SOCIAL CONSTRAINTS TO UTILIZATION OF CONTRACEPTIVES AMONG WOMEN IN NDHIWA SUB-COUNTY, HOMA BAY COUNTY, KENYA

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Abstract

The aim of this study was to investigate the social constrains to utilization of contraceptives among women in Ndhiwa Sub-county. It adopted a descriptive survey approach in this study with 164 respondents formed of married women of reproductive ages selected randomly from the two divisions, namely Pala and Riana. Questionnaire was used to collect data. The data were analyzed through stepwise multiple regression model using Statistical Package for Social Scientists (SPSS). Stepwise multiple regression analysis was used to find out how independent variables were related to contraceptive use. Findings revealed that infant & child mortality and spouses' perceptions on contraception use had significant relationship with contraceptive use. Through stepwise multiple regression model, it was possible to identify two major barriers; infant & child mortality and spouses' perceptions on contraception use as the predictors of contraceptive use among women in Ndhiwa Sub-county. There was no significant relationship between fears of side effects. The study concludes that infant & child mortality and spouses' perceptions on contraception use were found to be a barrier to contraceptive use. The study recommend that policy makers and family planning programme managers incorporate leaders in family planning campaign programmes to reduce child mortality and enlighten men to be more involved and participate fully in family planning.

Keywords: Social constraints, contraceptive, utilization

1.0 Introduction

Family planning is one of the most relevant current development goals and also directly connected with the role and position of women in society. United Nations (2007) reported that contraceptive use can prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space birth, avoid unintended pregnancies and abortion and stop childbearing when they reach their desired family size. However, inadequate contraceptive use is a major contributor to higher risks of illness and maternal death, the high rates of unintended pregnancies and births observed worldwide for women (Carl and Toshiko, 2013; United Nations, 2007). Although contraceptive use is the most effective method to overcome this problem, the problem still exists and has not been solved in many countries, especially developing countries United Nations (2007; United Nations 2005a). For example, a study conducted across Sub-Saharan Africa by (Singh et al., 2009; Guttmacher, 2010) found that about 39 percent of all pregnancies in the region are unintended, which rises to about 50 percent for adolescent pregnancies. Another study that explored the level of unmet need was conducted by (Cleland et al., 2011; UNICEF 2008) and the findings indicated that Sub-Saharan Africa had the

highest estimated level of unmet need of family planning (25 percent) and lowest rate of modern contraceptive use among married women (17 percent).

When the statistics are unpacked at the regional level, it evidently emerges that countries with low total fertility rates have better family planning practices and high contraceptive prevalence rates compared to their counterparts with high total fertility rates, hence poor family planning practices and low contraceptive prevalence rates (Carl and Toshiko, 2013). An example of Africa and sub-Saharan Africa had the lowest contraceptive prevalence at 31 percent and 26 per cent, respectively, as compared to 75 percent in Latin America and the Caribbean, and 65 percent in Asia. By the standards of the rest of the African countries, TFR in Kenya as a whole is still high (NCPD, 2012). A study by Carl and Toshiko, (2013) revealed that it's only Southern Africa that had a remarkably low total fertility rate (TFR) of 2.5 and much higher prevalence of all methods of contraception when compared to other regions of Africa

Due to the adverse impact of rapid population growth on socio-economic development, Kenya is among the many countries that have adopted policies and programmes aimed at reducing their population growth rates through family planning programmes (NCPD, 2012). Total Fertility Rate has declined radically from 8.1 children to 4.6 children in Kenya. Although Kenyans know about family planning, they are yet to match their level of knowledge which is relatively high at 98 per cent with use at slightly over 38 per cent. Its population has been increasing rapidly. According to (NCPD, 2012), the failure to realize the targeted population growth rate and fertility rate could be ascribed to ongoing challenges which include: low CPR; the unmet need for family planning and low use of contraceptives, a case in Homa Bay County.

Ndhiwa Sub-county being one of the sub-counties in Homa Bay County, there was need to examine the social constraints that affect the utilization of contraceptives among women. This would at the same time intensify the utilization of family planning among these women to bring them in line with the rest of the country and according to the demographic indicators of 2015.

2. Review of Empirical Literature

Inaoka et al., (1999) posits that there have been myths about fears of side effects especially the IUDs performance from excessive bleeding, weight gain to added cancer risk. He noted that the common side effects include nausea, vomiting, and weight gain Inaoka *et al.,* (1999). A study in Ethiopia notes that a reason for discontinuation of use of contraceptives is the disturbance caused by menstrual cycle (Weldegerima and Denekew, 2008). This finding is further asserted by Westoff and Cross (2006) in Kenya who found that discontinuation rate rose from 28 percent in 1998 to 33 percent in 2003 and was linked to side effects associated with hormonal methods like pills and injectables. Nonetheless, according to De Graaf, (2001) in Bangladesh, women stopped using injectables due to wrong information about side effects and their significance. This was further affirmed by (Westoff and Bankole, 1998) in Morocco.

Fear of side effects can be overcome through effective communications and information strategies, especially through community based distribution (CBD) programme (Omondi-Odhiambo, 1999). According to Yam, et al., (2007), health providers should demystify misinformation about contraceptives and instead provide factual information about risks, potential side effects, and incorporate it in family planning strategy that meet each client's personal needs.

Casterline (2001) observes that rapid mortality decline leads to even more rapid decline in fertility. Under-five mortality in Kenya stands at 74 deaths per 1000 live births, with Nyanza leading with 149.2 deaths per 1000

live births followed by Western at 121, Coast 87, North Eastern 80, Nairobi 64, Rift Valley 59 and Central 51 (Republic of Kenya, 2009. Complications and infections that happen at birth due to inadequate care are the greatest cause of child deaths, leading to the hesitation in using contraceptives thinking that the use may lead to childlessness or small families should any of their children die. Cleland and Bernstein (2006) note that shorter spacing between births increases chances of fetal death because of non-use of family planning methods, low birth-weight, prematurity and or infant and child death. NCPD (2012) recommends three-year spacing after birth for another pregnancy to help reduce the child and maternal mortality rate. Evidence from literature review points out that reduction in fertility, child mortality rates is critical to record a decline in population growth rate. This is particularly relevant to the study to investigate the impact of child mortality on the utilization of family planning.

Feyisetan (2000), Oyediran and Isiugo-Abanihe (2002b) observe that inter-spousal communication dictates whether or not to use family planning, the method to use, when to start and the number and timing of children as well as enabling spouses to know each other's attitudes towards family planning and use of contraceptives. It also allows spouses to say their concerns about reproductive health matters like unintended pregnancies, side effects of a method or STDs (Drennan, 1998). Communication may therefore affect contraceptive use by transforming attitudes into the physical act of using contraceptives. However, a study by DeRose et al. (2004) using DHS data from 21 sub-Saharan African countries contradicted the idea that discussion between partners helps increase knowledge of a partner's contraceptive attitudes. Their findings concluded that the anticipated reductions in unmet need for contraception may not be achieved through improvements in inter-spousal communication.

In most societies, discussing sexual matters is a taboo subject for men and women. In addition, men and women are often afraid of rejection by a sexual partner, especially if the discussion about sexuality takes place at the beginning of a relationship. Consequently, they may not feel comfortable discussing reproductive health issues, such as sexual history or contraception (Drennan, 1998). Furthermore, a husband might suspect his wife being promiscuous or unfaithful if she tries to discuss contraception with him. However, according to Lasee & Becker, (1997); Becker, 1996; Biddlecom *et al.,* 1997; Omondi-Odhiambo, (1999), inter-spousal communication can be regarded as a way toward increasing men's participation in family planning and reproductive health. Donahoe, (1996) reported that male involvement does not refer to use of male methods alone, it also comprises supporting female method use, which suggests that husbands should communicate family planning matters with their wives. Couples can disclose their fertility preferences to each other and make use of contraceptives as a result. The misconception that wives seem to have of their husbands' family planning approval is one area that spousal communication is expected to improve.

These reviews are important and shed some light that is significant to the current study. Nevertheless, few studies have been done in Ndhiwa Sub-county, hence the need for this study.

3. Research hypothesis

The following null hypothesis was established and tested in the course of this study to find responses to the problem under investigation in Ndhiwa Sub-county;

H_0: *There is no significant relationship between social constraints and contraceptive use among women in Ndhiwa Sub-county.*

4. Research Methodology

Table 4.1: Sample size breakdown

SAMPLE SIZES						
	95% Confidence			99% Confidence		
Population Size (N)	Plus or Minus 3%	Plus or Minus 5%	Plus or Minus 10%	Plus or Minus 3%	Plus or Minus 5%	Plus or Minus 10%
2,000	696	323	92	959	498	154
4,000	788	341	94	1142	544	158
5,000	880	357	95	1347	586	161
10,000	965	370	96	1556	622	164
20,000	1,014	377	96	1687	642	165

Source: Rea and Richard (1997)

The researcher used Rea and Richard (1997) comprehension table guide while determining a sample size in a survey research. Table 4.1 describes sample size breakdown for a range of various sizes of target population using either 99 per cent confidence levels or 95 per cent confidence levels. Since the households' size was 16,888 for the locations where the research was based on, a desired confidence level of 99 per cent and a margin of error of ±10 per cent were preferred. Therefore, the resulting sample size of respondents was 164 (Table 3.1). Such a broadened sample size of 164 women respondents was preferred to improve reliability.

Stratified random sampling procedure was adopted to choose respondents from the eight locations. These locations had the respondents of all socio-cultural backgrounds and therefore were a reflective of the whole target population. Each location constituted a stratum. The locations and the size of each stratum were; North Kanyamwa 20, South Kanyamwa 20, West Kanya-mwa 21, Central Kanyamwa 21, North Kanyikela 20, South Kanyikela 20, Central Kanyikela 21 and West Kanyikela 21. The sampling ensured inclusion which otherwise would have been omitted if other sampling methods were used because of their small numbers in the population (Mugenda and Mugenda, 2003). Free sampling was used to select married women respondents from each stratum. Researcher-administered questionnaire was used with the selected respondents. Both close-ended and open-ended questions were included.

Quantitative data was analysed using descriptive statistical analysis measurements like Stepwise multiple regression analysis which was performed in order to find how the independent variables were related to contraceptive use in Ndhiwa Sub-county. Following the guideline proposed by Pallant (2011) and Kothari (2004) in a multiple regression analysis of this kind, the independent variables were put into the model to determine the predictor variables of contraceptive use among the sampled population. Thus, the formula for the analysis model is:

$$Y = f(X_1, X_2 \ldots\ldots\ldots\ldots X_{n)} + e$$

Where, $Y = dependent$ variable, contraceptive use

$f(\cdot)$ = signifies the function of explanatory variables, (independent variables)

e = stochastic error term, (held constant)

By the nature of the step-wise regression model, independent variables which did not contribute significantly in explaining (predicting) the dependent variable were eliminated.

5. Results and Discussions

5.1 Results of stepwise multiple regression model

The study sought to investigate the influence of social constraints in Ndhiwa Sub-county that had significant impact on contraceptive use. A step-wise multiple regression analysis was performed and three variables: Child mortality, misconceptions & fears of side effects and spouses' perception on contraception were considered while the dependent variable was contraceptive use. The findings are as shown in Table 4.2.

Table 4.2: Model summary of the stepwise multiple regression

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.448[a]	.200	.195	.445
2	.517[b]	.234	.259	.427

a. Predictors: (Constant), Spouses' perception on Contraception
b. Predictors: (Constant), Spouses' perception on Contraception, Child Mortality

Source: Compiled from research data (2014)

The predictor variables in the model were Spouses' perception on Contraception and Child Mortality. The stepwise multiple regression output clearly reveal that the value of the R^2 (multiple coefficient of determination) is 23.4 per cent. This indicated that over 23.4 per cent of the total variance in the dependent variable is accounted for by the combination of the two variables (Table 4.2). The stepwise multiple regression model eliminated misconceptions and fears of side effects (Table 4.3).

Table 4.3: Evaluation of each predictor variables to the prediction of the dependent variable

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	.757	.111		6.838	.000
	Spouses' perception on Contraception	.443	.070	.448	6.370	.000
2	(Constant)	1.835	.250		7.351	.000
	Spouses' perception on Contraception	.313	.071	.316	4.418	.000
	Child mortality	-.229	.082	-.194	-2.791	.006

Source: Compiled from research data (2014)

The independent variables were entered into the model once. The results in Table 4.3 reveal how the set of variables is able to predict contraceptive use, and how much unique variance each of the independent variables explain in the dependent variable over and above the other independent variables included in the set. Interpretation was based on the standardized coefficients in Table 4.3 to ascertain the contribution of each

predictor variable to the prediction of the dependent variable using the beta values. The stepwise regression output in the table above indicates that the most important single predictor variable of contraceptive use was the spouses' perception on contraceptive use. The multiple coefficient of determination (r2) for this variable is 0.200, (Table 4.2), indicating that 20 per cent of the variation in contraceptive use is accounted for by the spouses' perception on contraceptive use. Its beta weight is 0.448 and is statistically significant (t = 6.370).

The next variable is child mortality. The multiple coefficient of determination (r2), when spouses' perception on contraception is included in the regression, is 0.234, (Table 4.2), indicating that over 23.4 per cent of the total variation in contraceptive use is accounted for by the combination of the spouses' perception on contraception and child mortality. This shows that the two variables account for about 23.4 per cent in the variation in contraceptive use. The addition of the independent variable, child mortality, adds 3.4 per cent additional explained variance in contraceptive use. It is statistically significant (t = -2.791). Its beta weight is -2.791. The sizes of the beta weights in the regression model indicate the relative importance of each independent variable. The larger the absolute value of beta weight, the more important the contribution of the independent variable. The beta weights show that much of the variation in contraceptive use is caused by spouses' perception on contraceptive use followed by child mortality.

Table 4.4: Standardized coefficients of the stepwise multiple regression for excluded variable

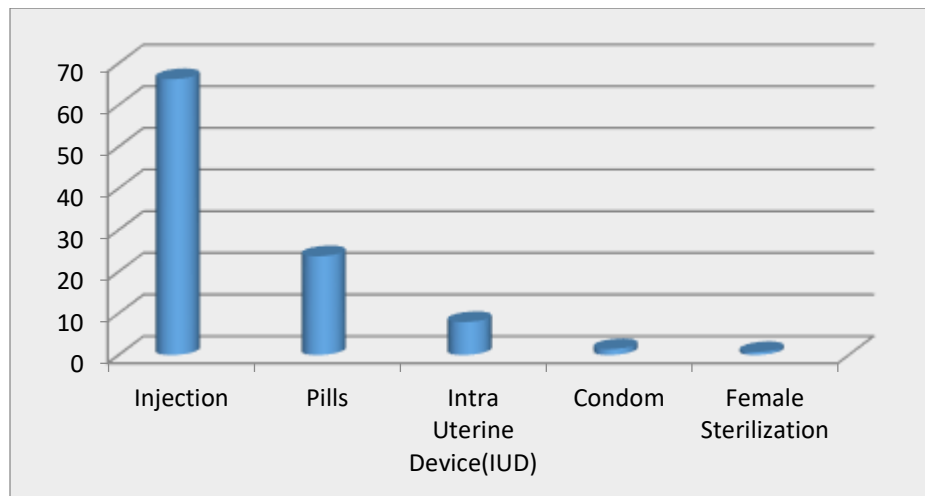| Model	Beta In	T	Sig.
Fears of side effects	-.094[b]	-1.321	.188

Source: Compiled from research data (2014)

Table 4.4 shows multiple stepwise regression analysis demonstrating the excluded variable. The beta value for fears of side effects was -.094. This beta value was very low indicating that it made very less of a unique contribution to explaining the dependent variable hence excluded in the model. The variable had significant values greater than .05 (Table 4.4), therefore, it did not make a unique and statistically significant contribution to the prediction of constrains to utilization of contraceptives and for this reason left out of the multiple stepwise regression model.

Descriptive statistical analysis of frequencies and percentages shows that 120 of the women respondents preferred either male or female child gender preference. This is because they regarded children as the same and God given. 26 preferred males whom they see as important in the continuity of the family name and as heirs, while 18 preferred the females because they believed that females were more responsible and could help parents more than the males. On religion the respondents affiliated to Catholics believed that all sexual acts were for procreation, while the Muslims said that the Quran states that it is against God's will to use contraceptives, thus hindering them from using contraceptives.

Figure 4.5 shows proportion of contraceptive methods that cause side effects. Injection and pills were the methods of contraceptives that had bigger percentage of side effects at 66.2 per cent and 23.7 per cent respectively, while intra uterine device, condom and female sterilization had comparatively smaller percentage of side effects at 7.9 per cent, 1.4 per cent and 0.7 per cent respectively. Side effects that were perceived to be major included irregular menstrual cycle, weight gain and increased menstrual bleeding at 20.7 per cent, 17.7 per cent and 14.0 per cent, respectively.

Figure 4.5: Proportion of contraceptives that cause side effects

Source: Compiled from Research Data (2014)

5.1 Summary of key findings

The use of stepwise regression model helped to identify two independent variables that were found predictor variables after controlling other variables and found significant hence related to contraceptive use. These were spouses' perceptions on contraceptive use and child mortality. Most of the women who had experienced child mortality did not use contraceptives. Majority of the partners' respondents disapproved the use of contraceptives. Moreover, most of the women respondents who had never discussed with their husband about contraception did not use contraceptives.

5.2 Recommendations

Religious leaders would provide informed counseling to families who seek advice on family size and birth spacing, using a multimedia presentation to deliver positive, compelling and evidence based messages. Other child survival activities include immunization, oral rehydration for diarrheal diseases and children be taken to the hospital whenever they fall sick. Moreover, expectant mothers should be encouraged at all times to utilize the free maternal care services and deliver in health centre to reduce child mortality.

The Government through the local leaders and health professionals at the local centers could organize intensive awareness forums that encourage and enlighten men to be more involved and participate fully in family planning. This should encompass influencing men's attitudes towards family planning to support and approve contraceptive use.

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