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Factors affecting utilization of family planning among refugees at IFO camp Dadaab in Kenya

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Abstract
Refugees should embrace family planning so as to avert health challenges as a result of unplanned pregnancies and sexually transmitted infections. The main objective of this study was to identify factors that hinder effective family planning among refugees in Dadaab Camp. Positivism research philosophy and a descriptive cross sectional research design were used. 6000 registered refugees were targeted and the sample size was 375 refugees. The empirical results revealed that wide range of affordable contraceptive methods, accessibility to contraceptive methods, evidence based technical guidelines that promote quality, client centered services, type of facilities women have access to, reliability and responsiveness to women needs of contraceptive, long waiting times and behavior of service providers affects uptake of contraceptives among refugees at Dadaab Camp. This study recommends that the refugees should be empowered economically to reduce the poverty level.

Keywords: family planning, refugees, un-planned pregnancy

1. Introduction

Reproductive health is an issue of great concern among refugees in the camps, women are struggling with unplanned pregnancy and poor spacing of children which put most women's health at risk, hence, a challenge of mothers of reproductive ages who get unplanned pregnancies due to lack of accurate information about reproductive health education. Family planning is the planning of when to have and use birth techniques to implement such plans (Olaitan, 2009). Other techniques commonly used include sexual education, prevention and management of sexually transmitted diseases, pre-conception counseling, management and infertility management.

Family planning measures are designed to regulate the number and spacing of children within a family, largely to curb population growth and ensure each family has access to limited resources.

Women experience frequent childbirth that lead to complication during delivery and result in maternal death and disability. Indeed family planning is important to preventing the social, economic and cultural health consequences that result from unplanned pregnancies.

The timing and spacing of pregnancies is very important to both mother and child health. The provision of family planning service provides couple with ability to choose the time and number of children they will have. Family planning services are undertaken in isolation from other aspects of reproductive health (Guest, 2003). The widespread adoption of family planning represents one of the most dramatic changes of the 21st century. The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has tremendous life saving benefits. Yet despite the impressive gains, contraceptive use is still low and the need for contraception is high in some of the world's poorest and most populous places (Smith, 2009) [10].

Studies have shown that use of family planning methods among women is strongly affected by woman's education. Other factors that play a role are urban-rural residence, woman's work status, woman's status relative to men, religion, culture and taboos, household standard of living or economic status of the household, exposure to mass media and community development (Smith, 2009) [10]. Few studies have been done on the factors that affect effective utilization of family planning more specifically among refugees in Kenya and hence the justification for carrying out this study. The main objective was to identify factors that hinder effective family planning among refugees in Dadaab Camp.

1.1 A snip Preview of Dadaab Refugee Camp

Dadaab Refugee Camp is located in Garissa County which is in Kenya. Dadaab is a semi arid area which lies on the boarder to Somalia; it is home to many refugees from different countries of origin, such as South Sudan, Ethiopia, Burundi, Rwanda, Democratic Republic of Congo, Eritrea, Sudan, Republic of Tanzania and Somalia. IFO was establish in 1991, to accommodate refugees from war zone Countries and is the oldest of the five refugee camps in Dadaab, currently accommodating refugees from ten Countries. Due to the influx of new arrivals fleeing war and famine in Somalia in 2010/11, the neighboring, IFO 2 camp was established in 2011 to decrease population pressure in IFO 1.

The main income for refugees are food aids from donation that is distributed by world food programme (WFP), the refugees get their cycle monthly and each person gets 8.2kg of maize or sorghum and a cup of oil however water and medication is provided by UNHCR with its partners agency who gets donation from UNHCR to take responsibility of a certain ministry to help refugees. Currently health is sponsored by Kenya Red Cross Society (KRCS) to assist refugees in the camp to access medical care. The remainder of this article paper is organized as follows. Section 2 covers

review of past studies. Section 3 covers materials and methods. Section 4 covers the results and discussion. Section 5 presents the conclusion and recommendations.

2. Literature Review

2.1 Factors Hindering Effective Utilization of Family Planning among Refugees

This section presents the factors that are impediment to the realization of the main intent of the introduction of family planning among refugees.

2.1.1 Socio Demographic Factors

In developing countries, use of modern health care such as maternal health services including use of contraceptive methods can be influenced by the socio demographic characteristics of women. Indian studies have shown that woman's education emerges as the strongest predictor of use of contraceptive methods (Das, Mishra and Saha, 2001) [2]. In one Yemen study, parity, age, marital status, religion, husband's education, husband's occupation, monthly family income, and woman's occupation were found to be associated with use of contraceptive methods (Almualm, 2007) [1]. The principal predisposing and enabling factors affecting use of contraceptive methods by women were socioeconomic status, knowledge, and education of the mother.

This leads to the conclusion that the main limiting factors to the use of contraceptive methods in the state are poverty, ignorance, and illiteracy. The study has clearly evidenced that knowledge of contraceptive use among Sudanese women is far from being universal (Ibnouf, van den Borne and Maars, 2007) [4]. Although education was associated with increase in the use of modern family planning methods, a drop was noticed in women with University and higher education. This might partly be explained by the fact that these women start their family life after their education, i.e. at a later age, and try to have the number of children they wish before their menopause begins (Ibnouf, van den Borne and Maars, 2007) [4]. The likelihood of use of contraceptive methods is higher for those with higher parity, literate (Gizaw and Regassa, 2011) [3]. Levels of knowledge of the contraceptive methods as well as communication between spouses regarding family planning issues were significantly associated with contraceptive use (Kessy and Rwabudongo, 2006) [5]. The long standing forms of African social organization including the high value attached to the perpetuation of the lineage, the importance of children as a means of gaining access to resources particularly land. The use of kinship networks to share the costs and benefits of children primarily through child fostering and the weak nature of conjugal bonds clearly inhibit contraceptive adoption and fertility decline. In the empirical examination of the factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels (NRCWG, 2009).

2.1.2 Socio Cultural Factors

Studies in Sudan, an Islamic country in the developing world, very few women reported that the use of contraceptive methods was against religion or cultural beliefs (Ibnouf, 2007) [4]. Other factors include urban-rural residence, woman's work status, woman's status relative to men, religion, culture and taboos, household standard of living (or economic status of the household), exposure to mass media, and community development (Das, Mishra and Saha, 2001) [2]. Contraceptive methods information provided was seldom sufficiently adapted to local beliefs and characteristics. Cultural barriers were especially noticeable when service providers were from a dominant or relatively successful ethnic group or social class, and clients from a relatively impoverished one.

In highly stratified societies, there is a tendency to underestimate the ability of lower class women to think for themselves, and thus to use family planning information to make informed decisions themselves. In addition, communication difficulties sometimes arise because of different languages or belief systems between providers and clients (UNPF, 1994) [12]. Women's decision about use, non-use or discontinuation of contraceptive methods can be affected by their perceptions of contraceptive risks and benefits, concerns about how side effects may influence their daily lives and assessment of how particular methods may affect relationships with partners or other family members (Moronkola, Ojediran and Amosu, 2006) [7].

The Nigerian study concluded that determinants of reproductive health service use, rest on the individual, household, service and community levels (Moronkola, Ojediran and Amosu, 2006) [7]. Therefore, when considering those influential determinants of use of reproductive health services, the household and community in which the individual lives as well as the characteristics of the health services available in the community must be taken into consideration. Providers should note that women do live in a context where they are not making unilateral decisions about their reproductive health. It is also significant to note that husbands' approval was also rated high as determinant of contraceptive use and this is consistent with literature that men are usually dominant decision makers when birth or fertility control issues are to be determined. One of the frequent reasons women gives for not beginning or continuing to use contraception is their partner's opinions (Moronkola, Ojediran and Amosu, 2006) [7].

2.2 Supply and Demand Factors

Studies have indicated that supply and demand factors have profound influence in utilization of family planning services which includes use of contraceptive methods (Mwaikambo, 2011) [8]. The overarching strategy of successful supply side family planning programs is to ensure that contraceptive methods are as readily accessible to clients as possible. This includes ensuring that a wide range of affordable contraceptive methods are offered, making services widely accessible through multiple service delivery channels, ensuring that potential clients know about services, following evidence based technical guidelines that promote access and quality, and providing client-centered services.

These types of supply-side interventions ensure that women and couples are able to use contraceptive methods and family planning services effectively (Mwaikambo, 2011) [8]. A different study in Lesotho, Africa by Tuonane, Nyovani and Diamond (2004) [11] found that the type of facilities to which women had access (e.g. hospital, clinic, community based and

employment based) was a significant predictor of current use of contraception. Accessibility, reliability and responsiveness to women needs of contraceptives were also a predictor in the use of contraceptive methods by Iranian women (Mackenzie, 2012) [6].

A study in Ethiopia showed that, problem of availability and accessibility influenced the use of contraceptive methods (Gizaw and Regassa, 2011) [3]. The study in Bangladesh indicated that the main reasons for women not visiting MCH clinics were non availability of commodities, behavior of service providers and long waiting times (Zainab, Sharmin and Islam, 2001) [13]. This was also evident in Iranian studies where women using contraceptive methods were dissatisfied with monthly provision of contraceptives and these led to seeking services from private outlets (Mackenzie, 2012) [6]. Distance from the nearest health facility and availability of an all-weather road have a greater effect on contraceptive knowledge than they do on use. By contrast, health or family-welfare visits to the village in the previous month have a greater effect on use (Das, Mishra and Saha, 2001) [2]. From the UNPF report it was observed that governments and service providers were aware of the importance of giving information as a part of family planning service delivery. Service providers are being trained to perform this function but such training did not seem to have the desired effect. Observation of consultations revealed that family planning clients often did not receive complete, accurate information about options available to them. When a method was selected, clients were only told how to use it and when to return for re-supply and/or check up. Possible side effects were rarely mentioned. No information was given during consultations regarding sexually transmitted diseases and HIV/AIDS and little or nothing of the relevant social situation of the client was discussed. The central goals of demand side family planning interventions include changing women's knowledge, men's knowledge, couples' knowledge, attitudes about contraceptive methods and increasing their knowledge of contraceptive sources and use of family planning to meet their fertility desires.

Communication through mass media (radio, television or print) is an appealing strategy for the promotion of family planning because of its potential for expansive reach and its ability to address (in entertaining or informative way) issues that in many settings are culturally taboo (Mwaikambo *et al*., 2011) [8]. Other studies have shown that opposition from husbands, spousal communication had influence in the use of contraceptive methods (Gizaw and Regassa, 2011) [3]. Thus, it is evident from different studies that use of contraceptive methods and uptake of contraception is a multifactor.

Socio economic status, cultural beliefs and value attached to children, educational level of a mother plays an important role. Perceptions of risks and benefits attached to contraceptive use have influence in the use of methods. Furthermore, the studies have shown that spousal acceptance and communication contributes to acceptance of contraception. Accessibility and availability of contraception methods are the factors that have been mentioned (Gizaw and Regassa, 2011) [3].

3. Materials and Methods

Research philosophy can simply be defined as a belief about the way in which data about a phenomenon should be gathered, analyzed and used. For this study, a positivism research philosophy was adopted. The choice for the positivism research philosophy is supported by the principle underlying this philosophy. According to the principles of positivism, the philosophy depends on quantifiable observations that lead themselves to statistical analysis. It is noted that positivism is in accordance with the empiricist view that knowledge stems from human experience.

This principle conforms to the nature of the study in that it deals with the quantifiable observations.With regard to the progression of this study; it was guided by the research questions in attempt to show the association between independent variable and dependent variable. All these attributes of the study apply for the positivism research philosophy hence its choice as the ideal research philosophy. The study was conducted at Dadaab IFO camp section E, Ethiopian block northeastern. A descriptive cross sectional research design was used. The target population was 6000 registered refugees. The sample size for this research was obtained using the Yamane's (1967) formula for finite population as cited by Adekola, Allen and Tinuola (2017):

$$N = N/ (1+N (e)^2 = 6000/ (1+6000 (0.05)^2 = 375$$

The sample size was 375 registered refugees. Stratified sampling was used to categorize the refugees in to three strata's that is, children, teenagers, widows, Couples. Then simple random sampling was used to pick the respondents. The researcher used structured questionnaires in data collection. Factor analysis was used to test for construct validity and cronbach's alpha was used to test for reliability of the research instrument. Descriptive statistics were used in data analysis with the help of statistical package for social sciences (SPSS) software version 20.0. The data was presented inform of tables.

4. Results and Discussion

The study findings revealed that 375 questionnaires were distributed to the respondents. 352 questionnaires out of the 375 were returned, which gives a response rate of approximately 93.9% percent. The response rate is adequate for analysis and reporting.

4.1 Descriptive Statistics for Bio Data

The demographic information of the respondents are as presented in table 1. The demographic information focused mainly on the respondents' gender, age, level of education and duration taken in the Camp. A person's age has been considered as a key demographic characteristic in understanding family planning. As evidenced in the findings, 29.6% (104) of the respondents are under 25 years of age, 21.1% (49) of them are between 31 to 35 years, 14.1% (45) of them are between 26 to 30 years, 11.3% (40) of the respondents are between 41 to 45 years of age and 11.3% (40) of the respondents are above 50 years. The results imply that majority (29.6%) of the respondents are less than 25 years. From the findings, 53.5% (188) of the respondents are female while 46.5% (164) of them are male.

From the study findings, female individuals comprise the majority. Education is also crucial in understanding the

concept of Family Planning. The findings on the education level of the respondents revealed that 47.9% (169) of the respondents have secondary as their highest education level, 32.4% (114) primary and 19.7% (69) diploma. The respondents therefore possess the basic knowledge to understand family planning. Based on the findings, majority of the respondents 33.8% (119) had been in the camp for between 1 and 5 years, 31.0% (109) of the refugees had been in the camp for less than one year, 23.9% (84) of them between 6 and 10 years and 11.3% (40) of the respondents have been in the camp for between 11 and 15 years as shown in Table 1 below;

Table 1: Descriptive Statistics of Bio Data

		Frequency	Percent
Age Bracket	< 25	104	29.6
	26 – 30	49	14.1
	31 – 35	74	21.1
	36 – 40	45	12.7
	41 – 45	40	11.3
	> 50	40	11.3
	Total	352	100.0
Gender	Male	164	46.5
	Female	188	53.5
	Total	352	100.0
Level of Education	Primary	114	32.4
	Secondary	169	47.9
	Diploma	69	19.7
	Total	352	100.0
Duration in the Camp	< 1	109	31.0
	1 – 5	119	33.8
	6 – 10	84	23.9
	11 – 15	40	11.3
	Total	352	100.0

***Source*:** Survey data, 2018

4.2 Socio Demographic Factors Affecting Uptake of Family Planning Among Refugees

In regards to whether woman's education level affects family planning, 154 (43.7%) of the respondents strongly disagreed, 198 (56.3%) of the respondents agreed, 0(0%) were neutral, 0(0%) of the respondents disagreed and 0(0%) of them strongly disagreed. The mean value was 1.5634 and standard deviation .49950 implying that woman's education level affects family planning.

Table 2: Socio Demographic Factors affecting Family Planning

		SA	A	N	D	SD	Mean	Std. Deviation
Woman's Education Level	Freq	154	198	0	0	0	1.5634	.49950
	%	43.7	56.3	0.0	0.0	0.0		
Marital Status affects Family Planning in the Camp	Freq	193	159	0	0	0	1.4507	.50111
	%	54.9	45.1	0.0	0.0	0.0		
Husbands' occupation influences uptake of Contraceptives	Freq	159	159	34	0	0	1.6479	.65680
	%	45.1	45.1	9.9	0.0	0.0		
Age of Refugee (s)	Freq	198	154	0	0	0	1.4366	.49950
	%	56.3	43.7	0.0	0.0	0.0		
Parity affects use of Contraceptives	Freq	198	154	0	0	0	1.4366	.49950
	%	56.3	43.7	0.0	0.0	0.0		
Ones' religion affects the use of Contraceptives	Freq	124	228	0	0	0	1.6479	.48103
	%	35.2	64.8	0.0	0.0	0.0		
Monthly Families Income	Freq	159	193	0	0	0	1.5493	.50111
	%	45.1	54.9	0.0	0.0	0.0		
Level of Poverty of the Refugees	Freq	154	198	0	0	0	1.5634	.49950
	%	43.7	56.3	0.0	0.0	0.0		
Composite Values							12.2857	1.37412

***Source*:** Survey data, 2018

Of the total respondents, 54.9% (193) of the respondents strongly agreed that marital status affects family planning in the camp, 45.1% (159) of them agreed, 0.0 % (0) disagreed, 0.0 % (0) strongly disagreed while 0.0% (0) of the respondents was neutral. The results summed up to a mean of 1.4507 and standard deviation of .50111 meaning that majority of the respondents agreed that marital status affects family planning in the camp. Further, 45.1% (159) of the respondents strongly agreed that husbands' occupation influences uptake of contraceptives. 45.1% (159) of them

agreed, 9.9% (34) were neutral, 0.0% (0) of the respondents disagreed and 0.0% (0) of them strongly disagreed. The results summed up to a mean of 1.6479 and standard deviation of .65680 meaning that majority of the respondents agreed that husbands' occupation influences uptake of contraceptives. The results revealed that 56.3 % (198) of the respondents strongly agreed that age of the refugee affect the use of family planning in the camp. 43.7% (154) of the respondents agreed, 0.0 % (0) disagreed, 0.0 % (0) strongly disagreed while 0.0% (0) of the respondents was neutral. The results summed up to a mean of 1.4366 and standard deviation of .49950.

In relation to whether parity affects use of contraceptives, the results were positive with 56.3% (198) of the respondents in strong agreement, 43.7% (154) in agreement, 0.0% (0) disagreement, 0.0% (0) strong disagreement while 0.0% (0) of them was neutral. The item realized a mean of 1.4366 and standard deviation of .49950. The respondents were also asked whether ones' religion affects the use of contraceptives. The results showed that 35.2% (124) of the respondents strongly agreed, 64.8% (228) of the respondents agreed, 0.0% (0) of them disagreed, 0.0% (0) strongly disagreed while 0.0% (0) of the respondents were neutral. In general, results on whether religion affects the use of contraceptives summed up to a mean of 1.6479 and standard deviation of .48103.

In a bid to establish if the respondents monthly families income affects family planning, the respondents, were asked to respond accordingly 45.1% (159) of the respondents strongly agreed, 54.9% (193) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed and 0.0% (0) of the respondents were neutral. The item realized a mean of 1.5493 and standard deviation of .50111. Furthermore, 43.7% (154) of the respondents strongly agreed, 56.3% (198) of them agreed, 0.0% (0) was neutral, 0.0% (0) of them disagreed and 0.0% (0) of the respondents strongly disagreed. The results summed up to a mean of 1.5634 and a standard deviation of .49950. Generally, the results on record keeping revealed a mean of 12.2857and standard deviation of 1.37412 which implies that on average the respondents were in agreement. The results are in tandem with the findings of Das, Mishra and Saha (2001) [2], Ibnouf, Van Den Borne and Maars (2007) [4], Gizaw and Regassa (2011) [3] and Kessy and Rwabudongo (2006) [5].

4.3 Socio Cultural Factors affecting uptake of Family Planning among Refugees

From the findings, 46.5% (164) of the respondents strongly agreed that urban- rural residence affects family planning, 45.1% (154) of them agreed, 8.5% (29) of them were neutral, 0.0% (0) disagreed while 0.0% (0) of the respondents strongly disagreed. The mean value of 1.6197 was confirmation that urban rural residence affects family planning while the standard deviation of .64067 further revealed the degree of variation in the responses. In relation to woman's work status, 54.9% (193) of the respondents strongly agreed, 45.1% (159) of them agreed, 0.0% (0) of the respondents were neutral, 0.0% (0) of them agreed and 0.0% (0) of the respondents strongly disagreed. The results summed up to a mean of 1.4507 and a standard deviation of .50111.

Furthermore, 45.1% (159) of the respondents strongly agreed that woman's status relative to men affects family planning. 54.9% (193) of them agreed, 0.0% (0) of the respondents were neutral, 0.0% (0) of them disagreed and 0.0% (0) of the respondents strongly disagreed. The results had a mean of 1.5493 and a standard deviation of .50111. In a bid to establish if the respondents culture and taboos affects family planning, the respondents, were asked to respond accordingly 45.1% (159) of the respondents strongly agreed, 54.9% (193) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed and 0.0% (0) of the respondents were neutral. The item realized a mean of 1.5493 and standard deviation of 0.50111. To establish whether the respondents exposure to mass media affects family planning, respondents were requested for their opinion and the results were such that, 45.1% (159) of the respondents strongly agreed, 54.9% (193) of them agreed, 0.0% (0) of them disagreed, 0.0% (0) strongly disagreed while 0.0% (0) of the respondents were neutral. The results summed up to a mean of 1.5493 and standard deviation of .50111 as shown in the table 3 below;

Table 3: Socio Cultural Factors affecting Family Planning

		SA	A	N	D	SD	Mean	Std. Deviation
Urban- Rural residence	Freq	164	159	29	0	0	1.6197	.64067
	%	46.5	45.1	8.5	0.0	0.0		
Woman's Work Status	Freq	193	159	0	0	0	1.4507	.50111
	%	54.9	45.1	0.0	0.0	0.0		
Woman's Status Relative to Men	Freq	159	193	0	0	0	1.5493	.50111
	%	45.1	54.9	0.0	0.0	0.0		
Culture and Taboos	Freq	159	193	0	0	0	1.5493	.50111
	%	45.1	54.9	0.0	0.0	0.0		
Exposure to Mass Media	Freq	159	193	0	0	0	1.5493	.50111
	%	45.1	54.9	0.0	0.0	0.0		
Fertility control issues affects use of Contraceptives	Freq	154	198	0	0	0	1.5634	.49950
	%	43.7	56.3	0.0	0.0	0.0		
Perceptions of contraceptive risks and benefits	Freq	193	159	0	0	0	1.4507	.50111
	%	54.9	45.1	0.0	0.0	0.0		
Characteristics of the health services available in the community	Freq	159	193	0	0	0	1.5493	.50111
	%	45.1	54.9	0.0	0.0	0.0		
Composite Values							12.2817	1.56007

***Source*:** Survey data, 2018

In order to ascertain whether fertility control issues affects use of contraceptives, results revealed that, 43.7% (159) of them strongly agreed, 56.3% (193) of them agreed, 0.0% (0) of them disagreed, 0.0% (0) of them strongly disagreed and 0.0% (0) of the respondents were neutral. This summed up to a mean of 1.5634 and standard deviation of .49950. Besides, 54.9% (193) of the respondents strongly agreed that perceptions of contraceptive risks and benefits affects family planning, 45.1% (159) of them agreed, 0.0% (0) of them disagreed, 0.0% (0) strongly disagreed while 0.0% (0) of the respondents were neutral. The results summed up to a mean of 1.4507 and standard deviation of .50111.

Further, the study sought to find out if characteristics of the health services available in the community affects uptake of family planning among Refugees. Results indicated that 45.1% (159) of the respondents strongly agreed, 54.9% (193) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed while 0.0% (0) of the respondents were neutral. The results summed up to a mean of 1.5493 and standard deviation of .50111indicating that the characteristics of the health services available in the community effect of family planning. The results on socio cultural factors summed up to a mean of 12.2817 and standard deviation of 1.56007. The results of this study are similar to the findings of Moronkola, Ojiediran and Amosi (2006), UNPF (1994) [12] and Ibnouf (2007) [4].

4.4 Supply and Demand Factors affecting uptake of Family Planning among Refugees

This section sought to establish the supply and demand factors that affect family planning utilization among refugees at Dadaab Camp. The results from the study indicated that 43.7% (154) of the respondents strongly agreed that wide range of affordable contraceptive methods is offered, 56.3% (198) agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed and 0.0% (0) of the respondents were neutral. The item reported a mean of 1.5634 meaning the respondents were in agreement though the standard deviation was .49950, an indication of variation in the responses.

In regards to whether contraceptive methods are readily accessible to clients. Of the total respondents, 43.7% (154) of the respondents strongly agreed, 56.3% (198) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed and 0.0% (0) of the respondents was neutral. This position was further confirmed by the 1.5634 mean and standard deviation of .49950. In relation to whether evidence based technical guidelines affects family planning, the results indicated that 54.9% (193) of the respondents strongly agreed, 45.1% (159) of the respondents agreed, 0.0% (0) of them disagreed, 0.0% (0) strongly disagreed while 0.0% (0) of the respondents were neutral. The results summed up to a mean of 1.4507 and standard deviation of 0.50111 as shown in the table 4 below;

Table 4: Supply and Demand Factors affecting Family Planning

		SA	A	N	D	SD	Mean	Std. Deviation
Wide range of affordable contraceptive methods is offered	Freq	154	198	0	0	0	1.5634	.49950
	%	43.7	56.3	0.0	0.0	0.0		
Contraceptive methods are readily accessible to clients	Freq	154	198	0	0	0	1.5634	.49950
	%	43.7	56.3	0.0	0.0	0.0		
Evidence based technical guidelines that promote quality	Freq	193	159	0	0	0	1.4507	.50111
	%	54.9	45.1	0.0	0.0	0.0		
Providing client centered services	Freq	243	79	30	0	0	1.3944	.64318
	%	69.0	22.5	8.5	0.0	0.0		
Type of facilities to which women have access	Freq	233	119	0	0	0	1.3380	.47641
	%	66.2	33.8	0.0	0.0	0.0		
Reliability and Responsiveness to women needs of contraceptive	Freq	238	114	0	0	0	1.3239	.47131
	%	67.6	32.4	0.0	0.0	0.0		
Long Waiting Times	Freq	193	159	0	0	0	1.4507	.50111
	%	54.9	45.1	0.0	0.0	0.0		
Behavior of service providers	Freq	159	193	0	0	0	1.7183	.84824
	%	45.1	54.9	0.0	0.0	0.0		
Composite Values							11.8028	1.66149

***Source*:** Survey Data, 2018

Further, the study sought to find out if providing client centered services affects uptake of family planning. Results indicated that 69.0% (243) of the respondents strongly agreed, 22.5% (79) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed while 8.5% (6) of the respondents were neutral. The results summed up to a mean of 1.3944 and standard deviation of 0.64318 indicating that providing client centered services affects uptake of family planning. In relation to type of facilities to which women have access, results indicated that 66.2% (233) of the respondents strongly agreed, 33.8% (119) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed while 0.0% (0) of the respondents were neutral. The results summed up to a mean of 1.3380 and standard deviation of 0.47641 indicating that type of facilities to which women have access affects uptake of family planning.

Furthermore, 67.6% (238) of the respondents strongly agreed that reliability and responsiveness to women needs of contraceptive, 32.4% (114) of the agreed, 0.0% (0) of them were neutral, 0.0% (0) of the respondents disagreed and 0.0% (0) of them strongly disagreed. These results summed up to a mean of 1.3239 and a standard deviation of 0.47131. Besides, 54.9% (193) of the respondents strongly agreed that long waiting times affects family planning, 45.1% (159) of them agreed, 0.0% (0) of them were neutral, 0.0% (0) of the respondents disagreed and 0.0% (0) of them strongly

disagreed. These results summed up to a mean of 1.4507 and a standard deviation of 0.50111.

Further, the study sought to find out if behavior of service providers affects uptake of family planning among Refugees. Results indicated that 45.1% (159) of the respondents strongly agreed, 54.9% (193) of them agreed, 0.0% (0) disagreed, 0.0% (0) strongly disagreed while 8.5% (6) of the respondents were neutral. The results summed up to a mean of 1.7183 and standard deviation of .84824 indicating that the behavior of service providers affects of family planning. The results on supply and demand factors summed up to a mean of 11.8028 and standard deviation of 1.66149. The study results concurs with the findings of Gizaw and Regassa (2011) [3], Mwaikambo (2011) [8], Tuonane, Nyovani and Diamond (2004) [11], Mackenzie (2012) [6] and Zainab, Sharmin and Islam (2001) [13].

5. Conclusions and Recommendations

In relation to socio demographic factors, woman' education level, marital status affects family planning in the camp, husband occupation, age of the refugees, parity, ones' religion, monthly families income and level of poverty of the refugees affects uptake of contraceptives by the refugees. In regards to socio cultural factors, urban rural residence, woman's' work status, woman's' status relative to men, culture and taboos, exposure to mass media, fertility control issues, perceptions and characteristics of the health services available in the community affects family planning uptake among refugees at Dadaab Camp. Finally, supply and demand factors such as wide range of affordable contraceptive methods, accessibility to contraceptive methods by refugees, evidence based technical guidelines that promote quality, client centered services, type of facilities to women have access, reliability and responsiveness to women needs of contraceptive, long waiting times and behavior of service providers affects uptake of contraceptives among refugees at Dadaab Camp. This study recommends that the refugees should be empowered economically to reduce the poverty level. The refugees should be enlightened on the meritocracy of family planning so as to avert their negative perceptions about usage of contraceptives.

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