

CHAPTER 2

FERTILITY AND REPRODUCTIVE HEALTH

2.0 Fertility and Reproductive Health

2.0.1 Summary

Studies on Reproductive Health (RH) have covered the following areas: Fertility differentials by occupation type among ever-married, determinants and proximate determinants of fertility, estimation of fertility using parity progression model, pace and length of reproduction of women, determinants of fertility preferences, female education and fertility behaviour, socio-economic correlates of fertility, assessment of knowledge and attitudes of adolescents towards RH education.

2.0.2 Methodology

The main source of secondary data was the KDHS. The main methods and tools of primary data collection used were interviews schedules and structured questionnaires, a few of the studies used FGDs. The main methods of data analysis were: Cross tabulations, percentages, chi-square, multiple linear regression and ordinary logistic regression, Coale and Trussel models P/F Ratio Technique were used for data analysis.

2.1 REPRODUCTIVE HEALTH

2.1.1 Issues

- Fertility and education.
- Fertility and type of marriage.
- Effect of lactation on fertility.
- Effect of RH information on fertility.

2.1.2 Findings

The following were the main findings emanating from past fertility works: Women with secondary level of education registered lower fertility compared to those with primary level and those with no educational level. The higher the level of education, the fewer the number of children. Spending more years in school and more

exposure to the mass media that provides more information on modern methods on FP affected fertility levels. Late age at marriage was also related to less number of children.

It was also found out that women in monogamous unions recorded higher fertility than those in polygamous unions although the difference is minimal while married women registered higher fertility rates than the single, separated, divorced and widowed categories. Differentials in fertility between some provinces could be attributed to women desiring smaller families (e.g. in central province).

Lactation was singled out as the most important fertility-inhibiting factor while the index of postpartum in fecundability was the lowest, followed by non-marriage and then contraceptives in most regions in Kenya. Contraception was found to be an important factor in fertility reduction among women in Nairobi and Central provinces and women with secondary and higher level of education.

There are marked differences in birth intervals and pace of family formation between women in urban areas and those in rural areas. Differentials in fertility between provinces could be attributed to women preferring smaller families (e.g. in central province).

Overall, most of the studies suggested that the important policy instruments that may influence fertility preference are education, access to health information and programmes designed to reduce infant and child mortality. Education is the most important variable in determining the extent of ages at first birth and the spacing of births.

2.1.3 Recommendations

- The studies recommended the intensification of FPPs where there is high fertility and provision of universal education especially

for girls to delay marriage and family formation.

- Programs are needed to increase the access of young women to sexual and RH information and services.
- Create safe environments where adolescents feel they have free access to RH information and preventive medical services.

2.1.4 Research gaps

The following areas were found to be wanting in terms of research:

- Behaviour change communications and IEC targeting sub-population groups at the highest risk of HIV/AIDS.
- Strategies through which the under served groups can have better access to RHS.
- Women's work patterns and the relationships between women, work and fertility.
- Adolescents' sexual and RH rights.
- Evaluate the adolescent RHPs in Kenya and programme effects on adolescent's RH behaviour.
- The capacity and capability of the majority of health institutions especially in the delivery of RHS remain largely undocumented and therefore unknown to policy makers, development partners and other stakeholders.

2.1.5 Research Agenda

- Study Fertility differentials by occupation type among all women. There is need to explore variations in women's work patterns and the relationships between work and fertility.
- Qualitative survey on behaviour change targeting sub-population groups at highest risk of HIV/AIDS.

- Study sexual and RH rights especially of adolescents. Premarital contraceptive demands paying attention to changes in the rate of premarital pregnancies (and/or births) and the timing of subsequent births.

- Analysis of preferred birth intervals and how they are likely to impact on the process of child bearing, and link between birth intervals and completed family size. Further researches on the implications of the effects of birth spacing on child survival as a key component in FP messages.

- Survey on the changes needed for appropriate RH services relating to responsible family size planning, reflecting variations among different socio-economic groups and geographic regions. Family size studies can be carried out to capture specific and unique regional characteristics. Fertility differentials by occupation type among all women should also be studied.

- Parental perception of child survival risks and proposals on how these perceptions relate to parental behavioural decisions in reproduction.

- Fertility preference studies that combine both men and women as respondents with sex as one of the variables under investigation.

- Role of breast-feeding as a strategy for birth spacing.

- Assess capacities and capability of RH health institutions in delivery of RHS.

- Premarital contraceptive demands with special attention to changes in high rate of premarital pregnancies and first and second birth timing.

In addition, future researchers should consider using various methodologies especially the application of fertility models to determine and recommend suitable models for establishing HIV/AIDS and fertility relationship.

2.2 FAMILY PLANNING

2.2.1 Summary

Contraception is the country's main tool in the control of population growth rate, and has met with numerous drawbacks. Some two major drawbacks are males' unfavourable attitudes towards contraceptive use and their generally high preference for large family sizes. This section presents the research agenda on FP.

2.2.2 Issues

Spousal or husband-wife communication about FP and contraceptive use, culture and reproduction.

- Failure rates of various contraceptive methods.
- Contraceptive use dynamics among migrant women.
- Analysis of contraceptive discontinuation.
- The effects of sex composition on contraceptive use.
- Fertility decline and demand for FP.
- Cultural values and norms as barriers to FP.

2.2.3 Findings

The main studies conducted in this area have been: Factors influencing utilization of breast feeding as a primary method of child spacing, women status in contraceptive use and fertility, FP projections analysis up to 2020. The knowledge, attitudes and opinions of policy makers, and other stakeholders on adolescent sexual and RH rights as well as the socio-demographic and health consequences of adolescent sexuality and fertility in Kenya have also been surveyed.

Other studies covered couples' unmet need for contraception, determinants of contraceptive non-use, and demographic significance of unmet need, factors underlying unmet need for contraception, informed choice and decision

making in FP counselling, FP communications and contraceptive use, spousal or husband -wife communication about FP and contraceptive use in Kenya and failure rates of different contraceptives.

Contraceptive use dynamics among migrant women, communication, culture and reproduction, analysis of contraceptive discontinuation were other areas of interest. The effects of sex composition on contraceptive use, fertility decline and demand for FP, assessment of knowledge, attitude and practice of modern methods of FP amongst men in rural Kenya and barriers to men's participation in FP form the basis of studies done in this area/topic.

Other studies were on condom use/non use: perceptions on condom and barriers to condom use, distribution and use of male condoms in Kenya, the female condom as a woman-controlled protective device.

There is still high-unmet demand for contraception across the population. The issue is important to researchers and policy makers because fertility behaviour is influenced by characteristics of places of residence. Women from the rural areas had higher unmet need than those from the urban settings. While women who had incomplete primary level of education had higher unmet need compared to those who had not been to school or had primary education or beyond. FP campaigns should be encouraged in rural areas. The factors underlying unmet need for contraception in Kenya, informed choice and decision making in FP counselling in Kenya, FP communications and contraceptive use in Kenya. The unmet need for contraception to space children was much higher than that for limiting further childbearing (14.7% against 10.4%) respectively.

Periodic abstinence and condom use were found to have been among the methods with the highest failure rate after other methods of contraception for married women in Kenya. Catholics had the highest failure rate, while Muslims had the lowest. Women of rural residence had the highest failure rate as compared to their urban counterparts. Women with primary education had the highest contraceptive failure rate, while women with secondary and above education had

the lowest. Younger women aged 15-24 had among the highest contraceptive failure rate.

There is an association between the source of FP information and service and the individual's age, marital status, region of residence and the education. There is also significant relationship between the age of women, logistics of sourcing contraceptives and contraceptive non-use.

FP providers could enhance client's contraceptive decision making if they took a more active role in contraceptive counseling, for example, by relating information on specific methods to women's personal circumstances and helping clients weigh the advantages and disadvantages of various methods.

The main causes for low use of FP were found to be beliefs, negative attitude towards modern FP methods, lack of permanent health facility in the area, poor male involvement in FP and fear of side effects of modern FP methods. Marital status and occupation were found to have influence on the knowledge that breastfeeding could be used as a child spacing method.

It was established that migration influences contraceptive use among migrants' women. That is, the probability of using contraceptive is higher among the migrants' women than the non-migrants.

Some studies agree that contraceptive use would increase if sex preferences were diminished. Consequently, the goal of controlling the high fertility rates would be achieved.

2.2.4 Recommendations

- Make FP services accessible and affordable to all including men who require them. Men should be enlightened on the use of contraceptives. Policy makers should encourage and make of contraception accessible to men.
- Urgent policy issues to be addressed if the current fertility decline is to be sustained such as increased accessibility and availability of FP services both in quality and quantity, especially in the rural areas where majority of

the population is found. There is also a need to intensify FPPs, which benefit women in terms of knowledge and use of contraception.

- FP Programmes in Kenya to intensify their activities to ensure that all eligible persons use FP methods, potential demand for contraception is satisfied, and that threats by contraceptive discontinuation rates are countered by ensuring that all the Service Delivery Points (SDPs) are equipped with expendable supplies.
- Post-partum mothers should be taught and encouraged to appreciate the need to breastfeed for long durations.
- Studies also emphasized the need to promote spousal communication and increasing male involvement in RH including encouragement to turn the universal knowledge towards contraceptive practice. There is need for education that emphasizes the advantages of the use of modern contraceptives. This should be to given to all irrespective of gender or status.

2.2.5 Research Gaps

- The impact of the CBD strategy and clinic based FP services on reaching serving FP clients
- Factors and rationale determining the use and non-use of the female condoms.
- Unmet need and access of contraception to men.
- Role of herbs as contraceptives.
- Men's unmet need for contraception and the proximate determinants of unmet need among them.

2.2.6 Research Agenda

- Focus on the underlying causes of unmet need for contraception among all potential users.

- Studies determining ways in which introduction of the female condom will affect women's ability to negotiate use to prevent HIV/AIDS and other STDs.
- Relationship between men's unmet need for contraception and the proximate determinants of unmet need among them.
- Incorporate changes in prevalence of some FP methods over others including new methods.
- Studies to determine the scope and efficiency of herbs as contraceptives.
- Research to establish ways of implementing FPPs to further accelerate fertility decline.
- Establish ways of increasing local resource mobilization for FPPs to reduce dependency on donors.
- Address stagnation in FP prevalence.

2.3 ADOLESCENT FERTILITY

2.3.1 Summary

This section has covered adolescent fertility and premarital sex issues. Studies focusing mainly on adolescent or youth issues have been patchy and scattered. Some studies were conducted in this area during the last decade. Examples of such studies are: socio-demographic and health consequences of adolescent sexuality and fertility as shown below:

2.3.2 Issues

- Factors that make girls drop out of school.
- Accessibility and use of contraceptives.
- High teenage pregnancy.
- Solutions to pre-marital sex problem.

2.3.3 Findings

Issues pertaining to adolescents covered in past studies were on adolescents or youth SRH and have revealed that young people are becoming sexually active at progressively early puberty. Economic hardships, urbanization, schooling and

weakening of traditional structures that regulated young people's sexual behaviour were found to be the main causes of high adolescent fertility. High teenage sexual activity was reflected in the high incidence of pregnancy, abortion and STDs. Other studies were on: Adolescent knowledge, attitude and practice or use of contraceptives among high school students in Kenya. Studies of secondary school students' communication and factors associated with adolescent sexual behaviour; early schoolgirl pregnancies; adolescent experiences and lifestyles were also undertaken. Characteristics of adolescent mothers; socio-demographic and health consequences of adolescent sexuality and fertility; determinants of contraceptive non-use among Kenyan youth and determinants of fertility among adolescents and youth (15-24 years) were also of interest.

Significant differences between the experiences of adolescent girls and boys in terms of lifestyles, communication, attitudes, knowledge, and behaviour were established. Female adolescents, especially those in the rural areas engage in sexual intercourse at an earlier age. However, contraceptive use generally increased with an increase in age.

A significant proportion of adolescents was found to be sexually active, some with multiple partners but contraception is low. When age at first sexual intercourse was examined, there was a generally increasing proportion of use of contraceptives.

Married youths and those who lived in the rural areas comprise majority of non-users of contraception among the youth in Kenya. Non-use of contraception among youth in Kenya varies according to education, age, place of residence, region of residence, ethnicity, marital status, exposure to mass media, and knowledge of FP. There is great association between the knowledge of contraception, source, attitude towards FP and peer communication on the subject.

Most studies found out that majority of the adolescents engage in sexual intercourse at tender age and the average age at first intercourse is on the decline. Results on age at first marriage show

that the mean age is also reportedly low and the trends in both age at first marriage and first birth show slight decline in age, which is mainly given at 18 years.

The majority of adolescents in secondary schools were sexually experienced. Majority of the girls had many sexual partners and engaged in unprotected sex. Many of the males were also sexually experienced. Among the sexually experienced students, few of them had ever used a contraceptive method the first time they had sex. The condom was the method frequently used, followed by the safe periods and the pill.

Many authors reported that poverty, cultural factors and lack of relevant information, socio-economic status of the parents/guardians, peer pressure and growth and development of individuals contributed heavily to the problem.

Adolescent fertility is therefore a consequence of interaction of multiple factors such as: family types and religion, education of adolescent, education of mothers, education of fathers, occupation of the adolescent, marital status, parents' marital status, marriage, age at first birth, age at marriage, age at first sexual intercourse, frequency of sexual intercourse, knowledge of contraceptives and use of contraceptives.

Studies showed that if contraceptives are used correctly, this could reduce the incidence of unwanted pregnancies among adolescent girls and a number of unsafe abortions among them thereby, reducing deaths due to complications of unsafe abortions. However, parents, religious institutions and society at large do not allow use of contraceptive use among adolescents. Some studies concluded that mass media messages are significantly associated with adolescents' attitudes to contraceptive use.

2.3.4 Recommendations

- Policy makers should come up with appropriate policies and programmes to address the issues of early pregnancy among the adolescents in schools. Such adolescent programmes should include counseling services and child-care training.
- Adolescents often engage in sexual intercourse early and so, efforts to have FLE in schools should be encouraged. Emphasis should be given to FLE services accessible to the youth despite the controversies that surround the subject as alternative measures. Adolescent RH programmes that target the youth must be designed to take account of their special needs, combine information and services and must be of high quality, accessible, affordable and must offer a comprehensive range of services that encourage the youth to seek services.
- There is need to strengthen the guidance and counseling departments in schools to address issues of RH as a strategy of preventing early pregnancy among adolescents. Youths should be informed and educated on matters affecting their lives through counseling and parental guidance.
- MOEST should include RH as a topic in the school curriculum to provide knowledge to children at the appropriate age. This would empower them to make informed decisions, which would lead to postponement of their sexual involvement.
- Parents/guardians should be enlightened on the continuous provision of basic needs of students at school through involvement in such forums as parents teachers association meetings. Parents should not shy away from the role of imparting sex education to their children. They should be free to discuss sex-related issues with them instead of assuming that teachers will do it. They should be open to their children in sexual matters and cultivate a good relationship with them.
- Young mothers should be allowed to return to school after delivery and should not be expelled. There should be a back to school policy to empower them deal with RH and socio-economic issues.
- Programs for young people should be sensitive to gender differences, and specifically aim at to reducing early pregnancies among youths.

- Stakeholders should make communities aware of the existing traditional practices that are harmful to the adolescents like premature marriages, female circumcision, and wife inheritance, which encourage early pregnancy among adolescents.
- Create a safe, supported passage for girls between ages 10-19, ensuring that their lives during this period of critical capability building and heightened vulnerability, does not end with marriage and child-bearing.
- Acknowledgement that adolescent girls' lives are often governed by harmful, culturally sanctioned gender rules imposed by males, parents and other elders and perpetuated at times by girls themselves.
- Expand girls' social participation, in economic opportunities and schooling understanding that these are basic entitlements that shape their reproductive behaviour.
- Recognize that a large proportion of adolescent girls are already wives and mothers, who need support as much as their unmarried female peers.
- Policy makers and opinion leaders should create awareness in their respective communities, and enlighten the community on the plight of youths.
- Teachers and parents must be provided with skills to socialize their children in sexual matters. Programs that build communication skills on sexual matters may be an important starting point.
- Youth-friendly health services should be introduced to encourage for adolescents to feel free to talk about their problems. Concerted effort should be made to increase the level of exposure to FP messages among adolescents. Such campaigns should also conspicuously try to stimulate interpersonal communication so that adolescents will talk more about the problems and the benefits of planned child bearing. If such campaigns are

to be effective, there is need for audience segmentation. Efforts should be made to reach adolescents who are young, unmarried and currently attending school since these are the least likely to report exposure to FP information and to exhibit appropriate contraceptive behaviour. School-based dissemination of FP information should be revamped. Since knowledge and skills without access to services are worthless, FP services should be made widely available and accessible to adolescents.

2.3.5 Research gaps

- Relationship between drug abuse by youth and pre-marital sex.
- Relationship between HIV/AIDS and STIs and adolescent sexuality.
- Prevalent variations of STD, HIV/AIDS between institutional adolescents and those in the community (out-of-school).
- Association between mass media messages and current use of contraception among these adolescents.
- Enhance basic knowledge in RH issues e.g. FP to enable TBAs be able to advise their clients effectively on seeking related RH care.
- The role of CBOs in the prevention of early adolescent pregnancy.
- National study on sexual behaviour of youths to establish age groups, cultural, inter-school, religious groups, seasonal and socio-economic group variations.

2.3.6 Research Agenda

- Premarital sex, and school category in Kenya.
- Studies on the constraints that adolescents face in resolving unwanted pregnancy early and in a safe way.
- Role of the school environment in the initiation of premarital sex among girls and boys in Kenya.

- Education as the major tool, which can enable more women in the rural areas to use FP and socio, economic and cultural barriers to Family Planning (FP) among rural women in Kenya.
- Linkages between incomplete abortion and FP services.
- The role played by traditional healers in abortion.
- Gender equity and improvement of women's socio-economic status through increased capacity and capability to have control over their RH.
- Variations of sexual behaviour of the youth within the country between age groups, cultural, inter-school, religious groups, seasonal and socio-economic group variations.
- Role of mass media and peer pressure on schoolgirl pregnancies should further be investigated.
- Determine the contraceptive methods appropriate for youth and effective contraceptive delivery and distribution methods to the youths.
- Determine the prevalent variations of STDs, HIV/AIDS between institutional adolescents and those in the community.
- Given that interpersonal communication plays an important role in changing contraceptive behaviour, there is need to investigate the content, intensity and accuracy of such communication, using qualitative methods in order to find out how they can be improved.
- A comprehensive investigation into the barriers leading to contraceptive non-use among the youth in order to explain the large discrepancy between knowledge and use. The studies should further identify strategies and interventions that can help increase contraceptive use among the sexually active adolescents.
- Examine the extent to which adolescent fertility affects the socio-economic and health scenario in Kenya.
- Community attitudes, and gender expectations that may serve to encourage or inhibit coercive sex, in order to determine how to enlist community support for the curtailment of such practices.
- Impact of adolescents' programmes run by government and NGOs using experience of married girls and first-time parents e.g. develop and test integrated health and social interventions of first-time parents, attitudes regarding delaying subsequent births information needs and role of family in reproductive decision-making.
- Explore the prevalence and circumstances of risky and non-consensual sexual experiences among young people.

2.4 MALE INVOLVEMENT IN FP

2.4.1 Summary

African men are often key figures in domestic decision-making, particularly on fertility behaviour. Men are also the main link between the family and prevailing culture. Given the importance of FP in improving the health of the women and children, and in reducing population growth rates, men's support and involvement are essential for FP to be widely accepted. Looking at the information on background characteristics of Kenyan men and how these promote or inhibit their knowledge and use of contraceptives is a crucial step to making FP more popular.

Few studies were conducted in this area during the last decade. Examples of such studies are: male involvement in the education on harmfulness of Female Genital Mutilation (FGM); acceptability and feasibility in Kenya; family size preferences, factors influencing the practice of FP among men; fertility behaviour and contraceptive use; the additive and interactive gendered preferences and reproductive behaviour; and expanding men's participation in RH.

2.4.2 Issues

- Male knowledge, attitude and practice of FP in general and contraceptives in particular.
- Integrating men into the RH equation.
- Barriers to male participation in FP.

2.4.3 Findings

The main causes for low use of FP by men were found to be their beliefs, negative attitude towards modern FP methods, lack of permanent health facilities in their areas, and fear of side effects of modern FP methods. Some studies indicated that men's favourable attitudes towards contraceptive use and achievements of their family size were significant contributors to the adoption of contraception.

Other studies show that there is high level of knowledge (awareness) of FP methods and sources as well as favourable attitudes among men in Kenya, but limited readiness to use them both as clients and supportive partners. The most widely known methods were the condom, the pill, female sterilization and periodic abstinence.

Some men in Kenya already participate in women-centered RH services. The structural management and attitudinal constraints at the health facilities were the main factors in keeping men away. "There is no place for them."

2.4.4 Recommendations

- Need to expand men's participation in RH, FP policies and programmes to help increase men's access to information on benefits of FP and expand information about FP to men to reduce misconceptions by improving their physical access to male-friendly FP and promote their interest in supporting FP.
- Reorganise FP facilities to accommodate men.
- There is need to promote the concept of family size limitation, instead of promoting FP solely for birth spacing purposes since this

practice has been found to dampen the effect of FP on overall fertility. (Acsadi and John – Acsadi 1990, cited in Gule, 1994).

2.4.5 Research Gaps

- Inter-spousal communication on FP
- Lack of male involvement
- Behaviour change in avoiding harmful traditional practices like FGM and wife inheritance.
- Male pro-natalist ideas.

2.4.6 Research Agenda

- Studies investigating men's understanding of actual and potential roles as supportive partners in various phases of RH.
- Investigate men's understanding, perceptions, beliefs and practices regarding FP, the socio-cultural context of those beliefs and the impact of the above on reproductive preferences and behaviour. Assessment of knowledge, attitude and practice of modern methods of FP amongst men in rural Kenya and barriers to men's participation in FP form the basis of studies done in this area/topic.
- Further research on factors affecting contraceptive use by men in Kenya and how men can be encouraged to take responsibility of their own and their partner's health is required. Research should be carried out at a micro-level to identify the main social, economic and demographic factors influencing male knowledge, attitude and practice of FP especially contraceptive usage in these respective areas.
- Further research on why FGM is still being practised is needed in the understanding of the demographic, social, economic and cultural factors that need to accelerate the eradication of FGM. Moreover, these factors should be looked into and how they affect contraceptive use by men in Kenya and how men can be encouraged to take responsibility for their own and their partner's health is required.

- At a general research and policy level, more should be done to understand the inclinations, preferences, and behaviour of men. Contrary to conventional wisdom, a high proportion of men in Kenya want to cease childbearing. This fact demands empirical attention.
- Researches on how RH decisions are made by men, including their roles and responsibilities in women's decision-making and identification of mechanisms to encourage positive involvement of men.
- Further researches on how to scale up FPPs, and particularly targeting young men, are needed.

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