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GLOBAL GAG RULE'S INFLUENCE ON ACCESS TO CONTRACEPTIVE SERVICES AT FAMILY HEALTH OPTIONS KENYA IN NAIROBI CITY COUNTY.

BY WEKESA ZEDDY NANJALA CHEROTICH (MBChB)
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DEPARTMENT OF POPULATION AND REPRODUCTIVE HEALTH

A research thesis submitted in partial fulfillment of the requirements for the award of the degree of Master of Public Health (Reproductive Health) in the School of Public Health of Kenyatta University.

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This proposal is my original work and has not been presented for a degree in any other university.

Name: …….

Registration number……

Signature……

Date……...

Supervisors: This proposal has been submitted for review with our approval as University Supervisors.

Name…Prof Keraka Margaret

Department…….

Signature…….

Date……

Name……Dr. Ngatia Justus

Department…….

Signature…….

Date……

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Abbreviations and Acronyms

USA - United States of America

NGOs – Nongovernmental organizations

MCH – Maternal and Child Health

USAID – United States Agency for International Development

FHOK – Family Health Options Kenya

SDG – Sustainable Development Goal

KDHS – Kenya Demographic and Health Survey

WHO – World Health Organization

UN – United Nations

NHIF – National Health Insurance Fund

HIV – Human Immunodeficiency Virus

STDs – Sexually Transmitted Diseases

PPFA –Planned Parenthood Federation of America

Operational Definition of Terms:

Family planning – this refers to the strategy that individuals or couples use to achieve their reproductive targets.

Unmet need for family planning – this refers to the estimated proportion of women whose pregnancy was mistimed; amenorrhoeic women whose last birth was mistimed; and women who are neither pregnant nor amenorrhoeic and are not on any family planning method but want to wait at least 2 years for their next birth.

The percentage with an unmet need for family planning – this is when the number of women who have an unmet need for family planning is expressed as a percentage of the women of reproductive age.(WHO 2010)

Unintended pregnancy – a pregnancy that occurs at a time when it was not the woman's or the couple's target to get pregnant.

Mistimed pregnancy - a pregnancy that was expected but might have occurred sometime earlier that than the woman would have liked.

Amenorrhoeic women – women who are not menstruating

Family planning methods- include the methods that are used to prevent pregnancy including contraceptives.

Reproductive age – This refers to women aged 15 – 49 years of age.

Abstract*:*

Introduction*:* This study was about the influence of the global gag rule on access to contraceptive services at Family Health Options Kenya in Nairobi City County and the level of unmet need for family planning among women aged 15-49 years who visited Family Health Options Kenya. **Problem statement:** This rule or policy creates inhibitions on family planning programs and results in loss of US funding for reproductive health NGOs that depend on donor funding for their activities such as contraception. **Objectives:** The objective of the study was to determine the access to contraceptive services among women who visited Family Health Options Kenya in Nairobi County and to determine their unmet need for family planning as a result of the global gag rule by examining the relationship between unmet need and affordability of contraceptive services, accessibility of FHOK clinics and quality of FHOK services. **Methods:** Data was collected from clients using questionnaires for quantitative data and key informant interviews of service providers for qualitative data. The study design was a descriptive cross sectional study design. Purposive sampling was used to select the participants of the study. Data Analysis was done using Statistical Package for Social Sciences (SPSS). Chi square was used to test the significance of the association between the dependent and independent variables. **Results:** The most popular contraceptive selected at FHOK was implants. Unmet need was found to be 46.1%. None of the factors of affordability, accessibility nor quality of FHOK services were found to have a significant relationship with unmet need as measured using desire for family planning and desired timing of last pregnancy. **Conclusion:** Unmet need, at 46%, was higher than the national estimate of 18% (KDHS 2014) due to the fact that the study population was women who visited the clinic specifically for family planning services, not the general population

of women in the community. None of the factors of affordability, accessibility nor quality of FHOK services were found to have a significant relationship with unmet need for family planning, as measured using, desire for family planning and desired timing of last pregnancy because the Global Gag Response project currently ongoing at FHOK has ensured continuity of care for patients.

CHAPTER 1: INTRODUCTION

1.1 Background of the study

The Global Gag Rule, also known as the Mexico City Policy, is a foreign aid health policy that was introduced in the year 1984 by the United States of America (USA) government, that states that in order to be given family planning funding from the US federal government, all nongovernmental organizations(NGOs) that receive these donor funds have to certify that they would not participate in the performance of abortions or the promotion of abortion as a form of family planning using funds that they get from other non-USA sources. Furthermore, as of January 2017, this policy was expanded, such that NGOs would also not receive other USA health funding such as HIV, Malaria and Maternal and Child Health (MCH) funding, not just family planning funding, if they did not adhere to the conditions set by this policy. (IPPF 2017)

Over the years, it has been adopted by Republican administrations and revoked when Democratic administrations took over.

Nongovernmental organizations (NGOs) that depend on donor funds from USAID are likely to be affected by the Global Gag Rule as evidenced by the effect it had when it was last in place in the year 2001. One of the NGOs in Nairobi County that have the widest networks of clinics that offer family planning services is Family Health Options Kenya, a member association of International Planned Parenthood Federation (IPPF). It is estimated that 222 million women in developing countries have unmet need for family planning (WHO 2013).

1.2 Problem Statement

This policy creates inhibitions on family planning programs and results in loss of US funding for reproductive health NGOs that depend on donor funding for their reproductive health activities such as family planning. Most of the clients that depend on these NGOs for their reproductive healthcare are women who lie in the lower income bracket. Therefore this policy takes away affordable family service planning services from those who need it the most- the poor. (Marie Stopes, 2017)

It is of critical significance to note that the Global Gag rule does not eliminate any US funding for abortion because US funding for abortion has been nonexistent since 1973 when the Helms Amendment was enacted. This amendment ensured that no US funding would be used to pay for performing abortions. Instead, what this global gag rule does is inhibit women's access to other very essential reproductive health services such as family planning.(USAID, 2017)

The inconsistency of reproductive health services provision that is created by the Global Gag Rule makes women's health to be held at ransom, such that, it can be given and it can be taken away at any time depending on the president or the political party that is in power at the US. The International Planned Parenthood Federation (IPPF) has calculated the cost of this policy on its activities and has documented what the USAID funding could have been used for in their activities around the world if they had received it. Their research and calculations found that they could have prevented 20000 maternal deaths, 4.8 million unintended pregnancies, 1.7 million unsafe abortions. They could also have been able to provide treatment for 275 000 pregnant women living with HIV, 70 million condoms, 725 000 HIV tests and 525 000 treatments for STDs. (IPPF, 2017)

FHOK had to close down 2 of its clinics already, the Mombasa and the Kitengela clinic. The organization lost about 2.2 million dollars in response to the rule, including 1.56 million dollars in future funding due to FHOK's inability to bid for US funds. The remaining funds were from a US PEPFAR program that was terminated after the organization declined to sign onto the policy.(FHOK 2017)

This study aimed at finding out the influence of the Global Gag Rule on access to family planning services at Family Health Options Kenya, a member association of International Planned Parenthood Federation (IPPF) in Nairobi County, Kenya.

1.3 Justification of the study

This study was important because aimed at shedding light on the devastating effects of the Global Gag Rule on the health of women and girls, who are mainly from low income areas, who depend on the essential family planning services provided by these NGOs which mainly depend on donor funding. Ultimately, the people who are most affected are the women and girls who no longer receive the quality and quantity of care that they may have previously enjoyed.

Maternal health is one of the components of the third Sustainable Development Goal (SDG). This SDG 3 aims at ensuring healthy lives and promotion of wellbeing for all at all ages, including that of women and girls. Policies such the Global Gag Rule will effectively inhibit the achievement of this goal because a significant proportion of maternal healthcare programs especially in developing countries all over the world, rely heavily on donor funding.

There is little data available on the extent of the effect of the Global Gag rule in Kenya and on access to family planning services in NGOs in Kenya. The only data available is on a study done by Engender Health, a global reproductive health

organization, published in the year 2006, titled ”The Global Gag Rule”. This study aimed at adding on to this Engender Health study done in 2006 which found that FHOK had to shut down 5 out of the 9 clinics that it had opened by that time, while Marie Stopes shut down 2 of its clinics, increased the cost of its services and got rid of some of its staff in the year 2002. Marie Stopes also had to stop all its community outreach programs. All these activities resulted in the loss of healthcare to at least 9000 people, who were mainly women and children. (Engender Health, 2006)

This study aimed at showing the unsustainability of dependence on donor funding for programs that are as essential as reproductive healthcare. It aimed at showing that this inconsistency in the provision of reproductive health services that is created by overdependence on donor funding is an issue that needs to be addressed by the policymakers and stakeholders in the Kenyan health sector.

1.4 Research questions

1) Which contraceptive methods are women selecting when they visit Family Health Options Kenya in Nairobi County?
2) What is the level of unmet need for family planning among the clients visiting Family Health Options Kenya in Nairobi County?
3) What is the relationship between affordability of seeking contraceptive services at Family Health Options Kenya in Nairobi County and unmet need for family planning?
4) What is the relationship between accessibility of Family Health Options Kenya facilities in Nairobi County and unmet need for family planning?

5) What is the relationship between the quality of services offered at Family Health Options Kenya in Nairobi County and unmet need for family planning?

1.5 Research Objectives

Broad objective

To determine the influence of the Global Gag Rule on access to family planning services at Family Health Options Kenya in Nairobi County, Kenya.

Specific objectives

1) To determine the contraceptive methods that women are selecting when they visit Family Health Options Kenya in Nairobi County.
2) To establish the level of unmet need for family planning among women seeking contraceptive services at Family Health Options Kenya in Nairobi County.
3) To ascertain the relationship between affordability of seeking contraceptive services at Family Health Options Kenya in Nairobi County and unmet need for family planning.
4) To establish the relationship between accessibility of Family Health Options Kenya facilities in Nairobi County and unmet need for family planning.
5) To determine the relationship between the quality of services offered at Family Health Options Kenya in Nairobi County and unmet need for family planning.

1.6 Significance and anticipated output

This study was significant in informing policymaking in nongovernmental organizations. For instance it highlighted the need for creation of measures to mitigate against fluctuation of donor funding.

It was useful to government by highlighting the need for government to take a more proactive role in provision of family planning services especially to low income women who form the bulk of patients who visit public health facilities in the country. For instance, currently NHIF only covers bilateral tubal ligation and vasectomy methods of family planning. Perhaps it would be more prudent for the Kenyan government to have NHIF cover all family planning methods, not just the permanent ones.

By taking a more proactive role in family planning, the government will also be able to slow the spread of HIV/AIDS by promoting the use of condoms as part of family planning, thus simultaneously prevent transmission of HIV and unwanted pregnancies. Furthermore, contraception also enables women who are living with HIV to prevent unwanted pregnancies.

Promotion of family planning by the government will also enable it to advance the agenda of environmental conservation by reducing population growth and the pressures it places on natural resources, such as arable land, fresh water, timber, and fuel.

The study aimed at aiding in reducing maternal mortality through highlighting the need to meet women's needs for contraception and thus decrease the total number of pregnancies, each of which places a woman at risk. Reducing unmet need will also

prevent pregnancies that are unwanted and hence more likely to end in unsafe abortions. Finally, reduction of unmet need will reduce the proportion of births that are at greater risk of complications because of the mother's age, parity, or birth spacing.

1.7 Delimitations

De-limitations are the choices that describe the boundaries that were set for this study. It defined the parameters of this investigation.

The scope of this study was that the researcher intended to carry out a descriptive cross sectional study .As much as it would have been better to study the entire population, due to time, costs and logistical factors, a smaller sample size was used that was used as a reflection of the whole population. The interest of the study was the global gag rule's influence on affordability, quality and access to contraceptive services at Family Health Options Kenya.

The extent to which the study was carried out was within the four Family Health Options Kenya clinics in Nairobi County. The participants were specifically women aged 15-49 years who are married or coupled.

1.8 Limitations

Limitations of the study are the factors that are considered to be beyond the researcher's control. These were the shortcomings, conditions or influences that could not be controlled by this research that place restrictions upon the methodologies.

The limitations of the study were in the nature of self reporting whereby the use of data collection using questionnaires and interviews depended on the participant's

memory of events and this may have led to recall bias. There may also have been response bias where the participants may modify their responses in order to please the researcher. Participants may also have had reporting bias by selectively revealing certain information such as that which is in regard to sexual history.

Costs- because of the expenses involved e.g. transport costs, cost of materials to be used, etc, the sample size had to be limited.

Instruments used- since random sampling methods was not used, there was a disadvantage in that the researcher needed to take a sample that accurately represented the entire population.

1.9 Conceptual Framework

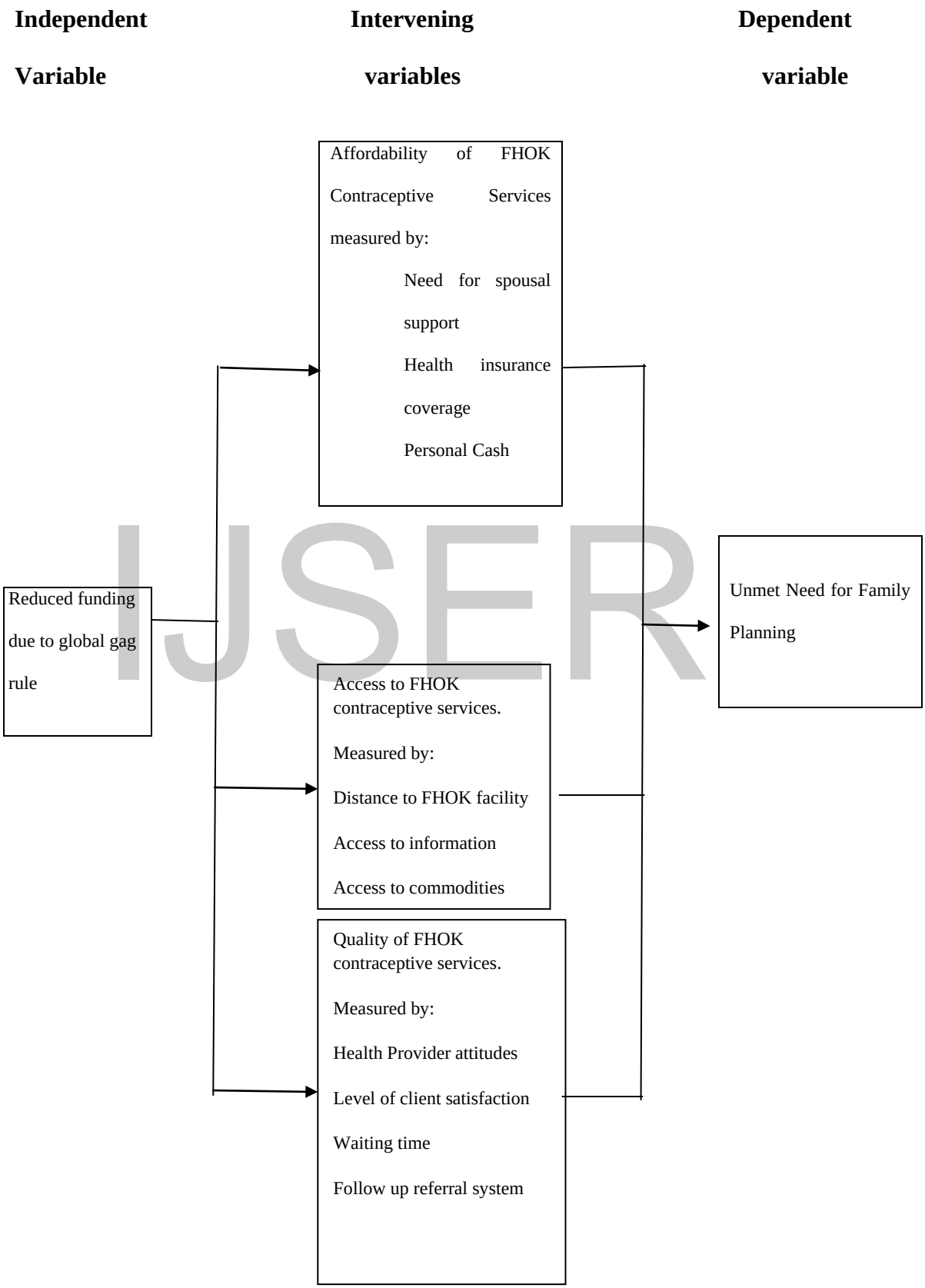

Figure 1: Conceptual framework

2.0 Theoretical Framework

Dorothy Norman and Gary Lewis operationally categorized unmet need into one for spacing and another for limiting (West off F. Charles, 2001). Their work paved a way in understanding methodological concepts about unmet need. By speculating flow in and flow out of the currently pregnant and the amenorrheic, they brought in a dynamic component which enabled estimation of unmet need for a year's period.

The Health belief model originally proposed by Rosen stock in 1966 but modified by Becker in 1974 (King R., 1999) held that health behavior is a function of an individual's socio -demographic characteristics, knowledge and attitudes. In the context of family planning, this theory provided a background upon which women's change in behavior towards family planning use could be based. Intention to use family planning to control one's reproductive experiences would differ among women of different ages. It would also differ depending on women's attitudes towards and knowledge about family planning.

CHAPTER 2: LITERATURE REVIEW

2.1 The Global Gag Rule's impact on reproductive health in Kenya from year 2001

Loss of reproductive healthcare

A study done by Engender Health, a global reproductive health organization, in the year 2006 helped document the impact of the Global Gag rule in Kenya the last time it came into effect in the year 2001. They found that this loss of funding necessitated budget cuts by NGOs through closure of clinics and retrenchment of the staff that provided the essential service of reproductive health provision to the local communities. Furthermore, other activities such as community outreach programs and programs that involved partnerships among NGOs that received USAID funding also got affected. After refusal of acceptance of the terms and conditions of this policy, FHOK and Marie Stopes Kenya lost their US funding. As a result, FHOK had to shut down 5 out of the 9 clinics that it had opened by that time, while Marie Stopes shut down 2 of its clinics, increased the cost of its services and got rid of some of its staff in the year 2002. Marie Stopes also had to stop all its community outreach programs. All these activities resulted in the loss of healthcare to at least 9000 people, who were mainly women and children. (Engender Health, 2006)

FHOK has had to close down 2 of its clinics already, the Mombasa and the Kitengela clinic. The organization has lost about 2.2 million dollars in response to the rule, including 1.56 million dollars in future funding due to FHOK's inability to bid for US funds. The remaining funds were from a US PEPFAR program that was terminated after the organization declined to sign onto the policy. (FHOK 2018)

Disruption of ongoing projects and NGO partnerships

The 2006 Engender Health study also followed up on a USAID funded project that had just been introduced at that time called "Amkeni", whose aim was to promote integration of reproductive healthcare to other health services. This project was unable to take off and was unsuccessful because it involved the partnership of a number of NGOs including FPAK (now called FHOK) and MSK, who now had to drop out of the project as they were no longer eligible for US donor funds.

Shortages and stock outs of contraceptives

The Kenyan reproductive health sector experienced constant shortages and stock outs of different family planning methods especially implants. As a result the Kenya Demographic and Health Survey found that fertility trends had changed from a fertility rate of 4.3 in 1998 to a fertility rate of 4.9 in 2003 and that there was stagnation in the Contraceptive Prevalence Rate which remained at 39% in both the 1998 and the 2003 KDHS. (Engender Health, 2006).

Contraceptives are an essential commodity in the control of population growth in a country and thus their absence creates high population growth rates that can become economically unsustainable especially in the long run.

2.2 The Possible Impact of the Global Gag rule reinstatement in January 2017

In 2017, FHOK received funding mainly from the following organizations:

International Planned Parenthood Federation (IPPF), United Nations Population Fund (UNFPA), Danish Family Planning Association (DFPA), Sweden Reproductive Health Association (RFSU) and USAID for the 'Afya Jijini' consortium. FHOK has

lost 620, 000 US dollars (62 million Kenya Shillings) from the Afya Jijini Consortium supported by USAID. The organization will no longer receive this funding.

The International Planned Parenthood Federation (IPPF) has calculated the cost of this policy on its activities and has documented what the USAID funding could have been used for in their activities around the world if they had received it. Their research and calculations found that they could have prevented 20000 maternal deaths, 4.8 million unintended pregnancies, 1.7 million unsafe abortions. They could also have been able to provide treatment for 275 000 pregnant women living with HIV, 70 million condoms, 725 000 HIV tests and 525 000 treatments for STDs. However, this will not happen because they declined to sign the Global Gag Rule and thus lost US funding for their activities. FHOK is an affiliate organization of Planned Parenthood and thus will be affected by this loss of funding.

However, these are all calculated estimates not actual data collected on the ground. This study aims at assessing the impact that is already being felt so far by the women who need access to the essential family planning services these organizations provide.

2.3 Unmet need for family planning

Women's access to family planning services is going to be affected by the reinstatement of the global gag rule. This access can be assessed by using the unmet need for family planning among the women who visit these clinics. Unmet need is gotten by giving women a specific set of questions in questionnaires. For instance they are asked whether they are currently using any form of contraception, and if they are using it, then these women do not have unmet need. If they are not using contraception, the researcher asks whether they are pregnant or amenorrhoeic. This data is then used to calculate unmet need as follows:

Unmet need (WHO 2010) = Women (married or in a union) who are not using contraceptives are fecund and desire to either stop childbearing or postpone their next birth for at least 2 years + pregnant women whose current pregnancy was unwanted or mistimed + women in postpartum period amenorrhea who are not using contraception and at the time they get pregnant had wanted to delay or prevent pregnancy ÷ Total number of women of reproductive age who are married or in union (15-49) × 100.

2.4 Classification of Family Planning Methods

Family planning methods can be classified into Hormonal and Non-hormonal methods.

Hormonal methods of Family Planning

These are family planning methods that contain oestrogen hormone, progesterone hormone or both.

Progestin only methods include injectables such as depo provera, subdermal implants such as implanon, jadelle, norplant or pills such as levonogestrel, microlut.

Combined hormonal methods include pills such as microgynon, injectables such as cyclofem, patches such as ortho evra or vaginal rings such as nova rings.

Hormonal releasing IUCD (Intrauterine Contraceptive device) such as Mirena.

Advantages of hormonal methods of family planning: Management of heavy painful menstruation and post-menopausal symptoms, reducing the chances of getting pelvic inflammatory syndrome, long term protection for both ovarian and endometrial cancer, reducing the cases of unsafe abortion thus reducing maternal mortality rate.

Disadvantages of hormonal methods of family planning: Increased risk of venous thrombosis, disruption of breastfeeding, excessive weight gain, prolonged return to fertility and the increase in the risk of breast cancer.

Non Hormonal methods of Family Planning

The non-hormonal methods include barrier method such as condoms, cervical caps and vaginal diaphragms, coitus interruptus, natural family methods, spermicidal preparations and sterilization.

Advantages of non- hormonal methods: Protecting against sexually transmitted diseases, they have minimal side effects.

Disadvantages of non- hormonal methods: allergy to latex in condoms or copper in IUCDs and professionalism in inserting an intra uterine device.

Other methods of classification of family planning methods include:

Modern methods and Traditional methods: Modern methods include hormonal methods and barrier methods which have already been mentioned. Traditional methods include coitus interruptus, post coital douching using vinegar or water, periodic abstinence which include the calendar method, temperature method, combining temperature and calendar method.

Short term methods and Long term methods: Short term methods include hormonal pills and condoms. Long term methods include IUCDs and implants. We also have permanent methods of family planning which include bilateral tubal ligation for women and vasectomy for men.

Dual method of contraception: It involves combining any two methods of contraceptives. This will lead to increased efficiency and increased protection against sexually transmitted diseases.

2.5 Side Effects of different family planning methods

Pills: They can either be COCs (combined oral contraceptives) or POPs (progestin only pills).COCs contains both estrogens & progestin while POPs contain only progestin hormone. Side Effects of COCs: These include: nausea, headaches, breast tenderness, fatigue, lowered libido, skin changes and mood changes. Some serious side effects are; hypertension, venous thromboembolism and leg cramps.

Side Effects of POPs: Most women do not suffer from these side effects. Only a small number of them do. They include: Irregular menses, spotting/inter-menstrual bleeding, breast tenderness, acne, headaches, nausea and dizziness.

Emergency Contraceptives: It is marketed as Postinor 2. It consists of 2 pills, which each contain levonorgestrel ingested 12 hours apart. The first dose should be taken within the first 72 hours after unprotected intercourse; however, studies demonstrate effectiveness if the pills are taken after that period. Side effects are same as the Progestin Only Pills.

Injectables: These include: Depo Provera (a 3 month progesterone based injection) & Noristerat (a 2month progestin injection). Since these are progesterone based contraceptives, they have the same side effects as the mini-pill. In addition, these

methods can cause: Delayed return to fertility, osteoporosis, acne and amenorrhea. Mesigyna & Cyclofem (a 1 month combined hormone based injection): Since they contain both estrogens & progesterone, they have same side effects as the COCs. In addition, there may be irregular menses for the first 3 - 6 months.

Implants: These include Norplant, Jadelle and Implanon. Norplant contains 6 sticks for subdermal insertion in the arms, Jadelle contains 2 sticks and lasts up to 5 years and Implanon has 1 stick and is effective for 3 years. All are progestin based, so side effects are the same as those of the POPs such as irregular bleeds, weight gain, breast tenderness, headache, and change in appetite and hair loss.

Intrauterine devices (IUD): They can be hormonal intrauterine systems e.g. Mirena or non-hormonal IUDs e.g. Copper T. Side effects of Copper T include: expulsion, increased vaginal discharge, abdominal pain or cramps, inter menstrual spotting and painful intercourse, perforation of uterus during insertion, heavier menses, increased risk of ectopic pregnancy, increased risk of infection

Side effects of Mirena include irregular menses, abdominal cramps and pain, expulsion, perforation of uterus, ectopic pregnancy risk, infection and ovarian cysts.

Barrier methods such as Condoms, Diaphragms, Cervical caps are as follows: Allergic reaction to latex, increased risk of urinary tract infections (in diaphragms), pain and discomfort upon insertion for cervical caps.

Permanent methods. Vasectomy- Side effects include Temporary bruising, infection, hematoma formation, bleeding, post vasectomy pain, sperm granuloma, regret and psychological effects. Bilateral Tubal Ligation- Side effects include: Abnormal pain

and bleeding, infection, bowel or bladder injury during surgery, in case of failure, there is risk of ectopic pregnancy.

Traditional /Natural Methods. Withdrawal: Side effects include: Failure rate is high and sexual frustration /dissatisfaction. Effectiveness depends largely on the man's capability to withdraw prior to ejaculation. Rhythm Method: Has high failure rate. In case of conception in the infertile days, the embryo can't implant itself hence there is increased risk of miscarriage and birth defects. Lactational Amenorrhea Method: Elevated prolactin levels and a reduction of gonadotropin-releasing hormone from the hypothalamus during lactation suppress ovulation. This leads to a reduction in luteinizing hormone (LH) release and inhibition of follicular maturation. The duration of this suppression varies and is influenced by the frequency and duration of breastfeeding and the length of time since birth. Mothers only need to use breastfeeding to be successful; however, as soon as the first menses occurs, she must begin to use another method of birth control to avoid pregnancy.

2.6 Accessibility of Contraceptive Services

It is estimated that 222 million women in developing countries have unmet need for family planning (WHO 2013). These are women that want, but for one reason or another, do not have access to contraception. Closer home, data shows that women in Kenya who fall in the lower income groups give birth to more children than women who fall in higher income groups. Accessibility to birth control strategies such as contraceptives is one of the factors that contribute to this higher fertility rate whereby in Kenya, women in the lowest wealth quintile had a Total Fertility Rate(TFR) that was more than twice that of women from the highest wealth quintile.(KDHS 2014). Thus these women have a higher unmet need for family planning.

Education is another factor that influences access to contraception and thus the number of children that a woman has in her reproductive years. KDHS 2014 found that women with no education had a TFR that was more than double that of women who had secondary or higher education. (KDHS 2014). This could be because women with education have a stronger ability to create income for themselves which they can then use to access contraceptive services at health facilities. Teenage pregnancy is also greatly influenced by the level of education among the teenage mothers. The percentage of women aged 15-19 years who were mothers or were pregnant with their first child was found to be 33% among teenagers with no education and 12% among teenagers with secondary education and above. (KDHS 2014)

Age is another factor that can influence accessibility to contraceptive services because younger women have been found to be at higher risk of unwanted or mistimed pregnancies than older women. This could because younger women's access to the contraceptives is determined by health providers who may not be trained in provision of Youth Friendly Services (YFS) and might make the young woman feel ashamed of asking for contraceptive services. Some health providers also have the attitude that contraception is meant only for women who already have a child, and most young women may be unmarried and childless and sexually active thus need contraceptive services.

Distance to the health facility is another factor that influences accessibility to contraceptive services. Health facilities that provide contraception may not be easily accessible in some parts of Kenya such as the arid and semi-arid regions of Kenya. Women who live in these regions have the highest fertility rates and the lowest Contraceptive Prevalence Rates (KDHS 2014).

2.7 Quality of Contraceptive Services

The quality of contraceptive services offered by service providers can also influence the unmet need for family planning among women. Policies such as the Global Gag Rule can influence health provider attitudes while doing their work. For instance health providers whose clinics get closed and are then transferred to other facilities may lose motivation at work. This may affect the quality of services they provide which may result in lack of client referrals to the facility which thus causes unmet need for family planning among clients.

Some clients may even change their minds about getting a contraceptive while already at the clinic due to the kind of reception and attitude they receive from the health providers.

Ensuring client satisfaction is important to meeting the need for family planning among women visiting health facilities. Satisfied clients refer their friends and relatives to receive the same contraceptive services at the health facilities. Satisfied clients who have been explained to and been made to understand all the possible side effects of a contraceptive are more likely to sustain the use of the contraceptive than a dissatisfied client who may not comprehend the signs and symptoms that they may experience as a result of the contraceptive. The dissatisfied client will likely go to a different facility and have the contraceptive removed or simply discontinue its use such as in the case of contraceptive pills or contraceptive injections or condoms.

2.8 Affordability of Contraceptive Services

The financial status of women greatly influences whether or not their contraceptive needs are met. Contraceptive Prevalence Rates(CPR) are lower among women in the

lower income brackets. Women in Kenya who fall in the lower income groups bear more children than women who fall in higher income groups. Accessibility to birth control strategies such as contraceptives is one of the factors that contribute to this higher fertility rate whereby in Kenya, women in the lowest wealth quintile had a Total Fertility Rate (TFR) that was more than twice that of women from the highest wealth quintile. (KDHS 2014) Thus these women have a higher unmet need for family planning.

Affordability of contraception includes the sources of funds that women use in accessing contraception. Most women pay for contraception using their own personal funds because many health insurers do not cover contraception as part of a client's health cover. In fact the most affordable health insurer in Kenya, the government's insurance company, the National Health Insurance Fund (NHIF), only pays for surgical methods of contraception, that is, bilateral tubal ligation and vasectomy. Spousal support of the use of family planning is also critical for many women in order to access contraception as they may be completely financially dependent on their spouses for all their needs, including their health needs. Some women depend on their strong social networks of families and friends in order to finance their trips to the health facilities especially in the rural areas.

NGOs provide free contraceptive services through outreach activities and through Private Public Partnerships (PPP) with public facilities by donating contraceptives and other necessary consumables such as gloves and alcohol swabs to the facilities. However, the patients still have to have the money to travel to the health facility where these free contraceptive services may be offered. Therefore, financial strength is a very important factor in meeting the family planning needs of women in any

community. Foreign aid policies such as the global gag rule reduces funding for these NGOs, thus outreach activities disappear and suddenly women have to spend more money to meet their contraceptive needs.

There is little data available on the extent of the effect of the Global Gag rule in Kenya and on access to family planning services in NGOs in Kenya. The only data available is on a study done by Engender Health, a global reproductive health nongovernmental organization, published in the year 2006, titled ”The Global Gag Rule”. This study aimed at adding on to this Engender Health study done in 2006 which found that Family Health Options Kenya had to shut down 5 out of the 9 clinics that it had opened by that time, while Marie Stopes, another nongovernmental organization shut down 2 of its clinics, increased the cost of its services and got rid of some of its staff in the year 2002. Marie Stopes also had to stop all its community outreach programs. All these activities resulted in the loss of healthcare to at least 9000 people, who were mainly women and children. (Engender Health, 2006)

CHAPTER 3: MATERIALS AND METHODS

3.1 Research design*:*

The study utilized a descriptive cross sectional study design. A cross sectional study was used to show the characteristics of a population at one point in time. A descriptive study was used to describe the population in terms of person, place and time.

This study design was selected in order to show the influence of the Global Gag rule on access to contraceptive services at Family Health Options Kenya as the point in time that this policy is in effect.

The qualitative data collected through key informant interviews showed the health providers view of how the global gag rule affected funding for their health facilities and the quantitative data that was collected using the questionnaires showed the patient's point of view.

3.2 Variables*:*

Independent Variable: Reduced funding due to Global Gag Rule

Dependent Variable: Unmet need for family planning

Intervening variables:

Affordability of FHOK contraceptive services measured by: Need for spousal support, Health insurance, and Personal cash.

Quality of FHOK contraceptive services measured by: Health provider attitudes, Level of Client Satisfaction, Waiting time, Follow up referral system.

Access to FHOK contraceptive services measured by Distance to FHOK facility, Access to information, Access to commodities.

3.3 Location of the study*:*

The study was done at the four Family Health Options Kenya clinics in Nairobi County. They included Family Care Medical Centre and Maternity hospital in Nairobi West, Family Care Medical Centre in Kibera, Family Care Medical Centre in Phoenix House on Kenyatta Avenue and Family Care Medical Centre in Jerusalem.

The services provided at these clinics included the Integrated Package of Essential Services (IPES) required by International Planned Parenthood Federation (IPPF). These services are Counselling, Family Planning, Gynaecological Services, Comprehensive Abortion Care (CAC), HIV Services, treatment of Sexually Transmitted Infections, Prenatal Care, and management of Gender Based Violence patients.

Some important reproductive health indicators for the Kenyan population that guide the work of reproductive health NGOs like Family Health Options Kenya, include the Maternal Mortality Rate which stands at 362 per 100,000 women, Contraceptive Prevalence Rate is 58% among married women and 65% among unmarried sexually active women, Unmet need For Family Planning is 18%, Fertility rate is 3.9 children per woman.(KDHS 2014). There were 1.5 million people living with HIV/AIDS in Kenya as at the year 2015. (NASCOP 2016)

3.4 Study population*:*

Women aged 15-49 years seeking contraceptive services at Family Health Options Kenya clinics in Nairobi County formed the target population.

Inclusion criteria: Women aged 15-49 years; and women seeking family planning services at FHOK.

Exclusion criteria: women who voluntarily chose not to participate in the study.

Women were sampled from this population using purposive sampling.

3.5 Sampling Techniques*:*

The participants in the study from each of the 4 Family Health Options Kenya clinics were selected using purposive sampling because of the need to select only women who were seeking family planning services and were of reproductive age. The FHOK clinics in Kenya were sampled using purposive sampling because of the need to select all the four FHOK clinics that are located in Nairobi County, which was the geographical location of this study.

3.6 Sample size determination*:*

The sample was calculated according to the formula as designed by Fisher(1998):

$$n_0 = \frac{Z^2 pq}{e^2}$$

Where:

n = desired sample size

Z = is the value which is found in statistical tables that contain the area under a normal curve, at 95% confidence level z= 1.96

P = is the estimated proportion of an attribute, in this case unmet need for family planning, that is present in the population, which in this case is 18% (KDHS 2014).

q = also represented as (1-P) refers to the proportion of non prevalence of this attribute in the population

e = refers to the desired level of precision, which is 0.05

Therefore:

$$n = \frac{1.96^2 \times 0.18 \times (1-0.18)}{0.05^2}$$

n is ~ 226

Based on the complementary formula:

For samples less than 10000 Cochran formula was used;

$$nf = \frac{n}{1 + (n-1)/N}$$

Nf= 168

The researcher added 10% to cater for any attrition rates, the desired sample size was ~ 184 participants.

This number was proportionately divided among the 4 FHOK clinics in Nairobi County depending on the monthly average number of family planning clients at each of the clinics.

The monthly average number of family planning clients:

FCMC Nairobi West is 277 clients.

FCMC Kibera is 76 clients.

FCMC Phoenix House is 253 clients.

FCMC Jerusalem is 55 clients.

Therefore the total average number of family planning clients for FHOK in Nairobi County is 661 clients per month. The sample size was distributed as follows:

277/661* 184= 77 respondents from FCMC Nairobi West clinic

76/661*184= 21 respondents from FCMC Kibera clinic

253/661*184= 71 respondents from FCMC Phoenix House clinic

.55/661*184= 15 respondents from FCMC Jerusalem clinic

FHOK CLINIC	NO. OF RESPONDENTS
FCMC NAIROBI WEST	77
FCMC KIBERA	21
FCMC PHOENIX	71
FCMC JERUSALEM	15

Table 1: Table showing Distribution of respondents

3.7 Construction and Research Instruments*:*

Self administered Questionnaires were used for quantitative data collection and Key Informant interviews of 2 health providers at each facility for qualitative data collection.

Questionnaires

A single set of questionnaires was used in this study. The questionnaires were constituted to examine the influence of the global gag rule on access to contraception at Family Health Options Kenya. There were questions which required "yes" or "no" responses. Other questions required the respondents to only pick the choices relevant to them. All questions were equally weighted.

Questionnaire validity was ensured by the fact that Socio demographic data was first collected to encourage the women to continue filling the questionnaire, The research design was descriptive and cross sectional, The questionnaire used was not a standardized one in any way because of its originality as pertaining to this specific

study, The questionnaire was comprehensive enough to collect all the information needed to address the goals and purposes of the research.

Key informant interviews

The same set of open ended questions was administered to all the family planning service providers that were recruited to this study. Audio recordings of each of the interviews was collected during the interview and stored by the researcher in order to prevent any loss of data given.

3.8 Pretesting of data collection tools*:*

Pretesting was done to check for any difficulty in understanding the questions. Unclear questions were reviewed and reconstructed in the final questionnaire. Pretesting was done in the 4 clinics in Family Health Options Kenya in Nairobi County.

3.9 Validity and Reliability*:*

Pre testing was also done. Questionnaire validity was ensured through the fact that: Socio demographic data was first collected to encourage the women to continue filling the questionnaire. The questionnaire that was used was not a standardized one in any way because of its originality and specificity to this study. The questionnaire was comprehensive enough to collect all the information needed to address the goals and purposes of the study.

3.10 Data collection techniques*:*

Collection of quantitative data was done using self administered questionnaires that were given to clients seeking family planning services at Family Health Options Kenya, after explaining of the study to the client and acquisition of written consent. The study used a single set of questionnaires. The quantitative data questions contained multiple choice answers about the woman's age, family planning history and the reasons for their family planning choices. It also included questions about the woman's fertility history including the number of children she had. It also included the sources of money that the woman used to pay for her contraceptive needs. Qualitative data was collected using Key informant Interviews with the facility's family planning service providers. These service providers were asked open ended questions about any trends they had noticed among their family planning clients' choices of contraceptive methods. They were asked about the sources and adequacy of funding for their clinics and the role government plays in family planning in Kenya. The interviews also had questions that showed health provider attitudes towards provision of contraception.

3.11 Data Analysis*:*

Data collected in the questionnaires was kept in the custody of the main researcher until all the respondents filled them. Afterwards, all the filled questionnaires were put together for Data Processing and Analysis to be done using Statistical Package for Social Sciences (SPSS). All the data collected will be entered into the SPSS software, then the software was used to analyze it. Chi square was used to test the significance of the association between the dependent and independent variables.

Unmet need for family planning was calculated according to WHO 2010:

Unmet need = Women (married or in a union) who are not using contraceptives are fecund and desire to either stop childbearing or postpone their next birth for at least 2 years + pregnant women whose current pregnancy was unwanted or mistimed + women in postpartum period amenorrhea who are not using contraception and at the time they get pregnant had wanted to delay or prevent pregnancy ÷ Total number of women of reproductive age who are married or in union (15-49) × 100.

3.12 Ethical considerations*:*

Ethical clearance was obtained from Kenyatta University Ethics and Review committee. Permission to conduct research was obtained from the National Commission for Science, Technology and Innovation. Written informed consent was sought from participants before acquisition of data. Participants were informed of the purpose and importance of the study and were given an opportunity to seek clarification. They were informed that they could decline to participate in the study with no consequences. Questionnaires were administered to the respondents in full confidentiality. Full confidentiality was ensured through the fact during data collection; the patient was alone with the researcher in a consultation room with the door closed. Afterwards, the filled questionnaires were kept in the custody of the researcher.

CHAPTER 4:

DATA ANALYSIS, RESULTS AND DISCUSSION

Survey response rates

The study was able to achieve the targeted number of 184 respondents. The period taken to achieve the numbers varied from clinic to clinic, with the clinics requiring more respondents needing more days for data collection than the clinics that required fewer respondents. The study collected data from 77 respondents from FCMC Nairobi West clinic, 21 respondents from FCMC Kibera clinic, 71 respondents from FCMC Phoenix House clinic and 15 respondents from FCMC Jerusalem clinic.

Response rates varied from one question to another due to non-response in some cases.

4.1 Respondents sociodemographic characteristics

Of the 184 women sampled in the study, 68.5% were married, 28.8% were single, divorced/separated women formed 2.2% of respondents and those remarried were 0.5% of respondents. The age groups with the highest number of women visiting the family planning clinics were the 30-34years age group forming 23.4% of respondents, followed closely by 25-29year olds who formed 22.3% of respondents and 20-24 year olds who formed 20.1% of respondents. The other age groups had fewer women seeking contraceptive services, 35-39 year olds formed 15.2% of respondents, 40-44 year olds formed 7.6% of respondents and 45-49year olds formed 7.1% of respondents.

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	single	53	28.8	28.8	28.8
	married	126	68.5	68.5	97.3
	divorced/separated	4	2.2	2.2	99.5
	remarried	1	.5	.5	100.0
	Total	184	100.0	100.0	

Table 4.1: Table showing marital status of women seeking contraceptive services at FHOK

Age of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	15-19	8	4.3	4.3	4.3
	20-24	37	20.1	20.1	24.5
	25-29	41	22.3	22.3	46.7
	30-34	43	23.4	23.4	70.1
	35-39	28	15.2	15.2	85.3
	40-44	14	7.6	7.6	92.9
	44-49	13	7.1	7.1	100.0
	Total	184	100.0	100.0	

Table 4.2: Table showing age of women seeking contraceptive services at FHOK

Objective 1: The contraceptive methods that women are selecting when they visit Family Health Options Kenya in Nairobi County.

The most frequently used contraceptive by women who were already on a contraceptive method when they visited FHOK was injections at 35.3% of women, followed in popularity by the IUD at 33.3% of the women, then the implant which was used by 17.6% of women, then the pill used by 9.8% of the respondents, female sterilization was used by 2.0% and other methods such as condoms were used by 2.0% of respondents. Contraceptive use was at 53.8%. Women who did not use contraception were 45.1%.

Family planning method

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	female sterilization	2	1.1	2.0	2.0
	Pill	10	5.4	9.8	11.8
	Iud	34	18.5	33.3	45.1
	injections	36	19.6	35.3	80.4
	implants	18	9.8	17.6	98.0
	other	2	1.1	2.0	100.0
	Total	102	55.4	100.0	
Missing	System	82	44.6		
Total		184	100.0		

Table 4.3: Table showing family planning methods used by women who were already on contraception when they visited FHOK.

Out of the 184 respondents, 58 women were not on any method and desired to be put on contraception. The method most frequently chosen by this group was implants which formed 41.4% and IUDs which formed 32.8% of the women. This was then followed by injections at 17.2%, the pill at 5.2% of respondents, condoms at 1.7% of women and other methods formed 1.7% of women.

Family planning method desired

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	pill	3	1.6	5.2	5.2
	condom	1	.5	1.7	6.9
	iud	19	10.3	32.8	39.7
	injections	10	5.4	17.2	56.9
	implants	24	13.0	41.4	98.3
	other	1	.5	1.7	100.0
	Total	58	31.5	100.0	
Missing	System	126	68.5		
Total		184	100.0		

Table 4.4: Table showing the family planning methods desired by women visiting FHOK who were not on any contraception.

4.2 Objective 2: The level of unmet need for family planning among women seeking contraceptive services at Family Health Options Kenya in Nairobi County.

According to World Health Organization 2010: Unmet Need = {Women (married or in a union) who are not using contraceptives are fecund and desire to either stop childbearing or postpone their next birth for at least 2 years + pregnant women whose current pregnancy was unwanted or mistimed + women in postpartum period amenorrhea who are not using contraception and at the time they get pregnant had

wanted to delay or prevent pregnancy ÷ Total who number of women of reproductive age are married or in a union (15-49)}*100

Women who are not using contraceptives are fecund and desire to either stop childbearing or postpone their next birth for at least 2 years = 58. Pregnant women whose current pregnancy was unwanted or missed = 27. Women in postpartum period amenorrhea who are not using contraception and at the time they get pregnant had wanted to delay or prevent pregnancy = 0. Total who number of women of reproductive age are married or in a union = 184. 58+27+0= 85. (85÷184) x 100% = 46.1%. Therefore unmet need = 46.1%

4.3 Objective 3: The relationship between affordability of seeking contraceptive services at Family Health Options Kenya in Nairobi County and unmet need for family planning.

Out of the 58 women who reported having a desire to use contraceptives, all of them who sought family planning services at Family Health Options Kenya paid through cash payment because contraceptives are not covered by insurance companies. 25 women reported not wanting a contraceptive at that clinic visit and also paid using cash.

With regard to desired timing of last pregnancy, 72.2% of the respondents had a mistimed pregnancy (wanted their last pregnancy later), 2.8% had an unwanted pregnancy (reported not at all wanting their last pregnancy) and 25.0% reported getting their last pregnancy at the desired time. All these women paid for their contraceptive services through cash therefore cash payment was a constant variable and as a result, there was no significant relationship between cash payment for family

planning services and unmet need for family planning as measured by desire for family planning and desired timing of last pregnancy.

Desire for family planning * Cash payment for family planning Crosstabulation

			Cash payment for family planning	
			Yes	Total
Desire for family planning	yes	Count	58	58
		% within Desire for family planning	100.0%	100.0%
		% within Cash payment for family planning	69.9%	69.9%
	no	Count	25	25
		% within Desire for family planning	100.0%	100.0%
		% within Cash payment for family planning	30.1%	30.1%
Total		Count	83	83
		% within Desire for family planning	100.0%	100.0%
		% within Cash payment for family planning	100.0%	100.0%

Table 4.5: Table showing cash payment method for family planning services against women desiring family planning

Desired timing of last pregnancy * Cash payment for family planning Crosstabulation

			Cash payment for family planning	
			yes	Total
Desired timing of last pregnancy	then	Count	9	9
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Cash payment for family planning	25.0%	25.0%
	later	Count	26	26
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Cash payment for family planning	72.2%	72.2%
	not at all	Count	1	1
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Cash payment for family planning	2.8%	2.8%
Total		Count	36	36
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Cash payment for family planning	100.0%	100.0%

Table 4.6: Table showing cash payment method for family planning against desired timing of last pregnancy

With regard to availability of health insurance to cover for contraceptive services, all the women who had a mistimed or unwanted or correctly timed pregnancy, as shown below in Table 4.8, reported that they did not have insurance coverage for their contraceptive needs. Therefore health insurance had no relationship with desired timing of last pregnancy. Out of all the 58 women who reported a desire for family planning, all of them reported not having health insurance that could cover for their contraceptive needs, as shown in Table 4.7. Therefore health insurance had no relationship with desire for family planning as its absence was a constant.

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Desire for family planning * Availability of health insurance for contraceptive services Crosstabulation

			Availability of health insurance for contraceptive services	
			no	Total
Desire for family planning	yes	Count	58	58
		% within Desire for family planning	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	69.9%	69.9%
	no	Count	25	25
		% within Desire for family planning	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	30.1%	30.1%
Total		Count	83	83
		% within Desire for family planning	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	100.0%	100.0%

Table 4.7: Table showing the availability of health insurance payment for family planning services and desire for family planning.

Desired timing of last pregnancy * Availability of health insurance for contraceptive services Crosstabulation

			Availability of health insurance for contraceptive services	
			no	Total
Desired timing of last pregnancy	then	Count	9	9
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	25.0%	25.0%
	later	Count	26	26
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	72.2%	72.2%
	not at all	Count	1	1
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	2.8%	2.8%
Total7		Count	36	36
		% within Desired timing of last pregnancy	100.0%	100.0%
		% within Availability of health insurance for contraceptive services	100.0%	100.0%

Table 4.8: Table showing the availability of health insurance payment for family planning services and desired timing of last pregnancy

Desire for family planning * Spousal presence in this clinic visit Crosstabulation

			Spousal presence in this clinic visit		
			yes	no	Total
Desire for family planning	yes	Count	20	38	58
		% within Desire for family planning	34.5%	65.5%	100.0%
		% within Spousal presence in this clinic visit	80.0%	65.5%	69.9%
	no	Count	5	20	25
		% within Desire for family planning	20.0%	80.0%	100.0%
		% within Spousal presence in this clinic visit	20.0%	34.5%	30.1%
Total		Count	25	58	83
		% within Desire for family planning	30.1%	69.9%	100.0%
		% within Spousal presence in this clinic visit	100.0%	100.0%	100.0%

Table 4.9: Table showing spousal presence in this clinic visit against desire for family planning

Spousal presence had no significant influence on desire for family planning, because in the above cross tabulation, chi square test established that p=0.187.

Spousal presence also had no influence on desired timing of last pregnancy because in the cross tabulation of spousal presence with desired timing for last pregnancy, the8 chi square test result was p=0.806.

Desired timing of last pregnancy * Spousal presence in this clinic visit Crosstabulation

			Spousal presence in this clinic visit		
			yes	no	Total
Desired timing of last pregnancy	then	Count	2	7	9
		% within Desired timing of last pregnancy	22.2%	77.8%	100.0%
		% within Spousal presence in this clinic visit	33.3%	23.3%	25.0%
	later	Count	4	22	26
		% within Desired timing of last pregnancy	15.4%	84.6%	100.0%
		% within Spousal presence in this clinic visit	66.7%	73.3%	72.2%
	not at all	Count	0	1	1
		% within Desired timing of last pregnancy	.0%	100.0%	100.0%
		% within Spousal presence in this clinic visit	.0%	3.3%	2.8%
Total		Count	6	30	36
		% within Desired timing of last pregnancy	16.7%	83.3%	100.0%
		% within Spousal presence in this clinic visit	100.0%	100.0%	100.0%

Table 4.10: Table showing spousal presence in this clinic visit against desired timing of last pregnancy

4.4 Objective 4: The relationship between accessibility of Family Health Options Kenya facilities in Nairobi County and unmet need for family planning.

Desired timing of last pregnancy * Distance to FHOK facility Crosstabulation

			Distance to FHOK facility		
			far	near	Total
Desired timing of last pregnancy	then	Count	1	8	9
		% within Desired timing of last pregnancy	11.1%	88.9%	100.0%
		% within Distance to FHOK facility	9.1%	32.0%	25.0%
	later	Count	9	17	26
		% within Desired timing of last pregnancy	34.6%	65.4%	100.0%
		% within Distance to FHOK facility	81.8%	68.0%	72.2%
	not at all	Count	1	0	1
		% within Desired timing of last pregnancy	100.0%	.0%	100.0%
		% within Distance to FHOK facility	9.1%	.0%	2.8%
Total		Count	11	25	36
		% within Desired timing of last pregnancy	30.6%	69.4%	100.0%
		% within Distance to FHOK facility	100.0%	100.0%	100.0%

Table 4.11: Table showing distance to family planning clinic against women desiring family planning

Distance to Family Health Options Kenya facilities was found to have no significant influence on desired timing of last pregnancy among the respondents. When it was cross tabulated with contraceptive use, chi square test established that p=0.13.

Distance to Family Health Options Kenya facilities was found to have no significant influence on desire for family planning among the respondents. When it was cross tabulated with contraceptive use, chi square test established that p=0.145.

Desire for family planning * Distance to FHOK facility Crosstabulation

			Distance to FHOK facility		
			far	near	Total
Desire for family planning	yes	Count	10	47	57
		% within Desire for family planning	17.5%	82.5%	100.0%
		% within Distance to FHOK facility	55.6%	73.4%	69.5%
	no	Count	8	17	25
		% within Desire for family planning	32.0%	68.0%	100.0%
		% within Distance to FHOK facility	44.4%	26.6%	30.5%
Total		Count	18	64	82
		% within Desire for family planning	22.0%	78.0%	100.0%
		% within Distance to FHOK facility	100.0%	100.0%	100.0%

Table 4.12: Table showing desire for family planning against distance to FHOK facility

4.5 Objective 5: The relationship between the quality of services offered at Family Health Options Kenya in Nairobi County and unmet need for family planning.

Desire for family planning * Client satisfaction Crosstabulation

			Client satisfaction		
			satisfied	dissatisfied	Total
Desire for family planning	yes	Count	50	8	58
		% within Desire for family planning	86.2%	13.8%	100.0%
		% within Client satisfaction	68.5%	80.0%	69.9%
	no	Count	23	2	25
		% within Desire for family planning	92.0%	8.0%	100.0%
		% within Client satisfaction	31.5%	20.0%	30.1%
Total		Count	73	10	83
		% within Desire for family planning	88.0%	12.0%	100.0%
		% within Client satisfaction	100.0%	100.0%	100.0%

Table 4.13: Table showing client satisfaction with desire for family planning

The quality of services provided at FHOK clinics had no influence on desire to be on family planning among the respondents because when the level of satisfaction was cross tabulated with family planning use, chi square established that p=0.457.

The quality of services provided at FHOK clinics had no influence on desired timing of last pregnancy among the respondents because when the level of satisfaction was cross tabulated with desired timing of last pregnancy , chi square established that p=0.533.

Desired timing of last pregnancy * Client satisfaction Crosstabulation

			Client satisfaction		
			satisfied	dissatisfied	Total
Desired timing of last pregnancy	then	Count	9	0	9
		% within Desired timing of last pregnancy	100.0%	.0%	100.0%
		% within Client satisfaction	27.3%	.0%	25.0%
	later	Count	23	3	26
		% within Desired timing of last pregnancy	88.5%	11.5%	100.0%
		% within Client satisfaction	69.7%	100.0%	72.2%
	not at all	Count	1	0	1
		% within Desired timing of last pregnancy	100.0%	.0%	100.0%
		% within Client satisfaction	3.0%	.0%	2.8%
Total		Count	33	3	36
		% within Desired timing of last pregnancy	91.7%	8.3%	100.0%
		% within Client satisfaction	100.0%	100.0%	100.0%

Table 4.14: Table showing client satisfaction against desired timing of last pregnancy

4.6 Key Informant Interviews findings

8 health providers were interviewed in this study, 2 from each of the 4 clinics used in the study. The main theme identified was that there is no significant decrease in family planning use among FHOK clients. This was due to the fact that FHOK as a donor funded nongovernmental organization is currently running a project called Global Gag Response(GGR) project funded by International Planned Parenthood Federation to mitigate the effects of the global gag rule. The health providers reported that the presence of this project enabled smooth and uninterrupted running of contraceptive services at FHOK.

"The GGR project has provided our clinic with all the contraceptives we needed" (Health Provider, FHOK).

The GGR project also enabled the reopening and restocking of the Mombasa branch of FHOK that had been closed for some months when funding decreased.

The health providers felt that the government has a major role to play in family planning provision including setting legal and policy frameworks, creating service standards, providing services through government facilities, providing special adolescent focused services, providing contraceptives and other Family Planning commodities, supporting information, education and communication. This will significantly contribute to the achievement of the government's Big 4 agenda of Universal Health Coverage (UHC).

"Universal Health Coverage cannot be achieved if women's reproductive health is not a part of it." (Health Provider, FHOK).

Unmet need for family planning still remains an important reproductive health issue among health providers, because women's health is greatly affected by lack of contraception through unwanted pregnancies that may end in unsafe abortions. Some of these unsafe abortions then cause maternal deaths. All health providers thought that all women should have access to contraceptive services regardless of age or parity and had a positive attitude towards provision of contraceptives to women from all walks of life. They also reported that good quality of care at FHOK is ensured by regularly conducting Quality of Care (QOC) assessments using tools such as Client Exit Interviews where clients report on their experience in terms of certain aspects such as waiting time, whether they were provided with adequate access to information and access to their chosen contraceptive commodities. A follow up referral system is in place at all FHOK facilities to ensure that any clients requiring specialized care are able to access it.

CHAPTER 5:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study was about the influence of the global gag rule on access to contraceptive services at Family Health Options Kenya in Nairobi City County.

5.2 Summary

The study found that there was a number of women aged 15-49years who were sexually active, and wanted to limit childbearing or wanted to space their childbearing, yet they did not practise any form of contraception. These women had an unmet need for contraception.

There were no factors that this study measured that increased or reduced this unmet need. All the factors, including affordability of services, accessibility of FHOK services and quality of FHOK services had no significant relationship with unmet need for family planning. This is explained by the mitigation measures that have been put in place through the presence of the Global Gag Response (GGR) project currently ongoing at FHOK that has ensured that all services continue normally at these clinics.

5.3 Conclusions

The study concluded that the most popular form of contraception among the women visiting Family Health Options Kenya who were already on contraception was injectables. The most popular methods chosen by women when they visited FHOK clinics was long term methods namely implants and IUDs.

The study also concluded that unmet need among the women visiting FHOK was 46.1% and was higher than the national estimate of unmet need for family planning, which is 18% (KDHS 2014). This is due to the fact that the study population was

women who visited the clinic specifically for family planning services, not the general population of women in the community.

There were no factors that this study measured that increased or reduced this unmet need. All the factors, including affordability of services, accessibility of FHOK services and quality of FHOK services had no significant relationship with unmet need for family planning. This is explained by the mitigation measures that have been put in place through the presence of the Global Gag Response (GGR) project currently ongoing at FHOK, that has ensured that the affordability, accessibility and quality of contraceptive services provided at these 4 clinics continues without any interruptions from the reduction in funding that was caused by the global gag rule.

5.4 Recommendations

The Ministry of Health needs to include contraception in the Universal Health Coverage policy of the government Big 4 Agenda. Private insurers need to be sensitized on the benefits of offering contraception as part of their insurance packages, for example through providing a woman with a 3 year implant, this insurer is assured of no maternity claims from this client for a 3 year period. This increases their profits. Policymakers and stakeholders in nongovernmental organizations need to create permanent measures to mitigate against fluctuation of donor funding because this has proven to be effective in ensuring continuity of care for patients..

5.5 Further Research

As the global gag rule will still be in effect for the foreseeable future, further research is needed on its continued effects while it is still in place.

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APPENDICES*:*

Consent form:

Hello. My name is Dr. Zeddy Wekesa. I am conducting a study about family planning and I would really appreciate your participation in this study. I would like you to take a few minutes fill a questionnaire. I assure you that whatever information you provide will be strictly confidential. Participation in this study is voluntary and you can choose not to participate. However I hope that you participate as your views are important to me.

At this point, do you have any questions that you would like to ask about this study?

May we begin?

I consent and accept to participate in this study.

Signature…… Date……..

Work plan*:*

Activity	Sept-Oct 2017	Oct-Nov 2017	Nov-Dec 2017	Jan – March 2018	April – June 2018	July- Aug 2018
Concept and proposal development						
Defense of proposal and corrections						
Submission to graduate school,KUERC, NACOSTI						
Data collection						
Thesis writing						
Thesis Defense						

Budget

Activity	**Amount**
Draft proposals	1000sh
Research assistants	50000sh
Transport cost	10000sh
Data Analysis	20000sh
Printing of questionnaires	1000sh
Pretesting	10000sh
Thesis printing and binding	1000sh
NACOSTI, KUERC	3000sh
Miscellaneous	10000sh
Total Cost	116000sh

Questionnaire:

Kindly answer the following questions about yourself**.**

1) What is your marital status?

☐ Single ☐ Divorced/Separated

☐ Married ☐ Remarried

2) How old are you?

☐ 15-19 ☐ 30-34 ☐ 40-44

☐ 25-29 ☐ 35-39 ☐ 44-49

☐ 25-29

3) Have you visited a family planning clinic before?

☐ Yes

☐ No

4) Are currently you on any family planning method yourself?

☐Yes

☐ No

5) If yes, which family planning method are you currently using?

☐ Female sterilization ☐ IUD ☐ Other

☐ Pill ☐ Injections

☐ Female condom ☐Implants

6) Do you want to change your family planning method today or are you going to get the same method that you have been using?

☐ I want to change to another method

☐ I want to get the same method I have been using

7) If you desire to change the family planning method, kindly tick the method you intend to switch to.

☐ Bilateral Tubal ligation ☐ IUD ☐ Other

☐ Pill ☐ Injections

☐ Condom ☐ Implants

8) Could you kindly provide a reason for your desire to change your family planning method

☐ Cost ☐ Ease or convenience of use

☐ Side effects ☐ Effectiveness

9) Are you paying for the family planning services from your own personal funds?

☐ Yes ☐ No

10) If you are not using family planning, do you desire to be on any family planning method?

☐ Yes

☐ No

11) If yes, which family planning method do you desire to be on?

☐ Bilateral Tubal Ligation ☐ IUD ☐ Other

☐ Pill ☐ Injections

☐ Condom ☐ Implants

12) Could you kindly provide the reason you have chosen the above family planning method

☐ Cost ☐ Ease or convenience of use

☐ Side effects ☐ Effectiveness

13) Have you come with your spouse to the clinic today?

☐ Yes

☐ No

14) Did you come with your spouse the last time you visited a family planning clinic?

☐ Yes

☐ No

15) Do you and your spouse ever discuss contraception?

☐ Yes

☐ No

16) Does your spouse approve of the use of family planning?

☐ Yes

☐ No

17) Do you have any form of health insurance to pay for your reproductive health needs?

☐ Yes

☐ No

18) If you were to find yourself unable to pay for your family planning needs, for instance if you ever decided to get a surgical method of family planning, would you be able to get public financial support from your families and friends?

☐ Yes

☐ No

19) I would now like to find out the number of live births that you have had. Can you give me the total number of children you have given birth to?

☐ Less than 5

☐ More than 5

20) Are you pregnant now?

☐ Yes

☐ No

21) If yes, how many months pregnant are you?

☐ Less than 3 months

☐ 3-6 months

☐ More than 6 months

22) At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all?

☐ Then

☐ Later

☐ Not at all

23) Do you feel that the distance you travelled to this clinic was:

☐ Far

☐ Near

24) How do you rate your level of satisfaction with our contraceptive services?

☐ I am satisfied with the services

☐ I am dissatisfied with the services

Key Informant Interview

1) In your opinion, how would you describe the use of family planning among your clients in the last one year?
2) Who is currently funding the family planning services offered at this clinic?
3) How do you feel about the level of family planning funding that is currently available to your clinic? Is it too little, enough, too much?
4) Is there any family planning project that is going on at this clinic?
5) If yes, which organization is funding it?
6) What do you think the role of government should be in supporting family planning?
    - Setting legal and policy frameworks
    - Creating service standards
    - Providing services through government facilities
    - Providing special adolescent focused services
    - Providing contraceptives and other FP commodities
    - Supporting information, education and communication
    - Other,……
7) In your opinion, is family planning key to achieving the Kenyan government's health agenda of Universal Health Coverage?
8) If yes, what is the link between family planning and Universal Health Coverage?
9) In your opinion, what are the barriers to the use of family planning services?
10) From what you know or have heard, are there women who would like to use family planning but are not currently using any method?

11) In your opinion, is there a relationship between the use of family planning and women's health?

12) If yes, what is the link between family planning and women's health?

13) What are the possible barriers to integrating into the following health services:

- Maternal and neonatal health
- HIV/AIDS
- Postpartum care
- Post abortion care

14) An important issue is maternal death. What would you say is the relationship between family planning or lack thereof and maternal death?

15) How has closure of some FHOK facilities affected the communities that used to receive services from those facilities?

16) Do you believe that some contraceptive methods are only meant for women who have had a child?