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Factors Influencing Use of Family Planning Methods among Couples in Shankoe Sub- Location, Transmara West Sub-County, Narok County

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Abstract:

Background: Although knowledge of contraceptive methods among sexually active men and women is high globally and in sub-Saharan Africa, the contraceptive prevalence rate among newly married Women aged 15-49 years in Kenya is estimated at 39%, compared to 14% in Shankoe sub-Location in Trans Mara West sub-County, Narok County.

Objective: To assess the factors influencing utilization of family planning methods in Shankoe Sub-Location, Trans Mara West Sub-County, Narok County.

Design: Community-based cross-sectional study.

Study Setting: Three villages of Shankoe Sub-Location namely Olempogit, Emorogi and Enayenyenyeny

Subjects / Participants: Three hundred and sixty respondents (149 males and 211 females) aged 15 years and above in Shankoe Sub-Location, Trans Mara West Sub-County, Narok County.

Results: Those respondents aged 25-35 years in reference to > 50 years were more likely to use family planning methods (OR =0.97, 95% CI [0.43-2.20] p=0.002) than those participants who had ≥ 50 years of age (OR =0.33, 95% CI [0.10-1.03] p=0.057) who were less likely to use family planning methods. Respondents aged 25-35 years had secondary education and understood more on family planning methods than age bracket ≥ 50 years whose members had not gone to school (OR =1, 95% CI [0.19-5.20] p=0.001) compared to participants with no education (OR =0.19, 95% CI [0.03-1.34] p=0.098).

Conclusion: The main barriers to the use of family planning methods amongst couples in Shankoe sub-Location, Narok County were: age, accessibility, religion, education, culture and occupation.

Introduction:

Family planning (FP) is the ability of individuals and couples to anticipate and attain their desired number of children, spacing and timing of their births. It is achieved through the use of contraceptive methods (Bongaarts, 2012). Family planning has public health, economic and

environmental importance and lessens stress on the natural resources and political environments at the national level (Prata, 2009). It is the most cost-effective health and development investments available to governments (Askew and Ian, 2012). It brings transformational benefits to women,

families, communities and countries. It also help females in achieving educational goal, start a business plan and achieve their employment needs (Starbird and Norton, 2016; Apanga and Adam, 2015). It improves the health of women and children by reducing the risk of unsafe abortion, low birth weight, preterm birth and premature rupture of membranes (Starbird and Norton, 2016; UNFPA, 2015). Family planning is an important intervention which has proven to reduce maternal and child mortality (Eliasonet al., 2013). Some family planning methods such as theuse condom can protect individuals from Sexually Transmitted Infections (STIs) including HIV/AIDS (Eliasonet al., 2013, Cates et al., 2010). Family planning has also been found to promote gender equality as well as promote educational and economic empowerment for women (Yueet al., 2010). Despite the enormous benefits of family planning services, the uptake of the service still remains low in sub-Saharan Africa (Eliasonet al., 2013). This has resulted into high rates of unwanted pregnancies, unplanned deliveries, unsafe abortions and maternal mortalities in sub-Saharan Africa, Kenya included (Eliasonet al., 2013, Crossette, 2005). The low uptake of family planning is largely blamed on many factors. It has been observed that awareness of the availability of family planning services has a great influence on the uptake of family planning services (Lauriaet al., 2014). Additionally, even though some women are aware of the availability of family planning services, they are not properly informed about the various forms of family planning methods and how they work (Maliniet al., 2014). Some of the women who went for family planning services were not adequately counseled on the side effects of some of the family planning methods (Maliniet al., 2014). For example, in Uganda, some women stopped using contraceptives after they experienced what they perceived were side effects of the contraceptives (Kabagenyiet al., 2014). Although most people are aware of the benefits of family planning services, they complained that it was difficult to access

family planning services as such services were provided by health facilities that were far from their homes (Gaetano et al., 2014). In addition, religious inclination has been noted to be a major constrain to the uptake of family planning services in Africa (Gaetano et al., 2014, Odimegwuet al., 2005). Also, some individuals perceived that family planning services were meant for only married couples whilst others fear that they will become sexually promiscuous if they go for family planning services once they cannot become pregnant (Eliasonet al., 2013; Gaetano et al., 2014; Odimegwuet al., 2005). In Kenya, efforts have been made by the government of Kenya and non-governmental organizations through the implementation of various programmes to improve the coverage of family planning services in the country (NCPD, 2015). Although some successes have been chucked in the area of awareness of family planning services in the country, the unmet need for family planning still remains high (NCPD, 2015). The Kenya Demographic and Health Survey (KDHS) observed that a large number of women have unmet need for family planning as the acceptor rate for family planning services remains low (KDHS, 2014). In Africa, the average life expectancy at birth is 49 years, infant mortality averages 149 per 1000 live births; maternal mortality is estimated to be between 110 and 647 children deaths per 100,000 live births and contraceptives are used more than 15% of married women of reproductive age (UN, 2017). Clearly, the health benefits of family planning associated with children spacing and use of specific methods can play a major role in protecting the lives of infants, Children, women and the family as a whole. (Sai, 1998). In some regions women still rely on traditional methods of contraception, the UN estimates that approximately 77 million women use these traditional methods to control their fertility. In Kenya, contraceptive use prevalence decreased by 39%, eroding the gains of 1990s, which means that one in every ninechildren dies before they attain five years of

age and has reversed with under five deaths increasing to 117 per 1000 deaths in 2009. In addition to attributing to the rise in infant and child deaths to the HIV/AIDS epidemics, increased childhood mortalities also result from short birth intervals or child spacing and low levels of maternal literacy (Yohannes, 2010).

Materials and methods:

Study Setting: Shankoe sub-Location, Trans Mara West sub- County, had been chosen for this study because the Maasai communities who are the natives are pastoralists with strong traditional /cultural attachment to have many children which they value so much for their economic development or sign of wealth. The area is also suitable for availability of health facilities with family planning services which are underutilized by the community.

Study Design: A descriptive cross- sectional survey design was used in the research

Target Population: The target population for this study was 880 households from which 357 respondents were administered questionnaire to and 9 key informants with whom focus group discussion was conducted. The couples within the households and their ages included female of reproductive age of 15-49 years and males of age above 18 years.

Sample Size Determination

A sample size that was representative of the target population was drawn from the three villages of Shankoe Sub-Location namely: Olempogit, Emorogi and Enayenyieny, using a sampling factor. This enabled the results obtained from the sample to be generalized to entire target population of the community. The ever increasing demand for research has created a need for an efficient method of determining the sample size needed to be representative of a given population (Fisher et al., 1998) where the formula for the determining the sample size for the study for population less than 10,000 was a given as follows:

$$\text{Therefore; } n_f = n \sqrt{\frac{1+n}{N}}$$

Where n_f - Desired Sample size where the study population is less than 10,000 (<10,000).

n -The Desired Sample size when the study population is more than 10,000 ($n > 10,000$)

N - The estimated population size.

Substitution:-

$$n_f = n$$

$$1+n$$

$$N$$

$$384$$

$$1+384$$

$$5145$$

$$= 384$$

$$1.0745$$

$$= 357$$

Actual Sample size=357

Out of the total 880 households, which are the population target, an approximate sample size of 357 was identified for interview using the 95% confidence level, with a margin error of 5.0%.

Sampling Procedure:

After the sample size of the three Villages have been determined as above, i.e. Olempogit, Emorogi and Enayenyieny, the Stratified Random Sampling (SRS) was used for each village to obtain households to be interviewed. The technique was to ensure selection of subjects for a sample in such a way that every member of the population has an equal chance of being selected. Both couples (males and females) from the households selected using the SRS technique were interviewed. The technique gives each household of the target population equal and independent chance to being included in the study sample. For this particular technique to succeed, the households were picked randomly until the required numbers of respondents were reached. Respondents from key informants on the other

hand were selected in a way that the chairperson, who was perceived to have more information than the other committee members, was identified for interviewing.

Data Collection Procedures:

Piloted and printed copies of questionnaires were given to trained research assistants who distributed them to sampled individuals of the respective couples. There were three research assistants engaged for this exercise in three villages. The researcher consistently supervised data collection. Respondents were made to relax by conducting interviews in the open and in as reasonably formal atmosphere as possible to pre-empt interviewer and interviewee biases. The exercise was conducted at a time that was considered convenient to the respondents to avoid interrupting their daily routine or engagements which would otherwise negatively influence the quality data collected. A rapport was created first between the research assistants and the respondent so as to eliminate any fear or suspicion which may hinder offering vital information required for the study. Ethical consideration and human relations issues were highly observed during data exercise.

Data Analysis Techniques:

The raw data collected were first cleaned, coded, classified and entered in to computer software. This data was then be subjected to analysis using Statistical Packages for Social Sciences (SPSS), computer programmer Most of the data collected were qualitative in nature highlighting the descriptive influence of socio- cultural factors on use and perception of family planning methods amongst the couples. In the analysis, quantitative data were through percentages and frequency tables while qualitative data werethrough descriptive method. Interpretation of the analyzed data was based on the magnitude of the percentages obtained. Consequently, recommendation for policy and further research were made based on the interpreted findings.

Ethical Consideration:

Ethical clearance for the study was granted from University of Eastern Africa, Baraton (REC: UEAB / 15/03/2016).

Results:

The study sought to assess the socio-demographic characteristics of the factors influencing the use of family planning methods .Therespondents of the study were three hundred and sixty six (N=366). The demographic characteristics they were asked to reveal were age, gender, residence, marital status, education level, religion and occupation.

Table 1: Socio-Demographic Characteristics of Respondents

Variable	N	%
Age (years)		
15 – 25	109	30.3
26– 35	167	46.3
36– 49	57	15.3
> 51	27	7.5
Gender		
Male	149	41.4
Female	211	58.6
Marital Status		
Married	275	76.4
Single	45	12.5
Separated	7	1.9
Widow/Widower	33	9.2
Education Level		
None	49	13.6
Primary	96	26.7
Secondary	141	39.2
Tertiary	74	20.5
Religion		
Christian	326	90.6
Atheist	1	0.3
Islam	1	0.3
Traditionalist	32	8.9
Occupation		
Peasant farmer	173	48.1
Businessmen/women	96	26.4
Salaried	61	16.9
None	31	8.6

Referring to the table 1, less than a half, 167 (45.6%) of the respondents were aged between 26- 35 years, followed by those aged 15-25 109 (30.3%) , followed by 36-49 (15.3%) and the least were over 51 years, 27 (7.5%). Respondents' gender were male 149 (41.1%) and female 211 (58.6%), although the female were overwhelmingly the majority since they have good health seeking behaviors than males. The marital status of the respondents were widow / widower were 33 (9.9 %), separated 7 (1.9%), single 45 (12.5%) and married 275 (76.4%) . The majority of the respondents 52 (42.98%) had secondary education, 51 (42.15%) primary and 7 (5.79%) had college / university education, only 8 (6.61%) had no education at all and 3 (2.48%) did not respond to the question. Majority were farmers 76 (62.81%), followed by small business and only 4 (3.31%) were employed, 2 were doing other activities, this results shows that the respondents are of low economic status 113 (93.39%) majority of the respondent were Christians 361 (90.6%) atheist 1(0.3%) Islam 1(0.3%) and traditionalist were 32 (8.9%). Occupation of the respondents were; Peasant farmers 173 (48.1%) Businessman / Women 9.6 (26.4%) Salaried employees 61(16.9%) and none 31 (8.6%)

Knowledge on family planning methods

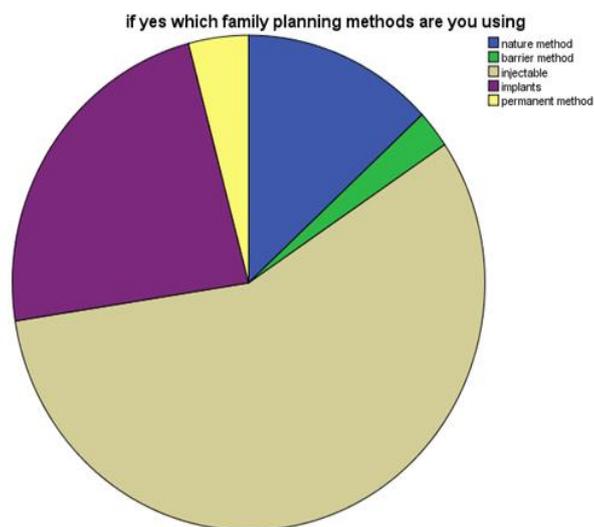


Figure1. Which family planning method are you using?

The majority of the respondents knew about the family planning methods (65.3%) well. One hundred and nineteen (32.5%) had never heard about family planning methods while 2 (0.6%) never answered the question. Out of those who knew about family planning, 6 (1.7%) used natural method of family planning, 139 (38.0 %) used barrier methods, 57 (15.6%) used implants while 10 (2.7%) used permanent methods.

Table 2: Correlates on use family planning and Participant Characteristics

Variable	Use	uOR(95% CI)	P value	P value
Sex			0.33	26
Male	80(33.47s)	ref.		
Female	159(66.53)	0.64(0.26-1.60)		
Age (years)			0.01	
15 – 25	109(45.6)	0.86(0.45-2.20)	0.001	
25 – 35	90(37.65)	0.97(0.43-2.20)	0.002	0.948
36 – 49	29(12.13)			
> 50	16(6.7)	0.33(0.10-1.03)	0.057	0.094
Educational status			0.011	
None	27(11.2)	0.19(0.03-1.34)	0.098	
Primary	40(16.7)	0.93(0.43-2.02)	0.003	
Secondary	100(41.8)	1(0.19-1.03)	0.001	
Tertiary	70(29.3)			
Marital Status			0.6696	
Married	157(65.7)	ref.		
Single	45(18.8)	0.50(0.15-1.70)	0.27	
Separated	7(2.9)	1.21(0.39-3.79)	0.746	
Widow/Widower	30(12.6)	0.87(0.35-2.20)	0.773	
Religion			0.0283	

Atheist	1(0.4)	ref.		
Christian	230(98.7)	1.03(0.47-2.27)	0.935	0.905
Islam	0(0.0)	0.28(0.05-1.58)	0.15	0.195
Traditionalist	0(0.0)	0.10(0.01-0.87)	0.037	0.229
Other specify				
Occupation			0.001	
Salaried	61(25.5)	ref.		
Businessman/women	95(39.7)	0.29(0.03-3.15)	0.314	
Farming	173(72.4)	0.43(0.04-4.37)	0.479	
None	0(0.00)	0.33(0.01-11.94)	0.547	
Accessibility				
Less than 5km	180(75.3)	Ref.	0.002	
Between 5 and 10 km	59(24.6)	0.78(0.08-7.52)	0.568	
More than 10 km	0 (0.0)	0.60(0.10-3.50)	0.827	
Don't know	0(0.0)			

Bivariate logistic regression was used to determine association socio-demographic and the use of family planning, the table results shows that some variables were significant to the use of FPM. Those respondents with 25-25 years in reference to > 50 years were more likely to use FPM (OR =0.97, 95% CI [0.43-2.20] p=0.002) than those participants who had ≥ 50 years of age (OR =0.33, 95% CI [0.10-1.03] p=0.057) who were less likely to use FPM. This can be due to education status of the respondents most of the age bracket (25-35) years had secondary education hence tend to understand more on family planning methods than age bracket ≥ 50 years whose most of the members have not gone to school hence did not understand family planning methods. Moreover those with secondary education were likely to take ART (OR =1, 95% CI [0.19-5.20] p=0.001) compared to participants with no education (OR =0.19, 95% CI [0.03-1.34] p=0.098). In reference to single and married, single were more likely to use family planning methods 1.21(0.39-3.79)

p0.746 than married 0.47(0.16-1.70)p.88 this is due the fact most single have not settled hence they tend to use family planning methods. In reference to Christianity and traditionalist, Christianity are more likely to use family planning methods 1.03(0.47-2.27)0.0935 than traditionalist 0.10(0.01-0.87)0.037. In reference to those people who are not doing any job and businessman/women, none are less likely to use FPM 0.33(0.01-11.94) p 0.54 than businessman/women 0.29(0.03-3.15) p0.314. According to accessibility, people living more than 10km from the facility were less likely to use the FPM 0.60(0.10-3.50) P0.827 than those who live place of less than 5KM0.30 (0.10-3.54)P0.413

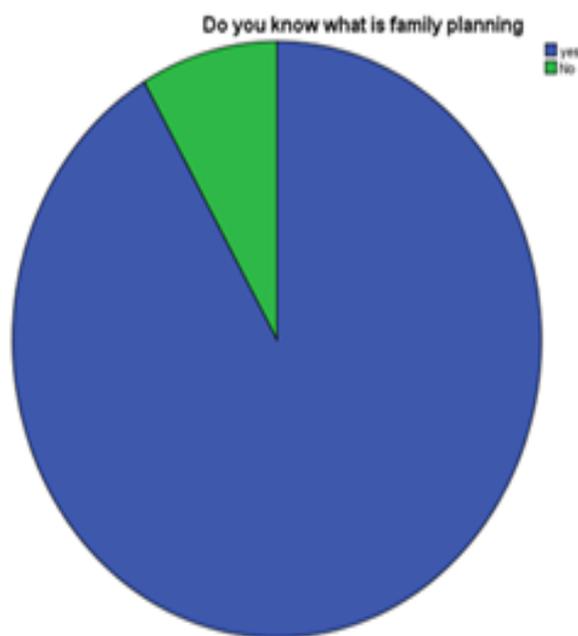


Figure 2: Do you know what is family planning?

When the respondents were asked if they knew what family planning is, 328 (91.1%) responded yes and 30 (8.3%) responded “NO,” while 2 (0.6%) did not respond. This is because the majority of the respondents were of the age brackets 49 years and below and most of them were literate, meaning that they had basic education and other factor can be due to majority of the respondent being Christians and that some churches teaches their members the importance of

having manageable number of children . When the respondents were asked whether they know where the family planning services were offered 322 (89.4%) responded YES while 37 (10.3%) responded NO. Those respondent who answered they knew what family planning was, were then asked to state where family planning services were being offered. Majority of the respondents, 260 (72.2%) said government health facilities, 18 (5%) said mission hospital and 42 (11.7%) said private clinics, while 4 (1.1%) said traditional herbalist. This was due to the fact that, the majority of the respondents visit the government health facilities because most of the services offered were free

Figure 3: Where family planning serves are offered

Socio-cultural factors influencing the use of family planning methods

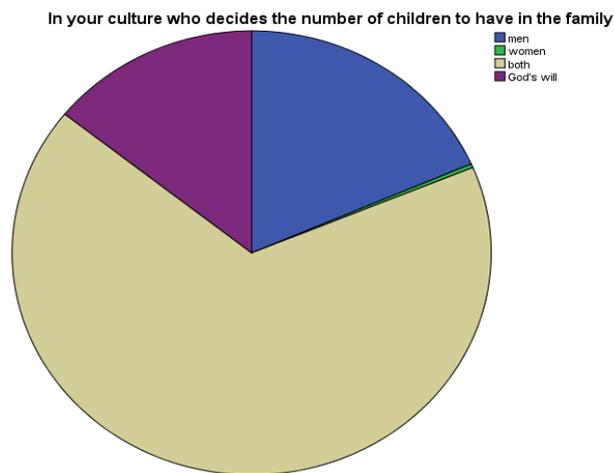
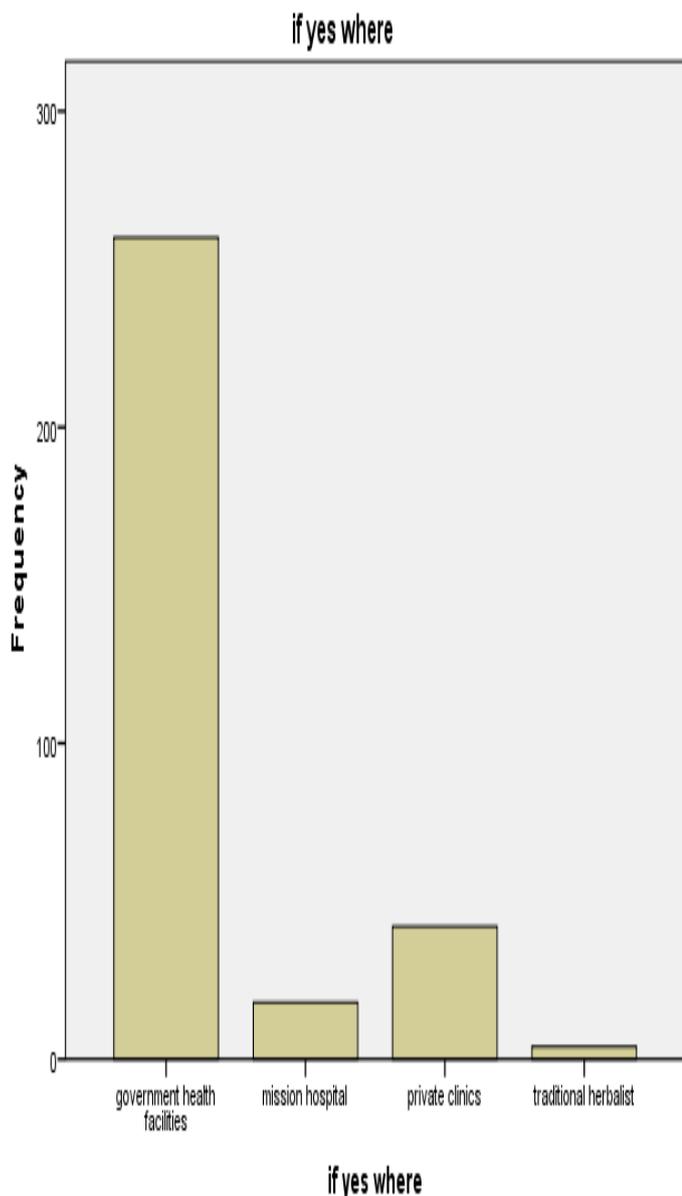


Figure 4: Who decide the number of children to have in a family

Majority of the respondents in the study 66.7% said both man and woman should decide the number of children the family should have, 18.3% said it is the man to decide the number of children, 0.3% responded it is the women to decide the number of children in a family, 14.2% responded it is God who decide the number of children to be born in a family. From the finding you can see culture has influence on the number of children to be born and who influence among the man and women. Women still do not have voice on the number of children to be borne in the family despite being the ones who carry the pregnancy.

Table 3: Association between Culture and Socio-Demographic Characteristics

Variable	How many children do you have	How many children do you wish to have	How long you wait before giving birth to another child	p value
Gender				0.001
	Male	1-3 74(20.6)	1-3yr 70(14.8)	
	4-6 44(12.2)	4-6yr 49(13.3)	2-4yr 70(14.8)	



	Above 6 28(7.9)	6&above 29(8)	5&above 49 (13.3)	
Female	1-3 150(41.7 .5)	1-3yr 140(38.9)	1yr 21(21.9)	
	04-Jun 64(17.8)	4-6yr 75(20.9)	2-4yr 140(37.4)	
	Above 6 22(6.1)	6&above 21(5.9)	5&above 75(20.9)	
Missin g	11(0.3)			
Age (years)				0.0 59
15 – 25	1-3 78(21.7)	1-3yr 68(19.51)	1yr 6 24(14.63)	
	4-6 32(8.8)	4-6yr 34(9.3)	2-4yr 30(47.4)	
	Above 6 2(0.6)	6&above 3(0.7)	5& above 2(0.6)	
25 – 35	1-3 67(18.7)	1-3yr 68(19.51)	1yr 69(20.63)	
	4-6 50(13.9)	4-6yr 48(12.3)	2-4yr 49(13.4)	
	Above 6 2(0.6)	6&above 2(0.6)	5& above3(0.6)	
36 – 49	01-Mar 36(20.1)	1-3yr 35(19.79)	1yr 12(21.05)	
	4-6 15(10)	4-6yr 16(12)	2-4yr 17(14.4)	
	Above 6 3(1.8)	6&above 3(1.8)	5& above2(1.7)	
> 50	01-Mar 2(0.6)	1-3yr 2(0.6)	1yr 20(5.26)	
	5(0.4)	4-6yr 5(0.3)	2-4yr 5(0.6)	
	Above 6 20(5.6)	6&above 20(5.4)	5&above5(0 .4)	
Religi on				0.7 71
Atheist	1-3 0(0.0)	1-3yr 160(0.00)	1yr0(0.00)	
	4-6 1(0.3)	4-6yr 1(0.3)	2-4yr 1(0.3)	
	Above 6 0(0.0)	6&above 0(0.0)	5&above0(0 .0)	
Christi an	1-3 189(52.5)	1-3yr 108(30.)	1yr198(52.5)	

)			
	4-6 108(30)	4-6yr 198(52.5)	2-4yr 108(30)	
	Above 6 16(4.4)	6&above 17(4.5)	5& above16(4.4)	
Islam	1-3 0(0)	1-3yr 0(0.0)	1yr0(0.0)	
	4-6 1(0.3)	4-6yr1 (0.3)	2-4yr 1(0.3)	
	Above 6 0(0.0)	6&above 0(0)	50& above0(0)	
Traditi onalist	1-3 6(1.7)	1-3yr 5(1.63)	1yr16(4.4)	
	4-6 10(2.8)	4-6yr11 (2.9)	2-4yr 9(2.4)	
	Above 6 16(4.4)	6&above 6(1.7)	5&above6(1 .7)	
Missin g	13			
Marit al Status				0.0 29
Marrie d	1-3 144(40)	1-3yr 140(39.3 8)	1yr105(27.9 2)	
	4-6 83(23)	4-6yr 85(24)	2-4yr 120(30.4)	
	Above 6 40(11.1)	6&above 43(12.1)	5& above39(10. 9)	
Single	1-3 25(6.1)	1-3yr 26(6.4)	1yr 24(6.0)	
	4-6 15(2.2)	4-6yr19 (3.3)	2-4yr 20(2.4)	
	Above 6 0(0)	6&above 0(0)	5& above0(0)	
Separa ted	1-3 5(1.4)	1-3yr 5(1.4)	1yr 5(1.4)	
	4-6 2(0.5)	4-6yr 2(0.5)	2-4yr 2(0.5)	
	Above 6 0 (0)	6&above 0(0)	6& above0(0)	
Widow /Wido wer	1-3 5(1.4)	1-3yr 2(0.5)	1yr 2(0.2)	
	04-Jun 2(0.5)	4-6yr5 (1.4)	2-4yr 5(1.4)	
	Above 6 6 (2.2)	6&above 6(2.2)	5& above6(2.2)	

Education				0.002
	None	01-Mar 6(1.7)	1-3yr 2(1.8)	
	4-6 10(2.8)	4-6yr 6(1.7)	2-4yr 10(2.8)	
	Above 6 30(5.5)	6&above 7(1.8)	5&above 5(1.6)	
Primary	1-3 20(5.6)	1-3yr 19(19.4)	1yr 20(5.7)	
	4-6 52(14.4)	4-6yr 50(15.3)	2-4yr 52(47.4)	
	Above 6 10(2.8)	6&above 8(2.9)	5&above 10(2.8)	
Secondary	1-3 60(16.8)	1-3yr 59(16.7)	1yr 20(5.5)	
	4-6 20(5.5)	4-6yr 21(5.4)	2-4yr 60(16.8)	
	Above 6 5 (1.5)	6&above 5(1.5)	5& above5(1.5)	
Tertiary	1-3 94(16.8)	1-3yr 94(16.8)	1yr 9(2.5)	
	4-6 9(2.5)	4-6yr 24(52.3)	2-4yr 94(16.8)	
	Above 6 5 (1.5)	6&above 5(1.5)	5& above5(1.5)	
Occupation				0.13
Salaried	1-3 40(11.1)	1-3yr 43(12)	1yr 15(4.5)	
	4-6 15(4.5)	4-6yr 13(4.3)	2-4yr 40(4.5)	
	Above 6 2(0.5)	6&above 2(0.5)	5& above2(0.5)	
Business	1-3 50(13.9)	1-3yr 54(14.4)	1yr 25(6.33)	
	4-6 25(6.59)	4-6yr 24(5.9)	2-4yr 55(13.4)	
	Above 6 15(4.1)	6&above 15(4.1)	5& above10(3.1)	
Farmin g	1-3 60(16.74)	1-3yr 65(17.63)	1yr 90(25.42)	
	4-6 90(25.5)	4-6yr 85(24.3)	2-4yr 60(16.4)	
	Above 6 15(3.5)	6&above 14(3.8)	5& above15(3.5)	
None	1-3	1yr1-3	1yr 30(8.3)	

	6(1.7)	10(2.8)	
	4-6 10(2.8)	4-6yr 6(1.7)	2-4yr 6(1.7)
	Above 6 30 (8.3)	6&above 30(8.3)	5& above2(0.7)

The above table shows the respondents social demographic variable and their association in regard to the following: How many children do you have, How many children do you wish to have and How long you wait before giving birth to another child. The result shows that gender (p value= .001 ≥.05) age (p value= .059 ≥.05), religion (p value= .771 ≥.05), marital status (p value= .029 ≥.05), education (p value= .002 ≥.05) and occupation (p value= .13 ≥.05). The majority of the respondents of the study who used family planning method used injectable method (38.6%), followed by those who used implant (15.8%), others used natural method (8.9%), some also used permanent method (2.8%) and barrier method (1.7%) The respondents of the study stated various reasons why they used family planning methods. Sixty percent (60.8%) said birth spacing, 26.9% birth control, 2.8% promote health of mother and child and 8.4% do not know (Figure 5).

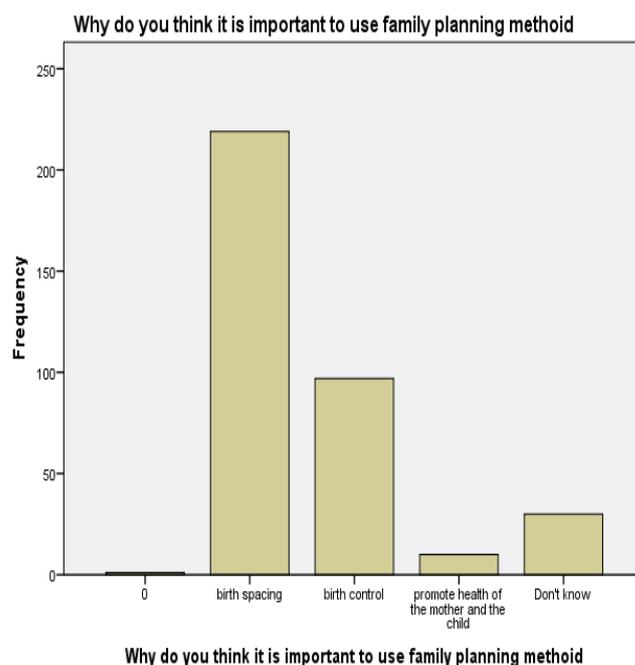


Figure 5: Importance / benefits of using family planning methods

Reasons why people don't use family planning methods

Table 4: Reasons why people are not using family planning methods

Reason why not using FPM		Frequency	Percent
Valid	spouse don't want	35	9.7
	has side effect	47	13.1
	long distance		
	walk to service point	7	1.9
	against church beliefs and doctrine	5	1.4
	Total	94	26.1
Missing	System	266	73.9
Total		360	100.0

Some respondents of the study did not use family planning methods because of the following reasons: About ten percent, (9.7%) said spouse did not want, 13.1% said family planning methods have side effect, 1.9% did not practices family planning methods because of long distance to service point and 1.4% of the respondent never practiced family planning methods because they believed it was against their religious beliefs and doctrines.

Discussion:

This is among the first comprehensive studies to evaluate contraceptive uptake and associated factors among newly married couples at sub-location level in Kenya. Those included in the study were females (n=211) and males (n=149), aged 15 to 51 years, mostly (90.6%) Christians and three quarters (76.4%) married. Globally, couples in rural areas share common demographic characteristics, for example, in a study among married women in Nigeria, Apuke, (2017) revealed that most of the respondents were secondary school educated, though other respondents hold both primary and tertiary

certificates and a few, none. Findings further revealed that, most of the respondents had been married. The findings are more or less similar to the current study in terms of education, where 141 (39.2%) were of secondary education followed by 96 (26.7%) primary, 74 (20.5%) tertiary and 49 (13.6%) no “western” education. In terms of age, the current study found out that, about half of the respondents (46.3%) were aged between 26-35 years, followed by those aged 15-25 were (30.3%) followed by 36-49 (15.3%) and the least were over 51 years (7.5%). This concurs to a study by Apuke, (2017) in Nigeria where data gathered shows that 30 (15%) of the respondents fall within the ages of 18-23, 80 (40%) fall within the ages of 24-29, 60 (30%) fall within the ages of 30-35, 20 (10%) fall within the ages of 36-40 while 10 (5%) fall within the ages of 41 and above. However, our results contradict those of Sing et al., (2016), where it was observed that the highest percentage of respondent were in the age group of 35–49. The gender respondents were male (41.1%) and female (58.6%), the females were overwhelmingly the majority since they have good health seeking behaviour than the males (Moumitaet al., 2018). The marital status of the respondents were widow / widower (9.9%), separated (7 1.9%), single (12.5%) and married (76.4%). Less than half of the respondents (42.98%) had secondary education, (42.15%) primary and (5.79%) had college / university education, only 8 (6.61%) had no education at all and (2.48%) did not respond to the question. Slightly over half of the respondents were farmers (62.81%), followed by small business traders and only (3.31%) were employed or were doing other activities. These results show that the respondents are of low economic status. The majority of the respondents were Christians (90.6%) atheist (0.3%) Islam (0.3%) and (8.9%) traditionalist. About the occupation of the respondents: peasant farmers were (48.1%), businessmen / women were (26.4%) salaried employees (16.9%) and none were (8.6%).

The majority of the respondents knew about the family planning methods 66.4% (n=360) while (33.1%) had never heard about family methods and (0.6%) never answered the question. An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include limited choice of methods, limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people, fear or experience of side-effects, cultural or religious opposition, poor quality of available services, gender-based barriers. Out of those who knew about family planning, 1.7% used natural method, 38.6% used barrier methods, 15.8% used implants while 2.8% used permanent methods. This is similar to study done by Sing et al., (2016) which revealed the higher prevalence of knowledge of contraceptives among respondents, and that, the knowledge varied from one method to another. This inequity is fueled by both a growing population, and a shortage of family planning services. In Africa, 53% of women of reproductive age have an unmet need for modern contraception. In Asia, and Latin America and the Caribbean regions with relatively high contraceptive prevalence, the levels of unmet need are 21% and 22% respectively. Those respondents aged 25-25 years in reference to > 50 years were more likely to use FPM (OR =0.97, 95% CI [0.43-2.20] p=0.002) than those who had \geq 50 years of age (OR =0.33, 95% CI [0.10-1.03] p=0.057) who were less likely to use FPM. This can be due to education status of the respondents most of the age bracket (25-35) years had secondary education hence, they tend to understand more on family planning methods than age bracket \geq 50 years whose most of the members have not gone to school hence do not understand family planning methods. Moreover, those with secondary education were likely to take FPM (OR =1, 95% CI [0.19-5.20] p=0.001) compared to participants with no education (OR =0.19, 95% CI [0.03-1.34] p=0.098) . This is because those who have gone to

school tend to know the importance of using FPM. In reference to single and married, single ladies were more likely to use family planning methods 1.21(0.39-3.79) p= 0.746 than married 0.47 (0.16-1.70) p=88. This is due the fact most single have not settled hence they tend to use family planning methods to prevent unwanted pregnancies. In reference to Christianity and traditionalist, Christianity are more likely to use family planning methods 1.03 (0.47-2.27) 0.0935 than traditionalist 0.10 (0.01-0.87) 0.037. This is because most Christian denominations teach about importance of FMP. With reference those people who are not doing any job and businessmen / women, none are less likely to use FPM 0.33(0.01-11.94) p= 0.54 than businessman / women 0.29 (0.03-3.15) p= 0.314. This also can be due to the fact that people in business tend to be busy and have less time with family hence have less children. According to accessibility in reference to more than 10 km and less 5 km. people living more than 10 km from the facility were less likely to use the FPM 0.60(0.10-3.50) p=0.827 than those who live place of less than 5KM 0.30 (0.10-3.54) p=0.413. Accessibility contributed to the use of FPM because those people who are near the facilities tend to use FPM compared to those who travel for more than 10 km. Majority (91.1%) of the respondents knew about family planning. Eight percent (8.3%) responded "NO" while (0.6%) didn't respond. This because the majority of the respondent were of the age brackets 49 years and below and most of the them are literate means that they basic education and other factor can be due majority of the respondent were Christianity some churches teachers their members the importance of having manageable number of children. When the respondents were asked whether the know where the FP service are offered (89.4%) responded yes while (10.3%) responded "NO". Those respondent who answered they knew what FP were and whether they were being offered, majority responded (72.2%) government health facilities (5%) mission hospital (11.7%) private clinics

(1.1%) traditional herbalist this is due to the majority of the respondent visit the government health facilities because most of the services offered are free From the study, over half of the respondents (66.7%) said both man and woman should decide the number of children the family should have, 18.3% said it is the man to decide the number of children, 0.3% responded it is the women to decide the number of children in a family, 14.2% responded it is God who decide the number of children to be born in a family. From the finding one can see culture has influence on the number of children to be born and who influence among the married partners. Women still don't have voice on the number of children to be borne in the family despite they are the one who carry the pregnancy. Most men believe that women are to submit to them to an extent that women have no say in decision making in the family and hence no say in proposing usage of FP methods. Therefore women's status in the society affects their ability to obtain and use different contraceptive methods of their choice (WHO, 2009). From the study we can see that religion and culture have a negative effect on FP. In some areas, religious or cultural beliefs affect a client's choice of FP Method. Strictly practicing Catholics are limited in their choice of contraceptive to natural FP. Some Islamic leaders claim that sterilization is prohibited while others say it is permitted, but in general, Islamic faith does not prohibit the use of contraceptives (Shah et al., 2004). Women may find the irregular bleeding patterns caused by some hormonal methods to be a hardship in light of the Islamic proscription against prayer during menstruation. Hindu women are prohibited from preparing meals during menses, so irregular bleeding pattern may again be a problem (W.H.O, 2010).It is widely believed among the illiterate families that sexual intercourse during the period of lactation can poison the child and because of this the traditional two-year period of nursing is common among the Maasai community. Also the Maasai regard it as sad for a man to have sexual intercourse with his

wife for the first six months following child birth; it is believed that the second child would be born congenitally weak and sickly (Hopkins, 2009). The study found out that most the respondents used contraceptive because of the following reasons: 60.8%, birth spacing, 26.9%, birth control 2.8%, promote health of mother and children and 8.4%, don't know. Also some respondents of the study didn't use FP methods because of the following reasons: 9.7%, said spouse don't want, 13.1%, said family planning methods have side effects, 1.9% were not practicing FP methods because of long distance to service point and 1.4% of the respondent never practiced FP methods because they believed it is against church beliefs and doctrine.

Conclusion:

In conclusion, the main barriers to the use of family planning methods amongst couples in Shankoe Sub-Location, Trans Mara West sub-County included, age, accessibility, religion, education, culture and occupation. Therefore, there is need to enhance the use of FP methods among couple an interventions targeting to improve the awareness about the importance of family planning among couples. The ministry of health should come up with Strategies to improve the use and management of FPM in order to achieve millennium development goals.

Recommendations:

Kenyan Government through the Ministry of Health should educate the community on the importance of using the family planning methods. Through seminars, radios, churches "barazas" (public community meetings), incorporation with ministry of education it should introduce sexual education in the curriculum. The County Government of Narok should set up mobile clinics which would bring serves close to the people to enhance the use of family planning methods. The Kenyan Government should educate people on the benefits of family planning methods associated with children spacing and protecting the lives of infants, children, women and the family.

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