

Socio –Economic and Cultural Barriers to Family Planning Practices among Rural Women in Murang’a North Sub County, Muranga County, Kenya

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Abstract: *The study examined the socio-economic and cultural barriers to family planning (FP) practices in Murang’a North District. It was guided by the Normative Reference Group Theory advanced by Huttler and Eden (1995) .Combinations of purposive and stratified sampling techniques were used to select 215 women from Kiharu, Kangema and Mathioya Constituencies in Muranga North sub-County, Muranga County, Kenya. Structured questionnaires, interview schedules and focus group discussion guidelines were the main research instruments used to collect data. The findings established that the main socio-economic and cultural factors inhibiting use of FP in decreasing order of magnitude were : bias, prejudices, and misconceptions regarding FP; value attached to children; gender inequality in decision making process regarding FP issues; and poor attitudes regarding FP amongst most members of community in the study locale. It was concluded that current use of FP is still very low in the study locale. It was recommended that FP campaigns should be intensified at county level, targeting both the educated and married couples whose current use of FP was still very low [174 words].*

Keywords: *Socio –Economic and Cultural Barriers; Family Planning; Practices; Rural Women; Murang’a North Sub County, Muranga County, Kenya.*

I. Introduction

1.1 Background to the study

Good health, which is basic to human welfare and a fundamental objective of socio-economic development, is closely related to effective and well planned family planning practices among women. The widespread adoption of family planning represents one of the most dramatic changes of the current millennium (United Nations, 2013). Yet, most of Africa’s forty five countries, including Kenya, still lag behind other developing countries in vital tasks of improving health (Africa Institute for Development Policy, 2010). The current circumstances present a critical opportunity to reconsider the importance of family planning and to revisit and update program strategies (UNFPA, 2008). Family planning programs in many countries have successfully used the mass media communication campaigns to raise awareness of the benefits of family planning, legitimize small families, and change reproductive preferences (UNFPA, 2008).

At the regional level, UNFPA (2008) contends that family planning is among a handful of feasible, cost-effective interventions that can make an immediate impact on maternal mortality in low resource settings. This observation is reinforced by the fact that, in 2006, unmet need for family planning was added to the fifth Millennium Development Goal as an indicator for tracking progress on improving maternal health. Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk (United Nations, 2008; Hassan & Yamisha, 2007). It has been estimated that meeting women’s need for modern contraceptive use would prevent about one quarter to one third of all maternal deaths, saving 140,000 to 150,000 lives a year in Sub-Saharan Africa (Darroch & Nadreau, 2011).

At the national level, family planning programs in Kenya are an essential part of services to reduce maternal and child mortality rates, because they enable women to postpone, space or limit pregnancy. The Contraceptive Prevalence Rate (CPR) among married women in Kenya has stagnated over the past 10 years, and currently stands at a low of 46% with only 39% of women using a modern family planning method. The unmet need for family planning is estimated at 24%, largely due to inadequate service provision and poor access especially among the poor and socially disadvantaged groups including adolescents and youth (Republic of Kenya, 2012).

Kenya’s population has risen rapidly over the past four years, with the proportion of youth also increasing. In 2009, 43% of Kenya’s population was under age 15 years – higher than for Africa as a whole. Early age at first marriage and birth, and low contraceptive use, are among factors that have contributed to Kenya’s youthful population. Despite impressive declines in fertility rate in the 1990s compared to other Sub-Saharan African countries, nearly one in four women aged between 15 and 19 have had a first child.

Unless youth are empowered to delay or have fewer births through family planning, the population will continue to grow at a rate too fast for the rate of economic growth (Republic of Kenya, 2012). According to Republic of Kenya (2012), the country is working towards increasing the overall CPR among married women to 56% by 2015, among adolescents (15-19 years) from 4% in 1998 to 8% and among youth aged 20-24 years from 19.9% to 40% by 2015. Kenya (2012), notes that one of the implementing strategies laid out in the National Reproductive Health Strategy 2009-2015, to achieve these goals, is behavior change communication (BCC). The focus on socio-economic and cultural variables in explaining current practices becomes important because schooling opportunities for girls and general mind shift will need to be improved, both for their intrinsic value but also as a means of accelerating reproductive change in the next generation (World Health Organization, 2012). Meeting the contraceptive needs reflects a complex range of processes that make up a woman's set of choices and challenges over her reproductive life. To achieve their desired family size and avoid unintended pregnancies, women will spend a majority of their childbearing years in need of contraception. For example, women who want four children will spend an estimated four years trying to get pregnant three years actually getting pregnant, two years in the postpartum period unable to get pregnant and 16 years trying to avoid a pregnancy (Darroch, Sedgh & Ball, 2011). More so, if a woman only needs two children, the number of years she needs to avoid pregnancy rises to almost 21 years of her reproductive life! (Smith, 2013). The need for contraception, and the type of method needed, is also likely to change over a woman's life course. She may move from using a traditional method to modern methods, from using a short-term method (pills, injections, to longer term methods (IUDs) or permanent methods (sterilization or vasectomy), condoms or she may have gaps between methods (because she is pregnant or postpartum or wants a child). In addition, shifts in pregnancies for having a child often occurs in response to changing life circumstances such as entering serious relationship, attaining the level of education desired, or changes in household finances (Smith, 2013).

1.2 The State Of Art Review

There is a large body of literature that attempts to show the various socio-economic and cultural barriers to family planning practices globally (AIDEP, 2013; Darroch & Nedrea, 2003; Green, 2010; Smith, 2013; USAID, 2010). Some of the scholars have examined the expenses that form part of the barriers including the cost of purchase of contraceptives and cost incurred in going to the source. According to Green (2010), 97 percent of users in Africa would be unable to pay the full cost of modern methods of contraceptives. In this regard, AFIDEP (2013) counsels that unless contraception are procured free of charge, or at a minimal cost, and as close to the communities as possible, chances are that many current users will discontinue use. Contraceptive supply also plays a role in the level of unmet need. In a recent study on availability of contraceptives in Sub-Saharan Africa, 12 out of 16 countries surveyed reported central store stock outs of one or more contraceptives as over a 12-month period (USAID, 2010). In many African countries, particularly in rural areas, long term- and permanent methods of family planning are not available (Smith, 2013).

The implications of socio-economic variables can erode the benefits which come along with family planning. First, family planning alleviates poverty and accelerates socio-economic development. In this context, with fewer, healthier children to provide for, families are less likely to become poor. They are also better able to feed and provide basic healthcare for their children, which creates a healthier and more productive workforce which can contribute to economic growth of the nation as a whole (Darroch, 2003).

On the national level, rapid population growth resulting from high levels of unmet needs often outstrips economic growth and undermines a country's ability to offer adequate educational, health, and other social services (United Nations, 2008). This study focused on the effect of socio-economic factors of family planning in the study locale.

According to Pott and Mash (2010), they contend that education reduces family size because more educated women are better able to surmount the many barriers separating them from the information and technologies they need to manage their childbearing. When these barriers are removed, then differences in fertility between illiterate and literate women largely disappear.

In this context, family planning can help ensure that all children go to school. Families are more likely to educate their children if they have smaller families (Darroch, 2011). For example, some girls are forced to drop out of school early to care for their younger siblings (Darroch & Nedrea, 2003). Girls and young women may also be forced to leave school early if they get pregnant. This therefore means that lack of adequate education can be a barrier to the effects towards family planning and its effect in the context of the study locale was a significant variable. Stanbark et al. (1999) have documented that the women's unmet family planning constrains also take a psychological dimension. They contend that, poor women, uneducated women and those in strongly patriarchal societies face the biggest barrier to contraceptive use especially where women require approval from husbands or mothers-in-law (Stanbark et al., 1999). According to Smith (2013), in sub-Saharan Africa, the leading reasons are concerns about the adverse effects of contraceptives and the fact that they are breastfeeding.

Darroch, Segh and Ball (2011) document that about one in six women in Africa believes, often incorrectly, that they cannot get pregnant when they are breastfeeding. In South Central Asia, the leading reason for not using family planning methods is that women oppose the use of family planning, while in South East Asia, women gave concerns about health and side effects as the primary reasons for not using effective methods (Darroch, Seghand Ball, 2011). These can be perceived as a combination of lack of appropriate information and psychological factors.

According to AFIDEP (2010), a good proportion of women do not access family planning services because of a combination of factors that include side effects, misinformation and fear. It has been observed that side effects, lack of accurate information, and misinformation interact to create a disproportionate fear of fertility regulating methods. Most contraceptives have side effects, and these can be a barrier to adoption or reason for discontinuing a method (Potts and Marsh, 2010).

The other misconceptions that pills cause cancer, IUD will float around the stomach, and injections can cause infertility and should be used only after you have several children have been other recently cited barriers (AFIDEP, 2010). The need for contraception, and the type of method needed, is also likely to change over a woman's life course. She may move from using a traditional method to modern methods, from using a short-term method (pills, injections, to longer term methods (IUDs) or permanent methods (sterilization or vasectomy) condoms, or she may have gaps between methods (because she is pregnant or postpartum or wants a child).

In addition, shifts in pregnancies for having a child often occurs in response to changing life circumstances such as entering serious relationship, attaining the level of education desired, or changes in household finances (Smith, 2013). The AFIDEP (2010) also observe that service providers sometimes deny women access to contraception because of their own prejudices about the method of delivery system of the device. For example, in Ghana, during family planning consultations, the healthcare provider did not recommend pills to some women as the first choice of contraception and focused more instead on health conditions that restrict the use of the pill. In this case, we see that health providers impose various restrictions including marriage requirements as well as minimum age restrictions. These conditionality create fear amongst prospective users of the family planning services (AFIDEP, 2010). Meeting the contraceptive needs reflects a complex range of processes that make up a woman's set of choices and challenges over her reproductive life. To achieve their desired family size and avoid unintended pregnancies, women will spend a majority of their childbearing years in need of contraception. For example, women who want four children will spend an estimated four years trying to get pregnant, three years actually getting pregnant, two years in the postpartum period unable to get pregnant, and 16 years trying to avoid a pregnancy (Darroch, Sedghand, Ball, 2011). If a woman only needs two children, the number of years she needs to avoid pregnancy rises to almost 21 years of her reproductive life. (Smith, 2013). The need for contraception, and the type of method needed, is also likely to change over a woman's life course. The complexity of the issue underscores two important points which constitute the problem for this study. First, the transitional nature of the need for family planning can pose serious challenges for women and their partner's ability to control their reproductive lives- especially in backgrounds where social and cultural barriers are prevalent and services are less available. Secondly, understanding these transitions enhances our ability to better meet couples contraceptive needs. For the purpose of this paper, the question that constitutes the research problem is what are the intricacies of the socio-economic and cultural barriers to family planning in the study locale? It is imperative that in attempting to understand the reasons explaining the unmet needs of women in sub-Saharan Africa, the general belief is that women are not using contraceptives because family planning services are either not available or the services are too expensive (Smith, 2013). But this is only one part of the story. It is argued in this study that there are many reasons why women don't use contraceptives and they vary across the regions.

According to Smith (2013), in Sub-Saharan Africa, the leading reasons are concerns about the adverse effects of contraceptives and the fact that they are breastfeeding. Darroch, Segh & Ball (2011) document that about one in six women in Africa believes, often incorrectly, that they cannot get pregnant when they are breastfeeding. In South Central Asia, the leading reason for not using family planning methods is that she or her oppose the use of family planning, while in South East Asia, women gave concerns about health and side effects as the primary reasons for not using effective methods (Darroch, Seghand; & Ball, 2011). Across the three regions, no access and cost of family planning services represented a relatively small portion of the reasons for not using contraception, ranging from 6 percent to 11 percent (Darroch, Seghand Ball, 2011).

In a recent study on availability of contraceptives in sub-Saharan Africa, 12 out of 16 countries surveyed reported central store stock outs of one or more contraceptives as over a 12-month period (USAID, 2010). In many African countries, particularly in rural areas, long term and permanent methods of family planning are not available (Smith, 2013).

1.2 Statement Of The Problem

The complexity of the foregoing issues raised underscores two important points which constitute the problem for this study. First, the transitional nature of the need for family planning can pose serious challenges for women and their partner's ability to control their reproductive lives- especially in backgrounds where social and cultural barriers are prevalent and services are less available. Secondly, understanding these transitions enhances our ability to better meet couple's contraceptive needs. For the purpose of this proposed study, the question that constitutes the research problem is what are the intricacies of the socio-economic and cultural barriers to family planning in the study locale?

1.3 The Objective Of The Study

The main objective of this study was to examine the socio-economic and cultural barriers to family planning in Murang'a North Sub-County, Muranga County, Kenya.

II. Theoretical Framework

This study was based on Normative Group Theory advanced by Huttler and Eden (1995). In this theory, context is a very important consideration for a reference group such as females who stay in a specific socio-economic and cultural context. The theory stipulates that the participant's behavior and attitude depends on the established norms, in this context an individual such as a woman has to conform to values and standards because the standards exert a certain pressure on the individual. For example, the standards may be to have a small and manageable family as stipulated by the expectations of family planning. Yet, the individual woman may or may not have her own preferences but experience the dictates of the wider family or the expectation of the state. As a member of the group, for example, the women of Murang'a North, she may have to pull or push the group expectations of the member of the county.

This group theory is appropriate because social or education research involves problems that investigate relationship between an individual and society through interactions with the social groups or contexts in which the research is taking place (Hox, 2002).

The society presents a normative group with diverse socio-economic and cultural variables that exert pressure on the individual entity within the group such as the woman grappling with multiple options of whether or not to adopt family planning devices and which among them to choose or reject. The research to be undertaken results in the interactions between variables that characterize the unique individual and those that characterize the diverse groups, hence, the normative group theory. Thus, the theory is quite appropriate in investigating the possible effects of chosen socio-economic and cultural variables and females' response to family planning practices.

III. Research Design and Methodology

2.1 Research Design and Locale

This study adopted a descriptive cross-sectional survey design. This design is considered appropriate because the study was concerned with describing, recording, analyzing and reporting conditions that exist or existed within a wider Murang'a North. This design according to Mugenda (2003) and Orodho (2012) is one of the widely used designs to obtain data useful in evaluating present practices and in providing a basis for decision making. In this context, this study used a descriptive survey to investigate the socio-economic and cultural barriers to family planning practices among rural women in Murang'a North, Kenya. The locale refers to the actual place or region where the study was conducted (Orodho, 2012). This study was conducted in Murang'a North Sub County formerly Murang'a North District, Kenya.

IV. Target population and Sampling

According to Borg and Gall (1989), target population is the number of real or hypothetical set of people, events, or study units which a researcher wishes to generalize the results of the sample study. Orodho (2009) goes further and specifies that a population sometimes also referred to as target population is the set of elements that the researcher focuses upon and to which the results obtained should be generalized. The target population for this study was drawn from 87,515 females in the age group of 15-49 who represent the female fertility cohort in Murang'a North Sub County of Murang'a County, Kenya (Republic of Kenya, 2009). From the target population of 87,515 females in the study locale, a manageable sample was selected through appropriate sampling techniques. Thus, sampling means the selection of a small representative portion of a population for study in order to make generalizations about the population from which the sample is drawn. According to Babbie (2004), working with a sample reduces the length of time needed to complete a research, cuts the costs of research, is manageable and is almost a mirror of the sample population. In this study a combination of stratified sampling and convenience sampling techniques was used to select the sampling units using the criteria of females practicing or capable of practicing family planning. According to the Murang'a

North District Development Plan 2008-2012, there are 87,515 females in the study locale distributed across the constituencies as depicted in Table 1.

Table 1 : Target population and sample size determination

Constituency	Female Population	Sample selected	Percent
Kiharu	43,758	110	0.25
Kangema	22,100	55	0.25
Mathioya	21,6657	50	0.23
Total	87,515	215	0.243

Source: (Adopted from Murang'a County Development, 2008:8)

As explained above , stratified random sampling technique using proportionate allocation was used to distribute the females in the study locale as displayed in Table 3.1, with Kiharu constituency yielding a sample of 110, Kangema constituency providing a sample of 55 and Mathioya constituency giving a sample of 50, all yielding a total sample of 215 for the study. From each constituency, convenience sampling technique was used to reach the females at convenient places such as markets and churches.

V. Research Instruments and Data Collection

The researcher used structured questionnaires, and focus group discussion guidelines to corroborate some of the responses obtained from the questionnaires. Before the questionnaires were used to collect data, they were piloted to determine their validity and reliability. Validity is the degree to which a test measures what it is supposed to measure (Best and Khan 1996; Orodho, 2012). In this study, academic staff members in the department of Geography at Mount Kenya University were requested to assess the content validity of the instruments before they were used in the main study. Similarly, reliability for the questionnaire was determined using a test-retest method. The reliability of the study was able to address the similarity of the results through repeated trials. Using this method, the questionnaires were administered to five females from a neighboring market centers but were not to take part in the main study. The items in the questionnaires were then analyzed to form the first set of scores. After two weeks period the same instruments were supplied to the same respondents. After doing the re-test, the results were analyzed using Spearman's rank order correlation to calculate the coefficient of correlation, yielding a correlation coefficient of .811 and declared the as reliable since it was higher than .75 (Cohen, Marion and Morrison, 2007; Orodho, 2012; Orodho, Ampofo, Bizimana & Ndayambaje, 2016).

VI. Data collection and Analysis

Data was collected through focus groups using unstructured interviews. Focus group discussions were conducted in one participant's home in each village. The village elder identified by the researcher during reconnaissance visits in the villages identified both the participants and the venues for the focus groups. The researcher then visited the owners of the venues to confirm the dates and make further arrangements. The homes provided the natural setting for discovery of the social world of cultures and natural setting by observing and talking to them (Halloway&Wheeler, 1996). On getting consent from the respondents, data were audio recorded, whilst field notes and observational notes were taken. The central question that directed the interviews was: 'in your opinion, what could be factors that influence (positively or negatively) the use of family planning and/or contraception by women in this locality?'

The researcher utilized both qualitative and quantitative approaches to analyze data. The qualitative data from interview guides and focus group discussions were analyzed according to emerging themes by objectives to find out the pattern of the interactions between the socio-economic and cultural barriers and family planning practices (Creswell 2009; Orodho, 2009b; Orodho, Ampofo, Bizimana & Ndayambaje, 2016).The quantitative data from questionnaires were first coded, and entered into a computer and analyzed using the statistical package for social science (SPSS) version 20 for Windows Computer programme (Orodho, 2009b; Orodho, Ampofo, Bizimana & Ndayambaje, 2016). The statistical techniques were chosen depending on type of data analyzed. The frequently used techniques were the Chi-square (χ^2) for categorical data. The findings were then presented in tabular form and graphically for quantitative data and in narratives and direct quotes for qualitative data. The triangulation of data from the two analytical approaches facilitated clear understanding of the socio-economic and cultural barriers to family planning practices in the study locale.

VII. Findings and Discussion

The Main Socio-cultural Factors Posing as Barriers to Family Planning Practices

The respondents were then requested to indicate the major socio-economic and cultural factors that are a barrier to family planning. Figure 4.1 carries information regarding the factors cited by women respondents regarding the major barriers to family planning practices in the study locale of Murang’a North District.

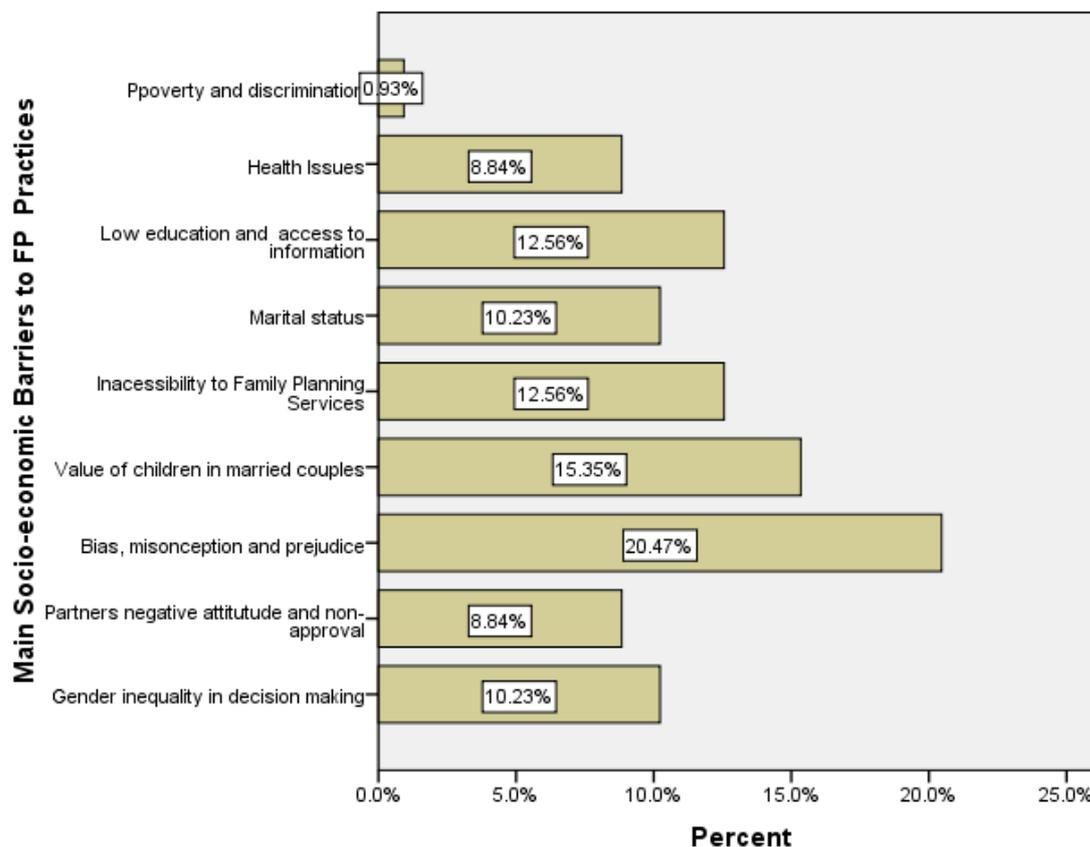


Figure 4.1: The major socio-economic and cultural factors posing as barriers to FP

The first factor which was identified by a majority of respondents, constituting 20.47 percent, as being a barrier to family planning practices was bias, misconception and prejudices about contraceptives. In general, family planning programmes were largely perceived as being female oriented and are incorporated in maternal and child-health services in most health centers.

It was also pointed out that most of the family planning services are headed by female staff. As a result, men were excluded yet they have a critical decision making power when it comes to adoption of these practices by their spouses. It was further reported during face-to-face interviews that some men (mostly husbands of the respondents) erroneously perceived family planning methods as promoting infidelity amongst women. In fact, one respondent reported that her husband became so angry to the point of beating her on discovering that she was using contraceptives.

The other misconception about contraceptives was that contraceptive devices or family planning methods cause infertility. In fact, over half of the women interviewed viewed contraceptives as being bad resulting in ill health. Other misconceptions influencing the use of contraceptives included contraceptive injections caused infertility while oral contraceptives caused abortions and condoms were associated with promiscuity. Some of the women respondents indicated that they received the contraceptive information through their organized women groups, and this information largely excluded their male counterparts.

Some of the women respondents suggested that there should be a clear policy targeting male motivators who should be trained to reach their fellow men and also be used to distribute critical messages regarding contraceptive use and the male condoms. In this regard, it is arguable that these strategies could promote open communication about sexuality issues among partners and correct the erroneous perception that there are negative consequences in using contraceptives. As a result, there would be increased positive attitude towards contraceptive use and actual practice.

The results of this study are in tandem with those of other scholars and researchers across the world. For instance, misconceptions that pills cause cancer, IUD will float around the stomach, and injections can cause infertility and should be used only after you have several children have been recently cited as being critical barriers to adoption of family planning (AFIDEP, 2010). According to Smith (2013), the need for contraception, and the type of method needed, is also likely to change over a woman's life course. She may move from using a traditional method to modern methods, from using a short-term method (pills, injections, to longer term methods (IUDs) or permanent methods (sterilization or vasectomy) condoms, or she may have gaps between methods (because she is pregnant or postpartum or wants a child). In addition, shifts in pregnancies for having a child often occurs in response to changing life circumstances such as entering serious relationship, attaining the level of education desired, or changes in household finances (Smith, 2013).

The second factor cited by 15.35 percent of the residents to be a barrier to family planning practices was the value attached to children amongst married couples. The majority of the women interviewed confided that they desired to have additional children. Children were perceived to enhance and solidify women's social status, explain why they desired to have more children.

When probed further why they did not embrace family planning during interviews, they averred: the use of contraceptives might impact negatively on their social status and even make them sterile. The implication of this finding is that most women do not have the right information regarding the use of family planning devices

. It was apparent that women of all ages spread across all the three constituencies in Murang'a North District covered lacked appropriate knowledge regarding the use of contraceptives to space the births of their children to enhance their own well-being, as well as that of their families, rather than limiting the number of children born in their respective families.

The third highly ranked factor posing as barriers to family planning practices is inaccessibility to family planning services. This factor was cited by 12.56 percent of the respondents. It is instructive to note that access to family planning services is determined by physical and other related logistical factors, including the proximity of family planning services to the homestead, as well as availability of transport. Economic factors such as cash to purchase more convenient contraceptive devices and the cost of transport also function as barriers to the use of contraceptives.

It was also revealed that:

most of the health care centers in Murang'a North District are geographically not accessible to some prospective women users. The women also lamented that some of the health centers not only had limited variety of family planning methods, but also minimum counseling services due to the limited number of trained personnel.

In the current devolved government, the medical staffs were not very comfortable working in the counties and quite a large number had resigned and started private practice. The family planning services in private centers were beyond the reach of most poor rural women.

The fourth set of factors perceived to pose as barrier to family planning practices in the study locale were gender inequality in decision-making process and the status of married women. The study established that socio-cultural factors which are grounded in gender relations that enforce the subordination status of women impede the practice of family planning. It was evident that high birth rate was an established pattern among community members in the study locale.

It was noted from the interviews that:

Single women used contraceptives more than their married counterparts who tended to shy away from their usage due to socio-cultural implications. The face to face interviews with married women revealed that over three quarters were of the opinion that their husbands did not approve the use of contraceptives and most of them hardly used any of the devices.

In addition, nearly all women interviewed reported that their husbands were not willing to accompany them to family planning centers. Yet, for the benefit of counseling, it is important that both partners should attend family planning sessions.

Female fertility was found to be of extreme cultural importance to the women in rural communities where the study was conducted. It was revealed that women are expected to bear as many children as possible and only get accepted as respected wives when they have children from their husbands. The finding from this study indicated that married as well as single women desired to bear many children, with a majority putting the preferred number of children between 5 and 6. These findings indicate that socio-cultural norms seem to play a significant role in the ability to fully embrace family planning practices in the study locale.

Finally, the other interrelated socio-cultural factors posing as barriers to family planning practices are: partners poor attitude and lack of approval of family planning practices, poverty and health issues. It is arguable from literature reviewed that most studies on family planning issues ignore men.

Yet, as has been documented elsewhere, most decisions regarding family planning are made by males. It is arguable that males knowledge, attitude and behaviours relating to fertility regulatory methods is low due to the fact that they do not attend family planning programs.

It was reported that:

men perceived family planning methods as promoting infidelity among women. Contraceptive health practices are influenced by the people's culture and by the availability and accessibility of such services.

The most readily available contraceptives according to two thirds of women currently using family planning methods were pills, followed with injections (mentioned by 68% of practicing women) and condoms, mentioned by 32% of the respondents. Family planning counseling was offered according to 43% of the respondents. Family planning providers advised 9 % of the respondents to obtain their partners consent before they could receive any contraceptives. This finding confirmed the minority status of women by requiring a male partner to decide when and how a woman could control her fertility. There is little doubt that the negative attitudes of men towards contraceptives are the main deterrent to the use of contraceptives and other family planning practices in Murang'a North District.

The findings are in tandem with a study conducted in South Central Asia, which revealed that the leading reason for not using family planning methods is that women oppose the use of family planning, while in South East Asia, women gave concerns about health and side effects as the primary reasons for not using effective methods (Darroch, Seghand Ball, 2011). These can be perceived as a combination of lack of appropriate information and psychological factors.

The findings are also in line with those of AFIDEP (2010), who aver that a good proportion of women do not access family planning services because of a combination of factors that include side effects, misinformation and fear. It has been observed that side effects, lack of accurate information, and misinformation interact to create a disproportionate fear of fertility regulating methods. Most contraceptives have side effects, and these can be a barrier to adoption or reason for discontinuing a method (Potts and Marsh, 2010).

The implications of socio-economic variables can erode the benefits which come along with family planning. First, family planning alleviates poverty and accelerates socio-economic development. In this context, with fewer, healthier children to provide for, families are less likely to become poor. They are also better able to feed and provide basic healthcare for their children, which creates a healthier and more productive workforce which can contribute to economic growth of the nation as a whole (Darroch, 2003). On the national level, rapid population growth resulting from high levels of unmet needs often outstrips economic growth and undermines a country's ability to offer adequate educational, health, and other social services (United Nations, 2008). This study will focus on the effect of socio-economic factors of family planning in the study locale.

VIII. Conclusion and Recommendations

The foregoing results conclusively demonstrate that there were myriad and intertwined socio-economic and cultural factors that thwarted efforts to embrace family planning in the study locale. It was also pointed out that most of the family planning services are headed by female staff. As a result, men were excluded yet they have a critical decision making power when it comes to adoption of these practices by their spouses. It was further reported during face-to-face interviews that some men (mostly husbands of the respondents) erroneously perceived family planning methods as promoting infidelity amongst women. In fact, one respondent reported that her husband became so angry to the point of beating her on discovering that she was using contraceptives.

The other misconception about contraceptives was that contraceptive devices or family planning methods cause infertility. In fact, over half of the women interviewed viewed contraceptives as being bad resulting in ill health. Other misconceptions influencing the use of contraceptives included contraceptive injections caused infertility while oral contraceptives caused abortions and condoms were associated with promiscuity. Some of the women respondents indicated that they received the contraceptive information through their organized women groups, and this information largely excluded their male counterparts.

When probed further why they did not embrace family planning, they argued that the use of contraceptives might impact negatively on their social status and even make them sterile. The conclusion emanating from this finding is that most women do not have the right information regarding the use of family planning devices. It was apparent that women of all ages spread across all the three constituencies in Murang'a North District covered lacked appropriate knowledge regarding the use of contraceptives to space the births of their children to enhance their own well-being, as well as that of their families, rather than limiting the number of children born in their respective families. It is instructive to note that access to family planning services is determined by physical and other related logistical factors, including the proximity of family planning services

to the homestead, as well as availability of transport. Economic factors such as cash to purchase more convenient contraceptive devices and the cost of transport also function as barriers to the use of contraceptives. It was also revealed that most of the health care centers in Murang'a North District are geographically not accessible to some prospective women users. The women also lamented that some of the health centers not only had limited variety of family planning methods, but also minimum counseling services due to the limited number of trained personnel. In the current devolved government, the medical staffs were not very comfortable working in the counties and quite a large number had resigned and started private practice. The family planning services in private centers were beyond the reach of most poor rural women.

It was evident that high birth rate was an established pattern among community members in the study locale. It was noted from the interviews that single women used contraceptives more than their married counterparts who tended to shy away from their usage due to socio-cultural implications. The face –to-face interviews with married women revealed that over three quarters were of the opinion that their husbands did not approve the use of contraceptives and most of them hardly used any of the devices. In addition, nearly all women interviewed reported that their husbands were not willing to accompany them to family planning centers.

It is arguable from literature reviewed that most studies on family planning issues ignore men. Yet, as has been documented elsewhere, most decisions regarding family planning are made by males. It is arguable that males knowledge, attitude and behaviours relating to fertility regulatory methods is low due to the fact that they do not attend family planning programmes. It was reported that men perceived family planning methods as promoting infidelity among women. Contraceptive health practices are influenced by the people's culture and by the availability and accessibility of such services.

As a result, it is recommended that:

1. The existing biases, prejudices and misconceptions should be demystified through appropriate family planning messages.
2. The families and/or single women should be sensitized regarding the need to have a manageable family size that they can adequately cater for.
3. The gender inequalities in decision making, especially with regards to FP should be discouraged.
4. The poor attitude towards family planning should be reversed through appropriate FP intervention and campaign strategies.
5. The intervention strategies for FP should be crafted in such a way as to be able to promote open communication about sexuality issues among partners and correct the erroneous perception that there are negative consequences in using contraceptives.

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