

DETERMINANTS OF DEMAND FOR MODERN FAMILY PLANNING SERVICES AMONG WOMEN OF REPRODUCTIVE AGE: A CASE OF IGEMBE SOUTH SUB-COUNTY, MERU COUNTY, KENYA

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ABSTRACT

The Kenya government, in collaboration with other stakeholders involved in the provision of family planning services, have put in place various strategies and policies to increase uptake of family planning services. These are aimed at increasing contraceptive prevalence rate (CPR), reduction in both total fertility rate (TFR) and unmet need for family planning services. Despite the various strategies and policies, total fertility rate still remains high at 4.6 percent, while CPR and unmet need for family planning are estimated at 46 percent and 24 percent, respectively. The purpose of the study was to examine the determinants of demand for modern family planning services among women of reproductive age in Kenya: A case of Igembe South Sub-County. The study objectives included the influence of income, cultural expectations, level of education and extent to which level of awareness influences demand for modern family planning services among women of reproductive age in Igembe South Sub-County. The study reviewed existing literature and used the socio-ecological model and identified a knowledge gap to be addressed through a cross-sectional household survey; targeting women aged between 15-49 years. This was conducted using a descriptive research design and an interviewer-administered questionnaire was administered to 289 participants on consenting to be part of the research. The findings showed that uptake of modern family planning services was quite low at 36% while awareness of modern family planning services was also low in that among those who had heard about modern family

planning services, only 42% of them were on modern family planning methods. Those within the age of 25-30 were the majority in seeking family planning services. Among those on family planning services 66% of them were married while 36% of them had attained at least primary level education. Majority of the women said that they sought for family planning services in private health facilities at 57% while they get information regarding family planning services from doctors at 44% compared to the media at 2%. Among the major findings of this study was that 42% of the respondents said they travel for more than 10 kilometers to seek for family planning services compared to 9% who lived less than a kilometer away from the health facilities. It is across this bridge that primary health care may advance understanding individual and community-level barriers to uptake of modern family planning services, improving healthcare worker performance by identifying effective methods for training, supporting and supervising community health care workers, identifying and evaluating strategies to strengthen the links between need for service and its uptake and identifying the optimal program design, outcomes and costs given the number of competing public health priorities facing the rural Kenyan women of reproductive age. It is also hoped that the findings may also form a significant reference material to researchers in conducting modern family planning studies.

Key Words: *Determinants of demand for modern family planning services among women of reproductive age: A case of Igembe South Sub-county, Meru County, Kenya*

INTRODUCTION

In recent years, the global community and many national governments have renewed their commitment to family planning. We have witnessed the dedication of new resources, the involvement of new actors and the emergence of new ideas for delivering high-quality services to women and couples who want to plan their families (Population Council, 2013). However, the work of family planning services remains unfinished despite great progress over the last several decades (Family Planning Handbook, 2011). The unmet need for modern family planning has been a core concept in the field of international population for more than three decades now.

Family planning (FP) is the use of birth control methods to determine the number of children there will be in a family and even after those children are born (WHO,2010).Other techniques commonly used as modern family planning services include sexual education, prevention and management of sexually transmitted diseases, pre-conception counseling and infertility management, (Olaitan, 2009). According to (WHO,2010),modern birth control methods adopted by women of reproductive age include long term methods, short term methods and emergency contraceptive methods? Most common birth control methods according to (WHO, 2015) include combined oral contraceptives(COCs) or the pill, Monthly injectable or combine injectable contraceptives (CIC),Combined contraceptive vaginal ring (CVR), Intrauterine device (IUD), Female condoms, Female sterilization and Emergency contraception.

Family Planning (FP) is one of the most important interventions in reproductive healthcare as it contributes to the improvement of the health of women and children in developing countries, through provision of safe and effective means to reduce the number of births and high-risk pregnancies (WHO ,2010).In spite of efforts towards fertility control, there remains a substantial proportion of women in the reproductive age group 15 to 49 years who are not using FP methods even though they do not want a pregnancy. About two thirds of women of reproductive age (15-49 years) are at risk of unintended pregnancy. This results from either non-use or ineffective use of contraceptive methods. Provision should be made for women of all ages throughout their reproductive lives to be able to space and limit their births according to their abilities and desires (Bongaarts et al., 2012). There are individual reasons why women do not use modern methods of contraception. An analysis of 13 developing countries found that a significant number of women do not have adequate knowledge about contraception, have health concerns about using modern contraception or could not afford or easily obtain contraceptive supplies or services (Sedgh et al., 2007).

At the broader political level, lack of access to supplies and services could be associated with reductions in political commitment and funding for family planning in recent decades. For example, restrictions on funding for reproductive health by the US Government during the presidency of George .W. Bush i.e., the Mexico City Policy or ‘Global Gag Rule’ led to dramatic

cuts in money available for family planning for a number of years. While these restrictions are no longer in place, they led to cuts in services in many countries, which is likely to have contributed to increasing unmet need for family planning, (Lancet/UCL, 2009). In addition, reductions in funding may have come about due to the belief by donors that family planning is already fully funded. In part, the success of family planning programmes has led to this false belief. Also, while there have been large increases in funding to population budget lines, much of this has gone towards HIV/AIDS rather than family planning, (Lancet/UCL, 2009).

The lack of transparency in budget lines and the lack of a dedicated budget line specifically for family planning have led to a false confidence that family planning has received. In lieu of the above, the expected consequences due to lack of adequate and effective family planning services include: increase in maternal and child morbidity and mortality, particularly when births cannot be adequately spaced (Ashford, 2003); Mackenzie, (Drahota et al, 2010). This leads to an increase in unsafe abortions ,(Ashford ,2003); Mackenzie, (Drahota et al.2010); contributes to the incidence of HIV and sexually transmitted infections (STIs) (WHO,2010); compromises women's abilities to be productive in their communities and national economies Mackenzie, (Drahota et al. ,2010); forces girls and young women to drop out of school due to unplanned pregnancies,(Barot,2008); exacerbates women's lower social status and gender inequality (FHI,2013);increases poverty and slows economic growth (Sinding et al,2009); and contributes to unsustainable population growth (Ashford, 2003).

According to World Health Organization (2015), an estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Population council (2013) further explains that 222 million women in the developing world who would want to avoid pregnancy are not using modern contraceptive methods. One in four people in developing countries are women of reproductive age 15 to 49. These 222 million women would wish to avoid a pregnancy completely or space or limit future pregnancies, (Singh et al, 2012). Despite these desires, they are not using any form of modern contraceptive. These 222 million women have an unmet need for modern contraception, (Singh Darics et al, 2012). They are women who are using either traditional methods of family planning, which have been shown to have high failure rates or no method at all (Singh et al, 2009).

The rate of modern contraceptive use is relatively low in the Eastern Europe and Central Asia (UNFPA, 2003). The region has a modern contraceptive prevalence rate of 54% for women in age group 15-49. This rate clearly lags behind Asia and the Pacific (62%) and Latin America and the Caribbean (67%) (Donna et al, 2000). National family planning programmes in Eastern Europe and Central Asia region have made significant progress during recent decades. However, this progress has been constrained by a number of factors including a decline in political and financial commitment to family planning. Out of 17 United Nations Population Fund (UNFPA) Programme countries, only five provide contraceptives to the public using the national budget.

All others rely on the private sector or donor support and Kenya is no exception (UNFPA, 2008). As a result the most disadvantaged populations lack access to affordable modern contraceptives and this contributes to high figures of abortion and in some cases maternal deaths. Inequity in accessing and using family planning services remains a challenge that slows down the achievement of Millennium Development Goal (MDG) and most especially the fifth MDG which is to improve maternal health which entails universal access to reproductive health including family planning (FHI, 2013).

Family planning has been cited as essential to the achievement of Millennium Development Goals (MDGs), and has a direct influence on women's health and consequence of each pregnancy (UDHS, 2012). The use of modern contraception significantly varies among countries. In Albania for example, only 11% of currently married women use modern contraception, whereas in Uzbekistan this figure is 59%. Furthermore, there are large disparities of access within countries related to income, age, gender, geographical location and marital status. Women with low income have less access to family planning services than their peers with higher income levels. Access in rural areas is significantly lower compared to urban locations. Many economies in the Sub-Saharan Africa (SSA) are characterized by rapid population growth. This according to Oyedokun, (2007) is partly attributed to high fertility rate, high birth rates accompanied by steady declines in death rates, low contraceptive prevalence rate and high but declining mortality rate. In these countries, the rate of population growth is one of the highest in the world, estimated at 2.8 percent compared to the rest of the world (USAID/HPI, 2007).

In Nigeria, the prevalence rate for modern contraceptives is approximately 11-13%. There is sample research evidence identifying the various factors that contribute to the low prevalence of modern contraceptive use in Nigeria, with the most common factor being the myth about the side effects of modern contraceptives (Health Project Policy, 2012). However, what is lacking is a political will in Nigeria to provide family planning programmes on a much larger scale, using community-oriented approaches and communication programmes, to help change the myth about the side effects of modern contraceptives (USAID, 2009). This review highlights current methods and concepts in contraception, reasons for low contraceptive use and practice in Nigeria, and the need for Nigeria to generate a political priority and a will to make a change in maternal health indicators, with the ultimate goal of providing direction to guide changes in the Nigerian Population Policy as it affects contraceptive use and family planning, (USAID, 2012). An average woman in Nigeria gives birth to 6.5 children in their lifetime (USAID, 2009).

Most of the world's population growth occurs in poor, developing nations, which are least able to support rapid population growth and whose socio-economic development is most likely to be hindered by high fertility. Uganda for example is the third fastest growing country in the world with a total population of approximately 40 million (World fact book, 2014). However, Contraceptive use is low and the unmet need for family planning is high (UDHS, 2007).

Tanzania has been experiencing a steady increase in contraceptive use although the country's total fertility rate remains high at 5.4 children per woman, and only 24% of women age 15-49 use a modern method of family planning. Childbearing in Tanzania begins early; 28% of women have given birth by age 18, 55% by age 20 and 88% by age 25 (FHI, 2012).

Kenya's total fertility rate was once about 8.3, the highest in the world, (WHO, 2008). By the early 80s Kenya became one of the very few countries alongside Botswana and Zimbabwe to implement a National Family Planning programme (Wawire, 2009). Since then the country's fertility narrative tells of a history marked with fertility declines, stagnation and lately a revitalized slowing of number of children a woman has as a result of renewed efforts to increase use of contraceptives. As fertility began to slowly drop in Kenya during the late 90s, a renewed focus on the HIV epidemic meant that a lot of domestic and donor-funding was redirected away from Family planning commodities (Population council, 2006). The initial progress made by FP efforts began to regress and with that, contraceptive use stalled and fertility began to rise once more. This stimulated a push for increased national prioritization for FP in the mid-2000s led by government bodies such as the Division of Reproductive health (DRH), National Council of Planning and development (NCPD), and partners who lobbied for funding to support Family Planning supply.

To increase service provision in Kenya, the Association of Social Franchising for Health was formed in the year 2013 by the coming together of Kenya's six leading Social Franchisee Networks into one consolidated body (ASFH,2015). This was done to strengthen the quality and provision of health services through the development of knowledge sharing platform. The Networks in the consortium include Population Services Kenya, Gold Star Kenya, Family Health Options Kenya, Marie Stopes Kenya, Kisumu Medical and Education Trust and Sustainable Healthcare Foundation. They work by organizing community outreach programmes in rural areas by offering subsidized or free services and use of modern family planning methods has been a major focus. According to World Bank, (2003), the use of family planning services is an important issue for a developing country like Kenya which needs to be taken up from all sectors so as to widen choices available to people, particularly women, by allowing individuals and society more opportunities for social and economic development.

Despite all these, Kenya still records high population growth particularly Igembe South sub county which has a total population of 252,885 according to KNBS, (2009). In Kenya the unmet need for family planning has stagnated at 25% over the last 10 years. According to Population Services Kenya (2012), as much as use of contraceptives has risen steadily from 33% - 39% in 2008, trends show increase in short-term methods and a decline in use of long-term methods. There are many reasons for this including lack of access to information and appropriate health services, traditional gender norms that prevent women from using contraception, opposition by community and family members, real and perceived concerns about safety and side effects, and cost. Other Underlying socio-behavioral issues, including risk perception,

ambivalence, and social costs, may also play a role in demand and use (Ian and Martha, 2013). To address this issue of unmet need for family planning needs to be scaled up from all points especially at the county levels, now that health services are devolved from the national government in Kenya.

STATEMENT OF THE PROBLEM

The Kenya health system is administered from top to bottom by the Ministry of Health and is strongly impacted by the work of NGOs, FBOs and private health facilities or providers. In the year 2008, the government of Kenya operated 48% of the country's health activities with NGOs and Faith Based Organizations (FBOs) at 2% and 13% respectively, (Ngigi & Macharia, 2006). This explains that although it is the government's mandate to ensure that every citizen in Kenya accesses quality healthcare, other entities too have a responsibility to provide healthcare as long as it is quality and standard. Like many other healthcare sectors, the issue of family planning services has been a challenge to both the government and other providers. In Igembe South Sub-County, there has been an unmet need for family planning and this is attributed to the four objectives which are to assess how level of income, cultural expectations, level of education and how awareness levels determine demand for modern family planning services among women of reproductive age in Igembe South Sub-County. Igembe South is a Sub-County in the larger Meru County and currently is the most populated in the county according to statistics in the 2009 census data with a total population of 252,885 and an area of 270.70 sq. (Kenya National Bureau of Statistics, 2009). The area has only 12 government health facilities thus 10 dispensaries and 2 district hospitals respectively which are likely to provide the family planning to the women of reproductive age (MOMS annual report, 2012). The private health providers who provide family planning services also are few compared to other sub counties in the county. Population Services Kenya for example is an NGO that works with private health providers in its Tunza Franchise network and according to the current statistics, there are only two clinics in the sub-county as compared to more clinics in other sub counties, (PSK, 2014).

According to Askew et al, 2013, adolescents are an important vulnerable group in all populations and they have a right to safe and efficient reproductive health services. Recently there has been a big number of girls who fall in this age group, dropping out of school due to early and unplanned pregnancies in Igembe South Sub-County. There is no doubt that this issue has had strenuous consequences on the budgets allocated for due to the increasing numbers of women seeking the services. Few studies have been conducted to establish the factors influencing demand for modern family planning services among women of reproductive age in Igembe South Sub-County. This study will therefore contribute significantly to this body of knowledge by finding out how the factors discussed determine the demand for modern family planning services among women of reproductive age.

GENERAL OBJECTIVE

The purpose of this study was to examine the determinants of Modern family planning Services among women of reproductive age in Igembe South Sub-County.

SPECIFIC OBJECTIVES

1. To assess how the level of income determine demand for modern family planning services among women of reproductive age in Igembe South Sub-County.
2. To assess extent to which cultural expectations determine the demand for modern family planning services among women of reproductive age in Igembe South Sub-County.
3. To establish extent to which the level of Education determines the demand for modern family planning services among women of reproductive age in Igembe south Sub-County.
4. To assess how the level of awareness determines the demand for modern family planning services among women of reproductive age in Igembe South Sub-County.

THEORETICAL FRAMEWORK

This study will adopt the Socio-Ecological Model. It was introduced as a conceptual model in the 1970s by Urie Bronfenbrenner, (Robinson, 2008). The social ecological perspective on health emphasizes the contextualized of health and health behaviors in terms of how individuals, their health and their surrounding physical and social environments interact at multiple levels of health problem and are interdependent. The ecological perspective has essentially two key propositions being 1.Behaviour both shapes and is shaped by multiple levels of influence and 2.Individual behavior affects and is affected by the surrounding social environment. Community is the context in which health behaviors take place and one of the primary settings for health promotion sources, making it a strategic entry point for collaboration and intervention. Research supports the notion that health promotion interventions should also be multi-domain, multidisciplinary and grounded in a social ecological framework in order to have the maximum reach, impact and potential for sustainability (Gottlieb, 2009).

This model overcomes the limitations on other health behavior models by incorporating a focus on individual-level health behavior change with an understanding of the reciprocal relationship between personal choices, biology and determinants of health and health behaviors at the level of social networks, communities and policies that impact health. Those multiple levels of influence which impact health related behaviors are as outlined: 1. Intrapersonal processes such as individual attitudes, behaviours, knowledge and skills; 2. Interpersonal processes such as social networks made of family, friends or colleagues that provide support; 3. Institutional factors such as formal or informal organizations which may have rules or expectations which impact health behaviours; 4. Community factors such as formal and informal networks and norms among individuals, families, groups or organizations; 5. Public policy such as local or state, and federal

laws or regulations which promote or inhibit certain health practices which influence disease prevention, control or management. Applying these ecological levels of influence to an analysis of Kenyan women's utilization of modern family planning services can provoke further inquiry into why and where these disparities occur and which levels of influence should be targeted for intervention.

KNOWLEDGE GAPS

These and other studies provide evidence that the correlates of modern family planning services are a multi-domain. More research is needed to show the barriers and facilitators of unmet need for modern family planning services among women of reproductive age especially in rural Kenya. This study intends to address the gaps in the literature which do not account for how modern family planning related health behaviors such as income levels, cultural expectation, education levels and awareness levels are determined by factors in the social environment.

RESEARCH METHODOLOGY

Research Design

Descriptive survey design was used in this study as it enables a researcher to gather data from a relatively large number of subjects at a particular time. The study aimed at collecting information from respondents on factors that influence demand for modern family planning among women of reproductive age in Igembe south sub-county.

Target Population

According to Mugenda & Mugenda (2003) a target population is that population which the researcher wants to generalize results. Kombo & Tromp (2006) describes population as a group of individuals, objects or items from which samples are taken for measurement or it is an entire group of persons, or elements that have at least one thing in common. This study was a household study targeting 289 women aged between 15-49 years since this is the reproductive age group.

Sample Size

Sampling is a means of selecting a part of a group from a population to represent the characteristics of the entire group or the population of interest. An advantage of sampling is that it reduces the length of time needed to complete the study and cuts costs. The sample size was obtained using Krejcie and Morgan Table (Appendix, IV) which is a table for determining sample size and it is flexible and easy to manipulate. The sample size for this study will be 289 respondents. A Kish grid (Appendix, IV) was used at the households to ensure that all respondents from among the household residents have an equal chance of selection during the interview process.

Sampling Techniques

The sampling procedure of this study adopted purposive sampling technique to select women aged between 15-49 years as they possess similar characteristics to help focus on the questions of significance to this study and generalization of the findings. Purposive sampling technique was employed in this study as the population was widely dispersed and a sampling frame was not available, (Patton, 1990).

Research Instruments

The questionnaire contained three major sections; Section one contained questions on the respondents socio-demographic characteristics; Section two contained questions based on the four themes derived from the study objectives namely: 1) Women's level of income, 2) Influence of cultural expectations, 3) Influence of education, 4) Levels of awareness. Section three dealt with factors influencing demand for modern family planning services among women of reproductive age in Kenya and particularly Igembe South Sub-County and finally Section four will deal with challenges and solutions. The questionnaires facilitated an evaluation of Determinants of demand for modern family planning services among women aged 15-49 in Igembe South sub-county.

Piloting of the Research Instruments

Piloting ensured that the questionnaire was free from ambiguity and the data generated was meaningfully analyzed in relation to the stated research questions. This was done by administering (10% of the sample size) similar age category as the actual respondents in Igembe south west division, one of the most remote areas in Igembe and which contained similar characteristics as the study area. After piloting, adjustments were made accordingly to address areas of concern.

Validity of the Research Instruments

Content validity of the instrument was used to measure the degree to which the items would represent specific areas covered by the study. Validity was ascertained by checking that the questions measured what they were supposed to measure such as: the clarity of the wording to make sure that the respondents interpreted all questions in a similar way; eliminating probable causes of ambiguity and confusion. To enhance the questionnaire's validity, it was appraised by the supervisor for evaluation of its applicability and appropriateness of the content and adequacy of the instrument from a research perspective.

Corrections on the identified questions were incorporated in the instrument and a field test was conducted with pilot randomly selected households that were not part of the study to ensure content of research instrument. Then the questionnaires were dispatched to the field and administered by the selected research assistants. In the field, the following measures were

followed to ensure validity: Where appropriate, interviewers spoke local language to enhance communication with the respondents, checking for one informant's description of a thing against another's description of the same thing, in addition to the answers received from some questions, answers were written down and looked at later to help in reducing distortions, recording personal thoughts while conducting observations and interviews. Responses that seemed unusual or incorrect were noted and checked on later against remarks and observations.

Reliability of the Research Instruments

The reliability of the questionnaires was tested using split-half method which is commonly used in survey research to experimentally determine the difference between two variations of survey recruitment protocol characteristics such as research instruments and collection data collection mode. Cronbach's Alpha of 0.81 was in line with Mugenda & Mugenda (1999) who recommend a threshold level of 0.70 for an acceptable reliability coefficient.

Data Collection Procedures

To generate data for this research study, the researcher obtained a letter of introduction from the University of Nairobi which was used to obtain a research permit from National Commission for Science, Technology and Innovation (NACOSTI). Copies of these two documents were presented at the Igembe South sub-county offices as a requirement before the commencement of the field work. The researcher, with the help of trained research assistants then visited the local administration offices to make appointments then later visit the sampled households to establish rapport.

Data was collected from the respondents on the dates agreed upon obtaining informed consent. Instructions were carefully explained to the respondents prior to the interviews after assuring them the information given would be confidential and be used only for the purposes of the study. Adequate time was accorded to each respondent to obtain appropriate answers to the questions after which the completed questionnaires were checked for completeness and accuracy. The data collection exercise took approximately 5 days after which the data will be entered in Microsoft Excel database and cleaned to verify for errors.

Data Analysis Techniques

Descriptive data collected from this study was entered in a Microsoft Excel database and cleaned to ensure accuracy and completeness. Statistical Package for Social Sciences (SPSS) version 17.0 was used to analyze the data and was presented using descriptive statistics such as frequency distributions, percentages and averages. Frequency tables, were used to analyze the background data on age, marital status, women's level of education and demand for modern family planning services. Percentages and correlations were also calculated for the various indicators. Chi-square statistic (χ^2) was calculated for the specified cross-tabulations, where appropriate with significance declared at a P -value =0.05.

RESEARCH RESULTS

From the bivariate analysis of determinants associated demand of modern family planning services among women in Kenya, awareness family planning services affects the use of the family planning methods, hence the fourth research question is accepted. On investigating whether cultural expectation and whether it influences the uptake of modern family planning services, it was significant as respondents said that their cultures influence their choice of family planning methods. On the level of income and education level, the findings were significant as the two variables as the relationship was highly hence it is acceptable that the two determinants determine the uptake of modern family planning services among women of reproductive age.

Income level and demand for modern family planning services

The study sought to find the determinants of demand for modern family planning services among women of reproductive age in Kenya and income was an important factor determining demand for modern family planning services. The findings show that majority of the women are self-employed (44%) earning very low wages as most of them reported to be earning between 5000-2000 Kenya shillings. Majority of the women reported the family planning service costs to be very expensive (22%) and out of the 150 who cited services to be very expensive, only 34 of them were on modern family planning methods. Further to this, 42% of the respondents said they travel for more than 10 kilometres to access health services where this family planning services received.

The findings were confirmed by previous studies on the role of financial support and geographical access to health facilities. Opportunistic costs for forfeiting work and income for a day prevents majority of them from going to health facilities for essential services (Goldie et al., 2001). In Nyarit, Mexico and Western Kenya, women reported that transportation costs and distance played a significant role in family planning use and loss of follow-up (PATH, 2002). Kenyan studies show that women travel from two to eight hours at an average cost of day's agricultural wage (Albwao et al., 2001) to seek for health services. Geographic factors also play an important role in access to and use of health services (Snow et al., 1994). The major limitation in describing physical access to health services are the assumptions that people use the nearest health facilities and that they travel to it in a straight line. Women interviewed in Kenya reported that it is often problematic for a woman to go to a health clinic to seek service if she is 'feeling healthy' as she has must convince her partner to get money for transport when she is visibly okay (Albwao et al., 2001).

Cultural expectation and demand for modern family planning services

According to Ismet (2000) from the reviewed literature, cultural background of a woman is likely to have an effect on the use of modern family planning services. The study reports findings on the relationship between cultural expectations and uptake of modern family planning services.

From the study, 57% of the respondents said that their cultural backgrounds determines their choice of modern family planning services while only 43% of the women said that their cultural backgrounds do not determine their uptake for modern family planning services. Women who are in a more liberal culture are more likely to use modern family planning services as opposed to those who are in conservative and exploitative cultures (Oyedakun, 2007).

Women's level of education and demand for modern family planning services

The study reports findings on the relationship between education and demand for modern family planning services as a form of preventative health -care activity. From the study population, 76% of the women using family planning methods had at least attained primary education and only 24% had no education at all. The results of this study, supports Ismet (2000) study that found that the use of modern method of family planning tended to increase with educational level of a woman. Moreover Clement and Nyovani (2004) also established that modern contraceptive use increased with the educational level of a woman in Tanzania.

This finding also compares with Oyedokun (2007) who found the use of family planning services to be high for women who had more years of schooling in Nigeria. Education can enhance the demand for preventive health services by raising awareness of the importance of being on modern family planning services and may also improve ways in which individuals understand information regarding medical costs, communication with health practitioners and interpreting results. It also enhances the inclusion of individuals in society, improving self-efficacy and confidence, and all these factors improve service uptake.

Women's awareness level and demand for modern family planning services

The study sought to find out the determinants of demand for modern family planning services among women of reproductive age in Kenya and awareness was an important factor in determining utilization of the services; but modern family planning uptake levels were quite low at 108 (37%), while 62% had heard of modern family planning services and the family planning uptake age debut was 25-30 years. Those who had attended health talks were 75 (26%) while those who said that the information they got from the awareness sources influences their choice for modern family planning uptake were 111 (39%) in the age bracket of 31-34 which matches Gichogo (2012) in his study to determine factors that influence family planning uptake at 28% among women aged 29-40, 229 women responded to questions of level of education, awareness on issues relating to demand for modern family planning services, support and accessibility of the services. The results showed that utilization or uptake was low at 37% despite that the study group consisted of women who had at least primary education and had autonomy in decision making regarding their utilization of family planning services. The study group was however a rural population which explains the low rate of family planning uptake.

CONCLUSIONS

Utilization of family planning services has been the concern of not only the government but also other stakeholders including researchers. In this study, it has been established that only a few women in Igembe South sub-county use family planning services. Various demographic, socio-economic and facility factors account for the low use of family planning services amongst women in slums. These include by order of their marginal effects income levels, cultural expectation, education levels and awareness.

It has been demonstrated that the vast majority of women in some countries had never heard of family planning services and even more know nothing about modern family planning services. This study had similar results whereby awareness was 37% among the respondents. The low awareness level of family planning services could be attributed to the study population being from a rural setting and therefore have little or no access to different forms of information through different avenues.

A person considered trustworthy by the population could have the possibility to effectively reach these people in their community. In this study the results show that doctors were the most information givers about family planning services and that majority of the women made decision regarding the uptake of family planning services based on the information they got from the sources or rather motivated them to proactively seek the services.

Even where health facilities existed in close proximity, there were different characteristics that determine whether a woman actually does access services. Women who use family planning are younger (aged 25-30), married and have a source of income and are better educated. Having financial resources and support from health care givers are among the significant determinants of demand for uptake of family planning services.

RECOMMENDATIONS

The study suggested there be need for Implementation of research to ensure that family planning services are widely accepted, cost-effective and achieve high coverage.

The study suggested there is need for training, supervision and follow up of CHWs activities as the interface between the formal health care system and the community, bridge the gap between health needs and provision.

The study suggested there is need to increase the number of government health facilities and provide efficient services so as to reduce transport costs incurred by women as they go seeking for the services over vast distances. Enhance donor partnership with private health facilities so as to provide subsidised family planning services as most women go for services in the private health facilities. Encourage and enhance Inter personal communication.

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