

**FACTORS HINDERING WOMEN'S ACCESS TO AND UTILIZATION OF
FAMILY PLANNING SERVICES IN FUNYULA IN BUSIA COUNTY,
WESTERN KENYA.**

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DECLARATION

This research project is my original work and has not been presented for an award of a degree in any university or other institution

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ABSTRACT

Access to Family Planning services not only assures individual women health but also improves the quality of life for her spouse, her children and the society at large. Utilization of FP services is estimated to save 32% of maternal lives and 10% of child lives. This study therefore sought to explore the factors that hinder women's access to Family Planning Services in Funyula, Busia County. The study adopted a cross sectional descriptive study design which targeted women aged between 18-49 years, health service providers, NGO staff in reproductive health and a local administrator. Data was gathered through survey questionnaires administered to 40 women who were conveniently sampled and supplemented by Focus Group Discussions and Key Informant Interviews administered to 2 health service providers, a local administrator and a NGO staff who were purposively sampled. The quantitative data collected from women was analyzed using SPSS version 20 while qualitative data was analyzed via content and thematic analysis with results presented in form of verbatim. Results from the research indicated that 47.5% of women were using modern FP methods mostly involving pills, implants and injectables, however unmet contraceptive use stood at 25% while contraceptive discontinuation rate was 22.5%. Primarily access to modern FP methods was hindered by acceptability since they were riddled with myths including beliefs that Family planning caused infertility and predispose to giving birth to twins, who were considered culturally unacceptable. Discontinuation of modern FP methods was predominantly blamed on experienced side effects including excessive bleeding, backaches and headaches. Also the study found out that use of modern FP methods increased with increase in women's highest education level and it decreased with decrease in number of living male children and polygamous marriages. Other factors like religion had minimal effect on use of modern FP methods as women went against their religious doctrines and used FP methods despite opposition from their religions. Therefore, the study recommends that there is need for the County Government and other health stakeholders to create public sensitization involving both women and men about modern FP methods so as to increase acceptability. The County Government and National Government should also ensure adequate number of health workers in health facilities to ensure that women are adequately counseled and medical examinations done prior to administration of modern FP methods.

DEDICATION

This Project is dedicated to my parents, Dad and Mom, for being my biggest inspiration and my first teachers, my mom for your unfailing love and encouragement. My father, who has pushed me through my entire career life and your able guidance, for trusting in me and supporting me to complete my studies, for encouraging me to believe in myself. I earnestly feel that I would not be able to go through the tiring process of this research without both of you, May the almighty bless you abundantly and grant you longer lives that you may live to see this candle you have lit, shine throughout my entire life.

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ABBREVIATIONS AND ACRONYMS

DHS	Demographic and Health Survey
FP	Family Planning
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
KDHS	Kenya Demographic and Health Survey
MoH	Ministry of Health
NACOSTI	National Commission of Science, Technology and Innovation
NCPD	National Council of Population and Development
NGOs	Non-Governmental Organizations
SDGs	Sustainable Development Goals
SES	Socio Economic Status
STDs	Sexually Transmitted Diseases
UN	United Nations
USAID	United States Agency for International Development
USD	United States Dollars
WHO	World Health Organization

CHAPTER ONE: BACKGROUND OF THE STUDY

1.1 Introduction

Globally, family planning (FP) is widely acknowledged as an important intervention towards achieving Sustainable Development Goals (SDGs) as it has been proven to reduce maternal and child mortality and entrench human rights for women and girls (Starbird et al., 2016). FP covers a wide range of services concerning women, children and their families including access to birth control, contraceptives, sexual education, and other health resources. Access to FP services can be a major source of knowledge for birth spacing and can help to make known the benefits of birth spacing. Infant mortality can be reduced by such knowledge as it plays a critical role. In addition, Maternal mortality, unwanted pregnancies and births, as well as improving the overall health of the mother, child, and ultimately the welfare of the family unit are, key benefits of Family planning.(Kavanaugh & Anderson, 2013). In a world characterized by dwindling natural resources, burgeoning population growth and escalating levels of poverty, FP has the potential to make enormous contributions to poverty reduction, enhancing sustainable development through the reduction of excessive child birth and stabilizing population growth. Family planning is well known to be crucial in the deterrence of unwanted pregnancies and unsafe abortions as well as the spread of Sexually Transmitted Infections (STIs) including the much threaded HIV/AIDS (USAID, 2008).

As a consequence of the actual and perceived positive impacts of FP, many countries around the globe especially those in Sub-Saharan Africa and Asia where birth rates are still unacceptably high, have embraced FP as one of the means to lessen the rate of infant mortality, improving women and children's health and even reducing the rate of

population growth (UN, 2010). Many countries in Sub-Saharan Africa including Kenya have over the last half a century, made substantial progress not only in promoting FP but also making FP services available and accessible to their citizens (UN, 2010). In Kenya, the government through financial and technical support from donor agencies and development partners has made useful strides in rolling out FP services in the country. The aim of such efforts is to enhance access to and utilization of FP especially by poor people in rural areas and urban slums. This is done against the hope that FP would make very useful contributions to the poverty alleviation, improving maternal and child health, and fostering development (WHO & UNICEF, 2012).

FP in Kenya has been shown to be both a cost-effective and successful means of reducing fertility and birth rates, thus decreasing population growth. Despite concerted efforts by the government and other interested parties to increase uptake and to bridge the gap in unmet FP need through provision of various FP services around the country, access to and utilization of these services remains very low. Over 40 percent of pregnancies in Kenya are unintended; these are either mistimed or unwanted (Mumah, et al., 2014). The high number of unplanned pregnancies is widely associated with unmet need for contraceptives – this is clearly demonstrated by the fact that one in every four married women in Kenya has an unmet need for family planning and the national modern contraceptive prevalence rate is said to be estimated at 39 percent (Tsui, et al, 2010). However there has been a hindrance to this important realization in different parts of the country. Also, persistently high levels of fertility in Kenya combined with declining mortality, have given rise to rapid growth in population (Ngethe, 2014)

One of the key objectives of Kenya's Ministry of Health is to increase access to family planning resources and as well the services offered. However, despite the fact that FP services are widely available, it is evident that the access to these FP services and more so in rural areas is still challenging for many women because of barriers related to distance, indirect costs and harassment and cultural resistance. Also, acceptance of family planning in the country is traditionally low, which is coupled with high cultural resistance to family planning (Sharan, et al, 2011).

Busia County is one of the regions in Kenya that has, over the last few decades, recorded a high and fast growing population and associated shortages of resources caused by, among other things, high fertility rate, early marriages, unmet family planning needs and low education. According to KDHS of 2014, Busia County has one the highest total fertility rates at 4.7 which is projected to be well above the national average total fertility rate of 3.9 (Kenya National Bureau of Statistics [KNBS], 2015). Busia County also experiences high infant and child morbidity and mortality. The Infant mortality rate of the county is currently at at 75 deaths per 1,000 live births ,and this can be easily attributed to high poverty levels (64.2% compared to national poverty level of 45.9%) , inaccessibility of health facilities and the HIV/AIDS menace (Busia County Government, 2015). This state of affairs is largely associated with women's inability to access FP services which are readily available. Large rural populations also add to the problem of acquisition of services. The current study therefore seeks to explore some of the factors that hinder women's access to FP services and the challenges they encounter in the process of trying to access those services in Funyula area of Busia County.

1.2 Statement of the Problem

Family planning is critical in safeguarding individual health rights but also in improving the quality of life for women. The World Health Organization observes that with low contraceptive use coupled with high fertility rates can always contribute to women's and young children's ill health, and yet family planning can avert up to 25–30 per cent of all maternal deaths that occur (WHO, 2015). Lule et al (2015) indicates that access to FP services can decrease the number of healthy years of life that are normally lost due to disability and premature deaths among women and their newborn babies by more than 60%. In Kenya, despite the efforts made to increase the ease of access to and use of family planning services through organizations such as the Ministry of Health and Non-Governmental Organizations, there are still many impediments as the unmet need for family planning still remains high at 26% in 2009 but has decreased to 18% in 2014. However unmet need of FP in rural areas is stagnant at 23% (KNBS, 2015). Furthermore, abortions, unwanted and unplanned births are high as a result of unintended pregnancies (43%) in Kenya (Guttmacher Institute, 2012).

Funyula alike, with women of reproductive age (18-49 years) having a low rate of FP access, share these experiences. (Cherotich & Okwatch, 2014). The state of affairs in this area has resulted into high rates of many children, uneven birth spacing, unwanted pregnancies, unplanned deliveries, unsafe abortions and maternal mortalities. Given the significance of FP in reducing poverty, promoting gender equality and empowerment, it was imperative to undertake empirical research in Funyula to identify and determine the actual factors that hinder rural women from accessing FP services. The study therefore sought to answer the following questions:

1. What FP services are available in Funyula?
2. What are the factors that hinder women's access to FP services in Funyula?
3. What are the factors that hinder women's utilization of FP services in Funyula?

1.3 Objectives of the Study

1.2.1 General objective

To explore the factors that hinder women's access to Family Planning Services in Funyula.

1.2.2 Specific objectives

1. To examine FP services available to women in Funyula.
2. To determine factors that hinder women's access to FP services in Funyula.
3. To identify the factors that constrains women's utilization of FP services in Funyula.

1.4 Assumptions of Study

The study assumed that

1. FP services were readily available to women in Funyula
2. There were factors that hinder women access to FP services in Funyula.
3. There were constrains to women's utilization of FP services in Funyula.

1.5 Justification of the Study

The present study was an attempt to identify the factors hindering women's access to

family planning in Funyula, Busia County. It was therefore anticipated that the findings from the study may shed more light on the challenges encountered by rural women who want to access and use FP services. Such information was deemed to provide a useful basis on which appropriate interventions can be designed to enhance the access to FP for women in this area. . Increased access to FP services can equip women with knowledge and skills that enhances their utilization of reproductive services including FP. This may in turn help reduce population growth and reproductive health problems especially those arising from unwanted pregnancies and births that many women face.

Many studies on FP have been conducted in Kenya. Most of these studies have tended to focus on issues such as utilization of FP services, types of services available, unmet needs for family planning as well the effects of FP on development. The current study therefore will attempt to fill in the gaps in the understanding and in the literature about this important topic.

The findings from the study is useful and of interest especially to researchers and reproductive health stakeholders. It also is of importance to policy makers in the reproductive health sector and to other interested parties on how to enhance access to FP services to ensure that many women are able to benefit from the services. The findings are hopefully useful to policy makers, planners and FP service providers in designing appropriate strategies to enhance access to FP services for women in rural areas

1.6 Scope and Limitations of the Study

The study was conducted in Funyula area and among 40 women aged between 18-49

years old in their reproductive age and living within Funyula. Data was collected from 40 women, 2 health workers, a village elder and 1 NGO staff working with Burinda Community Centre. The other limitation was that because of the small sample size, findings from this study may not be comprehensive enough to be generalized to all women. Thus any conclusions made were limited to the sampled women only. To mitigate against this, the researcher enhanced the generalizability by including focus group discussions with separate groups of women for data triangulation.

1.7 Definition of Terms

Access to FP services- The ability to obtain and make use or utilize family planning services. Access does not only imply the adequacy of supply, but will therefore encompass all of the aspects of utilization which are normally dependant on; physical accessibility of a service, affordability of the service and acceptability of the service.

Family planning- Is a practice which enables people to decide freely and responsibly the number of children, spacing and timing of the children they want

Family planning services -This term will be used to refer to any medical or social activities and educational or informational services in Family planning that facilitate individuals so as to make decisions on the number and spacing of children and to freely choose the means by which they want to achieve this..

Utilization – This is the actual use or consumption of family planning services.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter provides an evaluation of previous studies and review of theory adopted in explaining the relationships of the study variables. The literature reviewed is drawn from many sources including books, journal articles, reports and internet sources.

2.2 Family Planning in Kenya

Family planning in Kenya started in 1960's during the surge of population growth occasioned by higher child survival. Against a backdrop of increased political goodwill, FP services have been rapidly expanded to cover many parts of the country. Unfortunately, diversion of resources to the fight against HIV and AIDS in the 1990s greatly affected government funding to FP for instance in the financial year 2013/2014 Kenya allocated Kshs. 34.7 billion (representing 6% of national budget) of which only Kshs. 0.6 billion were set aside for FP (representing 1.7% of national health budget). This goes against the Abuja Declaration which required African governments to allocate at least 15% of their national budgets to health. This gap in government funding was however filled by NGO and multilateral donor funding (Arrieta et al, 2011). Despite the challenges in government funding, FP efforts in the country has borne fruits as it has seen the country Total Fertility Rate drop from a high of 8 in 1970s to 4.7 children per woman in mid 1990s, and 3.5 in 2014 as shown in Figure 2.1 below (Crichton, 2009; MoH, 2010).

Figure 2.1: Trends in Total Fertility Rate



Source: Knowledge for Health [K4Health] (2016)

Despite the persistent drop in TFR, it is projected that the Kenyan population will increase to from 40 million in 2014 to 83 million by 2050 (Cleland, et al, 2006). This state of affairs points out the need for continued strong financial support for provision of FP services to achieve sustainable population growth. As part of Structural Adjustment Programs championed by the World Bank in 1980s user fees were introduced in the health sector through cost-sharing strategy but FP services were exempted from paying user fees yet at times public health workers demand informal user fees (Tumlinson, et al., 2013). However despite wide subsidization of FP services, the unmet need of contraceptives has registered minimal decline from 28% in 1998 to 18% in 2014. In Western the unmet need for contraceptive is higher than the national average and stood at 20.8% in 2014.

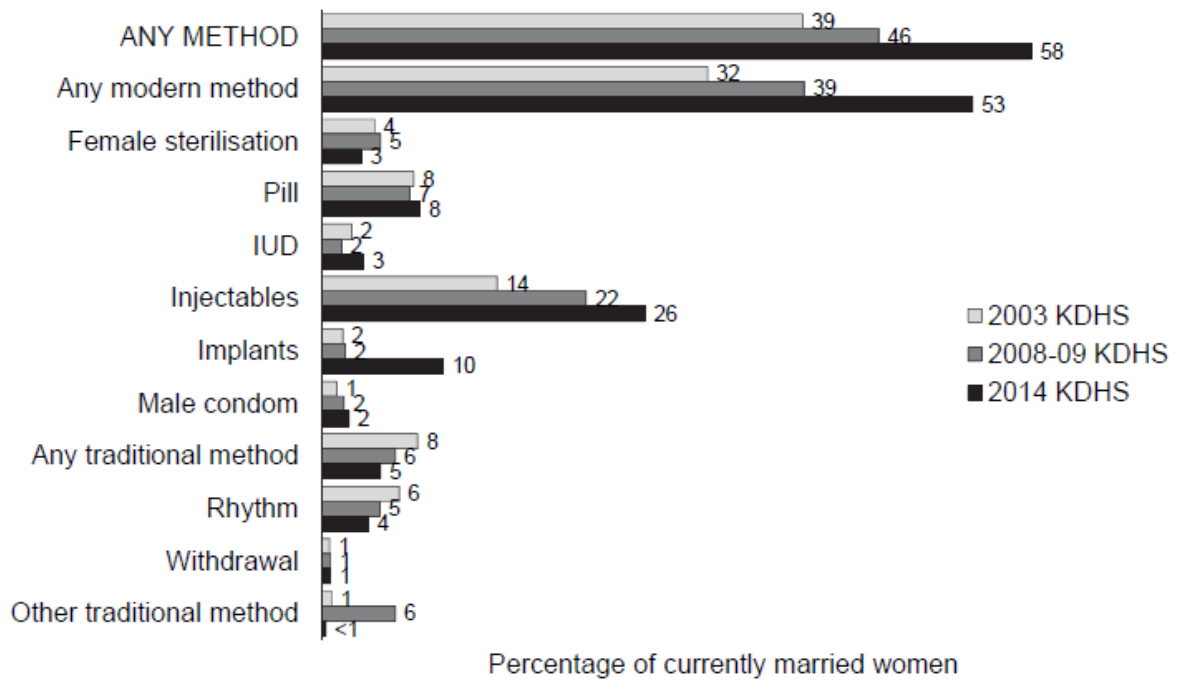
The government introduced the Kenya Reproductive Health Policy in 2007, which at the core champion community based approach to provision of FP services (Mukaba, et al, 2015). This approach is however uncertain as training of community of community health workers is incoherent and therefore can propagate FP

misconceptions among locals. In addition the 2010 Kenyan Constitution assures every Kenyan of "the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care".

FP services in Kenya are a broad range of services ranging from medical (methods) to educational services. The educational services serve to build cognizance on where to source FP services and instructional information on how to use of these methods. Adequate provision of educational services enables women to make informed choices on their appropriate and preferred methods which are critical to enjoyment of their reproductive health rights (Pierre & Clapis, 2010). This study focused on the medical methods of contraception.

Nationally, the modern FP prevalence according to the KDHS (2014) was estimated to be 53% up from 39% in 2009. Of the modern methods, injectable were the most widely used (26%), followed by implants (10%) and the pill (8%); all other modern methods were used by 3% or less of married women. In Busia County where this study was carried out, it is estimated that 56% of women were current users of modern contraceptives including implants (24%), injectables (20%), women sterilization (7%), pills (4%) and IUCDs (2%). Implants country wide as seen growth of 8% and lowest discontinuation rate as compared to other modern FP methods (Palladium Group, 2015). According to the Kenya Service Provision Assessment Survey (2010), 90% of public health facilities offered at least one modern FP methods (MoH & KNBS, 2010). However, there frequent stock-outs of modern FP method supplies affecting 30% of all health facilities in the country.

Figure 2.2: Trends in contraceptive use among currently married women



Source: KDHS (2014)

2.3 Factors Hindering Access to FP services

Access is multidimensional construct that assess the patient needs – healthcare system provision fit (Thiede, et al., 2007). According to Clark and Coffee (2011), accessibility of health services can be seen as a construct of services acceptability, accessibility, availability, affordability and accommodation. On the other hand Thiede, et al (2007) sees accessibility as a construct involving three constructs, that is, service acceptability, financial affordability and physical accessibility. This study will therefore adopt these later dimensions to assess accessibility of FP services in the study site.

First, physical accessibility involves the range at which proper quality of health services are available within sensible reach to enable those in need of the services get

the services whenever they need. Financial affordability is concerned with the ability of service consumers to purchase the services devoid of financial hardship resulting from purchase of the services as well as associated opportunity costs. This means that health services are considered affordable when purchasing it results to a remainder of household income to enable household meet other necessities of daily living (Kusi, et. al, 2015). Thirdly, acceptability measures the willingness of service users to look for concerned services. Acceptability can only be achieved if the service are perceived to be effective and does not have cultural and social barriers hindering seeking of the services.

2.3.1 Physical Accessibility of FP Services Centers

Short distance to the nearest health facility providing services reduces opportunity costs emanating from seeking a service such as reduction in travel time and transport costs incurred while seeking the services hence higher likelihood of seeking the services. As rational decision makers, women often weigh going to a health facility only when they perceive to have more serious illness. FP is most of the times not seen as a serious illness/need to warrant visiting a far health facility as they would have to forego other economically productive activities especially in rural areas. Although FP services in Kenya are provided in both public and private health facilities, public health facilities in Kenya are not evenly distributed despite accounting for 86% of FP market. A study in Kenya by Ettarh and Kyobutungi, (2012) found that women residing in less than 5km from an health facility were 26% more likely to use modern FP methods in comparison to those residing more than 5km away. In Ghana women residing within a radius of 5km from an health facility were 3.63 times more likely to

use modern FP methods in comparison to those residing more than 5km away (Eliason, et al, 2014).

2.3.2 Availability of FP Services

Availability of FP commodities is very essential in facilitating FP acceptance and use. Availability of wide range of contraceptive method-mix provides the opportunity for both men and women to make informed choices. Consistent availability of FP supplies in health facilities reduces the need for repeated visits to health facilities hence reduced costs that would have burdened women who are in need of FP services. However Kenyan health system is plagued with persistent shortage of health supplies which limits method-mix and method choice hence discourage use of these services. In general few facilities provide IUDs and implants, suggesting that these methods are only rarely available hence limiting method choices for women. A study in Mathere in Nairobi County found that women at times wasted time waiting at the public facilities for free services, only to find that their preferred method was not available (Keesara, et al, 2015).

2.3.3 Affordability of FP Services

Affordability of FP services is a construct composing of costs incurred in actual purchase of FP services as well as opportunity costs (transport) incurred while seeking FP services. The Kenya Reproductive Health Services exempted payment of user fees for FP services. However there are cases in which public health workers request for informal payment to facilitate the provision for these services (Okech, et al., 2011; Tumlinson, et al., 2013). In addition, medical examinations to test for eligibility of FP services are not exempted from user fees.

Transport costs play a significant role in hindering women's access to FP in Kenya especially in rural areas where there is poor road network coverage. This implies that poor women in the rural areas face constraints in fares to frequent travel to health facilities if they prefer short-term modern FP methods. As a result they would be forced to discontinue using modern FP methods and switch to other traditional alternatives available within their vicinity. In addition, those who brace long distance travel might again have to wait long in public health facilities as a result of shortage of health workers. This means that they would forego other productive activities they would have engaged in their homes.

Affordability of modern FP services disproportionately affects women in the lower socio-economic groups especially in countries with wider income disparities (Bongaarts & Sinding, 2009). A study in Zambia found that richer women were 56% more likely to access modern FP methods as compared to women drawn from poor households (Mutombo & Bakibinga, 2014). A study in Mozambique found access to modern FP methods was negatively correlated with both transportation costs and household monthly income (Agadjanian, et al., 2015). Similarly a study in Nairobi slums found that women access to modern FP methods increased with increase in women's monthly income (Okech, et al., 2011). Contrary findings were made in Uganda which did not find significant association between household wealth index and modern contraceptive use (Asiimwe, et al., 2014).

2.3.4 Acceptability of FP Services

Myths and misinformation about family planning most often lead to negative effects on contraceptive use (Chipeta, et al, 2010). For, instance, many studies have shown that a good number of women would not use contraceptives, especially the injectable

because some believe that contraception makes women become promiscuous and also some family planning methods cause cancer (Mosha, Ruben, & Kakoko, 2013; Ochako, et al., 2015). Mungai (1996) notes that the sources of information on family planning often will have a direct impact on women which will affect their decision on whether to use it or not within the family setting.

Sourcing FP information from health workers could enhance uptake of modern FP services but at times, health workers might have personal negative opinions that contradicts professional opinions regarding FP. The negative personal opinions at times perforate to clients which then forms a significant barrier to modern FP methods uptake. Given that the Kenya Reproductive Health Policy supports the use of Community Health Volunteers in provision of FP services, these volunteers mostly have low training on FP matters hence might not diffuse the negative perceptions in their communities regarding FP services. A study in Kisumu found that some health workers passed misinformation to clients seeking FP services (Tumlinson, et al., 2013).

A study conducted in Nigeria showed that women who disapproved modern FP methods were 6 times less likely to use modern FP methods as compared to women who approved modern FP methods (Amentie, et al, 2015). A study in Kenyan slums found that women who perceived modern FP methods to be effective were 17% more likely to use modern FP methods as compared to those who thought that they were not effective or those that were not sure of its effectiveness (Okech, et al., 2011).

Acceptability of modern FP methods is constrained by presence of myths and misconceptions about its effects. In Ghana contraceptives were perceived to cause infertility, breast and cervical cancer and fibroids as it inhibits menstrual flow which

was deemed to clean the uterus. Furthermore women who used FP were stigmatized as being promiscuous. At the same time some women perceived FP to reduce sexual urge. A study in Bungoma District which found that contraceptive use was believed to induce women to have continuous backaches and headaches, and bleeding continuously (Wambui, Ek, & Alehagen, 2009).

2.4 Factors Hindering Utilization FP Services

2.4.1 Spousal Attitudes

Decision making on uptake of FP services is frequently influenced by their husbands. In patriarchal African society, men are prime decision makers in households even on issues of women reproductive health while women are the implementers of these decisions. Men decide on FP and the number of children as well as how resources are used in a household. Therefore men being the decision makers are expected to initiate discussions on FP and the number of the children the couple want to have. Due to restrictive gender roles men mostly perceive that FP is a woman's domain and therefore their state of indifference could not enhance uptake of FP services (Kabagenyi, et al., 2014). Thus it is expected that husband approval plays a critical role in inducing a woman to use modern contraceptives since men's opinions about FP issues may overrule women's, even though the women often must implement the decisions made on these matters.

It has been found that some men negatively perceive use of FP by their spouses since it is seen as encouraging promiscuity without being discovered by their partners as the women would not be able to conceive (Okwor & Olaseha, 2009). In some societies when a women brings about discussions on FP the women are then at risk of gender

based violence (Schuler, et al., 2011). In cases where men do not approve the use of FP services, many women resort to covert use of contraception (Mosha, Ruben, & Kakoko, 2013). A study in Nigeria found that only 46 percent of men who approved women's contraceptive use would allow their own spouse to use contraceptives (Adelekan, et al, 2014). A study conducted in Western Kenya found that men were of the opinion that FP services were riddled with side effects thus discouraged their spouses from using it (Wambui, et al, 2009).

2.4.2 Spousal Communication

Communication among the couples is important in FP use and decision-making on the number of children a couple wants to have. Spousal communication helps couples to reach consensus on how to plan on child spacing as well as the contraceptive method they are going to use. In joint decisions for FP, adherence to the chosen method would likely be higher as the couples would remind each other of the method. In addition agreement on use of FP among spouses reduces the need for women to resort to clandestine use of FP services which at times have to be sought from far health facilities.

In a study among Tanzanian women, it was found that in rural areas, there was little or no communication among the couples on the use of FP and on desired number of children. In addition, the findings show that some people believe that discussing FP issues with their partners was not that important. Moreover, the findings show that it was difficult for women to engineer discussions, as they felt that men largely made key family decisions (Mosha et al., 2013).

According to a study in a refugee camp in Uganda, it was found that use of

contraceptives among adolescents and teenage mothers was significantly associated with partner discussion (Kabarangira, 2011) and spousal support (Lule, et al, 2015). In a study among rural women in Western Kenya it was revealed that women who deliberated modern FP methods with their spouses were more likely to have spousal approval of modern FP hence higher likelihood of utilization of modern FP methods (Bakibinga et al., 2015). Furthermore a study in Nigeria among women found that most women had not discussed FP with their spouses and mostly were not aware whether their spouses approved of the use of modern FP methods (Okonofua, et al., 2014).

2.4.3 Number of Living Children

In societies where number of children determines the social status, it is hypothesized that contraceptive use decreases with increase in number of living children as women (and their spouses if they approve) will seek to control giving birth to additional children. In addition in African societies, there is higher value for male children as compared to female children hence there will be a higher likelihood of FP use among couples with fewer male children as they seek to add more male children. Furthermore with prevalent early marriages in Africa, women married early tend to have lower education levels and married to spouses with lower education levels which further reduces the likelihood of contraceptive use despite having higher number of living children.

Infant mortality is also a barrier to FP use as women seek to compensate for the lost child. In a study in Ethiopia, women who gave birth and their child died were found to have a lower likelihood of using modern contraceptive methods (Lakew, et al., 2013). Similarly in a study in Ndhiwa constituency, most of the women who had experienced

child mortality were found not to be using contraceptives (Okech, et al., 2011).

On the other hand, having unintended pregnancy can serve as a waking-up call resulting in increased interest in future pregnancy prevention hence a higher tendency to contraceptive use or a discouraging factor towards use of FP after experience contraceptive failure leading to unintended pregnancy (Bradley, et al, 2011). A study in Nairobi found that previous experience of unintended pregnancy last pregnancy increased the likelihood of contraceptive use (Fotso, et al., 2014). Contrarily a study by Bakibinga, et al (2016) in their study in East Africa found that women who had ill-timed pregnancy had lower likelihood of modern contraceptive use as they deemed ineffective.

Studies in India have found that contraceptive use decreased with increase in the number of living male children and decreased with an increase in the number of living female children (Lasee & McCormick, 1996; Narzary & Sharma, 2013). Other studies in Ghana, Burkina Faso and Kenya did not find an association in gender differential of living children with contraceptive use but found association in FP use with absolute number of living children (Achana, et al., 2015; Maïga, et al., 2015; Okech, et al., 2011).

2.4.4 Education level

Education is a significant determinant of acceptability and utilization of contraceptives. Contraceptive prevalence increases with education. Women with higher education tends to be better informed about family planning services and are more likely to use the service than their peers with lower education. It is often assumed that better educated couples, being more exposed to family planning

information are more likely to practice contraception than others. Moreover better educated women are more likely to desire for fewer children who they can adequately provide for as compared to lesser educated women hence more desire to control the number of children (Anguko, 2014).

In a study among Indian women, higher education was found to lower their unwanted fertility rate due to higher rate of contraceptive use (Jiang & Hardee, 2014). In Kenya it is estimated that only 18 percent of currently married women with no education use a method, while more than half of women with at least some primary school level of education use contraception (KNBS, 2015). In a study among women in North Eastern Kenya, women with higher education level had higher rate of contraceptive use (Anguko, 2014). Similarly a study in rural Western parts of Kenya found that women with lower education had lower knowledge on contraceptives and lower approval of modern FP methods hence decreased likelihood of using contraceptives (Bakibinga, et al., 2015).

2.4.5 Religious influence

Catholics and other Fundamental Protestants view sexual activity as solely meant for procreation and therefore use of contraception goes against God's purpose of sex (Schenker & Rabenou, 1993; LoPresti, 2005). Muslims also believe that using contraceptives goes against God's as He is the one who determines the number of children a woman gives birth to. On the other hand other Protestants do not forbid use of contraception once a couple has a child. Several studies have documented the influence of religion on contraceptive use with different results (Gyimah, et al., 2006; Agadjanian, et al., 2009; Browne & Eloundou, 2012).

A study in Mozambique found that despite Catholic Church opposition to contraceptive use there was high contraceptive prevalence among Catholics as compared to other Protestants (Agadjanian, 2013). A study in Daadab Refugee Camp found that Muslims women were opposed to modern FP methods and hence they did not use them (USAID, 2008). Similarly study in Bondo District found that women were of the view it was God who determined the number of children a woman would have hence were mostly against the use of contraceptives (Nangendo, 2012). Contrarily a study in Western Kenya did not find any association between religion and contraceptive use (Bakibinga et al., 2015).

2.4.6 Polygamy

Polygamy is widely common among many African cultures. Women in polygamous marriages tend to have lower education levels and married to men of lower education levels also. This creates a barrier to access to information on FP which effectively determines their approval of modern FP methods. In addition women in polygamous marriages tend to have a higher desire for more children in order to have higher social status within the polygamous marriage arrangement (Ziyani, Ehlers, & King, 2003). Furthermore men in polygamous marriages tend to have more desire for higher number of children to command respect from the society hence a higher likelihood of higher disapproval of modern FP methods (Kasenene, 1993). A study among women in Gambia Ethiopia and Ndhiwa District found a higher prevalence of modern FP methods among monogamously married women as compared to women in polygamous marriages (Lakew, et al., 2013; Jammeh, et al., 2014; Ouma, 2014).

2.5 Theoretical Framework

The research will be guided by The Andersen's Behavioural Model (ABM) of health service use framework. This framework was initially developed in the 1960's and has been reviewed severally since then (Andersen, 1995). The aim of this framework was to help in the understanding of reasons why people use health services and in measuring reasonable access to health care while at the same time aid in the development of policies that can be used to improve access to health care (Andersen & Aday,1978). Initially, Anderson started by analyzing the family but later changed to using the individual as the unit of analysis where the framework explored conditions that enable or impede utilization of health care services. According to ABM, the likelihood to access and use a service depends on diverse components: the environment, population characteristics, perceived health status and consumer satisfaction, and the interaction between all these (Habibov & Fan, 2008).

In this framework, there are three characteristics that enable an individual to access and use health care: these factors include; tendency to use the services, factors that will facilitate or hamper use and their need for use of health care (Anderson, 1968). Tendency, also referred to as, predisposing factors, are interpreted as the socio and cultural characteristics of individuals they exhibit before illness and therefore women who have stronger faith in the efficacy of FP services are more inclined towards FP services access and utilization. Enabling factors are interpreted as the logistical part of acquiring health care such as know how to access FP services, income, availability of facilities and personnel, and waiting time. Lastly, the need factors which are the most immediate cause of health service use, and this may range from health problems that cause the need to seek for health care services (Andersen, 1995).A

woman's need for FP may be influenced by past experiences in pregnancy and childbirth or personal preferences. Thus, perceived need serves as a stimulus for the use of FP services. In summary, environmental (i.e., this is the external environment and the health care system) and person characteristics (i.e., tendency of people to use services, factors that facilitate or hinder this use, a person's perception of need for care) come together to influence health behavior (i.e., personal health practices and health service use), which in turn will influence health status outcomes (i.e., evaluated health status and professed health status).

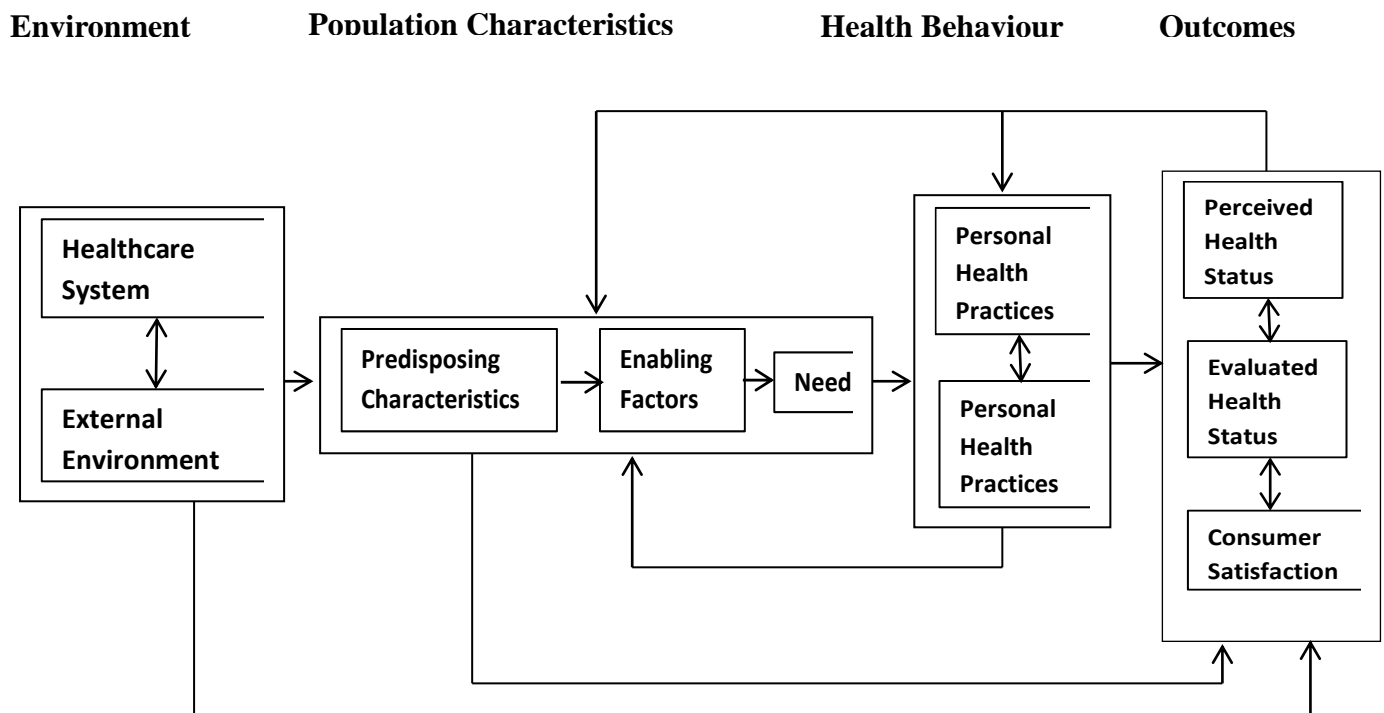


Figure 2. 3: Theoretical Framework

Source: Habibov and Fan (2008)

In this study, factors such as spousal attitudes and religious influence are viewed to be the predisposing factors to FP use while the ability to purchase the needed FP and its availability can be viewed as the enabling factors and the need to control the number of children becomes the evaluated and perceived need. In summary, health care access and can therefore be viewed as a manifestation of individual behavior which can be influenced by one or more of the three factors discussed this theory and these leads to different individuals being able to access or not able to access and use FP. The factors may discourage individuals or encourage them to make use of available FP services. This can be conceptualized as shown in Fig. 2.3.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

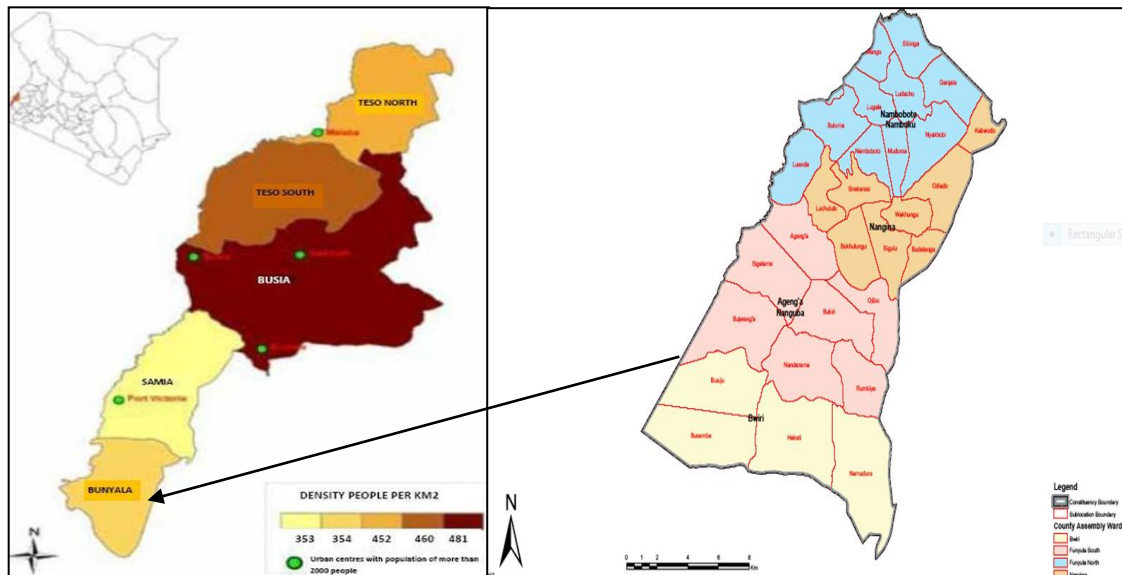
This section presents a description of the study site, the research design, the target population, sampling procedure, methods of data collection and analysis as well as ethical considerations that will guide this study.

3.2 Research Site

This study was conducted in Funyula area of Busia County in Western Kenya. (Figure 3.1).The sub-county covers an area of some 265.1km² and had a total population of 93,500 of whom 49,233 were female and the rest male (Kenya Open Data, 2009). According to KDHS of 2014, Busia County has a total fertility rate of 4.7 well above the national average of 3.9 (KNBS, 2015). Busia County has an estimated annual growth rate of 2.9% (Cherotich & Okwatch, 2014). Busia County experiences high child morbidity and mortality. In fact, the infant mortality stands at 75 deaths per 1,000 live births which is a result of high poverty levels (64.2% compared to national poverty level of 45.9%),inaccessibility of health facilities and HIV/AIDS menace (Busia County Government, 2015).

As of July 2015, 7 out of 11 public health facilities in Funyula provided FP services (Ministry of Health, 2015). Services offered in most of these facilities include both barrier methods and specifically barrier methods like condoms and hormonal contraception such as contraceptive oral pills and injectables. Other methods that fall under these two categories such as cervical caps and diaphragms plus other long-term methods like vaginal rings, implantable rods and intrauterine device offered through referrals at the district hospitals.

Figure 3.1: Study Area Map of Funyula in Busia County



Source: Busia County Government, 2015

3.3 Research Design

The study employed a cross-sectional descriptive research design using both quantitative and qualitative approach. Concurrent triangulation was used to triangulate qualitative and quantitative findings. The study described the factors that hinder women's access to and utilization of FP services as well as the socio cultural and socio economic factors that hinder women in Funyula from accessing FP. This was a snapshot of the state of affairs regarding how modern FP methods were utilized in Funyula.

3.4 Target Population and Unit of Analysis

The target population for the study comprised of all women aged between 18 and 49 years living in Funyula. Women in this age bracket were chosen because they constitute a large majority of potential and actual consumers of FP services and

therefore were well positioned to provide the required information to answer the questions posed in this research. The study also targeted health workers and NGOs involved in provision of FP services and also local administration. The health workers and NGO staff were targeted due to their involvement in reproductive health and therefore provided significant impetus to the study findings for triangulation with findings from women respondents. The unit of analysis was the individual woman living in Funyula as well as individual health worker and NGO staff.

3.5 Sample Size and Sampling Procedure

The sample size for this study was 40 women aged between 18 and 49 years old. Convenient sampling procedure was adopted to recruit women who responded to the study questionnaires. Purposive sampling was used to sample health workers and NGO staff involved in provision of FP services. FGD participants were also recruited based on their accessibility and willingness to participate in the discussions. Two FGDs were conducted each composed of a group of 6 women aged between 18 and 49 years old.

3.6 Methods of Data Collection

3.6.1 Questionnaire

The main method for primary data collection was structured interviews using a questionnaire (Appendix 2). The questionnaire was constructed to contain structured open and closed-ended questions and was used to gather both qualitative and quantitative data. The questionnaires were administered by the researcher through face to face interviews and collected data in three sections including; socio-demographic characteristics, factors that hinder women's access to FP services and

factors that constrains women's utilization of FP services.

3.6.2 Key Informants Interviews

In this study, four purposefully selected key informants were interviewed. These included 2 health workers in public health facilities, 1 NGO officer working in the field of FP and 1 local administrator. Key Informants were chosen because of their extensive knowledge, experience, expertise, and involvement with FP issues in the study area. The information collected from KIIs was used to supplement that collected from questionnaire interviews. Such information was important in supporting or disproving certain key assertions made during the interviews. A KII Guide has been developed to assist in such interviews (Appendix 3).

3.6.3 Focus Group Discussion

In this study two FGDs were conducted with women aged between 18 and 49 years where each group consisted of six women aged between 18 and 49 years old. This was done by the help of an FGD guide (see Appendix 4). The FGD aided in getting any additional and specific information regarding the topic under study as respondents was probed further for any further clarifications. The information from FGDs was used to enrich the data from the questionnaires.

3.6.4 Secondary Data

Secondary data was collected and used in this study. Secondary data was both qualitative and quantitative drawn from government publications, reports, policy documents.

3.7 Data Processing and Analysis

At the end of each interview, the filled questionnaires were checked for completeness and any missing entries. The quantitative data obtained from the questionnaires were entered, cleaned and analyzed using the Statistical Package for Social Sciences (SPSS) version 20. Descriptive statistics such as frequency and percentages were used to present quantitative findings using tables and charts. Qualitative data from KIIs and secondary sources were subjected to content and thematic analysis where the responses were transcribed and themes developed with these themes presented together with verbatim. Emerging patterns and themes were compared against the survey data and the study objectives and were used to complete and supplement quantitative data.

3.8 Ethical Considerations

The researcher upheld all the ethical principles pertaining to the study as a whole. The researcher considered the following in ensuring all the ethics are upheld during and after the study:

The researcher ensured a proper introduction and explanation about the research to the participants and only proceeded to collect data after the respondents have given their informed consent. The respondents were given an assurance that the information collected was to be kept and treated with strict confidence and for academic purposes only. Respondents' names and any other personal identifiers were not collected to ensure anonymity of respondents. Interviews with respondents were conducted in secluded environment to ensure privacy of the respondents. Collected data was used for this research's purpose only and the thereafter filled questionnaires were destroyed

save for where individuals concerned consent in writing to its inclusion beforehand at the end of the research.

CHAPTER FOUR: DATA ANALYSIS AND PRESENTATION

4.1 Introduction

This study sought to explore the factors that hinder women's access to Family Planning Services in Funyula. The study collected data from women of reproductive age through questionnaires and Focus Group Discussions and Key Informant Interviews with health workers and NGO staff involved in FP programs. The researcher managed to collect data from the 40 women of reproductive ages, 2 health workers, a village elder and 1 NGO staff working with Burimda Community Centre.

4.2 Socio-Demographic Characteristics

4.2.1 Socio-demographic characteristics of respondents

Three quarter of the respondents were aged below 35 years while nearly a third were monogamously married. However polygamous marriage was also prevalent with 3 in every 10 respondents being in a polygamous union. Over half (55%) of the respondents had attained primary level of education and below with only 2 respondents having not had any formal education. Over a third of the respondents were Protestants while 27.5% were Catholics, there was only 1 Muslim woman among the respondents. Over a third of the respondents were engaged in small businesses while 32.5% were housewives. Among the respondents with quantifiable income (except housewives), over half earned below Ksh. 10,000 per month while a paltry 10% earned above Ksh. 10,000.

Table 4.1: Socio-demographic characteristics of respondents

Characteristics	Categories	Frequency	Percent (n = 40)
Age	18 - 24	6	15.0%
	25 - 34	20	50.0%
	35 - 44	12	30.0%
	>= 45	2	5.0%
Marital status	Monogamously married	13	32.5%
	Polygamously married	12	30.0%
	Single (Never married)	8	20.0%
	Separated/Widowed/Divorced	7	17.5%
Education level	College/University	5	12.5%
	Secondary	13	32.5%
	Primary and below	22	55.0%
Religion	Catholic	11	27.5%
	Protestant	14	35.0%
	Muslim	1	2.5%
	Pagan	5	12.5%
	Other	9	22.5%
Occupation	Farmer	6	15.0%
	Housewife	13	32.5%
	Business lady	15	37.5%
	Employed	6	15.0%
Monthly income contributed	0	13	32.5%
	< 10,000	23	57.5%
	10,000 - 20,000	2	5.0%
	20,000 - 30,000	2	5.0%

4.2.2 Socio-demographic characteristics of spouses

Nearly half (44%) of respondents' spouses were aged above 45 years with over half (57.5%) having attained primary education. Over a third of the respondents were married to Protestant spouses (36%) who were mostly (48%) engaged in business activities. Majority (60%) of respondents' spouses were also earning less than Ksh. 10,000 per month.

Table 4.2: Socio-demographic characteristics of spouses

Characteristics	Categories	Frequency	Percent (n = 25)
Age of spouse	25 - 34	6	24.0%
	35 - 44	8	32.0%
	>= 45	11	44.0%
Education level of spouse	College/University	10	25.0%
	Secondary	7	17.5%
	Primary	23	57.5%
Religion of spouse	Catholic	8	32.0%
	Protestant	9	36.0%
	Muslim	1	4.0%
	Pagan	4	16.0%
	Other	3	12.0%
Occupation of spouse	Farmer	5	20.0%
	Business man	12	48.0%
	Employed	8	32.0%
Monthly income contributed by spouse	< 10,000	15	60.0%
	10,000 - 20,000	5	20.0%
	20,000 - 30,000	2	8.0%
	30,000 - 40,000	3	12.0%

4.2.3 Planned Parenthood

The respondents had between 0 and 9 living children but on average the respondents had 4 living children including 2 boys and 2 girls. There was however wide variation in the number of boys as compared to number of girls alive.

Table 4.3: Number of living children

	Minimum	Maximum	Mean	Standard Deviation
Number of living boy children	0	6	2	2
Number of living girl children	0	5	2	1
Total number of living children	0	9	4	2

Over two thirds of the respondents did not plan on the number of children they had wanted to give birth to while nearly a third had planned on the number of children they wished to give birth to. Out of the 32.5% who had planned on number of children,

2.5% gave birth to higher number of children than they had planned while the remainder stuck within their planned numbers.

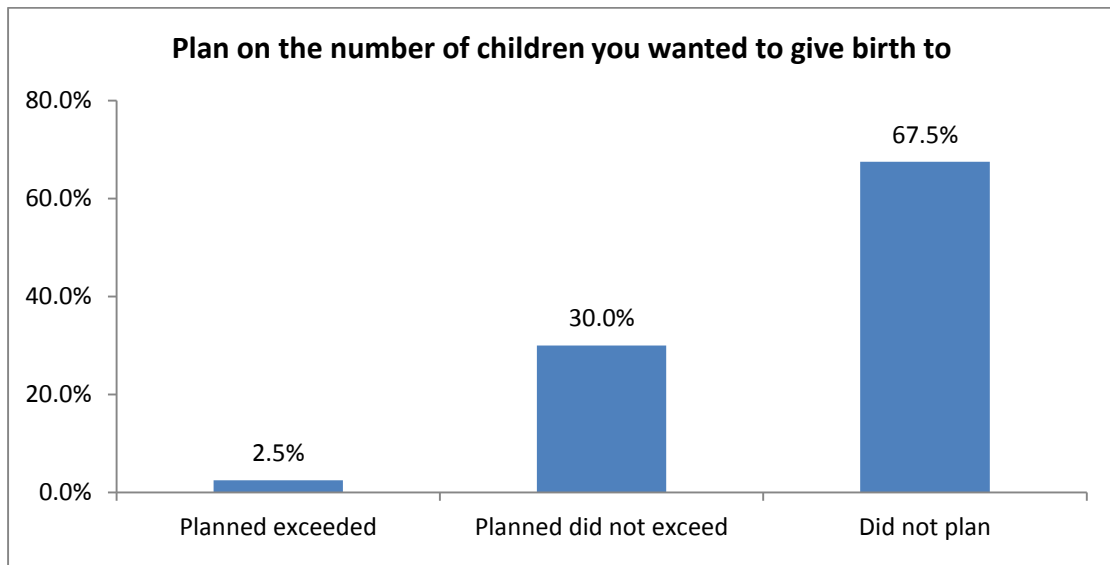


Figure 4.1: Planning on the number of children to give birth to

4.3 Contraceptive Use

4.3.1 Previous use of modern FP methods

Nearly a third (30%) of the respondents had never used a modern FP method while 70% had previously used a modern FP method. Among the respondents who had never used a modern FP method, only 5% were willing to use a modern FP method in future. Among the 70% who had previously used a modern FP method, over half (37.5%) had used injectables, 32.5% had used implants while 2.5% used sterilization. This indicated that most of the respondents had used more than one FP method previously. However the non-willingness of the respondents to use modern FP methods was blamed on religious objections, fear of side effects and husband's disapproval as well as desire to have more children.

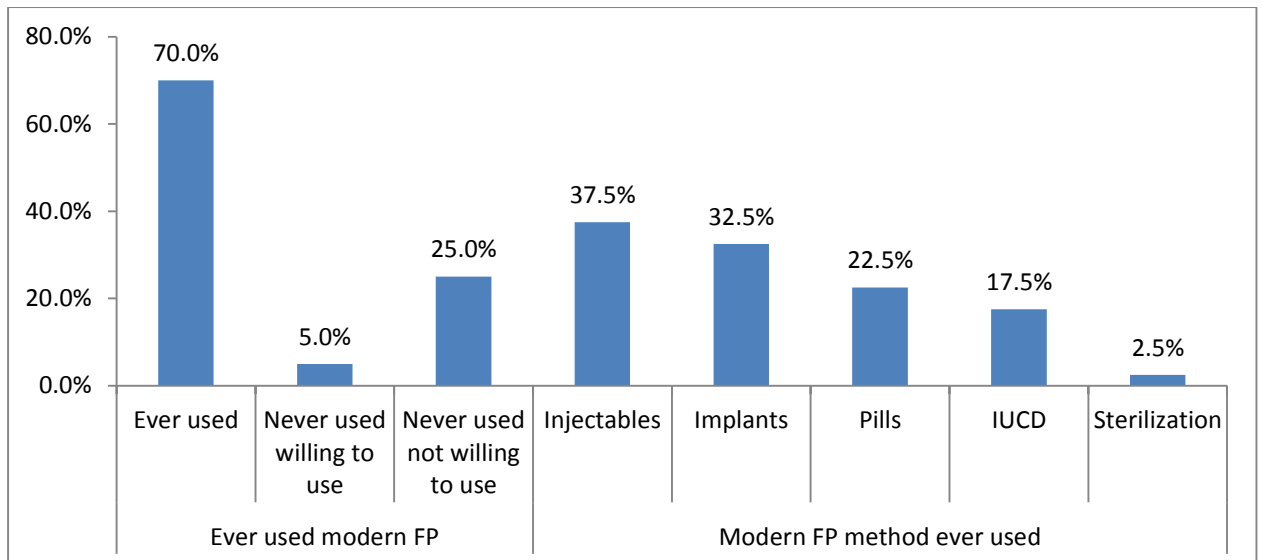


Figure 4.2: Previous use of modern FP methods

4.3.2 Current use of modern FP methods

Only 47.5% of the respondents were using a modern FP method while 62.5% were not using any modern FP method. This indicated that 22.5% had dropped from using modern FP methods as 70% had indicated they had previously used modern FP methods. Among the 22.5% who abandoned using modern FP methods, less than half had dropped using FP methods since they wanted to have another child while the remainder 12.5% abandoned using modern FP methods due to other reasons. In general, a quarter of the respondents did not like to have a child (or another child) in the near future. This means that the unmet contraceptive use was 25%.

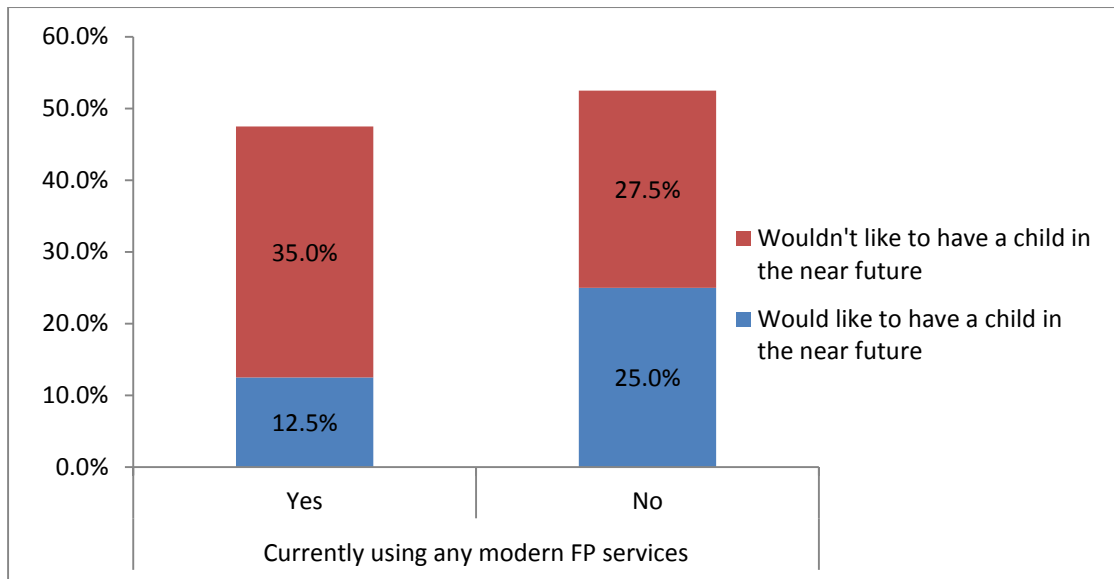
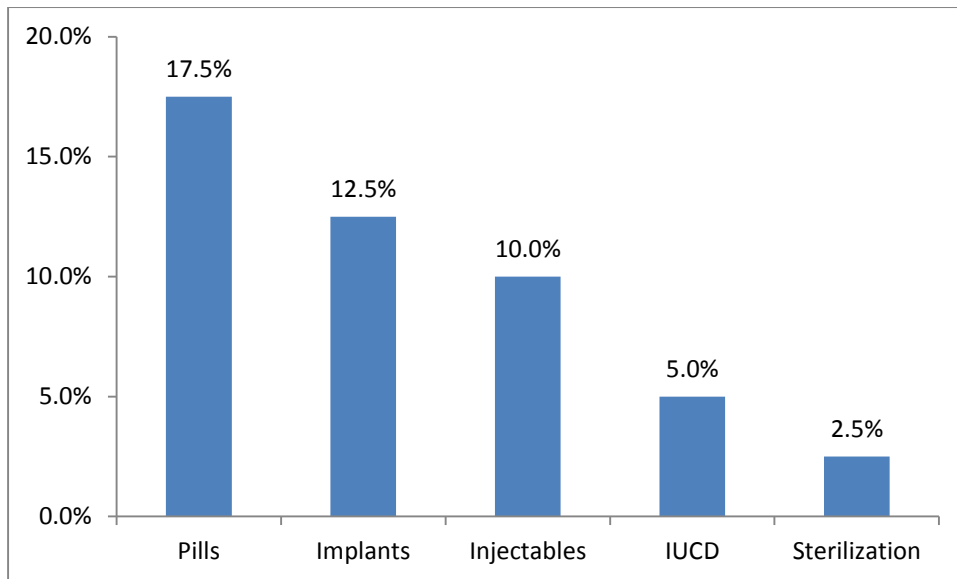


Figure 4.3: Current use of modern FP methods

Majority (7 out of 11) of public health facilities in Funyula provided FP services (Ministry of Health, 2015). Services offered in most of these facilities included both barrier methods like condoms and hormonal contraception such as contraceptive oral pills, cervical caps, diaphragms and injectables. Other long-term methods like vaginal rings, implantable rods and intrauterine device were offered through referrals at the District Hospitals.

Among the 47.5% of the respondents using FP methods, 17.5% were using pills, 12.5% were using implants while the injectable were the third commonest (10%) FP method used. Sterilization (tube ligation) was the least common (2.5%) type of modern FP method used. There was no respondent reporting the use of barrier methods of contraception (female condoms).



4.4 Factors Hindering Access to FP services

4.4.1 Physical Accessibility of FP Services Centers

Among the 47.5% of the respondents using FP methods, 42.5% sourced the FP method from health centers or dispensaries while 12.5% sourced from Chemists and 7.5% sourced from friends or relatives. This indicated that women sourced modern FP methods from more than one source.

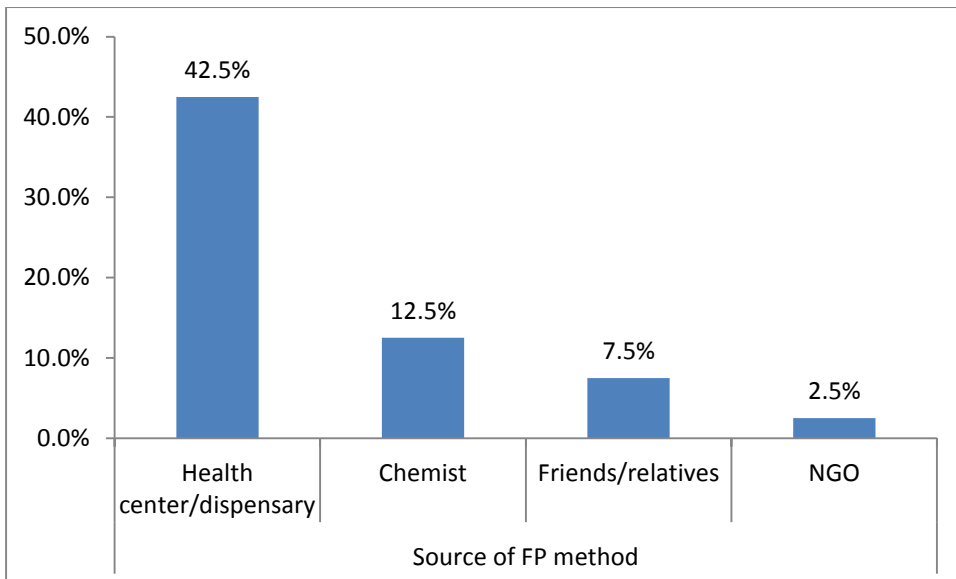


Figure 4.4: Current source of modern FP methods used

Among the 47.5% of the respondents using FP methods, over half (30%) of respondents currently using modern FP methods considered the place where they sourced the FP method not to be far and 32% thought that the cost implications in traveling to and from the source of modern FP were affordable. This shows that physical access was not a critical hindrance to modern FP method use.

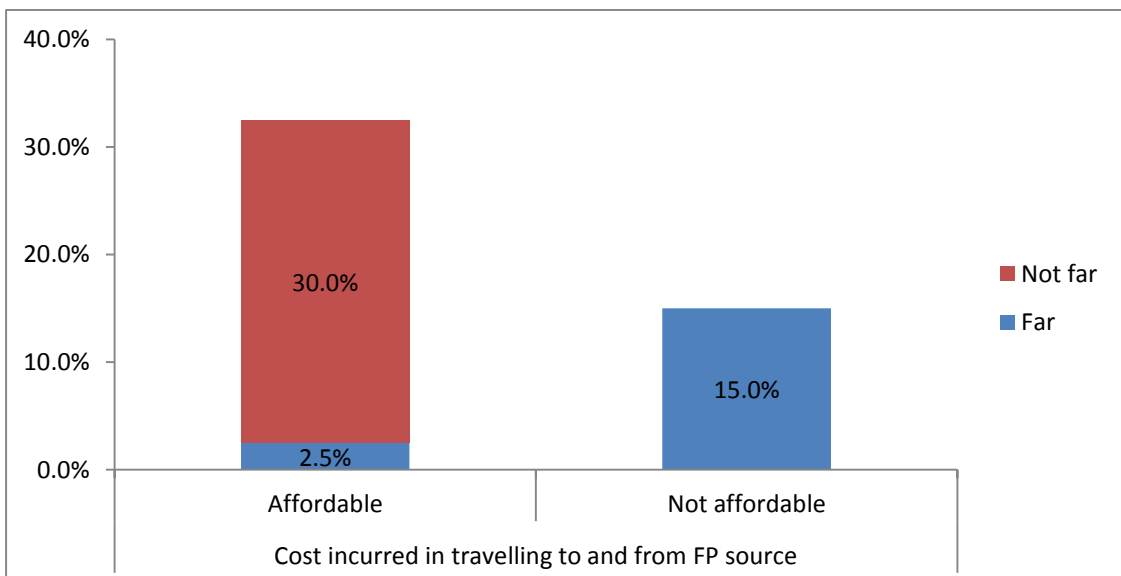


Figure 4.5: Physical Accessibility of FP Services Centers

4.4.2 Availability of FP Services

Among the 47.5% of the respondents using FP methods, 25% were of the opinion that the method they were using was not always available while the other 20% always got their chosen FP method. Similar observations were made in an interview with a nurse at a local health facility who observed that at times the health facility ran out of FP supplies.

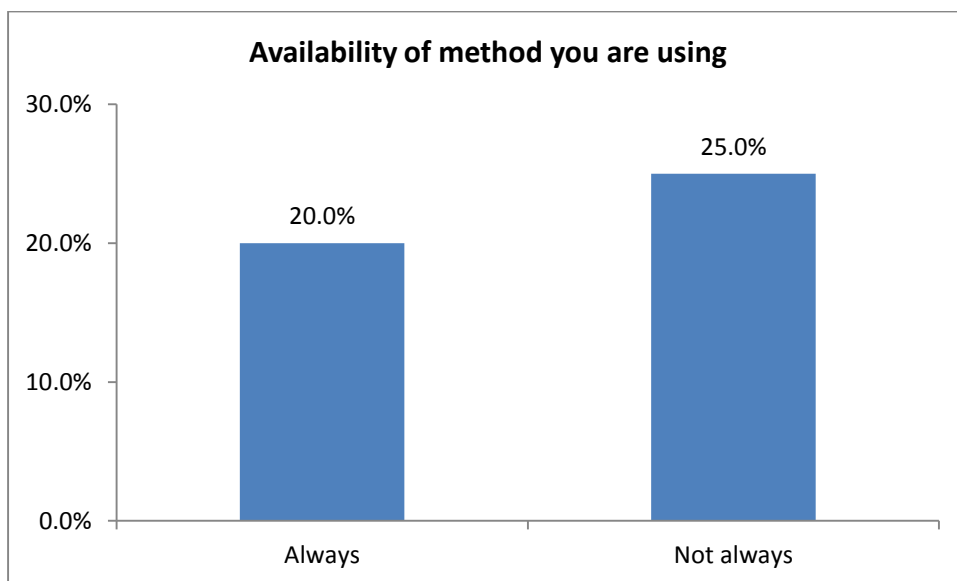


Figure 4.6: Availability of FP Services

Availability of FP services within the hospital was also hampered by shortage of personnel which led to limiting the time of delivering FP services as revealed by an interview with a nurse:

One nurse serves FP, Antenatal Clinics and Child Immunization which leads to a lot of workload. We are forced to stop FP service delivery at 1 o'clock.

4.4.3 Affordability of FP Services

Among the 47.5% of the respondents using FP methods, 42.5% thought that the costs they incurred in purchasing FP methods were affordable while the remainder 5% thought that purchasing FP methods were not affordable. The affordability of modern FP methods was linked to the fact that they were offered free of charge in public health facilities. All current users of modern FP methods who reported to not affording FP methods sourced these methods from chemists. However during FGD discussants observed that sometimes public health workers asked for money before giving out FP. This shows that affordability of FP services was not a major determinant in use of modern FP methods.

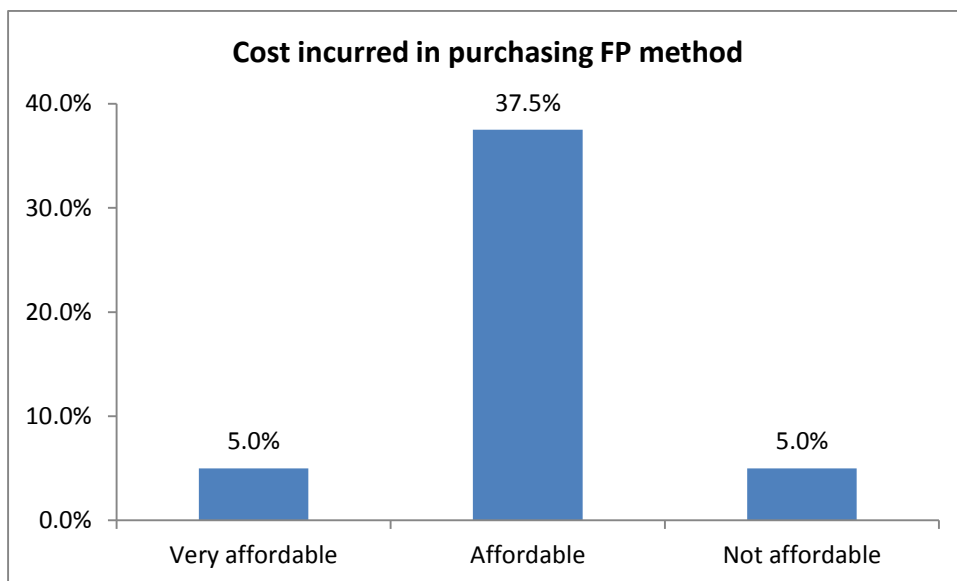


Figure 4.7: Affordability of FP Services

4.4.4 Acceptability of FP Services

There were widespread myths regarding the effects of modern FP methods especially with regards to its side effects. Some of the mythical effects included changes in body size, reduction in libido and fertility, abnormal births and that FP causes diseases such

as vaginal wall prolapses, fibroids, high blood pressure and cancer. Some of the respondents perceived the modern FP methods to be ineffective in preventing pregnancies as illustrated by the following statements:

“Many People complain that they still get pregnant even after use”

In agreement with a nurse informant, other respondents also feared that using modern FP services will result in giving birth to twins who are culturally unacceptable as it is perceived to lead to death of either the husband or the wife as illustrated by the following statement:

“FP use leads to twin pregnancies. Yet firstborn twins are not acceptable in the society as it will lead to death of either the husband or the wife.”

In addition to perceived resultant infertility, subsequent births after using modern FP methods was also riddled with myths. According to an interview with a nurse, there were some community members who believed that a child born after using FP will have disabilities.

Among the 47.5% of the respondents using FP methods, 22.5% had experienced side effects due to use of modern FP methods while 17.5% of those who were not currently using FP methods had also experienced side effects previously. 30% of the respondents were not included since they had never used FP services. This shows that side effects were equally experienced by current users and current non-users of modern FP methods hence the experience of FP side effects was widespread. Some of the side effects experienced by the respondents included excessive bleeding, general body weakness and backaches as illustrated by the following excerpt where one woman noted

“Personally I bled for a long time and it culminated to a divorce as I could not offer conjugal rights to my husband”

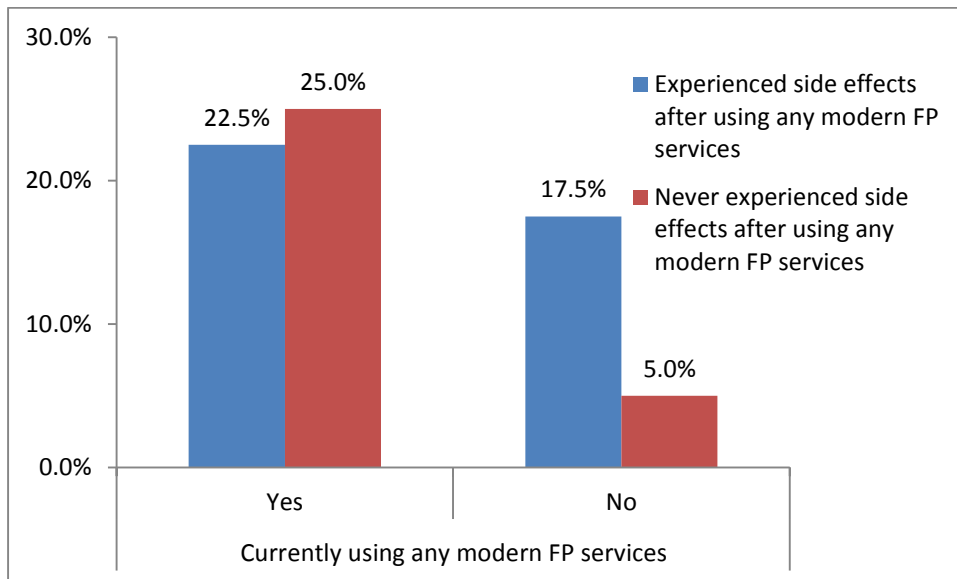


Figure 4.8: Experience of FP side effects

4.5 Factors Hindering Utilization FP Services

4.5.1 Spousal Communication

In total, over half (55%) of the respondents had talked with their sexual partners about the use of modern FP methods. Among the 47.5% of the respondents using FP methods, 30% had communicated with their sexual partners about the use of modern FP methods. However spousal communication about FP was found to be similar across different education level. There were cases in which sexual partners blatantly did not want to discuss issues regarding FP as illustrated by the following sentiments:

He just does not like discussing such matters

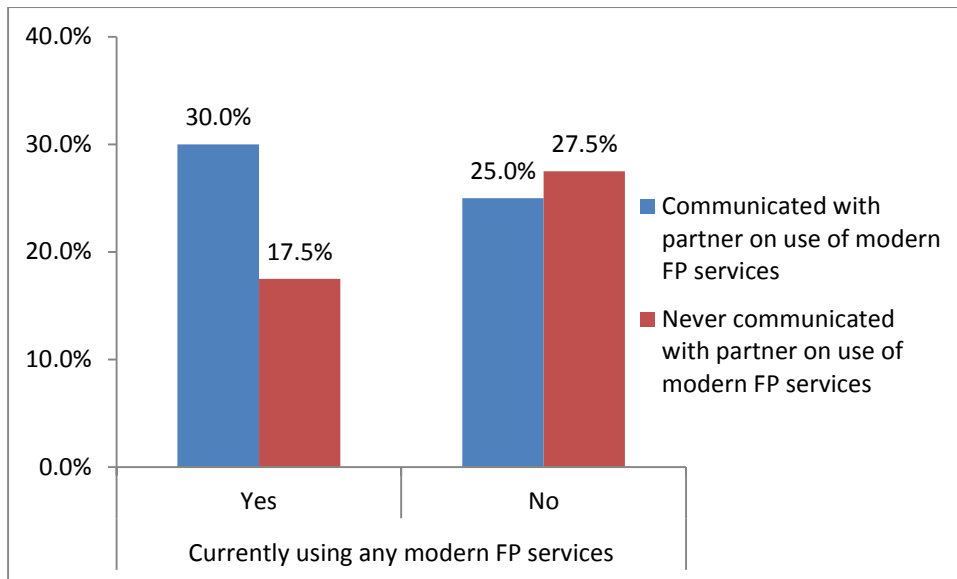


Figure 4.9: Spousal communication and use of modern FP methods

4.5.2 Spousal Attitudes

Among the 55% of the respondents who had talked with their sexual partners about the use of modern FP methods, half (27.5%) had spouses who did not approve use of modern FP methods. The sexual partners cited mostly the fear of modern FP methods side effects including perceived infertility and changes in body sizes as the reasons behind their modern FP methods disapproval. Spousal approval played a critical role in enhancing uptake of modern FP methods since among the 30% of the respondents who had communicated with their spouses about modern FP methods and were using modern FP methods, 25% reported that the spouses approved of its use. Despite disapproval from the spouses, some respondents (5%) reported using modern FP methods without their knowledge. Only 2.5% were not using modern FP methods despite spousal approval. An interview with a nurse indicated that spouses had negative attitudes and misconceptions about modern FP methods:

“They believe that Jadelle can move from the site of insertion to the heart”.

Spousal approval was critical to the survival of marriage unions as illustrated by an FGD discussant who observed that when husband disapproves modern FP use. When a disapproving partner finds the wives using it, the wives are subjected to humiliation or worse gender-based violence and even divorce as illustrated by the following excerpt.

“I was chased away to go back to my parents by mother-in-law after my husband reported to her that I was using FP.”

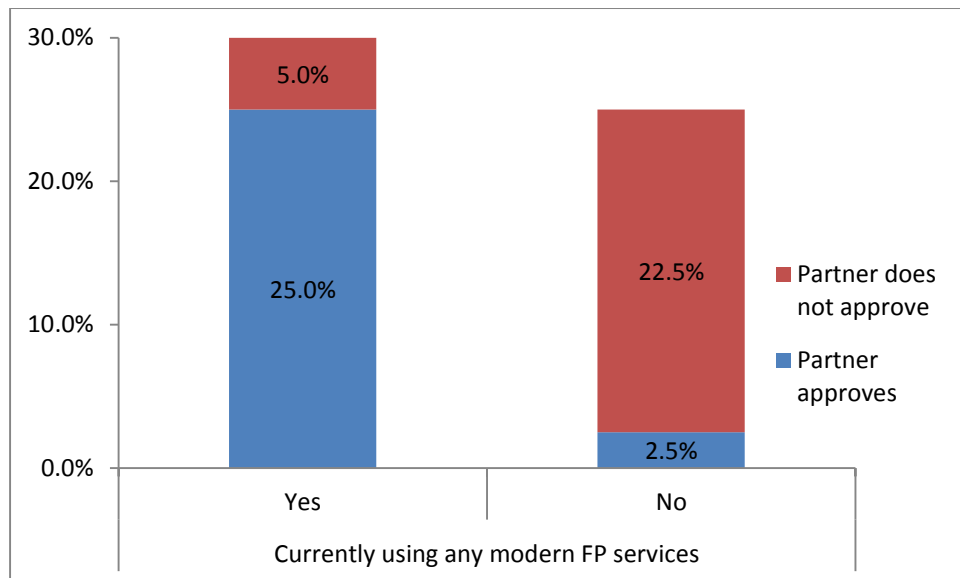


Figure 4.10: Spousal Approval and Modern FP Methods Use

4.5.3 Number of Living Children

The results indicated that current users of modern FP services had an equal number of living children. However the number of living children was different by gender, the number of boys was higher among current users of FP services as compared to girls and vice versa. This indicates that gender of living children was an important determinant of using modern FP methods. This could be attributed to value of boy

child in the society with the desire of women with fewer male children to have more male children hence avoiding use of modern FP methods.

Table 4.4: Number of Living Children and Modern FP Methods Use

	Currently using any modern FP services	
	Yes	No
	Mean	Mean
Number of living boy children	3	1
Number of living girl children	1	3
Total number of living children	4	4

4.5.4 Education Level

As shown in the table below, the prevalence of use of modern FP methods increased with increase in women's highest education level. In addition women with spouses who had College or university education had the highest prevalence of contraceptive use. This therefore indicates that higher education was associated with more use of modern FP methods.

Table 4.5: Education Level and Modern FP Methods Use

		Currently using any modern FP services			
		Yes		No	
		Frequency	%	Frequency	%
Education level	College/University	4	80.0%	1	20.0%
	Secondary	7	53.8%	6	46.2%
	Primary and below	8	36.4%	14	63.6%
Education level of spouse	College/University	7	70.0%	3	30.0%
	Secondary	1	14.3%	6	85.7%
	Primary and below	11	47.8%	12	52.2%

4.5.5 Religious Influence

Modern FP methods use was highest among respondents who thought that their religion supported their use while lowest among respondents who were not sure of whether their religion allowed the use of modern FP methods. However half of respondents whose religion did not support use of modern FP methods defied their religion doctrine and used modern FP methods. This shows that religion was not a significant determinant of modern FP methods use.

Table 4.6: Religious Influence and Modern FP Methods Use

		Currently using any modern FP services			
		Yes		No	
		Frequency	%	Frequency	%
Does your religion support the use of these services	Yes	7	63.6%	4	36.4%
	No	5	50.0%	5	50.0%
	Not sure	7	36.8%	12	63.2%

4.5.6 Polygamy

As shown in table 4.7 below, , modern FP methods had low prevalence among respondents in polygamous marriage while respondents who were never married had the highest prevalence of using modern FP methods. In comparison however, respondents in monogamous marriages reported higher use of modern FP methods compared to respondents in polygamous marriages. This in general shows that polygamous marriage discouraged and hindered the use of modern FP methods.

Table 4.7: Marital Status and Modern FP Methods Use

		Currently using any modern FP services			
		Yes		No	
		Frequency	%	Frequency	%
Marital status	Monogamously married	7	53.8%	6	46.2%
	Polygamously married	4	33.3%	8	66.7%
	Single (Never married)	5	62.5%	3	37.5%
	Separated/Widowed/Divorced	3	42.9%	4	57.1%

CHAPTER FIVE: DISCUSSION, SUMMARY OF FINDINGS AND RECOMMENDATIONS

5.1 Introduction

This section presents discussion of the findings made from this study, a conclusion derived from the study findings as well as recommendations in line with the study objectives and study conclusions. Areas for further research are also proposed herein.

5.2 Discussion

5.2.1 Contraceptive Use

The results indicated that up to 70% of women in Funyula had previously used a modern FP method with over half (37.5%) having used injectables, 32.5% had used implants while 2.5% used sterilization. According to this study it was found that 47.5% of women were currently using modern FP methods with 17.5% using pills, 12.5% using implants and 10% using injectables. The current contraceptive prevalence was found to be lower than the national average of 53% (KNBS, 2015). Also this study found that pill were the most commonly used modern FP method contrary to the national average where injectables and implants are the most widely used as compared to pills. Similar to a study by Tsui, et al, (2010) this study observed that one in four women had an unmet need of contraceptive. The level of unmet contraceptive need in this study was higher compared to the rural national average of 23% (KNBS, 2015)

The study also found that 22.5% discontinued modern FP method they previously used mostly due to perceived or real side effects. A small portion had discontinued FP

since they wanted to have another child. The discontinuation rate was however lower compared to a study among Kenyan women aged between 18 to 24 years which found a discontinuation rate of 42.4% (Aloo, et al., 2013). This study found that discontinuation rate was high among those using injectables and implants while those using pills had the lowest discontinuation rate. This was contrary to a study in Nairobi Slums that found that women previously using pills had the highest discontinuation rate (Mumah, et al., 2015).

5.2.2 Factors Hindering Access to FP services

5.2.2.1 Physical Accessibility of FP Services Centers

Women in Funyula sourced modern FP methods from more than one source mostly including health centers or dispensaries followed by chemists and relatives or friends. Despite sourcing from public health facilities there were some cases in which women were not counseled prior to being given these methods, however health workers remained the key source of information on contraceptives. This meant that the women who were not counseled then sourced information their social networks which could be attributed to widespread misconceptions about contraceptives. Contrary findings were made in a countrywide study which found that women mostly sourced contraceptive from other women in the community as compared to health workers (Ochako, et al., 2015).

Nearness to a health facility reduces the costs and time needed to travel to these health facilities hence increasing the likelihood of access and utilization of FP services. This study found that majority of women sourced their modern FP methods from facilities nearby hence did not spend much time and money traveling to and fro these facilities.

Given that the modern FP prevalence was not higher than the national average it was therefore inferred that their closeness to the source of modern FP methods did not enhance uptake of these methods in Funyula. This was contrary to studies in Kenya (Ettarh & Kyobutungi, 2012) and Ghana (Eliason, et al, 2014) which found that women in near to source of FP methods had a higher likelihood of using modern FP methods.

5.2.2.2 Availability of FP Services

Consistent availability of FP supplies in health facilities increases the probability for flexible choices and reduces the need for repeated visits to health facilities hence reduced costs that would have burdened women who are in need of FP services. The findings in this study however revealed that FP supplies were not always available therefore forcing women to have repeated facility visits or forced women to seek FP services from private chemists. The availability of FP services were further hampered by shortage of health workers which limited provision of these services. This was similar to observations in the Kenya Service Provision Assessment which indicated that Kenyan health system is beleaguered with ensuring consistent supply of health supplies which limits method-mix and method choice hence discourage use of these services (MOH & KNBS, 2010). Similar findings were also made in a study in Mathare in Nairobi County found that women at times spent long time waiting for FP services in public facilities but later found that FP supplies were out of stock (Keesara, et al, 2015).

5.2.2.3 Affordability of FP Services

Although modern FP methods in public health facilities were offered free of charge,

tests required in assessing eligibility for an FP method were not covered in costs subsidies. However all these services according to the respondents were affordable hence affordability of FP services did not hamper use of modern FP methods. Due to persistent shortage of FP supplies, some women were forced to seek FP services from private facilities which most of them considered to be unaffordable. Generally findings depicted that modern FP methods were affordable across all socio-economic status of women hence did not determine the use modern FP methods. Contrary findings were made in Uganda (Asiimwe, et al., 2014) and Zambia (Mutombo & Bakibinga, 2014) which found that women poorer households had a lower likelihood of using modern FP methods in comparison to women from wealthier households.

5.2.2.4 Acceptability of FP Services

In this study, perceived and actual side effects of contraceptive methods emerged as a primary barrier to use. Modern FP methods were believed to cause temporary infertility or reduce one's childbearing capacity, limiting the number of children they were able to conceive in their lifetime. It was also believed that modern FP methods predisposed women to giving birth to twins who were considered culturally unacceptable. Similar to a study by Sharan, et al (2011) this study therefore infers that acceptance of FP was traditionally low coupled with high cultural resistance to FP. Similar observations were also made in a study in Bungoma District which found that contraceptive use was believed to cause very serious diseases, induce women to have continuous backaches and headaches, and bleeding continuously (Wambui, Ek, & Alehagen, 2009). Similar observations were also made in KDHS (2014) which found that non-users of modern FP methods cited fear of side effects as the main reason behind their decision not to use modern FP methods.

5.2.3 Factors Hindering Utilization FP Services

5.2.3.1 Spousal Communication

Spousal communication is critical in eliciting support from the spouses which goes a long way in enhancing compliance to FP methods. The findings indicated that women who had communication regarding FP issues were more likely to use modern FP methods. However only a portion of women discussed with their spouses these issues for they feared that they might be opposed to FP methods. Similar findings were made in Western Kenya (Bakibinga, et al., 2016) and Uganda (Kabarangira, 2011; Lule, et al., 2015) which found that FP use was associated with partner discussion. This study also found that issues to do with contraceptive use were at times viewed as a women issue. Similar findings were made in a study in Tanzania which found that some men believed that discussing FP issues with their partners was not that important (Moshia, Ruben, & Kakoko, 2013). This was also noted in a study in Nigeria which reported the lack of interest in men as they viewed that it is the role of women to determine when to get pregnant (Adelekan, Omoregie, & Edoni, 2014).

5.2.3.2 Spousal Attitudes

In this study it was found that the decision to start or discontinue modern FP methods was not entirely decided by women but was significantly influenced by the spouse's and extended family views. In this study women who had approval and support from their spouses with regards to use of FP methods were more likely to use modern FP methods. The women who deviated from husband's views on contraceptives and proceeded to use contraceptives were deemed to have hidden agendas and thus linked to promiscuity. Spouses in this study who were opposed to using modern FP methods

feared it might have side effects on their wives, reduce their sexual urge or even result in difficulties in giving births or when the wife conceives it was feared that she might give birth to a child with disabilities. These findings were similarly recorded in a study in Nigeria which found that women using contraceptives without their husband's consent were brandished promiscuous (Adelekan, Omoregie, & Edoni, 2014). Similar findings were also recorded in a country-wide study which found that most Kenyan men raised concerns about FP resulting to diminished sexual urges, birth defects, or discomfort during sex hence were not fully supportive of modern FP methods use (Ochako, et al., 2015). Women in Western Kenya too, were found to depend on their husbands decision about whether to use or not use contraceptive with dire consequences if the women went against the husband's decisions (Wambui, Ek, & Alehagen, 2009).

5.2.3.3 Number of Living Children

In typical African society, people are socialized to attach more value to higher number of children and especially the boy child. In this study most users of modern FP methods were found to have a higher number of boys and vice versa. This was attributed to the desire for those with fewer boy child to seek more children (boys) hence avoided to use modern FP methods. There was also a misconception regarding reduction in ability to conceive after using modern FP methods hence women with fewer children tended to avoid using modern FP methods. This specifically discouraged the use of FP since social status in the community was viewed in the number of children a man has in his family. Similar findings were found in India which found that contraceptive use decreased with increase in the number of living male children and decreased with an increase in the number of living female children

(Lasee & McCormick, 1996; Narzary & Sharma, 2013). Similar findings were also reported in Ghana (Achana, et al., 2015) and Burkina Faso (Maïga, et al., 2015) which found that contraceptive use increased with the number of living male children.

5.2.3.4 Education Level

Education enhances access to information on FP which helps in demystifying the myths and misconceptions about contraceptives. In this study the prevalence of use of modern FP methods increased with increase in women's highest education level. The study further found that women with higher education tended to be married to spouses with higher education who happened to have higher approvals for modern FP methods. Higher education level enables women to mitigate effects of spousal locus of control hence increase her ability to use contraceptives despite opposition from the spouse as she will be able to purchase FP methods without having to rely on the spouse to provide. More educated women are also likely to keep women with higher education levels in her social networks who are likely to have utilized FP methods which further increases the likelihood of using modern FP methods. This finding concurs with several other local studies that have documented women with lower education levels tend to have low knowledge about benefits of FP, less likely to approve of FP and therefore less likely to use modern FP methods (Anguko, 2014; KNBS, 2015; Bakibinga, et al., 2015).

5.2.3.5 Religious Influence

According to the functional theory of religion, religion has a strong social and personal influence and control over the believers as it not only determines people's identity, but also guides their social and other forms of behaviour. According to this

study although prevalence of modern FP methods was higher among women whose religion supported FP, half of those whose religion opposed FP went against their religious views and used FP. This showed that religion had minimal effect on use of modern FP methods in Funyula. Findings of this nature were reported Western Kenya which found that religious affiliation was not significant predictor of FP approval among women (Bakibinga et. al, 2015). Contrary findings were made in Bondo District (Nangendo, 2012), Daadab Refugee Camp (USAID, 2008) and Cameroon and Senegal (Browne & Eloundou, 2012) which indicated that religion influenced women's fertility decision making including decisions on FP use and approval.

5.2.3.6 Polygamy

In this study woman in monogamous marriage reported higher use of modern FP methods compared to women in polygamous marriages. This could be attributed to the notion that women in polygamous marriages tend to have less education and a wider spousal age gap which limits their probability of having spousal communication in FP resulting in wide difference in FP approval. Women in polygamous households often feel a need to have more children than their counterparts to attain influence. On the other hand women in polygamous marriage often resort to clandestine use contraception due to spousal disapproval. Similar findings were made in Ndhiwa District (Ouma, 2014), Gambia (Jammeh, et al., 2014) and Ethiopia (Lakew, et al., 2013) which found that polygamous marriage discouraged and hindered the use of modern FP methods.

5.3 Summary of the Findings

5.3.1 Contraceptive Use

Majority (70%) of women in Funyula had previously used a modern FP method however currently 47.5% of women were using modern FP methods mostly involving pills, implants and injectables. A quarter of women did not like to have a child (or another child) in the near future but were not currently using any contraceptive method.

5.3.2 Factors Hindering Access to FP services

Given that most of women sourced their modern FP methods from public health facilities, access to these supplies were sometimes hindered by erratic supplies which forced some women to seek for these services from private chemists hence induced considerable costs. Primarily access to FP services was hindered by acceptability of modern FP methods. These methods were riddled with myths and misconceptions. The modern FP methods were believed to cause temporary infertility or reduce one's childbearing capacity, limiting the number of children they were able to conceive in their lifetime and predispose to giving birth to twins who were considered culturally unacceptable. These myths were spread through women's social network and further driven by shortage of health workers to provide adequate counseling services during administration. There were women who had genuinely experienced side effects including excessive bleeding, backaches and headaches as a result of FP which resulted to total discontinuation of these services.

5.3.3 Factors Hindering Utilization FP Services

Although just over half (55%) of women had discussed FP with their spouses, women who had communication regarding FP issues were more likely to use modern FP methods. In addition, despite low spousal approval of modern FP methods, women who had approval and support from their spouses with regards to use of FP methods were more likely to use modern FP methods. Due to the value of male child in the society, most users of modern FP methods were found to have a higher number of boys as compared to girls vice versa. Also use of modern FP methods increased with increase in women's highest education level but women's religion affiliation did not hinder utilization of modern FP methods as most women went against their religious doctrines when it was opposed to FP. Furthermore women in polygamous marriages had low prevalence of modern FP methods as compared to women in monogamous marriages as the former sought to attain influence in having a higher number of children.

5.4 Recommendations

Based on the study conclusions and objectives, the researcher recommends as follows:

1. Due to widespread misconceptions and myths about modern FP methods, there is need for the County Government and other health stakeholders to create public sensitization about modern FP methods. In these sensitization forums men should adequately be involved as their approval of FP methods would drive uptake of modern FP methods.
2. The County Government and National Government should ensure adequate number of health workers in health facilities and other community settings to

ensure that women are adequately counseled and examinations done before being administered modern FP methods. This will help in psychologically preparing them for the contraindications of modern FP methods. This can be achieved by enhancing the capacity of Community Health Volunteers to enable them deliver not only the FP methods but also provide FP counseling services.

3. There is need for the National Government to ensure adequate provision of educational services to both male and female children to ensure attainment of higher education levels as it has been shown that couples with higher education have higher prevalence of modern FP methods and higher approval of FP services.

5.5 Areas for Further Research

As this study was carried out on a small scale in only one Sub-County, there is need for a further large scale study in the larger Busia County to establish if the findings in this study apply to the entire county. This study found that myths and misconceptions presented a major barrier towards use of modern FP methods; there is need for a further study to examine how these myths are spread to enable design of strategies to counter these methods. This further study can adopt Social Network Analysis to establish the critical nodes (sources) of the FP myths.

REFERENCES

- Achana, F. S., Bawah, A. A., Jackson, E. F., Welaga, P., Awine, T., Asuo-Mante, E., et al. (2015). Spatial and socio-demographic determinants of contraceptive use in the Upper East region of Ghana. *Reproductive Health, 12*(29), 1-10.
- Adelekan, A., Omoregie, P., & Edoni, E. (2014). Male Involvement in Family Planning: Challenges and Way Forward. *International Journal of Population Research, 2014*(2014), Article ID 416457.
- Adongo, P. B., Tabong, P. T.-N., Azongo, T. B., Phillips, J. F., Sheff, M. C., Stone, A. E., et al. (2014). A Comparative Qualitative Study of Misconceptions Associated with Contraceptive Use in Southern and Northern Ghana. *Frontiers in Public Health, 2*(137).
- Agadjanian, V. (2013). Religious Denomination, Religious Involvement, and Modern Contraceptive Use in Southern Mozambique. *Stud Fam Plann, 44*(3), 259–274.
- Agadjanian, V., Hayford, S. R., Luz, L., & Yao, J. (2015). Bridging user and provider perspectives: Family planning access and utilization in rural Mozambique. *International Journal of Gynecology Obstetrics, 130*(Suppl 3), E47–E51.
- Agadjanian, V., Yabiku, S. T., & Fawcett, L. (2009). History, community milieu, and Christian Muslim differentials in contraceptive use in sub-Saharan Africa. *Journal for the Scientific Study of Religion, 48*(3), 462–479.
- Aloo, S. O., Mwendu, M., Wanderi, J., Kaimenyi, S., Herman-Roloff, A., & Oduor, C. (2013). Family Planning Method Switch and Discontinuation among Women aged 15-24 years in Kenya. *International Conference on Family Planning*. Addis Ababa, Ethiopia: Population Services International.
- Amentie, M., Abera, M., & Abdulahi, M. (2015). Utilization of Family Planning Services and Influencing Factors Among Women of Child Bearing Age in Assosa District, Benishangul Gumuz Regional State, West Ethiopia. *Science Journal of Clinical Medicine, 4*(3), 52-59.
- Andersen, R. M. (1968). *Behavioral Model of Families' Use of Health Services* (Research Series No. 25 ed.). Chicago: Center for Health Administration Studies.
- Andersen, R. M. (1995). Revisiting the Behavioural Model and Access to Medical Care: Does it Matter. *Journal of Health and Social Behaviour, 36*(1), 1-40.
- Andersen, R. M., & Aday, L. A. (1978). Access to Medical Care in the US: Realized and Potential. *Medical Care, 16*(7), 533-546.
- Anguko, A. A. (2014). *Determinants of Contraceptive Use Among Women of Reproductive Age in North Eastern Kenya*. Thesis, University of Nairobi, Institute of Tropical and Infectious Diseases (UNITID), Nairobi.
- Arrieta, A., García-Prado, A., & Guillén, J. (2011). The Private Health Care Sector and the Provision of Prenatal Care Services in Latin America. *World Development, 39*(4), 579–587.
- Asiimwe, J. B., Ndugga, P., Mushomi, J., & Ntozi, J. P. (2014). Factors associated with modern contraceptive use among young and older women in Uganda; a comparative analysis. *BMC Public Health, 14*(926), 1-11.
- Bakibinga, P., Matanda, D. J., Ayiko, R., Rujumba, J., Muiruri, C., Amendah, D., et al. (2016). Pregnancy history and current use of contraception among women of reproductive age in Burundi, Kenya, Rwanda, Tanzania and Uganda: analysis of demographic and health survey data. *BMJ Open, 6*, e009991.
- Bakibinga, P., Mutombo, N., Mukiira, C., Kamande, E., Ezech, A., & Muga, R. (2015).

- The Influence of Religion and Ethnicity on Family Planning Approval: A Case for Women in Rural Western Kenya. *Journal of Religious Health*.
- Barry, D., & Esenstad, A. (2014). *Ensuring Access to Family Planning Services for All*. Retrieved September 13, 2015, from Center for American Progress: <https://www.americanprogress.org/issues/women/report/2014/10/23/99612/ensuring-access-to-family-planning-services-for-all/>
- Bongaarts, J., & Sinding, S. W. (2009). A Response to Critics of Family Planning Programs. *International Perspectives on Sexual and Reproductive Health*, 35(1).
- Bongaarts, J., & Sinding, S. W. (2011). Family planning as an economic investment. *SAIS Review of International Affairs*, 31(2), 35-44.
- Bradley, S. E., Croft, T. N., & Rutstein, S. O. (2011). *The Impact of Contraceptive Failure on Unintended Births and Induced Abortions: Estimates and Strategies for Reduction*. Calverton, Maryland: USA: ICF Macro.
- Brenan, M., & Robey, B. (1998). *Reproductive Health: New Perspectives on Men's Participation*. John Hopkins University, School of Public Health. Population Information Program.
- Browne, A., & Eloundou, P. (2012). *What's religion got to do with it? Islam and fertility in Senegal and Cameroon*. Honors Thesis, Cornell University, College of Agriculture and Life Sciences, Development Sociology, Ithaca, NY.
- Busia County Government. (2015). *Demographics*. Retrieved November 23, 2015, from Busia County Government: http://www.busiacounty.go.ke/?page_id=144
- Cherotich, J., & Okwach, K. (2014). Busia County wary of population growth. *Standard Newspaper*.
- Chipeta, et al. (2010). Contraceptive Knowledge, Beliefs and Attitudes in Rural Malawi: Misinformation, Misbeliefs and Misperceptions. *Malawi Medical Journal*, 22(2), 38–41.
- Cleland, J., Bernstein, S., Faundes, A., Glasier, A., & Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*, 368(9549), 1810–1827.
- Creanga, A. A., Gillespie, D., Karklins, S., & Tsui, A. O. (2011). Low use of contraception among poor women in Africa: an equity issue. *Bulletin of the World Health Organization*, 89, 258-266.
- Crichton, J. (2009). Changing fortunes: analysis of fluctuating policy space for family planning in Kenya. *Oxford Journals: Health Policy and Planning*, 23(5), 339-350.
- Crichton, J., Ibisomi, L., & Gyimah, S. O. (2012). Mother-daughter communication about sexual maturation, abstinence and unintended pregnancy: experiences from an informal settlement in Nairobi, Kenya. *Journal of Adolescence*, 35(1), 21–30.
- Degni, F., Mazengo, C., Vaskilampi, T., & Essén, B. (2008). Religious beliefs prevailing among Somali men living in Finland regarding the use of the condom by men and that of other forms of contraception by women. *The European Journal of Contraception & Reproductive Health Care*, 13(3), 298-303.
- Egessa, J. J. (2010). *Utilization of Family Planning Services among Sexually Active People Living with HIV/AIDS in Taso Tororo*. Master's Thesis, Makerere University, School of Graduate Studies.
- Eliason, S., Awoonor-Williams, J. K., Eliason, C., Novignon, J., Nonvignon, J., & Aikins, M. (2014). Determinants of modern family planning use among women of reproductive age in the Nkwanta district of Ghana: a case-control

- study. *Reproductive Health*, 11(65), 1-10.
- Ettarh, R. R., & Kyobutungi, C. (2012). Physical access to health facilities and contraceptive use in Kenya: Evidence from the 2008-2009 Kenya Demographic and Health Survey. *African Journal of Reproductive Health*, 16(3), 47-55.
- Ezeh, A. C. (1993). The influence of spouses over each other's contraceptive attitudes in Ghana. *Stud Fam Plann*, 24(3), 163-74.
- Guttmacher Institute. (2012). *Abortion and Unintended Pregnancy in Kenya*. New York: Guttmacher Institute.
- Gyimah, S. O., Takyi, B. K., & Addai, I. (2006). Challenges to the reproductive-health needs of African women: On religion and maternal health utilization in Ghana. *Social Science & Medicine*, 62(12), 2930–2944.
- Institute for Work & Health. (2009). *Cross-sectional vs. longitudinal studies*. Retrieved May 18, 2015, from Institute for Work & Health: <http://www.iwh.on.ca/wrmb/cross-sectional-vs-longitudinal-studies>
- Jammeh, S. S., Liu, C.-Y., Cheng, S.-F., & Lee-Hsieh, J. (2014). Community based study on married couples' family planning knowledge, attitude and practice in rural and urban Gambia. *African Health Sciences*, 14(2), 273–280.
- Jiang, L., & Hardee, K. (2014). Women's Education, Family Planning, or Both? Application of Multistate Demographic Projections in India. *International Journal of Population Research*, Volume 2014(2014).
- Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J., & Atuyambe, L. (2014). Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda. *Reproductive Health*, 11(21), 1-9.
- Kabarangira, J. M. (2011). *Contraceptive use by adolescents in Internally Displaced Persons' (IDPs) camps in Pader District, Northern Uganda*. Master's Thesis, Makerere University.
- Kasenene, P. (1993). *Swazi tradition, religion and society*.
- Kavanaugh, M. L., & Anderson, R. M. (2013). *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*. New York: Guttmacher Institute.
- Keesara, S. R., Juma, P. A., & Harper, C. C. (2015). Why do women choose private over public facilities for family planning services? A qualitative study of post-partum women in an informal urban settlement in Kenya. *BMC Health Services Research*, 15(335), 1-10.
- Kenya National Bureau of Statistics [KNBS]. (2009). *Kenya Demographic Health Survey*. Nairobi: Kenya National Bureau of Statistics.
- Kenya National Bureau of Statistics [KNBS]. (2015). *Economic Survey 2015*. Nairobi: Kenya National Bureau of Statistics.
- Kenya National Bureau of Statistics [KNBS]. (2015). *Kenya Demographic and Health Survey 2014*. Nairobi: KNBS, MoH, NACC, KEMRI & NCPD.
- Kenya Open Data. (2009). *2009 Census Vol 1 B Table 1 Population and Density by Constituency*. Retrieved July 29, 2015, from Kenya Open Data: <https://www.opendata.go.ke/Population/2009-Census-Vol-1-B-Table-1-Population-and-Density/j2vg-j63y>
- Kusi, A., Enemark, U., Hansen, K. S., & Asante, F. A. (2015). Refusal to enrol in Ghana's National Health Insurance Scheme: is affordability the problem? *International Journal for Equity in Health*, 14(2).
- Lakew, Y., Reda, A. A., Tamene, H., Benedict, S., & Deribe, K. (2013). Geographical

- variation and factors influencing modern contraceptive use among married women in Ethiopia: evidence from a national population based survey. *Reproductive Health*, 10(52).
- Lasee, A., & McCormick, J. B. (1996). Demographic and Socio-Economic Determinants of Contraceptive Use in a Low Income Community of Karachi. *J Pak Med Assoc.*, 46(10), 228-231.
- Lassi, Z. S., Mansoor, T., Salam, R. A., Das, J. K., & Bhutta, Z. A. (2014). Essential pre-pregnancy and pregnancy interventions for improved maternal, newborn and child health. *Reproductive Health*, 11(Supp 1).
- LoPresti, A. F. (2005). Christianity. In C. Manning, & P. Zuckerman, *Sex and religion* (pp. 117–141). Toronto: Thomson Wadsworth.
- Lule, H., Echoru, I., Nnabagulanyi, M., & Mulumba, R. (2015). Determinants Of Contraceptive Utilization amongst Teenage mothers: A Case-Control Study In Kyangwali Refugee Settlement (Uganda). *International Journal of Current Advanced Research*, 4(8), 243-257.
- Maïga, A., Hounton, S., Amouzou, A., Akinyemi, A., Shiferaw, S., Baya, B., et al. (2015). Trends and patterns of modern contraceptive use and relationships with high-risk births and child mortality in Burkina Faso. *Global Health Action*, 8(29736), 1-14.
- Ministry of Health [MoH] & Kenya National Bureau of Statistics [KNBS]. (2010). *Kenya Service Provision Assessment Survey*. Nairobi: Ministry of Health and Kenya National Bureau of Statistics.
- Ministry of Health. (2015). *Kenya Health Facilities list with services as at July 29*. Retrieved July 29, 2015, from E-Health Kenya Facilities: <http://www.ehealth.or.ke/facilities/download-latest.aspx>
- Mosha, I., Ruben, R., & Kakoko, D. (2013). Family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania: a qualitative study. *BMC Public Health*, 13(523).
- Mugenda, O. M., & Mugenda, A. G. (1999). *Research Methods: Quantitative and Qualitative Approaches*. Nairobi: Acts Press.
- Mugenda, O. M., & Mugenda, A. G. (2003). *Research methods: Quantitative and qualitative approaches*. Nairobi: Africa Centre for Technology Studies.
- Muir, K., Mullan, K., Powell, A., Flaxman, S., Thompson, D., & Griffiths, M. (2009). *State of Australia's Young People: A Report on the Social, Economic, Health and Family Lives of Young People*. Australian Government Department of Education. Employment and Workplace Relations.
- Mukaba, T., Binanga, A., Fohl, S., & Bertrand, J. T. (2015). Family Planning Policy Environment in the Democratic Republic of the Congo: Levers of Positive Change and Prospects for Sustainability. *Global Health: Science and Practice*, 3(4), 163-173.
- Mumah, J. N., Machiyama, K., Mutua, M., Kabiru, C. W., & Cleland, J. (2015). Contraceptive Adoption, Discontinuation, and Switching among Postpartum Women in Nairobi's Urban Slums. *Studies in Family Planning*, 46(4), 369–386.
- Mumah, J., Kabiru, C. W., Mukiira, C., Brinton, J., Mutua, M., Izugbara, C., et al. (2014). *Unintended Pregnancies in Kenya: A Country Profile*. Nairobi: African Population and Health Research Center.
- Mungai, P. (1996). Mens knowledge attitudes and practices with regard to family planning. *Africa Link*, 5-7.
- Mutombo, N., & Bakibinga, P. (2014). The effect of joint contraceptive decisions on

- the use of Injectables, Long-Acting and Permanent Methods (ILAPMs) among married female (15–49) contraceptive users in Zambia: a cross-sectional study. *Reproductive Health*, 11(51), 1-8.
- Nangendo, S. M. (2012). Knowledge and use of family planning methods and services in West Yimbo Division, Bondo district, Western Kenya. *African Study Monographs*, 33(4), 233–251.
- Narzary, P. K., & Sharma, S. M. (2013). Daughter Preference and Contraceptive-use in Matrilineal Tribal Societies in Meghalaya, India. *Journal of Health Population and Nutrition*, 31(2), 278-289.
- National Council for Population and Development (NCPD). (2013). *Kenya Population Situation Analysis*. Nairobi: Government of Kenya.
- National Institutes of Health. (2015). *Social and Cultural Factors in Health*. Retrieved September 13, 2015, from National Institutes of Health: https://obsr.od.nih.gov/scientific_areas/social_culture_factors_in_health/
- Ngethe, P. N. (2014). *Family Planning in Kenya: A review of national and district policies and budgets*. Deutsche Stiftung Weltbevölkerung (DSW).
- Nichols, et al. (1986). Sexual behavior, contraceptive practice, and reproductive health among Nigerian adolescents. *Studies in Family Planning*, 100-106.
- Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., et al. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: a qualitative study. *BMC Public Health*, 15(118), 1-9.
- Okech, T. C., Wawire, N. W., & Mburu, T. K. (2011). Contraceptive Use among Women of Reproductive Age in Slums. *International Journal of Business and Social Science*, 2(1), 22-43.
- Okech, T. C., Wawire, N. W., & Mburu, T. K. (2011). Empirical Analysis of Determinants of Demand for Family Planning Services in Kenya's City Slums. *Global Journal of Health Science*, 3(2), 109-117.
- Okonofua, F., Okigbo, C. C., McCraher, D. R., Chen, M., Gwarzo, U., Vance, G., et al. (2014). Unmet Need for Contraception among Clients of FP/HIV Intergrated Services in Nigeria: The role of partner Opposition. *African Journal of Reproductive Health*, 18(2), 134-143.
- Okwero, M., Ssempebiva, B., Okwero, P., & Kipp, W. (1994). The realities of unmet need in Uganda. *Planned Parenthood Challenges*, 1, 17-19.
- Okwor, E. U., & Olaseha, I. O. (2009). Married Men's Perception about Spousal Use of Modern Contraceptives: A Qualitative Study in Ibadan Northwest Local Government Area, Southwest Nigeria. *International Quarterly of Community Health Education*, 30(3), 223-238.
- Otieno, R. (2014). Report lists counties with highest levels of poverty. *The Standard Media*.
- Ouma, A. H. (2014). *Socio-Economic and Cultural Barriers to Utilization of Contraceptives among Women in Ndhiwa District, Homa Bay County, Kenya*. Master's Thesis, Kenyatta University.
- Palamuleni, M. E. (2013). Socio-Economic and Demographic Factors Affecting Contraceptive use in Malawi. *African Journal of Reproductive Health September*, 17(3), 91-104.
- Palladium Group. (2015). *Diagnostic Assessment of Kenya's Family Planning Market*. Support to the ESHE Programme.
- Pierre, L. A., & Clapis, M. J. (2010). Family Planning in a Family Health Unit. *Revista Latino-Americana de Enfermagem*, 18(6), 1161-1168.
- Poston, L. (2005). Islam. In C. Manning, & P. Zuckerman, *Sex and religion* (pp. 181–

- 197). Toronto: Thomson Wadsworth.
- Schenker, J. G., & Rabenou, V. (1993). Family planning: cultural and religious perspectives. *Human Reproduction*, 969-976.
- Schuler, S. R., Rottach, E., & Mukiri, P. (2011). Gender norms and family planning decision-making in Tanzania: a qualitative study. *Journal of Public Health in Africa*, 2(2), e25.
- Sharan, M., Ahmed, S., May, J., & Soucat, A. (2011). Family Planning Trends in Sub-Saharan Africa: Progress, Prospects, and Lessons Learned. In P. Chuhuan-Pole, & M. Anqwafo, *Yes Africa Can: Success Stories from a Dynamic Continent*. Washington DC: The World Bank.
- Starbird, E., Norton, M., & Marcus, R. (2016). Investing in Family Planning: Key to Achieving the Sustainable Development Goals. *Global Health: Science and Practice*, 4(2), 191-210.
- Thiede, M., Akweongo, P., & McIntyre, D. (2007). *The economics of health equity*. (D. McIntyre, & G. Mooney, Eds.) Cambridge, UK: Cambridge University Press.
- Tsui, A. O., McDonald-Mosley, R., & Burke, A. E. (2010). Family Planning and the Burden of Unintended Pregnancies. *Epidemiologic Reviews*, 32(1), 152-174.
- Tumlinson, K., Speizer, I. S., Archer, L. H., & Behets, F. (2013). Simulated clients reveal factors that may limit contraceptive use in Kisumu, Kenya. *Global Health: Science and Practice*, 1(3), 407-416.
- UN. (2014). *Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions*.
- USAID. (2005). *Improving Access to Family Planning Services in Public Sector Facilities for Poor/Underserved Populations in Kenya*. Nairobi: POLICY Project.
- USAID. (2008). *Islam Somali Refugee Attitudes, Perceptions, and Knowledge of Reproductive Health, Family Planning, and Gender-Based Violence*. Washington, DC: The Extending Service Delivery (ESD) Project.
- Wambui, T., Ek, A. C., & Alehagen, S. (2009). Perceptions of family planning among low-income men in Western Kenya. *International Nursing Review*, 56(3), 340-345.
- Ziyani, I., Ehlers, V., & King, L. (2003). *Socio-cultural deterrents to family planning practices among Swazi women*. Curationis.

APPENDICES

Appendix 1: Consent Form

I am LilianAgesa, a Masters Student at University of Nairobi. I am conducting a research on access and utilization of Family planning services in Funyula. You have been conveniently selected to assist in this research by responding to the questionnaire questions intended for this research. Note that the information you provide will be treated with utmost confidentiality and will be used for the purpose of this research only.

It is anticipated that the questions will take 30 minutes of your time and they may include those related to access to FP services, socio-cultural and economic factors that influence access to FP services. The questionnaire is divided into four sections which address the above factors and socio-demographic characteristics.

Note that it is expected of you to complete all the questions to enhance validity and reliability of the findings. However, you may skip any questions you are not comfortable with. It is your right to stop your participation in the research at any time. There are no risks associated with participation and no financial benefits. Findings from the study will inform on FP accessibility strategies needed.

Respondent Agreement- Informed consent form

The research has been explained to me and I voluntarily consent to participate. I have had an opportunity for my questions to be answered.

Respondent signature

Date

Appendix 2: Questionnaire

Date _____

Participant's serial no. _____

Section A: DEMOGRAPHIC CHARACTERISTICS

1. Bio-Data (Respondent)

Age	Marital Status	Highest Level of Education	Religion	Occupation
18 - 24	Married Monogamous	University	Catholic	Farmer
25 - 34	Married polygamous	College	Protestant	Housewife
35 - 44	Single	Secondary	Muslim	Business lady
45 +	Separated	Primary	Pagan	Employed
	Windowed	None	Other	
	Divorced			

2. Bio-Data (Spouse's Characteristics if married)

Age	Highest Level of Education	Religion	Occupation
18 - 24	University	Catholic	Farmer
25 - 34	College	Protestant	Unemployed
35 - 44	Secondary	Muslim	Business man
45 +	Primary	Pagan	Employed
	None	Other	

3. Economic characteristic (Household)

Monthly income contributed by respondent	Monthly income contributed by spouse if married	Number of living children
0	0	Boys
< 10000	< 10000	Girls
10000-20000	10000-20000	Total
20000-30000	20000-30000	
30000-40000	30000-40000	
>40000	>40000	

4. Did you ever plan on how many children you wanted to give birth to?

a) Yes [] b) No []

5. If yes, do the children you have given birth to exceed the number you had planned for?

a) Yes [] b) No []

SECTION B: FACTORS HINDERING ACCESS TO FP SERVICES

6. Previous use of modern FP services

Ever used any modern FP services		Method ever used		If never used, would you consider using it?	
Yes		Barrier methods, e.g. condoms		Yes	
No		Hormonal methods, e.g. e-pills		No	
		Surgical contraception, e.g. Tubal ligation			

7. If never used and would not consider using it, why would you not use FP services?

.....

8. Would you like to have a child (or another child) in the near future?
 a) Yes [] b) No []

9. Current use of modern FP services

Currently using any modern FP services		Method you are using		Availability of method you are using		Cost incurred in purchasing this method	
Yes		Barrier methods, e.g. condoms		Always		Very affordable	
No		Hormonal methods, e.g. e-pills		Not always		Affordable	
		Surgical contraception, e.g. Tubal ligation				Not affordable	
		Natural methods, e.g. safe periods					

10. If used/using barrier or hormonal methods, where did/do you get it from?
 a. Health centers/dispensaries
 b. Chemists/shops
 c. Other specify.....

11. In the place where you sourced your modern FP services were you counseled before you got it?
 a) Yes [] b) No []

12. If no, where else do you get information on modern FP services?

.....

13. Preferred source of modern FP services

Preferred source		Distance to the preferred source		Cost incurred in travelling to and from preferred source	
Health centers/dispensaries		Very far		Very affordable	
Chemists/shops		Far		Affordable	
Other (specify)		Not far		Not affordable	

14. Have you ever experienced side effects after using any modern FP services?

- a) Yes [] b) No []

15. Is there any myth that hinders you from using modern FP services?

- a) Yes [] b) No []

16. If yes, describe these myths.

.....

SECTION C: FACTORS HINDERING UTILIZATION OF FP SERVICES

17. Have you ever communicated with your partner on use of modern FP services?

- a) Yes [] b) No []

18. If no, why not?

.....

19. If yes, does your partner approve the use of these modern FP services?

- a) Yes [] b) No []

20. If no in 19 above, do you use modern FP services without his knowledge?

- a) Yes [] b) No []

21. If no in 19 above, why does he not approve the use of modern FP services?

.....

22. Does your religion support the use of these services?

- a) Yes [] b) No [] c) Not sure []

23. What other cultural issues from your society may encourage or discourage you from using FP services.

.....

Appendix 3: Key Informant Interview Guide

1. Who are the major providers of FP services in this area?
2. What are the most commonly methods for FP in this area and why?
3. In your opinion how erratic is the provision of FP services in public health facilities?
4. What are some of the challenges experienced by women while accessing FP services in this locality?
5. Anything on utilization?
6. What are the main factors that hinder women in this locality from seeking FP services?
7. What are the main factors that hinder women in this locality from utilizing available FP services?
8. Are there some misconceptions/myths that hinder women from seeking FP services in this area? What are these misconceptions?
9. In your opinion what should be done or changed so as to ensure all women gain access to FP in the community?

Appendix 4: Focus Group Discussion Guide

1. Do you think FP services serve any useful purposes? How?
2. Who are the major providers of FP services in this area?
3. In your opinion how erratic is the provision of FP services in public health facilities?
4. Are the FP services consistently available upon visit to health facilities?
5. What is the opinion of spouses (men) on uptake of FP services? Do they approve?
6. Are there religious beliefs in your community that bars women from using FP services? What are these beliefs?
7. What are some of the challenges in terms of finances experienced by women while accessing FP services in this locality?
8. What hinders women in this locality from seeking FP services?
9. Are there some misconceptions/myths that hinder women from seeking FP services in this area? What are these misconceptions?
10. Are there side effects associated with use of FP products? Is there anyone who has experienced these side effects? Did you stop using the product thereafter?

Appendix 5: Budget Estimates

ACTIVITY BUDGET		
CORE ACTIVITY	ITEMS/PARTICIPANTS	COST (KSHS)
Consolidation of literature (2 months)	Library search Travelling expenses Kshs 100 x 20 days	2,000
Designing and developing research instruments	Typing and photocopying of research instruments	3,200
Finalizing of research instruments (typing and photocopying)	Questionnaire	5000
Main field data collection	Research Assistants	30,000
Data processing, analysis and report writing		40,000
10% contingency and institutional costs		8,020
Total		88,220

Appendix 6: Time Plan

Activity	2015 – 2016						
	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Finalize research proposal and obtain ethical clearance	X	X					
Pilot study		X					
Data collection			X				
Data entry and data cleaning			X				
Data analysis				X			
Thesis writing				X			
Submission of thesis to supervisor for correction and finalization					X		
Submit thesis to the External Supervisor					X		
Defending the thesis						X	
Final correction and submission for graduation							X