

**FACTORS INFLUENCING PERFORMANCE OF FAMILY PLANNING PROJECTS
FUNDED BY USAID: A CASE OF APHIA PLUS KAMILI IN KIRINYAGA
COUNTY KENYA**

BY

JENIFER WOTHAYA WAMBUGU

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REQUIREMENT OF AWARD OF A MASTERS OF ARTS DEGREE IN PROJECT
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DECLARATION

I hereby declare that this research project is my own work and effort and that it not been submitted to any other University for a degree award.

Signature

Date

JENIFER W WAMBUGU

L50/81836/2015

This research project is submitted for examination with my approval as the University of Nairobi Supervisor.

Signature.....

Date.....

MR. AMOS K. GITONGA

SCHOOL OF CONTINUING AND DISTANCE EDUCATION

UNIVERSITY OF NAIROBI

DEDICATION

My dedication goes to my late spouse Anthony whose love memories and motivation continue to inspire my research. I also dedicate to daughter Sharon Wangechi for encouragement and motivating me during the time of the coursework.

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ACRONYMS AND ABBREVIATIONS

CPR -Contraceptive Prevalence rate

FP - Family Planning

IUCD-Intrauterine Contraceptive Device

KDHS -Kenya Demographic Health Survey

LAPM -Long acting and permanent method

NRHS -National Reproductive Health strategy

TFR -Total Fertility Rate

USAID -United States Agency International development

WHO -World Health Organizations

WRA -Women of Reproductive Age

ABSTRACT

This research sought to examine factors influencing performance of family planning projects funded by USAID and to establish an understanding and knowledge on the factors that enhance family planning project performance. The objectives of the study were to determine how contraceptive security influence the performance of family planning projects in Kirinyaga County, to examine how staff competence influence the performance of family planning projects in Kirinyaga County, to find out how accessibility influence the performance of family planning projects in Kirinyaga County, and to establish how affordability influences the performance of family planning projects in Kirinyaga County. To realize the objectives, a descriptive survey design was adopted. The target population was constituted WRA registered as FP clients in GOK health facilities. The research study adopted the cluster sampling method. A sample size of 381 WRA and 12 service providers has been identified through cluster sampling. This study used both the questionnaire and an interview guide for data collection, the questionnaires were used among the women of reproductive age seeking family planning services and the interview guides were for the service providers. The data was analyzed using Frequencies, percentages and presented in tables. The study established that provision of contraceptive security presented FP users with a wide range of FP methods from which they could to choose from, it also granted FP users the autonomy to choose high-quality contraceptives and condoms for family planning, staff competence was key in promoting performance of family planning projects, the cost of family planning service is an important determinant on family planning uptake, ensuring accessibility of FP programs especially at very local level promoted the performance of family planning projects. The study concluded that ensuring contraceptive security, accessibility, staff competence and affordability all promoted the performance of family planning projects in Kirinyaga County. The study therefore discovered that it was important to ensure uninterrupted supply of a variety of contraceptives so that clients can choose and use their preferred method without interruption as this was associated with positive performance of family planning programs. The County government should come up with a more decentralized approach in health service provision, this will help to wave other miscellaneous cost incurred in seeking of seek FP services such as transport cost. Higher incentives can be given to people willing to go seek FP services from the nearby health centers. Community based distributors in Kirinyaga County should be revived and enhanced, promotion of family planning education and activities at the household level should be accorded priority. There is also need for formation of lobby groups to enhance cultural change, awareness creation and counseling. The county government should come up with staff development programs especially to health care providers; this should be done in view of enhancing competence among the health care providers, it is also important for the county government to recognize the role of community health workers and volunteers in effort of lobbying for family planning uptake. The county government programs must find a way to ensure that services remain available to those who cannot pay there is need for greater recognition of Health assistants (HA) at the local community; Health assistants should be thoroughly trained on primary health care services such as advocacy on family planning uptake.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

This is the first chapter that gives the foundation of the research study. The type of study is survey research that aims to determine and describe various variables and investigate their relationships that influence family planning performance in project funded by USAID; A case of APHIA PLUS KAMILI project in Kirinyaga County Kenya . The chapter defines the study topic, formulates the problem statement and gives specific objectives that guide the study. It also provide research questions that seek answers for the research study, provides scope, limitation, delimitation, justification benefits and challenges of the research study. It also defines significant terms used in the study and their meaning.

According to Pickens and Solak (2005) in their abstract; ‘Successful healthcare programs and projects: organization portfolio management essentials’, many healthcare organization projects take more time and resources than planned and fail to deliver desired business outcomes. Poor results are often not a result of faulty healthcare information and technology or poor project management or poor project execution alone. In 2009, The United States Agency for International Development (USAID) increased funding for family planning and reproductive health (FP/RH) activities in Kenya.

Over the past several decades, Kenya has become an economic hub in East Africa. However, many segments of the population have minimal access to high-quality healthcare and social services. In 2010, the Government of Kenya enacted a new constitution which outlines a framework to alleviate poverty, with a focus on improving governance and addressing inequalities in health, education, and economic growth. As a result, targeted health projects have been developed. According to Douglas Huber, et al (2008), ‘Achieving success with family planning in rural Afghanistan’ traditional rural communities can rapidly accept modern contraceptives, particularly injectables, introduced by CHWs when people are educated about common non-harmful side-effects and correct use. According to Bonnie, (2013) ‘family planning pilot project in Philippines is a success story’, in one community supported by a PATH Foundation family planning program, with funding from USAID, parents were able to

choose to have smaller families. There the family size went from an average of 12 children to no more than four children over the first six years of the program.

According to, Edorah, (1992), in ‘A Family Planning Success Story’ Thailand lowered its birth rate quickly – and substantially due to innovative projects in carrying out family planning approaches, the openness of the Thai people to new ideas, and the willingness of the government to work with the Population and Community Development Association (PDA), a private non-profit organization and the largest nongovernmental agency in Thailand. National Research Council (US) Working Group (1993), on Factors Affecting Contraceptive Use in Sub Sahara Africa in Sub Sahara A, describe cultural and socioeconomic barriers as a main reason for low contraceptive prevalence in the African region with even that small, well-managed projects and programs throughout the subcontinent achieving prevalence rates of 20 percent.

A report by the USAID’s Bureau for Africa and the Bureau for Global Health/Office of Population and Reproductive Health (PRH),(2012) on three Successful Sub-Saharan Africa Family Planning Programs indicated that Ethiopia, Malawi, and Rwanda had achieved modern contraceptive prevalence rates (CPR) much more rapid with an increase among married women of reproductive age was 2.3% in Ethiopia (2005-2011), 2.4% in Malawi (2004-2010),and a dramatic 6.9% in Rwanda (2005-2010), according to the DHS reports for the years noted.

Maura Graff,(2015) on his article, Family Planning Is a Crucial Investment for Kenya's Health and Development, indicated that family planning is an essential component of achieving development goals for health, poverty reduction, gender equality, and environmental sustainability, including Kenya's Vision 2030, a national framework for development. Pathfinder International has built successful approaches to delivering quality Reproductive Health and Family Planning (RH/FP) services in the world. In Kenya since 1969, pathfinder has implemented several projects successfully funded by USAID like community-based Distribution (CBD) of FP Method, Adolescent Sexual and reproductive Health and Post abortion care, Urban reproductive Health Initiative (UrHI II), Integrated reproductive Health and Peer counseling in Kenyan Universities, community-based HIV/AIDS Prevention, care and Support Project (COPHIA), community-based Family Planning in Kenya Project, the AIDS, Population, and Health Integrated Assistance Projects, APHIA II (Nairobi, central and

North eastern Provinces)APHIA II (Nairobi, Central and North eastern Provinces) implemented family planning projects in all the five counties in central region Kirinyaga being one of the counties. After the exit of APHIA II, USAID funded APHIA PLUS KAMILI to continue implementing the projects in Central region.

1.2 Statement of the Problem

Kirinyaga County is the best performing county in family planning project compared to other counties in Kenya. This statistical report puts Kirinyaga county on the lead in the use of utilization of family planning services. Programs in developing countries meet the family planning needs of more than 500 million women each year, preventing an estimated 187 million unintended pregnancies and averting 2.7 million infant deaths and 215,000 pregnancy-related deaths each year.

Over the past 40 years, family planning has reduced fertility rates in developing countries, from six births per woman to about three per woman. Lower birth rates contribute to slower population growth, which enables economic development and environmental sustainability. In Africa, 23.2% of women of reproductive age have an unmet need for modern contraception. According to Kenya demographic health survey that was conducted in 2014, Kenya has 18% of unmet family planning needs. Central region topped in the use of family planning with Kirinyaga County leading , with each household having an average of two children. North Eastern counties performed dismally in using contraceptives, with areas such as Wajir recording an average of eight children per household. Women in West Pokot, Turkana and Samburu were also found to be having more than seven children. This high performance in Kirinyaga County compared to others need to investigated to find out the story behind the great success. This study is therefore intended to establish factors that influence the performance of family planning project in Kirinyaga County.

1.3 Purpose of the study

The purpose of this study was to establish on factors influencing performance of family planning projects funded by USAID and to establish an understanding and knowledge on the factors that enhance or hinder family planning project performance.

1.4 Objectives of the study

This study was guided by the following objectives.

- i. To determine how contraceptive security influence the performance of family planning projects in Kirinyaga County
- ii. To examine how staff competence influence the performance of family planning projects in Kirinyaga County.
- iii. To find out how accessibility influence the performance of family planning projects in Kirinyaga County.
- iv. To establish how Affordability influence the performance of family planning projects in Kirinyaga County.

1.5 Research questions

This study was guided by the following research questions.

- i. How does contraceptive security influence the performance of family planning projects in Kirinyaga
- ii. To what extent does staff competence influence the performance of family planning projects in Kirinyaga
- iii. How does accessibility influence the performance of family planning projects in Kirinyaga
- iv. To what extent does Affordability influence the performance of family planning projects in Kirinyaga

1.6 Significance of the Study

Family planning programs has remained one of the key components in reducing maternal and neonatal deaths. Programs have tried to address, the total fertility rate of the country which is at 3.9 according to Kenya demographic health survey 2014 with 18 % unmet family planning needs. Maternal mortality rate 488/100000 all these were precursors of poorly applied FP programs.

The findings of this study will assist program managers to formulate effective strategies towards addressing the problem of family planning non-users and help to develop programs

aimed at addressing gaps in the current programming. The findings and recommendations of this study will help to design strategies that can help in success of a family planning program.

1.7 Limitations of the study

Limitations of the study are those characteristics of design or methodology that set parameters on the application or interpretation of the result of the study (Mitchell & Marshall, 1986).

Some respondents may not be willing to freely offer information required for this study. This will be delimited by assuring the informants of the confidentiality of their responses. The sampling frame of the study covered only health facilities supported by USAID thus limited to generalization.

1.7.1 Delimitation of the study

The scope of the research is to cover 44 health facilities that are supported by USAID APHIA PLUS KAMILI in Kirinyaga County the facilities are distributed within the five sub counties within Kirinyaga County.

1.8 Assumptions of the study

The study had the following assumptions.

The study expected to give accurate and valid data however these are external conditions or assumptions that must exist for the study to succeed. It is expected that the respondents would cooperate in giving accurate, adequate data and answer questions correctly that would produce the relevant information the research is intended to achieve in the study. No respondent errors were expected this involved both intentional and unintentional respondent errors hence there were less or no data collection biasness and good response rate from the chosen areas of study. That the respondents would spare their time to participate in the study and give their views without prejudice.

That the respondents would have adequate knowledge on the subject to give meaningful responses relevant to the study The sample of the study was chosen appropriately according to the required size, target population, sampling methods and data collection instruments to be used in research study. It is also expected that the logistics of doing the work in terms of research budget, time frame and transport of the researcher would be adequately available and

that no change of policy by university of Nairobi on research study procedures and format. The institution that the data was to be collected would cooperate.

1.9 Definition of significant terms

This section presents the definition of key terms as will be used in the study.

Contraceptive security: it is a situation whereby people are able to obtain and use high-quality contraceptives whenever they want them.

Staff competency: it is ability of a staff to have the appropriate knowledge, skills, motivation, and working environment to deliver quality services.

Accessibility: it is availability of services through a variety of delivery points, such as clinics, community-based channels, and retail outlets, makes contraceptive methods available to more potential users.

Affordability: this is the ability of a person to have a service or product based on cost. It target subsidies to low-income users while shifting users who can afford to pay from the public to the private sector keeps services affordable for all clients.

Project performance: the degree of success of an investment.

Family planning performance: the degree of success in update of family planning services

Family planning: A reproductive strategy that individual and/or couples employ to meet their reproductive goals and to prevent unwanted pregnancies.

1.10 Organization of the study

The study will be organized in five chapters that are highlighted as Chapter one to five, preliminary pages consisting of the declaration, dedication, acknowledgements table of contents, List of tables, acronyms and abbreviations and the abstract. The appendices are listed at the end of the document and include relevant authorities given for the study to be conducted and questionnaires used for the study.

Chapter one is the introduction to the study. It presents the background to the study, statement of the problem, purpose of the study, the objectives of the study, research questions, research

hypotheses, significance of the study ,Limitations and delimitations of the study, basic assumptions and the definition of significant terms as used in the study.

Chapter Two presents the literature review which looks at factors influencing performance of family planning projects. This chapter also provides the conceptual framework of the study.

Chapter Three outlines the study design, the target population, methods of data collection, validity and reliability of the research instruments and data collection procedures. The chapter also includes the ethical considerations of the study, data analysis and presentation, and the operationalization of the variables.

Chapter Four contains the response rate, Knowledge on family planning and the demographic, social, economic and service provider' factors performance family planning.

Chapter Five presents a summary of the findings and discusses the findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses the literature related to the factors influencing performance of family planning projects. It focuses on assessing the extent to which security of family planning commodity, staff competency, affordability, and accessibility. Influence performance of family planning projects.

2.2 Overview of health projects

According to Carolina, et al, (2014) on ‘Project Management success in health – the need of additional research in public health projects’, critical success factors change according to project features. The intangibility of most results and the challenge in measuring effects are some of the distinctive characteristics of projects focused on health promotion. According to Pickens and Solak (2005) in their abstract; ‘Successful healthcare programs and projects: organization portfolio management essentials’, many healthcare organization projects take more time and resources than planned and fail to deliver desired business outcomes. Poor results are often not a result of faulty healthcare information and technology or poor project management or poor project execution alone.

According to Bonnie, (2013) ‘family planning pilot project in Philippines is a success story’, in one community supported by a PATH Foundation family planning program, with funding from USAID, parents were able to choose to have smaller families. There the family size went from an average of 12 children to no more than four children over the first six years of the program. According to Bonnie T, (2013) ‘family planning pilot project in Philippines is a success story’, in one community supported by a PATH Foundation family planning program, with funding from USAID, parents were able to choose to have smaller families. There the family size went from an average of 12 children to no more than four children over the first six years of the program.

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one of the counties. After the exit of APHIA II, USAID funded APHIACF PLUS KAMILI to continue implementing the projects in Central region.

2.3 Contraceptive security

Hare et al. (2004) defined contraceptive security as a situation whereby people are able to choose, obtain, and use the reproductive health supplies they want. Julie,(2011) ‘on reproductive health commodity security’, defines that Contraceptive security exists when every person is able to choose, obtain, and use high-quality contraceptives and condoms for family planning and for the prevention of HIV/AIDS and other sexually transmitted infections. It has been recognized that ensuring a reliable supply of quality contraceptives is essential to reproductive health programs. The slogan, ‘No product? No program’ has become a common vocabulary in the developing countries with full understanding of the relationship between product availability and program success.

Inadequate availability of and access to essential health commodities are major barriers to the delivery of essential health care in developing countries. A survey in Nepal found that the availability of 32 selected essential reproductive health (RH) commodities in public sector outlets was less than 25 percent (Rao and Thapa 2005). Owens, et al, (2003) on ‘Concepts of Logistics System Design. Arlington, Va.: John Snow, Inc./DELIVER, for the U.S. Agency for International Development (USAID) described commodity anticipation of demand as a key factor to the success of family planning program.

Rao, Raja. (2008) on ‘Commodity Security for Essential Medicines: Challenges and Opportunities. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.’ Identified commodity security as very essential for success of family planning and reproductive health programs. Rao, et al, (2006) on ‘Procurement Strategies for Health Commodities: An Examination of Options and Mechanisms within the Commodity Security Context. Arlington, Va.: DELIVER, for the U.S. Agency for International Development, stated that commodity security is heavily affected by the country ability to procure commodities effectively and efficiently.

According to Nel (2006) on, ‘Reproductive Health Commodity Security (RHCS) Country Case’ identified that secure and sustained access to quality and affordable commodity supplies

is a critical driver of reproductive and sexual health. Access to the reproductive health commodities was also identified as key to achieving Millennium Development Goals (2015). Julie, (2011) 'on reproductive health commodity security', described the reliability of contraceptive commodity supply as a very important tool in the success of reproductive health programs. Commodity security involves all the logistics which includes; procurement, forecasting and distribution which are very critical and importance in reproductive health (RH) commodity security.

A report by Center for Communication Programs, (2008) on 'Elements of Success in Family Planning Programming' indicated that providing contraceptive is key to success. The report equally named "seven Cs" that contribute to contraceptive security as; contextual factors, commitment, capital, capacity, coordination, commodities, and clients Center for Communication Programs, (2008). Context; This entails the supportive government policies, laws and regulations that are necessary to facilitate public- and private-sector programs to secure and deliver contraceptive supplies. Context equally include the a conducive environment in the social and economic set up that are of paramount importance to influence an individual's ability to choose, obtain, and use family planning. Political, legal, social and economic context affects contraceptive security.

Commitment; for any program to succeed in Contraceptive security, strong leadership and long-term commitment at all levels are very necessary and hence involvement of all stake holders. The stakeholders need to show great commitments to make contraceptive security a top priority. They should also adoption and implementation of supportive policies and regulations, to ensure financing, to develop coordination mechanisms, to ensure adequate staffing (for example, for managing supply chains), and to develop the necessary capacities, Center for Communication Programs, (2008). Capital; there can never be any contraceptive security without funding. Good financial plan is necessary in order to procure, and distribute commodities. Program managers should recognize the sources funding which can be fro divers ways like; individuals purchase contraceptive products, governments subsidize public-sector services, and donors provide direct financing or donate products. Making services affordable while ensuring financial sustainability is a key to contraceptive security.

Capacity; in order to ensure good Contraceptive security, health care provides the right skills and knowledge to forecast contraceptive commodity, and help clients choose and successfully use family planning. All the stakeholders need to be involved in the entire chain since providers alone cannot ensure contraceptive security. The whole supply chain team is necessary to ensure, planning, procuring, transporting, storing, and distributing contraceptives and other clinical supplies and equipment, which are essential for contraceptive security. A team that is able to forecast estimates of needs and is necessary to ensure consistent supply. Strong leadership is important to ensure, efficient procurement practices, proper warehousing, and reliable deliveries.

Coordination; commodity security involves very many processes which include; planning, procuring, transporting, storing, and distributing contraceptives. All these processes requires many stakeholders who need to be coordinated in order to have a harmonized system. Stakeholders includes; government agencies, donors, service providers (public, private, and NGO), program planners, manufacturers, and distributors. There coordination helps to ensure complete coverage and decrease duplication of effort. Working together to develop a joint strategy for contraceptive security is very important since it ensures that there is no double work. In Kenya and many other countries, it is the government or the Ministry of Health that normally takes the lead in coordinating efforts.

Commodities; availability and accessibility of a range of quality family planning commodities are central to contraceptive security. Contraceptives may be imported or produced locally; they may be procured by governments, donors, multilateral agencies, NGOs, or the private sector. The public sector, NGOs, social marketing programs, and the commercial sector all have unique and important roles in providing family planning commodities to meet the needs of all clients, Center for Communication Programs, (2008).

Clients; clients are the ultimate beneficiaries of contraceptive security. Efforts to improve contraceptive security should focus on meeting clients' unique needs. All individuals who wish to use family planning regardless of economic status, education, ethnicity, geographic location, or other characteristic should be able to access family planning methods that suit their particular needs Center for Communication Programs, (2008).

2.4 Staff competence

Staff competencies are the measurable or observable knowledge, skills, abilities, and behaviors (KSABs) critical to successful job performance. Competence indicates sufficiency of knowledge and skills that enable someone to act in a wide variety of situations since each level of responsibility has its own requirements, competence can occur in any period of a person's life or at any stage of his or her career. Competence of staff is necessary in implementing any health program. Staff contributes greatly towards the success of any project. Various management schools of thought have managed to come up with various principles that guide organization to ensure good staff performance and maximize on the output of every staff.

According to Kak,et al, (2001), 'Measuring the competence of healthcare providers'. Operations Research Issue Paper 2(1). Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance (QA) Project, Competence is defined in the context of particular knowledge, traits, skills, and abilities. Knowledge involves understanding facts and procedures. Traits are personality characteristics (e.g., self-control, self-confidence) that pre- dispose a person to behave or respond in a certain way.

Boyatzis (1982) defined competence as a person's underlying characteristics that are causally related to job performance. Skill is the capacity to perform specific actions: a person's skill is a function of both knowledge and the particular strategies used to apply knowledge. Landy (1985) described abilities as the attributes that a person has inherited or acquired through previous experience and brings to a new task. Fleishman and Bartlett (1969), emphasized that abilities are more fundamental and stable than knowledge and skills. Lane and Ross (1998) defined competence as the ability to perform a specific task in a manner that yields desirable outcomes. This definition implies the ability to apply knowledge, skills, and abilities successfully to new situations as well as to familiar tasks for which prescribed standards exist. Benner (1984) stated that health workers acquire competence over time through; pre-service education or an initial training opportunity, after additional training and hands-on experience, reaches a level that can be certified as competent. Although competence is considered to be a major milestone in professional development, it is not the final point. That comes with proficiency, and the ultimate status of expert comes after many years of experience and professional growth.

Southgate and Dauphinee (1998) described competence as one of many determinants of performance. They explained relationship between competence and performance as complex and since competence does not always predict the performance. Though, less competent providers are less likely to provide quality services, and healthcare providers must have the competencies necessary to perform their jobs according to standards in order to provide quality services. While (1994) identified that despite the fact that there have been attempts to measure competence in terms of performance, competence should not be inferred from performance. He described the relationship between competence and performance in terms of capacity to perform and observed behavior. Therefore Competence is defined in terms of someone's capacity to perform, performance is the resulting behavior. "Performance is something that people actually do and can be observed.

Campbell et al. (1993), defined competence to include only those actions or behaviors that are relevant to the organization's goals and that can be scaled (measured) in terms of each person's proficiency (that is, level of contribution). Performance is what the organization hires one to do, and do well". From the book, Fundamentals of management theories, concept & practice by Kimombo, Gakuu and Keiyoro (2013), the classic school of thought in management, Frederick W. Taylor (1858-1920) who was the main proponent of scientific management wanted to create a mental revolution in the workplace in order to improve efficiency of workers and get best output. Taylor outlined that scientific management rested on four major principles mainly; Development of a true science of management so that method of performing each task could be determined, scientific selection of the worker so that each worker would be given responsibility for the task for which he/she was best suited, scientific education and development of the worker, and intimate, friendly cooperation between management and labor

Henry Fayol (1841-1925) and the Classical Organization Theory, believed that sound managerial practice falls into certain patterns that may be identified and analyzed. He strongly believed that management was not a personal talent but a skill like any other and therefore it could be taught or learned. Fayol also developed fourteen principles of management which he felt; should be applied by managers at the operational level. He listed these principles as: Division of labour, authority and responsibility, discipline, unity of Command, individual Subordination, and remuneration: centralization, scalar Chain, order, equity, stability of tenure,

initiative and Espirit de Corps: In union there is strength, teamwork should be encouraged. Management is universal among all organizations and Fayol argued that those with a general knowledge of the management functions and principles can manage any type of organization. He further advocated that these principles/functions can be learned by anybody who is interested. But qualities such as physical health, mental vigor, moral character which are essential for management cannot be learned - one must possess them.

Elton Mayo (1880-1949) in Human relation school of thought/ Neo- Classical Theory of Management described human relation in relationship to work and performance. Human relations is used to describe how managers interact with subordinates when the management of people leads to better performance then there is good human relations. When morale and efficiency deteriorate human relations in the organization is 'bad'. In the Abraham Maslow Hierarchy of Needs motivational model, Maslow developed the Hierarchy of Needs model in (1940-50s) USA, and the Hierarchy of Needs theory remains valid today for understanding human motivation, management training, and personal development. Indeed, Maslow's ideas surrounding the Hierarchy of Needs concerning the responsibility of employers to provide a workplace environment that encourages and enables employees to fulfil their own unique potential (self-actualization) . Maslow's Hierarchy of Needs states that we must satisfy each need in turn, starting with the first, which deals with the most obvious needs for survival itself.

Only when the lower order needs of physical and emotional well-being are satisfied are we concerned with the higher order needs of influence and personal development. Conversely, if the things that satisfy our lower order needs are swept away, we are no longer concerned about the maintenance of our higher order needs

David Clarence McClelland (1917-98) in the Motivational Need theory is chiefly known for his work on achievement motivation. David McClelland pioneered workplace motivational thinking, developing achievement-based motivational theory and models, and promoted improvements in employee assessment methods, advocating competency-based assessments and tests, arguing them to be better than traditional IQ and personality-based tests. His ideas have since been widely adopted in many organizations, and relate closely to the theory of Frederick Herzberg. David McClelland is most noted for describing three types of motivational need, which he identified in his 1961 book, *The Achieving Society*; achievement Motivation

(Need for achievement), authority/Power Motivation (Need for power) and affiliation Motivation (Need for affiliation)

According to a report by UNFPA and PATH, (2006) on ‘Meeting the Need; Strengthening Family Planning Programs’, indicated that unless staff are given adequate resources, training, and support, the quality of care may not be achieved and hence program may fail. John eat al, (2006) on ‘family planning: the unfinished agenda’ identified staff competency as a key to success of family planning program. Kidane.G. (2008) looked at providers and client attitude/knowledge towards family planning and assessed the content of information exchange between the provider and the client. Clients learn little about family planning at the facility, due to the providers approach to the counseling and sharing information. The providers tended to focus the family planning information they gave to a client on the method asked about, without carrying discussions first on the reproductive needs of the clients. The providers have good attitudes towards family planning but they are concerned more on temporary family planning methods.

In Rakai, Uganda, a community randomized trial of enhanced FP efforts program showed a statistically significant higher use of hormonal contraceptives and lower pregnancy rates in the intervention arm as compared to the control arm. Investigators found that using trained volunteers and social marketing of contraceptives can improve contraceptive uptake among WRA (Lutalo et al., 2000). The quality of provider interaction and client should be improved by retraining the providers, provider knowledge and understanding of the methods and procedures should be improved, printed materials should be made available to interested clients.

2.5 Accessibility

According to business dictionary, accessibility means, the extent to which a consumer or user can obtain a good or service at the time it is needed. It also defines accessibility as ease with which a facility or location can be reached from other locations. A report by Center for Communication Programs, (2008) on ‘Elements of Success in Family Planning Programming’ indicated that providing family planning services through various outlets like clinics, pharmacy, health facilities, e.t.c, , helps clients to obtain services easily.

The report also attributed easy access as a necessary tool in removing unnecessary medical barriers. According to Nguyen et al, (2002) on ‘accessibility and Use of Contraceptives in Vietnam’ emphasized on the importance of a country to comprehend well the accessibility of family planning services as a tool to support program planning. A report of family planning London summit, (2012), indicated that increasing access to contraceptives and family planning information and services is directly related to improvement of maternal child health programs. According to FP2020, an outcome of the 2012 London Summit on Family Planning, accessing contraceptive services and information is key to success of any family planning program. PATH and UNFPA,(2006), on ‘meeting the need- the Strengthening Family Planning Programs’ , rated access to family planning information, services, and commodities an essential to achieving health of the women and families and a major success indicator for family planning programs.

A report by USAID (2011), relaying the story behind the FP program’s success in Malawi pointed out that accessibility was one of the program successes through the use of community health extension workers who are close to the society. INFO Project Center for Communication Programs (2008) on, ‘Elements of Success in Family Planning Programming’ described accessibility of family planning as a situation where clients can easily obtain services; they are better able to use family planning and to obtain help when they want it. People can be termed as having good access to family planning services when the service delivery points are conveniently available to everyone; everyone knows where to find these services; everyone feels welcome; services are free of unnecessary administrative and medical barriers; and people can choose from a range of contraceptives. Info center for communication (2008) described ways of ensuring accessibility which includes:

Offering Services through Multiple Channels Increases Access; it is necessary that men and women are able to find family planning services within reach. Research that was done in Thailand revealed that some women would go to great trouble to obtain contraception. The findings also stated that during 1960s in Thailand, many women traveled to Bangkok from around the country to visit the only clinic that offered IUDs. The finding also revealed that farther people had to travel for services or supplies; the less likely they are to use family planning.

Pharmacies; Pharmacies remain a flexible channel of offering family planning services. A family planning project in Egypt, “Ask...Consult” identified pharmacist as an important channel of making contraceptives methods available conveniently to potential users. The project encouraged women to seek advice and service at private-sector pharmacies and clinics bearing the “Ask...Consult” logo, a symbol of high- quality services. Clinics: clinics are good outlets for family planning services. Clinics offering family planning are usually diverse in nature some being public, , NGO, or private, community based, faith based, private providers’ offices, and mobile or temporary facilities.

Retail outlets: a variety of retail outlets sell contraceptives. Many programs use a mix of service delivery points to make methods available to all potential users. Clinics are a conventional source of family planning services, and remain the backbone of delivery systems in most countries. Clinical facilities can be at the primary, secondary, and tertiary levels in the government health care system, or run by private establishments or NGOs. Most government and NGO family planning programs provide clinic based services that are free or at very low cost to users. Regardless of the type of clinic, convenient hours of service and short waiting times are important for good access. Clinics often offer other health services in addition to family planning, which is convenient for clients. Clinics are usually placed in a location that can serve many people. This requires some people to travel long distances, which is inconvenient for them. Mobile clinics are sometimes used to reach communities that are far from other service delivery points. Some mobile clinics are equipped to provide long-acting and permanent methods, including implants, IUDs, and male and female sterilization, INFO Project Center for Communication Programs (2008).

Community based services train community residents to provide family planning within their communities. This strategy is particularly useful where health care infrastructure is weak or the population is widely dispersed. For example, in sub-Saharan Africa nearly 7 of every 10 people live in rural areas. Even where a clinic is close by, clients may find CBD a convenient and comfortable alternative. Community-based programs typically offer just condoms and oral contraceptives, and refer people to clinics for other methods. Increasingly, community-based programs are considering injectable. Pilot pro- grams in such a wide range of countries as Bangladesh, Bolivia, Ethiopia, Ghana, Guatemala, Kenya, Peru, and Uganda have

demonstrated that well-trained community-based workers can safely provide injectable contraceptives. Madagascar, for one, is scaling up the practice nationwide. The handbook “Provision of Injectable Contraception Services Through Community-Based Distribution” helps programs introduce injectable into existing CBD programs INFO Project Center for Communication Programs (2008).

Private-sector providers are usually in business for themselves. They charge their clients enough to provide themselves with an income. In contrast to the public sector, which often has the mandate to serve everyone, the private sector serves those who can afford to pay. Many people choose private-sector providers and services because of perceived higher quality, greater privacy, and shorter waits INFO Project Center for Communication Programs (2008). Retail outlets sell family planning supplies or services, either at subsidized prices through social marketing, or at full retail price. Pharmacies, drug shops, and kiosks sell condoms and oral contraceptives. These outlets offer easy and convenient access in familiar surroundings for those who can afford to pay.

Expanding the Role of the Private Sector; Strong private-sector provision of family planning benefits everyone, including public-sector programs. For example, the private sector may have capacity to handle increases in demand that could overwhelm public facilities. Also, when marketing directs those who can afford to pay to the private sector, the public-sector can serve more poor clients. In most countries the primary private-sector sources of modern contraceptives are pharmacies, shops, private hospitals, and private clinics. Various approaches have strengthened private-sector provision of family planning and standardized their services—for example, branding, as in the case of Indonesia’s Blue Circle program and franchising, as in the Philippines’ Friendly Care clinics.

Social marketing efforts are growing. Social marketing uses retail outlets and private providers to sell branded products and services at subsidized prices that are set to maximize use. Social marketing programs brand their products and services and promote their high quality. They are also marketed as ordinary consumer products, which decreases stigma and makes them more appealing. Family planning social marketing programs typically offer supply methods, such as male condoms, oral contraceptives, and injectable. Some programs also offer IUDs and female condoms. The number of couples who receive family planning through social

marketing is increasing. Sales of social marketing programs in 68 countries contributed 39.3 million couple-years of contraceptive protection (CYP) in 2006, an increase of 20% since 2004, INFO Project Center for Communication Programs (2008)

Access and Quality Go Hand in Hand; Access is not just a matter of convenient outlets. Also, those outlets should be free of unnecessary restrictions and conditions on who can be served. On a national level supportive policies can eliminate barriers such as requirements for a certain age or parity, spousal consent, or married status from service delivery guidelines. At the service delivery level, good training and simple job aids and tools can help reduce common medical barriers and facilitate evidence-based practices. For example, the checklist “How to be reasonably sure a client is not pregnant” can help providers recognize opportunities to provide hormonal methods and IUDs to women even if they are not having monthly bleeding at the time.

Among new family planning clients, the number of clients who were denied their desired method because they were not menstruating decreased significantly after the introduction of the checklist, from 16% to 2% in Guatemala and from 11% to 6% in Senegal. Similarly, checklists available for nearly every method help providers to apply the WHO Medical Eligibility Criteria and to avoid outdated or incorrect criteria. Offering family planning information and services at key times, such as to postpartum women in delivery facilities, also increases access INFO Project Center for Communication Programs (2008).

2.6 Affordability

According to the English dictionary, affordability means what is within one's financial means. Implementing the Affordable Care Act: Enrollment Strategies and the U.S. Family Planning Effort. Adam, (2011), on “One of the primary goals behind the Patient Protection and Affordable Care Act (ACA) ; enrollment Strategies and the U.S. Family Planning Effort ” emphasized on the need of having medical insurance in order to make health care services affordable which was informed by health care reform law enacted in 2010 in USA. Family planning was one of the health components that needed to be covered by the insurance to ensure that women of reproductive age were able to afford family planning services and hence get method of choice without straining.

Sharma and Dayaratna (2004), identified limited resources and competing health problems constrain many developing countries in providing buffer stock for family planning commodities. Due to shortage of commodities in public facilities, patients go to seek services in private facilities which is not affordable to many women. For a successful family planning program, affordability needs to be put into consideration. A report by USAID (2011) relating the story behind the FP program's success in Malawi pointed out that Malawi's achievements in rapidly expanding the use of modern FP methods was a reflection of improvements in FP policy and program implementation. The government commitment which enhanced, continued financing, expanded and innovative service delivery options, and receptive communities and clients all combined to make FP more acceptable, accessible, and affordable to Malawian households.

According to Julie and David, (2010) in the article, 'Family Planning in Developing Countries; an Unfinished Success Story', it pointed out the economic benefit of family planning. If family planning is made affordable, it will have excellent savings on other aspects of life and ensure economic growth. At the macroeconomic level, reduced fertility has helped create favorable conditions for socioeconomic development in some countries. A prime example of this connection has been the so-called Asian Economic Miracle. From 1960 to 1990, the five fastest-growing economies in the world were in East Asia: South Korea, Singapore, Hong Kong, Taiwan, and Japan. Two other Southeast Asian nations, Indonesia and Thailand, were not far behind. During this 30-year span, women in East Asia reduced their childbearing from an average of six children or more to two or fewer in the span of a single generation. Analysis of the experience of East Asian countries suggests that the reductions in fertility in the past decades relieved not only dependency burdens but also dependence on foreign capital by contributing to high saving rates.

A report by PATH and UNFPA (2006) on, 'strengthening family planning programs' pointed out that there was need to effectively reshape service delivery to ensure affordability, accessibility, and quality in order to maximize the reach of family planning services. The main key to achieving the reshaping was to ensure that family planning is integrated with other health services which would help in meeting the special needs of different populations and bring family planning services to new audiences, as can reaching out to the poor, adolescents, men, and other under-served groups. Improving contraceptive counseling and ensuring

contraceptive supplies can make the goal of informed choice a reality. Finally, strengthening day-to-day service delivery can improve the quality of care that family planning clients receive.

INFO Project Center for Communication Programs (2008) on , ‘Elements of Success in Family Planning Programming’ pointed out that as the number of contraceptive users are increasing in the world , growth will significantly be as fastest among people with least ability to pay for services. With a decrease in donor funding, and government assistance many family planning programs are constrained. In Kenya, family planning is wholly dependent on donor funding. This scenario challenges programs to keep services affordable while ensuring that people are able to choose, obtain, and use high quality contraceptives whenever they want them. Targeting subsidies to low income users while encouraging people to pay what they can keeps services affordable for all clients. It also contributes to the financial sustainability of programs. The report suggested ways of making the family planning services affordable which includes:

Public-Private Partnerships Help Address Financial Challenges; the goal of the public sector is to make a range of family planning methods available to those who need them. Public-sector resources are often not sufficient to address the family planning needs of an entire population, however. Shifting users who can afford to pay from the public sector to the for-profit private sector can reduce financial pressures on governments, donors, and NGOs. This can be done if private-sector care is an attractive alternative for clients who do not need subsidized services, INFO Project Center for Communication Programs (2008).

Whole market approach; a “whole market approach” helps target services to appropriate groups. Understanding how demand and supply are segmented across different socioeconomic groups helps managers make services more affordable and target subsidies more efficiently. This strategy is known as a whole market approach. A market segmentation analysis helps determine where and on whom public, commercial, and NGO programs each should focus marketing efforts INFO Project Center for Communication Programs (2008). Demographic and market research data; Using demographic and market research data for example, from Demographic and Health Surveys—a market segmentation analysis divides a population into five segments, ranging from high to low on an index of standard of living. It identifies both who is being served in the family planning marketplace and who is underserved. Marketing

then can lead clients in higher economic quintiles to partially subsidized or unsubsidized social marketing or commercial services, while subsidized public-sector services can focus on poorer populations. For example, in Romania a market segmentation analysis found that a large percentage of potential family planning users in urban areas were both willing and able to pay commercial prices. Consequently, free public supplies were targeted to rural family planning clinics and low-income urban areas, and the private sector scaled up services in wealthier urban areas.

Programs can also use results from a market segmentation analysis to target branded products to different economic groups. For example, in Bangladesh the Raja condom is promoted as a mainstream condom brand, while the higher-priced Sensation condom brand targets a more upscale market. Various Financing Approaches Make Services Affordable; a variety of strategies can help public and NGO programs target subsidies and establish appropriate fees. Establish fees that people can pay. Instituting or increasing fees may be necessary or desirable in some cases. If so, programs must find a way to ensure that services remain available to those who cannot pay. Means testing needs assessments, and wealth index can help programs decide who can and cannot pay for services. These approaches can be difficult and time-consuming. In some cases the cost of designing and implementing means testing can be so high that it seriously offsets the revenues gained from the fees. Other financing mechanisms are available, such as voucher systems and insurance schemes.

Use of vouchers; Vouchers make private-sector services affordable for the poor. Research around the world indicates that many people—including those in lower economic quintiles—prefer private-sector health care because of perceived higher quality. One way to make private-sector services affordable is by subsidizing poorer clients directly, through voucher systems—also known as output-based aid. Vouchers usually take the form of certificates or other tokens that people can redeem with providers who meet certain standards—often a pool of pre-approved providers. Vouchers contributed to the success of family planning programs in South Korea and Taiwan in the 1960s and 1970s. More recently, small-scale programs in Bangladesh, China, India, Kenya, Nicaragua, and Uganda have experimented successfully with voucher systems to subsidize vasectomy, female sterilization, and IUD services, and safe deliveries. These are services with one-time costs that many people cannot afford.

2.7 Theoretical frame work

This study will adopt the scientific management theory which is a theory introduced in an attempt to create a mental revolution in the workplace. This theory can be defined as the systematic study of work methods in order to improve efficiency. Frederick W. Taylor was its main proponent. Other major contributors were Frank Gilbreth, Lillian Gilbreth, and Henry Gantt.

The main objective of Scientific Management in the early days was to determine how jobs could be designed in order to maximize output per employee (efficiency). The main contributor to scientific management was Fredrick W. Taylor until the Husband Team of Frank and Lilian Gilbreth and also added more light to scientific management. Taylor was an industrial Engineer who worked in the United States at a time when industries were facing shortage of skilled labour. For factories to expand productivity, ways has to be looked for to increase the efficiency of employees. Management faced questions such as whether there was ``one best way'' of doing a job. He made several observations that caused inefficiency:

Workers deliberately restricted production in their daily work due to fear of unemployment and lack of pieces rate system, lack of work rationalization leading to overlapping of jobs made the method of working complicated, due to poor remuneration, workers formed themselves into groups and labor unions to press for better wages, management left the initiative of working methods to the ingenuity of workers, thus rule of thumb. In trying to answer these question Taylor slowly developed a body principles that Taylor`s first job was a Midvale Steed Company in Philadelphia. While here Taylor analyzed and timed steel workers movement on a series of jobs. With time he was able to establish the best way to do particular job. But he noticed the workers did not appreciate the speed factor because they feared that work would finish and they would be laid off. So Taylor encouraged employers to pay the more productive workers at a higher rate based on the profits that would result. This system is called the differential rate system. Taylor was encouraged by the results of his work and decided to become a private consultant. His most significant work was consulting for two companies.

Simonds Rolling Machine Factory and Bethlehem Steel Corporation. At Simonds he studied and redesigned jobs introduced rest breaks and adopted a piece and rate pay system. In one operation he studied 120 women employed in tedious work with long working hours. The work involved inspecting bicycle ball bearings. Taylor started by studying the movements of the best workers and timed them. Then he trained the others in the methods of their more effective co-workers and either transferred or laid. At Bethlehem Steel Taylor and a co-worker studied and timed the operations involved in unloading and loading railcars. At the time each worker earned \$ 1.15 per day unloaded average of 12½ tons. Taylor introduced rest periods in the day and realized that each man could handle about 48 tons a day. He set a standard of 47 ½ tons and a rate of \$ 1.85 for those who met the standard. The results were increased efficiency.

However despite his achievements trade unionist and workers started to resist the ideas of Taylor and his defending his philosophy Taylor outlined that it rested on four major principles. The development of a true science of management so that for example the methods for performing each task could be determined. The scientific selection of the worker so that each worker would be given responsibility for the task for which he/she was best suited. Scientific education and development of the worker, and intimate, friendly cooperation between management and labor.

In conclusion Taylor said the principles could only succeed if there was a complete mental revolution on the part of both management and labour to the effect that they must make their eyes off the profit and together concentrate on increasing production, so that the profit were so large they did not have quarrels about sharing them. He strongly believed that the benefits from increased productively would accrue to both management and labour. Frank (1888-1924) and Lillian (1878-1972) were a husband and wife team who contributed to scientific management. Lillian focused her studies on ways of promoting the welfare of the individual worker. To her scientific management has one ultimate aim: to help workers reach their full potential as human beings. Lillian also assisted Frank who began his work as an apprentice's bricklayer, developed a technique that tripled the amount of work a bricklayer do in a day. He studied motion and fatigue and said that they were intertwined. Every motion that was eliminated also reduced fatigue. Both Gilbreths argued that motion study would raise morale because of its obvious physical benefits. They developed a three position plan promotion that was intended to serve

as an employee development program as well as a morale booster. According to this plan a worker would do his or her present job, prepare for the next one and train his/ her successor all the same time. Thus every worker would always be a doer, a learner and trainer and hence workers would look forward to now opportunities.

2.8 Conceptual Framework

According to Jabareen, (2009:51), Conceptual framework is a network, or “a plane,” of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena. The concepts that constitute a conceptual framework support one another, articulate their respective phenomena, and establish a framework-specific philosophy. The conceptual frame work in this research is more of a map that conceptualizes if independent variables (commodity security, affordability, staff competence and accessibility) contribute to independent variables (performance of family planning projects).

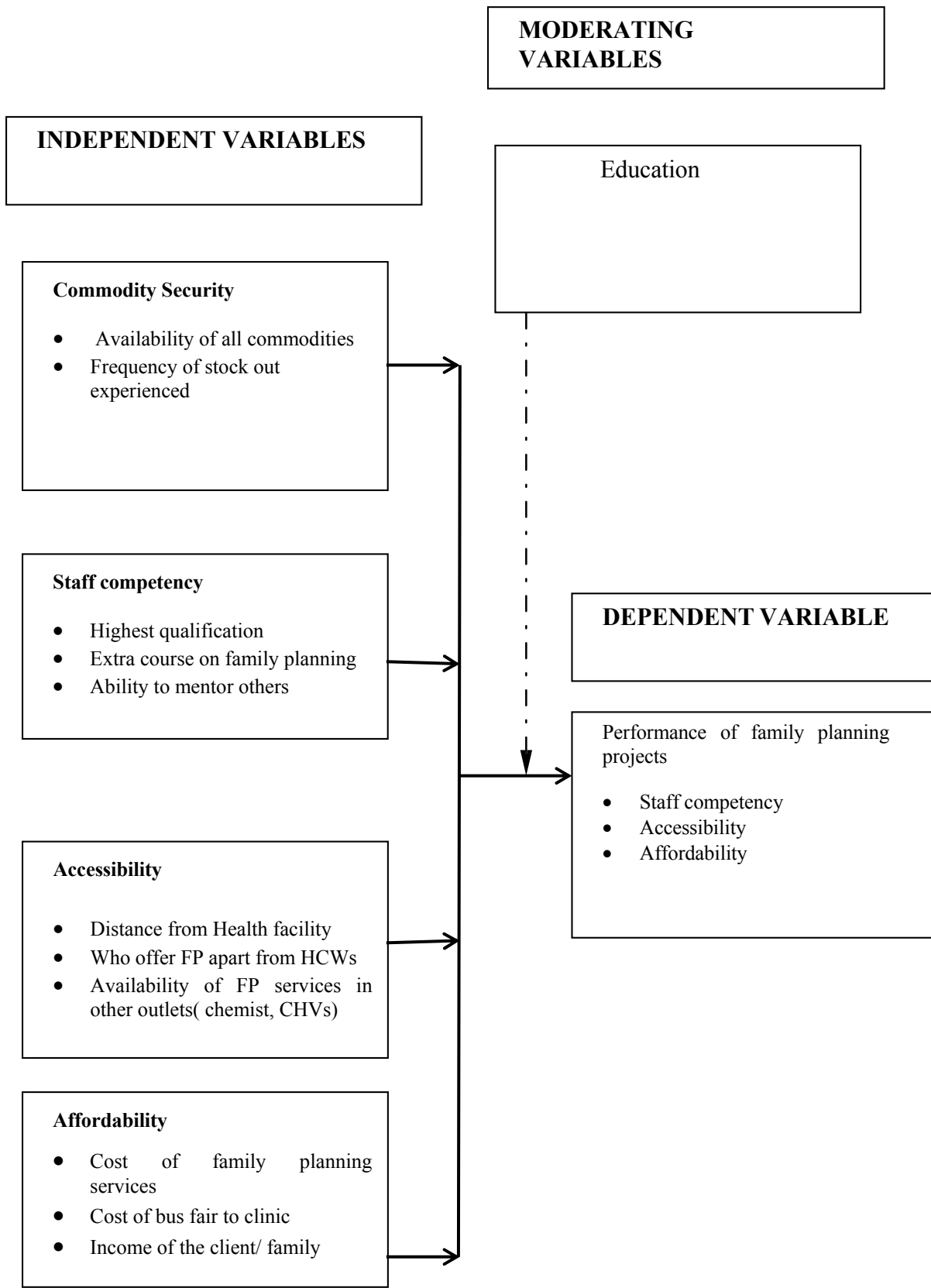


Figure 1 Conceptual Framework:

2.9 Literature gaps

Most of the studies have not tackled the issues of performance of family planning projects as a research issue in-depth; most of the studies have studied this as a subsidiary to the large aspect of Performance of family planning projects. This study will want to go deeper in matters of performance of family planning projects. The previous research focused mostly on developed countries, this research will have a focus on all family planning projects funded by USAID in Kirinyaga County. The study will go deeper to ascertain the performance of each facility.

2.10 Summary

Literature was reviewed on the factors that influence Performance of family planning projects. This study will deal with commodity security, staff competency, affordability and accessibility factors that are thought to have a great influence on the same. The proximate factors are religion, religion, culture and education which will lead to performance of family planning projects. Literatures show that performance family planning projects are influenced by many factors which are all unique according to the country and location. Accessibility and affordability is critical for the family planning consumption and hence project success. Staff play a key role in the family planning programs hence the need to the right skills to offer family planning services.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter gives an overview of the methods used in the study. The areas covered includes, the research design, target population, sample size, sampling procedure, data collection methods and procedure, the validity and reliability of the research instruments, ethical considerations and data analysis and presentation techniques are discussed in detail. The operational definition of variables is provided in the final section of this chapter.

3.2 Research Design

According to Kothari (2004), research design is designed as a framework that shows how problems under investigation will be solved. The design of this study is descriptive survey. Polit and Beck (2004) states that the purpose of descriptive survey is to observe, describe, and document aspects of a situation as it naturally occurs and sometimes to serve as a starting point for hypothesis generation.

A survey is a research design where data is collected from members of a population in a bid to determine the current status of the population with regard to one or more variables (Adeyemi and Adu, 2010). The design is suitable for studies where data is intended to describe the existing conditions (Simiyu, 2009). The study examined the target population through the selection of a sample to analyze and discover occurrences. The design enabled the researcher to establish how each of the independent variables increased or decreased the probability of occurrence of the dependent variable.

3.3 Target Population

A population is a complete set of possible observations of the type which is to be investigated. Mugenda and Mugenda, (2003) describes, population is an entire group of individuals, events or objects having common characteristics that conform to a given specification. The target population in the study women of reproductive age seeking family planning services and health care providers offering family planning services.

This target population was useful in providing the required data in the topic under investigation which is to determine factors influencing performance of family planning projects in Kirinyaga County. The target population consisted of 44600 women of reproductive age in health facilities in Kirinyaga County supported by USAID.

The choice of 44600 clients was guided by the data available for registered women of reproductive age who sought family planning services. This study targeted the clients receiving Family planning service at the time of the interview. The inclusion of the service providers in this study was to enhance an understanding on how their competence influences success of family planning programs.

3.4 Target Population

Table 3.1 shows the total number of women of reproductive age who sought family planning services in the year 2015 and there specific sub counties. It also describes the sample size per Sub County in the given area.

Table 3.1: Target population

Sub counties (cluster)	No of facilities	No of registered FP clients	Proportionate factor(distribution factor) 0.0085	Sample Simple
Kirinyaga West	9	9429		81
Kirinyaga East	8	8565		73
Kirinyaga North	6	4087		35
Kirinyaga South	8	9103		78
Kirinyaga Central	13	13416		114
TOTAL	44	44600		381

3.4.1 Sampling (design) procedure

According to Orodho (2003), a sample design is the most definite plan determined before any data is collected by obtaining a sample size from the population. Sampling procedure is a technique of selecting and choosing a sample, where a sample is a portion of population taken purposely for study investigation. Sampling methods allow for representative of cross-sections, or particular groups to be identified or targeted. To elicit the views of larger groups, some form of sampling is usually necessary to attempt to gather opinions that are likely to be representative of the whole group. Sampling enables researcher get data easily and economically than doing census of whole population, get good quality and well manageable data, high accuracy and follow up for research. A good sample should provide good estimates on mean values and proportions and generalization on population (J. Wilkins, R. Laitois 1983). In a positivistic research study, when seeking the views of a group of fifty or less, research Henry (1990) argues against any form of sampling. He argues that you should distribute the questionnaires and collect data and information to the entire population, if possible. The research study adopted the cluster sampling method. This is a probabilistic method of sampling where samples of population are randomly selected in their naturally occurring groups or clusters and the population is geographically scattered in a large area. This is considered to be the most appropriate in terms of convenience where the researcher has no influence that gets selected and cost efficiency of sampling, time saving, there is elimination of bias in selecting the sample and samples have equal chances of selection and representation. The target population is geographically located in different sub countries in Kirinyaga County. Five sub counties with 44600 as target population was considered as clusters of the study, where sample units were randomly chosen from health facilities in each sub county. A sample size of 381 based on estimate proportion of target population was used in this diagnostic research study. The type of data to be collected and analyzed is discrete data.

3.4.2 Sampling Size

This study employed two approaches in determining the sample size. The approach to be used to determine the sample size of women of reproductive health was adopted from (Kothari 2004) as illustrated below;

$$n = \frac{z^2 \cdot p \cdot q \cdot N}{e^2 N - 1 + z^2 \cdot p \cdot q}$$

Where;

N - Size of the sample

Z-Value of standard variety at a given confidence level

p- Sample population

q - (1-p) and

e - Acceptable error

In this study, a 95% level of confidence was used which gives the value of z as ± 1.96 and an acceptable error of 0.05. Faraday (2006) states that the acceptable error is generally set at 0.05 or at 5% probability that a significant difference occurred by chance. Kothari (2004) recommends a value estimate of p at 0.5 as this gave a maximum sample value and yields the desired results. Using these values, the sample size was calculated as follows;

$$n = \frac{1.96^2 \times 0.5 \times 0.5 \times 44600}{0.05^2(44600-1) + 1.96^2 \times 0.5 \times 0.5}$$

n =42833.84
112.4579
n =380.8877811
n =381

The approach used to determine the sample size from the service providers and the list of health facilities was adopted representing 10% as proposed by Mugenda & Mugenda (1999). The quoting from Gay (1983) recommends 10% of cases in descriptive studies which is representative of the total population.

Proportionate factor of each sub sample (cluster) is $381/44600 = 0.0085$

The sample size is shown in the Table 3.2 in relationship to total population and clusters; The

approach used to determine the sample size from the service providers and the list of health facilities was adopted representing 10% as proposed by Mugenda & Mugenda (1999). The quoting from Gay (1983) recommends 10% of cases in descriptive studies which is representative of the total population.

Table 3.2 Sample size

Sub county	No of Facilities	10%	No of Health Providers	10%
Kirinyaga West	9	0.9 = 1	22	2.2= 3
Kirinyaga East	8	0.8= 1	18	1.8 = 2
Kirinyaga North	6	0.6 =1	16	1.6= 2
Kirinyaga South	8	0.8= 1	18	1.8= 2
Kirinyaga Central	13	1.3= 2	24	2.4= 3
Total	44	6		12

Therefore, a sample size of 381 for women of reproductive age, 6 health facilities and 12 service providers was drawn using cluster sampling technique. Cluster sampling is a sampling technique used when "natural" but relatively homogeneous groupings are evident in a statistical population. The principle of cluster sampling selection procedure assigns each individual in the sample the same chance of selection.

In this technique, the total population was divided into clusters and a simple random sample of the groups is selected (Williams, 1998)The six health facilities within Kirinyaga County were the clusters; an equal number of questionnaires were distributed. The respondents were drawn from the registered clients who were receiving family planning services within the data collection period in each of the clusters.

3.5 Data Collection Methods

This study used both the questionnaire and an interview guide for data collection, the questionnaire were used among the women of reproductive age seeking family planning services and the interview guide was for the service providers. The selection of these tools is guided by the nature of data to be collected, the size and distribution of the population and the objectives of the study.

Questionnaires increase the chances of getting honest responses since they ensure anonymity of the respondent. The questionnaire used both open ended and closed ended questions. The use of open ended questions offered flexibility for the respondent to provide more details. Closed ended questions allowed for quantitative analysis. This balance was useful for a comprehensive analysis.

Interview is a purposeful conversation in which one person asks prepared questions and another answers them (Frey & Oishi 1995). This was done to gain information on a particular topic or a particular area to be researched. The use of the interview approach was flexible, providing a large amount of detail.

3.6 Data Collection Procedure

Once the project is approved by the University academic panel, the researcher started the data collection process by seeking permission from the county health management team at Kirinyaga County. This study used student nurses as the research assistants; they were trained on the tools and then issued with the questionnaires to administer to the women receiving family planning services. The researcher then collected the questionnaires from the student nurses. Aware of the challenges involved in interviews, the researcher made adequate preparations to maximize the chances of successful interviews.

3.7 Validity and Reliability of Research Instruments

This section explained the validity and reliability of research instruments.

3.7.1 Validity of Research Instruments

Validity is the accuracy and meaningfulness of inferences, which are based on the research results (Mugenda & Mugenda, 2003). According to Cooper & Schindler (2007), pretesting questionnaires helps the researcher find ways to increase participants' interest; helps in discovering question content, wording and sequencing problems before the actual study and also helps in exploring ways of improving overall quality of study.

Mugenda & Mugenda (1999) contend that the usual procedure in assessing the content validity of a measure was to use a professional or expert in a particular field. To establish the validity of the research instrument the researcher sought opinions of experts in the field of study

especially the lecturers in the department of project management. This facilitated the necessary revision and modification of the research instrument thereby enhancing validity. Expert opinions were requested to comment on the representativeness and suitability of questions and give suggestions of corrections to be made to the structure of the research tools. This helped to improve the content validity of the data that were collected. Content validity was obtained by asking for the opinion of the supervisor, lecturers and other professional on whether the questionnaires were adequate.

The instruments were then validated through content validity index. The survey instrument was sent and reviewed by three quality experts to check on the following issues: The representativeness and relevance of the items to the factors influencing performance of family planning projects funded by USAID; The degree of the difficulty, clarity and semantic content of the items. The experts agree that the items are appropriate based on the study objectives and that the items are representative of the important factors for performance of family planning projects.

3.7.2 Reliability of Research Instruments

According to Cooper & Schinder (2007), reliability referred to the consistency of measurement and was frequently assessed using the test–retest reliability method. Reliability was increased by including many similar items on a measure, by testing a diverse sample of individuals and by using uniform testing procedures. A number of measures were taken to ensure reliability. Themes on the interview questions were based on the objectives stated in the study.

To achieve reliability of the questionnaire, the instrument has been designed with great care matching questions with objectives for the study. The questionnaires were tested in two health facilities targeting 15 women seeking family planning services in a pilot study. The responses from the pilot study revealed presence of any inconsistencies in the questions within the questionnaire and ability of respondent to respond to all questions. The pilot study gave proper guidance on whether there is need for revising the tools.

3.8 Data Analysis

Data Analysis is a stage where data collected by research study from sample is analyzed, and interpreted into organized and useful information that can be used for decision making process on population. Data Analysis is a process that makes data understandable and useful to other users (Munywoki & Mulwa 2012). The entire process begins after data collection and come into conclusion at the point of interpretation of the results there of, is data analysis (Cooper & Schindler, 2003). Statistics happens to be a discipline that offers tools of data analysis in research and one which refers to facts data to a system of data collection and analysis (Chandran, 2004).

The raw data collected with the help of questionnaire instrument were edited, summarized, coded, tabulated and analyzed using descriptive statistics and inference statistics. It was sorted according to similarity and classes for further analysis. The data was tabulated in form of data matrices, data reduction and then discussed, this provided easy data computation, easy data understanding and communication and extrapolation (Munywoki & Mulwa 2012).

Generally, both qualitative and quantitative research approaches were used for data analysis. Qualitative data comes in form of words rather than in numbers like giving opinion, quality, and judgment on worthiness of something. For quantitative data, descriptive statistics analysis was used to analyze the data in form of mean, ratio, frequencies and percentages. Other data analysis techniques like computer Microsoft excel scientific calculators and statistic approaches using statistical inference and non-parametric chi square test.

Finally data tabulation matrices and data analysis was useful for further analysis and preparation for data interpretation and presentation. Data was presented in form of tables, graphs, bar charts and pie charts

3.9 Ethical Considerations

Ethical consideration issues are important when dealing with people with diverse cultural backgrounds. Rules and regulations should be there to guide conduct of researcher when collecting data for the study from people in various fields and areas. Ethical consideration requires that research ethics be observed and respected when relating with people in research undertakings especially in field data collection and in research reporting. Permission was sought from Kirinyaga County health management. Consent was sought from research

respondents, confidentiality was assured and data collection instrument shall not bear their names and those not willing to participate in the study was not be forced to do so.

Data collection by research study should be planned and conducted to respect and protect the rights and welfare of people and the communities of which they are members, in accordance with the UN Universal Declaration of Human Right and other human rights conventions.

The research team, that is interviewers and their supervisors should respect the dignity and diversity of the respondents when planning, carrying out and reporting on research study, in part by using data collection instruments appropriate to the cultural setting. Further, prospective host team and respondents should be treated as autonomous, be given the time and information to decide whether or not they wish to participate, and be able to make an independent decision without any pressure (Collin 2007).

The following Ethical principles should always uphold when conducting research surveys; principle of confidentiality, principle of not harm, principle of privacy, principle of integrity, principle of fairness and principle of honesty (Gatimu 2015).

Saunders, Lewis and Thornhill (2003) make the following suggestions on conducting a semi-structured interview: The interviewee is thanked for agreeing to the meeting, the purpose of the research, its funding (if relevant) and progress to date are briefly outlined, the interviewee is given an assurance regarding confidentiality , the interviewee's right not to answer questions is emphasized and the interview could be terminated at any time by the interviewee, the interviewee is told about the use intended to be made of the data collected during and after the project, the offer of any written documentation to the interviewee promised in advance of the meeting should be emphasized, the interviewer describes the process of the interview, e.g. approximate number and range of questions to be asked and the time is was likely to take. The researcher would want to intervene in the following situations: If one group member was dominating the discussion, if the group strayed from discussing the topic in question, to encourage quieter members of the group to contribute to the discussion and to resolve any conflicts that arose between group members.

3.10 Operational Definition of variables

According to Martyn (2008) operationalization is defined as the process of strictly defining variables into measurable factors. This process defines fuzzy concepts and allows them to be measured, empirically and quantitatively. Operationalization is achieved by looking at behavioral dimensions, indicators, facets or properties denoted by the concept, translated into observable and measurable elements to develop an index of the concept. Measures can be objective or subjective. It is not possible to construct a meaningful data collection instrument without first operationalizing all the variable

Table 3.3 Operational of variables

Objective	Independent variable	Indicators	Tools for data collection	Measurement scale	Type of analysis
To determine how contraceptive security influence the performance of projects	Contraceptive security	Availability of all contraceptive commodities How often stock out is experienced	Questionnaire	Nominal Interval scale	Descriptive Means Frequencies Percentages
To examine how staff competence influence the performance of family planning County	competence influence	Extra course on FP Ability to offer all methods Ability to counsel client on all methods Ability to mentor others on FP	Interview	Nominal Nominal Nominal Nominal	Descriptive Percentages
To find out how accessibility influence the performance of family planning projects	Accessibility	Distance from H/F Availability of commodities in other outlets Availability of all methods in	Questionnaire	Interval Nominal Nominal	Descriptive
To establish how Affordability influence the performance of family planning projects in Kirinyaga County	Affordability	Cost of Bus fair to the clinic Cost of family planning services If client has an income	Questionnaire	Nominal Nominal Ratio/ interval	Descriptive Percentages Mean

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATIONS

4.1 Introduction

This chapter discusses the interpretation and presentation of the findings obtained from the field. The chapter presents the background information of the respondents, findings of the analysis based on the objectives of the study. Descriptive and inferential statistics have been used to discuss the findings of the study.

4.2 Response rate of the study

The questionnaires were distributed to 393 respondents and 347 were completed and returned, giving a response rate of 91.00 %. This response rate was satisfactory to make conclusions for the study as it acted as a representative. According to Mugenda and Mugenda (1999), a response rate of 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent. The unreturned questionnaire 34 (9%) could be attributed to delay on the part of the respondent completing and hence being unable to return. The analysis of the response rate was as shown in table 4.1;

Table 4.1: Response Rate

Questionnaires	Frequency	Percentage	Cumulative
Filled and returned	347	88	91
Not returned	46	12	100
Total	393	100	

4.3 Background of Family Planning Service Seekers

The demographic characteristics of the respondents are analyzed in terms of gender, highest Educational level, age and categories and as shown below

4.3.1 Age of respondents

The respondents stated their age brackets as requested in the questionnaire and the results are shown in table 4.2. Various age group hold different opinion regarding the uptake of family planning initiative, in view of ensuring that various age groups were fairly engaged in this research, Respondents were requested to indicate their age category

Table 4.2: Age of Respondents

Age category	Frequency	Percentage
15-24 years	82	23.6
25-34 years	134	38.6
35-44 years	78	22.5
45 years and above	53	15.3
Total	347	100.0

Investigation results on age category as shown in table 4.2 show that most of the respondents as shown by 38.6% were aged between 25-34 years, 23.6% of the respondents were aged between 15-24 years, 22.5% of the respondents were aged between 35-44 years whereas 15.3 % of the respondents were aged between 45 and years above. This implies that majority of the respondents were in youthful age which is commonly termed to as the reproductive age.

4.3.2 Marital Status

Establishing marital status was critical as family setting was perceived to be key determinant in uptake decision of family planning method. In this essence Respondents were requested to indicate their marital status. The analysis of the marital status was as shown in table 4.3;

Table 4.3 : Marital Status

Marital status	Frequency	Percentage
Single/ never married	51	14.7
Married	236	68.0
Separated/ divorced	26	7.5
Widowed	34	9.8
Total	347	100.0

Table 4.3, shows that majority of the respondents as shown by 68.0% were married, 14.7% of the respondents were single/never married, 9.8% of the respondents were widowed whereas 7.5% of the respondents were either separated or divorced this implies that women various family settings were fairly involved in this research.

4.3.3 Number of Children

The family size was also considered as a key determining factor while deciding on family planning method to adopt. The analysis of the number of children was as shown in table 4.4

Table 4.4: Number of Children

Number of children	Frequency	Percentage
1-2 children	174	50.1
3-4 children	106	30.5
5-6 children	67	19.3
Total	347	100.0

Table 4.4 shows that majority of the respondents as shown 51.9 % had 1 or 2 children, 35.2 % indicated that they had 3 or 4 children whereas 13.0% had between 5 or 6 children this implies that respondents with various family size were fairly engaged in this research.

4.3.4 Number of Surviving Children

Respondents were requested to indicate the number of surviving children, stating the Number of surviving children was critical as this could influence women’s decision in uptake of family planning initiative. The analysis of the number of surviving children as shown in table 4.5;

Table 4.5 :Number of surviving children

Number of surviving children	Frequency	Percentage
1-2 children	174	50.1
3-4 children	106	30.5
5-6 children	67	19.3
Total	347	100.0

Table 4.5 shows results on the number of children in each family size, the findings shows that 50.1% of the families had 1-2 surviving children, 30.5% of the families had 3-4 children surviving children while 19.3% of the families had 5 or 6 children surviving children. The findings based on comparison notes child motility especially with families having 5 to 6 children.

4.3.5 Whether the Respondents Was Looking To Have More Children

The research sought to determine whether the respondent was looking forward to have more children. This was factor was perceived to influence ones’ decision on FP uptake. The analysis were shown in table 4.6;

Table 4.6: Whether the respondents was looking to have more children

Opinion	Frequency	Percentage
Yes	46	13.3
No	301	86.7
Total	347	100.0

From the research findings as shown in table 4.6 majority of the respondents (86.7%) indicated that currently they were not looking forward to having more children while 13.3% indicated that they were currently willing to have more. This implies that majority of the respondents were currently not looking forward to having more children.

4.3.6 Means of Preventing Pregnancy

Respondents were requested to indicate the family planning method that they were currently using to prevent pregnancy. The analysis was shown in table 4.7;

Table 4.7: Means of preventing pregnancy

Family planning method	Frequency	Percentage
Abstaining	35	11.6
Pills	97	32.2
Inject able	53	17.6
IUD	27	9.0
Implants	20	6.6
Condoms	69	22.9
Total	301	100

From the research findings as shown in table 4.7, most of the respondents as shown by 32.2% indicated that they were using pills, 22.9% of the respondents indicated that they were using condoms, 17.6% of the respondents indicated that they were using inject able 11.6% of the respondents indicated that they were abstaining from sex, 9.0% of the respondents indicated

that they were using IUD while 6.6% of the respondents indicated that they were using implants. This implies that among the family planning methods women in FP program were using included pills, abstaining from sex; inject able, IUD, implants and condoms.

4.3.7 Religion of the respondents

Religion, cultural beliefs and norms were perceived to influence women decision in uptake of family planning. Therefore as a determining factor, respondents were requested to indicate the religion they professed. The analysis was shown in table 4.8;

Table 4.8: Religion of the respondents

Religion	Frequency	Percentage
Catholic	172	49.6
Protestant	113	32.6
Muslim	62	17.9
Total	347	100.0

Table 4.8 shows respondents religious affiliation, based on the findings, majority of majority of the respondents as shown by 49.6% indicated that belonged to roman Catholics religious society, Protestant % of the respondents were Protestants whereas 17.9% of the respondents were Muslims, the study also noted that some of the respondents belong to traditional religious groups, this implies that respondents fairly various religious groups (catholic, protestant. Muslim and traditional religious groups) were fairly were fairly engaged in this research

4.4. Contraceptive Security

Provision of contraceptive security presents to reproductive men and women with various choices of FP method from which one can adopt. Therefore this degree of autonomy to PF users was perceived to be critical in uptake of family planning. The study therefore sought to determine to determine extent to which provision of contraceptive security influenced the success of family planning projects in Kirinyaga County

4.4.1 Whether the Responded Had Ever Used Family Planning Method Before

The research sought to establish whether the respondent had ever used family planning method before, this factor was considered critical in establishing respondent's level of courage, trust and attitude toward the uptake of FP. The analysis were shown in table 4.9;

Table 4.9: Whether the responded had ever used family planning method before

Opinion	Frequency	Percentage
Yes	347	100.0
Total	347	100

The findings as shown in table 4.9 show that all the respondents as shown by 100% agreed to have been using family planning methods before. This implies that respondents were in a position to give credible information based on their experiences.

4.4.2 Type of Family Planning Method

Based on user's experiences, the types of family planning method to some extent could influence ones decision to continue, or change family planning, this is mostly attributed to cost, effectiveness and availability of the FP method. In this essence, the study therefore requested FP users to indicate the family planning method they were currently using. The analysis was shown in table 4.10;

Table 4.10: Type of family planning method

Family planning method	Frequency	Percentage
Pills	128	36.9
Inject able	124	35.7
Condoms	95	27.4
Total	347	100.0

Results on table 4.10 shows results on the distribution respondents in respect to the current type of FP method they were using, based on the results, most of the respondents as shown by 36.9% indicated that they were using currently using pills, 35.7% respondents indicated that

they were currently using injectable whereas 27.4% of the respondents indicated that they were using condoms. This implies that among the family planning methods currently being used by women in reproductive age included pills, abstaining, injectable, IUD, implants and condoms.

4.4.3 Type of Family Planning Method That Respondents Were Coming For

Respondents were requested to indicate the family planning method they were coming for at that visit, this was important in establishing the respondents' level of consistency with uptake of adopted FP method as well as the effectiveness and level of comfort with adopted FP method. The analysis was shown in table 4.11;

Table 4.11 Type of family planning method that respondents required at that visit

Family planning method	Frequency	Percentage
Pills	179	51.6
Injectable	99	28.5
Condoms	69	19.9
Total	347	100.0

Table 4.11 shows the type of family planning method that respondents required at that visit, investigation results show that majority of the respondents as shown by 51.6% were coming for pills, 28.5% of the respondents were coming for injectables while 19.9% of the respondents were coming. Based on earlier results, the study notes a degree of volatility in numbers as per each planning method, this implies that the decision by the respondents to continue with uptake of family planning method were indirectly influenced by various factors like cost, availability, level of comfort based on experience with certain FP method and altitude among others.

4.4.4 Reasons Why Respondents Had To Change FP Method

Establishing reasons as to why respondents periodically change FP method could help enhance the performance of family planning projects in Kiringyaga County. In this essence, understanding the factors associated with frequent changes of FP method among users could help the bench better strategize on the programme as well as ensure effectiveness, of the program and ultimately encourage FP uptake. The analyses were shown in table 4.12;

Table 4.12 : Reasons why respondents had to change FP method

Reasons	Frequency	Percentage
Cost	40	11.5
Side Effects	297	85.6
Total	234	100

Table 4.12 shows the reasons as to why respondents had to change the previous family planning method. From the research findings, majority of the respondents as shown by 85.6% indicated that they changed the from previous family planning method due to side effects whereas 11.5% of the respondents indicated to have changed due to cost related factors. This implies the decision to change family planning method commonly attributed to Side Effects and level availability of the FP at the local healthy facility

4.4.5 Cases Where FP Users Missed the Service at the Facility Due To Stock Outs

Issuance of family planning to society requires high level of preparedness in terms of medical stock availability and personnel arrangement. These two factors to some extent were perceived to play a critical role in respondents' continuous uptake of FP method. In this essence the study sought to ascertain the healthy facilities level of preparedness and especially in quantity of stock available. The analysis were shown in table 4.13;

Table 4.13 :Cases where FP users missed the service at the facility due to stock outs

Opinion	Frequency	Percentage
Yes	304	87.6
No	43	12.4
Total	347	100.0

From the research findings as shown by table 4.13, majority of the respondents as shown by 87.6% agreed to have missed the FP service at the facility due to stock outs whereas 12.4% of the respondents indicated to have not, this implies that periodically respondents missed to get their choice of family planning method family planning service due to stock out in the facility.

4.4.5 Number of Times That Responders Missed To Get Their Choice of Family Planning Service

Cases of responders missed to get their choice of family planning service family planning service could were associates with decreased morale uptake of FP and thus suppressing the county governments efforts on continuous provision family planning service and primary health care, therefore the research sought to determine the number of times that responders missed to get their choice of family planning service family planning service due to stock out in the facility. The analysis was shown in table 4.14;

Table 4.14 : Number of times that Responders Missed To Get Their Choice of Family Planning Service

Number of times	Frequency	Percentage
1 to 2 times	137	45.1
3 to 4 times	103	33.9
5 to 6 times	44	14.5
lost count	20	6.6
Total	304	100.0

Table 4.14, shows the number of times that responders missed to get their choice of family planning service family planning service due to stock out in the facility, from the research findings, most of respondents as shown by 45.1% indicated to have missed their choice of family planning service due to stock out in the facility, 33.9% of the responders indicated 3 to 4 times, 14.5% of the responders indicated 5 to 6 times while 6.6% to have lost count, this implies that majority responders missed to have their choice of family planning service due to stock out in the facility in approximately 3 to 4 times.

4.5 Staff Competency

The success of family planning projects in Kirinyaga County dependent on competent health workers, competent health workers were in a better position to convince young reproductive men and women to consider the uptake of family planning measures than any other advocacy means. Family planning healthy workers played a critical role in creating awareness on family planning services. In this essence the this sub section investigates to level of staff competency

in provision of family planning services and its influence on family planning projects in Kirinyaga County

4.5.1 Respondents' Satisfaction Level with Info Received On Adopted FP Method

The extent to which medical staff, varnish the reproductive men and women with details attributed with various family planning methods, play an instrumental role in uptake of family planning initiative. In this essence the study sought to determine the respondent's degree of satisfaction with information provided on FP method adopted. The analysis was shown in table 4.15;

Table 4.15 Degree of satisfaction with information provided on FP method adopted

Opinion	Frequency	Percentage
Yes	293	84.4
No	54	15.6
Total	347	100.0

Table 4.15 shows the respondent's degree of satisfaction with information provided on FP method adopted, from the research findings, majority of the respondents as shown by 84.4% agreed that to be satisfied with the information and the method they had requested on that day whereas % indicated not. This implies that majority of the respondents were fairly satisfied with the quality of service provided by staff.

4.5.2 Satisfaction with Skills/Service of the Staff in the Clinic

As argued in the literature, client's level of satisfaction in relation to extensiveness with staff ability and provision of FP method determined the choice of FP method uptake in every clinic, in this essence respondent's level of satisfaction with the skills/service of the staff in clinic was considered essential in success of family planning initiatives by the Kirinyaga county government .The analysis were shown in table 4.16;

Table 4.16 :Level of satisfaction with skills/service of the staff in the clinic

Opinion	Frequency	Percentage
Yes	326	93.9
No	21	6.1
Total	347	100.0

Table 4.16 shows the respondent's level of satisfaction with the skills/service of the staff in the clinic, from the findings; majority of the respondents as shown by 93.9% indicated that they were well satisfied with skills/service of the staff in this clinic whereas 6.1% of the respondents were of the of the contrary opinion. This implies that considerable numbers of FP users were satisfied with skills/service of the staff in this clinic.

4.5.2 Staffs Friendliness

Effective provision of medical services depends on welcoming levels with medical workers in every healthy facility, as argued in the literature staffs friendliness may influence patient's decision to re-see medical help in the same facility or shift. Likewise, the success of family planning (sub-set of primary health care) initiatives by the Kirinyaga county government relies of extent to which medical staff exercise public relations, therefore the study sought to determine the extent to which medical staff influenced the uptake of FP methods among reproductive women. The analysis was shown in table 4.17;

Table 4.17: Staff friendliness

Opinion	Frequency	Percentage
Yes	293	84.4
No	54	15.6
Total	347	100.0

Table 4.17, shows results on respondent's perception on medical staff's friendliness during the clinical visit, as per the results, majority of the respondents as shown by 84.4% agreed that hospital staff were friendly whereas 15.6 % of the respondents indicated otherwise. This implies that considerable numbers of respondents were served in cautious friendly manner.

4.5.3 Whether the Respondent Could Recommend His Friend for Family Planning In the Clinic

The study sought to establish whether respondents would recommend his friend to come for family planning in the same clinic. The analysis was shown in table 4.18 ;

Table 4.18: Whether the respondent could recommend his friend for family planning in the clinic

Opinion	Frequency	Percentage
Yes	267	76.9
No	80	23.1
Total	347	100.0

From the research findings as shown in table 4.18, majority of the respondents as shown by 76.9% indicated that they would recommend his friend to come for family planning in the same clinic, whereas 23.1% indicated otherwise. This implies that majority of the respondent would recommend his friend to come for family planning in the same clinic.

Further investigations on reasons as to clients who would recommend their friend to seek family planning in the same clinic, praised the facility for, excellent service in terms of patient handling, provision of medical information, high level of operational efficiency, greater value for clients and reliability of their services .

Investigation on those who declined to recommend their friend to seek family planning in the same clinic, blamed the facility for poor service, i.e. unfriendliness with the staff, limited family planning programs, hidden miscellaneous charges long queues.

4.5.4 Suggestions for Improving the Family Planning Services

Respondents were requested to give suggestion for improving the family planning services of offered in the facility. The analysis was shown in table 4.19 ;

Table 4.19: Areas that required improvement

Area that required improvement	Frequency	Percentage
Staff skill	175	50.4
Customer care	172	49.6
Total	347	100.0

Table 4.19 shows suggestions for improving the family planning services, based on the finding, 50.4% of the respondents suggested that the management of the hospital needed to improve on staff skill 49.6% of the respondents suggested that the management of the hospital needed to improve on customer care service. This implies that in view of improving the family planning services healthy facilities needed improved on staff skill development and customer care service.

4.6 Accessibility

Accessibility to family planning programs is the key to performance of family planning projects in Kirinyaga County, providing family planning services through various outlets like clinics, pharmacy, health facilities, and helps clients to obtain services easily, easy access as a necessary tool in removing unnecessary medical barriers. In this essence establishing the level of family planning programs accessibility deemed important in performance of family planning projects in Kirinyaga County.

4.6.1 Proximity to the Healthy Facility

Establishing proximity to the healthy facility was important in determining the respondent's uptake of family planning. The transportation cost as argued in the literature was seen as a key consideration uptake of family planning method by reproductive mothers, the research therefore sought to establish the distance between respondent's home and the family planning clinic. The analysis was shown in table 4.20;

Table 4.20: Proximity to the healthy facility clinic

Distance	Frequency	Percentage
Less than 2 km	54	15.6
2 km to 4 km	70	20.2
4 km to 7 Km	91	26.2
more than 7 Km	132	38.0
Total	347	100.0

Table 4.20, shows the investigation on proximity between respondent's home and the family planning clinic, From the research findings, majority of the respondents as shown by 38.0 % indicated that the healthy facility was located more than 7 Km from their home, 26.2% of the respondents indicated the healthy facility was located 4 km to 7 Km from their home 20.2% of the respondents indicated that the healthy facility was 2 km to 4 km whereas 15.6% of the respondents indicated the healthy facility was located Less than 2 km from their home. This implies that majority of the respondents had to travel more than 7 Km before they could get to the local family planning clinic.

4.6.2 Common Transport Means Used By FP Users

The distance from clients resident to healthy facility is directly related to the transport cost charged, this mean that transport means is also directly associated with choice or mode of transport to be adopted and may influence clients morale to seek such services depending on affordability. Transport charge therefore becomes an influential factor in uptake of FP method, in this essence the study sought to determine the influence of transport means on performance of family planning projects in Kirinyaga County. The analysis was shown in table 4.21 below;

Table 4.21: Means of transport used by FP users

Means of transport	Frequency	Percentage
Walking	63	18.2
Motorbike	49	14.1
Public vehicle	200	57.6
Own vehicle	35	10.1
Total	347	100.0

Investigation on common transport means used by FP users as shown in table 4.21 show that majority of the respondents as shown by 57.6% used Public vehicle to get to the family planning clinic, 18.2% of the respondents indicated that they walked all the way to the family planning clinic, 14.1% of the respondents indicated that they used Motorbike to get to the family planning clinic whereas 10.1% of the respondents that they indicated they used their own vehicle to get to the family planning clinic. This implies that majority of the respondents used Public transport means to get to the family planning clinic.

4.6.3 Transport Cost Incurred To Get To the Family Planning Clinic

Respondents were requested to indicate the transport cost incurred to get to the family planning clinic. The analysis was shown in table 4.22;

Table 4.22: Transport cost incurred

Transport cost in KSH	Frequency	Percentage
Less than Ksh 50	9	2.6
Ksh 51-100	105	30.3
Ksh 101-200	100	28.8
Above Ksh 200	70	20.2
no transport fee Incurred (I walk)	63	18.2
Total	347	100.0

From the research findings as shown in table 4.22, majority of the respondents as shown by 30.3% indicated that they incurred between Ksh 51-100 to get to the family planning clinic, 28.8% of the respondents indicated that they incurred between Ksh 101-200 to get to the family

planning clinic, 18.2% of the respondents indicated that they incurred no transport fee as they walked to the family planning clinic, whereas 2.6 % of the respondents indicated that they incurred less than Ksh 50 to get to the family planning clinic. This implies that majority of the respondents incurred between Ksh 101-200 to get to the family planning clinic. The study also noted that the greater the distance the higher the transport cost.

4.6.4 Other Service Providers Who Offer Family Planning

The study sought to establish whether other than health facility, are there other service providers who offer family planning at the village. The analysis was shown in table 4.23;

Table 4.23: Other family planning service providers

Opinion	Frequency	Percentage
Yes	347	100.0
Total	347	100.0

Table 4.23 shows the results on whether there existed other FP service providers at the village level other than county health facilities, from the research findings; all the respondents as shown by 100% response rate agreed that there were there were other service providers who offer family planning at the village besides health facility.

4.6.5 Other Family Planning Providers

The study sought to establish whether other service providers who offer family planning at the village. The analysis was shown in table 4.24;

Table 4.24 Other Family planning providers

Other Family planning providers	Frequency	Percentage
Private Clinics	136	39.2
Chemists	201	57.9
Community Health Volunteers	0	0
Total	347	100.0

Table 4.24, shows results on other service providers who offer family planning at the village, from the research findings, majority of the respondents as shown by 57.9% indicated that Chemists second leading FP service providers after county health facilities, followed by This implies that among the local medics providing family planning al local level included chemists, and private clinics.

4.7 Affordability

The cost of family planning service is an important determinant on adoption and use of family planning service, socioeconomic factors of the woman and also the, woman’s perception in terms of the facility/provider factors such quality, user fees charged for family planning services, and proximity of the family planning facility influence the uptake of family planning service. Under this sub section the study investigates the influence of affordability on performance of family planning projects in Kirinyaga County.

4.7.1 Education Level

Different studies as reveled in the literature show a strong positive correlation between uptake of family planning initiative and individual level of education. The study therefore sought to determine respondent’s level of education. The analysis was shown in table 4.25;

Table 4.25: Education level

Education level	Frequency	Percentage
Class 5-8	198	57.1
Form 3-4	92	26.5
Certificate/diploma	43	12.4
Degree and above	14	4.0
Total	347	100.0

Investigations on respondents level of education level as showed table 4.25 show that majority of the respondents as shown by 57.1% indicated were Class 5-8,,26.5% of the respondents indicated their highest education qualification as form 3-4, 12.4% of the respondents indicated Certificate/diploma, whereas 4 % of the respondents indicated Degree and above. This implies that literacy levels amongst reproductive women in Kirinyaga County are relatively low.

4.7.2 Husbands' education level

Literacy levels amongst male spouses were perceived to be influential in convincing their female spouses in uptake of family planning method. In this essence the study sought to determine influence of male spouse's literacy in uptake of FP method in every family. The analysis was shown in table 4.26;

Table 4.26: Husbands' education level

Husbands' education level	Frequency	Percentage
Class 5-8	155	65.7
Form 3-4	45	19.1
Certificate/diploma	22	9.3
Degree and above	14	5.9
Total	236	100

Investigations on respondents husbands' education level as shown table 4.26 depict that majority of the respondents' husbands' as shown by 65.7% indicated class 5-8, 19.1% of the respondents indicated their husbands highest level of education as form 3-4 9.3% of the respondents indicated their husbands highest level of education as certificate/diploma whereas 5.9% of the respondents indicated degree and above their husbands' highest. This implies that literacy levels amongst the spouses of reproductive women in Kirinyaga County are relatively low.

4.7.3 Current occupation

The study sought to determine the respondent's current occupation. The analysis was shown in table 4.27;

Table 4.27: Current occupation

Current occupation	Frequency	Percentage
Formal Employment	63	18.2
Self Employment	139	40.1
Casual employment	111	32.0
Un Employment	34	9.8
Total	347	100.0

Table 4.27 shows the distribution of respondent in respect to current occupation, from the research findings most of the respondents as shown by 40.1% indicated that they were in self-employment, 32.0% of the respondents indicated that they were in casual employment 18.2% of the respondents indicated that they were in formal employment whereas 9.8% of the respondents indicated that they were in unemployment this implies that majority of the respondents were in informal employment.

4.7.4 Average Monthly Household Income

Respondents were requested to indicate the average total monthly household income, from the research findings .The analysis was shown in table 4.28 ;

Table 4.28: Average monthly household income

Average Monthly Household Income	Frequency	Percentage
Below Ksh 2500	103	30
Ksh 2500-5000	174	50
Ksh 5000-10000	70	20
Total	347	100.0

Table 4.28 shows the average total monthly household income, from the research findings, the study revealed most of the families as shown by 50% earned an average household income of Ksh 2500-5000, 30% of the respondents indicated that the family earned an average household income not exceeding Ksh 2500.4%while 20%of the respondents indicated that the family earned an average household income of Ksh 5000-10000. This implies that the average total monthly household income in most of the families raged between Ksh 2500-5000.

4.7.5 Amount Charged On Family Planning Service

Respondents were requested to indicate the amount charged on family planning service .The analysis was shown in table 4.29;

Table 4.29: Amount charged on family planning service

Amount in KSH	Frequency	Percentage
Free	116	33.4
Ksh 0-50	80	23.1
Ksh 51-100	86	24.8
Ksh 101- 200	33	9.5
Ksh 200-1000	32	9.2
Total	347	100.0

Table 4.29, shows the amount charged on family planning service, from the research findings, majority of the respondents as shown by 33.4% indicated that the service was offered to them at a free cost, 24.8% of the respondents indicated that they paid between Ksh 51-100 family planning service, 23.1% of the respondents indicated that they paid less than Ksh 0-50 for family planning service 9.5% of the respondents indicated that they paid between Ksh 101-200 family planning service whereas 9.2% of the respondents indicated that they paid between Ksh 200-1000 for family planning service.

4.7.6 Respondents Level of Satisfaction with the Fee Charged

The research sought to determine the respondent's level of satisfaction with the fee charged. The analysis was shown in table 4.30 ;

Table 4.30: Whether the respondents were satisfied with the fee charged

Opinion	Frequency	Percentage
Yes	315	90.8
No	32	9.2
Total	347	100.0

Table 4.30 show respondents level of satisfaction with the fee charged, as per the study results, majority of the respondents as shown by 90.8% were satisfied with the fee charged whereas 9.2% indicated not. This implies that considerable numbers of respondents were content with the amount charged on their choice of family planning method.

4.8 Response from Service Providers

This section shows the analyses of the service providers.

4.8.1 General Information

The study sought to establish the background information of the respondents including respondents' gender, age group, job designation and period in medical practice.

4.8.2 Gender Distribution

Family planning service providers were requested to indicate their gender category. The analysis was shown in table 4.31;

Table 4.31: Gender distribution

Gender	Frequency	Percentage
Male	7	58.3
Female	5	41.7
Total	12	100.0

Table 4.31 the study established that majority of the respondents as shown by 58.3% were females whereas 41.7% were males. This implies both males and women clinical service providers were fairly engaged in this research. The analysis was shown in table 4.32 below;

Table 4.32: Age Distribution of the service respondents

Age category	Frequency	Percentage
Below 30 years	3	25.0
31 to 40 years	3	25.0
41-50 years	3	25.0
51-59 years	3	25.0
Total	12	100.0

Table 4.32 show age distribution among clinical service providers, the finding show equal distribution of respondents across all the age groups with each cadre recording 25% response rate, this implies that respondents were equitably distributed in terms of their age.

4.8.3 Profession

The study sought to determine the respondent's job designation. The analysis was shown in table 4.33;

Table 4.33 : Profession

Profession	Frequency	Percentage
Clinical Officer	3	25
Nurse	9	75
Total	12	100.0

The study results on profession as shown in table 4.33 show that majority of the respondents as shown by 75% worked as nurses whereas 25% of the respondents indicated worked as clinical doctors; this implies that respondents engaging in various areas of clinical practice were fairly engaged in this research.

4.8.4 Period in clinical practice

The study sought to determine the period which the respondent had been in clinical practice. The analysis was shown in table 4.34;

Table 4.34: Period in clinical practice

Period of practice	Frequency	Percentage
1-5 years	3	25.0
6-10 years	4	33.3
10-20 years	5	41.7
Total	12	100.0

Table 4.34 shows the period which the respondent had been in clinical practice, from the research findings, most of the respondents as shown by 41.7% indicated that they had in medical practice for a period of 10-20 years, 33.3% indicated that they had in medical practice for a period of 6-10 years whereas 25.0% indicated that they had in medical practice for a period of 1-5 years. This implies that majority of the respondents have been in medical practice for a considerable period of time and thus they were in a position to give credible information based on their years in practice.

4.8.5 Factors Influencing Performance of Family Planning Projects

Table 4.35 Statements relating to Family Planning Projects

Statements	Strongly Disagree	Disagree	Neither Agrees Or Disagrees	Agree	Strongly Agree	Mean	Std Deviation
I have received formal training on Family Planning and Reproductive Health in the past three years (6wks course)	0	0	0	41.7%	58.3%	4.58	0.51
I have attended a continuous medical education or on job training on family planning in the past one year	0	0	0	41.7%	58.3%	4.58	0.51
I have the acquired on the job right knowledge and skills that is needed to offer family planning?	0	0	0	58.3%	41.7%	4.42	0.51
I counsel every client on all family planning methods before issuing her with a method.	0	0	8.3	75.0%	16.7%	4.08	0.51
I am competent to offer family planning to teenagers who are sexually active below 20year (including school going boys and girls)	0	0	16.7	58.3%	25.0%	4.08	0.67
I am competent to mentor medical students on family planning	0	0	0	50.0%	50.0%	4.50	0.52

The research sought to determine the level of responded agreement with the above statements relating to medical practitioners competence in provision of family planning. From the research findings majority of the medical personnel strongly agree that they had attended a continuous medical education or on job training on family planning in the past one year, majority of medical care givers indicated to have received formal training on family planning and reproductive health in the past three years (6wks course) as shown by mean of 4.58, medical care givers indicated that they were competent to mentor medical students on family planning as shown by mean of 4.50.

The study further established that majority of the medical practitioners had acquired on the job right knowledge and skills that is needed to offer family planning as shown by mean of 4.42, and that medical practitioners counseled every client on all family planning methods before issuing them with a method, majority of the medical practitioners indicated that they were competent to offer family planning to teenagers who are sexually active below 20 year(including school going boys and girls) as shown by mean of 4.08 in each case.

4.8 Inferential statistics

The study used inferential statistics to make inferences based on probability.

4.8.1 Pearson Correlation Analysis

After the descriptive analysis, the study conducted Pearson correlation analysis to indicate a linear association between the predicted and explanatory variables or among the latter. It, thus, help in determining the strengths of association in the model, that is, which variable best explained the relationship between the variables. The analysis was shown in table 4.36 ;

Table 4.36: Correlations table

		Performance Of Family Planning Projects	Contraceptive Security	Staff Competence	Family Planning Accessibility	Family Planning Affordability
Performance Of Family Planning Projects	Correlation Coefficient	1.000				
	Sig. (2-tailed)	.				
	N	347				
Contraceptive Security	Correlation Coefficient	.553	1.000			
	Sig. (2-tailed)	.001	.0012			
	N	347	347			
Staff Competence	Correlation Coefficient	.711	.142	1.000		
	Sig. (2-tailed)	.003	.011	.004		
	N	347	347	347		
Family Planning Accessibility	Correlation Coefficient	.672	-.037	.046	1.000	
	Sig. (2-tailed)	.002	.000	.001	.	
	N	347	347	347	347	
Family Planning Affordability	Correlation Coefficient	.644	.001	.008	.124	1.000
	Sig. (2-tailed)	.000	.001	.003	.000	.
	N	347	347	347	347	347

On the correlation of the study variable, the researcher conducted a Pearson moment correlation. From the finding in the table 4.35, the study found a strong positive correlation between performance of family planning projects and contraceptive security as shown by

correlation factor of 0.553, this strong positive relationship was found to be statistically significant as the significant value was 0.001 which is less than 0.05. The study also found strong positive correlation between performance of family planning projects and staff competence as shown by correlation coefficient of 0.711, this too was also found to be statistically significant at 0.003 confidence level. the study further found a strong positive correlation between performance of family planning projects and family planning accessibility as shown by correlation coefficient of 0.672, this too was also found to be statistically significant at 0.002 confidence level and finally the study also found a strong positive correlation between performance of family planning projects and family planning affordability as shown by correlation coefficient of 0.644 at 0.000 level of confidence.

The findings concur with Franks and Sharma and Dayaratna (2004), who found out that strong positive correlation between family planning affordability and performance of family planning projects. The findings further agree with Douglas Huber, et al (2008), who found out that strong positive correlation between Contraceptive Security and sustainability of family planning projects.

4.9 Regression Analysis

In this study, a multiple regression analysis was conducted to test the influence among predictor variables. The research used statistical package for social sciences (SPSS V 21.0) to code, enter and compute the measurements of the multiple regressions. The model summary are presented in the table 4.37;

4.9.1 Model Summary

Table 4.37: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.887 ^a	.787	.753	.37290

From the value of the adjusted R², also called the coefficient of multiple determinations, is the percent of the variance in the dependent explained uniquely or jointly by the independent variables. The model had an average coefficient of determination (R²) of 0.753 and which implied that 75.3% of the variations in performance of family planning projects in Kirinyaga

county are caused by the independent variables understudy (contraceptive security, staff competence family planning accessibility and family planning affordability).

4.9.2 Analysis Of Variance

The study further tested the significance of the model by use of ANOVA technique. The findings are tabulated in table below 4.38 ;

Table 4.38: Summary of One-Way ANOVA results

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	59.72	4	14.93	5.59	.003 ^b
	Residual	945.18	354	2.67		
	Total	1004.9	358			

F critical = 2.79

From the ANOVA statics, the study established the regression model had a significance level of 0.3% which is an indication that the data was ideal for making a conclusion on the population parameters as the value of significance (p-value) was less than 5%. The calculated value was greater than the critical value ($5.59 > 2.79$) an indication that contraceptive security, staff competence family planning accessibility and family planning affordability all have a significant effects on performance of family planning projects in Kirinyaga county. The significance value was less than 0.05 indicating that the model was significant.

4.9.3 Coefficients

In addition, the study used the coefficient table to determine the study model. The findings are presented in the table below 4.39;.

Table 4.39 Table of Coefficients

The following tables gives the coefficients which helps in establishing the regression line

Model	Unstandardized		Standardized	t	Sig.
	Coefficients				
	B	Std. Error	Beta		
1 (Constant)	-	.3294		-2.234	.000
	.736				
Contraceptive Security	.464	.141	.452	3.291	.019
Staff competence	.535	.097	.529	5.515	.014
Family Planning Accessibility	.446	.103	.433	4.330	.002
Family Planning Affordability	.563	.112	.552	5.027	.011

The established regression equation was

$$Y = (-0.736) + 0.464X_1 + 0.535X_2 + 0.446 X_3 + 0.563 X_4$$

The regression results show that that a unit increases in contraceptive security would increase the performance of family planning projects in Kirinyaga county by a factor of 0.464, a unit increase in staff competence would enhance the performance of family planning projects in Kirinyaga county by a factor of 0.535 and vice versa, also a unit increase in family planning accessibility would enhance the performance of family planning projects in Kirinyaga county by a factor of 0.446 and vice versa, also a unit increase in family planning affordability would enhance the performance of family planning projects in Kirinyaga county by a factor of 0.563 and vice versa

The analysis was undertaken at 5% significance level. The criteria for comparing whether the predictor variables were significant in the model was through comparing the obtained probability value and $\alpha=0.05$. If the probability value was less than α , then the predictor variable was significant otherwise it wasn't. All the predictor variables were significant in the model as their probability values were less than $\alpha=0.05$

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The following chapter presents a summary of the study findings and comes up with conclusions based on the outcome of the data collected and analyzed. From the analysis and data collected, the following discussions, conclusion and recommendations were made. The responses were based on the objectives of the study. The sought to determine how contraceptive security influence the performance of family planning projects in Kirinyaga County, to examine how staff competence influence the performance of family planning projects in Kirinyaga County, to find out how accessibility influence the performance of family planning projects in Kirinyaga County and to establish how Affordability influence the performance of family planning projects in Kirinyaga County.

5.2 Summary of the Findings

The following section explains the summary of the findings as per the objectives of the study and data analysis

5.2.1 Contraceptive Security

From the findings, the study notes that provision of contraceptive security enhanced the performance of family planning projects in Kirinyaga County as users were presented with wide range of FP methods from which they could choose from, it also granted users the autonomy to choose high-quality contraceptives and condoms for family planning and therefore enhancing FP objective of preventing HIV/AIDS and other sexually transmitted infections.

5.2.2 Staff Competence

The research deduces that staff competence was key in promoting performance of family planning projects in Kirinyaga County, healthcare workers played a critical role in creating awareness on family planning services which enhanced chances of uptake, competent health workers were in a better position to convince young reproductive women to consider uptake of family planning measures than any other advocacy means.

5.2.3 Accessibility

Results on Accessibility showed that, ensuring accessibility of FP programs especially at very local level promoted the performance of family planning projects in Kirinyaga County, The study also notes that Failure of the supply chain or logistics system causes an erratic supply of contraceptives, which may result in loss of credibility and eventual failure of the family planning program and that Ensuring the continuous availability of contraceptives at the client level is a key contributor to increasing the use of family planning services.

5.2.4 Affordability

Research findings on affordability showed that the cost of family planning service is an important determinant of the use of family planning services thus county government programs must find a way to ensure that services remain available to those who cannot pay. Poverty and longstanding County regional inequities also perpetuate the exclusion of many people from accessing effective contraception in Kirinyaga County.

5.3 Discussion of the findings

5.3.1 Contraceptive Security

From the findings, the study noted that ensure successful a family planning programs Kirinyaga, there is need to provide contraceptive security, whereby people are able to choose, obtain, and use high-quality contraceptives whenever they want them. Offering a full range of contraceptive options is also important. the findings are in line with the research by Julie,(2011) ‘on reproductive health commodity security’, defines that Contraceptive security exists when every person is able to choose, obtain, and use high-quality contraceptives and condoms for family planning and for the prevention of HIV/AIDS and other sexually transmitted infections

The research further noted that the systematic tracking of contraceptive security (CS) indicators can be an effective way for Kirinyaga County to regularly monitor planning projects status and inform decision making, advocacy, and program planning. Systematic tracking of contraceptive security can provides an opportunity for stakeholders at Kirinyaga County to look at trends across the related five component areas (leadership and coordination, finance

and procurement, commodities, policies, and supply chain). the findings are in support of the research findings by Owens, et al, (2003) that contraceptive security requires planning and commitment on several levels to ensure that the necessary commodities, equipment, and other supplies are always available.

Further, the study established that provision of contraceptive security presents to reproductive men and women with various choices of FP method from which one can adopt, among the common family planning currently being used by women in Kirinyaga County include pills, abstaining from sex, inject ables, IUD, implants and condoms. the decision by the responded to continue with uptake of family planning method were indirectly influence by various factors like cost, availability, level of comfort based on experience with certain FP method and altitude among others. The study noted that at some point women changed from previous family planning methods due to side effects or cost related factors, periodically some of women in family planning missed to get their choice of family planning method family planning service due to stock out in the facility.

5.3.2 Staff Competence

The study noted that family planning healthy workers played a critical role in creating awareness on family planning services, competent health workers were in a better position to convince young reproductive women to consider uptake of family planning measures than any other advocacy means. The findings supports the literature by Bonnie, (2013) that appropriately trained competent health workers are an essential component of family planning progress. further the study noted that Provision of sufficient numbers of properly trained competent health care workers to deliver adequate health services in Kirinyaga County should be treated as matter of urgency, the Growing staff shortages in healthy facilities and community health workers repress performance of family planning projects in Kirinyaga County, seriously impacting provision of family planning service to the community. The findings are in line with the argument by Lutalo et al., (2000) that the quality of provider interaction and client should be improved by retraining the providers, provider knowledge and understanding of the methods and procedures should be improved, printed materials should be made available to interested clients.

Further, the study revealed that majority of the family planning users were fairly satisfied with the quality of service provided by staff, considerable numbers of FP users were satisfied with skills/service of the staff in the clinic, considerable numbers of respondents were served in cautious friendly manner, that majority of the FP users would recommend his friend to come for family planning in the same clinic, Further investigations on reasons as to clients who would recommend their friend to seek family planning in the same clinic, praised the facility for, excellent service in terms of patient handling, provision of medical information, high level of operational efficiency, greater value for clients and reliability of their services ,the findings are in line in the research by Kak,et al, (2001), dissatisfied patients normally blamed the healthy facility for poor service, including unfriendliness with the staff, limited family planning programs, hidden miscellaneous charges long queues.

5.3.3 Accessibility

The study established that accessibility to family planning programs enhanced the performance of family planning projects in Kirinyaga County, providing family planning services through various outlets like clinics, pharmacy, health facilities, and helped clients to obtain services easily, easy access as a necessary tool in removing unnecessary medical barriers. Majority of the family planning users had to travel more than 7 Km before they could get to the local family planning clinic. the findings concur with research by PATH and UNFPA,(2006), that The distance from clients resident to healthy facility is directly related to the transport cost charged, the mode of transport was also directly associated with choice or mode of transport to be adopted and thus influenced clients morale to seek FP services depending on affordability, majority of the FP clients used motorbike transport means to get to the family planning clinic, FP clients incurred between Ksh 101-200 to get to the family planning clinic, the study also noted that the greater the distance the higher the transport cost.

Further the research noted that there were there were other service providers who offer family planning at the village besides health facility, among the local medics providing family planning al local level included chemists, private clinics, community health volunteers, and traditional birth attendance. The study also notes that Failure of the supply chain or logistics system causes an erratic supply of contraceptives, according to INFO Project Center for Communication Programs (2008) this may result in loss of credibility and eventual failure of

the family planning program, ensuring the continuous availability of contraceptives at the client level is a key contributor to increasing the use of family planning services, the findings are in support of the argument by Nguyen et al, (2002), that family planning programs depend on the uninterrupted flow of contraceptives through multiple levels of the supply chain, ranging from central warehouses to health clinics and community-based distributors.

5.3.4 Affordability

The study noted that the cost of family planning service is an important determinant of the use of family planning services. Government health facilities in Kirinyaga County offered the services free of charge; proximity was considered an ideal proxy for price of the contraceptives. The further away from the facility a respondent is the higher would be transport cost or transaction cost of accessing the facility. The findings are in support of findings by Adam, (2011) that Family planning was one of the health components that needed to be covered by the insurance to ensure that women of reproductive age were able to afford family planning services and hence get method of choice without straining.

The study also noted that Poverty and longstanding County regional inequities also perpetuate the exclusion of many people from accessing effective contraception in Kirinyaga County, according to health care providers it is hard to keep services affordable and ensure that people can choose, obtain, and use high-quality contraceptives whenever they want them. the findings affirms the call by Sharma and Dayaratna (2004) Due to shortage of commodities in public facilities, patient go to seek services in private facilities which is not affordable to many women.

The study noted that demographic and socioeconomic factors of the woman and also the, woman's perception in terms of the facility/provider factors such quality, user fees charged for family planning services, and proximity of the family planning facility. Woman's income level, proximity to the provider and the religious background of the woman and level of education, determined the uptake of contraceptive use.

5.4 Conclusions

The study established that ensuring the continuous availability of contraceptives at the client level is a key contributor to increasing the use of family planning services and that there is need to provide contraceptive security, in order to enable people to choose, obtain, and use high-quality contraceptives whenever they want them, according to Rao, Raja. (2008) contraceptive security requires planning and commitment on several levels to ensure that the necessary commodities, equipment, and other supplies are always available. Therefore the study concludes that ensuring contraceptive security is key in promoting performance of family planning projects in Kirinyaga County

The study noted that family planning healthy workers played a critical role in creating awareness on family planning services, competent health workers were in a better position to convince young reproductive women to consider uptake of family planning measures than any other advocacy means. Therefore the staff competence had a positive influence on the performance of family planning projects in Kirinyaga County.

The study also notes that failure of the supply chain or logistics system causes an erratic supply of contraceptives, which may result in loss of credibility and eventual failure of the family planning program. Ensuring the continuous availability of contraceptives at the client level is a key contributor to increasing the use of family planning services, thus the study concludes that ensuring accessibility of FP methods had a positive influence on the performance of family planning projects in Kirinyaga County.

The study noted though the county health facilities in Kirinyaga offered the FP services free of charge; proximity was considered an ideal proxy for price of the contraceptives. The further away from the facility a respondent is the higher would be transport cost or transaction cost of accessing the facility, thus the study concludes that the cost incurred during the acquisition of family planning services to some extent hindered the performance of family planning projects in Kirinyaga County.

5.5 Recommendations

In view of enhancing contraceptives security, there is need to ensure uninterrupted supply of a variety of contraceptives so that clients can choose and use their preferred method without interruptions this was associated with positive performance of family planning programs . In view of enhancing affordability, the County government should come up with a more decentralized approach in health service provision, this will help to wave other miscellaneous cost incurred in seeking of seek FP services such as transport cost. Higher incentives can be given to people willing to go seek FP services from the nearby health centers.

In view of enhancing accessibility of family planning programs, community based distributors in Kirinyaga County should be revived and enhanced, promotion of family planning education and activities at the household level should be accorded priority. There is also need for formation of lobby groups to enhance cultural change, awareness creation and counseling. The county government should come up with staff development programs especially to health care providers, this should be done in view of enhancing competence among the health care providers, it is also important for the county government to recognize the role of community healthy and volunteers in effort of lobbying for family planning uptake. The county government programs must find a way to ensure that services remain available to those who cannot pay. There is need for greater recognition of Health Assistants (HA) at the local community; Health Assistants should be thoroughly trained on primary health care services such as advocacy on family planning uptake

5.6 Suggestions for Further Research

The study recommends that future studies;

- i. Should aim to broaden the factors influencing family planning projects not identified in this study.
- ii. The study also suggests that a study on the factors that affect the use of family planning among women should be conducted.
- iii. This would assist to establish more factors that family planning projects implementers should take into consideration for enhanced family planning project implementation

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APPENDIX I: INTRODUCTION LETTER

JENIFER WAMBUGU,
P.O BOX 24
KERUGOYA
TO WHOM IT MAY CONCERN
DEAR SIR / MADAM,

RE: REQUEST FOR PARTICIPATION IN A RESEARCH STUDY

I am student currently pursuing a Master's Degree in Project Planning and management at the School of Continuing and Distance Education of the University of Nairobi. I am currently undertaking a research on factors influencing performance of family planning projects funded by USAID in Kirinyaga County. This is a part of the requirements for the fulfillment of the course. The findings of this study will be useful in helping to design messages on family planning projects.

The attached questionnaire is therefore intended to seek your views on the various aspects of Family planning among WRA. Please fill it with all sincerity and honesty. The information you provide will be utilized purely for academic purposes and will be treated with utmost confidentiality.

Jenifer Wambugu,
Student (MA. PPM) - L50/81836/2015
University of Nairobi (SCDE)
EMBU.

APPENDIX II: QUESTIONARE FOR WRA

Please tick (✓) in the appropriate box or filling the empty spaces. Kindly respond to all question freely and honestly. Your response will be kept strictly confidential and your name not required.

Section A: Demographic Information (Tick appropriately)

1. Your age in years?

15-24	25-34	35-44	45-54

2. What is your marital status? a) Single/ never married [] b) Married [] c) Separated/ divorced d) Widowed []

a) How many children do you have?

0	1-2	3-4	5-6	7 and above

b) How many are surviving?

0	1-2	3-4	5-6	7 and above

3. Are you looking to have more children?

Yes	No	Undecided

4. If no, how are you preventing pregnancy? Explain

Abstaining	Pills	Injectable	IUD	Implants	Condoms	Others specify

6. What is your religion? a) Catholic [] b) Protestant [] c) Muslim [] d) Others (explain) []

Section: Contraceptive Security

7. Have you ever used family planning method before? YES [] NO []

8 If the answer to question 1 above is yes, which method?

[1] IUCD []

[2] Implants []

[3] Pills []

[4] Tubal ligations []

[5] Inject ables []

[6] Condoms []

9 Which method are you coming for today?

[1] IUCD []

[2] Implants []

[3] Pills []

[4] Tubal ligations []

[5] Inject ables []

[6] Condoms []

10. If different from the above mentioned, why have you changed?

[1] Cost []

[2] Side Effects []

[3] Others (Specify) []

11. Have you ever experienced a situation when you came for family planning services and you missed to get your choice of family planning SERVICE due to stock out in your facility?

[1] YES [] [2] NO []

12. If the answer to question 5 above is yes, how many times have you experienced stock out?

1-2	3-4	5-6	LOST COUNT

Section C: Staff competency

13. Do you feel you received the information and the method you requested today?

[1] YES [2] NO

Yes	No	NON COMMITAL

14. Were you satisfied with the skills/SERVICE of the staff in this clinic? Explain

15. Were your questions answered during the visit?

[1] YES [2] NO

Yes	No	NON COMMITAL

16. Were the staffs friendly during the visit?

[1] YES [2] NO

Yes	No	NON COMMITAL

17. Will you recommend your friend to come for family planning in this clinic?

[1] YES [2] NO

Yes	No	NON COMMITAL

18. If yes, why?

19. If no, why?

20. Do you have any suggestions for improving the family planning services offered in this facility?
? TICK THE AREAS THAT NEED IMPROVEMENT IN ORDER OF PRIORITY

STAFF SKILL	CUSTOMER CARE	AVAILABILITY OF OPTIONS	ETC	ETC

Section D: Accessibility

21. What is the distance between your home and the family planning clinic?

a) Less than 2 km []

b) 2 km to 4 km []

c) More than 4 km []

1-2	3-4	5-6	7 and above

22. What means of transport do you use to come for family planning services

a) Walking []

b) Motorbike []

c) Public vehicle []

d) Own vehicle []

23. How much money do you use on transport from your house to the facility?

<50	51-100	101-200	>200

24. Other than health facility, are there other service providers who offer family planning at the village?

[1] YES []

[2] NO []

26. If yes who are they ?

Traditional birth attendance /	PRIVATE CLINICS	Chemists	Others specify	Community health Volunteers

Section E: Affordability

27. What is your education level?

NO FORM AL EDUC	ADUL T EDUC	CLAS S 1-4	CLAS S 5-8	FOR M 1- 2	FOR M 3- 4	CERTIFICATE/DIPL OMA	DEGR EE AND ABOV E

28. If married, what is your husbands' education level?

NO FORM AL EDUC	ADUL T EDUC	CLAS S 1-4	CLAS S 5-8	FOR M 1- 2	FOR M 3- 4	CERTIFICATE/DIPL OMA	DEGR EE AND ABOV E

--	--	--	--	--	--	--	--

29. What is your current to occupation?

FORMAL EMPLOYMENT	SELF EMPLOYMENT	OTHERS SPECIFY

30. What is the average TOTAL monthly HOUSEHOLD income in your family?

<2500	2500-5000	5000-10000	10000-20000	20000-40000	Above 40000

31. How much did you pay for family planning service?

NOTHING	0-50	51-100	101- 200	200-1000	1001 AND ABOVE

32. Were you satisfied with the fee charged?

[1] Yes []

[2] No []

[3] Any other specify []

[4]non committal []

APPENDIX III: FOR SERVICE PROVIDERS

Instructions the purpose this interviews to gather information the services provider relevant to the of study. Please tick (√) in the appropriate box or fill in the empty spaces. Kindly respond to all questions freely and honestly. Your response will be kept strictly confidential and you names are not required

General Information

1. Gender

[1] Male [] [2] Female []

2. What is your age.....

< 30	30-40	40-50	50-59

3. What is your profession?

DOCTOR	NURSE	CLINICAL OFFICER

4. How many years have you been practicing?

1-5 YRS	6-10YRS	10-20 YRS	ABOVE 20 YRS

5. PLEASE ANSWER THE FOLLOWING QUESTIONS ACCORDINGLY

No	Question	Strongly disagree	disagree	neither agrees or disagrees	Agree	Strongly Agree
	I have received formal training on Family Planning and Reproductive Health in the past three years (6wks course)					
2.	I have attended a continuous medical education or on job training on family planning in the past one year					
3.	I have the ACQUIRED ON THE JOB right knowledge and skills that is needed to offer family planning?					
	I counsel every client on all family planning methods before issuing her with a method.					
	I am competent to offer family planning to teenagers who are sexually active below 20year (including school going boys and girls)					
	I am competent to mentor medical students on family planning					