

SOME FACTORS AFFECTING HUSBANDS'
CONTRACEPTIVE ACCEPTANCE AND
FERTILITY PREFERENCE IN KENYA

BY

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This project is submitted in partial fulfilment for Postgraduate
Diploma in Population Studies of the University of Nairobi.

POPULATION STUDIES AND RESEARCH
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DECLARATION

I declare that this research project is my original work and that it has not been produced in any other University or education institution.

Signed *Grace Wairimu*

Grace Wairimu Gachango

This research project has been submitted for examination with my approval as the University supervisor.

Signed *A. B. Ochieng*
Prof. A.B. Ochieng



DEDICATION

This project is dedicated to my parents Mr. Stanley Kimani Muhia and Mrs Hannah Wanjiru Kimani for taking good care of me when I was young and the decision they made to take me to school.

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ORGANIZATION OF THE STUDY

The project is represented in Five Chapters. Chapter 1 covers the General Introduction, Statement of the Problem, Study Justification, Study Objectives, Scope and Limitation of the Study and Variable considered in the study.

Chapter 2 contains the Literature Review, Study Hypotheses and Framework.

Chapter 3 is made up of Research Methodology, Reliability and Quality of Data, Method of Data Analysis and Limitations of Cross-Tabulation methods.

Chapter 4 contains the presentation of Data Analysis and result findings, and summary of findings.

Finally, Chapter 5 includes the conclusions together with recommendations from the Study.

EXECUTIVE SUMMARY

The purpose of the study is to examine how some demographic, socio-cultural, socio-economic and contraceptive acceptance affect husbands total number of living children in Kenya.

The objective of the study is based on the fact that the level of family planning participation is very low despite the fact that the programme was started three decades ago and to date it has made no major impact on Kenyan husbands. therefore, there is need to examine what has contributed to this low contraceptive prevalence and consequent high fertility.

The study uses secondary data which was collected during Kenya Demographic and Health Survey in 1989. A sub-sample of 1,116 husbands were reached in this survey and this is the target group in the study. For analysis the study has employed cross-tabulations, chi-square tests empirical and operational models as tools of analysis.

The following are the major findings:

- (a) Knowledge of family planning methods was quite high 91% but the level of current use was very low among Kenyan husbands 49.3%.
- (b) That husbands depends mainly on their wives to practice birth control with their highest choice being female sterilization with 24% and female injection 23% a preferred future methods. Male sterilization of 4% scored least.
- (c) Since family planning information is passed face to face to women at the MCH/FP clinics, the husbands who are excluded

from this setting misses this reliable source of information and are subjected to misinformation and rumours.

(e) Religion, ethnicity, contraceptive acceptance, marriage type and age had negative and positive influence respectively on the total number of children per husband. Fertility preference by husbands of all ages was found to be generally high.

(f) Finally, husbands discussions, with wife, approval of and a general positive attitude of family planning had a significant influence on wives contraceptive use.

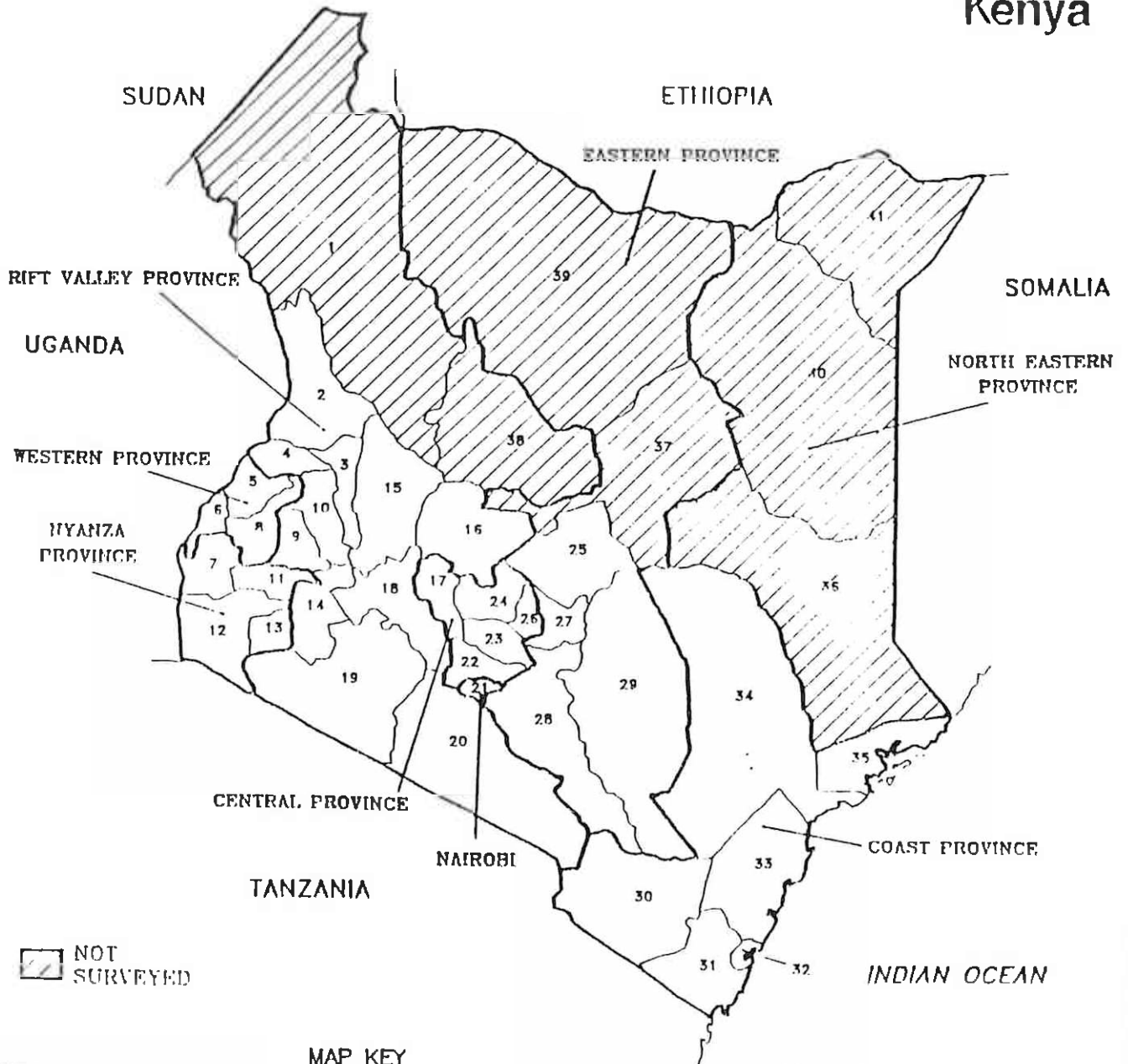
The following recommendations were suggested:

- MCH/FP approach should be looked into and be biased towards including male barriers to attend this clinics. It is necessary for creation of an attached department specifically concerned with male reproductive health.
- Family Planning IEC should tirelessly convince and convey the necessity for men to regulate their fertility responsibly and dutifully to facilitate the health and economy of their wives, children and nations.
- Family Planning IEC should be promoted and geared towards reaching more husbands. Population Education should be introduced to out of school men especially youths so that they can make better informed fertility decisions early enough. Daddies clubs should be formed to reach husbands in their offices, churches, factories with family planning messages to avoid them relying on rumours and myths.

- CBD should device a culturally relevant, relaxed approach and maintain good interpersonal relations with male clients.
- Further research should be carried out to find ways and means and policies designed to narrow the big gap existing between knowledge and current use.

MAP OF KENYA

Kenya



NOT SURVEYED

MAP KEY

21 NAIROBI	EASTERN PROVINCE	RIFT VALLEY PROVINCE
CENTRAL PROVINCE	27 Embu	15 Baringo
22 Kiambu	37 Isiolo	3 Elgeyo Marakwet
28 Kirinyaga	28 Kitui	20 Kajiado
23 Muranga	28 Machakos	14 Kericho
17 Nyandarua	39 Meru	16 Laikipia
24 Nyeri	25 Meru	18 Nakuru
COAST PROVINCE	NORTH-EASTERN PROVINCE	9 Nandi
33 Kilifi	36 Garissa	19 Narok
31 Kwale	41 Mandera	38 Samburu
35 Lamu	40 Wajir	4 Trans Nzoia
32 Mombasa	NYANZA PROVINCE	1 Turkana
30 Taita	13 Kisumu	10 Uasin Gishu
34 Tana River	7 Siaya	2 West Pokot
	12 South Nyanza	WESTERN PROVINCE
		5 Bungoma
		6 Busia
		8 Kakamega



1.1 GENERAL INTRODUCTION

Currently, the Tropical African countries are experiencing the highest fertility rates and the fastest population growth rates in the world. Kenya is among the top of these countries.

The need to slow down population growth rate of a country becomes necessary when it is apparent that the rate of national development and the available resources cannot sustain it. Slowing down population growth rate involves solving many other problems. The Kenya Government through the Family Planning Association of Kenya Programmes has initiated and over years reinforced changes towards this goal by using the "persuasive policy".

According to 1979 Kenya Population Census report, the country's total fertility rate had remained above 7.0 children per woman (S.H. Ominde 1986) meaning that this figure was higher for polygamous men. This gave an estimated annual population growth rate of 3.8% per annum (World Bank 1982).

Within Kenya, Western, Nyanza and Central Provinces have consistently recorded the highest fertility rates over the last three decades. Recently, researchers have investigated the factors contributing to these high fertility rates in various parts of Africa and Kenya in particular in order to understand the underlying causes and the proximate determinants of fertility.

The relevant surveys and studies includes: 1962, 1969, 1979 and 1983 Kenya National Population Surveys, Kenya Fertility Survey

KFS (1979), Kenya Contraceptive Prevalence Survey (KCPS), 1984, and most recently Kenya Demographic and Health Survey (KDHS) 1989 going on to Phase II and III 1993.

Table 1 Fertility Trends (TFR) in Kenya By Province
(CPR and GR in Percentages)

Province	Year					
	KFS		KCPS		KDHS	
	1969	1979	1978	1984	1989	1989
Coast	4.9	5.9	5.5	7.2	6.7	5.5
Eastern	6.0	6.7	7.0	8.2	8.0	7.0
Nairobi	4.6	5.4	4.6	6.1	5.6	4.6
Central	7.1	7.3	6.0	8.6	7.8	6.0
Rift Valley	6.1	7.1	7.0	8.8	8.6	7.0
Nyanza	7.7	7.9	7.1	8.0	8.2	7.1
Western	8.2	8.4	8.1	8.2	6.3	8.1
Kenya TFR	6.7	7.9	6.7	8.1	7.7	6.7
Kenya GR	3.3	3.8	3.5	4.1	3.7	3.6
Kenya CPR	5.0	7.0	7.0	12	17	27

Source: CBS, Population Census Report (KDHS 1989)

Consequently, this above evidence makes Kenya's growth rate one of the highest in Tropical Africa and among the highest in the world. Most of this work has concentrated on studying women's

fertility behaviour perhaps because it is the women who become pregnant and actually deliver the babies. Furthermore, in Tropical Africa, the women do almost all the work of child rearing (Ntozi J.P.M., 1993).

However, because fertility decision making in Sub-Saharan Africa is dominated by men (Caldwell, 1982), it is important to investigate the fertility behaviour of men in order to better understand the fertility situation prevailing in Kenya. Unfortunately, such studies about African men have been limited. The need to manage the rapid population growth was felt earlier in Kenya and different strategies have since been developed towards this end.

The well recorded decline in mortality and rising fertility are manifested in rapid population growth which puts pressure on all areas of social and economic development i.e. agriculture, land, education, health, employment, urban problems and general high population density problems. At national level, this population reduces the country's capacity to save and invest as a greater proportion of the nations output tends to be devoted to the consumption needs of a youthful population, while each year larger numbers than ever before enters both the reproductive age as well as working age bracket.

A few years before independence, the Government of Kenya became concerned about the negative effects of rapid population growth on socio-economic development, and a population policy biased towards fertility reduction evolved.

Family planning in Kenya started as early as 1955 when a voluntary Family Planning Committee in Nairobi and Family Planning Association in Mombasa 1956 were formed in the two major urban centres. These two agencies specifically catered for the needs for non-African clientele who needed contraceptives. The first Family Planning Clinic for African clientele was opened in May 1957 and did not have much foreign support. In July 1959, the Pathfinder Fund gave a grant to Family Planning Association of Nairobi to recruit an organizing secretary. At this time, the African population were not emotionally prepared to accept modern contraceptives (although practising various traditional methods (J. Oduho and Ayiemba, 1989) because of strong cultural norms which supported reproductive behaviour favouring large family size norms in the face of high mortality and large scale illiteracy conditions (Molins, Angela, 1973).

Through the amalgamation of Nairobi and Mombasa Family Planning Associations the Family Planning Association of Kenya (FPAK) was formed in 1962 and became the first Family Planning Association to be affiliated with the International Planned Parenthood Foundation (IPPF). The rural areas of the country got a raw deal as clinics established were purely urban in Nairobi and Mombasa.

After 1962 census, a population of 8.6 million people was recorded with a growth rate of 3% per annum. These demographic revelations as well as efforts already made in family planning through the urban based association induced the government to take

two steps in handling the population problem. First it developed a sound population policy published by Ministry of Planning in 1965 in Sessional Paper Number 10 entitled "African Socialism and its Application in Kenya". The Government requested the Population Council of New York to send an advisory mission to study the population programme in Kenya and make recommendations, was yet another most important concern. The council recommended Kenya Government to declare an objective whose policy was reducing population growth rate.

In 1967, the government launched National Family Planning Programme and integrated contraceptives and family planning services into Maternal and Child Health (MCH/FP) under the Ministry of Health which indirectly excluded male participation from the programme.

This was an atmosphere of political goodwill which bureaucratically spelled out the following conditions in promoting Family Planning Services:

- (a) maternal and child health were to be integrated with family planning services.
- (b) acceptance of family planning services was to be voluntary.
- (c) campaigns to increase family planning services had to respect individuals customs and decision.
- (e) the idea of family planning had to place emphasis on family size and family decision.

The emphasized goal here is making every pregnancy the result of voluntary choice. The existence of these conditions creates

serious bottlenecks for the programme e.g. integrating MCH with F.P. (MCH/FP) creates management problems like shortage of personnel, male exclusion and women requiring family planning services resent the idea of queuing with women/children waiting for medical services.

However, these contraceptive hitches has not deterred the Kenya Government desire and efforts to reduce population growth rate and thus enhance the quality of life as it is consistently articulated in the successive 5 year Development Plans since 1974. Moreover, the government continues to subsidize family planning services and maintains an open door policy to foreign government, international donor agencies and local organizations willing to collaborate in intensifying Information, Education and Communication (IEC) on family planning as well as technical assistance for family planning.

The 1989 census results indicated Kenya to have a growth rate of 3.3% per annum one of the highest in the world which fuelled the quest for a more vigorous and intensified family planning programme. To this effect, a National Family Welfare Centre was established, initiated by World Bank, 1974, which later became the Division of Family Health in Ministry of Health. The Population Studies and Research Institute at the University of Nairobi was conceived in 1976 through bilateral agreement between the Kenya Government and USAID, with Population Council, New York as the contractor. The involvement of these two donor agencies was a further commitment to make the National Family Planning Programme

(NFPP) succeed.

Although the goal of 1975-1979 phase of the programme was to reduce the annual rate of natural increase (RNI) from 3.3% in 1975 to 3.0% by 1979 and to 2.5% by the end of the century, the 1979 census results revealed that the rate of population growth had actually increased to 3.9% with a TFR of 8.1 children per woman. This was an increase of 18% rise and a doubling time of less than 20 years.

In response to this increase, the government established the National Council of Population and Development (NCPD) in 1982, which was a population issue policy making body given the responsibility to formulate population policies and to co-ordinate all population activities in Kenya. It is assisted by NGOs e.g. Family Planning Private Sector (FPPS) formed in 1984, AMREF, Christian Health Association (CHAK), the NCCCK, KCS, Division of Family Health of Ministry of Health and PSRI (University of Nairobi). Through these institutions IEC has expanded and training of social workers, field educators and medical personnel has expanded.

The NCPD, has also been a channel for donor funds for population related activities which has increased considerably over the past decade. Increased awareness generated by debates on abortion, need to introduce family life education curriculum in schools, contraceptive use by youths and AIDS menace have boosted acceptance levels. A National Leaders Seminar on Population held in July 1984 called on Kenyans to adopt small family norms and

stronger implementation of the governments' population policy during the 1980, has also contributed to this practice.

In September 1989, NCPD held a conference on Population and Development whose concern was to review problems plaguing the family planning programme and to update appropriate recommendations. This conference revealed that the political goodwill towards the programme was enlisted, though a few leaders still favoured pro-natalist tendencies. A pro-natalist culture favours and encourages the production of many children thus frustrating the programme.

However, according to 1979 estimations and projection, the programme showed signs of possible success. It achieved 90% of its service delivery targets by establishing 300 medical centres by 1979. A survey carried out by International Labour Organisation (ILO) 1975, showed achievements and a Rural Health Programme was launched. Contraceptives were provided free of charge in Government hospitals and clinics and clinical services were being expanded. The relevant information and education was being disseminated through seminars, radio and workshops.

In 1989, the NCPD conducted the Kenya Demographic and Health Survey (KDHS) and a contraceptive prevalence rate of 27% was obtained compared to 12% indicated by Kenya Contraceptive Prevalence Survey (KCPS) of 1984 and 7% Kenya Fertility Survey (KFS) of 1977/78. The KDHS indicated large differentials in the level of contraceptive use by province and by district. Generally prevalence was highest (52%) in the country's central region

districts namely Kirinyaga, Kiambu, Nyeri, Machakos, Meru, Muranga and Embu and lowest in districts in the Western and Coast regions.

This information shows that there are pockets of contraceptive practice that reach levels as high as those found in more developed countries (Cross et al, 1989). This study, therefore, investigates which factors determine high contraceptive rates in some areas especially Central region and lowest in Kilifi district with majority of men with over 8 children (Kekovole J., 1991). From above facts, it is clear that the history of Kenya Family Planning Programme has had impressive development.

It is also documented that marriage patterns, value of children, cultures and non-use of effective contraception are behind the high fertility levels of couples in African region. Most of these factors are men related as it takes two to conceive a fertility outcome. Focusing on the role of men in determining fertility helps develop families and nations fully, it also enlightens and educate men and women in regard to human fertility and welfare. Through a deeper understanding of the underlying cultural and social factors behind men's sexual behaviour, the human society will be able to legislate in order to guard and step up the status of the woman. Then she can be confident enough to control "her environment and body for the benefit and health of her family and the nation (Ndoleriire O., 1993). Men's potentially positive role in family planning has so often been neglected because of the negative attitude many men hold towards birth control. The aim of this study is therefore to investigate the

attitude and behaviour of men as regards those factors.

1.2 THE STATEMENT OF THE PROBLEM

Like the other sub-Sahara Africa countries, Kenya is still characterised by high fertility, mortality and rate of population growth when compared with other countries of the developing world. Further, while growth rates of many Asians and Latin American countries have shown a rapid decline marginally very recently.

Kenyan husbands pose to have a very high knowledge of contraception and understands very well the necessity to reduce fertility as indicated by various studies. But they find it very hard to put this knowledge into practice resulting with the problem of their very low contraceptive use. The implication of this high fertility is a rapidly increasing population which means growth of school age populations, of working age populations (labour force) causing high unemployment and dependency ratio, population pressure and generally slowing down economic growth of the country (Ominde, S.H. 1983).

A youthful age structure has the consequence of "population momentum" i.e. even if the total fertility rate was to decline to replacement levels the high number of couples reaching together into reproductive years sustains rapid growth far into the future. This puts much strain on the economy to provide basic services like education, housing, health etc. More capital will be required to support the increased number of people even at subsistence level.

The high population growth rate and the problem of poverty

alleviation are closely related. Deterioration and decline of economic developments are alarming population warnings. Over population has led to rural decline, out-migration to fragile low potential areas, and degradation of natural resources, like over grazing, soil erosion and destructive income activities due to these population resource imbalances.

In view of the foregoing, and the dire need to improve nutritional, health housing and general rise in productivity hence improve standards of living, any social and economic policy should have as a matter of priority the need to reduce population growth rate. Thus there is a big challenge to all development planners to reduce fertility.

According to 1989 KDHS results, the level of husband's contraceptive prevalence was shown to vary across the country being highest in Nairobi Province 66%, Central 64.3%, Eastern 60.7% and lowest in Western 22.7%, Coast 37.0% and Nyanza 43.7% Provinces.

This situation as indicated by KDHS (September 1993) preliminary report shows a change of above contraceptive levels with Eastern province leading with a male contraceptive prevalence of 85%, the highest in the country, Central 59.5%, Nairobi 58% and with least in Nyanza 37.1%, Western 42.0% and Coast 42.4%. These provinces represent socio-cultural diversity, ecological differences and different socio-economic levels.

This study analyses these factors that have contributed to this high and low contraceptive discrepancies across the country by trying to find out answers to the following questions:

- i) What are the major husbands' determinants of contraceptive acceptance and consequent use in the country and how different are they from one ethnic group to another?
- ii) What is the future of men's acceptance and practice for contraception in the country?
- iii) Is there any relationship between contraceptive acceptance and husband's age, number of children, level of education, residence, religion, region/province, occupation, type of marriage etc.

From various studies, Kenyan men have been shown to have a high non-use of contraceptives yet they are waited upon to give their wives permission to use contraceptives. For instance, husbands and wives interviewed (KDHS, 1989) on who obtains condoms shows that 16.7% have ever used condoms, 7.7% husbands obtain them which implies that 9% women obtains the condoms (KDHS, 1989). The knowledge of condoms is high 81.5% while 74.3% knows where to obtain them and only 3.4% are current users. This discrepancy between knowledge and practice is prevalent throughout the country. This study will try to analyse the reasons for this scenario.

Since the conception of Family Planning Programme (FPP), the government and NGO services have been offered free and a lot has been done on Information, Education and Communication (IEC) to the people on the need to regulate the couples fertility. Despite of all this, there is high knowledge of contraceptives 91% but low contraceptive use of 27%. This is known to result in alot of wastage of governments' and donor efforts and capital. Although

Family planning activities have officially been promoted for 3 decades now, the level of contraceptive use is still low and the reasons poorly understood. One of the realities is that the intervening efforts by family planning organizations seems not to have improved the basic knowledge and practices of male birth control. This discrepancy needs investigations.

1.3 STUDY JUSTIFICATION

With high level of contraceptive knowledge of 91% and low level of contraceptive prevalence of 27% as well as poor understanding of factors responsible for this situation as shown by above discrepancies, Kenya requires studies aimed at establishing the determinants of husband contraceptive acceptance and consequent use. These factors can be utilised in formulating appropriate policies and programmes to increase acceptance and level of use of contraceptives.

The study on husband's contraceptive use and non-use as related to their background characteristics could be used to develop education and communicational strategies on which target groups could be recruited and help promote male family planning activities which will raise levels of contraceptive users that is necessary if a substantial decline in fertility is to be achieved.

The KDHS being the main source of my research data for this analysis is of high quality and is reasonably reliable. The data will help find out why the contraceptive knowledge is so high 91%, and the practice is so low only 27%. This contraceptive

knowledge/use gap has persisted in Kenya yet family planning activities started more than 4 decades ago and the National Family Planning Programme has been in existence for almost 30 years now. Therefore, it is of vital importance to investigate factors that come into play in the contraceptive scenario in Kenya.

The peak rate of growth in the world's population has now been passed, but growth is still at high levels in almost all developing countries particularly Kenya which registered a growth rate of 4.1% (KCPD) in 1984, the highest growth rate in the world. Fertility limitation is strongly supported by the government as shown above, and contraceptive services are available from a variety of providers in public and private sectors (Escharia, 1984).

According to KDHS, contraceptive use among current users is 27%. NB. According to WHO (1992) report, the total number of contraceptive users has risen tenfold in the developing world in the past 25 years to over 390 million users. The contraceptive rate discrepancies so apparent in Kenya needs their determinants investigated so as to encourage high characteristic use and discourage behaviours and activities causing low use of contraceptives.

The study findings can also be utilized in developing strategies for educating and communicating to appropriate target groups especially men.

In Africa, it is reported that men dominate fertility decision making (Caldwell, 1982) and that marriage patterns, value of children, cultures and non-use of effective contraception are

behind the high fertility levels in the region. These factors are all men related and it is important to investigate the fertility behaviour of men in order to better understand the fertility situation in the region. Unfortunately, such studies about African men have been limited.

From KDHS, it is possible to analyse men's responses separately. This study will not only serve to supplement and complement the women's responses, it would also provide an independent report on the men's role in fertility in Kenya. Focusing the role of men in determining fertility helps develop families and nations fully.

Until recently, most of such studies have been on women, ignoring the role played or participation by men in fertility. But in Africa where women's decisions on fertility are strongly influenced by their sexual partners and male relatives, there is a gap with regard to studies of the part played by men in fertility. There is further need to analyse the role played by socio-economic, socio-cultural factors that influence and explain the high differential fertility levels in the country. For example, discussions of several customs, taboos, traditional family planning methods, marriage and value of children relating them to male fertility in Kenya and extend these study findings to other developing countries in general to increase contraceptive use levels. This will help discourage and reduce contraceptive practice constraints.

Investigating influences of contraceptive use and non-use will

shed light on why low contraceptive use persists with Kenya men in spite of high knowledge and approval of contraceptives and the availability of supportive services.

1.4 STUDY OBJECTIVES

1.4.1 ULTIMATE OBJECTIVE

The overall objective of this study is to investigate some background characteristics (demographic, environmental, socio-cultural and socio-economic factors) which are responsible for variation of husbands contraceptive acceptance, use and non-use of fertility control methods, and whether these consequently affect his total fertility or number of living children in Kenya.

1.4.2 IMMEDIATE OBJECTIVES

1. To investigate whether current age relates to husbands fertility or total number of living children.
2. To determine whether ever use of any family planning method affects contraceptive approval.
3. To determine which family planning method has the highest approval with Kenyan husbands and which is the most preferred future family planning method by Kenyan husbands.
4. To investigate whether there is a discrepancy between men's knowledge of, and practice of family planning method.
5. To investigate how the provincial/regional and ethnicity factors influences husband's demand for children.
6. To relate type of marriage (monogamy/polygamy) to

contraceptive knowledge, fertility patterns and levels and husband's number of living children.

7. To assess whether husband's discussions on family planning matters influence wife's contraceptive use.
8. To examine whether religious background relate to husband's contraceptive acceptance and family size.
9. To determine the association between husbands educational and occupational status on contraceptive acceptance.
10. To evaluate the effect of place of residence on contraceptive use and non-use.

1.5 SCOPE AND LIMITATIONS OF THE STUDY

The study will focus on currently married husbands and intends to find out what men actually know about family planning in general and about specific methods. All applicable forms of contraception will be recognized including female oriented methods indicated by husbands as the method they are currently using, have ever used or intend to use. The background characteristic variables included in the study are:-

i. Independent Variables

Husbands' age, demand for children, level of education, region/province, marriage type, religion, socio-economic status e.g. residence.

ii. Intermediate Variables

Acceptability, perception, attitudes, use or non-use of contraception, (fertility regulation)

iii. Dependent Variables

Number of living children or achieved family size (fertility level).

An examination is done on how (i), (ii) and (iii) above factors influence and relate to one another in chapter 4.

There are certain limitations in this study. My main source of data information is KDHS 1989 which was a National Survey involving other major topics like women Family Planning, Maternal and child health and not merely the one I am studying. Only 1,116 husbands through out the country were interviewed. This means that information on husband's contraceptive knowledge and practice was not collected in details as it was based on a very small group of husbands. At the same time the area covered was too large (all provinces except North-Eastern) to allow special attention on husbands contraception. This husbands sub-group interviewed can only give a general picture of the real situation. The age range for these husbands was very wide 19-85 years and the group 55 years and above recall capacity may be poor since they are less educated and older and they often suffer from memory lapse when giving any information.

The information to be gathered from the data being on husbands contraceptive already excludes those adult men not married and contracepting. As such in the real sense the use rate may be higher if they are taken into account. Some respondents may have reported what they ever used or intent to use as currently using which may exaggerate the figures.

This data therefore is limited as it was collected with other objectives in mind not necessarily those of the present study. Thus further information is referred from various other studies and surveys e.g. urban men motivation and attitudes towards contraception by Population and Health Services (PHS), Rural Men Contraceptive Attitudes by Community Health Unit of Chogoria Hospital and Male Motivation in Family Planning Acceptance in Central and Western Kenya study by NCPD.

CHAPTER 2

LITERATURE REVIEW

Socio-economic, socio-cultural and demographic factors exerts a powerful influence on human fertility.

Fayorsey (1989), pointed out the importance of African men in decisions about family size, in giving their wives permission to use contraceptives, in obtaining contraceptive supplies especially condoms and initiating and sustaining the use of traditional methods. He also argues that increasing male involvement in family planning will improve the status of women, because in the long run, doing so will lead to enhanced communication within marriages and greater decision making equality for women.

Muhawenimana (1988), found greater support for family planning among men than women in the 1983 fertility survey in Rwanda and attributed the low levels of contraceptive use to the lack of communication between spouses regarding their family matters.

2.1 MEN'S ROLE IN FAMILY PLANNING

Globally, men have not shared equally with women the responsibility for fertility regulation while family planning efforts have been directed almost exclusively towards women. The lack of male involvement may also reflect the limited options available to men (Karin Ringheim, 1993). Even though the majority of men surveyed on the subject have expressed the belief that men should assume or share the responsibility for birth control with

their wives. a far smaller proportion in most countries is doing so (Davidson, 1985; McGinn, 1989; Keith, 1974; Posner and Mbodji, 1989). This discrepancy between belief and action may be due, in part, to the limited contraceptive choices.

In most of world societies, the husband is usually the dominant decision maker and his wife is expected to abide by this decision (Carlos, A.C., 1984). Cultural patterns vary of course, but usually a wife's economic dependence on her husband gives him great influence in major household decisions. This dominant male role often extend to a couple's reproductive behaviour. Men have an important say in decisions about family size and the use of family planning (Adebayo A. and Adamchak D.J., 1987). Regardless of which partner actually uses a family planning method, the man often has a major say in decisions on child bearing and family planning. Evidence is limited, but it suggests that many men will take responsibility for family planning when they have the information and means. Infact, $\frac{1}{3}$ of all couples using family planning rely on a male method - condoms, vasectomy or withdrawal or on periodic abstinence which requires full male co-operation (Population Report, 1986): (Moira E. Gallen, 1986).

In countries as varied as Hong Kong, Indonesia, Mexico, Nigeria, South Africa, Thailand and the USA, studies have found that her partners' attitude influences a woman's decision whether to use family planning (Boria-Berna, 1972). In both Mexico and South Africa studies, the husbands attitude was the reason that women gave most often for using or not using contraceptives

(Population Crisis Committee, New York, 1985). In Nigeria, among married female students, 1/5 who were not using a modern contraceptive method said that her husband's objection was the reasons (Ojeifo and Singh B, 1984). In Indonesia, focus group research suggests that the husband's influence on use of contraceptives is strong, especially early in marriage (Survey Research, Indonesia, 1985). Thus, even if a woman favours family planning, she may not take the initiative to use a contraceptive without her husbands' consent (Figa - Talamanca, 1972). In many countries, law or programme policy prevents a woman from obtaining family planning services without her husband's consent (Cook R.J. and Maine D, 1987).

What are men's attitudes towards family planning? In the past most fertility research focused on women. Now more surveys are questioning men, too, about the attitudes towards family planning, their knowledge and their use of contraceptive methods. the Caribbean male contraceptive prevalence surveys (Heisler D. and Lewis G.L., 1985), plus studies in India (Dhar, G.M. and Zutshi, M.L., 1977), Latin America (Hall, M.F., 1977) and U.S.A. (Keith, L. Green R. et al, 1971) are among the few surveys of men's attitudes towards family planning. Although small in number, they suggest that many men favour family planning. In these surveys 65% to over 90% men expressed approval.

Nevertheless, there is little recent evidence that male opposition is a major obstacle to family planning except regions with strong socio-cultural ties (for example marriage for

procreation, religious/traditional beliefs). The few male fertility surveys suggest that, many men want to share responsibility for family planning decisions (Cartwright A., 1976).

2.2 MALE FERTILITY REGULATION METHODS

Men have expressed a willingness to use methods that are as yet hypothetical, such as a pill for men. However, among the currently available male methods - condoms, withdrawal, periodic abstinence and vasectomy - none has the widespread acceptability of some methods for women (Davidson et al., 1985). New methods of male fertility regulation currently, undergoing clinical trials have the potential of being effective as well as reversible, non-surgical and long acting (WHO, 1990, Shen-cai, 1990; Li and Liu, 1990; Waites, 1992). If male and female fertility goals are indeed compatible (Mason and Tai, 1987), overcoming the draw backs of currently available methods for men may lead them to assume a more equal partnership with women in the control of fertility (Leridon, 1978). Couples who might not have found an acceptable method may be motivated to use a new method and to practice contraception more effectively for the first time (Martinez - Manaton et al., 1991; Vernon et al., 1991).

As the number of reproductive aged women world wide is expected to increase by 200 million between 1990 and year 2000 (U.N., 1991) the challenge of meeting existing and encouraging new demand for fertility control could be greatly assisted by the introduction of new male method that is not only safe and

effective, but also reversible, would be a welcome scientific advancement.

At least $\frac{1}{3}$ of world couples practising family planning uses a method that requires male participation or co-operation. Recent studies indicates that men have much more interest in family planning and willingness to practice it than they are given credit for (Ernest Feigenbaum, 1978).

The four family planning methods among men are:-

1. Vasectomy

Methods for controlling male fertility have been known for centuries, but social science research on Such methods have existed for only 20 years coinciding roughly with the widespread introduction of vasectomy. Vasectomy, voluntary male sterilization is a permanent method used by over 41 million men world wide. It is almost completely effective, and recent improvements are making the procedure even simpler (Population Report, 1986). More literature on vasectomy reveals vast differences in its use across cultures. Though it is one of the most prevalent methods in U.S.A, Australia and New Zealand, it remains little used in Europe, Africa, Latin America and Asia outside of China and India (Vernon et al, 1989 and 1991; Alderman and Gee, 1990; Ross and Huber, 1983).

Although the safety and acceptability of vasectomy appear to have been improved through the development of a "no-scalpel

technique" (Martinez - Manaton et al, 1991; Li and Liu, 1990), the difficulty and expense of its reversal still limit the appropriateness of vasectomy to those wishing to stop rather than space child bearing and the methods irreversibility remains the biggest obstacle to its acceptability (Almed, 1976; Fathala, 1978. Sananayahe, 1984).

2. Withdrawal

Historical demographic research indicates that withdrawal was the principal method for men responsible for Demographic Transition in Europe in the last century (Wrigley, 1969). Withdrawal is still widely practised in many countries. Withdrawal is estimated to be used by 35 million couples. Pregnancy rates are often high because the man does not always withdraw in time. Still the method is always available and costs nothing.

3. Periodic Abstinence

Studies of periodic abstinence have rare exceptions (Caldwell et al, 1987), focused on evaluating the success of techniques for identifying the safe period (Thapa et al, 1990; Belts, 1984). Periodic abstinence can be effective if a woman can monitor signs of fertility period and if she and her husband co-operate in abstaining from sex when indicated. Most of the method's 17 million users just guess about the fertility period, however this and failure to abstain leads to unplanned pregnancies.

4. Condoms

Condoms are used by more than 35 million couples and is on the increase during the spread of AIDs. Condoms are effective if used with perfect consistency. But couples do not always use them (Population Report, 1986). Condoms are used by the majority of contracepting couples in Japan (Matsumoto et al. 1972), but until the spread of AIDs promoted studies on condom use, little was known of their acceptability or prevalence of use in developing world. Most of this research has confirmed a wide disparity between knowledge of condoms and their use (Kirumira, 1991; Lemptey, 1978; Mbizuo and Adamchalk, 1989; Sekadde Kigundu, et al. 1991).

2.3 MEN RELY MORE ON FEMALE ORIENTED METHODS TO FAMILY PLAN

Slow progress in male methods development is due at least in part to complexity of the male reproductive system. By comparison the female reproductive system has numerous intervention points (Bremner and De Krester, 1976). Biology and the Macho-Myth (Bruce Stokes, 1980) indicate that women's fertility is cyclical: only one egg is produced each month and women can normally conceive only a few days around that time. Men begin producing millions of sperms each day at about age 15 years and are fertile from then on. So while it is prudent to use birth control whenever one is sexually active, strictly speaking, women need only protect themselves during certain days of the month. Men, on the other hand, need to take definite precautions at all times. These biological differences also have important implications for the development of

a male pill. Chemically, stopping the periodic production of one egg may prove to be easier than halting the on going creation of millions of sperms (Population Reports, 1992).

The method of birth control men and women use also reflects their current contraceptive options. Among the conventional methods those that physically block the passage of sperm or chemically inactivate the sperm - men's only choice is the condom, while women can choose between the diaphragm, cervical cap, spermicidal suppositories, tablets and foam. Women can prevent pregnancy for a defined period of time by taking the pill or using an IUD and then regain their fertility when they want. Without a male pill, men do not have that option (Bruce Stokes, 1980). These practical constraints merely define the outer limits of men's involvement in birth control. Within these limits men's use of contraception and their co-operation with their partners in planning or preventing pregnancies is often determined by what society expects of them. Few cultures assume that men will take the primary responsibility for birth control or that they will support women in their choice of contraceptives. And in few societies are men expected to share equally the task of children rearing (Louis Keith et al, 1975).

The attitude towards family planning held by men in parts of developing world are often attributed to cultural or religious traditions different from those in the west. It is true that many of these societies are pronatalist. Women do not have equal status with men and males are often not held accountable for their acts

(Bremner, 1976). Yet no major culture of religious tradition be it Catholicism in Latin America, Islam in the Middle East, or tribal culture in Africa encourages men to be irresponsible, to have more children than they, their wives, and their community can support (Bruce Stokes, 1980).

Men in the past have had a negative attitude towards birth control. In industrial world, men frequently use the availability of women's method to escape use of contraception. In developing world, some men still insist on the sole right to decide on family size matters, many deny their wives access to contraception and culturally everywhere there are men who oppose birth control, yet when interviewed they express the economic burden that large families pose, but their actions suggest that their feelings often rule their reason. Some men fear that their wives will be too independent and promiscuous (Breimer, 1976). Moreover, public sentiment suggesting women have a right to control their own fertility and to be something more than wives and mothers can be threatening, many men may feel they are losing their role as the head of the family. So they dig in their heels, become stubborn and refuse to cooperate on family planning matters even though they may acknowledge that taking responsibility for birth control would be in their own and their families' best interests. (Studies in Family Planning, 1992).

And poverty, not male chauvinism, often shapes men's attitudes. It is no coincidence that in the United States of America, where the standard of living is high vasectomies are

popular and condom use is increasing. Economic status is also a determinant of men's attitudes and behaviour (Misra, B.D. 1966). Among black Americans, men with higher income and better education are more supportive of family planning than are those who are less fortunate. Middle and upper income Mexican men are more concerned about the impact of repeated childbearing on their wives's health than are with low incomes. And studies in Ghana suggest that increased job opportunities, educational achievement and urbanization (economic pressure) motivates men to want smaller families (B.D. Misra, 1966).

Men's supposedly strong negative feelings about contraception and their desires for large families often contain a mass of contradictions or are the product of forces beyond their control (Bruce Stokes, 1980). Yet the very passion of concerned feelings about family planning decisions that affect their lives and their posterity. In Attempting to broaden men's role in family planning, there is nothing society can do about human biology. And, unfortunately, the mere availability of a male pill one day will not necessarily ~~change~~ men's attitudes (studies in family planning, 1986).

Society can ill afford to have men play this peripheral and negative role in family planning and must encourage men or the opposite. The world faces the daunting prospect of supporting 10 to 12 million people by middle of the next century unless birth rates fall rapidly. More than $\frac{1}{3}$ of world's couples do not use contraceptive and they are concentrated in the poorest parts of

developing world. Many of these societies are patriarchal and men still dominate family decisions (Bruce Studies, 1982). The ultimate success of birth control programmes in these countries may rest on the availability and use of effective male contraceptives and the full involvement of men in family planning programmes.

Research and training opportunities for medical specialities are structured funding agencies which provides little funding for research in methods for men, which may reflect a bias in favour of leaving the responsibility for contraception with women (Segal, 1972).

Early contraceptive was spurred by political pressure and financial support from feminists who sought a method by which women could regulate their own fertility (Bremner and De Krester, 1976). Following the success of oral contraceptives for women, little interest developed for waging a comparable all out campaign for a male method (Diller and Hambree, 1977).

2.4 FACTORS AFFECTING CONTRACEPTIVE ACCEPTANCE

What factors determine the extent to which a new birth control method will be used? Prevalence of use is dependent on various (economic, cultural, demographic) factors. Acceptability of contraceptive methods have been the focus of social research. As defined by Marshall (1977), acceptability is "a quality which makes an.....idea attractive, satisfactory, pleasing or welcome". Acceptability is a subjective evaluation because perceptions vary. Thus, the acceptability of a given phenomenon may differ according

to the source, context and timing of evaluation. Policy makers and service providers determine acceptability to some extent (Marshall, 1977), since they control access to a method through public policy decision, information and education, availability of the method and the physical location of services (Karin Ringheim, 1992). Early identification of a new method's potential "Resistance points" (Zimmerman, 1990) may ward off problems. There may be financial, psychological or cultural costs standing in the way of use. Acceptability is recognized as culture specific, but failure should not be attributed to cultural bias until access to method and appropriate education information channels have been used to best effect. While method and human factors are intertwined, studies and distinction between the two is useful to pin point important cultural and human factors that affect use (Population and Family Planning, 1993).

All fertility regulating methods may be considered unacceptable in terms of meeting ideal standards or because they are seen as unnatural in a particular cultural setting (Caldwell, 1987); yet people who are motivated to limit child bearing may use them because there are no perfect alternatives (Keller, 1979) intention that is not based on experience and action.

Method factors such as safety and efficacy affects acceptability. successful prior use of a method is likely to be a good predictor of future use, because questions regarding the modality, social acceptability and utility of contraception for the user have already been answered. In a study, behavioural

intention was examined as the primary measure of acceptability in developing countries (Davidson et al. 1985). Five countries Fiji, India, Iran, Korea and Mexico were selected for their cultural, religious and geographical diversity, as well as for socio-demographic characteristics. A sample of married fertile men from urban and rural areas in each country was asked if men should play a role in birth control, either by assuming responsibilities themselves or by taking action jointly with their wives. About 50% men in Iran and Mexico expressed a willingness to do so. the other 3 countries had even higher response (De Silva, et al. 1988; Cleland and Mauldin, 1991; Haws et al. 1992). A precondition for using any method is that the potential user has entertained the concept of fertility regulation and has perceived it as advantageous (Coele, 1973). A method's acceptability is influenced first by the potential user's desire to avoid pregnancy (Marshall, 1977). A research in Africa has shown where this motivation is weak, the acceptability and use of any contraceptive method will be greatly reduced (Frank, 1987; Heisel, 1973; Kirumira, 1991; Adeokon, 1979).

Research in Latin American and Africa has revealed that the personal attitude and training of service providers can also strongly influence acceptable methods, attitudes which can in turn be passed on to clients. A study in urban and rural Zaire found that 75% of clinicians interviewed believed that a couple should have an average more than 5 children before they consider sterilization (Bertrand et al. 1990). Lack of adequate personnel

training in control methods is another limiting access method. An increase in the number of trained physician to perform vasectomy have been accompanied by an encouraging increase in the number of vasectomy acceptors in Mexico, Brazil and Colombia.

Another consideration in contraceptive choice is the potential users' life-style and the stage of his reproductive life. The scourge of AIDs has made the technology appropriate for fertility regulation dependent upon the sexual behaviour of the user. Awareness of AIDs may eventually alter cultural and individual bias against the condom among both men and women (Green, 1990).

In various cultural contexts, the "gate keepers" of new technologies include village leaders, headman and politician (political goodwill). Attitudes of village leaders in rural India towards family planning were found to have a strong influence on the use of contraceptive methods and continuation rates (Kumar, 1973). Religious leaders particularly in Muslim world, are key figures in influencing whether male methods are used or not (Ahmed, 1976). (Martrines - Marianton et al, 1991). Thus the skills and resistance by physicians could interfere with attempts to improve with attempts to improve awareness and use of male methods. After all users prefer methods that involve "nothing to remember over those that are coitus dependent. Men further insist that a method have no adverse effect on lipide or sexual performance if it is comfortable (WHO, 1982).

2.5 FAMILY PLANNING IN AFRICA

Recent surveys have shown that male approval of family planning in Africa has increased especially for spacing births (Gallen et al. 1986). In addition, research in Zimbabwe in the late 1980, began to suggest the importance of reaching men with family planning information. According to 1984 Zimbabwe Reproductive Health Survey, (ZNFPC), 42% of married women stated that it was the husbands responsibility to decide whether his wife should use family planning methods (Karin Ringheim, 1992).

Family planning programmes in Africa have traditionally concentrated on reaching women through the Maternal and Child Health care (MCH), and have largely ignored the involvement of men. The most striking indicator of the lack of male involvement in Africa is the very low use of male contraceptive methods as well as caring for their children. A common assumption regarding traditional and modernizing societies is that men have little good to say about family planning. This assumption is perhaps most strongly felt about men in Africa, where patriarchy has a long history and families have traditionally been very large (Greene, P. 1992).

Contraceptive use increase programmes among African populations are paying attention to contraceptive knowledge, attitudes and practices of African men (T. McGinn, 1989). Studies in Ghana suggest that increased job opportunities and educational achievements motivate men to want smaller families (Misra, B.D., 1966). A household survey conducted in Korin, Nigeria 1988/89

yielded data on contraceptive knowledge, attitude and practice of 1,022 men. It was found that contraceptive knowledge is virtually universal among men, with condoms and oral contraceptives being most popular. Yet less than 1/2 men from the most educated and highest socio-economic groups have never used contraceptives. General knowledge of contraception is acquired through radio and T.V. but more detailed and practical information is typically provided at MCH centres and clinics that focus their services on women and children and rarely visited by men (Oni, G.A. and McCarthy, 1991). A report from Chad, a conference on "The role of men in family planning" indicates that the programme in Chad has focused solely on the improvement of MCH. This has completely excluded the man who is traditionally and culturally the decision maker in the home, leading to his rejection of contraceptives even for his wife (Bruce Stokes, 1980).

The study also found that majority of men at all education and residence levels have positive attitudes towards family planning and that effective contraceptive use is strongly associated with communication between husbands and wives. Among men who says they have had such discussions, 22%-60% reports that their wives uses a method, compared with only 4-10% of those who have not discussed family planning with their wives (Greene, P., 1992).

Boserup E, (1985) claimed that since women do most of the child rearing in Sub-Sahara Africa, men's motivations for family planning is weak. She was supported by Omondi-Odhiambo (1989) who attributed the failure of the Kenyan aggressive anti-natalist

policy in the last two decades to absence of male involvement and neglect of men in Information, Education and Communication (IEC) efforts in Kenya's predominantly patriarchal society. He stressed that large family size guaranteed men economic and social rewards and did not carry penalties from the men's point of view. He blamed the situation on the lack of research data on the social, cultural and economic reasons of men's fertility rate behaviour.

In a study of 100 married men, aged 15-39, from the Vio society of Liberia, Campbell (1985) showed that the husband's desire for large numbers of children had a dominating influence on fertility decisions.

The low use of contraceptives was also found among black men in the modern, urban community of Daveyton in South Africa (Van der Marwe and Van-Wyk, 1982). Only 2% of the 227 men were using male contraceptives. Although their average desired family size was 4.1, the South African black men wanted more than 2 sons. Such strong desires for several sons were also found to be associated with protection of property, continuity of the lineage and other socio-cultural values among Akamba of Kenya (Kabwegyere, 1977) and Banyankore of Uganda (Ntozi, et al, 1991). Pool (1963), found that 45% of women in rural Ghana were in polygamous marriage had a lower fertility and low use of contraceptives. Ukaegbu (1977) study in Eastern Nigeria, reported that the wide age differential between polygamous ^{men} and their wives was responsible for the association between reduced fertility and polygamy in the area. Over a decade later, Garenne and Van de Walle (1980) agreed with Ukaegbu's

conclusion by attributing low fertility among the severe polygamists of Senegal to the lower fecundity of the older men.

2.6 FAMILY PLANNING IN KENYA

One value embraced by majority of Kenyans is that children form the basis of family life (NCPD, 1989). In Kenya, a recent study reports that in order to motivate Kenyan men to use contraceptives technology, family planning programmes must be tailored to their social, cultural and economic contexts (Shumba P., 1992). communication between husbands and wives is important for decisions of family size (PSRI, 1992).

Evidence from contraceptive prevalence and fertility indicates that while both knowledge and approval of family planning are high (91%), the use of contraceptive is still much lower than that of developed western societies (Ayiemba, E. and Oucho, J., 1989). In the past, modern contraceptives were not freely acceptable because of strong cultural norms which supported societal institutionalization of reproductive behaviour favouring large family size norms in the face of high mortality and large scale illiteracy condition (Molnos Angela, 1973). With increased education, employment and rising costs of living, more individuals are using contraception. The element of "cost sharing" in health and education recently introduced by the Kenya Government will raise the desire for not only family planning but also smaller families (Oucho, J., and Ayiemba, 1989). This will mean increased dependent burden. Going by censuses, 46% of Kenyans were under age

15, a dependency ratio of 106, in 1962; was 112 by 1979; rose to 122 by 1984 and 128 by 1988 (Ominde, S.H., 1984). At family level, this young dependent population will place more demands on parents who will have to provide more land and most of the family resources will be invested in supporting the large family. Majority are young who are potential parents and are landless. A large family entails a lot of expenditure on food, education, clothing and health care and the problem is compounded by low household incomes (Kekovole, J., 1991).

Studies by Caldwell (1976), Dow and Wesner (1982) found that where the generational flow of wealth is more towards parents, the chances are that the need for more children is enhanced (economic factors of children). In most Kenyan communities marriage is early and universal (Ocholla-Ayayo, A.B.C., 1981). Majority of women are married before age 20. Polygamy is widely practised and valued with a cultural and economic significance. 88% men expresses high desire for many children in the Kilifi District study compared to 63% by women (Kekovole, J., 1991). Population growth rate of 3.9% in Kilifi District indicate a high fertility coinciding with the highest mortality rate in the country and the lowest contraceptive use of 7.4%. If mortality rate cannot be reduced, it is unkind to speak about fertility control (Ocholla-Ayayo, A.B.C., 1991). Thus, there is very limited family planning practices and the major hindrance has been lack of male involvement and general community disapproval.

Men's support is necessary to assist the women folk in their

endeavour to use various family planning methods by providing psychological, material and personal understanding (Muinde, F., 1992). Family planning programmes should also intensify their activities in districts of high fertility as it has been shown that the stronger the family planning effort, the sharper the birth rate decline. The corollary being that people are more likely to practice contraception in areas where there is a strong family planning programme (Cucho, J., 1989). At the same time, the incidence of fertility control has been shown to be even greater when a strong family planning programme is introduced into a favourable socio-economic and socio-cultural setting (Mauldin and Berelson, 1978).

Acceptance and effective use of contraceptives are affected by traditional values and beliefs. This has resulted in low contraceptive use in most ethnic groups in Kenya (Ocholla-Ayayo, A.B.C., 1991). "An African marries because he wants children. *"Iverorum quaerendorum gratia"* (Redcliffe-Brown, 1976).

Table 2 Percent Distribution of Mens Responses Whether Children Strengthen Family Ties by District and Ethnic Group

District	Ethnic Group			
	Kikuyu		Luhya	
	No	Yes	No	Yes
Busia	3	100	174	78.7
Bungoma	3	100	240	93.4
Kakamega	175	25	426	96.8
Nyeri	179	75.4	2	100
Murang'a	239	83.6	1	100
Kiambu	75	61.0	-	66.7
Kirinyaga	53	57.8	2	66.7

Source: NCPD 1989

N=?

Information in Table 2 clearly supports the claim that children strengthen family ties in all district and among ethnic groups

Table 3 Percent Distribution on Men's Responses to Whether They Share The Child Value That Children Inherit and Transmit Man's Wealth to Subsequent Generations by Ethnic Group

Men's Responses to Inheritance and Transmission of Heritage to Subsequent Generations

Ethnic Group	Yes		No		NS		Totals	
	N	%	N	%	N	%	N	%
Kikuyu	700	71.1	190	19.3	94	9.6	984	100
Luo	38	77.6	8	16.3	3	6.1	49	100
Kamba	11	78.6	3	21.4	-	-	14	100
Luhya	844	91.0	57	6.2	26	2.8	927	100

Source: NCPD 1989

The men's responses in Table 3 overwhelmingly concur that children inherit and transmit a man's wealth to subsequent generations irrespective of ethnic groups affiliation. These results confirms the above quotation that an African man marries because he wants children.

2.7 SUMMARY OF LITERATURE REVIEW

According to existing literature men's knowledge of contraception is high while their contraceptive prevalence is very low. This study will further carry a research on why this discrepancy persist despite of intensified family planning programme in Kenya. Socio-economic, socio-cultural, demographic and fertility regulation factors will be analysed to investigate whether they contribute to the high demand for children expressed by Kenyan husbands. It is also clear that men's support is necessary to assist their women folk in using various family planning methods by providing psychological, material and personal understanding. This study will further analyse whether men in Kenya discuss and encourage their wives to practice family planning in Kenya.

Much of family planning programme activities and research have been geared towards female reproduction leaving out men who are the major family decision makers. Therefore much more of research remain to be done to find out causes of low contraceptive prevalence by men while at the same time they show a high fertility preference in Kenya.

2.7.0 STUDY HYPOTHESES AND FRAMEWORK

The hypotheses of this study will be dictated by the available data. From theoretical formulations and review of relevant literature, various assumptions will be derived upon which the study will be centred. Hypotheses and models will be derived from the general relational findings and tested in this study. It has been documented that there are positive and negative relationships between various background variables and contraceptive use and consequent number of children.

2.7.1 THEORETICAL FRAMEWORK

It is important to define the dimensions of the role played by socio-economic, socio-cultural and demographic effects in the study of fertility. Given the complexity of fertility and degree at which it is surrounded by solid socio-cultural institutions and shared values it is important to device rational and adequate strategies for reducing it. The sociological framework by Davis and Blakes (1956) provide basis for empirical studies on how to reduce fertility using intervening variables and background characteristics.

2.7.2 CONCEPTUAL HYPOTHESES

The study assumes that:-

- i) Demographic factors (husband's age, mortality) affects husbands fertility or number of living children.

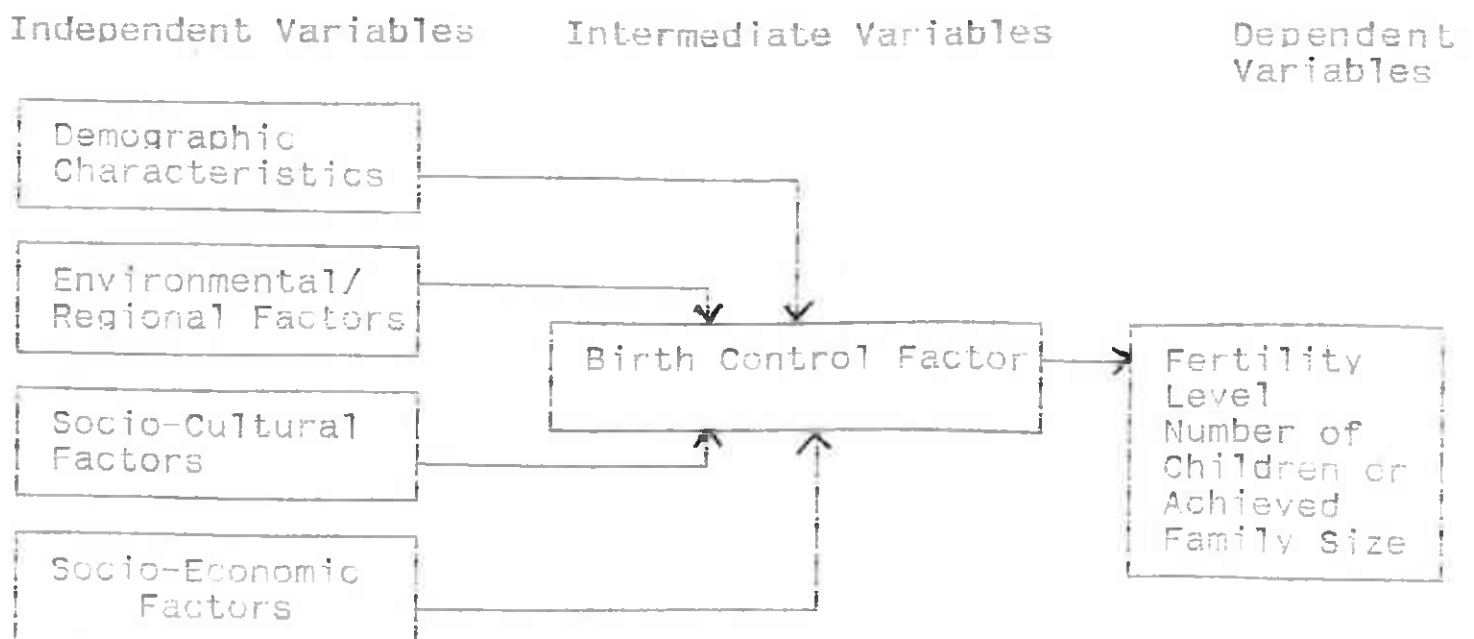
- (ii) Husband's fertility preference affect contraceptive approval and consequent use.
- (iii) The socio-cultural factors of a place (marriage type, region/province, ethnicity, religion) play a major role in determining contraceptive acceptance and consequent number of children per husband.
- (iv) A man's socio-economic factors (education, residence and occupation) influences his use of family planning methods and number of living children.



Source: Simon and Farooq, 1985

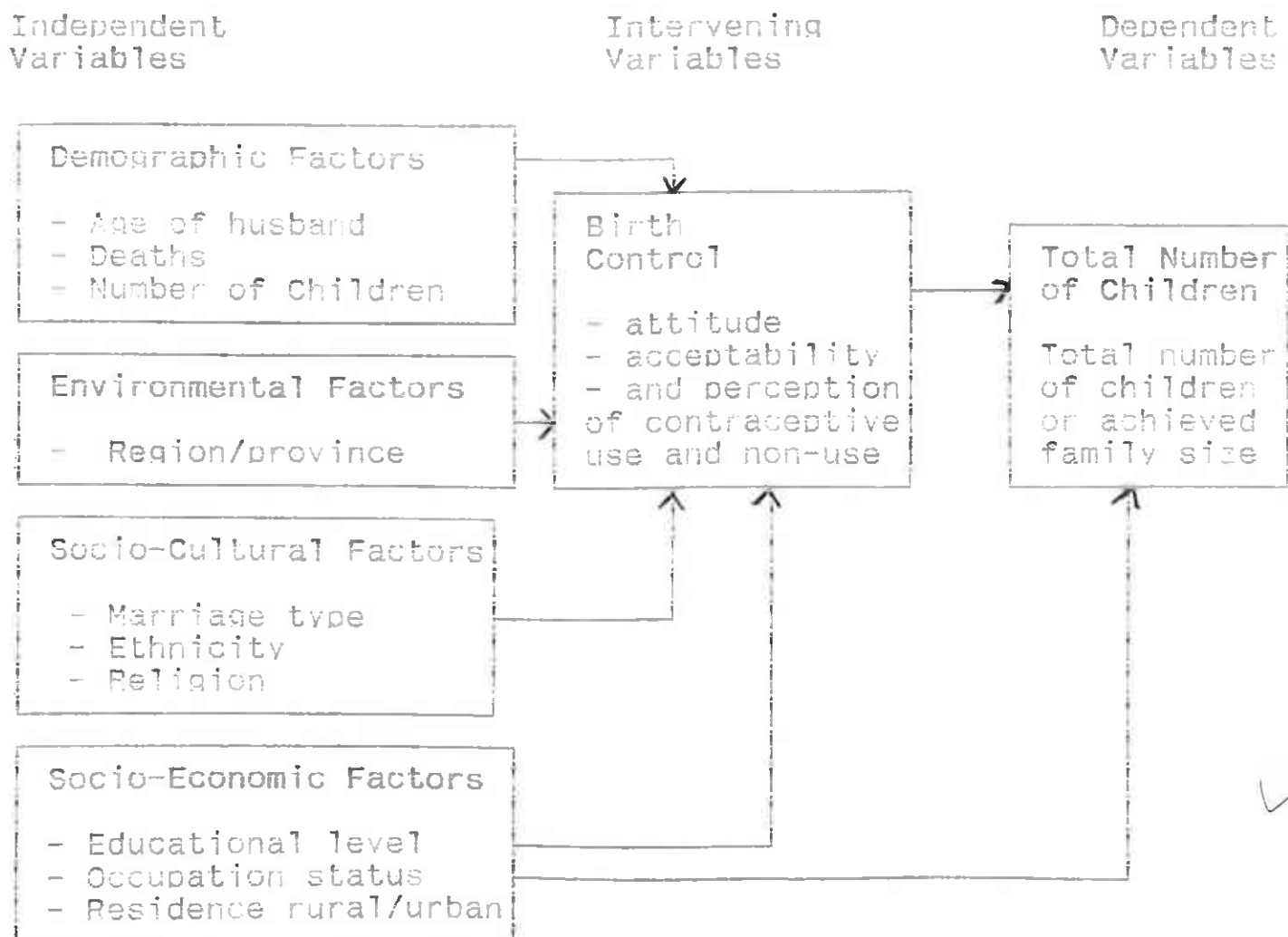
This is a single view of the determinants of fertility.

2.7.2 Conceptual Framework for Understanding the Determinants of Contraceptive Use and Family Size



2.7.3 OPERATIONAL FRAMEWORK

2.7.3 Operational Framework for Understanding the Determinants of Contraceptive Use and Family Size



The study will statistically analyse and validate these hypotheses.

Any operational formulation proposed will show how various demographic, regional, socio-cultural and socio-economic variables will relate to husbands fertility regulation or contraceptive acceptance and consequent family size at household or micro-level. The following are operational hypotheses to be tested during data analysis:

- 1) Age is positively related to husbands demand for children and resultant number of children.

- ii) The demand for children lowers with age in the more economically advanced provinces and those without strong cultural ties.
- iii) Those husbands who have ever used both traditional and modern family planning methods are more likely to approve of family planning than those husbands who have never used any method.
- iv) Most husbands are aware of condoms hence it is more popular than other male related family planning methods.
- v) The higher the level of husband's contraceptive awareness the higher the acceptance.
- vi) An overwhelming majority of Kenyan husbands are negative about male sterilization (vasectomy).
- vii) Female sterilization is a highly preferred future method by most Kenyan men.
- viii) Husbands knowledge of contraception is very high while current use is very low.
- ix) Economic pressure coupled with degradation of cultural attachments increases husband's for no more children.
- x) Provinces with higher child/infant deaths have increased husband's desire for more children.
- xi) Husband's demand for children is lower in provinces neighbouring Nairobi.
- xii) The demand for children are clear with Nairobi Province husband's than other provinces.
- xiii) Generally husbands have higher demand for children than their wives.

- xiv) The more the number of wives the less the husband's contraception knowledge especially modern methods.
- xv) The more the number of wives per husband, the higher the number of sons and daughters and the higher is his number of children.
- xvi) A monogamous husband knows more of modern family planning methods than a polygamous husband.
- (xvii) The more a husband discusses with their wives, the more they encourage them to regulate their total fertility rate.
- (xviii) The more zealous a husband is to a religion, the higher the demand for children and the less the contraceptive acceptance.
- (xix) More Protestant than Catholic husbands uses modern methods.
- (xx) Catholics have lower contraception response and uses more of traditional than modern methods.
- (xxi) Muslims relies mostly on traditional methods of family planning.
- (xxii) The more the ethnic loyalty and cultural ties, the bigger the husbands family size.
- (xxiii) Urban husbands are likely to family plan more than their rural counter parts.
- (xxiv) The higher the educational attainment, the higher the occupational status and this leads to higher contraceptive use and lower husbands fertility.

CHAPTER 3

RESEARCH METHODOLOGY

This chapter covers sources of data, target group, reliability and quality of data and method of data analysis.

3.1 SOURCE OF DATA AND DATA COLLECTION

The study involves secondary data obtained from Kenya Demographic and Health Survey, (KDHS) which was a National Survey carried out by National Council of Population and Development (NCPD), Central Bureau of Statistics (CBS) and the Institute of Resource of Development (IRD) in 1989. It was funded by the Kenya Government, assisted by USAID and IRD. It excluded North Eastern province and 4 Northern Districts.

The KDHS sample are based on the National Sample Survey and Evaluation programme, (NASSEP) master sample maintained by CBS. The NASSEP master sample is a two sample design stratified by urban-rural residence and within the rural stratum by individual districts. A total of 34 districts were included in the whole country.

About 10,000 households were selected for KDHS 3,000 of which were urban.

KDHS had 3 questionnaires:-

- (1) One on list of households.

- (2) The other on information from women 15-49 years present on the night before the interview.
- (3) The last on information from husbands of women aged 15-49 years (to be precise the youngest husband interviewed was 19 years and the oldest was 85 years). i.e. Household/Women's/Husband's Questionnaire.

The target group of my research particularly refer to the quantitative and qualitative information obtained from these 1,116 male respondents made up of currently married husbands. This husbands survey also included a Knowledge Attitude and Practice (KAP) section. The KDHS sub-sample was designed to produce completed interviews with 1,116 husbands which was an 81% response out of a total of 1,397 eligible husbands who spent the night before the interview in the selected households and whose wives were successfully interviewed.

However, this study will focus on data collected using the husbands questionnaire which collected information on respondents background (such as age, residence, educational level, occupation, religion, ethnicity, region, marriage type etc), reproductive behaviour, knowledge, attitude and use of family planning methods and fertility preferences.

The study has also sought data from other supplementary information sources: government publications, population reports, magazines and has borrowed alot from studies by NCPD and Development and Research Services (DRS) on Male Motivation in

Family Planning Association in Central and Western Kenya (1989), from Family Planning Association of Kenya on Male Involvement in Family Planning prepared by J. Kekovole (1991) and from the District Contraceptive Prevalence Survey conducted by Population Studies and Research Institute (PSRI, 1992).

3.2 RELIABILITY AND QUALITY OF DATA

The KDHS being a secondary source of the study data is not free from various errors commonly found in surveys. The excluded districts of North Eastern Province and Isiolo, Marsabit and Turkana accounts for $\frac{1}{4}$ of Kenya's land area and about 5% of the nation's population. This means that the KDHS survey covered 95% of total population which is comprehensive and representative enough. The KDHS questionnaires were even translated into local languages and thus the respondents best understood what was required i.e. they gave quite relevant and reliable information.

The survey collected demographic, environmental, socio-cultural, socio-economic as well as contraception information of these husbands and therefore it contains all the variables required for this study. The study was also carried by qualified personnel made up of staff of indigenous languages, male and female interviewers, editors and supervisors. The teams were guided and further instructed by local District Population Officers and Statistical Officers and supervisors from NCPD headquarters. Few problems were encountered during the interviews and the response rate was high 98% for households, 96% for female respondents and

21% for husband respondents.

3.3 METHOD OF DATA ANALYSIS

Contraceptive acceptance and consequent use is usually determined by a host of different factors. The main objective of the study is to examine how demographic, environmental, socio-cultural and socio-economic factors relate to husband's contraception. Attempts by previous studies on these relationships with selected variables have used various other methods of data analysis like multiple variance classification. However, due to time constraint, this study will utilize cross-tabulation and chi-square (χ^2) tests to show percentages and frequencies of contraceptive use according to each selected independent variable. The chi-square results will help identify whether two named variables will be dependent or independent at a given level of significance. Percentage and frequency distribution tables will be used. The method is simple to compute and understand and is appropriate for comparative purposes. Descriptive analysis will also be used especially in writing the report of the findings.

The cross tabulation will give the tables in Chapter 4.

3.4 LIMITATIONS OF CROSS TABULATION METHOD

Cross tabulation has various limitations:-

- i) Since the method only indicate the association between dependent and independent variables e.g. contraceptive acceptance and number of living children and variables like

ethnicity, region, religion, residence, type of marriage, it does not show the extent or by how much these variables influence contraceptive use, acceptance and consequent use.

ii) Cross-tabulation does not either indicate which variable has a stronger influence than the other of the independent variable on contraceptive acceptance and number of living children.

CHAPTER 4

DATA ANALYSIS AND RESULT DISCUSSIONS

4.1 INTRODUCTION

This chapter deals with the presentation and analytical interpretation on how demographic, environmental, socio-cultural and socio-economic factors relate to contraceptive acceptance and fertility preference in Kenya. Contraceptive acceptance is measured through husband's knowledge, approval and practice of family planning methods; while fertility preference is measured through husbands time duration for next child, wants but unsure, undecided and wants no more children and total number of living children. Independent variables analysed as affecting above dependent variables includes respondent's.

- Demographic factors like age.
- Contraception factors like approval and use of family planning methods (fertility preference).
- Environmental factors like region/province.
- Socio-Cultural factors like religion, ethnicity and type of marriage.
- Socio-economic factors such as education and residence.

The analysis is done using percentages, frequencies and cross-tabulations and the chi-square test to show whether the relationships between above variables are significant or not. These results later helps us to accept or reject the quoted hypotheses.

CHI-SQUARE ANALYSIS

In this section we examine if there exist a relationship between the named independent variable with the dependent variable which is total number of children born per husband. The chi-square (χ^2) shows if any two variables are dependent or independent at a given level of significance. The chi-square, however, does not show the strength of the relationship.

The chi-square describes the magnitude of discrepancy between theory and observation, that is, with the aid of chi-square test, one can know whether a given discrepancy between theory and observation can be attributed to chance or whether it result from the inadequacy of the theory to fit the observed facts. If the chi-square is zero, then it means that the observed and expected frequencies completely coincides. Thus, the greater the value of chi-square, the greater will be the discrepancy between observed and expected frequencies. The formular for computing chi-square is:

$$\chi^2 = \sum (O - E)^2/E$$

Where O is observed frequency and E - Expected or theoretical frequency. The calculated value of χ^2 is compared with the table value of χ^2 for given degrees of freedom at specified levels of significance. If the calculated value of χ^2 is greater than the table value, the difference between theory and observation is considered to be significant, that is, it could not have arisen due to fluctuation of the sampling. The number of degrees of freedom is described as the number of observations that are free to vary

after certain restrictions have been imposed on the data. Thus the number of degrees of freedom for all the cells is $(C-1)(r-1)$ where: C - refers to columns and r - refers to rows. Thus in a two by two table the degrees of freedom will be $(2 - 1)(2 - 1) = 1$ and in a three by three table it will be $(3 - 1)(3 - 1) = 4$.

However, because the computer will be used to calculate the chi-square, the interpretation shall be that if observed significance level of the test is small, i.e. less than 0.05, 0.0, 0.01, then the null hypothesis shall be rejected and alternative hypothesis accepted that the two variables are dependent. Chi-square usually employs two types of hypotheses, the null (H_0) and alternative hypotheses (H_1). Thus H_0 : states that the two variables are independent while H_1 : states that the two variables are dependent.

Thus it is on the basis of this technique that we set to perform our analysis. In order to capture fully the relationship with total number of children per husband, the data results are analysed using:

- (a) Demographic factors, (b) contraception and fertility preference factors, (c) environmental or regional factors, (d) socio-cultural factors, and (e) socio-economic factors.

This was also necessary for the computer run. Analysis by various dependent variables are considered below:

A. DEMOGRAPHIC FACTORS

4.2 DATA ANALYSIS AND FINDINGS

4.2.1 CURRENT AGE OF HUSBAND BY TOTAL LIVING CHILDREN

Table 4.1 Percent Distribution of Husbands Age by Total Number of Living Children

Current Age	Number of Children						Row Totals
	0	1	2	3	4	5+	
15-19	100	-	-	-	-	-	1 (.1%)
20-24	9.0	65.8	25.2	-	-	-	19 (2.0%)
25-29	3.5	18.6	34.3	29.4	10.3	3.9	90 (9.7%)
30-34	1.2	6.5	16.5	21.8	25.9	28.1	132 (14.2%)
35-39	.8	3.1	7.1	13.6	16.5	58.9	162 (17.4%)
40-44	.4	.2	3.4	10.4	13.8	71.8	151 (16.3%)
45-49	2.0	.3	5.8	2.9	3.0	86.0	120 (12.9%)
50-59	-	.7	.7	7.1	4.5	87.0	174 (18.7%)
60+	1.2	.9	2.0	2.1	5.8	87.9	81 (8.7%)

Total Respondents Interviewed = 930
 $\chi^2 = 593.00120$
 DF = 40
 Significance = .00000

Table 4.1 above shows the percentage distribution of Kenyans husband's age by the total number of living children. 930 husbands were interviewed of ages between 19-85 years.

From the table, it is clear that the older the husband the bigger the family size and the younger the smaller the number of

children. 65.8% husbands aged 20-24 years had fertility level of 1 child compared to 87.9% with 5 or more children of those aged 50-59, none of the later had no child while 100% had no child of those aged 15-19 years.

These results indicates that Kenyan men starts having children immediately they marry and generally have high fertility as shown by the fact that 26.1% aged 30-34 years and 58% aged 35-39 years had 5 or more children which is almost a completed family size. The incidence of 1.2% husbands of 65+ years without children could be accounted due to the problem of sterility among those husbands or those whose wives were barren. The χ^2 test of 593.00120 further confirm the strong relationship that exist between age of husband and total number of living children which is highly significant (.00000). Thus we confirm the hypotheses that age is positively related to total number of children.

The evidence presented by above table indicate that husbands fertility in Kenya is very high and increases with age.

4.2.2 CURRENT AGE OF HUSBAND BY NUMBER OF OWN SONS AND DAUGHTERS

Table 4.2: Percent Distribution of Husband's Current Age by Number of Own Sons

Age	Number of Own Sons						Row Totals
	0	1	2	3	4	5+	
15-19	100	-	-	-	-	-	1 (.1%)
20-24	23.2	59.6	17.1	-	-	-	19 (2.0%)
25-29	23.6	37.7	28.6	6.3	2.9	.9	90 (9.7%)
30-34	13.3	23.5	30.8	18.7	11.1	2.6	132 (14.2)
35-39	10.4	20.2	29.1	20.1	13.6	6.6	162 (17.4%)
40-44	6.3	13.7	24.6	23.7	19.3	12.4	151 (16.3%)
45-49	5.0	2.0	11.5	24.9	19.2	37.4	120 (12.9%)
50-59	1.8	3.1	18.7	13.6	16.5	46.3	174 (18.7%)
60+	3.6	9.9	9.4	7.9	13.7	55.5	81 (8.7%)

Total Interviewed = 930
 DF = 40
 $\chi^2 = 378.79001$
 Significance = .00000

Table 4.3 Percent Distribution of Husband's Current Age by Number of Own Daughters

Age	Number of Daughters						Row Totals
	0	1	2	3	4	5+	
15-19	100	-	-	-	-	-	1 (.1%)
20-24	77.7	22.3	-	-	-	-	19 (2.0%)
25-29	26.0	47.9	20.8	4.3	.4	.6	90 (9.7%)
30-34	11.0	42.0	26.7	12.8	4.6	2.9	132 (14.2)
35-39	7.2	20.9	15.1	28.4	15.4	13.1	162 (17.4%)
40-44	6.0	12.7	18.6	24.3	18.1	20.3	151 (16.3%)
45-49	6.3	10.9	10.9	16.1	19.5	36.4	120 (12.9%)
50-59	1.5	11.8	12.0	10.3	18.0	46.5	174 (18.7%)
60+	3.7	3.5	7.9	5.6	16.5	61.7	81 (8.7%)

Number Interviewed = 931
 $\chi^2 = 485.47801$
 Significance = .00000

Table 4.2 and 4.3 distributes the percentages of husband's ages according to number of own sons and daughters respectively. The relationship between age and number of sons and daughters is positive conforming with findings of Table 4.1. From the two tables, it appears that most of the husbands interviewed had first born sons (59.6%) as compared to first born daughters (22.3%) for ages 20-24 years. However, it is apparent that at higher parities, older men have more girls (61.7%) than boys (55.5%) of 5 and more. This conforms with the biological fact that many births are boys but most survivors are girls at early ages.

At higher husband's ages of 40 years and above, it is

important to note that inspite of the current average number of surviving sons being smaller, than the average number of living daughters, men do not necessarily desire to have more sons than daughters. Similar findings were indicated by Ntozi J.P.M. (1993) among the Banyakore of South Western Uganda. The higher the ages of husbands, the higher the fertility levels. This is due to the pro-natalistic culture and high value of children in Kenya.

B. CONTRACEPTION AND FERTILITY PREFERENCE

4.2.4 EVER USE OF ANY METHOD BY CONTRACEPTIVE APPROVAL

Table 4.6 Percent Distribution for Ever Use of Any Method by Husbands Approves Family Planning

Use	Family Planning Approval		Row Totals
	Yes	No	
Never Used	75.6	24.4	335 (36.1%)
Used Only Traditional	94.6	5.4	284 (30.6%)
Used Modern	94.4	4.6	309 (33.2%)
Column Totals	826 (89.1%)	101 (10.9%)	

Total Interviewed = 928
 $\chi^2 = 100.34505$
 Significance = .00000

The general comment from Table 4.6 is that a very high percentage of Kenyan husbands, 89.1%, approves of family planning methods of contraception regardless of ever use or not of any method as compared to a small percentage of 10.9% of those who do not approve of family planning. 24.4% of husbands who have never

used any method did not approve of family planning while only 5.4% and 4.6% of those who used traditional or modern methods respectively do not approve. From this we conclude that since those who have never used any method do not know the ease and advantage of family planning, then they reject it. Yet, since a good percentage of those who have never used any method, 75.6% approves and say "yes" to family planning approval question, then generally we can conclude that majority of Kenyan husbands approve of family planning although the practice is very low. This satisfies objective 2 and confirms hypothesis (iii) above.

The table also indicates that Kenyan husbands are almost equally distributed to never used any method, used only traditional method and used modern method with 36.1%, 30.8% and 33.1% respectively.

4.2.5 APPROVAL OF CONTRACEPTION METHODS

Table 4.6 Percent Distribution for Ever Use of Any Method and Approval of Condoms

Method	Condoms Approval			Row Totals
	Accepts	Not Accept	Do Not Know	
Never Used	33.1	32.9	34.0	338 (36.3%)
Used Traditional	51.7	37.8	10.5	285 (30.6%)
Used Modern	69.0	24.8	6.2	308 (33.1%)
Column Totals	472 (50.7%)	295 (31.7%)	164 (17.6%)	

Total Interviewed = 931
 $\chi^2 = 131.48527$
 DF = 4
 Significance = .00000

Table 4.7 Percent Distribution for Ever Use of Any Method by Husband's Approval of Sterilization

Method	Approval			Row Totals
	Accepts	Not Accept	Do Not Know	
Never Used	4.2	59.2	36.8	335 (36.1%)
Used Traditional	11.2	73.8	15.0	285 (30.8%)
Used Modern	12.7	73.3	14.0	307 (33.1%)
Column Totals	85 (9.2%)	633 (68.9%)	209 (22.5%)	

Total Interviewed = 927
 $\chi^2 = 68.37889$
 DF = 4
 Significance = .00000

Table 4.8 Percent Distribution for Ever Use of Any Method by Husband's Approval of Withdrawal

Method	Approval			Row Totals
	Accepts	Not Accept	Do Not Know	
Never Used	17.9	47.4	34.8	363 (36.0%)
Used Traditional	51.8	34.5	13.7	284 (30.6%)
Used Modern	48.0	40.8	11.2	308 (33.3%)
Column Totals	354 (38.3%)	382 (41.2%)	189 (20.4%)	

Total Interviewed = 925
 $\chi^2 = 116.10884$
 DF = 4
 Significance = .00000

From the ongoing tables 4.7, 4.8 and 4.9 condoms approval by husbands interviewed is highest with 50.7% followed by withdrawal with 38.3% and least approved is sterilization with only 9.2% approval. This is confirmed by a χ^2 score of 131.48527 (condoms), 116.10884 (withdrawal) and 64.37889 (sterilization). Thus the mostly approved male method of contraception is the condom and the least is sterilization. Thus we accept the hypotheses that husbands are negative towards vasectomy and that condoms are more acceptable male contraception method among Kenyan men. With the AIDS scourge, STD prevalence and frequent unwanted pregnancies, many men have come to be aware approve and known the importance and use of condoms, hence its approval. Condoms are easy to use and have no known health consequences or side effects. Sterilization

ranks last in popularity, after all, most men view it as castration and have problems with its irreversibility. These findings justifies hypothesis (vi) above.

The question on preferred family planning method in the future had the following response.

Table 4.10 Percent Distribution of Husband's Preferred Future Family Planning Method

Method	Frequency	Percent
Pill	42	17.8
IUD	3	3.4
Injections	54	22.9
Diaphragm/Foam/Jelly	2	.8
Condom	15	6.4
Female Sterilization	56	23.7
Male Sterilization	1	.4
Periodic Abstinence	25	10.6
Withdrawal	1	.4
Other	13	5.5
Unsure	19	8.1

From Table 4.10 above the future of female sterilization preference is very high 23.7% showing how men rely on women's contraception as they see family planning as a womans business. Male sterilization (vasectomy) ranks last with only .4% future preference. This is associated with its draw-backs like irreversibility, association with impotence, loss of virility or

physical weakness. These factors limits further the acceptance of vasectomy despite its effectiveness, little cost, and ease due to the fact that it involve nothing to remember. Other popular methods are those women related like injections (22.9%), pill (17.8%) and periodic abstinence 10.6% are quite popular. This is in conformity with WHO, (1980) reports that men preferred a future method that would be "liked by women". However this could be explained by the fact that women have a wider methods to choose from while that of male is very limited.

However, this response is only a behaviour intention and we know a great discrepancy does exist between ideal intention and practice. Often the picture displayed by most men is of a concerned and committed partner in family planning which usually contrasts with the way they act. In most cases they rely on their wives to use birth control. Many women have wryly pointed out, men's hearts may be in the right place, but when dealing with sexual matters, men are often far less mature than women.

4.2.6 KNOWLEDGE, EVER USE AND CURRENTLY USING BY CONTRACEPTIVE METHOD

Table 4.10 Percent Distribution of Husbands Who Know Contraceptive Methods, Who Have Ever Used, Users and Non-Users by Specific Method

Method	Knows Method	Ever Used	Current Users	Non Users
Any Method	94.7	65.0	49.3	50.7
Any Modern Method	93.1	35.1	24.6	75.4
Pill	87.5	16.9	7.8	92.2
IUD	67.4	8.8	5.3	94.7
Injection	79.8	6.3	3.5	96.5
Diaphragm/Foam Jelly	29.2	2.4	0.7	99.3
Condom	81.5	16.7	3.2	96.8
Female Sterilization	83.0	7.1	7.1	93.7
Male Sterilization	35.0	0.3	0.3	99.7
Any Traditional Method	82.6	54.4	29.0	71.0
Periodic Abstinence	76.5	48.1	25.8	74.2
Withdrawal	47.4	15.3	2.5	97.5
Other Methods	18.1	8.2	2.8	97.2

Total Interviewed = 930

Table 4.10 above generally indicate that contraceptive knowledge is high by specific methods with periodic abstinence, 25.8% widely used by husbands. However going by each method non-users have a very high percentage indicating that husbands mostly rely on their wives family planning as indicated by figures above. Periodic abstinence and condoms which needs cooperation by both partners are of higher use than any other method.

The big gap between knowledge and use shows men's reluctance to use family planning methods.

In Kenya like many other African countries women do much of the work of raising the children and as such knows the pinch of close number of children hence their increased family planning concern than men. Male dominance especially in patrilineal societies strongly and positively influences their hierarchial behaviour and as such fertility and other decisions are made the way they want especially considering their pride and high value for large families. After all men have very few contraceptive alternatives and non available is reversible like for their female counterparts. Since the burden of child bearing and rearing is more on women than men, the women contraceptive decisions came early enough to warrant its free and often participation while the debate for male contraception has been rare and shy. However, the higher current use of periodic abstinence and condoms is an indication that men given the correct IEC and need to family plan are willing to co-operate and use any available method as they dominate fertility decision making in Africa (Ntonzi J.P.M., 1993).

C. ENVIRONMENTAL OR REGIONAL FACTORS

4.2.7 FERTILITY PREFERENCE BY PROVINCE AND ETHNICITY

Table 4.11 Respondent's Fertility Preference by Province

Province	Fertility Preference					Row Totals
	Wants within 2 years	Wants After 2 years	Wants but Unsure	Undecided	Wants no More	
Western	16.6	21.7	8.5	27.5	25.6	127 (13.6%)
Rift Valley	14.0	26.5	6.0	6.2	47.3	192 (20.66%)
Nyanza	12.3	35.1	3.0	4.8	44.8	165 (17.76%)
Central	5.0	15.3	2.4	3.4	74.0	141 (15.17%)
Coast	22.4	20.9	21.2	12.7	22.8	68 (7.31%)
Eastern	8.7	17.9	5.9	7.2	60.3	231 (24.86%)
Nairobi	-	28.6	-	-	71.4	5 (0.57%)

Total Interviewed = 929

In Table 4.11, those husbands who want no more children come in high percentage in Central Province 74.0%, Nairobi 71.4% and Eastern 60.3%. The least of those who want no more children are found in Coast 22.8% and Western 25.6% Provinces. These findings are in accordance to hypotheses that economic pressure and degradation of cultural attachments leads to increased husband's

desire for smaller family size in Nairobi and neighbouring Provinces of Central, Eastern and Rift Valley. Thus we accept this hypothesis. In Provinces of high child mortality like Coast and Western, we find the lowest percentage of husbands who want no more children 22.8% and 25.6% respectively. A province like Coast comes out as the one with highest percentage of husbands wanting a child within 2 years (22.4%) in the shortest time possible meaning there is a high need for child replacement due to high mortality. This confirms the hypothesis that the higher the child mortality, the higher the fertility preference of 77.2% in Coast and 74.4% in Western Provinces.

Fertility preference of respondents by ethnicity is similar to fertility preference by Provinces. This is due to the fact that Kenyan Provinces are significantly divided on ethnic lines and as such the outcome of provincial comparative analysis is a result of ethnic groups in these Provinces.

4.2.8 FERTILITY PREFERENCE BY AGE PER PROVINCE

Table 4.12.1 Percent Distribution of Husbands Fertility Preference by Age

4.12.1 COAST PROVINCE

Age	Fertility Preference				
	Wants within 2 years	After 2 Years	Wants Unsure	Undecided	Wants no More
15-19	-	-	4.5	-	-
25-29	2.3	-	4.5	4.1	-
30-34	23.6	5.0	7.3	7.5	10.6
35-39	4.3	38.8	4.9	37.2	14.8
40-44	4.7	41.7	-	4.1	21.6
45-49	2.3	12.0	26.8	11.6	6.5
50-59	30.0	2.5	2.5	23.2	40.0
60+	32.7	-	49.5	12.3	6.5
Column Totals	15 (22.4%)	14 (20.9%)	14 (21.2%)	9 (12.7%)	15 (22.8%)

Total Respondents Interviewed = 68
 $\chi^2 = 49.58232$
 DF = 28
 Significance = .00000

4.12.2 EASTERN PROVINCE

Age	Fertility Preference				
	Wants within 2 Years	After 2 Years	Wants Unsure	Undecided	Wants no More
20-24	-	2.9	-	-	-
25-29	11.1	42.9	17.3	-	5.0
30-34	38.6	9.4	8.7	6.3	9.5
35-39	38.6	18.7	8.7	14.4	16.4
40-44	11.8	26.1	8.7	13.5	17.0
45-49	-	-	24.9	24.9	16.0
50-59	-	-	23.1	23.1	28.2
60+	-	-	8.7	8.7	7.8
Column Totals	20 (8.7%)	42 (17.9%)	14 (5.9%)	14 (5.9%)	140 (60.3%)

Total Interviewed = 233
 DF = 28
 $\chi^2 = 108.03269$
 Significance = .00000

4.12.3 NYANZA PROVINCE

Age	Fertility Preference				
	Wants within 2 Years	After 2 Years	Wants Unsure	Undecided	Wants no More
20-24	4.6	2.9	13.0	-	-
25-29	3.2	25.9	-	8.1	2.4
30-34	15.4	17.8	-	-	7.9
35-39	21.4	14.9	18.2	40.2	8.3
40-44	14.1	26.8	-	40.2	11.8
45-49	15.8	4.8	-	11.4	21.8
50-59	17.7	4.8	68.8	-	32.7
60+	7.8	2.7	-	-	15.1
Column Totals	20 (12.3%)	58 (35.1%)	5 (3.0%)	8 (4.8%)	74 (44.8%)

Total Interviewed = 165
 DF = 28
 $\chi^2 = 77.17081$
 Significance = .00000

4.12.4 WESTERN PROVINCE

Age	Fertility Preference				
	Wants within 2 Years	After 2 Years	Wants Unsure	Undecided	Wants no More
20-24	-	4.5	-	-	-
25-29	25.4	9.9	17.4	5.0	9.2
30-34	22.1	37.1	-	19.5	7.7
35-39	19.5	10.8	32.1	20.7	15.4
40-44	11.8	5.4	4.6	12.0	9.2
45-49	-	3.6	34.5	12.4	9.7
50-59	10.6	26.9	-	21.2	26.1
60+	7.8	1.8	11.5	9.2	22.8
Column Totals	21 (16.6%)	28 (21.7%)	11 (8.5%)	35 (27.5%)	33 (25.6%)

Total Interviewed = 127

DF = 28

 $\chi^2 = 43.20770$

Significance = 0.3323

4.12.5 RIFT VALLEY PROVINCE

Age	Fertility Preference				
	Wants within 2 Years	After 2 Years	Wants Unsure	Undecided	Wants no More
20-24	26.4	-	34.1	6.3	-
25-29	11.0	7.7	12.9	12.6	1.5
30-34	23.3	34.2	-	13.0	8.1
35-39	13.4	24.4	34.6	15.6	15.5
40-44	5.5	7.0	18.5	19.3	18.2
45-49	-	6.3	-	-	23.2
50-59	17.6	14.1	-	33.3	19.2
60+	2.8	6.3	-	-	14.2
Column Totals	27 (14.0%)	51 (26.5%)	12. (6.0%)	12 (6.2%)	91 (47.3%)

Total Interviewed = 192
 DF = 28
 $\chi^2 = 98.82177$
 Significance = 0.00000

4.12.6 CENTRAL PROVINCE

Age	Fertility Preference				
	Wants within 2 Years	After 2 Years	Wants Unsure	Undecided	Wants no More
20-24	-	7.1	-	-	-
25-29	10.9	31.8	10.3	-	6.5
30-34	16.1	32.0	-	15.6	11.7
35-39	9.2	15.2	-	15.9	20.7
40-44	15.9	12.3	44.6	36.8	22.5
45-49	27.0	1.7	22.3	15.9	15.7
50-59	15.9	-	-	15.9	15.7
60+	5.2	-	22.3	-	7.1
Column Totals	7 (5.0%)	22 (15.3%)	3 (2.4%)	5 (3.4%)	105 (74%)

4.12.7 NAIROBI PROVINCE

Age	Fertility Preference				
	Wants within 2 Years	After 2 Years	Wants Unsure	Undecided	Wants no More
40-44	-	-	-	-	60
45-49	-	-	-	-	20
50-59	-	100	-	-	20
60+	-	-	-	-	-
Column Totals	7 (5.0%)	22 (15.3%)	3 (2.4%)	5 (3.4%)	105 (74%)

Total Interviewed = 5
 DF = 28
 $\chi^2 = 2.40684$
 Significance = .30017

From the ongoing Tables 4.12.1 to 4.12.7 the responses from

majority of provinces is that at middle ages 30-49 years some husbands want more children while at younger ages below 29 years almost all husbands want more children while at higher ages of above 50 years majority of the husbands want no more. In Eastern, Central, Nyanza, Western and Rift Valley provinces the higher the ages above 45 years the lower the fertility preference and these provinces have a lot in common as far as fertility preferences are concerned. However, Coast and Nairobi Provinces shows a different pattern. A bigger group of husbands 60+ years in Coast Province wants a child within 2 years 32.7% while only 6.5% of the same age wants no more. This is a very high fertility preference by Coast husbands of 60+ years. In the same Province 49.5% and 12.3% are unsure and undecided respectively at ages above 60 years. This indicates how strong a desire for more children Coast Province husbands have.

In Nairobi Province, the fertility preference pattern takes a different pattern as all respondents are sure whether they want after 2 years or wants no more children. This means that fertility decisions are clear with Nairobi husbands as majority 60% by age 44 years do not want any more children. However, the information from Nairobi Province might not be representative enough as only 5 respondents were interviewed. The table also shows Coast people to have a higher fertility preference while Nairobi have low due to high mortality and higher economic pressure in the Provinces respectively.

A substantial group of husbands over 60 years wanting more children in most of ethnic provinces is an indication that at old age men realizes the value of children i.e. economic importance (benefits) old age insurance, to continue family line and psychological satisfaction. By definition the value of children is "A hypothetical net worth of children, with positive values (satisfactions) balanced against negative values (costs). (Arnold et al. 1975).

These regional differences reflect mainly different biological capacities to reproduce such as differential morbidity and nutritional status which have an impact on fecundity. Some provinces e.g. Coast, Western, Nyanza are prone to child morbidity leading to high child mortality.

Norms exist in all societies to control fertility as well as sexual behaviour. No society uses the fecundity or capacity to reproduce to the fullest. Restrictions laid on fertility varies amongst Kenyan ethnic groups and have variations which consequently brings about fertility preference differentials. The highest fertility (shown by high population density regions) is found among ^{Nyanza, Western and} Central parts of Eastern provinces, Nairobi and Coast Provinces shows low fertility ^{due to} changing economy in all Kenyan communities consequently causing a transition in fertility patterns and levels at present.

D SOCIO-CULTURAL FACTORS

I) TYPE OF MARRIAGE (MONOGAMY/POLYGAMY)

Table 4.13 Number of Times Married by Knowledge of Any Method
Marriage Contraception Knowledge

	Know No Method	Knows Traditional	Knows Modern	Totals
Once	3.5	1.3	95.2	9.8 (82.5%)
More than Once	13.3	3.4	83.4	198 (17.5%)

Total Interviewed = 1116
 $\chi^2 = 38.90401$
 DF = 2
 Significance = .00000

Cultural practices are known to significantly affect fertility levels in Africa. Marriage type i.e. monogamy/polygamy directly influences the number of children born per husband. However, the more the wives a husband has in polygamous union the higher the number of his children but the lower the TFR per wife. Monogamy has been said to raise TFR per woman slightly above polygamy (Ocholla Ayayo, A.B.C. 1991). From above Table 4.13 it is apparent that the more the wives the lower the husbands knowledge on family planning especially modern methods 83.4% as compared to 95.2% by monogamous husbands. A bigger group of 13.3% in polygamous union than 3.5% in monogamous union indicated that they do not know of a method. A polygamous husbands might not need to family plan strictly as he is with one wife per time while others are

abstaining from sexual activities and thus lowering their conception chances. In monogamous marriages husbands are aware that coital frequency is high and with time have had a higher knowledge of both traditional methods of 1.3% and modern methods 95.2% than their polygamous counterparts with 3.4 and 83.4 respectively. Polygamous husbands rely more on traditional methods of sexual abstinence and cultural taboos i.e. tridem and siphon sleeping arrangements practised by Karungu and Kandem clans of Luo communities of Nyanza Province in Kenya. (Ocholla-Ayayo, 1991).

The Chi-square test of 38.90407 and significance of .00000 further proves that knowledge of family planning method decreases with increase in number of wives per husband, thus showing a strong relationship.

These findings that the higher the number of wives per husband the higher his fertility are in conformity with or supported by research in Kenya among the Kipsigis (Mulder, 1989) and in Senegal (Garenne and Van de Walle, 1989) where polygamous societies have lower fertility than monogamous ones. It is evident that while men with high polygamous index may have higher fertility in terms of total number of children, women married to these men tend to have lower fertility than women in union with monogamous men. Male fertility is however, higher in Provinces of relatively high prevalence of polygamy.

II. NUMBER OF CURRENT WIVES BY NUMBER OF OWN CHILDREN

Table 4.14 Percent Distribution of Number of Current Wives by Own Sons

Wives	Own Sons						Row Totals
	0	1	2	3	4	5+	
1	8.7	11.9	27.0	19.1	16.2	17.1	174 (46.1%)
2	5.7	6.5	14.9	12.0	11.1	49.8	152 (40.3%)
3	2.7	10.4	12.7	9.5	10.5	54.3	31 (8.0%)
4	-	8.8	-	-	4.5	86.6	14 (3.8%)
5+	-	-	-	-	-	100	7 (1.8%)

Total Interviewed = 378
 $\chi^2 = 82.44008$
 Significance = .00000

Table 4.15 Percent Distribution of Number of Current Wives by Own Daughters

Wives	Own Daughters						Row Totals
	0	1	2	3	4	5+	
1	10.0	18.8	17.5	19.7	12.8	21.2	174 (46.1%)
2	1.3	11.5	6.4	9.0	15.9	55.9	152 (40.3%)
3	-	2.7	1.2	9.2	1.2	82.8	30 (8.0%)
4	-	8.8	-	-	4.5	86.6	14 (3.8%)
5+	-	-	-	-	-	100	8 (2.1%)

Total Interviewed = 378
 $\chi^2 = 121.86836$
 Significance = .00000

Tables 4.14 and 4.15 once again shows that the number of daughters per husband with 1 or more wives is higher than those of sons. For example, the distribution of husbands with 5 daughters

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4	-	8.8	-	-	4.5	86.6	14 (3.8%)
5+	-	-	-	-	-	100	7 (1.8%)

Total Interviewed = 378
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Wives	Own Daughters						Row Totals
	0	1	2	3	4	5+	
1	10.0	18.8	17.5	19.7	12.8	21.2	174 (46.1%)
2	1.3	11.5	6.4	9.0	15.9	55.9	152 (40.3%)
3	-	2.7	1.2	9.2	1.2	82.8	30 (8.0%)
4	-	8.8	-	-	4.5	86.6	14 (3.8%)
5+	-	-	-	-	-	100	8 (2.1%)

Total Interviewed = 378
 $\chi^2 = 121.86836$
 Significance = .00000

Tables 4.14 and 4.15 once again shows that the number of daughters per husband with 1 or more wives is higher than those of sons. For example, the distribution of husbands with 5 daughters

and more but 1 wife was 21.2% as compared with 17.1 for sons. Those husbands with 3 wives and 5 daughters or more had 82.8% distribution as compared with 54.3% for those with same number of sons. Since those with more sons and daughters had higher number of living children, it appears that husbands with many children end up having more daughters. The higher χ^2 test of 121.86836 for daughters and 82.44008 for sons further confirms this. The significance of .00000 also confirms hypothesis that the more the number of wives the higher the number of living children.

The question on how often husbands talked with wife about family planning matters had the following response:

Table 4.16 Percent Distribution Of Husband's Discussions With Their Wives on Family Planning Matters

Discussions	Frequency	Percentage
Never	326	36.9
Once or Twice	113	12.8
Three or More	444	50.3
	Total Respondents	883

From the above Table 4.10 it is apparent that husbands do discuss with their spouses on matters concerning family planning with 50.3% high response. Those who have never discussed with their wives make a substantial percentage of 37% a group which should not be ignored. Because little has been done to inform men about family planning, most of what they know about the subject comes from their wives, girlfriends and relatives. Such debates are mostly initiated by their wives as per assumption regarding

traditional and modernizing societies that men have little good to say about family planning. This assumption is most strongly felt about men in Africa where patriarchy and male chauvinism have a long history and families have traditionally been very large (Greene P., 1992). The reproductive behaviour of African men favours large families in the face of high mortality and large scale illiteracy (Molinos Angela, 1993). This low discussion is blamed on disapproval and fear among spouses, its interference with religious conviction, it being against nature and dis-stabilizing families (Kekovole J., 1991).

However, according to the government policy to let the decision of family size rest with the individual couple, the communication between husbands and wives play an important role. Such free communication is dictated by the couples social, cultural and economic backgrounds. The more a husband discusses with the wife on family planning matters, the wider the knowledge on family planning methods. This justifies hypotheses xvii and viii above.

III. RELIGIOUS INFLUENCE

Table 4.17.1 Frequency Distribution of Ever Use of Any Method By Religion

Religion	Ever Use of Any Method			Row Totals
	Never Used	Used Traditional	Used Modern	
Catholic	130	110	141	381
Protestants	202	156	240	598
Muslim	17	11	16	44
Others	4	6	8	18
No Religion	43	0	1	44
Column Totals	396	283	406	1085

Total Interviewed = 1085
 $\chi^2 = 44.61890$
 DF = 10
 Significance = .00000

Table 4.17.2 Frequency Distribution of Knowledge of Any Method by Religion

Religion	Ever Use of Any Method			Row Totals
	Never Used	Used Traditional	Used Modern	
Catholic	15	2	370	387
Protestants	23	9	576	600
Muslim	2	1	41	44
Others	1	1	16	18
No Religion	6	2	51	59
Column Totals	47	15	1053	1116

Total Interviewed = 1116
 $\chi^2 = 12.89261$
 DF = 10
 Significance = .00023

Table 4.17.3 Frequency Distribution of Husbands Who Are Currently Using A Method by Religion

Religion	Currently Using		Row Totals
	Traditional Method	Modern Method	
Catholic	191 (73.7%)	68 (26.3%)	259 (35.5%)
Protestant	309 (75.0%)	103 (25.0%)	412 (56.5%)
Muslim	19 (70.4%)	8 (29.6%)	27 (3.7%)
Others	12 (85.7%)	2 (14.3%)	14 (1.9%)
No Religion	8 (50%)	8 (50%)	16 (2.4%)
Column Totals	540 (74.1%)	189 (25.9%)	729

Total Interviewed = 729
 $\chi^2 = 6.55770$
 DF = 5
 Significance = .00256

From the ongoing Tables 4.17.1 to 4.17.3 religious affiliation is seen to influence family planning method ever use, knowledge of, and current users especially so for Catholic and Protestant faithful. Throughout the above responses protestants seem to have a higher ever use, knowledge of, and current users than the Catholics. Taking information on currently using only 259 Catholic respondents were currently using a method, 191 and 68 of whom were using traditional and modern methods respectively. The case for Protestant was out of 412 Protestant respondents 309 (75.0) were using traditional methods with 103 (25.0%) Protestants are aware and uses modern family planning methods than do Catholics. With Catholicism, modern methods are highly disapproved and strongly

approves of traditional methods especially natural family planning. This satisfies objective 8 above and confirms true hypotheses xviii to xxi. It also indicates that traditional methods are quite popular with husbands than modern methods. This could be due to the fact that traditional methods are of easy access, costs little, less disapproved and with little or no health implications unlike modern methods.

As contraception is directly related to family size and that children form an important base for religious and moral values in most Kenyan communities, we find that the more zealous one is about religious commitment, the less the concern about family planning.

However, it is difficult to measure use and knowledge towards family planning methods as other influences like education, place of residence, occupation come into play in determining these attitudes and practices.

E. SOCIO-ECONOMIC FACTORS

I. PLACE OF RESIDENCE

4.18.1 Percentage of Husbands Currently Using Any and Modern Method by Place of Residence

Residence	Method		
	Any Method	Modern Method	Frequency
Urban	55.7	39.8	141
Rural	48.3	22.1	974

Total Interviewed 1115

II. LEVEL OF EDUCATION

4.18.2 Usage of Husband's Current Using Any and Modern Method by Level of Education

Level of Education	Method		Frequency
	Any Method	Modern Method	
No Education	38.1	16.7	186
Prim. Incomplete	44.8	18.4	367
Prim. Complete	47.6	18.3	260
Secondary & Higher	63.2	42.2	303

Total Interviewed = 1116

From the above Table 4.18.1 it is evident that rural-urban differentials do exist. The place of residence influences the contraceptive use in that more of urban husbands 55.7% uses more of family planning methods than their rural 48.3% counter parts. Modern methods are used more 39.8% in urban than in rural 22.1% residence. This satisfies objective 10 and proves correct hypothesis xxiii above. These findings further confirms NCPD (1989) findings that urban husbands contracepts more than rural ones.

These husband fertility differentials seem to reflect the same traits everywhere. i.e that the costs of children in urban families are increasing rapidly. This indicates that there is higher rate of voluntary family planning by majority of urban husbands which consequently lowers their (urban) fertility.

The information obtained from Table 4.18.2 is that the higher the educational level, the higher the husbands fertility control. 38.1% of those with no education ^{uses a} method while 16.7% and 42.2% using modern method respectively. These results satisfies objective 9 and proves right hypothesis xxiv. Similar findings were obtained by NCPD 1989 and again 1993 KDHS preliminary report. Current use is thus seen to increase with increase ⁱⁿ educational attainment. Husbands level of education is an important factor for promoting contraceptive use and thus reducing husbands fertility levels.

4.18.3 SUMMARY OF FINDINGS

The objective of this study as indicated by the model developed earlier is to examine some factors that affect or influence contraceptive acceptance and its consequent use which finally affect the total number of children per husband. These factors were traced back to be of socio-economical, socio-cultural and demographic settings which proves very important to husbands family planning perception and acceptance. They also play a role on the decision to adopt or not adopt fertility regulating methods.

In summary, the following points attempt to present together the results of the cross-tabulations cited in Chapter 4 above.

— Demographic factors with age being one of them shows that the higher the husbands ages, the higher the fertility level in Africa as evidenced by Kenya Demographic Health Survey (KDHS 1989) data

information. This help achieve objective 1 and hypotheses i and ii the study had hypothesized that age has a negative effect on contraception and a positive effect on total number of children per husband. This can be explained by the high value of children and pro-natalist cultural attitudes practiced by African men. In addition, the lack of use of effective modern contraception means that an important fertility reducing mechanism is missed plus above rigid pronatalist cultures all results in persistently high fertility levels of Kenyan husbands. Husbands interviewed reveals a high level of knowledge for both modern and traditional family planning methods. Although widespread use of traditional family planning methods was noted, the future intended use of modern method showed a high acceptance score or approval. This coincides with FPAK findings in the Kilifi District study where older men advised young husbands to be more concerned and educated on family planning issues early enough and that old traditional methods although costing little and posing no health problem could no longer be practical now as the way of life has completely changed. After all the traditional methods have failed them many times due to improper application. Evidently, a big discrepancy between approval, intention and practice does exist. Respondents interviewed highly approve female sterilization followed by the pill. Male family planning methods have a very low use despite high future approval.

— As concerns environmental or regional factors we find desire for a smaller family size in Nairobi where economic pressure has

been realized and to a smaller extent in Central, Eastern and Rift Valley neighbouring Provinces. On the other hand those Provinces of Coast, Nyanza and Western shows a higher fertility preference of those husbands who wants more children of 77.2% in Western, 84.9 in Nyanza and 93.5 in Coast due to high child mortality in these Provinces and rigid observation of traditional customs. This achieves objective 5 and it is in accordance to hypotheses 10 to 12 above.

— Ethnicity influences highly coincides with regional factor effects as Kenyan Provinces are predominantly divided on ethnic lines. Luhya of Western Province have a slightly higher percentage of husbands who want no more children (23%). This could be due to the fact that the Province's population density is high and the size is small. This leads to high demand for land and as the husbands respondents do not have enough land to give to more children (economic pressure realization) hence the slight decrease in fertility preference.

— Marriage type as a cultural obligation has so many taboos and customs associated to it that dictates the sexual and reproductive behaviour of couples in Africa. Traditional practices are higher among older men than among younger ones as shown in tables 4.12.1 to 4.12.6 where older men of over 60 years want more children. It is noticed from the data that the more the number of wives the higher the total fertility rate per husband as all husbands with more than 4 wives (100%) have more than 5 sons and 5 daughters and none had less. This proves correct the hypotheses that the more a

husband is loyal to cultural ties the higher the fertility rates.

— There exists another fertility differential on religious grounds. As response above show, tables 4.17.1 to 4.17.3. Protestants appears to have a higher ever use, knowledge of, and currently using a method. Catholics have a lower response and shows to use more of traditional than modern methods. This proves further the hypotheses that more Protestant than Catholic husbands use traditional and modern methods. This achieves objective 8 and satisfies hypotheses 18 to 19 above.

CHAPTER 5

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

Since it takes two to produce a fertility outcome, it should be a joint effort to family plan successfully. Hence the reasons why some men rely on their wives' family planning methods to regulate their fertility. Women who discuss family planning matters with their husbands form a bulk of contraceptive users as other research have found out. Most women adapt family planning as long as they have discussed with their husbands, who first have to approve of it. Generally most husbands do not practice contraception but participate only by encouraging and influencing their wives to do it. One reason for this fatalistic attitude is that family planning services in Kenya have been directed to women and children especially MCH/FP. High intention of future family planning application is a reflection of politeness on the part of the husbands rather than a serious promise. It seems easy for men to say and intend to do something but practically it becomes difficult to do it and yet they do not surrender.

Periodic abstinence which needs a lot of cooperation by both partners is highly used followed by the pill (reverse of KDHS, NCPD findings) and then female sterilization. Similar findings were made by Keraka, M. (1991). Condoms approval as a future intended method is high mostly due to the fact that relying on condoms could help curb the spread of STDs and AIDs unlike any other method. Male sterilization current use and approval are minimal. This

further proves Kenyan men to be highly pronatalist as they have a strong desire to fathering more children in the future hence cannot accept vasectomy. This fulfils the objective that husbands uses contraceptive less but relies and encourages their wives to use it. The future of female sterilization and injections is of wider choice by most husbands implying that husbands discuss with their wives and come to know which methods their wives prefer most. This satisfies operational hypothesis (vii) thus achieving objectives 3 and 7 above. This is only a behaviour intention and in most cases they rely on their wives to practice birth control. This needs a lot of further research to establish why husbands find it difficult to practice family planning yet they are in favour of it.

The discrepancies that exists between husbands responses of high family planning knowledge, high acceptance, minimal contraceptive use and large family sizes is quite contradictory. These findings help achieve objective 4 above. There is no simple explanation of men's seemingly contradictory views on family planning. Their attitudes when surveyed suggest they understand the burdens of large families and advantages of smaller ones. But their actions like desire for many children and reluctance to use contraceptives suggest that their feelings often rule their reasons or are a product of forces beyond their control. Yet the very passion of their wives and family responsibilities suggest that men are concerned about family planning decisions that affect their lives and their posterity.

Although husbands from all regions of the country expresses inclinations to plan their families and economically need fewer number of children they seem bound by barriers of cultural significance in keeping with traditional practices which finally result in many children. For example naming systems, preference for boys, prevalence of polygamous marriages continuity of family lineage etc. which means more to the predominantly patrilineal Kenyan communities. This is in accordance to hypothesis (xxii) above.

Socio-cultural factors like polygamous marriage lowers contraceptive use and increases the number of children per husband. Marriage is one of the most respected institutions by majority of Kenyan communities. Children were found to form an important base for marriage. religious and moral values in most Kenyan societies and the more zealous one is about religious commitment especially Catholics and Muslims the less the concern about family planning method. This help achieve objective 6 and 8 and satisfies hypotheses xiv to xxi above.

The bigger fertility preference discrepancy between Nairobi and Coast Provinces is due to economic pressure felt by husbands in terms of bringing up the children and high mortality driving forces in the two provinces respectively.

The assumption that men have little good to say about family planning is strongly felt about in Kenya where patriarchy and male chauvinism have a long history and traditionally families have been very large. Place of residence does not affect contraceptive

acceptance as most of urban people have moved to towns with their cultural values and traditional practices of many children.

However, it should be noted that none of these determining factors discussed above works in isolation from the rest. All of them contribute to low contraceptive acceptance and consequent high fertility for Kenyan husbands. For example, an individual considers wanting no more children when one has given the allowance for mortality, place of residence is influenced by education, cultural influences, religious beliefs etc. In a nutshell, all these factors of contraceptive acceptance and consequent number of children per husband are important but the degree of their importance varies.

5.2 RECOMMENDATIONS

The results yielded by this research project helps spell out or offer some recommendations aimed at improving and enhancing male contraceptive acceptance and help to lower their family sizes in the future.

The attitudes towards family planning held by men in many parts of developing world are often attributed to cultural or religious traditions different from those in developed world. It is true that many of these societies are pronatalist, women do not have equal status with men and males are often not held accountable for their acts. Yet no major cultural or religious traditions be it Catholicism in Latin America, Islam in the middle East, or tribal cultures in Africa encourages men to be irresponsible, to have more

children than they, their wives and their communities can support. For without male involvement, the gap between the desired family size of many women and the actual size will continue to be wide. Thus women will continue to bear unwanted children and to seek contraceptive help in secret if lack of co-operation and help from their husbands continues.

1. One of the most important findings from the research project is the fact that men in particular lack appropriate information about family planning and advantages of a smaller family. Information, Education and Communication (IEC) is very important. In absence of family planning information, husbands and their wives will be susceptible to rumours about the perceived dangers of contraceptives disseminated by their friends, neighbours and relatives etc. To change husbands attitudes to family planning, there should be an increase in the availability of male methods so that their acceptance can go up with a variety to choose from. The educational programme should stress the need for males to have positive attitudes towards family planning. They should also be involved as participants in education programmes and policy makers should focus on younger men of below 30 years regarding family planning because their attitudes are less rigid. The society should be sensitized to appreciate the benefits accruing from family planning.
2. Population education should be enhanced to reach out of school

men and emphasis put on the health benefits of birth spacing. Educational materials e.g. posters, leaflets and pamphlets used in motivational campaigns should be simple and culturally relevant. This recommendation arises from the fact that majority of husbands are rural and of low level of education, who are highly attached to traditional values.

3. The family planning information should reach the appropriate target groups such as the rural folk, less educated and young couples so that they can be reliably informed and regulate their fertility early enough.
4. Husbands should be encouraged to discuss family matters often with their wives so that they can interchange ideas and make more beneficial and practically non strenuous decisions. This will improve cooperation and spousal support.
5. Most important, the cultural background of ethnic groupings should be put into consideration when designing policies not to meet with a lot of opposition during their (policies) implementation. For example, given the prevalence of polygamy in Coast, Western and Nyanza Provinces of Kenya, the type of counselling and choice of what method men should use should be dictated by the overall happiness and satisfaction of couples involved. It might be challenging to recommend vasectomy to a polygamous man whose youngest wife has aspirations to complete her desired family size. Thus family planners need to know the local traditions and culture to effectively involve in family planning.

6. Seminars and conferences should be held for community leaders to train them on how to convince their colleagues in the villages and towns. Daddies clubs should be encouraged and future strategies to reach husbands even at their offices, churches, factories to win more converts.
7. Roman, Catholic couples should be reached with the appropriate facts through dissemination of information on natural family planning method by the national secretariat.
8. CBD should maintain a good interpersonal relations with male clients who needs good clinic setting, proper and convincing attention in the clinics i.e. these family planning clinics should start being male biased to encourage and sustain a substantial male patient flow.
9. With the high husband approval of family planning, it is evident that some men will seek help and advice if this is provided in the right setting. In the family planning clinics men should be provided with proper services that meet their needs, including those for sexual counselling and reproductive health care. Clinicians should not work on the assumption that men are hostile to family planning which could create the greatest problem of all.
10. Pertinent information should be directed to men. Focus groups and other qualitative techniques can be utilized to help understand the issues than concern men and the findings can then be incorporated into educational campaigns and

counselling programmes designed specifically for men. Such programmes may do best by targeting its messages to potential acceptors and letting the changing social climate alter unfavourable opinions over time.

11. Public health intervention should be integrated into societal transformation to convince male participants of the importance of improved family planning and child health to enhance the perception of changes in child mortality. This will considerably stimulate the emergence of positive attitude for survival of children and couples will be less worried about child mortality and thus trust that with few, they will survive to adulthood without having excess children.
12. The obvious discrepancy existing between husbands' contraceptive knowledge and practice and their resultant high fertility should be recognised by planners and policy makers as a problem of ignoring the views of men in a society where most of the important family decisions are still made by the man. The time is right for this ignorance to be seriously addressed and remedial measures undertaken.
13. Family Planning IEC to tirelessly convey and convince Kenyan husbands of their duty and responsibility towards the welfare of their families hence reaffirms the necessity to regulate the fertility.
14. On the other hand, further research should be done to seek ways and means of reducing the economic need and motivation for having many children. Such approaches would include

better IEC services and improved family planning services with male inclinations. Further research should be done to find out the reasons for differentials that exists between knowledge, approval of contraception and its very low current use by husbands reasons for dissatisfaction and non-use of available services and adamant refusal of contraception by men in general.

15. Since male attitudes now seem to be more positive from high approval of family planning than it is supposed to be, family planning programmes should emphasize the advantages to men as well as women, such as easing their economic load and contributing to a healthier family.
16. Policies that ensure fully acceptable effective means of fertility control should be professionally planned, carefully targeted, and followed through with personal counselling to meet with individual fears and uncertainties. Such an action will no doubt increase the effectiveness of a national programme and the practice of fertility regulation might even achieve the status of being considered routine.

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