Journal of Biology, Agriculture and Healthcare
ISSN 2224-3208 (Paper) ISSN 2225-093X (Online)
Vol.5, No.7, 2015

Asessing Utilization of Family Planning Services among Women of Reproductive Age (15-49 Yrs) in North Kanyabala Sub-Location, Homabay Sub-County

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Abstract

Introduction

The Kenya government in collaboration with other stakeholders involved in the provision of family planning services have put in place various strategies and policies to increase uptake of family planning services. These are aimed at increasing contraceptive prevalence rate (CPR), reduction in both total fertility rate (TFR) and unmet need for family planning services. Despite the various strategies and policies, total fertility rate still remains high at 4.6 percent, while CPR and unmet need for family planning are estimated at 46 percent and 24 percent, respectively.

Methods

The purpose of the study was to assess the utilization family planning services and to identify the determinants of demand for family planning services among women of reproductive age in North Kanayabala sub location, Homa bay Sub County The study used a cross sectional descriptive design to assess to realize the objectives of the study. The target population constituted women of reproductive age between15-49 years, who were identified through cluster convenience sampling. Primary data was collected from the women using a semi structured questionnaire. Data collected was cleaned, coded and edited for completeness and accuracy before it was entered into the computer package. Data was then analyzed using statistical package for social sciences (SPSS).

Results and findings

The study revealed low usage of contraceptives compared to the national level (53 %). Use of the services varied in terms of level of education and sources of income. Various factors accounted for the low use of family planning services. These included partner's approval, personal choice, pregnancy and the woman's knowledge on family planning.

Conclusion

To increase the use of family planning services among women of reproductive age in North Kanayabala Sub-location, activities of community based distribution should be revived and enhanced, promotion of family planning education and activities at the household level should be accorded priority. Formation of lobby groups to enhance cultural change, awareness creation and counselling and integrating family planning services with other health care services are recommended.

CHAPTER ONE: INTRODUCTION.

1.0. BACKGROUND INFORMATION

Many developing economics are characterized by population growth, high birth rate accompanied by steady declines in death rates, low contraceptive prevalence rate (Oyedokun, 2007). In sub Saharan Africa (SSA), the rate of population growth is one of the highest in the world, (2.8%) compared to the rest of the world (USAID, 2007). The number of people in need of health and education, among other services is large and increasing which in turn require large amount of resources, personal and infrastructure. This is likely to be impediment towards the realization of child mortality, improvement of maternal health, achievement of universal primary education, combating HIV/AIDS and malaria as part of millennium development goals (Health Policy initiative, 2007). To address this, many countries in the sub Saharan Africa (SSA) including Kenya focused their attention on birth control measures, especially the use of FP services. In Kenya FP services have been used since 1957 when the government started operating family planning clinics within ministry of health facilities.

Planning ahead has always been imperative in affecting the outcome of the life changing situations for everyone, which mostly applies when it comes to pregnancy. Nearly 15% of the pregnancies nationwide each year are unplanned and the occurrence is far more prevalent among women under the age of 25 years or with low income status. Lack of emotional and financial preparation often derives from unplanned parenthood that subsequent lead to a serious burden to the surrounding family members. Optional government aid became the only hope for many who are financial broken. Therefore women for women who are sexually active and have no intentions for parenthood birth control pills offer simple and effective deterrent to unplanned pregnancy that can adversely affect both family and society.

Behavioral methods that include intercourse such as withdrawal and calendar based methods have little

upfront cost and are readily available, but less effective in typical use than the most other methods, such as IUCD and implant are highly effective and convenient, requiring little user action.

When cost of failure is included, IUCD and vasectomy are much less costly than other methods. According to one child policy of China which forces couples not to have more than one child, China has been credited with a very significant slowing of China's population growth which has been higher before the policy was implemented.

According to family planning articles West Africa 2008, contraceptive use is low, 23% of women of reproductive age in the region indicated that they would prefer to avoid becoming pregnant, but are not using any form of family planning. This phenomenon is referred to as unmet need for family planning. Among these women 1 in 10 would like to space births.

Family planning use is lower among poorer group of women in the region only 4% use some form of family planning either modern or traditional. In southern Africa, the prevalence rate among the wealthiest group is 69%.

High fertility, combined with declining mortality, gave Kenya one of the world's fastest population growth rates in 1970's and 1980's. But it became one of the first African countries to encourage family planning as a way to lower fertility rates and mitigate pressure on land. Kenya total fertility rate has declined estimated 8.1 children per woman in late 1960's to 5.4 in the early 1990's (NCAPD, 2010).

Although fewer than half couples 46% of Kenyan couples use contraceptives according to the just concluded Kenya demographic health survey that marks a significant increase compared to 39% reported similar study in 2003.

1.1. PROBLEM STATEMENT

The Kenya government in collaboration with other stakeholders involved in the provision of family planning services have put in place various strategies and policies to increase uptake of family planning services. These are aimed at increasing contraceptive prevalence rate (CPR), reduction in both total fertility rate (TFR) and unmet need for family planning services. Despite the various strategies and policies, total fertility rate still remains high at 4.6 percent, while CPR and unmet need for family planning are estimated at 46 percent and 24 percent, respectively nationally (Oketch *et al*., 2011).

This trend in the uptake of family planning services has not spared North Kanyabala where there is large estimated number of birth per household (strategic plan 2012-2018). Standards of living tend to worsen when the rate of population growth exceeds the rate of economic growth. At the household level, the high fertility rate may be contributing towards depletion of productive resources in the society, rising cost of living, ill health, poor nutrition and limited educational opportunities, ultimately trapping women in a poverty cycle. In the case of slums where poverty levels are high, the situation is likely to be worse. Although 2008 KDHS demonstrated that education, marital status, woman's income, and other demographic and socio-economic factors affect utilization of family planning services, the significance of these factors and provider factors have not been determined for the majority poor women living in informal and low income earning settings. The purpose of the study was to empirically examine the utilization and determinants of family planning services by women in North Kanyabala sub-location.

1.2. JUSTIFICATION OF THE STUDY

Population growth in Kenya continues to increase at an alarming rate. Currently the population growth rate is estimated to be 2.6 (World Bank, 2012) which still remain the highest as per the government target. This is an indicator that utilization of family planning services is low and needs to be addressed with great attention to avert the situation.

Government and other agencies have come up with various strategies and polices but these have fallen short of achieving the intended objectives. This can be attributed to these policies and strategies failing to focus on essential and key determinants and how to address these hindering factors to contraceptive use among women of reproductive age. Therefore, this study aims at assessing knowledge on family planning, identifying sources of information about family planning and determining factors associated with non use of family planning services among women of reproductive age.

Results obtained from this study will e therefore enable policy makers, programme designers and other interested stakeholders to come up with interventions that are results oriented hence improving accessibility and utilization of family planning services, reducing maternal and infant mortality rate, improving maternal health and controlling population growth for economic development.

1.3. HYPOTHESIS

- Socio-cultural factors influences utilization of family planning services among women in North Kanyabala sub-location.

1.4. OBJECTIVES
1.5. BROAD OBJECTIVE.

This study aims at assessing utilization of family planning services among women of reproductive age in North Kanayabala sub location.

1.6. SPECIFIC OBJECTIVES.

1. To assess awareness of women on family planning services.
2. To identify the source of family planning information among women.
3. To determine the common preferred family planning methods among women.
4. To explore factors associated with non use of family planning services among women.

1.7. RESEARCH QUESTION

2. Do women have knowledge on family planning services?
3. What are the main sources of information on family planning services?
4. What is the most preferred family planning method among women?
5. What are the factors associated with non use of family planning services?

1.8. STUDY VARIABLES

1. Independent variables
   - knowledge
   - Cultural beliefs
   - contraception method
   - Level of education
2. Dependent variables
   - utilization of Family Planning services.

CHAPTER TWO: LITERATURE REVIEW

2.1. Trends and patterns in contraceptive use in Kenya.

Kenya become the first country in Sub-Saharan to introduce an official policy on family planning in 1967.Kenya registered a rapid increase in contraceptive and remarkable decline in fertility rate, estimated to drop from 8.1 children per woman in 1977 to 4.7 in 1998. Although the country had started to achieve some improvement in contraceptive prevalence rate and drop in fertility, the momentum declined after 1998 and between 1998 and 2003 there was little change in the contraceptive rate and the fertility rate that had dropped to 4.7 in 1998 increased to 4.9 in 2003 (CBS *et al*., 2004).This increase in fertility rate in 2003 is a clear indicator that there still exist a gap in contraceptive use among women. According to a report by Kenya Demographic and health survey (2008-2009) indicated that the prevalence of unmet need for family planning increased from 24% in 2003 to 26% in 2008.

2.2. Maternal Knowledge on family planning.

Acquiring knowledge about fertility control is an important step towards gaining access to contraceptive methods and using a suitable method in a timely and effective matter. In 2002-2003, Indonesia Demographic and health survey (DHS) data on knowledge of family planning methods were obtained by first asking the respondents to name ways that a couple can use to delay or avoid a pregnancy or birth. The record showed that the most widely known methods among ever married and currently married women are Injectables and pill (97% and 96% respectively)

About four in ten of both women and men know at least one traditional method. Other family planning methods such as IUD 87%, lactating amenorrhea method 20%, diaphragm 12% are the least known methods both ever married and currently married women.

According to Radulovic *et al* .,2006, in which the study included 1584 women, aged 15-49, living in municipality of Nis 98 with primary education, 1080, with secondary education and 389 with higher degree. It showed that most of the interviewers with higher degree gave the best definition.

2.3. Sources of information among women.

Most of the interviewers reported that their source of information about contraception was newspapers and electronic media. The interviewees mostly choose a condom as the most efficient method of contraception. One third of the women with primary education estimate their knowledge as unsatisfactory which makes the highest percentage.

The women with primary education use less protection from unwanted pregnancy than women with secondary and higher degree. The greatest number who chose traditional method of contraception comes from

the group of interviewees with primary education. The greatest number of interrupted pregnancies has primary education.

2.4. Factors that influence utilization of family planning services.

According to study conducted in Pakistan, researchers found that 76% of husbands and 66% of wives feared that God would become angry if they practiced FP (population council 1997) FP methods may challenge bro cultural beliefs, e.g. women I some societies believe it is healthy to menstruate monthly and therefore refused to use Injectables because it result into irregular bleeding/spotting or amenorrhea (Makundi, 2001).Class, ethnicity, status, age and gender all shape clients' experiences with FP and reproductive health services. Clients may fear disrespectful or discrimination treatment. A study in Jordan, women in urban areas reported that clients who "looked better" received better information from clinic staffs (Mawajdeh , 1995). A study in Bangladesh and Nepal found that providers gave the least information and disrespectful treatment to the poorest, least educated (Scholar and Hossain ,1998) .According to another study conducted in Cambodia, some women said lack of money was the main obstruction to obtaining health care. (National institute of statistics and ORC Marco 2000).Many women cannot easily get to clinics, which are often apart, if transportation is available, travelling alone may not be socially accepted for women. Some women may prefer to travel to far places if they feel those facility offer better services. A study conducted in Nigeria 40% of women interviewed did not attend clinic nearest their homes. (Makundi, 2001).in summary according to a study by National coordinating agency for population and development (2010),identified various contributory factors to unmet needs of family planning which were: Fertility-related issues, Opposition to use by partner, Lack of knowledge and Method-related.

CHAPTER THREE: METHODOLOGY

3.1. RESEARCH DESIGN

This was a descriptive crossectional study involving women of reproductive age in North Kanyabala sub-location.

3.2: Study area

The study sites were villages of North Kanyabala Sub-location of Asego Location, Homa Bay Town Division. The location covers an area of approximately 5.4 km^2 with a population density of 1,683 and a population of 9,114. There are approximately 20,196 households in the location and approximately 1,000 households in North Kanyabala Sub-location (KNBS 2009).

3.3: Study population

Study population included all women of reproductive age between 15-49 years, residents of North Kanyabala sub-location who consented for the study.

3.4: Inclusion criteria

- Any woman who was between 15 and 49 years.
- Women who are Residents of North Kanyabala sub-location.
- Women who are willing to participate in the study.

3.5: Exclusion criteria

- women who were away during the time of study
- women who declined to respond though selected for the study

3.6: Determining the sample size

When the target population is more than 10,000 the required sample is calculated using the following formula (Fisher et al, 1983).

$$S = \frac{z^2(pq)}{e^2}$$

Where:

S-sample size

P-The proportion of the targeted population that has the characteristics of focus in the study. In this study the particular characteristics were women of reproductive age. This study used a proportion of 50% since no data is available on contraceptive prevalence among women of reproductive age in North Kanyabala sub location.

Z- The number relating to the degree of confidence.

This study was based at 95% degree of confidence i.e. 1.96 deviate.

q- 1-p

e- Degree/ proportion of error that was accepted in the study. This study adopted 5% degree of error (0.05)

Therefore S= $\frac{1.96^2(0.5)(1-0.5)}{0.05^2}$

S=384.16

When the population is less than 10,000), this formula is used.

$$nf = \frac{n}{1+(n/N)}$$

Where; nf= desired sample size (when the population is less than 10,000).
n= desired sample size (when the population is more than 10,000).
N= the estimate of the population size.

Hence: $nf = \frac{384.16}{1+(384.16/1000)}$

$nf = \frac{384.16}{1+0.10976}$

$nf = \frac{384.16}{1.10976}$ 58

Sample size was **58** women.

3.7: Sampling technique and procedure

Purposive sampling was used to select study sites namely Radiro lower,Radiro A and B,Nyagidha,Kobwana,Got Opiyo, Got Kandiwo, Maguti, Olodo A and B, Magare, Lala, Adongo, villages in North Kanyabala Sub-location of Asego Location, Homa Bay Town Division. These villages were purposively selected because they were easily accessible and were doing poorly in terms of community health indicators.

3.8: Data collection method

During the field visit, the students began with a transect walk through the study site to identify the health indicators that guided in the formulation of the questionnaire. The data collection tool was developed and piloted to assess its effectiveness and reviewed.

The data collection tools were piloted in Omoya village, Kochia Location of Asego division and reviewed for accuracy, completeness and uniformity before data collection. The method used to gather primary data from the community was a questionnaire. Questionnaires were administered in sampled households in the villages that were visited.

3.9: Assumptions

1. Respondents will give genuine information.
2. Respondent will be willing to participate in the study.
3. Participants selected will not feel intimidated.

3.10 : Study limitations

The major challenge was language barrier. Most of the respondents preferred speaking the local mother tongue, Dholuo language. Most local community members feared that the students could be Public Health Officers coming to arrest those who have not observed sanitation requirements.

3.11: Data management, entry and analysis

Data collected was entered to the computer immediately to prevent distortion and enhance objectivity. Completeness and consistency was checked for all questionnaires before data analysis was commenced and any inconsistent or incomplete questionnaire was discarded (data cleaning). Analysis of the data was done by application of computer software SPSS version 16.0 where descriptive statistics was used to summarize descriptive data while frequency was used to analyze occurrences in proportions.

3.12: Data presentation

Data obtained after processing and analysis was be presented in form of pie charts, graphs and tables for easy understanding of utilization of family planning services among women of reproductive age.

3.13: Ethical considerations

Collection of data from the participants requires ethical aspects are observed to protect the rights of participant(s) and information given in the questionnaire will be made confidential. In this case, questionnaire serial number

was used instead of the name of the respondent. Consent from the respondent was sought first before answering the questionnaire and only those who agreed participated in answering the questionnaire. Permission to conduct the survey was given by relevant authority.

CHAPTER FOUR: RESULTS AND FINDINGS

1. BIODEMOGRAPHIC DATA

1.1. AGE

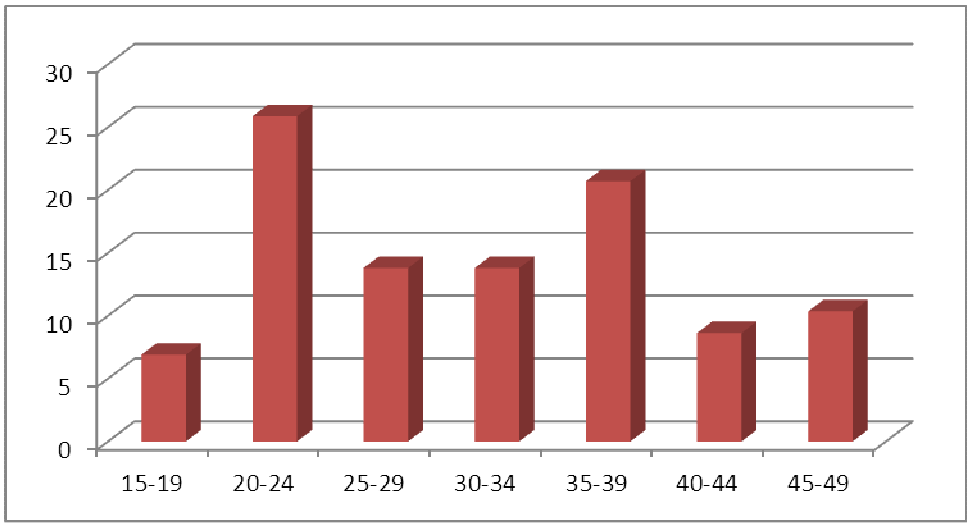

Fig.1.a.

1.2: LEVEL OF EDUCATION

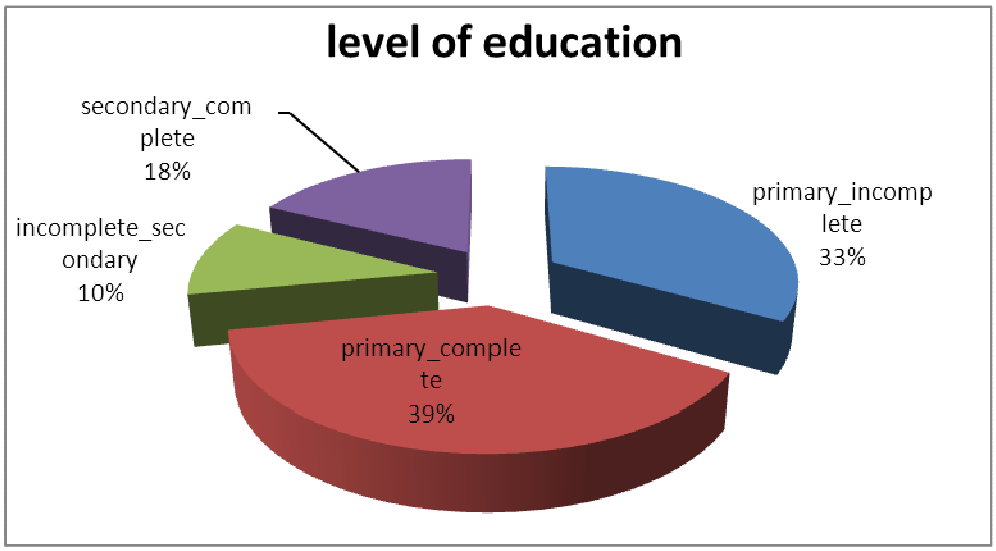

Fig: 1.b.

The pie chart above shows the level of education for the women interviewed. Among the respondents interviewed, majority were those who had completed primary school education (39 %) and 18 % of the respondents had completed secondary school education.

1.3: MARITAL STATUS

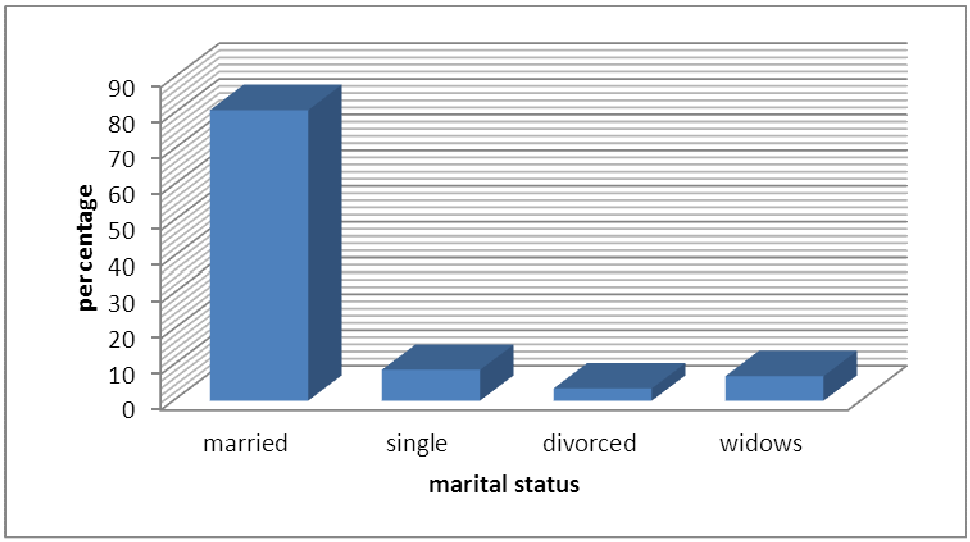

Fig.1 c.

The bar graph above indicates the marital statuses of the respondents.81% of the respondents were married, 9 % were not married, 3 % were divorced and 7 % were windowed.

1.3: NUMBER OF CHILDREN IN THE FAMILY

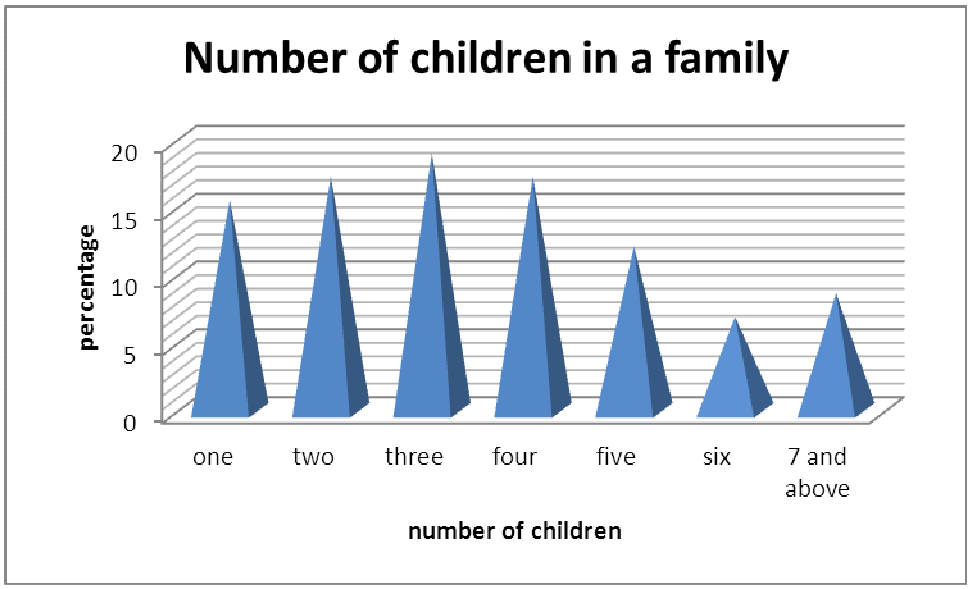

fig.1.d.

Majority of the women interviewed had three children and below (52 %) whereas the remaining 42 % had four children and above with 9% of women having seven children and above.

1.4: DENOMINATION

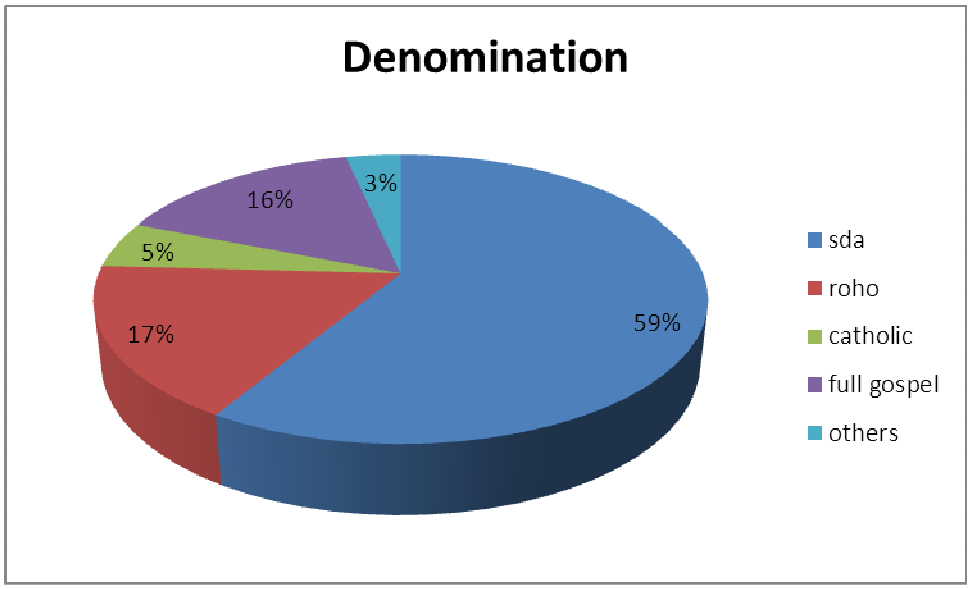

fig.1.e.

Majority of the respondents were of SDA denomination (59 %) with the rest being of other denomination as showed on figure 1.d above.

1.5: SOURCE OF INCOME

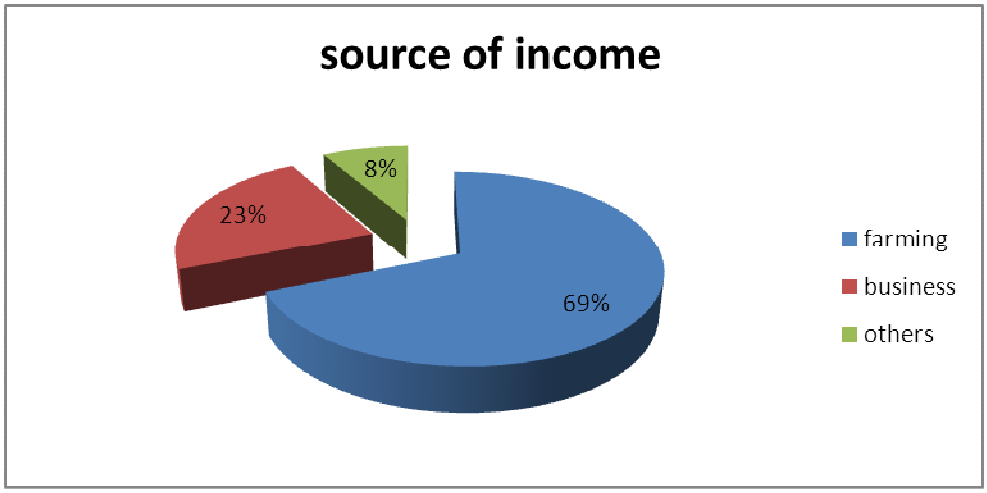

fig.1.f.

As showed in figure 1.e, majority of the respondents were farmers (69 %) and business women (23 %)

2: FAMILY PLANNING SERVICES AWARENESS

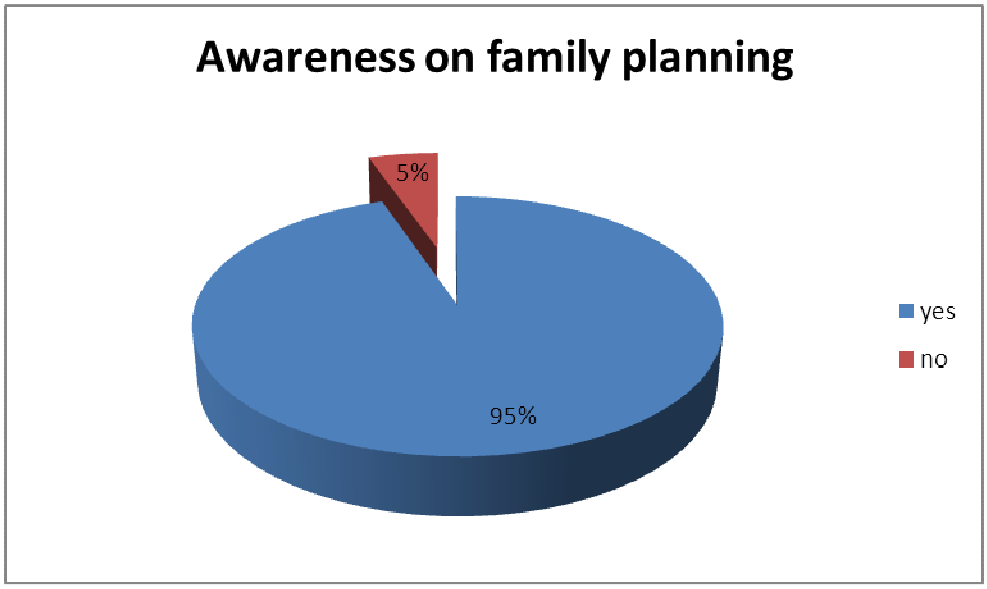

fig.2.a.

As showed in the above bar chart, 95 % of the women are aware of the existence of family planning services while only 5 % of them were not aware of the existence of such services.

3. SOURCES OF FAMILY PLANNING INFORMATION

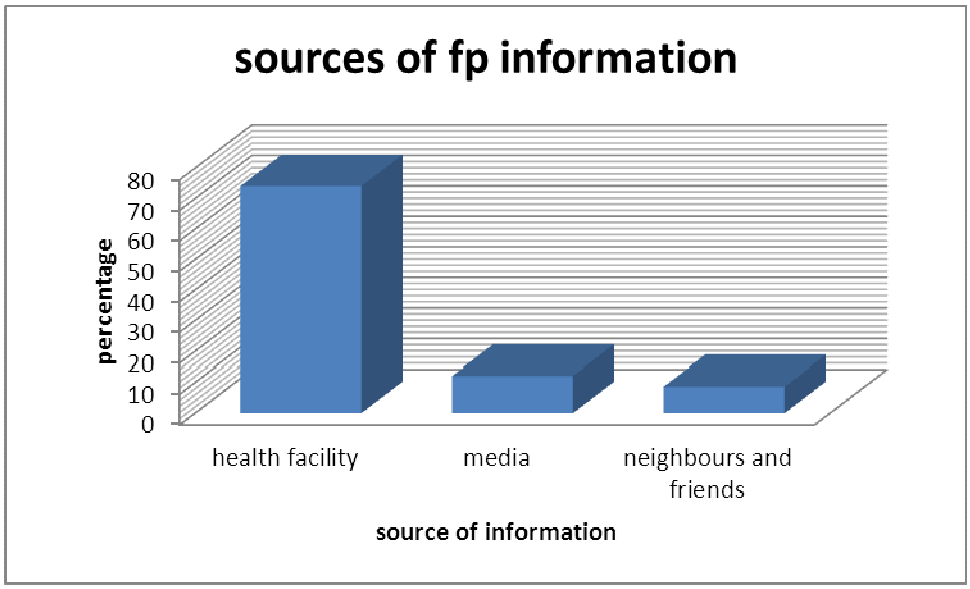

fig.3.a.

Majority of the women receive information regarding family planning from health facilities (74 %) followed by media (12 %) and 9 % of women get information from their friends and neighbours.

4: UTILIZATION OF FAMILY PLANNING SERVICES.

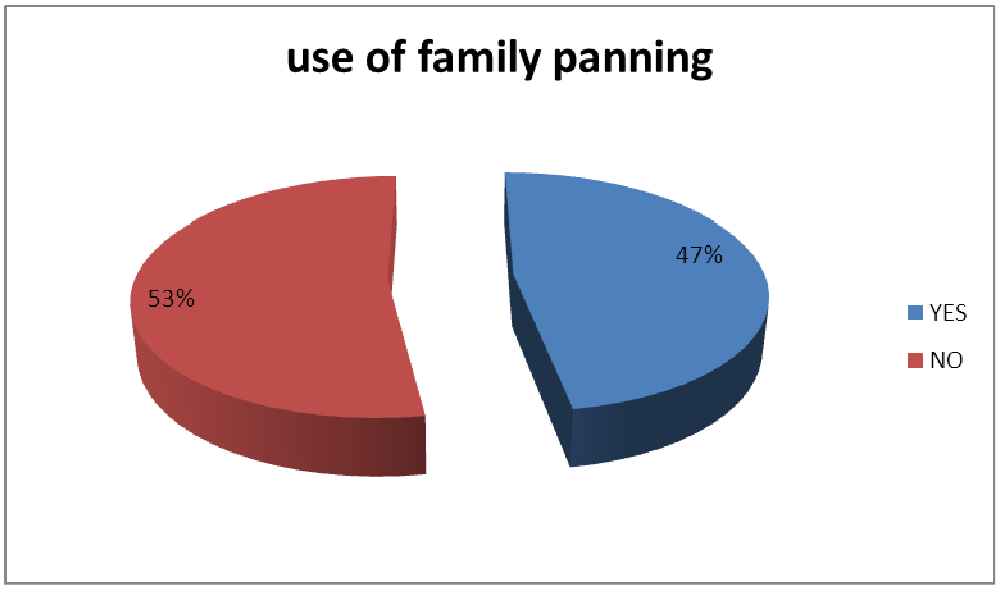

fig.4.a.

The bar chart above shows the utilization of family planning services among women in North Kanayabala sub-location. According to the above results, 53 % are using family planning whereas 47 % are not using any form of family planning method.

5: FAMILY PLANNING METHODS USED

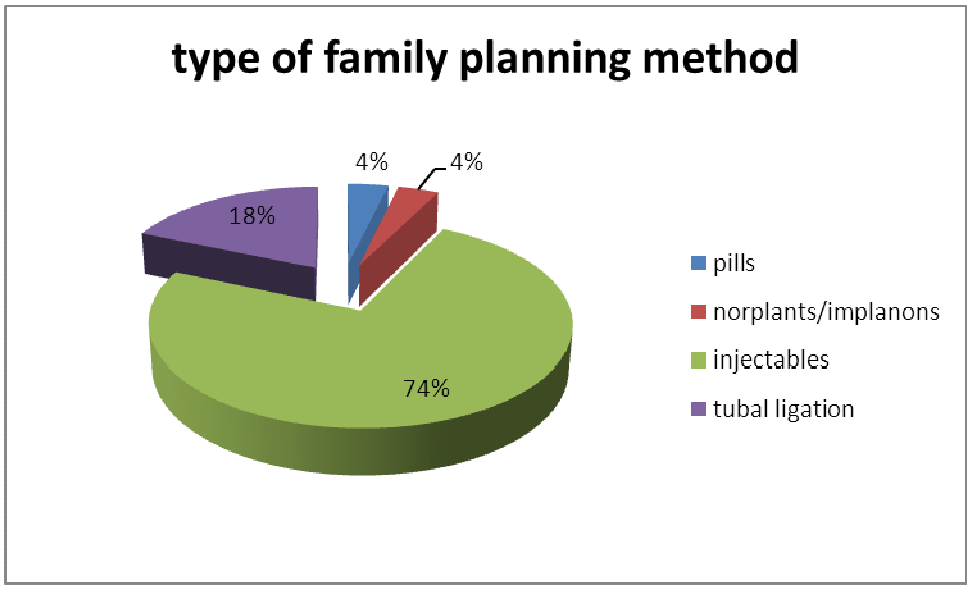

fig.5.a.

The pie chart above shows that majority of the women use Injectables as their preferred choice with tubal ligation following as showed above.

6: REASONS FOR NON-USE OF FAMILY PLANNING SERVICES

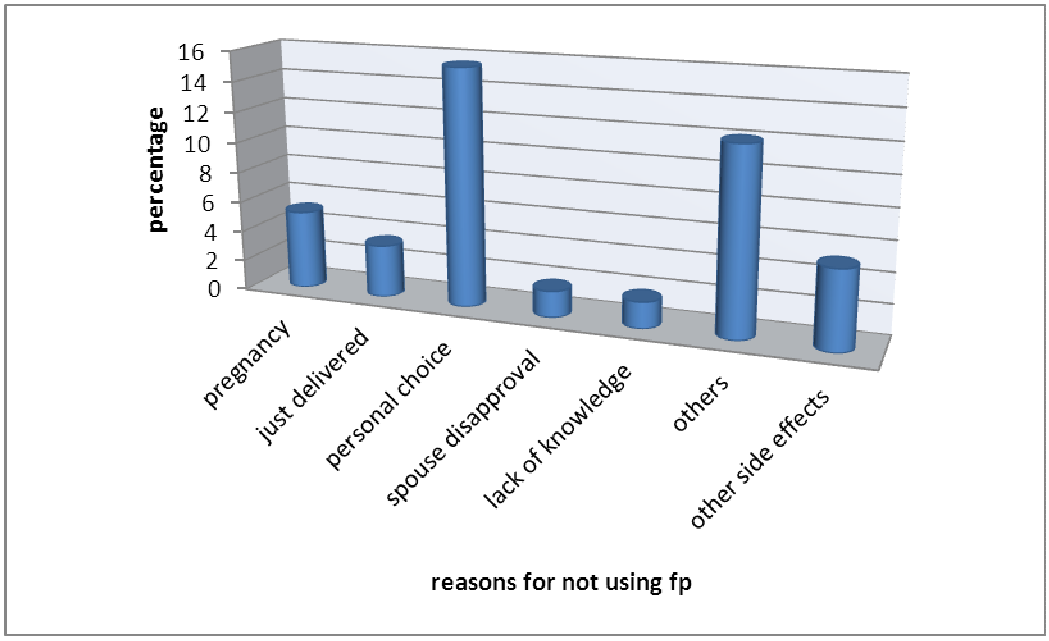

fig.6.a.

16 % of the women who were not using any form of contraceptive method said they were not using because of their personal choice, spouse disapproval and lack of knowledge on family planning services were least reasons why others were not using any family planning with 2% each.

CHAPTER FIVE: DISCUSSION AND CONCLUSSIONS

Family planning has been the main focus in trying to control population growth in Kenya. The government of Kenya has since 1967 been putting various strategies in ensuring the fertility rate is reduced. However, despite all these government efforts still the fertility rate continues to increase and contraceptive prevalence rate continues to decrease (CBS *et al*., 2004).

Results obtained from North Kanayabala sub location on utilization of family planning services confirm similar trends in use of family planning methods. Although majority of women (95 %) were aware that family planning services exist only 53 % of the women are using family planning services. This shows that there is a gap between knowledge and utilization of these services. This also explains why the fertility rate in North Kanayabala is may be slightly high at an average of four children in each family.

Majority of women said that they obtained information regarding family planning from health facilities. This shows that majority of the women are accessing health services but they are not translating the information into use. This trend needs to be investigated further to evaluate information package health care providers give so as to provide ways of strengthening health education as a pertains to contraceptive use.

Many women prefer using Injectables as their method of family planning. This can be attributed to the conveniences Injectables give simply because one needs not to take pill every day. Some may prefer Injectables as a way of concealing use of contraceptives to their un consenting husbands. Depo provera has in the recent past become the commonly and most preferred method of family planning and the use of long term methods have consequently gone down. This makes it necessary for the family planning services providers to provide good family planning counselling to ensure that the users are well informed when choosing their contraceptive method.

As earlier indicated, only 53 % of women are practising family planning. Those who are not practicing do so due to various reasons ranging from personal choice to spouse disapproval. These factors are important in understanding approaches to be used in addressing issues pertaining family planning uptake.

CONCLUSSIONS

Contraceptive prevalence rate (CPR) still remains low with fertility rate continuing to increase. This indicates that there still a gap between knowledge and utilization of family planning services among women of reproductive age. Government, health care providers and other affiliated agencies should come up with strategies and approaches to increase the uptake of contraceptives as a way of empowering people to be able to meet basic needs for all of their family members.

RECOMMENDATIONS

To improve the uptake of family planning services, the following is recommended:

- Health care workers should provide comprehensive family planning counselling to all women attending family planning clinics to enable them make informed choice.
- Health facilities should organize family planning outreach services to be able to take services closer to the people
- Family planning campaigns should be initiated by the DHMT to improve on contraceptive prevalence rate and reduce fertility ratio.
- Close the gender gap in education by enrolling and keeping girls in school, particularly through secondary level. Devote government funds to the elimination of adult illiteracy and assist innovative literacy programmes aiming to reach adult women.
- Policy makers should tailor family planning policies to address the specific needs of different groups of women who experience high unmet need for family planning, particularly young women, those who are poor or poorly educated, and women in rural and underserved areas.

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