    Vaccine ( ) Non-Hormonal contraceptive ( ) Natural Methods ( ) others specify……..

15. What reasons do you have for using the above mentioned contraceptive?

    Has no side effects ( ) Very effective ( ) Readily available ( ) Cheap ( )

    Easy to use ( )

16. How long have you been using contraceptives method?

    0-4 years ( ) 5-9years ( ) 10-14years ( ) 15-19years ( ) 20-24years ( )

    above than 25 years ( )

Section D: Effects of Economic Status on Use of Contraceptives

17. How much money would you spend on a contraceptive?

    Ksh 1-200 ( ) Ksh 201-400 ( ) Ksh 401-600 ( ) Ksh 601-800 ( ) Ksh 801-1,000

    More than Ksh 1,001 ( )

18. Do you think the level of income influence the choice of contraceptive you use?

    Yes ( ) No ( ).

    If Yes how……..

19. Does the health facility near your household provide subsidized contraceptives?

    Yes ( ) No ( )

Section E: Perception of Households' Heads towards the use of contraceptive

20. How long have you been married?

    0-4years ( ) 5-9 years 10-14 years ( ) above 15 years ( )

21. How many sexual partners do you have?

    1 ( ) 2 ( ) 3 ( ) 4 ( ) above 5 ( )

22. What is your perception concerning the following statements? Tick where appropriate

STATEMENTS	RESPONSE				
	STRONGLY DISAGREE (1)	DISAGREE (2)	NEUTRAL (3)	AGREE (4)	STRONGLY AGREE (5)
The use of contraceptives methods is important for a healthy family					
Contraceptives are used on unmarried sexual partner					
Contraceptives are used on married sexual partners					
Contraceptives have side effects					
Contraceptives are expensive					
Contraceptives lower libido on both women and men					
Use of contraceptives is time wasting					
Contraceptives make the body to slim or enlarge					
Men contraceptives are not common					

23. What is your perception concerning the following statements? Tick where appropriate

STATEMENTS	RESPONSE				
	STRONGLY DISAGREE (1)	DISAGREE (2)	NEUTRAL (3)	AGREE (4)	STRONGLY AGREE (5)
The use of contraceptives should be women affair					
Contraceptives should only be used by unmarried couples					
Contraceptives should only be used after the woman gives birth					
Church discourage the use of contraceptives					
Married couples should not discuss issues on contraceptives					
Use of contraceptive is seen as promiscuity					
Men should decide when to use contraceptive					

Appendix B: Interview Schedule for Key Informants

My Name is Joseph Macharia, a Master of Arts student at Egerton University. I have cleared my course work and am currently embarking on a research project. This questionnaire has been prepared for the sole purpose of getting feedback from you in relation to a survey that is conducted on, perception on the use of contraceptives among households' heads in low income families in Kuresoi North Sub-county, Nakuru County Kenya. This may take less than 25 minutes to complete. Please provide responses that show personal and independent opinions on issues being asked. This is purely academic research, and thus your confidentiality is guaranteed. Your participation in this study should be completely voluntary. You may refuse to participate or leave the survey at any time without penalty or any negative consequences. Your responses will be kept confidential.

Instructions

1. Do household's heads use contraceptives in your area of duty?
   (Specify the types and how often)?

.....

2. Which age of households' heads commonly use contraceptives?

(Which age use which contraceptives, why age variant and why those specific contraceptives on specified age?)

……

3. Does the income of the household affect the use of contraceptives?
   (Specify why and how age affect the use of contraceptive.)
   ……..……

4. What other factors affect use of contraceptives by households' heads other than level of income? (Specify; how do they affect the use of contraceptives?)
   …….

5. Which type of contraceptives are commonly used by households' heads in your area?

(Specify and justify why they are commonly used)

……

6. Do the government provide free or subsidized contraceptives?
   (Yes or no; if yes, how regular? Does the community around aware of free/subsidized contraceptives?)……
   ……..

7. How frequent do households' heads seek for contraceptive information?
   (Everyday, weekly, monthly etc, which specific age group come for this information?)
   ……
8. Do you have forums with households' heads to educate them on use of contraceptive?
   (Specify and how often? and are they effectives?
   ……
9. What is your role on advocating for use of contraceptive by households' heads?
   (Specify; which challenges do you encounters?)
   ……
10. In your own opinion what is the perception of contraceptive use by households' heads?
    (positive or negative? Why do you think so?)
    ……
11. Are there challenges in the use of contraceptives by households' heads?
    (Yes or no, if there are there, specify them and how do they cope with them?)
    ……
12. What major strategies do you use to increase the use of contraceptive by households' heads? (in your capacity in terms of information sharing, providing free or subsidized contraceptives, providing referral services among others)
    .....

Appendix C: NACOSTI Research Permit

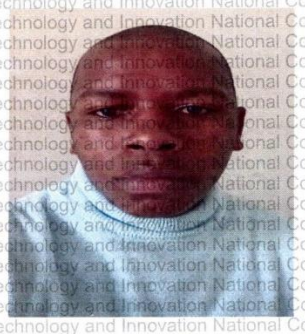
THIS IS TO CERTIFY THAT:
MR. JOSEPH GATHINJI MACHARIA
of EGERTON UNIVERSITY, 0-43 MOLO,has been permitted to conduct research in *Nakuru County*

on the topic: *PERCEPTION ON THE USE OF CONTRACEPTIVES AMONG MEN IN LOW-INCOME HOUSEHOLDS IN KURESOI NORTH SUB-COUNTY, NAKURU COUNTY, KENYA*

for the period ending:
5th September,2019

.....
Applicant's Signature

Permit No : NACOSTI/P/18/33306/24780
Date Of Issue : 15th October,2018
Fee Recieved :Ksh 1000



.....
Director General
National Commission for Science, Technology & Innovation

Appendix D: Ethical Clearance

EGERTON
TEL: 051-2217808
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e-mail: dvcre@egerton.ac.ke
website: www.egerton .ac.ke

UNIVERSITY
P. O. BOX 536-20115
EGERTON

RESEARCH ETHICS REVIEW COMMITTEE

EU/RE/DVC/009 **10th October, 2018**
Approval No.EUREC/APP/073/2018

Mr. Joseph Gathinji Macharia
Institute of Gender, Women and Social Studies
P. O. Box 536-20115,
EGERTON

Dear Mr. Juma,

RE: INITIAL SUBMISSION - ETHICAL CLEARANCE APPROVAL OF THE STUDY

Reference is made to your application for Ethical Clearance of your Research Project entitled: '**Perception on the Use of Contraceptives among Men in Low- Income Households in Kuresoi North Sub-County, Nakuru County, Kenya. "**

It was observed that you addressed all the ethical issues that were raised in a Committee Meeting held on **27th September, 2018** through your response dated **4th October, 2018**. The study is granted **Approval No.EUREC/APP/073/2018** for implementation effective **9th October, 2018**. Please note that authorization to conduct this study will automatically expire on **9th October, 2019.** Please further note that the Standard Operating Procedures (SOPs) requires that you submit progress reports twice in a year and a final report at the end of your study to the Committee.

Any unanticipated problems resulting from the implementation of this protocol should be brought to the attention of the Committee notifying them of any proposal change(s) or amendment(s), serious or unexpected outcomes or study termination for any reason. You are also required to inform the Committee when the study is completed or discontinued.

Your proposal has therefore been given ethical approval. You are required to obtain a Research permit from NACOSTI before commencement of your study.

Yours faithfully,

Prof. P. Makenzi, PhD
FOR: CHAIRMAN, EGERTON UNIVERSITY RESEARCH ETHICS COMMITTEE

PK/JKK/SK/sam
cc. DVC (R&E) - To note the file copy