

**FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY  
PLANNING DECISIONS IN KENYA: A CASE OF NAIROBI  
PROVINCE, KENYA**

**BY**

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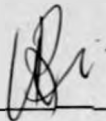
**A RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL  
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## DECLARATION

This research Project Report is my original work and has not been submitted for a degree in any other University.

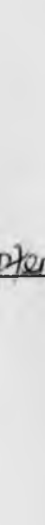
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# DEDICATION

**This research project report is dedicated to my daughter Sydney and to my niece Maureen.**

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I wish to acknowledge and appreciate all those who assisted me in one way or another in the course of this study. This research project would not have been possible without your generous support and contribution that you provided.

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## ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>BDHS</b>	Bangladesh Demographic and Health Survey
<b>FGDs</b>	Focus Group Discussions
<b>FHOK</b>	Family Health Options Kenya
<b>FP</b>	Family Planning
<b>FPAK</b>	Family Planning Association of Kenya
<b>FWC</b>	Family Welfare Center
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICPD</b>	International Conference on Population and Development
<b>IDIs</b>	In-depth Interviews
<b>IUD</b>	Intrauterine Device
<b>KAP</b>	Knowledge, Attitude and Practice
<b>K-MET</b>	Kisumu Medical and Education Trust
<b>MDGs</b>	Millennium Development Goals
<b>NGO</b>	Non-Governmental Organization
<b>PACNET</b>	Post-Abortion Care Network
<b>RH</b>	Reproductive Health
<b>SMP</b>	Social Marketing Project
<b>SRH</b>	Sexual and Reproductive Health
<b>STDs</b>	Sexually Transmitted Diseases
<b>ZPG</b>	Zero Population Growth
<b>UNFPA</b>	United Nations Population Fund

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background to the Study

The concept of male involvement in family planning is broad in nature. According to the Report of the International Conference on Population and Development (ICPD) (1994), it was noted that special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; pre-natal, maternal and child health; prevention of Sexually Transmitted Diseases (STDs); and prevention of unwanted and high-risk pregnancies. Use of male methods is one important aspect of male involvement in family planning.

Evidence from several countries demonstrates that, increasingly, reproductive decisions are being made jointly by couples, not by men alone. In Sri Lanka where women's levels of education and literacy are high, a study among couples currently using contraception reported that more than half of the wives and about two-thirds of the husbands said that decisions about family planning were made jointly (De-Silva, 2000). Also, Japan's patriarchal culture has been changing away from decision-making primarily by husbands and parents towards decisions made jointly by couples (Ogawa and Hodge, 1999). According to Sharan and Valente, 2002, further studies carried out in Nepal concluded that spousal communication does, indeed, predict contraceptive behaviour, even when other factors are controlled. On spousal communication regarding family planning, a study carried out in Bangladesh showed that nearly 40 percent of female respondents reported that the decision to first use a contraceptive method was reached jointly with their husbands, Donahoe, (1996).

Studies carried out in Nigeria and South Africa on male attitudes towards family planning show that while there is strong male approval of family planning as a method of fertility regulation, male practice and spousal communication regarding fertility regulation is poor ( Isiugo-Abanihe, 2000). In Sudan, studies show that even educated

and motivated women may not use contraception due to opposition from husbands (Bankole and Singh, 1998).

Figures from the Kenya's Ministry of Health show that between 1976, the year the family planning campaigns began, and 1995, Kenya's birth rates dropped only slightly. The reason, according to the Family Planning Association of Kenya (FPAK), a non-governmental organization (NGO), was mainly because many men rejected the use of contraceptives. The Government of Kenya's (GoK) policy is to provide access to family planning for every Kenyan who needs and wants it. Beyond this, policy is that every client should have good quality of care, including method choice. Primarily this policy is implemented through public services, but the government is also committed to enabling and strengthening Non Governmental Organizations (NGOs), local authorities, and private and mission sector health care providers. The national programme includes static hospitals and clinics, community-based health workers, and community-based distribution (CBD) agents. According to the Kenya Demographic and Health Survey held in 1989, there are about 35 health planning providers in Nairobi Province. These include tertiary, secondary, primary and private health facilities.

Realization of the need to focus on men had resulted at the 1994 International Conference on Population and Development (ICPD) in Cairo as well as at the 1995 World Conference on Women in Beijing. The Programme of Action endorsed at the Cairo conference calls for the need to recognize men as equal partners with women in all matters relating to reproductive health and family planning. The movement to involve men in reproductive health has many names, including men's participation, men's responsibility, male motivation, male involvement, men as partners and men and reproductive health (Ghosh, 1999). They all broadly refer to a complex process of social and behavioral change that is needed for men to play more responsible roles in reproductive health (Population Reports, 1998). The involvement of men in reproductive health encompasses activities at many levels. It involves planning the number of offsprings with the partner, approving of contraceptive use and using them, taking special care of wives and partners when they are pregnant, seeking skilled health care, taking

care after the baby is born, and being responsible fathers.

According to Magnani et al., 2001, in some developing countries, husbands dominate reproductive decision-making, whether regarding contraceptive use, family size, birth spacing, or extramarital sexual partners. Ijadunola et al, 2009 also noted that the role of men in initiating discussions about contraceptive use was generally poor. It is now generally recognized that the efforts of family planning organizations must focus on couples and not just women. The evolved focus on men's participation in family planning stems from valid concerns. Firstly, as already indicated, women of many cultures seek the approval of their husbands to use contraception and do not use contraception if the husband has not agreed to its use. Even educated and motivated women may not use contraception due to opposition from husbands as a survey in Sudan shows (Bankole and Singh, 1998). Involving men in matters related to reproductive health is an indispensable strategy to contain the incidence and spread of STDs and HIV/AIDS which are evidences of men's risky sexual behavior (Riley, 1997). Involving men actively in reproductive decision- making will also reduce the incidence of unwanted pregnancies.

## **1.2 Statement of the Problem**

A study carried out in western Kenya in 1997 revealed that although men and women have practiced contraception for many years, men have been effectively excluded from participating in many FP programmes. Their views on sexuality, reproductive health, family size, birth spacing and similar topics have rarely been sought in fertility or family planning surveys (Omondi-Odhiambo, 1997). Figures from the Kenya's Ministry of Health show that between 1976, the year the family planning campaigns began, and 1995, Kenya's birth rates dropped only slightly. The reason, according to the Family Planning Association of Kenya (FPAK), a non-governmental organisation (NGO), was mainly because many men rejected the use of contraceptives. According to the 2003 Kenya Demographic Health Survey, unintended pregnancy is a major reproductive health concern in Kenya and nearly half of all pregnancies in the last five years were

unintended. Family Health International reported in 1995 that men are more interested in reproductive health than most people think. A long term effort is therefore still required to investigate factors influencing male involvement in family planning decision making in Kenya. Also, according to the Millennium Development Goals Report (United Nations, 2008), important progress towards all eight goals has been made but we are not on track to fulfill some commitments such as high risk of dying in pregnancy or childbirth and deaths of under five children which remains unacceptably high in sub-Saharan Africa and Southern Asia. According to the report, a collective, long-term effort is therefore still required in order to address these tasks (MDG Report, United Nations, 2008). Managing population growth is also the third strategic imperative in the Second National Health Sector Strategic Plan 2004-2010 (Ministry of Health, 2004). Therefore, there is still a great need to seek ways to increase male participation in family planning decision making in Kenya. The study seeks to determine the factors influencing male participation in family planning decisions in Nairobi Province, Kenya.

### **1.3 Purpose of the Study**

The study sought to establish the factors influencing male involvement in family planning decisions in Nairobi Province, Kenya.

### **1.4 Objectives of the study**

The objectives for this study are given below:

1. To determine the extent to which the level of male awareness of contraceptive methods influence male involvement in family planning decisions in Nairobi Province, Kenya.
2. To determine the extent to which the level of male practice of family planning influence male involvement in family planning decisions in Nairobi Province, Kenya.
3. To determine the extent to which the level of spousal communication influence male involvement in family planning decisions in Nairobi Province, Kenya.

## **1.5 Research Questions**

The study was guided by the following research questions:

1. What is the level of male awareness of contraceptive methods in Nairobi Province, Kenya?
2. What is the level of male practice of family planning in Nairobi Province, Kenya?
3. What is the level of spousal communication in family planning decision making in Nairobi Province, Kenya?

## **1.6 Significance of the study**

The study may help other researchers interested in investigating the factors influencing male involvement in family planning initiatives specifically in Nairobi Province, Kenya and also in other areas.

The study may help family planning healthcare providers in Nairobi Province, Kenya to gain more insight on the status of male involvement in family planning not only in Nairobi Province but in other part of the world.

Researchers interested in carrying out more studies in this topic will also find this study a useful guide to further their studies in reproductive health.

## **1.7 Limitations of Study**

The study included males and females in Nairobi Province aged 15 years and above. The target population was identified using criteria of social status (low, middle and high income groups).

The major limitation of this study was finding willing respondents to take part in the survey. In order to overcome this challenge, the researcher used company employees who are married with the help of an official letter from the University to formally introduce the researcher. The respondents from companies were more willing to take part in the survey.

### **1.8 Delimitation of the Study**

This study focused on Nairobi Province. Nairobi province was selected because of its proximity to the researcher thus the research costs were minimized. Another reason why Nairobi province was found suitable was because of the fact that such studies have been done in Western and Nyanza provinces and therefore it would be important to study an urban setting. The respondents were drawn from different income populations with the comparative analysis being performed vis-à-vis low income versus middle or high income population. This helped to establish whether male involvement in family planning decisions differ across the income brackets.

### **1.9 Assumptions of the Study**

The major assumption of the study was that the sample represented the entire population of interest. Further, the study made an assumption that the respondents would truthfully and correctly answer the questions.

### **1.10 Definitions of Significant Terms**

**Family planning** - means the planning of when to have children, and the use of birth control and other techniques to implement such plans.

**Male** – refers to men of 15 years and above.

**Female** – refers to women of 15 years and above.

**Fertility** - means natural capability of giving life.

**Male awareness of contraceptive methods** – refers to knowledge about the types of family planning methods available.

**Male practice** – refers to the extent of male participation in family planning initiatives such as actual use of the male methods, approving use of family planning

methods and accompanying spouses to family planning clinics.

**Millennium development goals** – refer to eight goals contained in the Millennium Declaration to be achieved by 2015 that respond to the world's main development challenges.

**Spousal communication** – refers to couples holding discussions regarding family planning issues.

**Strategic plan** - refers to the process of defining strategy, direction and making decisions on allocating resources to pursue the strategy.



## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

There are a limited number of studies which have attempted to reveal the various aspects of the broad theme on 'Male participation in family planning'. According to the Kenya Demographic and Health Survey, 1989, the Government of Kenya's (GoK) policy is to provide access to family planning for every Kenyan who needs and wants it. Beyond this, policy is that every client should have good quality of care, including method choice. Primarily this policy is implemented through public services, but the government is also committed to enabling and strengthening NGOs, local authorities, and private and mission sector health care providers. The national programme includes static hospitals and clinics, community-based health workers, and community-based distribution (CBD) agents. Family Health Options Kenya (FHOK) contributes to the improvement of the health of all Kenyans particularly youth through provision of quality sexual and reproductive health information and services and according to the 1998 Kenya Demographic Health Survey (KDHS), 4.5% of the users of modern contraceptive methods received their supplies from FHOK facilities. FHOK pioneered innovative strategies focusing on men as the target group. It set male-only clinics, trained workplace motivators to canvas their colleagues, referee them to the male-only clinic, motivated men to use condoms, and used puppetry in communicating sensitive Sexual and Reproductive Health messages. The project's main message was "Men who care plan and protect their families".

Studies carried out in Nigeria and South Africa on male attitudes towards family planning show that while there is strong male approval of family planning as a method of fertility regulation, male practice and spousal communication regarding fertility regulation is poor. Further studies carried out in Nepal concluded that spousal communication does, indeed, predict contraceptive behaviour, even when other factors are controlled.

This literature review focuses on the findings of some recent studies on the topic.

## **2.2 Male Awareness and Practice of Family Planning**

In many countries, traditional male and female gender roles deter couples from discussing sexual matters, condone risky sexual behavior, and ultimately contribute to poor reproductive health among both men and women (Moser, 2001). Programmes can encourage men to adopt positive gender roles, such as being supportive husbands and caring fathers. Gender roles and gender norms are culturally specific and thus vary tremendously around the world. Almost everywhere, however, men and women differ substantially from each other in power, status and freedom. In virtually all societies, men have more power than women have (Berer, 1996; and Moser, 2001). Gender has a powerful influence on reproductive decision-making and behavior (Blanc et al., 1996).

In many developing countries men are the primary decision-makers about sexual activity, fertility, and contraceptive use. Men are often called "gatekeeper" because of the many powerful roles they play in society-as husbands, fathers, uncles, religious leaders, policy-makers, and local and national leaders (Greene and Biddlecom, 1997). In their different roles men can control access to health information and services, finances, transportation, and other resources (Robey et al., 1998).

According to Hull, 2000; Jolly, 2001; and Magnani et al., 2001, little is known about the dynamics of couples' sexual and reproductive decision-making or about how gender roles affect these decisions. Such decisions can include whether to practice family planning, choosing when and how to have sexual relations, engaging in extramarital sexual relations, using condoms to prevent STDs, breastfeeding, and seeking prenatal care. Gender is just one of many factors that influence couples and affect their reproductive decisions. Education level, family pressures, social expectations, socioeconomic status, exposure to mass media, personal experience, expectations for the future, and religion also shape such decisions (Hull, 2000; and Hollerbach, 2001).

In some developing countries husbands dominate reproductive decision-making, whether regarding contraceptive use, family size, birth spacing, or extramarital sexual partners (Magnani et al., 2001). In Ghana, for example some men in focus group discussions

claimed to make all family decisions. As one man asserted: We control them from the initial stage. When she comes to the house and may be she thinks she is now the lady of the house and does something contrary to your regulations, you warn her. We don't allow our women to have influence on us (Ezeh, 2001).

A study of more than 3,000 urban Nigerian couples found that, while men do not dominate decision-making, they still wield more power than women do. Men and women were asked who decides such matters as family size, when to have sex and how long periods of sexual abstinence should last. Close to 60% of men said that they decide, and 40% to 50% of women agreed that men decide (Isiugo-Abanihe, 2000).

A study of the fertility decisions made by five generations of one South Indian Family also found that the men tended to control contraceptive use and to make fertility decisions. The men in the older generations chose to limit their own fertility by getting vasectomies, usually without telling their wives. The men said that economic pressures were their main motivation to limit the number of children. A survey of all five generations in this family by Karra et al., 1997 revealed that more than half of the men thought the decision-making was mutual, but only 38% of their wives saw it that way.

In many societies, as social, economic and educational opportunities for women increase, traditional gender roles are starting to change. As a result, power is being redistributed between men and women. Evidence from several countries demonstrates that, increasingly, reproductive decisions are being made jointly by couples, not by men alone. In Sri Lanka, where women's levels of education and literacy are high, a study among couples currently using contraception reported that more than half of the wives and about two-thirds of the husbands said that decisions about family planning were made jointly (De-Silva, 2000). Also, Japan's patriarchal culture has been changing away from decision-making primarily by husbands and parents towards decisions made jointly by couples (Ogawa and Hodge, 1999).

Men's low acceptance and near rejection of family planning is due to numerous reasons according to preliminary findings of a joint study by the Kisumu Medical Education Trust (K-MET), a community based organization involved in provision of reproductive health services in western Kenya and Boston University. Research conducted between December 2008 and January 2009 in Rift Valley, Nyanza and Western provinces found that most men were reluctant to visit reproductive health clinics for advice on family planning because they viewed the facilities as 'women's places', and did not want to mix with women for fear of being seen to be henpecked or considered effeminate. The overriding factors are widespread myths and misconceptions about family planning for women and men. A majority of the male respondents indicated that family planning made a woman cold in bed, while many others elicited fears that vasectomy would render them unable to have sex. They held that this would harm their standing in society, as well as cause their spouses to look for other partners.

Traditional reproductive health programmes almost exclusively focused on women. The popular view about men's participation and involvement in family planning for example has been that men know little about contraception and do not want their partners to use it. As a Kenyan nongovernmental organization, K-MET has been implementing community based reproductive health programmes for over 13 years in five provinces of Kenya. One of K-MET's objectives is to enhance the involvement of up to 400 male partners in sexual and reproductive health (SRH) services by 2010 in western Kenya.

Onyango, Owoko and Oguttu (2009) did a study on strategies for male involvement in reproductive health in Western Kenya. The objectives were to establish the influences of male involvement in reproductive health services in Western Kenya; to investigate the best strategies to involve male partners in reproductive health services; and to identify an appropriate service delivery model that incorporates current evidence, views of men, women and health providers in Western Kenya. A total of 12 in-depth interviews and eight FGDs were conducted. The study revealed that there was varied understanding of reproductive health (RH) by participants. Majority of participants could not provide a comprehensive description of RH. Most answers were related to contraception, family

planning and maternal health. Also, the sources which influenced their understanding of RH were the traditional ones like the health care system, educational and work institutions and with the family and/or community. A large majority of study participants were of the opinion that men should be involved in sexual and reproductive health programmes; sexual and reproductive health (SRH) in western Kenya. Two main patterns emerged from the various factors which participants thought influence male involvement in SRH: 1) gender norms; and 2) the traditional approaches used to implement RH and family planning programmes. Among the gender norms are cultural practices manifested by men which influence male involvement and impact women's reproductive health negatively. These include polygamy, extra marital sex, preference of children of a certain sex and the general male indifference to SRH issues. Furthermore, in western Kenya men being heads of households are not expected culturally to discuss SRH matters with their wives and female children. This role is for the mothers. Men are not under any obligation to practice family planning or worry about limiting the number of children. It is the woman's responsibility to decide when to stop giving birth. Men in western Kenya are also not enthusiastic to accompany their wives to the clinics. If they do, this is perceived by their peers as a demonstration of weakness. Remarks from peers like - this man drops the wife to the clinic- are viewed as insulting and keep men from SRH programmes. Women are therefore under a lot of pressure to fulfill their reproductive functions alone most of the time. Nevertheless, if the clinics can be able to address the male SRH needs such as prevention of STIs; access and knowledge of condom use, infertility counseling and prostate gland issues, men would probably consider attending the clinics. The traditional approaches taken by the health systems in SRH interventions discourage male involvement. These programmes have been introduced as relevant for women and children. Moreover, men who have attempted to accompany their wives to the clinics are always told to "wait outside", by the health providers.

Kaida et al (2005) studied male participation in family planning in Mpigi District, Uganda. The aim of this study was to determine men's perceptions about family planning and how they participate or wish to participate in family planning activities in Mpigi District, central Uganda. Four focus group discussions were conducted with

married men and with family planning providers from both the government and private sector. In addition, seven key informants were interviewed using a semi-structured interview guide. The results indicate that men have limited knowledge about family planning, that family planning services do not adequately meet the needs of men, and that spousal communication about family planning issues is generally poor. However, almost all men approved of modern family planning and expressed great interest in participating. The positive change of the beliefs and attitudes of men towards family planning in the past years has not been recognized by family planning programme managers, since available services are not in line with current public attitudes. A more couple-oriented approach to family planning is needed. Measures could include, for example, recruiting males as family planning providers, offering more family planning counseling for couples, and promoting female-oriented methods with men and vice versa.

Ha, Jayasuriya and Owen (2003) did a study on male involvement in family planning in rural Vietnam. The Transtheoretical Model of behavior change was used to examine men's involvement in general contraception and intrauterine device (IUD) use by their wives. The study tested whether the constructs of the model, decisional balance and self-efficacy, are sensitive to differences in stages of change. Reliable scales to test decisional balance and self-efficacy were developed. The study was carried out in rural Vietnam with 201 eligible participants. The staging algorithm identified that 25.8% of men were in the precontemplation stage, 10.5% of men were in the contemplation/preparation stages and 63.7% of men were in the action/maintenance stages. Disadvantages of IUD use for men in precontemplation were significantly higher than those in the action/maintenance stages, while the reverse was true for self-efficacy for convincing their wives to use an IUD. Interventions that are targeted to stage of change, that seek to reduce cons and that increase self-efficacy have the potential to influence male involvement in IUD adoption by their wives.

Ijadunola et al (2009) did a study on male involvement in family planning decision in Ile-Ife, Osun State in Nigeria. The study aimed to determine the extent of male involvement in reproductive goal decision making and family planning service

utilization among couples. A quantitative (cross-sectional) and qualitative focus group discussions (FGDs) and in-depth interviews (IDIs) designs were used to carry out the study. The sample size consisted of 400 males and 200 females. The study found that the men possessed adequate knowledge of modern family planning methods. Men's attitude towards and practice of modern family planning methods was fair. A level of spousal communication about family planning was poor and the role of men in initiating discussions about contraceptive use was equally poor. The study recommended that there was need for more male targeted information in the mass media.

Maharaj (2001) presents findings from a qualitative study of male attitudes towards family planning in the province of KwaZulu-Natal in South Africa. The study found that there is strong male approval of family planning as a method of fertility regulation. However, with reference to condoms as a specific method of contraception, although men's knowledge of condoms is relatively good, condoms are not a popular method of family planning and there is much male resistance to their use. An important reason is that condoms are associated with illicit sex and promiscuity. They are thus unlikely to be used in stable, ongoing relationships. These negative attitudes are major obstacles to the development of condom use as a means of protecting against the spread of HIV as well as family planning.

Another study by Oladeji (2008) sought to establish the influence of gender roles and norms factors on the reproductive behaviour among couples in Ibadan. A total of three hundred men and women randomly selected from five different professions in Ibadan constituted the sample for the study. The two instruments used were author-constructed questionnaires with 0.71 and 0.69 reliability co-efficient, respectively. The data obtained was analyzed using multiple regression analysis. The results indicated that significant relationships existed between extramarital sexual partners, family size, prenatal care, contraceptive use and breastfeeding and reproductive behaviour but not with birth spacing practices. The results further indicated that a combination of the independent variables significantly predicted reproductive behaviour and relationship. The result therefore, indicates the need for those in the helping professions to design

intervention programmes for couples on reproductive behaviour.

Donahoe (1996) did a study on Men and Family Planning in Bangladesh. This report has been prepared on the basis of research findings of survey data and other literature covering a variety of topics such as, male fertility preferences, male knowledge, attitude and practice (KAP), opinion about male methods of contraception, family planning decision-making and recent efforts to involve Bangladeshi men in FP programmes. This report has largely drawn on the findings from the Bangladesh Demographic and Health Survey (BDHS), 1993-94. A man's desired family size in Bangladesh is small, only one third of the respondents wanted more than two children and knowledge of at least one modern method of family planning is virtually universal (BDHS 1993-94). The same survey revealed that men's attitudes towards family planning (FP) are overwhelmingly favorable even in the country's most conservative division, Chittagong (combined with Sylhet). Religious opposition to FP among men seems to be less common than usually thought (Bernhart and Mosleh 1990, Mazumder, 1993). The use of vasectomy remains insignificant in Bangladesh. A considerable number of both men and women report unfavorable impressions due to perceived side-effects (Islam and Rahman 1993). The method's unpopularity is largely attributed to supply-side constraints i.e., the emphasis on other methods and deficiencies in the availability and quality of vasectomy services (Khuda, 1994). An increasing number of both men and women have also negative impressions about the use of male method- condom. It is thought to be detrimental to one's health (Mitra et al., 1990) and to be unreliable (Khan, 1993). With regard to information on spousal communication on contraceptive use, nearly 40 percent of female respondents in the DHS reported that the decision to first use a contraceptive method was reached jointly with their husbands. Some husbands are both significant sources of information about methods and supplies of methods for their wives (Akther and Ahmed 1991). Finally, it seems that not much efforts have been as of yet, undertaken in Bangladesh to involve men in family planning programmes. This study had two limitations. Information on the use of traditional male methods of contraception (i.e., withdrawal and periodic abstinence) in Bangladesh is not provided in this report. Little is



mentioned about the status of male participation in the national family planning programmes.

Ubaidur et al (1996) examined the status of male involvement within the family planning (FP) programme in Bangladesh, in addition to constraints in the way of promotion of male methods. In early 1950, FP activities were first initially initiated on voluntary basis, mainly concentrated in urban areas. Male sterilization programmes were introduced in 1965 and over one million vasectomies were performed during the period 1965-70. In 1975, a separate directorate was established to gear up population activities in Bangladesh. Several steps were taken to co-ordinate FP activities in conjunction with health services. To reduce high maternal and infant deaths the programme changed its target audience and shifted its focus towards females by promoting female methods. To achieve greater female involvement, the programme was re-organized at the field level. Females were deployed in large numbers as front line field workers and male workers were withdrawn. Moreover, introduction of minilap technique and availability of trained female paramedics encouraged females to accept clinical methods, particularly IUD and tubectomy. This resulted in reduction of male methods acceptance. To provide services the government established hundreds of family welfare centers (FWC) in rural areas and Thana Health Complex at the Thana level.

The paper also gives a short description of special projects on family planning and non-governmental organizations (NGO) programmes in Bangladesh. During 1975-80, two projects, namely, Zero Population Growth (ZPG) Project and Social Marketing Project (SMP) were initiated. The ZPG project failed to produce desired results while SMP continued its operation. The World Bank funded Fourth Health and Population project was introduced in Bangladesh in 1991. However, no major focus was given on greater male involvement in this project. The article does not mention the major programmatic constraints in the way of promotion of male method use. The primary objective of the study (i.e., position of male involvement in the national family planning programmes) has not been consistently discussed in the article.

Alauddin and Rafiqz-zaman (1996) present an analysis on performance and quality of male providers in family planning services in Bangladesh specifically promoting male methods. Several measures are also suggested to increase the use of male methods. In FP programmes, there are more than seven thousand male field staff. In the Health Directorate, there are almost six thousand physicians (with at least 60 per cent males), in addition to a large number of health assistants (14,381) at the grass root level. Moreover, a considerable number of male providers are also employed in the NGO and private sector. According to the study, nearly 60 per cent of total 51,599 workers in 169 NGOs were males. Several studies, however, reported gross under performance of the male field staff of the directorate of health and family planning (Hosseini, 2003). All service sites did not have trained male physicians to offer male sterilization services even in the face of declining performance in sterilization (for example, less than 1000 vasectomies performed per month in 1995). There is evidence of significantly high performance because of strong programmes' action. The following measures, among others, are suggested for increased utilization of male methods: appropriate use of male field-workers in the government health and FP programmes to provide men with FP services and prevent STDs; involve the village practitioners to promote male methods. The paper needs to state the reasons of low performance of the male field staff.

Piet – pelon and Al-Kabir (1996) compared the status of Bangladesh with some other selected countries in Asia and the Middle East, with regard to current use of male methods during the period 1991 to 1995. There is great variation across countries (i.e., India, Indonesia, Pakistan, the Philippines, Egypt and Turkey) in the use of contraceptive methods which require male participation. With a high level of contraceptive prevalence rate (CPR) (62.6 per cent) in Turkey, withdrawal is the most popular method (26.2 per cent) and condom use is nearly 7 per cent of all current users (BDHS 1994). In the Philippines, with 40 per cent of the contracepting couples, withdrawal and periodic abstinence are each used by 7 per cent of current users (PNDS 1993). Indonesia has very low use of all male methods (3.2 per cent) out of CPR 50 per cent (IDHS 1991). With CPR of about 41 per cent in India, participation of male methods to it is 9.8 per cent. Only the current use rate of vasectomy (3.4 per cent) exceeds the other male methods

(NFHS 1992-93). Half of the total contraceptive use (8.9 per cent) is shared by male methods in Pakistan, withdrawal being most dominant in use (4.2 per cent) and vasectomy acceptance is nil. In Egypt, share of male methods to overall level of contraceptive prevalence (47 per cent) is strikingly low (BDHS 1992). Among these countries, Bangladesh's position in terms of current use of male methods (11.4 per cent) is next to Turkey and the Philippines. The article does not specify why Turkey has the highest use rate of the traditional male method - withdrawal.

Faisal & Ahmed (1996) emphasize the role of male in the use of contraceptive methods. In a patriarchal society, men as the husband in a couple's life have an important say in decision-making about family size and use of contraceptives. As the FP service delivery system is largely female-oriented, there are very limited opportunities for men to receive FP information from service providers. Vasectomy remained to be a popular method until 1984-85. Since then along with tubal ligations vasectomy acceptance started declining (Hosseini, 2003).

Male respondents had first heard of vasectomy, mainly from radio and health or family planning workers. The major reason mentioned by all the men for choosing vasectomy was its permanency. Inter-spousal communication on reproductive issues is minimum in Bangladesh (BDHS 1993-94). The measures suggested in the paper are mainly as follows:

1. Services and male contraceptives need to be well publicized, emphasizing on benefits of use of male methods and Information, Education and Communication (IEC) activities have to be carried out.
2. The health and FP service delivery centers should counsel men on their reproductive responsibilities and use of contraceptive methods.
3. Service sites need to be set up within the reach of men to cater to their needs.

The article has mainly concentrated its discussion on the use of vasectomy -a permanent male method. But little is mentioned about the use of other male methods e.g. condom, withdrawal and periodic abstinence.

In many societies, decisions about family size and the use of contraceptives by wives and their continuation depend largely on the decisions of their husbands. A study (Hassan and Huq, 1990) revealed that decisions about adoption of family planning are mainly taken by the males. Other two studies (Hassan and Huq, 1990, Ahmed, et.al. 1990) showed that the males had the highest influence in deciding about the acceptance of sterilization.

One of the pioneering studies showed that male involvement in contraception decision is seldom recognized in family planning (FP) programmes, even though men play a key role in the contraceptive decision-making process (Gulhati 1986). The studies show that both socio-economic and socio-cultural factors are responsible for less participation of women in decision-making. Male involvement in family planning can be described in three forms, such as (i) males as users of contraceptives (ii) males as supportive partners of contraceptives and (iii) males as service providers. Comparative position of males as contraceptive user, supportive partner and service provider in Bangladesh is not analyzed here.

Kamal (2000) studied the influence of husbands on contraceptive use. Using the data from the 1993-94 BDHS, the objective of the paper is to examine the role of husbands on a couple's use of contraception in Bangladesh. In all three categories of use of modern contraceptive methods (oral pill, IUD/injection and female sterilization) considered in this study, husband's approval of family planning led to the increase of any method used by females. Other studies found that women in Bangladesh have a tendency to use contraception only when they perceive that their husbands do not object (Kamal and Sloggett, 1993). In other countries, for example, in Sri Lanka, women whose husbands disapproved of contraception had a four times higher risk of unwanted pregnancy compared with those whose husbands approved (De Silva 1992). One of the limitations of this study is husband's influence on contraceptive use was investigated on the basis of only one variable (husband's opinion of family planning as perceived by the wife). It appears from the above reviews that there exists a gap to identify the factors constraining or facilitating greater male participation in family planning.

### **2.3 Spousal Communication on Family Planning**

A study by Sharan and Valente (2002) was based on spousal communication and family planning adoption. Panel data from a population-based survey in Nepal were collected over three waves, from 1994 to 1999, to evaluate the impact of a radio drama serial among couples of reproductive age. Data from 1,442 women were used to assess changes in couples' family planning decision-making, identify predictors of spousal communication and family planning use in relation to program exposure, and clarify temporal relationships among these variables. The study found that women exposed to the program had significantly elevated odds of believing that their spouse approved of family planning and of having discussed family planning with their spouse (odds ratios, 1.8-1.9). Those who communicated with their spouse had elevated odds of using family planning (10.2). Spousal communication at baseline was associated with subsequent family planning use, independent of campaign exposure. In addition, among couples who had not already been discussing family planning, exposure led to communication, which in turn led to family planning use. Over time, husbands' dominance in making family planning decisions gave way to joint decision-making and an increase in women's decision-making power. Another study on spousal communication and family planning was done by Bawah (2002) through a longitudinal assessment in Navrongo. Results from both cross-sectional and longitudinal analysis demonstrated that spousal communication does, indeed, predict contraceptive behavior, even when other factors are controlled.

Equity in gender relations and responsible sexual behaviour highly stresses the need for men's active involvement in family planning. The interest in increasing active male participation in fertility regulation is two-fold: (1) to balance reproductive health care more evenly between men and women and (2) to increase the overall level of active users of fertility regulation (Martinez Manautou et.al. 1991). Donahue (1996) said male involvement in family planning generally signifies two distinct, yet-inter related, programmatic goals of encouraging the use of male contraceptive methods and expanding men's involvement in family planning decision-making process. The health of both men and women will improve, if men play a greater role in birth control. Male practice gives a balanced situation. Both from the perspective of birth prevention or reproductive health,

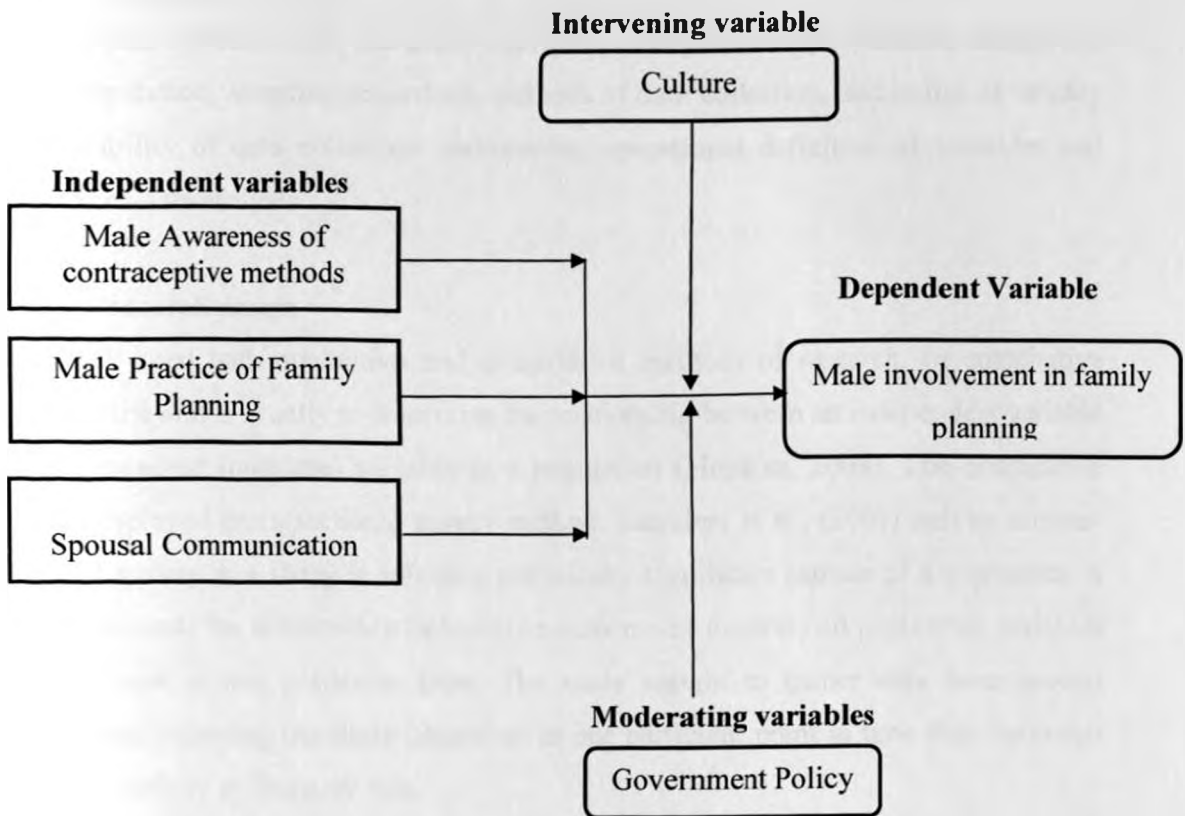
increased participation in family planning by males is therefore an essential step for augmenting the CPR.

The most important reason that emerges to promote male participation in family planning is that of fostering a better relationship between men and women through the practice of family planning as a joint and equal responsibility. Moreover, with increasing awareness and concern about the role men play in the transmission of STDs and HIV/AIDS, marginalizing men in family planning and reproductive health services is not, therefore, proper. It does not adhere to the principle of equity in gender in service dispensation.

Giving little importance to men's needs largely increases their health risks as well as those of their partners. In recent years, global increase in the prevalence of STDs/ HIV/ AIDS has drawn attention to reproductive health needs of men. This has further added importance to the use of condoms as a male method. Increased reliance on condoms can also help curb the spread of the STDs. This, in turn, prevents the infection of the deadly diseases (HIV/AIDS). On medical grounds, condom promotion has now gone beyond family planning. Men need to share the responsibility of disease prevention (HIV/AIDS) as well as the risks and benefits of contraception. The need to increase men's participation and sharing of responsibility was also a recommendation of the 1994 International Conference on Population and Development – ICPD (United Nations 1995).

## 2.4 Conceptual framework

The following is a diagrammatic representation of the variables of interest in a conceptual framework.



**Figure 1: Conceptual Framework**

Male involvement in family planning is dependent on the level of male awareness of contraceptive methods; the higher the awareness level, the higher the likelihood of male involvement in family planning. Male involvement in family planning is also dependent on the level of male practice of family planning; the higher the male practice of family planning, the more the male involvement. The level of Spousal communication directly affects male involvement in family planning. The higher the level of communication, the higher the likelihood of involvement. Culture is an intervening variable; research has shown that male attitude toward family planning is sometimes affected or dominated by cultural practices. Government is a moderating variable in male involvement in family planning; policies enacted can either encourage or discourage male involvement in family planning.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter indicates how the study was done and presents the research design, the target population, sampling procedure, methods of data collection, and issues of validity and reliability of data collection instruments, operational definition of variables and methods of data analysis.

#### **3.2 Research design**

The study used both qualitative and quantitative methods of research. In quantitative research, the aim is usually to determine the relationship between an independent variable and a dependent (outcome) variable in a population (Hopkins, 2008). The quantitative design employed cross-sectional survey method. Saunders et al., (2009) defines a cross-sectional survey as a study in which a statistically significant sample of a population is used to estimate the relationship between an outcome of interest and population variables as they exist at one particular time. The study sought to gather data from several respondents regarding the study objectives at one particular point in time thus the cross-sectional method sufficed for this.

According to Saunder et al., (2009), qualitative research is a loosely defined category of research designs or models, all of which elicit verbal, visual, tactile, olfactory, and gustatory data in the form of descriptive narratives like field notes, recordings or other transcriptions from audio- and videotapes, and other written records and pictures or films. This was carried out through interviews. A survey was used given that it would be possible to elicit views from a larger sample of respondents.

#### **3.3 Target population**

The target population varied according to the objectives of the study. For objective one and two, the target population included men of reproductive age group of 15 years and above who are living in Nairobi Province. Data from the Kenya Bureau of Statistics



showed that the number of males in this age category in Nairobi was about 900,000. For objective three, the target population included men of the age group of 15 years and above and women of age group of 15 years and above who are living in Nairobi Province. The men in this category were about 900,000 while the female were about 1.1 million.

### 3.4 Sample Size and Sampling procedure

The sample size was selected from the given population in Nairobi Province using simple random sampling method. Simple random sampling is described as a random selection of sampling units from the known population of interest. (Jacqueline and Erniel, 1991). This method has been used by Family Health International in conducting family planning surveys on Egyptian women (Saneya and Donald, 1998). A sample size of 200 male respondents from the age group of 15 years and above was selected from households in Nairobi Province. Then, a sample size of 100 female respondents was also selected from the age groups of 15 years and above from households in Nairobi Province. A sampling matrix is provided in Table 3.1.

**Table 3.1: Sampling Matrix**

	<b>Population</b>	<b>Sample Size</b>
Male	900,000	200
Female	1,100,000	100

### 3.5 Data Collection Instruments

Primary data was collected in the study in order to assess the awareness and practice of contraceptive methods. The data was collected using structured household questionnaires. A total of 200 structured household questionnaires were administered to the male respondents by the researcher.

In order to assess the level of spousal communication in family planning decision making, 200 structured household questionnaires were administered to men by the researcher while 100 such questionnaires were also administered to females by the

researcher.

The questionnaires were also self-administered by the researcher with the help of research assistants who were trained on administration of questionnaires in order to ensure that the data collection process would run smoothly. The researcher chose to self-administer the questionnaires because this method enhances the response rate as opposed to the drop-and-pick later method, the telephone survey or the mail survey. The authenticity of research is also enhanced in the process.

### **Data collection procedures**

A letter from the University of Nairobi stating that the researcher is a student from the university and is taking the said study for the purposes of her master's degree was also attached to the questionnaires and presented together with an introductory letter from the researcher. These were used to formally introduce the researcher and to authenticate the entire research process. Ethics were also observed by the research assistants during the study. The questionnaires were administered within a period of four weeks in order to cover the desired sample size.

#### **3.5.1 Validity**

Validity is the extent to which a measurement gives consistent results; whether a study is able to scientifically answer the questions it is intended to answer; the extent to which a concept, conclusion or measurement is well-founded and corresponds accurately to the real world (Ghosh, 1996). In order to ensure that the data collection instruments were valid, a pilot study was carried out at the researcher's workplace. 15 Questionnaires were distributed to a randomly selected sample of respondents.

#### **3.5.2 Reliability**

Reliability is the consistency of a set of measurements or of a measuring instrument, often used to describe a test, (William and Trochim, 1993). Reliability is the fact that a scale should consistently reflect the construct it is measuring (Field, 2005). A test-retest method was employed. A reliability coefficient of 0.7 or above was used as basis of testing for the reliability.

### **3.8 Methods of data analysis**

Data collected through the questionnaires was analyzed using descriptive statistics and quantitative methods. The questionnaires were coded and entered into the Statistical Package for Social Sciences (SPSS) software version 12.

Results of male awareness of contraceptive methods and level of male practice of family planning in Nairobi Province were assessed using percentages. These results were then presented using tables.

The level of spousal communication was assessed using percentages and frequencies. The results were then presented using tables.

In order to analyze results from the interviews, content analysis method was used and the results were presented following objectives of the study. Results were also presented in a tabular form.

### **3.9 Summary**

This chapter explicitly elaborates how the research was carried out. The research used both quantitative (cross-sectional) and qualitative (interview) methods. The target population included male and female in the age group of 15 years and above in Nairobi Province. A sample size of 200 males and 100 females was selected using simple random sampling technique. Primary data was collected using household questionnaires and interview guides. These were tested for validity and reliability. Data from the questionnaires was analyzed using descriptive statistics while the interviews were analyzed through content analysis.

### 3.10 Operational definition of variables

**Table 3.2: Operationalisation of variables**

Objectives	Variables	Indicators	Measurement	Measuring Scale	Type of Analysis	Tools of Analysis
To assess male awareness of contraceptive methods.	<p><u>Independent variable</u></p> <p>(i) Improved male involvement in family planning.</p> <p><u>Dependent variable</u></p> <p>(i) Number of male respondents who agree that they are aware of modern contraceptive methods.</p>	<p>High</p> <p>Medium</p> <p>Low</p>	<p>80-150</p> <p>40-79</p> <p>0-39</p>	Interval	Descriptive	Mean
To assess the level of male practice of family planning.	<p><u>Independent variable</u></p> <p>(i) Improved male involvement in family planning.</p> <p><u>Dependent variable</u></p> <p>(i) Number of male respondents who attend family planning clinics with spouses.</p> <p>(ii) Number of male respondents who have ever used one of the family planning methods.</p> <p>(iii) Number of male respondents currently using any of the methods.</p>	<p>High</p> <p>Medium</p> <p>Low</p>	<p>80-150</p> <p>40-79</p> <p>0-39</p>	Interval	Descriptive	Mean

5. To assess the level of spousal communication in family planning decision making.	<u>Independent variable</u>					
	(i) Improved male involvement in family planning.	High	80-150	Interval	Descriptive	Mean
		Medium	40-79			
<u>Dependent variable</u>		Low	0-39			
	(i) Number of male respondents who initiate discussion on when to achieve pregnancy.					
	(iii) Number of male respondents who initiate discussion on when to avoid pregnancy.			Nominal		Mode
	(iii) Number of times family planning has been discussed by the spouses.			Interval		Mean

## CHAPTER FOUR

### DATA ANALYSIS, PRESENTATION AND INTERPRETATION

#### 4.1 Introduction

This section analyses, presents and interprets the level of male awareness, male practice and level of spousal communication in family planning issues in Nairobi, Kenya.

The results are presented based on the analysis done using the SPSS and data is presented using tables. The analysis was based on gender (male and female) and on the income levels of the respondents (high income and low income) where applicable.

#### 4.2 Response Return Rate

From the 300 questionnaires distributed, 230 questionnaires were collected and were suitable for analysis purposes. This indicates that the response rate was 76.7%. This is a high response rate suggesting that the target population was interested in the research.

#### 4.3 Demographic information

##### 4.3.1 Gender Demographic information

The Gender Demographic information is given in Table 4.1

**Table 4.1: Distribution of respondents according to gender**

			Income		
			Low	High	Total
<b>Gender</b>	Male	Frequency	71	79	150
		% within Income	55.5	77.5	65.2
	Female	Frequency	57	23	80
		% within Income	44.5	22.5	34.8
<b>Total</b>	Frequency		128	102	230
	% within Income		100.0	100.0	100.0

$\chi^2 = 12.092, p = 0.001$

The study revealed that 65.2% of the respondents were males while 34.8% were females. It is also noted that 55.5% of the males were from low income while 77.5% were from high income. Further, 44.5% of the female respondents were from low income areas while 22.5% were from high income areas.

### 4.3.2 Age of Respondents

The age of respondents is given in Table 4.2

**Table 4.2: Distribution of respondents according to age**

		Income			
Age		Low	High	Total	
<b>Age (Years)</b>	15-20	Frequency	12	0	12
		% within Income	9.4	.0	5.2
21-30		Frequency	104	34	138
		% within Income	81.3	33.3	60.0
31-40		Frequency	0	54	54
		% within Income	.0	52.9	23.5
41-50		Frequency	12	14	26
		% within Income	9.4	13.7	11.3
<b>Total</b>		Frequency	128	102	230
		% within income	100.0	100.0	100.0

The study found that 5.2% of the respondents were in the age group of 15-20 years, 60% in the age group of 21-30 years, 23.5% in the age group of 31-40 years while 11.3% in the age group of 41-50 years. Further, 9.4% of the low income respondents were in the group 15-20 years, 81.3% in the group 21-30 years, and 9.4% in the group 41-50 years. The study further revealed that 33.3% of the high income respondents were in the age group of 21-30 years, 52.9% in the group 31-40 years, and 13.7% in the group 41-50 years.

### 4.3.3 Type of Marriage

The type of marriage is given in percentages in Table 4.3

**Table 4.3: Type of marriage**

			Income		
			Low	High	Total
<b>Type of marriage</b>	Monogamous	Frequency	101	67	168
		% within Income	100.0	78.8	90.3
	Polygamous	Frequency	0	18	18
		% within Income	.0	21.2	9.7
<b>Total</b>	Frequency		101	85	186
	% within Income		100.0	100.0	100.0

The study found that 90.3% of the marriages were monogamous while 9.7% were polygamous. It was also noted that all the low income respondents were in monogamous families. Further, the study revealed that 78.8% of the high income respondents were in monogamous marriages while 21.2% were in polygamous marriages.

#### 4.3.4 Number of respondents with children by income

The number of respondents with children by income is given in Table 4.4

**Table 4.4: Number of respondents with children by income**

			Income		
			Low	High	Total
<b>Children</b>	Yes	Frequency	89	70	159
		% within Income	69.5	68.6	69.1
	No	Frequency	39	32	71
		% within Income	30.5	31.4	30.9
<b>Total</b>	Frequency		128	102	230
	% within Income		100.0	100.0	100.0

The study found that 69.1% of the respondents had children while 30.9% did not have children. The study noted that of the low income respondents, 69.5% had children while 30.5% did not. Of the high income respondents, 68.6% had children while 31.4% did not have.



**Table 4.5: Distribution of Number of children**

	<b>Frequency</b>	<b>Percent</b>
1-2 children	105	66.0
3-5 children	48	30.2
Over 5 children	6	3.8
<b>Total</b>	<b>159</b>	<b>100.0</b>

For those who had children, the minimum number of children was 1 and the maximum was 7. From Table 4.5, it can be observed that those with up to two children were 66%, 3-5 children were 30.2% while those with over 5 children were 3.8%.

#### 4.3.5 Employment Status

The Employment status is given in percentages in Table 4.6

**Table 4.6: Employment status in percentages**

			<b>Income</b>		
			<b>Low</b>	<b>High</b>	<b>Total</b>
<b>Employment status</b>	Employed	Frequency	22	2	24
		% within Income	17.2	2.0	10.4
	Unemployed	Frequency	64	21	85
		% within Income	50.0	20.6	37.0
	Self-employed	Frequency	42	79	121
		% within Income	32.8	77.5	52.6
<b>Total</b>	Frequency	128	102	230	
	% within Income	100.0	100.0	100.0	

In terms of their employment status, the study found that 10.4% were employed, 37.0% were unemployed and 52.6% were self-employed. The results also show that 17.2% of the low income respondents were employed, 50% were unemployed and 32.8% were self-employed. Of the high income respondents, 2% were employed, 20.6% were unemployed while 77.5% were self-employed.

#### 4.3.6 Level of Education

The level of education of respondents by income levels is given in Table 4.7

**Table 4.7: Level of education by income**

			Percentate of Income		
			Low	High	Total
<b>Education</b>	Primary school	Frequency	34	0	34
		% within Income	26.6	0	14.8
	Secondary school	Frequency	40	0	40
		% within Income	31.3	.0	17.4
	Tertiary education	Frequency	54	102	156
		% within Income	42.2	100.0	67.8
<b>Total</b>	Frequency		128	102	230
	% within Income		100.0	100.0	100.0

In terms of their levels of education, the study revealed that 14.8% of the respondents had primary level of education, 17.4% had secondary level education, and 67.8% had tertiary level of education. The study noted that 26.6% of the low income respondents had primary level of education, 31.3% had secondary level while 42.2% had tertiary level of education. Of the high income respondents, all had tertiary levels of education.

#### 4.4 Awareness of Contraceptive Methods

##### 4.4.1 Awareness of contraceptive methods by income levels

The awareness of contraceptive methods by income levels is given in Table 4.8

**Table 4.8: Awareness of contraceptives by income levels**

				Income		
				Low	High	Total
<b>Awareness of modern family planning methods</b>	Yes	Frequency		87	72	159
		% within Income		68.0	70.6	9.1
	No	Frequency		41	30	71
		% within Income		32.0	29.4	30.9
<b>Total</b>	Frequency			128	102	230
	% within Income			100.0	100.0	100.0

The study found that 69.1% of the respondents were aware of modern family planning

methods and 30.9% were not. In terms of their income levels, it was noted that 68% of the low income respondents knew about the modern family planning methods while 32% were not aware. The study also revealed that 70.6% of the high income respondents knew about modern family planning methods while 29.4% did not know.

#### 4.4.2 Awareness of contraceptives by Gender

The awareness of contraceptive methods by gender is given in Table 4.9

**Table 4.9: Awareness of contraceptives by gender**

		Gender			
		Male	Female	Total	
<b>Awareness of modern family planning methods</b>	Yes	Frequency	79	80	159
		% within Gender	52.7	100.0	9.1
	No	Frequency	71	0	71
		% within Gender	47.3	.0	30.9
<b>Total</b>	Frequency	150	80	230	
	% within Gender	100.0	100.0	100.0	

In terms of gender, the study revealed that 52.7% of the male knew of the modern family planning methods while 47.3% did not. It was also revealed that all the female respondents knew about the modern family planning methods.

#### 4.4.3 Awareness of contraceptive methods by source of information

The awareness of contraceptive methods by source of information is given in Table 4.10

**Table 4.10: Awareness of contraceptives by source of information**

		No. of responses	% of responses	% of Cases
<b>Multiple response for source of information on family planning methods</b>	Radio	156	21.0	98.1
	School	33	4.4	20.8
	Friends	144	19.4	90.6
	Television	117	15.8	73.6
	Internet	19	2.6	11.9
	Health worker	81	10.9	50.9
	Books/Journals	86	11.6	54.1
	Newspapers	106	14.3	66.7

The study revealed that 21% of the respondents knew of modern methods of family planning through radio, 4.4% from school, 19.4% from friends, 15.8% from television, 2.6% from the Internet, 10.9% from health workers, 11.6% from books and journals and 14.3% from newspapers.

Other places included hospitals, seminars and campaigns. On the methods of family planning known by the respondents, several were identified such as condoms, Femi plan, NOR plant, natural methods, contraceptives such as pills, injections, IUD, vasectomies, coils and tubal ligations.

#### 4.5 Level of male practice of family planning

##### 4.5.1 Male approval of contraceptive use by Income levels

Male approval of use of contraceptives by income levels is given in Table 4:11

**Table 4:11 Male approval of contraceptives use by income levels**

		Income			
		Low	High	Total	
<b>Do you (husband) approve of family planning in your marriage</b>	Yes	Frequency	38	69	107
		% within Income	63.3	81.2	3.8
	No	Frequency	22	16	38
		% within Income	36.7	18.8	26.2
<b>Total</b>	Frequency	60	85	145	
	% within Income	100.0	100.0	100.0	

The study found that in terms of their income levels, 63.3% of low income respondents agreed that the husbands approved of the use of family planning within the marriage while 36.7% did not approve. Further, 81.2% of the high income respondents agreed that the husbands approved while 18.8% cited that they did not approve.

#### 4.5.2 Male approval of contraceptive use by Gender

Male/husband approval of use of contraceptive methods in terms of gender is given in Table 4.12

**Table 4.12: Male/husband approval of family planning by gender**

			Gender		
			Male	Female	Total
<b>Do you (husband) approve of family planning in your marriage</b>	Yes	Frequency	62	45	107
		% within Gender	80.5	66.2	73.8
	No	Frequency	15	23	38
		% within Gender	19.5	33.8	26.2
<b>Total within</b>	Frequency	77	68	145	
	% within Gender	100.0	100.0	100.0	

In terms of gender, it was noted that 80.5% of the males approved of family planning methods within their marriages while 19.5% did not. Further, 66.2% of the females cited that their husbands approved of the family planning methods while 33.8% said that their husbands did not approve.

The reasons for approval ranged from issues like not wanting to have many children and need to plan for the future of the families. The reasons for disapproval of family planning included the fact that some methods had side effects on the users and hence they were scared to use any of the modern family planning methods.

#### 4.5.3 Male use of modern family planning methods

Male use of modern family planning methods by level of income is shown in Table 4.13

**Table 4.13: Male use of modern family planning methods by level of income**

			Income		
			Low	High	Total
Used modern family planning method	Yes	Frequency	15	62	77
		% within Income	26.8	78.5	7.0
	No	Frequency	41	17	58
		% within Income	73.2	21.5	43.0
Total	Frequency		56	79	135
	% within Income		100.0	100.0	100.0

The study found that none of the male respondents had ever attended a family planning clinic with their spouses or alone. The study also found that 57% of the respondents had used modern family planning methods while 43% had not. Of the low income respondents, the study found that 26.8% had used modern family planning methods while 73.2% had not. Further, 78.5% of the high income respondents agreed that they had used modern family planning methods while 21.5% had not.

#### 4.5.4 Current use of modern family planning methods by males by level of income

Current use of modern family planning methods by males by level of income is given in Table 4.14.

**Table 4.14: Current use of modern family planning methods by level of income**

			Income		
			Low	High	Total
Currently using modern family planning method	Yes	Frequency	0	17	17
		% within Income	.0	21.5	12.6
	No	Frequency	56	62	118
		% within Income	100.0	78.5	87.4
Total	Frequency		56	79	135
	% within Income		100.0	100.0	100.0

The study revealed that at the time of the study, 12.6% of the male were using one of the modern family planning methods while 87.4% were not. Of these, none of the low income respondents were using any modern family planning methods at the time. On the other hand, 21.5% of the high income respondents were using modern family planning method while 78.5% were not.

#### 4.5.5 Most effective family planning methods

Family planning methods considered as most effective are shown in percentages in table 4.15

**Table 4.15: Family planning methods considered as most effective**

	Frequency	Percent
Coil	32	17.0
Condoms	50	26.6
Injection	39	20.7
Natural	24	12.8
Pills	24	12.8
Vasectomy	19	10.1
<b>Total</b>	<b>188</b>	<b>100.0</b>

On the most effective method of family planning, the study found that 17% considered coils the most effective, 26.6% said condoms, 20.7% said injections, 12.8% said natural methods, 12.8% said pills, and 10.1% said vasectomy.

#### 4.6 Spousal Communication

##### 4.6.1 Frequency of who initiates discussions of when to achieve pregnancy

Frequency of who initiates discussion of when to achieve pregnancy is shown in Table 4.16

**Table 4.16: Initiation of discussion of when to achieve pregnancy**

			Income		
			Low	High	Total
<b>When to achieve pregnancy</b>	Male	Frequency	60	50	110
		% within Income	68.2	58.8	63.6
	Female	Frequency	28	14	42
		% within Income	31.8	16.5	24.3
	Both	Frequency	0	21	21
		% within Income	.0	24.7	12.1
<b>Total</b>	Frequency	88	85	173	
	% within Income	100.0	100.0	100.0	

The study found that 63.6% of the husbands initiated discussions on when to achieve pregnancy, 23.4% of the discussions were initiated by wives while 12.1% of the

discussions were initiated by both of them. From the results, it is also observed that 68.2% of the husbands in the low income category initiated the talks on when to achieve pregnancy, while 31.8% of the wives initiated. In the high income category, 58.8% of the husbands initiated the discussions while 16.5% of the wives initiated them. Further, 24.7% of the discussions in this category were initiated by both.

#### 4.6.2 Frequency of who initiates discussion of when to avoid pregnancy

Frequency of who initiates discussion of when to avoid pregnancy is shown in Table 4.17

**Table 4.17: Initiation of discussions on when to avoid pregnancy**

		Income			
			Low	High	Total
<b>When to avoid pregnancy</b>	Husband	Frequency	54	37	91
		% within Income	53.5	43.5	48.9
	Wife	Frequency	47	45	92
		% within Income	46.5	52.9	49.5
	Both	Frequency	0	3	3
		% within Income	.0	3.5	1.6
<b>Total</b>	Frequency	101	85	186	
	% within Income	100.0	100.0	100.0	

The study found that 48.9% of the discussions on avoiding pregnancy in marriages were initiated by husbands, 49.5% by wives while 1.6% by both. The study also revealed that in the low income category of respondents, 53.5% discussions were initiated by husbands and 46.5% were initiated by wives. Further, in the high income category, 43.5% of the discussions were initiated by husbands, 52.9% by wives while 3.5% by both

#### 4.6.3 Frequency of who initiates discussion the use of contraceptives

Frequency of who initiates discussion the use of contraceptives is shown in Table 4.18



**Table 4.18: Initiation of discussions on the use of contraceptives**

			Income		
			Low	High	Total
Use of contraceptives	Husband	Frequency	26	0	26
		% within Income	53.1	.0	29.9
	Wife	Frequency	23	35	58
		% within Income	46.9	92.1	66.7
	Both	Frequency	0	3	3
		% within Income	.0	7.9	3.4
Total	Frequency		49	38	87
	% within Income		100.0	100.0	100.0

On the use of contraceptives, the study found that 29.9% of the discussions were initiated by the husbands, 66.7% by wives and 3.4% by both. In the low income category, 53.1% of the discussions were initiated by husbands and 46.9% by wives. It was also revealed that for the high income category, none of the discussions were initiated by husbands, 92.1% were initiated by wives while 7.9% were initiated by both.

#### 4.6.4 Number of times family planning is discussed

Number of times family planning is discussed is shown in Table 4.19

**Table 4.19: Number of times family planning is discussed**

			Income			
			Low	High	Total	
Number of times family planning is discussed	Never	Frequency	52	13	65	
		% within Income	51.5	15.3	4.9	
	Once	Frequency	0	20	20	
		% within Income	.0	23.5	0.8	
	Twice	Frequency	15	1	16	
		% within Income	14.9	1.2	8.6	
	Three times	Frequency	11	0	11	
		% within Income	10.9	.0	5.9	
	More than 3 times	Frequency	23	51	74	
		% within Income	22.8	60.0	9.8	
	Total	Frequency		101	85	186
		% within Income		100.0	100.0	100.0

The study found that 34.9% of the respondents had never discussed family planning in

their marriages, 10.8% had discussed it once, 8.6% had discussed it twice, 5.9% had discussed it three times while 39.8% had discussed it more than three times. For the low income category, 51.5% had never discussed family planning, 14.9% had discussed it twice, 10.9% had discussed it three times while 22.8% had discussed it more than three times. For the high income category, the study found that 15.3% had never discussed family planning, 23.5% had discussed it once, 1.2% had discussed it twice and 60% had discussed it more than 3 times.

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## CHAPTER FIVE

### SUMMARY OF FINDINGS, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter summaries the findings of the study and presents the discussion, conclusions and recommendations from the study.

#### 5.2 Summary of findings

Table 5.1: Summary of main findings

Objectives	Main Findings
1. To assess male awareness of contraceptive methods.	1. More than 50% of the male respondents were aware of modern family planning methods. Knowledge of these methods was highest among the high income category.  2. All female respondents were aware of modern family planning methods.  3. The various sources of information included radio, friends, television, newspapers and health workers.

<p>2. To assess the level of male practice of family planning.</p>	<ol style="list-style-type: none"> <li>1. None of males had attended a family clinic with their spouses or alone.</li> <li>2. 80.5% of male respondents said they approved of family planning methods. Higher approval was from the high income category.</li> <li>3. More than half of the female respondents agreed that their husbands approved the use of contraceptives. Approval was highest among the high income category.</li> <li>4. More than 57% of the male respondents (both low and high income) had used a modern family planning method. Highest use was from the high income category.</li> <li>5. A small percentage of the interviewed male respondents were currently using modern family planning methods and none of them was from the low income category.</li> <li>6. Condoms, injection and coil were considered as most effective family planning methods.</li> </ol>
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<p>3. To assess the level of spousal communication in family planning decisions.</p>	<ol style="list-style-type: none"> <li>1. In both low and high income categories, discussion on when to achieve pregnancy was initiated mostly by the male spouses.</li> <li>2. Both husband and wife have initiated discussion on when to avoid pregnancy in both low and high income categories.</li> <li>3. In the high income category, none of the discussion on the use of family planning has been initiated by the males while in the low income category; wives have initiated the discussion more often than their husbands.</li> <li>4. In the high income category, more than 50% of the respondents had discussed family planning more than three times.</li> </ol>
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The study revealed that 65.2% of the respondents were male while 34.8% were female. It is also noted that 55.5% of the males were from low income while 77.5% were from high income. Further, 44.5% of the female respondents were from low income areas while 22.5% were from high income areas. The study found that 90.3% of the marriages were monogamous while 9.7% were polygamous. The study found that 69.1% of the respondents had children while 30.9% did not have children. The study noted that of the low income respondents, 69.5% had children while 30.5% did not have children. In terms of their employment status, the study found that 10.4% were employed, 37.0% were unemployed and 52.6% were self-employed. In terms of their levels of education, the study revealed that 14.8% of the respondents had primary level of education, 17.4% had secondary level education, and 67.8% had tertiary level of education.

The study found that 69.1% of the respondents were aware of modern family planning methods and 30.9% were not. In terms of their income levels, it was noted that 68% of the low income respondents knew about the modern family planning methods while

70.6% of the high income respondents knew about modern family planning methods. In terms of gender, the study revealed that 52.7% of the male knew of the modern family planning methods while all the female respondents knew about the modern family planning methods. The study revealed that 21% of the respondents knew of modern methods of family planning through radio, 4.4% from school, 19.4% from friends, 15.8% from television, 2.6% from the Internet, 10.9% from health workers, 11.6% from books and journals and 14.3% from newspapers.

The study found that in terms of their income levels, 63.3% of low income respondents agreed that the husbands approved of the use of family planning within the marriage while 81.2% of the high income respondents agreed that the husbands approved of family planning. In terms of gender, it was noted that 80.5% of the males approved of family planning methods within their marriages while 66.2% of the females cited that their husbands approved of the family planning methods.

The study found that none of the male respondents had ever attended a family planning clinic with their spouses or alone. The study also found that 57% of the respondents had used modern family planning methods. Of the low income respondents, the study found that only 26.8% had used modern family planning methods while 78.5% of the high income respondents agreed that they had used modern family planning methods. The study revealed that at the time of the study, 12.6% of the males were using one of the modern family planning methods while 87.4% were not. Of these, none of the low income respondents were using any modern family planning methods at the time. On the most effective method of family planning, the study found that 17% considered coils the most effective, 26.6% said condoms, 20.7% said injections, 12.8% said natural methods, 12.8% said pills, and 10.1% said vasectomy.

The study found that 63.6% of the husbands initiated discussions on when to achieve pregnancy, 23.4% of the discussions were initiated by wives while 12.1% of the discussions were initiated by both of them. From the results, it is also observed that 68.2% of the husbands in the low income category initiated the talks on when to achieve pregnancy, while 31.8% of the wives initiated the discussion. In the high income

category, 58.8% of the husbands initiated the discussions while 16.5% of the wives initiated them. Further, 24.7% of the discussions in this category were initiated by both. The study found that 48.9% of the discussions on avoiding pregnancy in marriages were initiated by husbands, 49.5% by wives while 1.6% by both. The study also revealed that in the low income category of respondents, 53.5% discussions were initiated by husbands and 46.5% were initiated by wives. Further, in the high income category, 43.5% of the discussions were initiated by husbands, 52.9% by wives while 3.5% by both. On the use of contraceptives, the study found that 29.9% of the discussions were initiated by the husbands, 66.7% by wives and 3.4% by both. In the low income category, 53.1% of the discussions were initiated by husbands and 46.9% by wives. It was also revealed that for the high income category, none of the discussions were initiated by husbands, 92.% were initiated by wives while 7.9% were initiated by both.

The study found that 34.9% of the respondents had never discussed family planning in their marriages, 10.8% had discussed it once, 8.6% had discussed it twice, 5.9% had discussed it three times while 39.8% had discussed it more than three times. For the low income category, 51.5% had never discussed family planning, 14.9% had discussed it twice, 10.9% had discussed it three times while 22.8% had discussed it more than three times. For the high income category, the study found that 15.3% had never discussed family planning, 23.5% had discussed it once, 1.2% had discussed it twice and 60% had discussed it more than 3 times.

The main reasons given as to why men do not patronize family planning services were that family planning is still very much seen as a woman's responsibility and that most family planning providers do not cater for men's needs as they are designed for women. Majority of the respondents were in agreement that family planning should begin after marriage.

### **5.3 Discussion**

The study sought to assess male awareness of contraceptive methods. The results revealed that 53% of the males were aware of modern family planning methods. The

knowledge of these modern family planning methods was highest among the high income category than the low income category. Most of the knowledge on modern family planning methods was through the radio (21%) and friends (19%). This finding concurs with findings of a study carried out in Osun State in Nigeria (Ijadunola et al, 2009) which found that majority of the male respondents possessed adequate knowledge of modern family planning methods.

The study also sought to assess the level of male practice of family planning. The results showed that 63% of the females agreed that their husbands approved the practice. Further, it was noted that most of the males who approved these methods were from the high income category. It was also revealed that 81% of the male respondents approved the family planning methods within their marriages. But none of the males had attended a clinic with their wives. It was also noted that 57% of the males had used the family planning methods but most use was from the high income level category. In addition, 13% of the males were currently using modern family planning methods and none was from the low income category. Maharaj (2001) found that there is strong male approval of family planning as a method of fertility regulation but although the knowledge is relatively good, practice is still not very popular and there is much male resistant to their use mostly because of cultural reasons.

The study further sought to assess the level of spousal communication in family planning decision making. It was noted that 64% of the husbands initiated when to achieve pregnancy, 49% of the husbands initiated when to avoid pregnancy while 30% initiated when to use contraceptives. It was also revealed that 45% of the respondents had never discussed family planning in their marriages while 55% had discussed it. Further, 52% of the low income respondents had never discussed such issues. It was noted that in the high income bracket, no male respondent had ever initiated discussion on use of contraceptives. This finding agrees with Kaida et al (2005) where a study carried out in Mpigi District in Uganda on male participation in family planning showed that spousal communication about family planning issues is generally poor and also the Osun State study in Nigeria (Ijadunola et al, 2009) which concluded that spousal communication



about family planning was poor and the role of men in initiating discussions about contraceptive use was equally poor.

Research on males' involvement in reproductive health issues shows that:

1. Men do not seek medical care as often as women.
2. Men do not usually accompany their wives/partners to family planning appointments.
3. Men do not normally discuss sexual health or family planning even with their own medical providers.

It is clear that women cannot achieve gender equality and sexual and reproductive health without the cooperation and participation of men. Mostly, it is men who usually decide on the number and variety of sexual relationships, timing and frequency of sexual activity and use of contraceptives, sometimes through coercion or violence. The 'feminization' of the AIDS pandemic is a sad reminder that in many places women do not have the power to protect their own health.

Men, as community, political or religious leaders, often control access to reproductive health information and services, finances, transportation and other resources. As heads of state and government ministers, as leaders of religious and faith-based institutions, as judges, as heads of armies and other agencies of force, as village heads, or indeed as husbands and fathers, men often wield enormous power over many aspects of women's lives. Thus, men's involvement in family planning initiatives is key in order for any health programme to succeed. This study also shows that men also want to be involved, and that many welcome the idea of mutually satisfying relationships built on trust and communication. UNFPA's work in the field also shows that male leaders, when presented with relevant data, can become valuable allies in addressing reproductive health issues, from maternal mortality to violence against women.

Towards this end, many health programmes should continue to seek to increase men's comfort with seeing themselves as responsible, caring, and non-violent partners thus not only increasing their willingness to participate in family planning programmes but also to

promote their awareness and increase the level of communication with their spouses on reproductive health matters.

#### **5.4 Conclusions**

The following conclusions were made from the study.

The study sought to assess male awareness of contraceptive methods. The results revealed that 53% of the males were aware of modern family planning methods. The knowledge of these modern family planning methods was highest among the high income category than the low income category. Most of the knowledge on modern family planning methods was through the radio (21%) and friends (19%).

1) The study therefore concludes that most of the males in Kenya are aware of the modern family planning methods.

The study also sought to assess the level of male practice of family planning. The results showed that 63% of the females agreed that their husbands approved the practice. Further, it was noted that most of the males who approved these methods were from the high income category. It was also revealed that 81% of the male respondents approved the family planning methods within their marriages but none of the males had attended a clinic with their wives. It was also noted that 57% of the males had used the family planning methods at least once but most use was from the high income level category. In addition, 13% of the males were currently using modern family planning methods and none was from the low income category.

2) These results lead to the conclusion that although the level of awareness on modern family planning methods is high among the males in Kenya, the level of practice is still low.

The study further sought to assess the level of spousal communication in family planning decision making. It was noted that 64% of the husbands initiated when to achieve pregnancy, 49% of the husbands initiated when to avoid pregnancy while 30% initiated when to use contraceptives. It was also revealed that 45% of the respondents had never discussed family planning in their marriages while 55% had discussed it. Further, 52% of the low income respondents had never discussed such issues.

3) The study concludes that the level of spousal communication of family planning issues in Kenya is still below average as most of the discussions are initiated by women.

## 5.5 Recommendations

The following recommendations were made from the study in order to increase male awareness of contraceptive methods:

1. There is need to create more awareness among males in Kenya on modern family planning methods so that they can make informed choices on what methods they can use. One way of doing this is by including more male targeted information in the mass media.
2. One approach to educating men and getting them involved in family planning is to use peer-based outreach groups where they can share their experiences and talk with other interested men and their partners.
3. Effective programmes should recognize that gender roles and relations are not static but are dependent on social contexts in which cultural, religious, economic, political and social circumstances are intertwined.
4. Health practitioners who work with men on family planning should have knowledge about certain socio-cultural issues in their particular community, such as: values and expectations related to gender; men's position in the family; roles of masculinity; and, if applicable, issues related to polygamy. In some situations, it may be necessary to have men-only clinics especially in societies where men and women are often segregated because of cultural norms.
5. Having men-only clinics may also be appropriate in populations which are not yet accustomed to the idea of involving men in reproductive health as this would probably make men feel more comfortable with the idea. Furthermore, in order to broach an often stigmatized and uncomfortable topic, practitioners must be trained to put men at ease, by talking frankly about family planning, sexuality and sexual behavior.

In order to increase male practice of family planning, the study recommends that:

6. Efforts should be made to make men feel more welcome in family planning facilities for instance through hiring male nurses and peer educators at the clinic as well as making the waiting room area more inclusive of men for example by having magazines that appeal to men as well as women.

7. More should be done to reach out to men with information, education and services on family life and family planning including reproductive and sexual health concerns, maternal health, HIV/AIDS prevention and reduction of gender-based violence.

8. In many societies, risk-taking and aggressive sexual behavior on the part of young men are often applauded by peers and condoned by society. These stereotypes result in harm to both women and men, and erode possibilities of establishing satisfying, mutually respectful relationships. Ideally boys and young men can be encouraged to reflect upon and discuss issues surrounding masculinity, relationships and responsible sexual behaviors. This can contribute to the deconstruction of negative and harmful attitudes and to the construction of positive responsible behaviors.

9. Family Planning programmes should recognize the diversity of men's reproductive and sexual health needs, including those of young men, and those who are economically deprived or displaced.

10. There is need to encourage men in Kenya to make clinic visits together with their wives so as to enable them understand more about family planning methods available for them. In order to increase the level of spousal communication in family planning:

11. More should be done to educate men on the importance of communicating with their wives/partners on issues related to family planning. Couples who communicate may perceive their spouses to be more supportive, feel less fatalistic about childbearing and more in control of their reproductive decisions, and be less embarrassed about discussing these issues with their spouses than couples who do not communicate. Furthermore, as men become more educated about and less threatened by family planning, the dialogue

occurring between couples will be heightened thus enhancing spousal communication in regard to family planning issues. While not all women will feel comfortable including their partners for a variety of reasons, it's important to invite the women to bring their partners with them to appointments and include male partners when talking about birth control.

12. Seminars and workshops can give men a chance to talk more openly about sensitive issues with their partners.

13. Governments create the conditions for gender equality. Governments can remove legal barriers and change the law to promote gender justice; they can pay attention to gender equality in the design of policies and programmes; and they can encourage supportive institutional environments. As the biggest direct and indirect employers, government can set standards and provide an example to others. Finally, political leaders can advocate and promote gender equality, and encourage their followers at all levels to do so.

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## **5.6 Suggestions for further research**

1. More research to identify the factors constraining or facilitating greater male participation in family planning initiatives should be done.

2. There is need to carry out more research on ways to further improve male awareness of contraceptive methods.

3. Further research on factors that may make males in Kenya to feel more comfortable with the subject of family planning and also to help them feel like equal partners in family planning issues.

4. More research should be carried out to identify ways of encouraging more spousal communication in regard to family planning matters. Spousal communication has been associated with subsequent family planning practice.

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## APPENDICES

### Appendix 1: INTRODUCTION LETTER

Rose Wangechi Wachira

P.O. Box 2607, 00200

Nairobi

26 April, 2010

Dear Respondent

RE: REQUEST FOR PARTICIPATION IN DATA COLLECTION

The above named researcher is a student at the University of Nairobi. She is carrying out an investigation on Male Involvement in Family Planning Decisions in Kenya, for purposes of her Master of Arts degree in Project Planning and Management. It will be appreciated if you could assist by answering the questions on the attached questionnaire as honestly and completely as possible. The information you provide will be treated in strictest of confidence.

Please tick your favorable response, where applicable, in the boxes provided.

Thanking you in advance.

Yours truly,

Rose Wachira

**Appendix 2: QUESTIONNAIRE FOR MALE RESPONDENTS**

**Section 1: General information**

1. What is your age?

- 15-20 years            ( )
- 21-30 years            ( )
- 31-40 years            ( )
- 41-50 years            ( )
- 51-60 years            ( )

2. What kind of marriage union do you belong to?

- Monogamous            ( )
- Polygamous            ( )

3. Do you have any children?

- Yes            ( )            No            ( )

If yes, how many?

.....

4. What is your employment status?

- Employed            ( )
- Unemployed            ( )
- Self-employed            ( )

5. What is your level of education?

Never been to school ( )

Primary school ( )

Secondary school ( )

Tertiary education ( )

**Section 2: Awareness and Practice of Contraceptive Methods**

6. Are you aware of any modern family planning method?

Yes ( )

No ( )

7. If yes in 3 above, where did you hear about it?

Radio ( )

School ( )

Friends ( )

Television ( )

Internet ( )

Health worker ( )

Books/Journals ( )

Newspapers ( )

Other (specify) ( ) .....

8. What methods of family planning do you know?

.....  
.....  
.....

9. Do you approve the use of family planning within your marriage?

Yes ( ) No ( )

10. Explain your reasons for approval/disapproval of family planning.

.....  
.....  
.....  
.....

11. Have you ever attended a family planning clinic?

Yes ( ) No ( )

12. Have you ever used any modern family planning methods?

Yes ( ) No ( )

13. Are you currently using any of the modern family planning methods?

Yes ( ) No ( )

14. Which family planning method do you think is most effective?

.....



**Section 3: Spousal Communication**

15. Who initiates discussions on the following decisions regarding family planning in your marriage?

i. When to achieve pregnancy

Me ( ) My wife ( )

ii. When to avoid pregnancy

Me ( ) My wife ( )

iii. Use of contraceptives

Me ( ) My wife ( )

16. How many times has family planning been discussed in your marriage?

Never ( )

Once ( )

Twice ( )

Three times ( )

More than 3 times ( )

17. How can service delivery be improved?

.....  
.....

18. How can male awareness of family planning be improved?

.....  
.....

19. When do you think family planning should begin? Before or after marriage?

.....

**Thank you for your participation**

**Appendix 3: QUESTIONNAIRE FOR FEMALE RESPONDENTS**

**Section 1: General information**

1. What is your age?

15-20 years ( )

21-30 years ( )

31-40 years ( )

41-50 years ( )

2. What kind of marriage union do you belong to?

Monogamous ( )

Polygamous ( )

3. Do you have any children?

Yes ( ) No ( )

If yes, how many kids?

.....

4. What is your employment status?

Employed ( )

Unemployed ( )

Self-employed ( )

5. What is your level of education?

Never been to school ( )

Primary school ( )

Secondary school ( )

Tertiary education ( )

**Section 2: Awareness and Practice of Modern Contraceptive Methods**

6. Are you aware of any modern family planning method?

Yes ( )                      No ( )

7. If yes in 3 above, where did you hear about it?

Radio ( )

School ( )

Friends ( )

Television ( )

Internet ( )

Health worker ( )

Books/Journals ( )

Newspapers ( )

Other (specify) ( ) .....

8. What methods of family planning do you know?

.....  
.....  
.....

9. Does your husband approve the use of family planning within your marriage?

Yes ( ) No ( )

10. Explain his reasons for approval/disapproval of family planning.

.....  
.....  
.....  
.....

11. Which family planning method do you think is most effective?

.....

**Section 3: Spousal Communication**

12. Who initiates discussions on the following decisions regarding family planning in your marriage?

iv. When to achieve pregnancy

Me ( ) My husband ( )

v. When to avoid pregnancy

Me ( ) My husband ( )

vi. Use of contraceptives

Me ( ) My husband ( )

13. How many times has family planning been discussed in your marriage?

Never ( )

Once ( )

Twice ( )

Three times ( )

More than 3 times ( )

14. How can service delivery be improved?

.....  
.....

15. How can awareness of family planning be improved?

.....  
.....

16. When do you think family planning should begin? Before or after marriage?

.....

**Thank you for your participation**

#### **Appendix 4: INTERVIEW GUIDE**

1. What is your opinion on male involvement in family planning?
2. What reasons can you give for why men do not patronize family planning services?
3. How can service delivery be improved?
4. How can awareness of family planning be improved?
5. When do you think family planning should begin? Before or after marriage?

## **Appendix 5: MILLENIUM DEVELOPMENT GOALS**

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV / AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development