SJIF Impact Factor: 5.464

WORLD JOURNAL OF ADVANCE HEALTHCARE RESEARCH

ISSN: 2457-0400
Volume: 6.
Issue: 2.
Page N. 15-24
Year: 2022

Original Article www.wjahr.com

# BARRIERS TO UPTAKE OF FAMILY PLANNING SERVICES AMONG WOMEN OF REPRODUCTIVE AGE (18-45 YEARS) IN MFANGANO ISLAND, HOMABAY COUNTY, KENYA

**Deus Oendo*[1], Venah Bogonko[2] Dr. Osman Abdullahi PhD[3] and Dr. Jane Mumma PhD[4]**

[1]Department of Nursing, Kenya Medical Training College, Mwingi Campus, Box 232-90400 Mwingi Town, Kenya.
[2]Department of Nursing, Kenya Medical Training College, Homabay Campus, Box 512- 40300, Homabay Town, Kenya Kenya.
[3]Pwani University, Box 195-80108, Kilifi, Kenya.
[4]Great Lakes University Kisumu, Box 2224 – 40100, Kisumu Town, Kenya.

**Received date:** 29 November 2021 **Revised date:** 19 December 2021 **Accepted date:** 09 January 2022

***Corresponding Author: Deus Oendo**

Department of Nursing, Kenya Medical Training College, Mwingi Campus, Box 232-90400 Mwingi Town, Kenya.

## ABSTRACT

Family Planning (FP) is voluntary prevention of pregnancy and it entails the interruption of a chain of events that leads to conception. Family planning is important because it helps reduce the Total Fertility Rate (TFR), maternal deaths and morbidity as well as improving the health of the child. In Kenya, only 58 % of women of reproductive age currently use family planning services, the uptake is even lower in Homabay County (56.4 %). The study explored the potential barriers to utilization of family planning services among women of reproductive ages (18-45 years) in Mfangano Island, Homabay County, Kenya. A facility based cross-sectional study was conducted from January 2 to February 28, 2019 among women aged 18-45 years in Mfangano Island Homabay County. Simple random sampling technique was used to select five (5) health facilities out of the seven (7). The participants were selected through convenience sampling whereby a total of 396 participants were recruited from those who came to seek care in the facility and met the inclusion criteria. A pre-tested questionnaire was used for data collection. Barriers to uptake of FP were identified using logistic regression analysis. Of the total sample of (396 participants) 183 (46 %) were using family planning methods. Knowledge level on the methods of family planning was high, with 87.3 % of the participants reporting knowledge of at least three methods. The study examined the challenges the clients experienced in seeking family planning services in the clinics. Results show that participants were not satisfied with the information offered by health care providers on FP. Clinics were closed on some days and sometimes the FP methods were out of stock for at least three months. In the multivariable regression model, secondary education level Adjusted Odds Ratio (AOR) 4.72 (95% CI 2.70 to 8.26) and above secondary education level (AOR 14.45 (95% CI 5.18 to 40.29) were associated with higher odds of FP uptake compared to primary or no education. Being unemployed (AOR 0.36 (95% CI 0.20 to 0.64) and having at least eight children (AOR 0.23 (95% CI 0.06 to 0.84) were associated with lower odds of FP uptake after the adjustment. Utilization of family planning services in Mfangano Island, Homabay County was lower (46%) compared to the national average of 58%. Although knowledge level on the methods of family planning was high, the uptake of family planning services was reported to be low. Lack of spousal consent was the main barrier hence; Program planners should put strategies geared towards education and involvement of men on family planning. Further longitudinal studies on uptake of family planning should be carried out to enhance generalizability of the results.

**KEYWORDS:** Family planning, uptake, reproductive age.

## 1.1 INTRODUCTION

Family planning is the ability to attain a desired number of children which one can be able to take care of.[22] Family planning enables one to attain the highest standard of reproductive health indeed, it enables people to space births, prevent unwanted birth and sexual transmitted diseases STDs.[17] It has a major impact on the health of the mother and well-being of family

members through reduction in maternal and child deaths, decreased cases of HIV transmission, therefore enabling the community improve in productivity and socio-economic status.[2] Proper child birth spacing and decrease in overall fertility helps in reducing infant deaths by 50 % and maternal deaths by 20%.[19] Women who are infected with HIV need to space and reduce births, not only to reduce chances of mother to child transmission of HIV, but to preserve their strength to enable them care the children they have, thus ensuring their existence.[2] Short birth intervals also decrease the survival chances of the preceding child. The arrival of a new baby means that breast-feeding stops suddenly and the mother has less time to devote to caring for the older child. A birth interval of less than 12 months raises the overall average risk of death for the preceding child between ages one and five by at least 70 to 80 percent; a birth within 18 months raises the risk by 50 percent or more.[5] Postponing first births until the mother is at least 18 years of age is another important factor in reducing child deaths. An infant born to a teenage mother is more likely to be born too early and weigh too little at birth and is 24 percent more likely to die in the first month of life than is an infant born to a mother aged 25 to 34 years; the increased risk continues through early childhood.[1] Delaying first births until women are at least 18 years old could potentially reduce the risk of death for first born children by up to 20 percent on average and by up to 30 percent in a few countries.[8]

According to the World Bank report,[20] it was identified that the use of family planning services is an important factor for a developing country like Kenya. This is because of the advantages gained in terms of development through reductions in fertility levels. The advantages include prevention of health risks associated pregnancies.[18,21] Family planning improves women's education by enabling them finish schooling hence increasing chances of getting jobs plus their contribution in social and political domains in the community.[8]

Parents who have means to control their fertility are able to devote more resources in each child, which in turn raises the standard of health of the child, good education and prosperity in a population [11,15]. Moreland identified that meeting unmet FP needs in Kenya could avert 14,040 maternal deaths and 434,306 child deaths to meet the SDGs target date of 2030.[13,14]

## 1.2 MATERIALS AND METHODS

### Study Design

A facility based cross-sectional survey study design was conducted to identify potential barriers to utilization of family planning among women of reproductive age (18-45years) in Mfangano Division, Homabay County. A quantitative approach to data collection and analysis was used. This design was used in this study as it enabled a researcher to gather data from a relatively large number of subjects at a single point in time.

### Study setting

The study was carried out in Mfangano Island. It lies in the eastern part of Lake Victoria,at the mouth of the Winam Gulf. The Island is 65km$^2$ in area and rises to 1,694m at Mount Kwitutu. Mfangano lies between latitude $0^0$ 27' north and between longitude $34^0$ 60' East It had a total population of 32,300 as of 2014, with five (5) Sub-locations, Wakinga, Waware, Wakula South, Soklo West, and Soklo North. It is served by ten (10) health facilities and clinics; seven are public, one Mission Hospital and two private clinics. Public health facilities and private clinics provide a wide range of family planning services which includes pills, condoms, Intra-Uterine Contraceptive Devices (IUCDs), implants, injectable plus natural ways of family planning, while Mission Hospital advocate for natural family planning like basal body temperature, calendar-based methods, lactation amenorrhea and withdraw method. Fishing and small-scale farming are the main economic activities carried out in the area.

### Study population

The study targeted; women aged 18-45 years attending the five sampled health facilities. Since they are in their reproductive years and are legally able to give informed consent. Family planning service providers in the 5 sampled health facilities were also involved to support the study.

### Eligibility criteria

#### Inclusion criteria

Women who have not undergone hysterectomy
Women seeking health care services at the sampled Hospital and are aged 18-45 years
Women who provided an informed consent for study participation were included in the study.
Clinically stable clients

#### Exclusion criteria

Severely ill female patients aged 18-495years incapable of participating.
Women below 18 years of age
Women who refused to consent for the study
Those who do not stay within Mfangano Island
Women who had undergone hysterectomy

### Study variables

#### Dependent variable

Family planning uptake was the dependent variable. Family planning uptake refers to a couple who have continuously used family planning in the past six months. Family planning uptake was measured by asking question on family planning use or not use.

#### Independent variables

**Education:** Education refers to the level of attainment in formal education by the individuals and it is classified into three categories: Primary or no education, Secondary education and College education. The

variable was collected by use of questionnaire and analyzed

**Religion**: The variable was grouped into four categories: Catholic, Protestant, Islam and Indigenous. Information for the variable was collected by use of questionnaire.

**Quality of family planning services:** quality of family planning services are grouped according to satisfaction of existing services by family planning providers. The "yes" and "no" are answers to measure it. The data collection instruments were by use of questionnaire and analyzed.

**Sampling Method**

The study chose five public health facilities in Mfangano Island out of the seven public health facilities. Simple random sampling procedure was adopted. The simple random sample was taken by writing the name of each facility on a slip of paper. These facilities were Sena, Ugina, Soklo, wakula, Takawiri, Yokia and Nyakweri. The seven slips of papers so prepared were put into a cup and mixed thoroughly and then the researcher drew as a lottery (without looking) the required number of slips, five, for the sample one after the other without replacement. The researcher ensured that in successive drawings each of the remaining elements of the division had the same chance of being selected.

The participants were selected through convenient sampling from those who came to seek care in the facility and met the inclusion criteria.

**Sample Size**

Cochran, (1963:75) formula was used to determine the number of participants. The formula was appropriate since the population was large and we were dealing with proportion.

This was determined as follows.

$$\frac{n = Z^2pq}{d^2}$$

Where,

n = Desired sample size when population is greater than 10,000 (The

Population in Mfangano Island according to Census 2010 was 32,300)

Z = standardization Z score at 1.96

P = Proportion of women using FP (women using Family Planning in Kenya cannot exceed 46 % KDHS)

q = 100% – 46%= 54%

$d^2$ = Level of precision expressed as a proportion (0.05)

$n = 1.96^2 \times 0.46 \times 0.54 \backslash 0.05^2 = 380$

Sample size was increased to 400 to cater for dropouts and non-responders

**Data collection tool and procedure**

Data collection was done between months of January and February 2019. The researcher trained five research assistants (one from each of the selected health care facility) to assist in data collection in their respective facilities. Eligible participants were recruited using the daily attendance register in maternal child health family planning clinic. The aim of the research and its procedures was explained to the participants and those who signed the consent to participate were provided with the questionnaire to fill. Clients who were not able to read and write were assisted by the research assistants. The participants were asked of previous participation in the study before administration of the questionnaire to ensure no participant fills the questionnaire more than once. Administration time was approximately 30-45 Minutes. The questionnaire was translated to dholuo verbally by the research assistants during data collection as it is widely understood and spoken within the study area. The responses were then translated back to English. The Participants were interviewed individually in a separate and private room within clinical study area. Data was collected between 8.00 A.M to 4.00 P.M daily.

**Content validity and reliability of questionnaire**

Content validity of the questionnaire was examined through piloting study by checking clarity of words to ensure respondents understood all questions in equal manner. The questionnaire was also assessed by the supervisor, with a wide knowledge on the subject and who declared no interest and with a social scientist on applicability, appropriateness and adequacy of the instruments. Further, the questionnaires were administered by research assistants who understood English, Kiswahili and local language and trained by the researcher on data collection.

**Sources of data**

The study relied on two complimentary sources of data: primary and secondary. The important sources of secondary materials included books, journal articles, and MA theses, PhD dissertations, planning documents, statistical abstracts, sessional papers and population census reports. These were accessed through the libraries of Kenyatta University and University of Nairobi. The primary sources were the primary information gathered directly from respondents.

**Data management**

Immediately after administration of the questionnaire the research assistant checked the returned questionnaire for completeness to include checking for errors and omissions and corrected them. Coding of the questionnaire was done then the data was double entered on EPI info database.

**Data analysis**

Data were exported to R-statistic version 3.0.2 software for analysis. Bivariate analysis was performed to test for association between the dependent and each of the independent variables using Chi-square test of association or Fisher's exact test where appropriate. Prevalence of uptake of family planning services was reported as a proportion at 95% confidence interval.

Multivariate association with uptake of family planning services was examined using Logistic Regression analysis and Crude odds ratios and their respective 95% confidence interval reported. All independent variables explored in the univariate regression analysis were retained in the multivariable regression model. Statistical significance was considered at $\alpha < 0.05$

**Ethical considerations**

Ethical approval to carry out the research was obtained from the Institutional Review Board of Pwani University and Sub - County Health Office.

Women who visit the sampled health care facilities during data collection period were explained to about the study and the procedures by health care providers providing family planning services. The subject information sheet was given to them to read for those unable to read the information was explained to them in the language they understood best. Enough time was given for clients to read the information sheet, ask questions and receive explanation. Those who agreed to participate signed the informed consent. There was no measure taken against those who declined to participate and neither was there any reward for participation.

All data collected during the course of the research was kept confidential, the participant's identities were not revealed at any instance as no individual identities were used in any part of the report from the study. Data was entered in a safe database accessible only to the research team to maintain confidentiality.

## 1.2 RESULTS

**Study participants characteristics**

A total of one hundred and eighty-three were using modern family planning methods (Family planning uptake prevalence of 46% (95% confidence interval (CI) 41 to 51%). Of the 396 study participants, 321 (81%) were youths aged between 18 and 35 years. Our study participants were; self-employed 223 (56%), had completed at least primary school 387 (98%), Christians 306 (77%), married 282 (71%) and had given birth 376 (95%) details of representation per variable are presented in Table 1.

**Table 1: Study participant characteristic.**

| Characteristics* | All participants (N=396) | Using family planning (N=183) | Not using family planning (N=213) | p-value |
|---|---|---|---|---|
| Age in years | | | | |
| 18 to 35 | 321 (81) | 160 (88) | 160 (75) | 0.002 |
| 36 to 45 | 75 (19) | 22 (12) | 53 (25) | |
| **Education levels** | | | | |
| Primary or no education | 231 (60) | 65 (36) | 166 (78) | < 0.001 |
| Secondary education | 115 (29) | 75 (41) | 40 (19) | |
| College education | 50 (13) | 43 (23) | 7 (3.3) | |
| **Occupation** | | | | |
| Employed | 262 (66) | 141 (77) | 121 (57) | <0.001 |
| Unemployed | 118 (30) | 32 (17) | 86 (40) | |
| Student | 16 (4.2) | 10 (5.5) | 6 (2.8) | |
| **Religion** | | | | |
| Catholic | 123 (31) | 56 (31) | 67 (31) | <0.001 |
| Protestant | 183 (46) | 102 (56) | 81 (38) | |
| Islam | 1 (0.3) | 1 (0.5) | 0 | |
| Indigenous | 89 (23) | 24 (13) | 65 (31) | |
| **Marital status** | | | | |
| Married | 282 (71) | 144 (79) | 138 (65) | <0.001 |
| Single | 43 (11) | 19 (10) | 24 (11) | |
| Divorced/widow/cohabiting | 71 (18) | 20 (11) | 51 (24) | |
| **Ever given birth** | | | | |
| Yes | 376 (95) | 174 (95) | 202 (95) | 0.990 |
| No | 20 (5) | 9 (5) | 11 (5) | |
| **Number of children** | | | | |
| 1 to 4 | 254 (64) | 128 (70) | 126 (59) | 0.020 |
| 5 to 8 | 100 (25) | 43 (23) | 57 (28) | |
| Above 8 | 42 (11) | 12 (6.6) | 30 (14) | |

Apart from whether the woman had ever given birth (P = 0.99), all other variables examined (age, education, occupation, religion, marital status and number of children) P < 0.05 were different between those women on FP and those not on FP as shown in Table 1.

In this study, 213/396 (54%, 95 % CI 49 to 59%) were not using any modern FP method during the time of this study. The main reasons cited for non-use of any modern family planning method includes; lack of spousal consent (28.1%), desire to have more children (23.4%), lack of information on FP methods (3.3%), sexually inactive (1.8%) and either religious or cultural reasons 3 (1.3%).

**Knowledge and use of family planning services**

The two main sources of information on family planning services were through radio 200 (51%) and from fellow women 96 (24%). Study participants rarely got FP information from the internet 5 (1.3%) as evident in Table 2. Only 20 (5.0%) of the participants never knew of any family planning methods. At least 210 (53%) knew three family planning methods and more as captured in Table 2.

**Table 2: Sources of information and knowledge of family planning.**

| | N=396 |
|---|---|
| **Family planning sources of information,** | **N (%)** |
| Radio | 200 (51) |
| Other women | 96 (24) |
| Print media | 24 (6.0) |
| Television | 13 (3.3) |
| Internet | 5 (1.3) |
| **Total** | **396 (100)** |
| **Number of family planning methods known,** | |
| Zero | 20 (5.0) |
| 1 | 66 (17) |
| 2 | 100 (25) |
| 3 | 160 (40) |
| 4 and above | 50 (13) |
| **Total** | **396 (100)** |

On average, 109 (60%) study participants involved their spouses in deciding on use of family planning methods. Injection and use of pills were the most commonly preferred methods of family planning reported at 88 (40.3%) and 44 (24%) respectively. Most of these family planning services were accessed from hospital as shown in Table 3.

**Table 3: Sources and type of FP methods used.**

| | n=183 |
|---|---|
| **Types of FP methods used** | **n (%)** |
| Injection | 88 (40.3) |
| Pills | 44 (24) |
| Implant | 28 (15) |
| IUCD | 17 (9.1) |
| Condoms | 10 (5.3) |
| Surgical | 7 (3.7) |
| Natural methods | 6 (2.7) |
| **Total** | **183 (100)** |
| **Area of access for FP methods** | |
| Hospital | 143 (78) |
| Chemist | 26 (14) |
| Clinics | 14 (7.7) |
| **Total** | **183 (100)** |

**Social economic and cultural factors associated with uptake of family planning services**

In the multivariate regression analysis, elderly age (36 to 45 years), secondary and above secondary education levels were associated with high odds of uptake of FP; crude Odds ratios (COR) 2.4 (95% CI 1.4 to 4.2), 5.8 (95% CI 1.4 to 12.9) and 4.5 (95% CI 2.8 to 7.4) respectively. Being unemployed (COR 0.4 (95% CI 0.3 to 0.7), a catholic (COR 0.4 (95% CI 0.2 to 0.8), a protestant (COR 0.3 (95% CI 0.2 to 0.5) and having at least eight children (COR 0.4 (95% CI 0.2 to 0.8) were associated with lower odds of FP uptake (Table 4). Further, in the multivariable regression model, secondary education level (adjusted OR (AOR) 4.72 (95% CI 2.70 to 8.26) and above secondary education level (AOR 14.45 (95% CI 5.18 to 40.29) were associated with higher odds of FP uptake compared to primary or no education. Being unemployed (AOR 0.36 (95% CI 0.20 to 0.64) and having at least eight children (AOR 0.23 (95% CI 0.06 to 0.84) were associated with lower odds of FP uptake after the adjustment as shown in Table 4.

**Table 4: Association of demographics and social factors with FP uptake.**

| *Characteristics* | *Crude Odds ratios (95 % CI)* | *P-values* | *Adjusted odds ratios (95% CI)* | *P-values* |
|---|---|---|---|---|
| **Age in years** | | | | |
| 18-35 | 1.0 (Reference) | | 1.0 (Reference) | |
| 36-45 | 2.4 (1.4 to 4.2) | 0.001 | 0.69 (0.32 to 1.47) | 0.34 |
| **Occupation** | | | | |
| Employed | 1.0 (Reference) | | 1.0 (Reference) | |
| Unemployed | 0.4 (0.3 to 0.7) | 0.004 | 0.36 (0.20 to 0.64) | 0.001 |
| Student | 1.9 (0.7 to 5.3) | 0.24 | 1.02 (0.12 to 8.40) | 0.980 |
| **Education level** | | | | |
| Primary or no education | 1.0 (Reference) | | 1.0 (Reference) | |
| Secondary level | 5.8 (1.4 to 12.9) | 0.01 | 4.72 (2.70 to 8.26) | <0.0001 |
| Above secondary level | 4.5 (2.8 to 7.4) | 0.0001 | 14.45 (5.18 to 40.29) | <0.0001 |
| **Religion** | | | | |
| Indigenous | 1.0 (Reference) | | 1.0 (Reference) | |
| Catholic | 0.4 (0.2 to 0.8) | 0.009 | 0.82 (0.46 to 1.45) | 0.49 |
| Protestants | 0.3 (0.2 to 0.5) | <0.0001 | 0.68 (0.32 to 1.42) | 0.30 |
| **Marital status** | | | | |
| Married | 1.0 (Reference) | | 1.0 (Reference) | |
| Single | 1.3 (0.7 to 2.5) | 0.40 | 0.33 (0.11 to 1.00) | 0.05 |
| Divorced/widowed | 1.4 (0.5 to 3.7) | 0.54 | 0.67 (0.31 to 1.43) | 0.30 |
| **Number of children** | | | | |
| 1-4 | 1.0 (Reference) | | 1.0 (Reference) | |
| 5-8 | 0.7 (0.5 to 1.2) | 0.21 | 1.20 (0.65 to 2.21) | 0.56 |
| Above 8 | 0.4 (0.2 to 0.8) | 0.01 | 0.23 (0.06 to 0.84) | 0.03 |

**Quality of care in family planning service provided**

The average time spent at the FP provision clinics/hospitals was <1 hour for majority of participants on modern FP methods; 151/183 (83%).

A total of 10/183 (5.5%) could not get any information about modern FP methods from the clinic. Information about FP provided were predominately on advantages of each method 53/183 (29%) and the correct use of the specific FP method 42/183 (23%). Of the 183 study participants, currently on modern FP; 99(54%) were provided with more than six FP methods. Women were recruited for modern FP services mostly on their ability to pay for the service 133/183 (73%). Among the 183 study participants currently on modern FP methods; 108 (59%) had access to their family planning method of choice and 75 (41%) could not access FP methods of their choice. Despite the challenges of accessing the FP services, 163/183 (89%) reported good satisfaction with the services as revealed in Table 5.

**Table 5: Quality of FP services offered.**

| | **n=183** |
|---|---|
| **Average time (hours) spent in FP clinics** | **n (%)** |
| <1 hrs | 151 (83) |
| 1 to 2 hrs | 24 (13) |
| >2hrs | 8 (4.3) |
| **FP methods information provided** | |
| Advantage of each method | 53 (29) |
| Correct use of the method | 42 (23) |
| Side effect | 36 (20) |
| What to do in case of side effect | 27 (15) |
| Mode of action | 15 (8) |
| No information | 10 (5.5) |
| **Distribution of FP methods provided** | |
| At least 2 | 9 (4.9) |
| 3 to 6 | 68 (37) |
| > 6 | 99 (54) |
| **Criteria for qualifying for FP services** | |
| Ability to pay | 133 (73) |
| Being a woman in reproductive age | 23 (13) |
| Return date | 11 (6.0) |
| Number children | 8 (4.4) |

| | |
|---|---|
| Pregnancy test | 5 (2.7) |
| Spousal consent | 3 (1.6) |
| **Satisfaction with FP services** | |
| Good | 163 (89) |
| Better | 15 (8.2) |
| Bad | 1 (0.6) |
| Don't know | 4 (2.2) |
| **Total** | **176(100)** |

## 1.4 DISCUSSION

This study assessed the potential barriers to family planning utilization among women of reproductive age in Mfangano Island, Homabay County. In our study, the prevalence of family planning uptake was 46%. This finding concurs with those of a study done in Nairobi slums among women of reproductive age which recorded 46%.[16] Contraceptive Prevalence Rate (CPR). But these findings were higher than the previous study conducted in rural Kenya in 1997 which recorded 35.5% CPR.[7] This increase could be due to the increase in; the use of injectable contraceptives, media coverage on the importance of family planning and where the services are offered without payment. The decline in use of traditional methods could also partly explain the increase in uptake of modern family planning services. Globally and nationally there has been an increase in uptake of modern family planning services and our results would be a reflection of this increase from 39% in 2008-2009 to 53% in 2014.[22]

We found that 54% of the participants were not using any form of family planning. The main barrier for uptake of FP among respondents in this study was lack of spousal consent. This concurs with a study done in Nairobi Kenya where it was reported that most women who would need modern family planning were not on family planning because they needed spouse and in-laws concurrence.[1] These findings suggest that in improving family planning uptake, male spouse involvement plays a vital role. The other barrier to uptake of FP among the participants was desire for more children. This was in line with studies done in Kenya, Ethiopia and Ghana where it was identified that women who have not attained the desired number of children will not go for family planning services.[1,8,15] The desire to have more children was in line with the findings of a study conducted in the slums of Kenya that pointed out that low utilization of family planning services was related to the desire for more children which was related to traditional belief of associating richness with number of children.[2] In communities where women don't have sons; they will continue giving birth until they get enough sons.[6,7,10] We found out that some FP services were not free; this could have reduced access mostly among the poor who prioritized their meager resources on other basic needs like food. Similarly, a study conducted in Sudan revealed that poverty was a major factor to underutilization of family planning services.[9]

Our study showed that higher education levels were associated with increased odds of uptake of modern family planning. This might be partly explained by the fact that these women understand the importance of family planning and they would like to space their births.[21] The findings concur with those of Imbuki that; better educated women have less fatalistic attitudes towards reproduction and would therefore use contraception to space and limit family size.[9] Education of women therefore plays an important role in terms of family planning use. Similarly, results from previous research conducted in Kenya and Sudan it was evident that the higher one goes in the ladder of education the more likelihood of family planning uptake.[6,9]

Being unemployed was associated with lower odds of family planning uptake. This concurs with a study conducted in Sudan and data from Demographic and Health Surveys for nine Latin American countries, whereby they reported that poverty was a major factor to underutilization of family planning services.[10]. Having at least eight children was associated with lower odds of family planning uptake. This differs with previous studies from Nigeria, Bangladesh, Tanzania and Kenya which reported that as number of living children increases family planning uptake increases.[2,4,5]

In our study the main source of information on family planning was through radio. This choice could be because radio is easily available in community setting than other sources such as newspaper and internet, which can be accessed by those in high social economic status. This finding concur with a survey conducted by KDHS,[16]which indicated that 69% women get family planning messages through radio, 40% through television, and 34% through print media.

Likewise, Mekonnen, in his study which was conducted in Ethiopia pointed out that better mass media coverage increases peoples knowledge on FP hence increasing the uptake of the commodity.[12]

In our study, most of the participants were aware of at least three methods of family planning. Knowledge on family planning methods is essential; because women are more likely to embrace family planning when they are aware of the available methods.[6] This finding was similar to a study conducted in Kenya whereby it was pointed out that those women who knew less methods of family planning were less likely to use family planning. Assessing the level of awareness on different methods of

family planning gives a rough estimate of the accessibility of family planning information in the country.[16]

The average time spent at the FP provision clinics/hospitals was <1 hour for majority of participants on modern FP methods. The study also identified that a wide range of family planning methods were mentioned to participants though just a few were available at the hospital and clinics: this concurs with a study carried out in Nyanza Kenya where they reported that providing a range of family planning methods improves the utilization of the services. The study indicated that the providers give incomplete or no information about the method that one has chosen. This indicates that the counseling being provided was poor. These findings are similar to those by Kasadde, where poor information provision due to limited counseling about modern FP methods was noted.[3] For women who seek family planning, it is important to improve the quality of care particularly counseling on the full range of available methods so that women can choose the method that best matches their individual circumstances and intentions and can change methods when they want to. Hence basing on the availability of different method, the quality of the services offered was low.

Notably, the quality of family planning is good when clients gets full information of all methods available and how each works. Provider has technical competence, good communication skills, good attitude, and providing appropriate collection of services. Majority of our study participants were very satisfied with the client provider interaction during service provision. These findings indicate that the quality of family planning services offered was good and should have transformed to high prevalence of family planning services utilization as identified that good care enables one to make decision on family planning. It can inspire one to find out about family planning, continue using contraception and inform others hence influencing them.[12,14]

The major strength of the study was that it utilized facility-based participants to sample views and satisfaction with FP services offered at the respective health facilities. We also recorded very low non-response rate.

The limitation of our study was that, our data were self-reported and therefore subject to reporting bias. This was also a cross-section study meaning we could not follow up the study participants to confirm uptake of FP services and changing trends in FP uptake. Our study being a facility-based survey conducted in the rural areas, might not be generalizable to urban regions or among community women who don't seek FP services in public health facilities.

## 1.5 CONCLUSION

Utilization of family planning services in Mfangano Island Homabay County was lower 46% in comparison to national average which stands at 58%.[11]

However the knowledge level on the methods of family planning was high, the uptake of family planning services was low. Most clients preferred using short term methods of family planning maybe due to the information provided by health workers which mainly targeted on advantages and disadvantages of family planning methods and the skills of the health care workers on provision of the methods.

Most health facilities within Mfangano Island were accessible in terms of distance and a wide range of family planning services available (most hospitals provided 3-6 methods). In socio- economic and cultural factors older age and higher level of education was the main factor associated to high uptake of family planning services. Higher literacy lead to reduced ignorance, improved health seeking behavior, better adherence to health-related interventions and ability to pay for health services.[10]

Unemployment, religion, high parity, spousal consent and preference of male child were the main social cultural issues that contributed to low up take of family planning.

From the findings of this study the level of satisfaction was high however, the counselling on family planning was not sufficient. Availability of the family planning commodities was not consistent. Ability of the clients to pay for service was the main determinant of accessing family planning services; this could have made the services inaccessible to some of the clients who were willing to use family planning.

## 1.6 Recommendation

**Recommendations to policy and practice**

1. The findings of the study have shown serious issues of concern in family planning service uptake. Low family planning uptake results to high fertility rate which in turn contributes to high infant and maternal morbidity and mortality rates thus the government of Kenya, County Government of Homabay and other stakeholders like implementing partners should acknowledge that family planning and control of population growth is a major public health concern that should be prioritized among other health care services. This can be realized by increasing health care budgets allocations on family planning commodities and equipment, reduce the cost of the family planning commodities, especially the long-term methods and support outreach and health education programs.
2. Since family planning uptake is lower within Mfangano Island, more public and community-based health awareness and education programs should be

directed to women and men to provide them with information they need on family planning that includes: importance of family planning, methods of family planning, eligibility criteria for various family planning methods, mode of action, side effects, how to use the method, effectiveness, myths, follow up, advantages and disadvantages. This will empower them to come forward for the family planning services. This can be achieved through providing outreach FP services, carrying health education sessions at the health facility especially maternal child health clinic and maternity department that have access to high numbers of women of reproductive age and their spouses, carrying out public rallies target towards educating the public on family planning, use of posters and used of media especially the local stations that use vernacular in its programs.

3. The Homabay county government should Sensitize and train health workers on family planning services to include in-service training on the modern family planning methods to enhance their ability to counsel clients comprehensively and provide a wide variety of methods to the clients. This can be achieved through support supervision to assess gaps in service provision and on job training to update the health care worker's knowledge and skills especially on changing technology and procedure in service provision.
4. There in need for the Mbita sub county department of reproductive health to improve the health information system and link it to the County health information system. These will assist in effective provision of information that will inform family planning related interventions, effective and timely support, guiding making of informed decisions on family planning issues, ongoing monitoring and evaluation of the coverage or progress as well as support supervision.
5. Maternal and child health care and family planning is an element in primary health care and according to the theory of family planning it should be based on practical, scientifically sound and socially acceptable methods and technology, that should made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain. The government through the county government of Homabay, department of health should ensure that family services are:

a. Accessible; that is, the services are geographically, financially and culturally within easy reach to the whole community within the county
b. Acceptable; the quality of family planning services offered are appropriate, adequate, and

**Recommendations for further research**

- There no Facility based study that has been carried out within Mfangano to assess barriers to uptake of family planning. More studies in different settings would need to be done to enhance generalizability of findings .Similar studies should be carried out in other parts of the county with respect to diversity of socio-cultural beliefs and infrastructure of the County are recommended.
- The study did not focus on use of emergency family planning, the relationship between infant mortality rate and uptake of family planning services, uptake of long-term and short-term methods of family planning and the current political influence of regional population numbers in selection of leaders as a factor that would influence the uptake of family planning. These are some of the areas recommended for further research.

## 1.6 REFERENCES


1. Akelo, V., Girde, S., Borkowf C.B., Angira F., Achola, K. Attitudes toward Family, 2013.
2. Planning among HIV-Positive Pregnant Women Enrolled in a Prevention of Mother-To-Child Transmission Study in Kisumu, Kenya.
3. Akyeah, F. Factors Influencing the Utilization of Family Planning Services in, 2007.
4. Kwabre District, Ghana.
5. Bankole, A. and Malarcher, S. Removing barriers to adolescents' access to contraceptive information and services", *Studies in Family Planning*, 2010; 41(2): 261–74.
6. Bertrand, J. T., Hardee K., Magnani, R. J., & Angle, M.A. "Access, Quality of.Care and Medical Barriers in Family Planning Programs", *International Family Planning Perspectives*, 1995; 21(2): 64-694.
7. Bulatao, R. A., Palmore, J.A., & Ward, S.E. *Choosing a Contraceptive: Method Choice in Asia and the United States. London*, Westview Press, Inc., 1989.
8. Casterline, J. Diffusion process and fertility transition. *In Diffusion processes and fertility transition: selected perspectives* (ed. J. Casterline): 1 – 38. Washington: National Academic Press, 2001.
9. Gwako, E. Married Women's Ideal Family Size Preferences and Family Planning Practices: Evidence from Rural Kenya. *The Social Science Journal*, 1997; 34(3): 369-382.
10. Hawkins, J., Matteson, P. S., & Tabeek, E. S. *A Fertility Control in Fogel, C. I. and N. F. Woods:A Comprehensive Handbook*. London, UK, Sage Publishers, Inc., 1995.
11. Ibnouf, A., Van, D. B. H., Maarse, J. Utilization of family planning services by married Sudanese women of reproductive age. *East Mediterr Health J*, 2007; 13(6): 1372–1381.
12. Imbuki, K., Catherine, S.T., Mark, A.S., Douglas, N. S., & Samuel, K. Factors Influencing Contraceptive Choice and Discontinuation among HIV-Positive Women in Kericho, Kenya. *African Journal of Reproductive Health*, 2010; 14(4): 1-03.
13. Kenya National Bureau of statistics (KNBS) & ICF Macro. Kenya demographic and health survey 2014

[online]. Government of Kenya: Central Bureau of Statistics, 2014.
14. Mekonnen, W., & Worku, A. Determinants of fertility in rural Ethiopia: the case of Butajira Demographic Surveillance System (DSS). *BMC Public Health*, 2011; 11(1): 782.
15. Ministry of Health (MOH) *National Reproductive health Strategy 1997-2010*. Ministry of Health, Kenya. Government Printer: Nairobi, 2010.
16. Moreland, S., & Talbird, S. Achieving the Millennium Development Goals: The Contribution of Fulfilling the Unmet Need for Family Planning.Washington, DC, Constella Futures, POLICY Project, 2006.
17. Oyedokun, A. O., Determinants of Contraceptive Usage: Lessons from Women in Osun State, Nigeria. *Journal of Humanities and Social Science*, 2007; 1*(2).*
18. Republic of Kenya KDHS 2008 – 2009. *Kenya Demographic and Health Survey*, 2009.
19. United Nations Population Fund (UNFPA). *Achieving ICPD Goals- Reproductive Health Commodity Requirements, 2000-2015*.New York, UNFPA, 2005.
20. USAID. Report to Congress: Health-Related Research and Development Activities Washington, DC, 2005.
21. USAID/HPI. Achieving Equity for the Poor in Kenya: Understanding Level of Inequities and Barriers to Family, 2007.
22. World Bank World Development Report 2004: Making Services Work for Poor People.Washington, DC: World Bank, 2003.
23. World Health Orgainisation, *Achieving Millennium Development Goal 5: Target 5A and 5B on Reducing Maternal Mortality and Achieving Universal Access to Reproductive Health*, WHO/RHR/09.06. Geneva: World Health Organization, 2005.
24. World Organization World Health Report 2005, Geneva: World Health Organization, 2014.