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**MALE PARTICIPATION IN FAMILY PLANNING DECISION MAKING: A CASE
STUDY OF MARRIED MEN IN VIHIGA COUNTY, WESTERN KENYA.**

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DECLARATION

STUDENTS DECLARATION

I declare that this research project is my original work and has not been submitted to any other university for an academic credit.

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APPROVAL BY SUPERVISOR

The project has been submitted with my approval as the university supervisor.

Signature: _____

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Date : _____

DEDICATION

I dedicate this work to my late Aunt, Dr Ebbie Kavetsa Adagala.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AFIDEP	African Institute for Development Policy
CDC	Center for Disease Control
CEDPA	Center for Development and Population Activities
CPR	Contraceptive Prevalence Rate
CoK	Constitution of Kenya
FGD	Focus Group Discussions
FP	Family Planning
GHC	Global Health Care
HIV	Human Immunodeficiency Virus
ICPD	International Conference for Population and Development
ICS	Innovation Communication Systems
IPPF	International Planned Parenthood Federation
IUD	Inter Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU	Johns Hopkins University
KI	Key Informants
KMET	Kisumu Medical Education Trust
KNBS	Kenya National Bureau of Statistics
MOH	Ministry of Health
NCPD	National Coordinating Agency for Population and Development
PAI	Population Action International
PCS	Population Communication Services
PPFA	Planned Parenthood Federation of America
RHRA	Reproductive Health and Rights Alliance
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
US	United States
WHO	World Health Organization

Definition of Concepts

- a) **Abortion** – The expulsion of the products of conception from the uterus before it is capable of independent life. They may be spontaneous or induced in the case of unintended pregnancies.
- b) **AIDS** – Acquired Immunodeficiency Syndrome: A disease defined by a set of signs and symptoms caused by the HIV virus, also transmitted through body fluids such as blood and semen.
- c) **Contraceptive Prevalence Rate (CPR)** – The percent of women of reproductive age (15-49) using any method of contraception at a given point in time.
- d) **HIV** – Human Immunodeficiency Virus: the virus that causes AIDS and is transmitted through body fluids such as blood and semen.
- e) **Total Fertility Rate (TFR)** – The average number of children a woman would have if she went through her entire reproductive period, from 15 to 49 years.
- f) **Vasectomy** – A surgical procedure in which segments of the male reproductive organ are removed and the ends tied to permanently prevent passage of sperm and thus prevent conception.

ABSTRACT

Traditionally, family planning programmes have always focused on women since they are the sole child bearers, to the disregard of men. Despite this, men are still the heads of the households and the principal decision makers at this level. There is very limited research which has been conducted to explore the role men play in family planning and fertility regulation in Kenya. This study therefore examined the role men play in family planning decision making, specifically in the consumption of male methods, in Vihiga County.

Quantitative data were obtained from a randomly selected sample of 150 men who had regular sexual partners (married or cohabiting) aged between 18 and 49 years. The areas of focus were on their sources of information, attitudes towards family planning, participation in decision making and socio-cultural factors that influenced their decisions to use specific male methods as their preferred choice. Additional qualitative data was further obtained through focus group discussions and key informant interviews.

The study found that generally the participation of men in decision making on methods to use was quite low. It was found that about 43% of men left decision making to women alone while an even lower percentage (12%) supported joint efforts in deciding on which methods to use as a couple. The findings showed that some of the most commonly known methods were the male condom (100%) and the coil/IUD (81%), while only 15% reported to know about vasectomy. This information was mostly derived from mass media (43%) but in most cases the information was inadequate and inaccurate and this resulted in 43% of men leaving decision making to women only. Only 43% of men reported to have ever discussed family planning with their spouses which contributed to the low level of men participating in decision making on methods to use. It was also found that only 15% of men stated that it was their responsibility to use family planning methods within their marriages compared to 55% who said that it was the responsibility of the woman. Decision making on method among men was found to be influenced by various socio-cultural factors such as health of the wife and children (40%), social acceptance of family planning methods and fear of social stigma (50%), religious factors (22%) as well as sex of the children born into the family (24%). However, findings also revealed that 85% of men were willing to be more involved in family planning programmes.

The study concluded that the level of male participation in making decisions about which methods to use was quite low in Vihiga County. To enhance the level of decision making, there is need to: (i) design more holistic family planning programs to include both men and women; (ii) include both men and women in family planning discussions at health centers; (iii) establish male-only family planning clinics to encourage men to seek family planning services (iv) to ensure the dissemination of accurate family planning information through various forms of mass, social and print media to enhance use of male methods.

CHAPTER ONE: INTRODUCTON

1.1 Background

Family planning (FP) refers to practices that help couples to attain certain objectives; avoid unintended pregnancies, regulate intervals between pregnancies; control the time at which birth occurs in relation to the ages of the parents and determine the number of children in the family (WHO Expert Committee, 1971). It empowers men and women to have control over their own fertility.

Family planning is a combination of practices that allows both individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. The practice, therefore, enables couples to plan their families in accordance with their needs and resources (WHO, 2002).

Since the 1994 International Conference on Population and Development (ICPD), there has been significant commitment from policy makers to move away from demographic reproductive health targets towards a broader focus on human welfare, individual choice and the goals of gender equality (Basu, 1994). As part of this change there has also been increasing attention on constructive male involvement in reproductive health (WHO, 2002). Similarly, at implementation level, reproductive health professionals have recognized that failure to target men has weakened the impact of reproductive health decision-making and use of health resources (Mungai, 1996). The issue is especially important in such societies where men are the leaders and decision makers in the family and in the community. However, there is only limited knowledge about how to incorporate men fully in reproductive health programmes although their participation in family planning decision making is thought to have various socio-economic benefits.

Historically, the sexual and reproductive health needs of men in low income countries have received very little attention from both the research community and public health care planners and providers (Hawkes, 2000). The situation is based on the fact that women bear a greater burden of reproductive mortality and morbidity as they shoulder the physical, and most of the social responsibility for child bearing and child care (Danforth, 1995).

Kenyan women have an average of about 4.6 children (KNBS and ICF Macro, 2010) over their lives. After a period of stagnation between 1995 and 2002, recent evidence suggests that the national contraceptive prevalence rate (CPR) and the total fertility rate (TFR) are on the increase and decrease (KNBS and ICF Macro, 2010). Despite these positive indicators, unmet need remains significant and there are notable differences between counties, wealth, education and rural/urban residences. While urban families tend to have fewer children than rural families, Kenya is now in a state that can best be described as a population momentum (KNBS and ICF Macro, 2010).

One of the reasons for this stagnation in number of children born into Kenyan families is because family planning services are offered mainly as part of maternal and child health packages only and this arrangement does not favor male participation in the planning and decision making process. Furthermore, to date male methods that contribute towards efforts to participate in family planning are limited to only withdrawal, condoms and vasectomy (a permanent method) rendering very little choice for them if they decide to take it upon themselves to use a family planning method instead of their wives. Addressing these unmet needs of men for family planning would avert not only early and unintended pregnancies but also reduce the instances of unsafe abortions as well as of both maternal and child deaths. It would slow population growth in Kenya, more than half of which is attributed to unwanted fertility (National Coordinating agency for Population and Development [NCPD], 2009).

Several key documents, including the Constitution of Kenya (CoK), address reproductive health in general and family planning explicitly. In the Constitution, Article 43, on economic and social rights gives specific attention to reproductive health rights by declaring that “every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health” (Republic of Kenya, 2010).

Vision 2030 [a development plan for the economic, social and political pillars of Kenya] aims to transform Kenya into a “middle-income country, providing a high quality of life to all citizens in a clean and secure environment” by the year 2030. Family planning has been identified by both government and private organizations as a key strategy if this vision is to be realized and more importantly that family planning programs need to include men so as to ensure harmonious development. The Government of Kenya has made efforts to try and achieve these goals despite the many challenges that threaten to jeopardize its mission, including setting the goal of increasing the

use of family planning to 70% of women aged 15-49 by 2015 (Republic of Kenya, Policy Brief No.13 2010). This is a powerful mission statement though it fails to factor in male participation and involvement in family planning consumption and decision making.

In this regard, this study aimed at investigating the role males play in family planning decision making in order to understand the factors that continue to undermine more active participation. The findings of the study were used to make recommendations that may assist family planning programme providers to promote male participation which will consequently assist in meeting national goals and policies within the set time frames.

1.2 Problem Statement

Kenya is predominantly a patriarchal society and in most communities, men hold the ultimate power in decision making at the family level (Mungai, 1996). As much as many women would like to cease child bearing, many times it is their husbands who determine whether this will occur or not (Population Action International, 2010). In a study conducted by APHRC (2013), findings showed that 43% of all pregnancies in Kenya are unintended and this is mainly because couples are not using family planning as they are supposed to. More so, it was found that men were not allowing their spouses to use female methods to plan for children and neither were they willing to use male methods for the same. This was found to be one of the main reasons for the high number of maternal and infant deaths caused by unsafe abortions due to unintended pregnancies. The study also highlighted that it was the wish of many women not to get pregnant but could not use family planning without the approval or knowledge of their husbands.

Despite efforts by the government to try to lower the total fertility rate (TFR) of women in Kenya to 2.6 by the year 2030, the numbers are still high. Data from the 2008/09 KDHS survey reveals that on average the Kenyan woman has about 4.6 children over her life, a slight decrease from 4.9 in 2003 (KNBS and ICF Macro, 2010). This study therefore sought to assess male participation in family planning decision making as a factor that would assist the government in meeting its 2030 goal. Relatively few studies have been conducted on men and their involvement in family planning decision making and none has so far been conducted in Vihiga County, Western Kenya. The 1994 ICPD pressed the agenda for all countries to involve men in reproductive health matters, including decision making and use of male methods. This study therefore sought to assess the participation of men in family planning decision making and as well as identify the various socio-cultural factors that influence their decisions to use or not use male designed methods..

Existing family planning programmes in Kenya are geared towards increasing the acceptance and use of modern family planning methods. However, these programmes tend to target women more often than men; the participation of men has not been studied enough and this study sought to identify the socio-cultural factors that determine and influence their decision making on choice method.

1.3 Research questions generated from the review of empirical literature

1. What are the major sources of family planning information among men and how does this influence how they make their decisions?
2. What is the general attitude of men in Vihiga County towards family planning?
3. To what extent do men in this county participate in deciding on methods to use?
4. What are the socio-cultural factors that influence the decision to use male methods?

1.4 Objectives of the Study

1.4.1 General Objective

The main objective of this study was to examine factors underlying the participation of men in family planning decision making for the purpose of generating information that would be helpful in designing holistic family planning programs.

1.4.2 Specific Objectives

Specifically, the study sought:

1. To identify men's sources of information on family planning.
2. To explore men's attitudes towards family planning.
3. To determine the participation of men in family planning decision making.
4. To identify the social-cultural factors that influences the participation of men in family planning decision making.

1.5 Rationale of the Study

Understanding factors that influence the participation of men in family planning decision making is important because it will enable family planning programmers to design programmes that are more inclusive of men and that cater to their needs concerning family planning in Kenya. The changes that these organizations make will also be in line with national goals such as Vision 2030 and also international ones such as the Millennium Development Goals (MDGs) [See Republic of Kenya, Policy Brief No.13 2010]. Engaging men in family planning decision making lead to shared responsibility of their reproductive lives without placing the burden on women alone as has been the case historically

Men's participation in family planning programmes is a promising strategy for addressing some of the world's most pressing reproductive health problems. Men can assist in preventing early and unintended pregnancies and reduce unmet needs for family planning; foster safe motherhood and practice responsible fatherhood. Increased men's participation involves more than program activities conventionally associated with men. It also involves encouraging a range of positive reproductive health and social behavior by men to help ensure the well being of all those affected by their decisions.

1.6 Scope and Limitations of the study

The scope of the study intended to explore participation of men in family planning decision making, especially on the use of male methods. The study was therefore limited to studying the following: men's sources of family planning information; male attitudes towards family planning; participation in decision making and use of male methods and lastly the socio-cultural factors influencing decision making among married men in Vihiga County. Although women are also involved in this important decision, the study was only limited to men and their opinions and thus women's perspectives on the research study were not obtained. Any other issue outside the above specifications was left out for other researchers to explore.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This section reviews existing literature on family planning, specifically; the history of family planning in Kenya, family planning policy, mass media and family planning, male attitudes and family planning, decision making and factors influencing male participation. Similarly, it describes the theoretical framework and its relevance to the study. This section also outlines the assumptions that will guide the study.

2.1 Literature Review

2.1.1 History of Family Planning in Kenya

Kenya's population can be classified as "very young", that is one in which at least two-thirds of the population is composed of people under age 30 years, and only 5 percent of the population is above 60 years (Population Policy, 2013). This is as a result of persistent high fertility in Kenya that has resulted in a relatively large and increasing youthful population. Further reduction of fertility and childhood mortality rates are critical if Kenya is to record a decline in population growth rate in the future.

Since independence, the Kenyan government recognized that population control is key in the realization of sustained socio-economic development. Facing an annual population growth rate of 3 percent, the Government of Kenya (GoK) incorporated family planning into the country's overall development policy in 1965, and by the mid- 1980s, the growth rate began to decline (KDHS, 2003). Kenya's Total Fertility Rate (TFR) declined from 8.3 children per woman in the late 1970s, to 4.7 children by the end of the 1990s. According to studies conducted by Pathfinder International, these dramatic declines in fertility rates have now stagnated, and even reversed in some instances (KDHS, 2003). Despite Kenya being the first country in sub-Saharan Africa to establish a National Family Planning Programme in 1967, the programme began stalling and has since stagnated since the early 1990s due to inadequate investment in family planning, diversion of resources to HIV and AIDS and reduced commitment to family planning from leaders.

To assist its efforts to lower fertility rates, Kenya continued to invest in family planning by developing a number of population policies, strategies and programmes to address population management challenges over time. Indeed, Kenya has assented to global and regional agreements including ICPD, Maputo protocol, The Abuja Declaration (which calls for all governments to allocate at least 15% of their annual budgets to the health sector, of which Kenya only allocates 6%) and Family Planning 2020 protocols. The Family Planning 2020 (FP2020) is a global partnership that supports the right of women and girls to decide freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. However, with increasing male opposition to the use of family planning especially in traditional societies, this goal might not be realized as planned.

Since 1948 when the first census was conducted in Kenya, researchers have been using Demographic Health Survey data to investigate the unmet need for family planning. In most parts of the world, studies have shown that women want to have smaller families; hence rapid population growth will not be an ongoing phenomenon. Worldwide, nearly 100 million married women would prefer to avoid pregnancy but are not using any method of family planning, which means that they have an unmet need for family planning (Robey, et al., 1996). In Kenya, the unmet need for family planning is at currently at 43% which has led to many women undergoing unsafe abortions due to unintended pregnancies and endangering their own lives in the process (APHRC, 2013). Kenya's population has doubled over the last 25 years, to about 40 million people, and rapid population growth is set to continue. According to recent United Nations projections, Kenya's population will grow by around 1 million per year – 3,000 people every day – over the next 40 years and will reach about 85 million by 2050 (United Nations Population Division Fact Sheet, 2007).

In 2003, findings from the KDHS indicated a TFR of 4.9 children per woman, a number which has only now slightly decreased to 4.6 children per woman. Since then the country's fertility narrative tells of a history marked with fertility declines, stagnation and lately a revitalized slowing of number of children a woman has as a result of renewed efforts to increase use of contraceptives. Although relative progress has been made with the average fertility falling to about 4.6 children, approximately one million babies are born in Kenya each year. Kenya's current population, approximately 41

million people, is expected to more than double to 97 million by 2050 and reach 160 million by 2100 (AFIDEP & PAI, 2012).

Despite efforts by the government to increase access of family planning services to all people in Kenya, its use is still quite low among many couples especially those in rural areas. This can be attributed to the traditional family structure where men are the heads of the household and all major decisions that affect them and their families are left to them. Although it is the wish of many women to cease child bearing, men do not allow them do so, yet they are also unwilling to use male family planning methods that are available to them to space and limit the number of children they have. The sources of information on family planning often have a direct impact on men which affects their decision on whether to use it or not within the family setting (Mungai, 1996).

In the past, men's involvement has been seen to be lacking even among family planning organizations because it was assumed that adding these services will damage the quality of women's services and create additional competition for already scarce resources. However, adding programs for men can enhance rather than deplete existing programs if the designers of these programs carefully integrate them into the existing health care structure in a way that benefits both women and men. Both the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing endorsed the incorporation of reproductive health services that include men, mandating that men's constructive roles be made part of the broader reproductive health agenda.

In fact, neglecting to provide information and services for men can detract from women's overall health. For example, men who are educated about reproductive health issues are more likely to support their partners in making decisions and even taking up responsibility for contraceptive use and family planning (Grady & Wilkinson, 1996). Men need to share the responsibility of disease prevention, as well as the risks and benefits of contraception. By actively engaging in matters pertaining to family planning and decision making, men make themselves equal partners in reproductive health as compared to passive recipients of the benefits of these programs.

2.1.2 Mass Media and Family Planning

Evidence from a number of studies suggests that individuals' exposure to mass media messages promoting family planning may affect their contraceptive behaviour (Piotrow et al.,1990; Bankole et al.,1996; Westoff and Bankole 1997; Kincaid 2000). For example in Nigeria, the use of modern contraceptives, the intention to use them, and the desire for fewer children were found to be associated with exposure to mass media messages about family planning (Bankole et al., 1996). A similar study in Tanzania found that women exposed to a combination of such messages were more likely than those who were not exposed to practice contraception (Jato et.al.,1999).

Well-designed mass-media campaigns have proved their ability to increase the use of family planning in Nigeria. Between 1985 and 1988, television promotion of family planning in the cities of Ilorin, Ibadan, and Enugu helped increase the numbers of new and continuing contraceptive users (Piotrow et al., 1990). After the campaign, the number of new clients had almost quintupled in Ilorin, tripled in Ibadan, and more than doubled in Enugu. About half of respondents surveyed reported having seen the family planning messages on television; of these viewers, more than two-thirds recalled the specific clinics promoted. In Borno State, meanwhile, a mass-media campaign involving radio, television, print materials, and an advocacy forum with religious leaders showed similar results. The number of first-time users in sentinel clinics rose by 24 percent over pre-campaign levels, and the number of continuing users rose 37 percent (Kiragu and Omotara, 1992).

According to data from the 1989 Demographic and Health Survey (DHS) in Kenya, men and women who were exposed to mass-media messages were more likely than their peers who had not been exposed to use family planning and to use a modern method (Westoff and Rodriguez, 1995). Non-users who had also been exposed to family planning messages were more likely to report that they intended to use contraception in the future. Mass media exposure was also associated with a desire to space or to limit pregnancies. More so, determinants such as dwelling in urban or rural areas, ownership of mass media outlets, and level of education have also been found to influence exposure to family planning messages as well as their use among couples (Westoff and Rodriguez, 1995). The above are just few of some studies which have been useful in explaining the effects of mass media campaigns of fertility related behaviour.

A number of models have emerged from different fields identifying specific pathways to behavioral change and offering insights to aid programs intended to influence and change behaviour. The steps-to-behavior change theory is an adaptation of the diffusion-of-innovation theory which consists of five major stages of change: knowledge, approval, intention, practice and advocacy (Piotrow et al., 1997). This framework emphasizes several intermediate steps that people move through before they change their behaviour, suggesting that different messages and approaches in communication are required to reach people at different stages in the process of change.

Several empirical studies have confirmed that mass media campaigns are effective at different stages in the process of altering reproductive behaviour. According to a study conducted in Nepal, exposure to messages in the mass media had an indirect effect on contraceptive use by increasing interpersonal communication and encouraging positive changes in attitudes and perceived social norms regarding family planning (Storey et al. 1999). In Tanzania, Jato et al. (1999) found that the more kinds of media vehicles used to promote family planning, the greater the change of use among both men and women.

Mungai (1996) noted that while Kenyan men are largely apathetic to family planning, they are not necessarily uninterested. Many men want to participate more actively in deciding how many children they should have and when to have them, but they lack sufficient information to do so. According to Casterline and Sinding (2001) inadequate knowledge about male family planning methods is one of the reasons for the male social opposition to its use. It can therefore be hypothesized that there is a strong positive relationship between being exposed to family planning messages and the inclination to using male methods. One of the issues addressed in this study were: what the major sources of family planning information are for men in Vihiga County and how does this information influence their decisions of whether or not to use family planning.

2.1.3 Male attitudes towards family planning

Exposure to family planning messages has in the past been known to influence and shape peoples' attitudes towards family planning. In a study carried out in Tanzania, findings revealed that women and men who were frequently exposed to mass media messages on family planning had developed more positive attitudes and were more likely to discuss family planning with their spouses than those

who were not frequently exposed (Jato et al., 1999). In Mali, exposure to a campaign was linked to an increase in favorable attitudes towards contraception and a decline in the proportion of men and women who believed that Islam opposes family planning (Kane et al, 1998) In addition to mass media exposure, trends in family planning attitudes and practices are likely conditioned by other factors as well, notably women's and men's socio-demographic characteristics.

Other studies have further suggested that family planning programs in many African societies were unsuccessful because they failed to take into account the power relations between couples, and the patriarchal nature of the societies (Ezeh et al 1996). In India, a study to assess the attitude of people towards family welfare demonstrated that men in the study area had shown poor interest to adopt family planning due to various social, economic and demographic factors (Alok et al 2011). These studies did not address the cultural, traditional and gender roles affecting male participation as it has been suggested by Amirrtha et al (2008) as they could influence attitudes and consequently contraceptive use among people from different backgrounds.

While Cleland et al (2011) explains that attitude resistance is the major barrier to the utilization of family planning services, Tawaih et al (1997) elaborates that male participation in family planning is very low and little is known about their attitudes and willingness to use modern family planning methods, especially those designed for men. The advantaged position of males at the domestic family level and their roles in family planning remains largely un-utilized in this context. For acceptance of family planning to increase in traditional rural societies, men should also be targeted by program providers (Nte et al., 2009). The factors influencing the attitude and willingness of men to use modern family planning methods should be addressed in order to increase consumption of services by men.

In a study conducted in Darkar (Senegal), it was found that acceptance of family planning among men was significant even among very conservative backgrounds when it was for the purpose of spacing births. In order for husbands and wives to agree on the use of family planning, couples must not only discuss the topic but also accurately perceive each other's attitudes on it (Becker, 1996). More so, in a study done in Ghana by Machipisa, (1997) it was found that while approximately 73% of men approved of family planning, only 22% of couples used either a modern or traditional method. This low rate of consumption can be assumed to be influenced by the source of family planning information which consequently determined the attitude that men held towards modern methods. A study done in Kenya by Fapohunda and Rutenberg (1998) found that family planning awareness was

high, but many modern family planning methods were found to be highly stigmatized among men especially within marriages. Evidence suggests that men have been known to give limited support to the use of family planning because they believed that its usage had an adverse effect on the couples sexuality and general health.

There is an existing knowledge gap regarding the attitudes and willingness of men towards the use of modern male family planning methods. Of all methods available, those that require male involvement, such as condoms, periodic abstinence, withdrawal and vasectomy are less used by married men because they hold certain attitudes towards their use in marriage. This study therefore sought also to explore the attitudes of men in Vihiga County towards modern family planning methods, especially male methods, and its implication on use and none use.

2.1.4 Family planning decision making

In the past, demographic research has primarily focused on women's reproductive health behaviour (Roudi & Ashford, 1996). The underlying assumptions behind this approach seems to have been that reproductive health matters are primarily a concern for women, and that men are generally disinterested in reproductive health matters. In the 1990s, however, demographers and population specialists have turned their attention to men's reproductive health behaviour (Roudi & Ashford, 1996; Greene & Biddlecom, 2000). A number of reasons account for this growing interest in men. First, it is now recognized that the sexual and reproductive behaviour of men puts them at risk themselves, and also impacts on the health status of their sexual partners. (Nzioka, 2002). Men are uninformed and irresponsible with regard to fertility control, they are barriers to women's contraceptive use, and are sexually promiscuous (Greene, 2000). Moreover, it is currently estimated that only one-third of the world's couples are using a male dependant method such as condoms, vasectomy, withdrawal, periodic abstinence or other traditional methods (Green, Cohen & Ghouayel, 1995). Male participation and cooperation is therefore important in the effective and sustained use of these methods.

The 1994 ICPD conference in Cairo and the 1995 Fourth World Conference on Women in Beijing, whose consensus documents were endorsed by more than 180 governments, called for special efforts to promote men's active involvement in responsible parenthood and sexual and reproductive

behaviour, including family planning; prenatal and maternal health; prevention of sexually transmitted diseases including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of equal value of children of both sexes (United Nations, 1994). The consensus documents of the two conferences further recognize the need for research into new methods for regulation of fertility for men and also behavioral research into factors inhibiting male participation so as to find ways of enhancing male involvement and responsibility in family planning.

Research in the sub-Saharan Africa region has shown that male participation in fertility decision-making is critical to the wider acceptance and use of family planning, and improvement in sexual and reproductive health (Toure, 1996a; 1996b). Since gender power relations in much of Africa are skewed in favor of men and African men wield a lot of power in the home and within society, they are the key gatekeepers to decisions relating to contraceptive use and fertility control. In the sub-Saharan region, it is basically men who decide when to have children, and how many children a couple should have (Nzioka, 2000). Too often these decisions are devoid of partner consultation.

Studies have also shown that involving men in inter-spousal communication has also been found to be critical in the sustained use of male and female family planning methods because it shapes their attitudes and perspectives about it. For example, Demographic and Health Survey data from 14 African countries shows that the percentage of women using contraceptives is consistently higher in the group that discussed family planning with their husbands, although the percentage of men who are using male family planning methods is still significantly low (Roudi & Ashford, 1996).

Studies conducted in Nairobi and Mombasa have shown that men usually want to be involved in reproductive health and especially in family planning programs and in situations where they are involved, improvements have been seen in the utilization of services by both sexes (Population Council, 2005). Efforts however are still being made to assist men in embracing the use of male family planning methods to relieve women of the burden they have carried alone over the past decades. The HIV and AIDS scourge has also rendered increased involvement of men in reproductive health programmes and decision-making processes even more crucial. Against this background, this paper therefore sought to determine whether men participate in family planning decision making and to what extent this occurs.

2.1.5 Factors Influencing Decision Making Among Men

Fertility studies indicate that men play a major role in using family planning methods and in determining the number of children a couple should have (Campbell, 1985; Mbizvo, Adamchek, 1991 and Carlos, 1984). Research also indicates that men's involvement in family planning can have a significant effect on fertility levels and trends (Karra et al., 1997).

In much of Africa, Kenya included, there are ideological and pragmatic obstacles to men's participation as both clients and supportive partners in reproductive health programmes. These obstacles mostly include long-cherished cultural and traditional practices that are still held by many traditional communities. Past research has shown that men hold certain traditional beliefs or misconceptions regarding modern contraception which act as barriers to them using these methods or even approving of use by their sexual partners. This suggests that men who subscribe to these notions may not approve of their own or their partners' use of the same.

There have been numerous research endeavors on factors associated with the use of family planning methods in most parts of Africa among women but only few have studied men independently. In Kenya, such studies are limited and those which have been conducted have been restricted to urban areas only. Although family planning is used by people in both urban and rural areas, their reasons for use and none-use tend to vary due to various factors which this study sought to establish. This study aimed to fill this gap by exploring the socio-cultural factors which influence the participation of men in family planning decision making and how these factors can be addressed to enhance male involvement in these programs.

2.2 Theoretical Framework

2.2.1 The Health Belief Model (HBM)

The Health Belief Model (HBM) is by far the most commonly used theory in health education and promotion (Glanz, Rimer & Lewis, 2002; National Cancer Institute [NCI], 2003). It was developed in the 1950's as a way to explain why medical screening programmes offered by the U.S Public Health Service, particularly for tuberculosis, were not very successful (Hochbaum, 1958). The focus of the HBM is to assess health behavior of individuals through examination of perceptions and attitudes someone may have towards disease and negative outcomes of certain actions.

The underlying concept of the HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958). Personal perception is influenced by the whole range of intrapersonal factors affecting health behaviour. The following four perceptions serve as the main constructs of the model:

- i. Perceived seriousness
- ii. Perceived susceptibility.
- iii. Perceived benefits.
- iv. Perceived barriers.

Each of these perceptions, individually or in combination can be used to explain health behaviour. More recently, other constructs have been added to the HBM: thus, the model has been expanded to include cues to action, motivating factors and self efficacy.

Perceived seriousness

The construct of perceived seriousness speaks to an individual's belief about the seriousness or severity of negative health behaviour. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties negative health behaviour would create or the effects it would have on his or her life in general (McCormick, 1999). For example, if one has HIV/AIDS and they live in a malaria infested area, they may begin to ponder on how much more serious their health would deteriorate if they were to catch malaria as well. It therefore calls for action to take greater precautions so as not to get sicker. The HBM seeks

to increase awareness of how serious the outcomes of certain health behaviors can be in order to increase the quality of one's life.

Perceived susceptibility

Personal risk or susceptibility is one of the more powerful perceptions in prompting people to adopt healthier behaviours. The greater the perceived risk, the greater the likelihood of engaging in behaviours that decrease the stated risk. This is what prompts men who have sex with men to be vaccinated against hepatitis B (De Wit et al., 2005) and to use condoms in an effort to decrease susceptibility to HIV infection (Belcher et al., 2005). It is only logical that when people believe they are at risk for contracting a disease, they will be more likely to do something to prevent it from happening. However, the opposite also occurs. When people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviours tend to result. This is what has been found among older adults in the U.S. and HIV prevention behaviour. Because older adults generally do not perceive themselves to be at risk for HIV infection, many do not practice safe sex (Rose, 1995; Maes & Louis, 2003). When the perception of seriousness is combined with perception of susceptibility, it results in perceived threat (Stretcher & Rosenstock, 1997). If the perception of threat is high to a serious disease for this there is real risk, behaviors changes.

Perceived Benefits

The construct of perceived benefits is a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease or negative health outcomes. People tend to adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a disease. They have to believe that change in health behaviour will be of a certain benefit to them. Individuals must be able to rationally think about how changing their behaviour will be of benefit to them so as to facilitate and maintain change (Graham, 2000).

Perceived Barriers

Since change does not come easily, the last construct to the HBM is the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. Of all the constraints, perceived barriers are the most significant in determining behaviour change (Janz & Becker, 1984). In order for a new behaviour to be adopted, a person needs to believe that the benefits of the new behaviour outweigh to consequences of continuing the old

behaviour (CDC, 2004). This enables barriers to be overcome and the new behaviour to be adopted. Some barriers to adopt new behaviour and developing new habits may be the fear of not being able to maintain the new behaviour and or facing embarrassment in society after changing (Umeh & Rogan-Gibson, 2001).

Modifying Variables

The four main constructs of perception are modified or influenced by other variables such as culture, education level, past experiences, skills and motivation just to name a few. These are individual characteristics that influence personal perceptions. For example, if one is diagnosed with an STI, they may become more self-conscious and practice safer sex due to lessons from that past diagnosis.

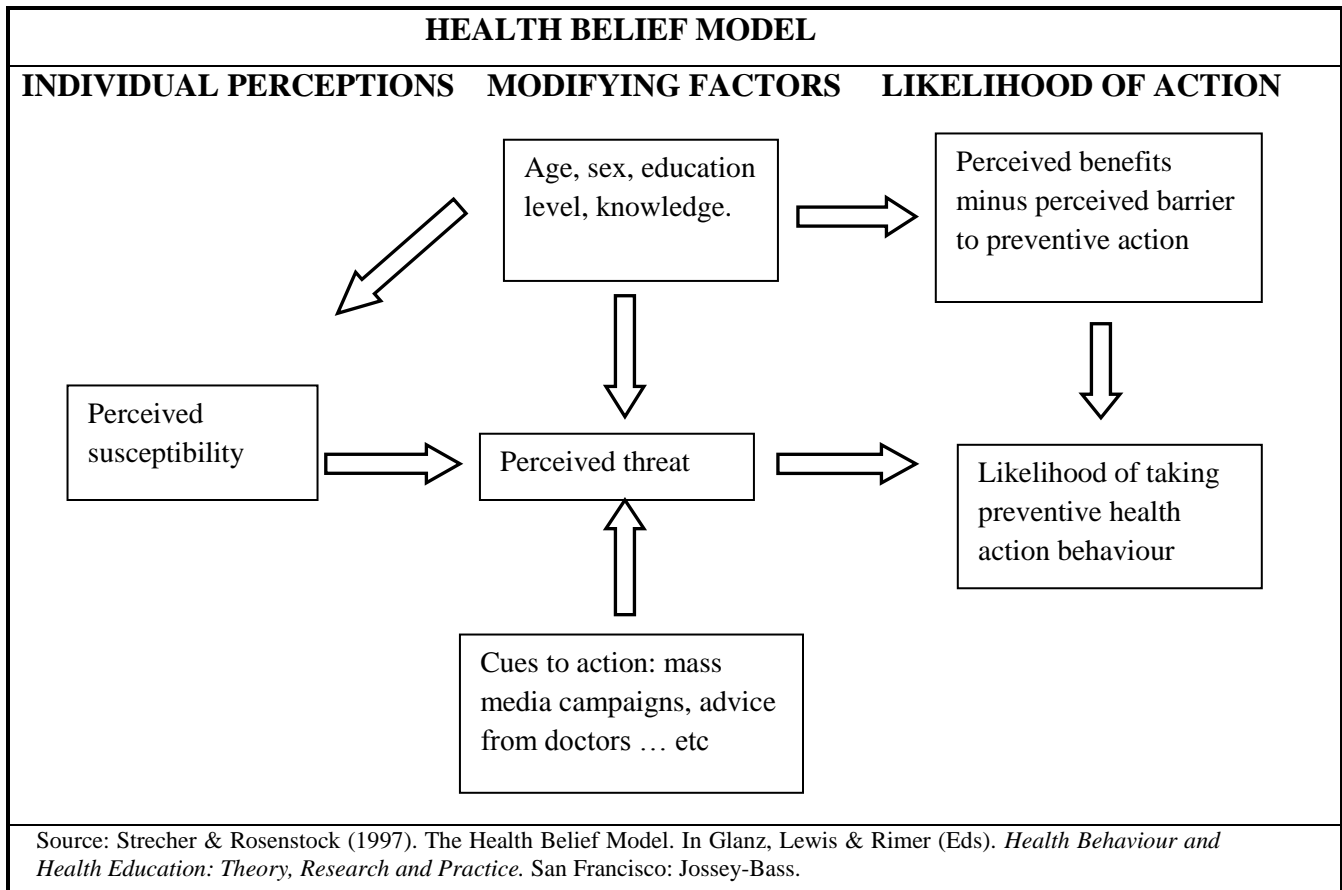
Cues to action

In addition to the four beliefs or perceptions and modifying variables, the HBM suggests that behaviour is also influenced by cues to action. These are events, people or things that move people to change their behaviour. Examples are media reports and media campaigns (Graham, 2000), advice from others, reminder postcards from a health care provider (Ali, 2002) or health warnings on product labels. Knowing a person who has gone through a health behaviour change and how it has benefited them can also act as a cue to action for others (Graham, 2000).

Self efficacy

In 1988, self efficacy was added to the original four beliefs of the HBM (Rosenstock, Strecher & Becker, 1988). Self efficacy is the belief in one's own ability to do something (Bandura, 1977). People generally do not try to do something new unless they think they can do it. If someone believes a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. Unless an individual believes that they are capable of engaging in certain beneficial health behaviours, it will not be performed.

Figure 1: The Health Belief Model



In relation to this study, men who are married or cohabiting with their sexual partners must take time to think about how their lack of participation in family planning decision making could have negative outcomes. Unplanned pregnancies may result in unsafe abortions (perceived seriousness) by women thus endangering their lives and those of their families. Men must give adequate thought to the serious consequences that could result from lack of participation in decision making (susceptibility) and if they manage to overcome the barriers that prevent them from using male methods, the benefits will be realized eventually.

Using this model, family planning providers could develop messages that are tailored to target men especially those that explain the use and benefits of modern male family planning methods. It is crucial that they understand that the benefits of family planning may not be felt immediately but eventually they will be experienced but only if change in health seeking behaviours among men is adopted.

2.2.2 Rational Choice Theory

Rational choice theory is an approach used by social scientists to understand human behavior. It is basically about how incentives and constraints affect human behavior. Rational choice theory is based on several assumptions: One of those is individualism; it focuses on individual behavior. The second assumption is that individuals have to maximize their goals, and the third is the assumption that the individuals are self-interested.

Keel (1997) describes the central points of this theory as follows:

1. The human being is a rational actor.
2. Rationality involves an end - means calculation.
3. People freely choose their behavior, negative or positive, based on their individual rational calculations.
4. The central element of calculation involves a cost benefit analysis: Pleasure versus pain or hedonistic calculations.
5. Choice, with all other conditions equal, will be directed towards the maximization of individual pleasure.
6. Choice can be controlled through the perception and understanding of the potential pain or punishment that will follow an act judged to be in violation of the social good, the social contract.

In rational choice theories, individuals are seen to be motivated by the wants or goals that express their 'preferences'. They act within specific, given constraints and on the basis of the information that they have about the conditions under which they are acting. At its simplest, the relationship between preferences and constraints can be seen in the purely *technical* terms of the relationship of a means to an end. As it is not possible for individuals to achieve all of the various things that they want, they must also make choices in relation to both their goals and the means for attaining these goals. Rational choice theories hold that individuals must anticipate the outcomes of alternative courses of action and calculate that which will be best for them. Rational individuals choose the alternative that is likely to give them the greatest satisfaction (Heath 1976: 3; Carling 1992: 27; Coleman 1973).

The idea of 'rational action' has generally been taken to imply a conscious social actor engaging in deliberate calculative strategies. Homans (1961) argued that human behaviour, like all animal

behaviour, is not free but determined. It is shaped by the rewards and punishments that are encountered over their lifetimes. People do those things that lead to rewards and they avoid whatever they are punished for. Reinforcement through rewards and punishments - technically termed 'conditioning' - is the determining factor in human behaviour. This behaviour can, therefore, be studied in purely external and objective terms; there is no need to invoke any internal mental states. People learn from their past experiences, and that is all we need to know in order to explain their behaviour.

According to Homans (1961), the character of the rewards and punishments may differ, but the mechanisms involved are the same. In social interaction, individuals are involved in mutual reinforcement. Each participant's behaviour rewards or punishes the other, and their joint behaviour develops through this 'exchange' of rewarding and punishing behaviours. While any behaviour can, in principle, reinforce the behaviour of another, Homans (1938) held that *approval* is the most fundamental human goal. Approval is a 'generalized reinforcer' that can reinforce a wide variety of specialized activities. Because of its generalized character, Homans saw approval as directly parallel to money. Both money and approval are general means of exchange in social interaction, one in economic exchange and the other in social exchange.

Critique of Rational choice theory

1. The problem of social norms, the other aspect of the Hobbesian problem of order, also poses difficulties. Rational choice theories cannot explain the origins of social norms, especially those of altruism, reciprocity, and trust.
2. The problem of collective action poses great difficulties for rational choice theory, which cannot explain why individuals join many kinds of groups and associations.
3. The problem of social structure is a feature of methodological individualism, rather than rational choice theory *per se*, but it creates difficulties for the theories considered. Solutions to this problem have been in terms of the unintended consequences of individual action.

In summary and in relation to this study, it can be said that men require adequate knowledge and proper understanding of modern family planning methods in order to facilitate their participation in family planning decision making. When deeper understanding is gained and learning occurs through

experience men can have a better standard of living and quality of life. As much as the use of male family planning methods among married couples is a controversial issue, men need to weigh the costs and benefits of not participating in decision making which facilitates consumption. It can also be concluded that men need a strong social support system as well as an education system that encourages them and approves of their participation in family planning matters. In this way, they will be more comfortable and give serious thought to family planning as their social system will have approved this behaviour for themselves and their families.

No action taken by any man is haphazard, but rather is as a result of a well thought out and rational evaluative process. Men in rural and urban settings should feel. Both men and women in rural settings should be liberated enough as a result of social education and be able to rationalize behaviour beyond their norms and cultural values which many times are a hindrance to social and economic development. With the proper systems, modern family planning can be embraced especially by men in Kenya which will lead to achieving vision 2030 and other national and international goals more efficiently.

2.2.3 Social Exchange Theory

This theory arose out of the philosophical traditions of utilitarianism, behaviorism, and neoclassical economics. Early social exchange theory applications in family science arose out of the work of sociologists (Blau, 1964; Homans, 1961; Thibaut & Kelley, 1959) who focused on the rational assessment of self-interest in human social relationships. At its most basic, social exchange theory may be viewed as providing an economic metaphor to social relationships. The theory's fundamental principle is that humans in social situations choose behaviors that maximize their likelihood of meeting self interest in those situations.

In taking such a view of human social interactions, social exchange theory includes a number of key assumptions. First, the theory operates on the assumption that individuals are generally rational and engage in calculations of costs and benefits in social exchanges. In this respect, they exist as both rational actors and reactors in social exchanges. This assumption reflects the perspective that social exchange theory largely attends to issues of decision making.

Secondly, the social exchange theory builds on the assumption that those engaged in interactions are rationally seeking to maximize the profits or benefits to be gained from those situations, especially in terms of meeting basic individual needs. In this respect, social exchange theory assumes social exchanges between two or among more individuals are efforts by participants to fulfill basic needs.

Third, exchange processes that produce payoffs or rewards for individuals lead to patterning of social interactions. These patterns of social interaction not only serve individuals' needs but also constrain individuals in how they may ultimately seek to meet those needs. Individuals may seek relationships and interactions that promote their needs but are also the recipients of behaviors from others that are motivated by their desires to meet their own needs.

Lastly, the social exchange theory argues that individuals participate in a relationship out of a sense of mutual benefit rather than coercion. Thus, coercion should be minimized at all times in mutual relationships in order to meet desired goals for all parties involved in this mutually beneficial relationship.

From a social exchange perspective, then, human behavior may be viewed as motivated by desire to seek rewards and avoid potential costs in social situations. Humans are viewed as rationally choosing more beneficial social behaviors as a result of rational reviews of all available information. Because all behavior is costly in that it requires an expenditure of energy on the part of the actor, only those behaviors that are rewarded or that produce the least cost tend to be repeated. Thus, social exchanges take on an air of consistency in that patterns of rewards often remain stable in social relationships.

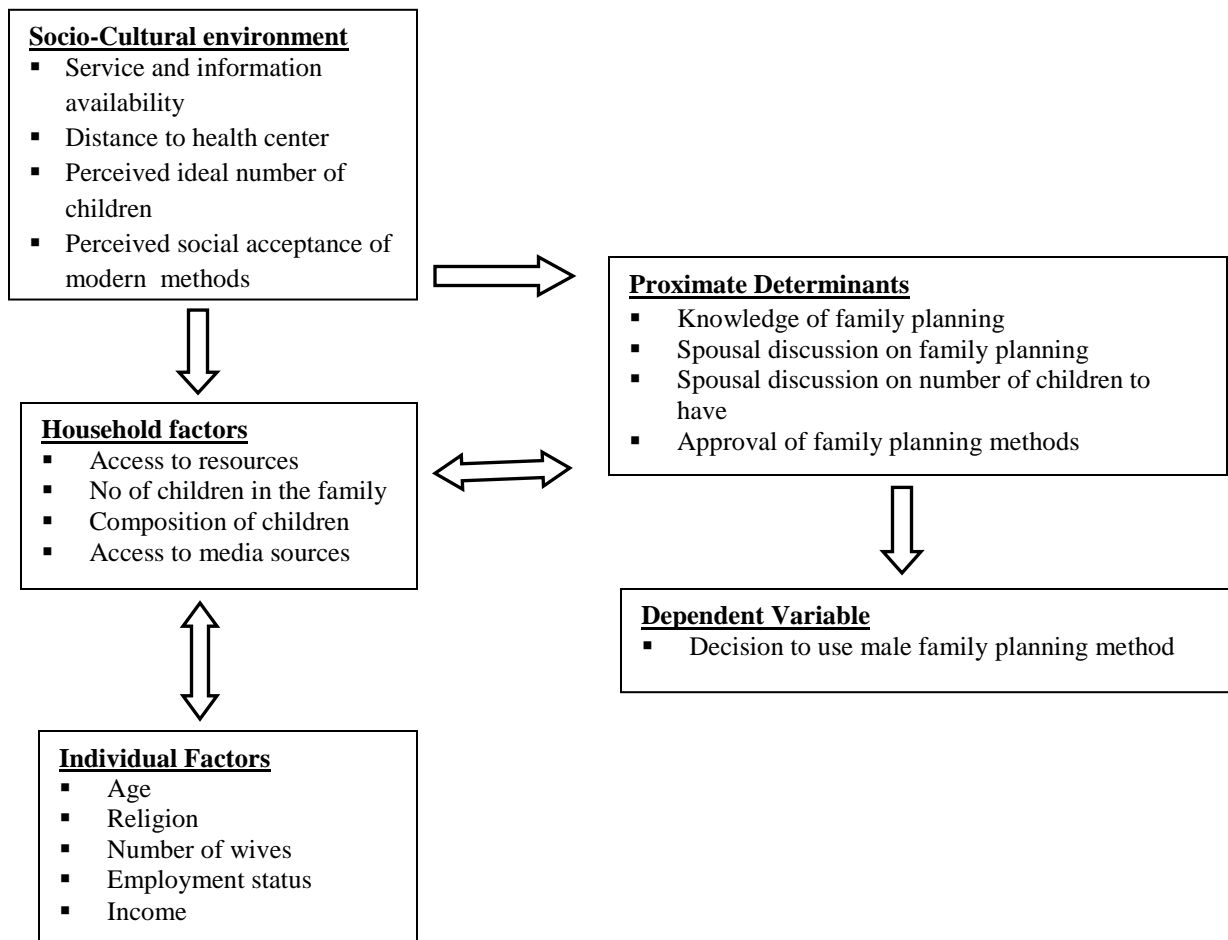
In relation to this study on male participation in family planning decision making, the social exchange theory can be applied among men and their sexual partners because both are in a mutually beneficial relationship. Because both parties are assumed to be voluntarily in the relationship, men should also be able to take up as equal responsibility for decision making and use of male family planning methods. When there is readily available and accurate information on family planning, men will weigh the costs and benefits of using these methods and relate them to the eventual social and economic gain that they will experience when using the methods. The social exchange theory therefore acts as a guide to assist men in making the choice of participating in and using male family planning methods to space births as well as prevent the spread of disease. Not only is it beneficial for their spouses, but for themselves as well in the long run.

2.3 Conceptual Framework

The schematic presentation below examines the relative roles of various interrelated characteristics as determinants of participation in family planning decision making.

Figure 2: Conceptual Model

Independent Variables



NB: The arrows indicate hypothesized relationships between variables.

Figure 2 above tries to show how an individual may possibly make decisions to use male family planning methods as influenced by his individual characteristics and beliefs, household characteristics and most importantly the socio-cultural environment which surrounds him. For instance, if a man wanted to undergo a vasectomy, in his decision making process he would factor in his age, religious values, number and well being of his children and also the social acceptability of the method as dictated by his environment. With all this in mind coupled with the information he may have about the process, a decision will be made of whether or not to use the male method in mind.

CHAPTER THREE: SITE DESCRIPTION AND RESEARCH METHODOLOGY

3.0 Introduction

This section describes the methodology that was used in this study. The research site, study population, study design and unit of analysis, research tools, sampling procedures, data analysis and the ethical issues relating to the study.

3.1 Site Description

The study was undertaken in Vihiga County, Western Kenya. Vihiga County covers an area of 530.9 square kilometers. It is among the four main counties in Western province inclusive of Bungoma, Busia and Kakamega. It receives annual rainfall of between 1,800mm and 2000mm and has an average temperature of 24 degrees Celsius (Vihiga County Data Sheet, Open Kenya, Transparent Africa, 2012). Agriculture is the main economic activity with crops planted including tea, maize, millet, bananas, sweet potatoes and cassava. According to the 2009 KDHS results, Western Province holds the record of the highest TFR of 5.6 compared to Nairobi which has the lowest TFR of 2.8 (KNBS and ICF Macro, 2010). Vihiga County was chosen as the most suitable research site because the researcher is familiar with the territory making it easy to travel within the area and also because it consists of a largely homogenous rural Luhya community¹.

According to the 2008-09 KDHS findings, Vihiga County has a total population of approximately 544,622 and approximately 123,347 households and a population density of about 1,045 people per square kilometer which is on the higher side. Its total population comprises of 47% male and 53% female in the county. The age distribution in this county with respect to population demographics has been recorded as follows: 0 -14 years (44.2%), 15 – 64 years (49.4%) and 65 and above (6.1%) which indicates that majority are the young persons (KNBS and ICF Macro, 2010).

¹ The Luhya community consists of a cluster of 19 dialects but the residents of Vihiga county are homogenous because they speak Maragoli dialect, which the researcher is familiar with.

<u>Table 1: 2008-09 KDHS TFR rates per province</u>			
<u>Total Fertility rates according to province and residence</u>			
<u>Background Characteristic</u>	<u>1998 KDHS 1995-98</u>	<u>2003 KDHS 2000-03</u>	<u>2008-09 KDHS 2006-08</u>
Residence			
Rural	3.1	3.3	2.9
Urban	5.2	5.4	5.2
Province			
Nairobi	2.6	2.7	2.8
Central	3.7	3.4	3.4
Coast	5.1	4.9	4.8
Eastern	4.7	4.8	4.4
Nyanza	5.0	5.6	5.4
Rift Valley	5.3	5.8	4.7
Western	5.6	5.8	5.6
North Eastern	μ	(7.0)	(5.9)
μ = unknown (not available)			
Note: Total Fertility Rates are for the period 1-36 months prior to interview. Data for the 1998 KDHS exclude North Eastern Province and several other northern districts. Total fertility rates in parentheses are based on fewer than 750 unweighted women.			

In the previous years, a study on family planning practices was conducted within the Western and Nyanza regions of Kenya because these areas are well known for their large families, and their populations have often been reluctant to embrace modern methods of family planning partly due to traditional norms and values (APHRC, 2009). The total TFR for both Western and Nyanza regions is 5.5 which is higher than the national average of 4.6. These differentials in fertility are closely associated with disparities in educational levels and knowledge and use of family planning methods (KNBS and ICF Macro, 2010).

Figure 3: Map of Kenya showing specific study area

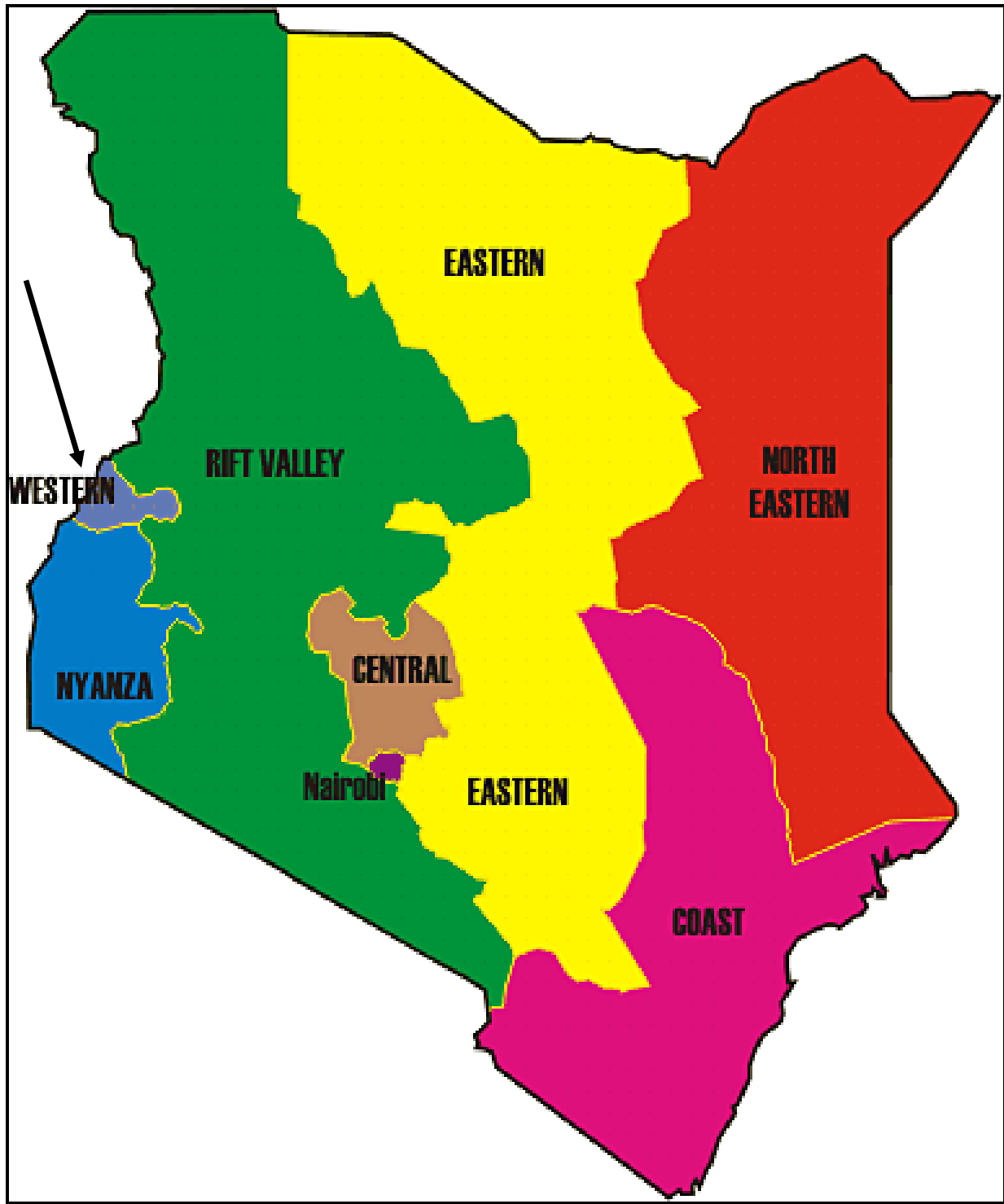


Figure 4 : Administrative Map of Vihiga County



The study was carried out in three sub-counties namely Emuhaya, Hamisi and Sabatia. This is because these three areas have the highest population count among all five as represented in the table below (KNBS and ICF Macro, 2010). More so, Vihiga County also consists of a largely homogenous Luhya community (Maragoli speaking) which was important because it assisted in forming informed generalizations about the family planning seeking behaviour of men in this community.

Table 2 : Sub-County total population

SUB-COUNTY	MALE	FEMALE	TOTAL
EMUHAYA	72,132	88,934	161,066
HAMISI	58,874	67,787	126,661
SABATIA	61,438	58,240	119,678
LUANDA	29,856	36,863	66,719
VIHIGA	34,673	35,825	70,498
TOTAL	256,973	287,649	544,622

Source: KNBS and ICF Macro, 2010

3.2 Research Design

This was an exploratory study which adapted both quantitative and qualitative data collection methods aimed at investigating male participation in family planning decision making. According to Cuthill (2010), an exploratory design is taken up on a research problem when there are few or no earlier studies to refer to for the purpose of gaining insight and familiarity for deeper investigations in future. It is purposed to gain a broad understanding of a situation, phenomenon or community.

3.3 Units of analysis and observation

The unit of analysis for this study was participation in decision making among married men in Vihiga County, Western Kenya. This is because it has a high TFR of 5.6 compared to Nairobi which has the lowest TFR of 2.8 (KNBS & ICF Macro, 2010). The units of observation for this study were married men who participated in the survey and FGD as well as family planning providers, who were key informants.

3.4 Target Population

The total target population for this study was 192,444 men from the three sub-counties indicated above.

3.5 Sample Size and Sampling Procedures

A sample can be defined as a smaller representation of a whole (Savaharel & Mahal, 1992). It is a section of the population selected from the latter to represent the whole population. It is used to seek knowledge or information about a population by observing part of it in order to extend the findings to the whole population (Singleton, 1988).

Three data collection methods were used to collect information pertaining to the research study. These methods were; the survey method, focus group discussions and key informant interviews. The sample size and sampling procedures for each data collection method are further discussed below.

i. Survey method

A survey is an attempt to collect data from members of a population in order to determine the current status of that population with respect to one or more variables (Gay, 1983:55). The sample size selected for this exploratory study was 150 married men. This sample was chosen using the proportionate random sampling method which is a method that involves selecting participants from a universe that is not equally distributed in terms of numbers. The formula below was used to obtain equal representation from each sub-county.

$$\frac{\text{Number in Cluster} \times \text{Intended Sample}}{\text{Total Cluster (Universe)}}$$

Using the formula above, and the criteria of men only from the three sub-counties, the following number of respondents were then to be selected randomly within their administrative boundaries to take part in the study.

$$\text{Emuhaya; } 72,132 \times 150 / 192,444 = 56$$

$$\text{Hamisi; } 58,874 \times 150 / 192,444 = 46$$

$$\text{Sabatia; } 61,438 \times 150 / 192,444 = 48$$

To further ensure that the sample remained random and biasness was eliminated while selecting the sample, the lottery method was then further used to select respondents who would partake in the study. For instance in Ebwali village – Emuhaya sub-county – the researcher employed the lottery method to select 56 men for the study. Pieces of paper with the words ‘yes’ and ‘no’ were put in a small bag, mixed thoroughly and 100 men were asked to pick a piece each. Those who selected the ones with ‘yes’ participated in the study. The same random sampling procedure was executed in Jivuye village (Hamisi sub-county) and in Evojo village (Sabatia sub-county) to select the remaining 46 and 48 men respectively.

The survey comprised of a standard structured questionnaire as the data collection tool / instrument for the collection of quantitative primary data. It consisted of mostly closed ended questions meant to capture relevant information and also had open ended but just enough to only capture significant information as well. To facilitate this, one on one interviews were carried out by the researcher and four trained assistants on each of the randomly selected respondents over a period of two weeks. Each

interview took approximately 75 minutes to complete and was conducted in open fields identified by the researcher. The aim of using this method was to generate a general opinion or explanation about family planning decision making behavior among men in this county before getting into details using other data collection methods.

Some advantages of using the survey data collection method was that it offered good statistical significance because of high representativeness brought about by the random sampling procedures used. It also provided basis to further analyze multiple variables such as age, religion and education levels against knowledge of family planning methods of individuals. Another advantage was that the survey method provided the participants with a standard stimulus which assisted in obtaining findings of high reliability because the researcher's own biases were eliminated during responding to the questions. One disadvantage however was the inflexibility of the tool used. In some instances, respondents desired to discuss issues in detail but because of the structure of the tool and to ensure fairness, it was not permitted at that time.

Pre-testing: The questionnaire was pre-tested in Luanda² sub-county with the aim of clarifying meanings, consistency, getting the vernacular versions of the family planning methods and approximating the time required for completion of the questionnaire by the principal investigator and the research assistants. After pre-testing some amendments were made and a final version of the questionnaire was produced for the study.

ii. Focus Group Discussions

A total of 3 FGDs were conducted – at least one in each sub county. A total of 18 men, 6 per group, participated in these discussions which were held outdoors in an open field and took approximately 2 hours to discuss the questions the researcher had. The participants were selected using the purposive sampling method because the study targeted men who were either married or cohabiting, with the intention of forming generalizations about their family planning seeking behaviour. To obtain the sample of six men per sub-county, the researcher ensured that those chosen for FGDs were not the same as those who participated in the survey method. They also had to be married or cohabiting at the time of the study to partake in the group discussions.

² Luanda is one of the five sub-counties in Vihiga County. It was the best location for pre-testing the questionnaires because of its proximity to the targeted three sub-counties for the study.

The purpose of conducting the FGDs was to enable the researcher to collect qualitative data which acted as a supplement to the quantitative data collected using the survey method. It was used to validate the quantitative information submitted by the respondents to the researcher on the research subject. This was an effective method of collecting qualitative data because it provided a forum for the respondents to discuss deep seated issues they have as men about family planning decision making and use of male methods. One research assistant accompanied the principal researcher to each FGD to take notes on issues brought out and this allowed the researcher to engage the men continuously without any interruptions.

One advantage of using this method to obtain data was that because of the interactive manner of the discussions that took place, the participants were able to build on each other's responses, thus improving richness of data being collected for the study. A disadvantage that was noted during this process was that not all opinions from the respondents were found to be agreeable with the whole population and those who held the less popular opinions were openly criticized and ridiculed by their peers. However, such differences were useful in illustrating the different perspectives men held in regard to the use of male family planning methods.

iii. Key informant interviews

Six (6) key informant interviews were conducted for this study. Two (2) family planning specialists were selected from the most popular health facilities in each of the three sub-counties to participate in the study in order to get information and opinions on male involvement in family planning issues.

This sample of 6 key informants was also selected using the purposive sampling method. This is because they possessed the desired characteristics and knowledge that the researcher was looking for in order to assist in filling the gaps identified in this study. The purpose of the key informant interviews was to retrieve information regarding family planning seeking behavior and attitudes among men, especially towards the use of male methods within the selected sub-counties of Vihiga County.

The health centers visited by the researcher were Hamisi Sub-District Hospital, Sabatia Health Center and Emuhaya District Hospital. The interviews took place during lunch hour when the health professionals were available to participate in discussions with the researcher. Each discussion took

approximately one hour and fifteen minutes. This was done to gather information from persons who were knowledgeable in the area of family planning and who had firsthand experience in dealing with men and the issues they encountered while seeking these services.

This qualitative information collected was used to supplement and verify information collected through other methods used such as the survey and FGDs. This data was triangulated in order to enhance the validity and reliability of data obtained in the study. This assisted in forming informed generalizations about men in this specific community and their family planning decision making practices.

An advantage of using this method to collect data was that it provided the researcher with rich information regarding men and family planning in Vihiga County. Collecting data from family planning providers generated information that gave an overview of the attitudes of men towards male family planning methods. One disadvantage however, was that because women are known to be the most common family planning seekers, biasness towards men could have influenced the responses given by the family planning providers.

3.6 Ethical Considerations

Ethics is the application of moral rules and professional codes of conduct to the collection, analysis, reporting, and publication of information about research subjects. With regard to this study, an introductory letter from the Department of Sociology, University of Nairobi was first used to introduce the researcher and purpose of the intended study. The researcher also complied with the principle of voluntary participation and of informed consent to ensure that the respondents knowingly and willingly agreed to participate in the research. Those willing to withdraw from the study at any particular time were also at liberty to do so. The anonymity and confidentiality of the respondents was guaranteed by using serial numbers on the questionnaires instead of their names to conceal their identity for their safety, dignity and privacy.

3.7 Data Analysis Methods and Procedures

Quantitative data collected using the survey method was analyzed using descriptive statistics. This was done using pie charts, graphs and percentage distributions and means as needed, tabulated using the statistical package for social sciences (SPSS) software.

Qualitative data, collected through focus group discussions and key informant interviews was analyzed for content that would be used to support other findings from the study. The information was grouped into broad themes, organized, summarized and presented in direct quotations of relevant verbatim responses and selected comments. Narrative analysis was used.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents the findings of the study on male participation in family planning decision making in Vihiga County. It is organized into thematic areas as based on the objectives of the study stated in chapter one which are: to identify men's sources of information, to explore the attitude of men towards family planning, to determine male participation in decision making and to identify socio-cultural factors influencing participation in decision making.

Sample Description

This section gave an overall description of the sample population and their characteristics that was found during the study.

4.1. Age Distribution

From the sample population of 150 men, majority of the respondents (78%) were found to be between the ages of 25 and 38. Twenty two (12%) were found to be between 35 and 49 years, those between 18 and 24 were 3% while those aged 45 and above constituted of 7% of the sample.

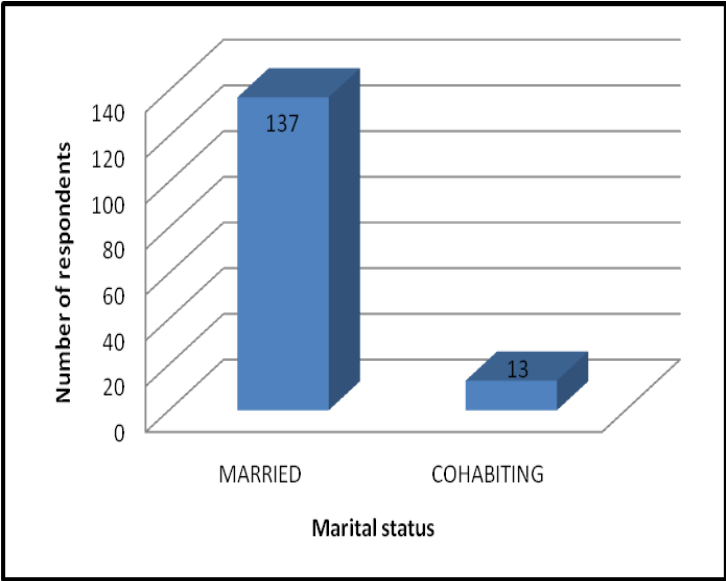
Table 3: Age of respondents

AGE	FREQUENCY	PERCENTAGE
18-24	4	2.67
25-31	72	48.00
32-38	45	30.00
39-45	18	12.00
45 and above	11	7.33
TOTAL	150	100.00

4.1.2 Marital status

The study targeted men who had regular sexual partners. Those who considered themselves as married were 91% (137 respondents) while those who considered themselves as cohabiting were 9% (13 respondents).

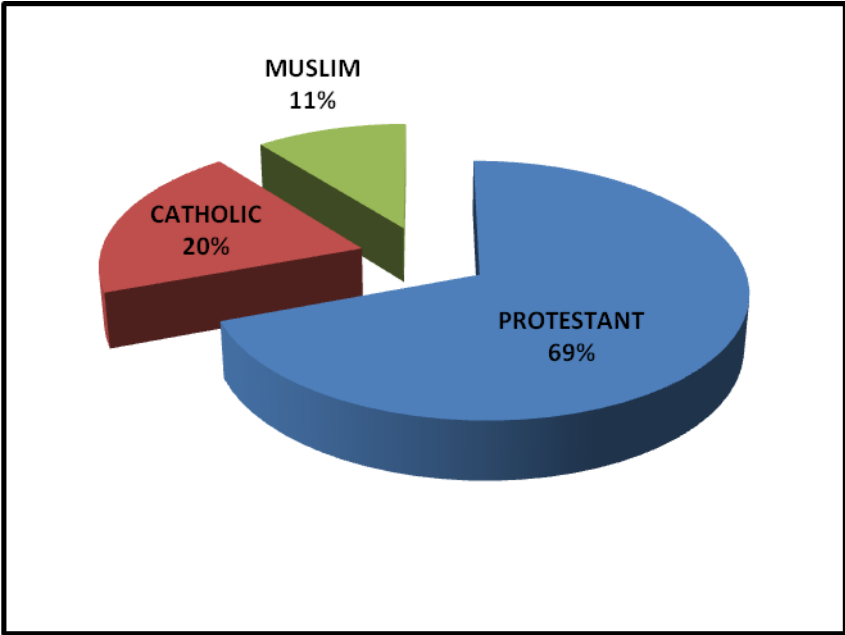
Figure 5: Respondents marital status



4.1.3 Religious background

The study found majority of the respondents were Christians (69%), followed by Catholics at 20% and Muslims at 11%.

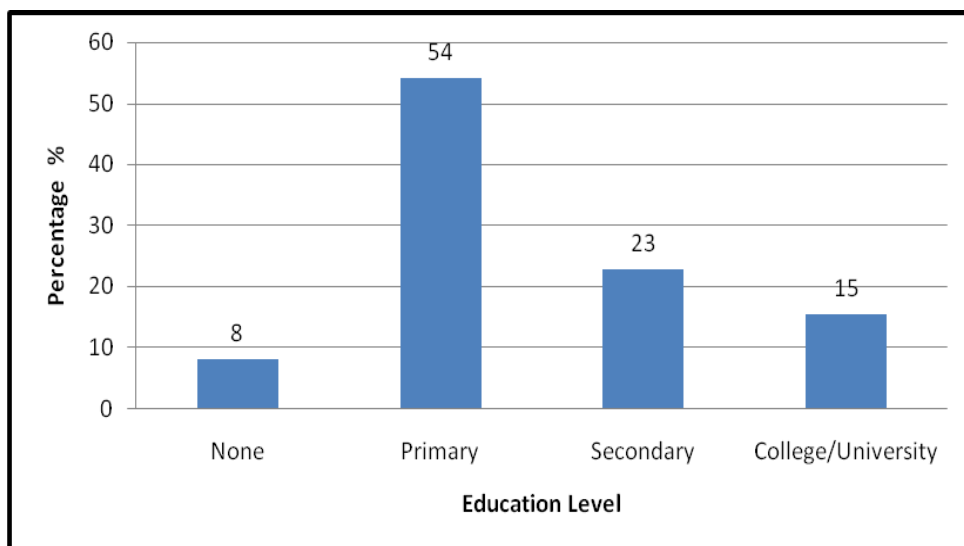
Figure 6: Distribution of religious affiliations



4.1.4 Education level

More than half of the targeted respondents (54%) were found to have obtained primary level education, 23% had secondary education, and 15% had college/university education while a minority 8% had no schooling at all.

Figure 7: Respondents Education Levels



4.1.5 Occupational status

Table 4 reveals that 27% of the respondents were engaged in agricultural activities due to the climate in the area, 20% were formally employed, and 50% were engaged in informal and other types of employment while only 1% reported not to be engaged in any economic activity at all. This could be assumed to be as a result of the type and level of education that the respondents received which consequently led them to their current status.

Table 4: Respondents employment status

OCCUPATION	FREQUENCY	PERCENTAGE
None	2	1.33
Farmer	41	27.33
Teacher	13	8.67
Make Crafts	12	8.00
Trader/Sell Goods	22	14.67
Barber	2	1.33
Manage Hotel	15	10.00
Casual Laborer	27	18.00
Other	16	10.67
TOTAL	150	100.00

4.1.6 Number of wives

On average, about 57% of the respondents, (5 in every 10 men), reported to have only one wife while 43% reported to have more than one as indicated in table 5 below.

Table 5: Respondents' number of wives

NO. OF WIVES	FREQUENCY	PERCENTAGE
1	86	57.33
2-3	38	25.33
4-5	22	14.67
5-6	4	2.67
TOTAL	150	100.00

This data therefore tells us that in this county, both monogamous and polygamous unions exist and can be due to several reasons such as inheritance of wives, social status that comes with having many wives or the search for children of specific genders from other women.

4.1.7 Number of living Children

During the time of the study, it was found that 89% of the respondents reported to have had between 3-8 children, 9% had 1-2 while only 2% had more than 9 at the time of the study.

Table 6: Number of children

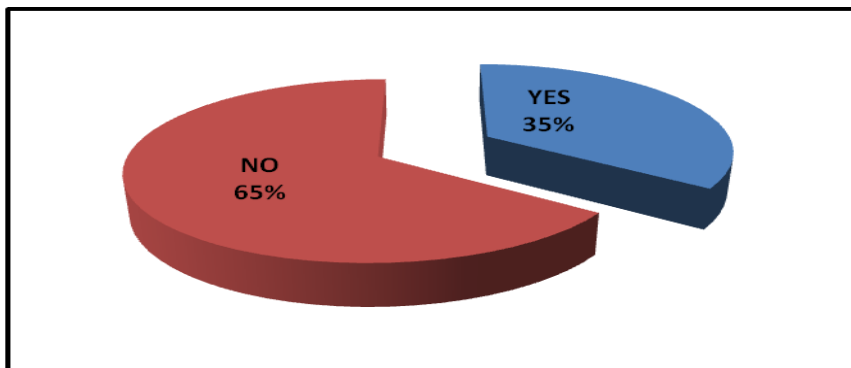
NO. OF CHILDREN	FREQUENCY	PERCENTAGE
1-2	13	8.67
3-4	66	44.00
5-6	45	30.00
7-8	23	15.33
9-10	3	2.00
TOTAL	150	100.00

It can therefore be assumed that in this county, there is a high cultural value placed on having many children. Traditional societies in Kenya place intrinsic value on children and having many has always been a sign of ultimate manhood. More so, literature suggests that many rural families like to have many children as a form of social security and to have care takers when in old age.

4.1.8 Loss of Children

When asked if they had lost any children through death, 35% reported to have ever lost children while 65% had not.

Figure 8: Percentage of respondents who have ever lost children

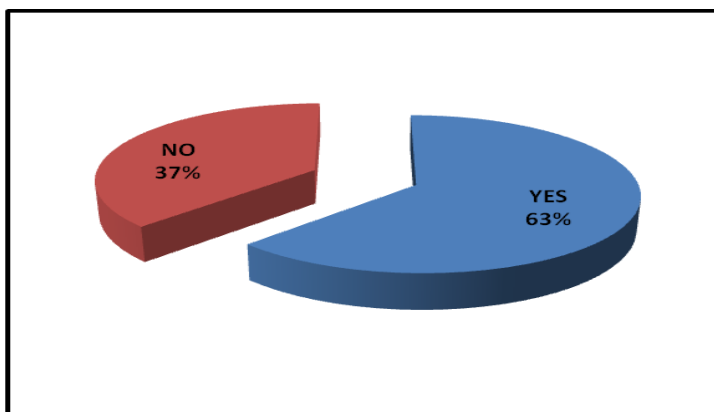


According to the 2008-09 KDHS survey, the current child mortality rate is 52 out of every 1000 live births, a number which is slowly reducing over time, but is still significantly high especially in rural areas. According to the survey, some of the leading causes of child and infant deaths are caused by diarrhea, dehydration, malaria and acute respiratory illnesses such as tuberculosis which are all preventable.

4.1.9 Desire for more children by men

Approximately 6 out of every 10 men (63%) reported they would like to have more children. In contrast with 37% who indicated they did not want any more. In a previous study carried out in Western and Central Kenya (NCPD, 1989), findings revealed that 44.7% of men living in rural areas desired to have more children despite most of them having an average of about four living ones at the time.

Figure 9: Men who want more children



4.1.1.0 Desired sex of children

When asked whether one sex was preferable over the other, majority of the respondents (75%) reported that they preferred having male children as opposed to female ones (25%) as indicated in table 7 below.

Table 7: Preferred gender of children by men

SEX	FREQUENCY	PERCENTAGE
MALE	113	75.33
FEMALE	37	24.67
TOTAL	150	100.00

One respondent, who was a teacher by profession and had 6 children, supported his preference for sons by stating that:

If I had no sons at all I would keep trying until I have at least one. It is important for your family name to be carried out for as long as possible.

Similar to this are findings from a study conducted in Zimbabwe (Machipisa,1997) where reports indicated that traditionally, men preferred male children (47.6%) so that they could depend on them for socio-economic support in old age after their daughters are married and are away from home. In rural China, findings also revealed that 84% of the population also had sex preference and in the occasion that a couple would have a girl, she would be cared for less and even breastfed much less than a boy would be.

More so, a study by NCPD (1989) showed that although the Kenyan Kikuyu and Luhya communities have never been known to prefer sons to daughters as it is in most Asian countries such as India, it is true that most would want at least one son to ensure that there their lineage will be carried on and inherited property to remain within the family.

To conclude this section, it can be deduced that sex preference among rural families in this county is sometimes used as an excuse by couples who have had too many children and seek to justify it with the reason of looking for a boy which consequently acts as a barrier to the use of male family planning methods.

Analysis of the main findings

This section consists of the analysis of findings grouped into thematic areas based on the objectives that this study sought to meet.

4.2 Knowledge of family planning information

The first objective sought to identify men's sources of information on family planning. Literature suggests that exposure to mass media promoting family planning methods can affect contraceptive behaviour. In this study, it was hypothesized that there is a strong positive relationship between being exposed to family planning messages and the inclination to use male methods which the findings sought to prove if factual.

Table 8: Knowledge of methods

METHOD	NUMBER OF RESPONSES	PERCENTAGE OF TOTAL RESPONSES
Coil/IUD	122	81.33
Condom	150	100.00
Diaphragm	87	58.00
Female Injections	115	76.67
Norplant	86	57.33
Periodic Abstinence	85	56.67
Pill	78	52.00
Tubal Ligation	36	24.00
Vasectomy	22	14.67
Withdrawal	150	100.00

Table 8 shows the number of responses obtained from the respondents on each method when asked whether they had ever heard of the family planning methods listed above. From the findings, 100% reported they knew of condoms, 81% of the coil/IUD and 77% of female injections which were the commonly used methods in the areas explored by the study. It was also found that 100% of the men had heard of withdrawal as a traditional method but only 15% reported to have ever heard of vasectomy as a modern male method of family planning.

Proper knowledge of family planning methods is an investment for any family planning program provider. It is always important to know how many people in a target population have knowledge on the various methods available before embarking on an awareness program. In knowing this, family

planning providers can improve the distribution of services and dissemination of information thus enhances the number of men and women who consume these services. It is also worth noting that knowledge of methods is also influenced by variables such as age, education level, marital status, religion as well as place of residence (rural/urban areas).

4.2.1 Sources of family planning information among men

Because knowledge of family planning methods is determined by exposure to messages, the researcher then sought to determine the major source of information and how it influenced decision making among the respondents.

Table 9: Major sources of information

SOURCE	NUMBER OF RESPONSES	PERCENTAGE OF RESPONDENTS INDICATING SOURCE
Radio	72	24.32
Television	55	18.58
Newspaper	23	7.77
Magazine	7	2.36
Leaflet	29	9.80
Poster	37	12.50
Health centre	15	5.07
Friends	42	14.20
Neighbors	16	5.40
TOTAL	296	100.0

Table 9 shows the number of responses given on the major sources of family planning information. From the table, 43% of the respondents stated that audio-visual forms of mass media (radio and television) were the most common source, 32% stated print media (newspapers, magazines, leaflets and posters), 20% got their information from individuals (friends and neighbors) while only 5% from health centers.

Findings from the 2009 KDHS data showed that about 1 in every 4 men have not been adequately exposed to family planning messages through the media. It was revealed that 71% of men heard of family planning information through the radio while 40% heard through the television while 34% of men got this information through various print media sources. Findings from this survey also showed that there is a sharp contrast between rural and urban areas in exposure to family planning messages.

To verify this information is a statement from a nurse at Hamisi sub-district hospital:

“From the few men we have spoken to, we know that most of them get their information from what they hear on radio, television, from friends and sometimes, but rarely, from health centers. The information they receive out there is usually not accurate and therefore they develop bad attitudes on family planning. We wish they would come to health centers to get accurate family planning information.”

It can therefore be concluded that audio-visual sources seem to be already accepted and authoritative sources of information about family planning and they have the potential to reach an even wider audience. On a daily basis, men are exposed to mass media as most own radios and sometimes televisions can be viewed at social areas such as bars while newspapers are also widely shared among those who can afford them. Mass media therefore has high credibility as sources of information which should be used by service providers to disseminate accurate information about male methods of family planning. It is also important to note however, that poverty, low literacy levels may be a barrier to this especially when using print media to give information.

4.2.2 Current use of male methods by respondents

To determine whether the hypothesis about exposure to family planning messages and inclination to use male methods was accurate, the researcher probed further to find out if the respondents were currently using any male designed family planning method. The following responses were obtained from the sample:

Table 10: Male methods currently in use

METHODS	RESPONSES	PERCENTAGE
Condoms	108	55.67
Withdrawal	56	28.87
Periodic abstinence	28	14.43
Vasectomy	2	1.03
TOTAL	194	100.00

From the findings above, it can be concluded that there were respondents who were using more than one male method simultaneously. Table 10 shows that more than half of the respondents (56%) were using condoms and the second most popular method was withdrawal (29%). Periodic abstinence was reported by 14% of the respondents while only 1% reported to have undergone vasectomy. On further inquiry during the focus group discussions, the respondents were asked what influenced their use of the stated methods, whether it was exposure to mass media messages or not. One respondent who reported to use both condoms and vasectomy with his wife stated the following:

“Sometimes I use condoms and sometimes I use withdrawal with my wife. Although I sometimes hear messages of radio, my choice is not influenced by any messages but because we are poor and condoms are sometimes free and so is withdrawal. We cannot afford other family planning methods although if I knew of other good methods I would consider using them. One of my sons will soon be married and I have told him how he can spill his seed outside of his wife. It is a free method but sometimes very hard to control.”

The responses obtained in table 10 correspond with findings on knowledge of family planning methods. It can be noted that the more popular the male method among the respondents, the higher the probability of them using it.

It can therefore be said that although knowledge of methods and exposure to family planning messages may influence the contraceptive behaviour of men, other factors such as literacy levels and poverty also influence their decisions. Poverty is a major bottleneck to male involvement in reproductive health programmes. Due to poverty, access to a radio or television is a preserve of very few men. The situation is more acute in rural areas (such as the research site) where the vast majority of the population in sub-Saharan Africa lives, yet where the infrastructure is poor and wanting. Lack of access to print and electronic media coupled with high illiteracy levels means that few men have access to quality reproductive health information.

4.3 Perceived male attitudes towards family planning

The second objective sought to explore men’s attitudes towards family planning. In this study, it was hypothesized that the source of information, coupled with spousal discussions on family planning influenced the attitude that men held towards family planning. To determine if this is accurate, spousal discussion, knowledge of modern family planning methods which leads to the formation of attitudes was analyzed in this section.

4.3.1 Spousal discussion on family planning

In order for couples to adopt the use of male family planning methods, spousal discussion is prerequisite because it assists in perceiving and forming partners’ attitudes about it which then determines participation in decision making. Literature suggests that spousal discussion is a key tool when it comes to increasing the knowledge and improving the attitude of partners towards family planning which should increase uptake among couples.

Table 11: Discussion among couples

EVER DISCUSSED	RESPONSES	PERCENTAGE
YES	64	42.67
NO	86	57.33
TOTAL	150	100.00

When respondents were asked whether they have ever discussed family planning in general with their spouses, 57% stated that they had never while only 43% reported to have done so. This finding can be attributed to the power relations in the traditional Kenyan communities where the man is the head of the household and the gate keeper of all that goes in and out of his homestead. This is indeed a strong determinant of whether couples discuss family planning at all. If the man does not initiate this conversation, it does not take place because it has not come from him as the head. One respondent who reported to have never discussed family planning with his wife, stated that

“My wife and I have never discussed family planning because it is not natural. Even the Bible does not say anything about family planning and children will come when God gives them to us. She cannot dare ask me about that nonsense”

Contrary to his opinion, was a statement from a respondent who reported to have one wife and six children. He stated that:

“My wife and I already had more children than we could manage. She was becoming weak and tired and eventually we had this talk on family planning. We agreed on using family planning and went to the clinic together to seek advice and she was put on a method. Many methods available are for women. Men have very little options”

These findings are similar to a study carried out in Ghana (Ezeh et al., 1996) which showed that nearly 50% of married men reported to have never discussed family planning with their wives and none of their spouses had ever initiated this conversation with them probably for fear of disapproval or damaging family relations. In East Africa (Uganda), the same study showed that about 40% have never discussed it and in North Africa (Tunisia) the numbers were even lower (Ezeh et al, 1996). These findings therefore suggest that spousal discussion on family planning is still quite low in Kenya and other African countries and needs to increase in order to enhance male participation and use of methods designed for them.

4.3.2 Spousal discussion on female methods

Table 12: Ever discussed female methods

EVER DISCUSSED	RESPONSES	PERCENTAGE
YES	98	65.33
NO	52	34.67
TOTAL	150	100.00

Table 12 shows that majority of men (65%) reported to have discussed female methods with their spouses while only 35% reported to have never done the same. A trader who had one wife and two children, and reported to have discussed female methods stated that:

“It is easier to discuss female methods because they are well known and more common, especially the pill and the injection. It is true that we do not know how exactly how they work but it works all the same.”

Another respondent who reported to be cohabiting and had one child and had never discussed any female methods with his spouse stated that:

“It is not acceptable in our culture for men to get mixed in womens business and for women to do the same for mens business. Family planning matters are best left to women because they are the ones who get pregnant.”

In India, studies have shown that countless women have been interviewed on family planning (Barua and Kurz 2001, Edmeades et al. 2011, Kumar et al. 2010, NFHS-1 1992, NFHS-2 1999) and very few studies have sought men’s views which has contributed to the low numbers in their participation (Balaiah et al. 1999, Balaiah et al. 2005, Chankapa et al. 2010, Das and Ray 2007, IIPS 2005–06). This finding demonstrates that although female methods continue to be the number one option of family planning in rural India, its ‘popularity’, according to men, is more because it is the method that is most known and understood by eligible couples. In this study, 65% of men reported to have ever discussed female methods, due to their popularity against male methods (35%) indicating a trend of preference for female methods across the globe.

4.3.3 Spousal discussion on male methods

Table 13: Methods discussed

METHOD	RESPONSES	PERCENTAGE OF RESPONDENTS
Condoms	123	65.08
Withdrawal	42	22.22
Periodic Abstinence	18	9.52
Vasectomy	2	1.06
No answer	4	2.12
TOTAL	189	100.00

When the respondents were asked which male methods they had ever discussed with their spouses, the responses given were recorded in Table 13 above. Findings showed that the most common method ever discussed was the male condom (65%) followed by withdrawal at 22%. Periodic abstinence was discussed by 10% of the respondents while vasectomy was discussed by only 1% of the respondents.

Findings from a study conducted in Uganda, Zimbabwe and Tanzania (Beckmann, 1983; Mbizvo & Adamchak, 1991), found that partner discussion regarding male family planning was found to increase fertility-regulating behaviour and encouraged men to participate more in using methods designed for them. However, the study also found that only 38% of women were comfortable discussing family planning with their husbands alone while 62% preferred to carry out this discussion in the presence of a family planning health provider. In conclusion, we can presume that frequent spousal discussion on male designed family planning methods can lead to an increase in its use. However, because of power relations, many women feel intimidated to bring up the issue, no matter how important to them thus men are always excluded in decision of whether to use these methods themselves.

4.3.4 Knowledge of vasectomy

As noted in findings from Table 8, and also in Table 14 below, only 22 respondents (15%), reported to know about vasectomy. The low percentage of those who are aware of the most advanced male family planning method can be attributed to lack of exposure to messages through various forms of media as well as to low levels of spousal communication on male methods.

Table 14: Awareness of vasectomy

AWARENESS	RESPONSES	PERCENTAGE OF RESPONDENTS
YES	22	14.67
NO	128	85.33
TOTAL	150	100.00

In a study conducted in Nairobi and Mombasa on vasectomy (JHU/ICS, 1992), it was found that over two-thirds (69%) had heard of the “operation for men to have no more children” though only 23% could name it correctly. These findings are contrary to those found in Vihiga County and one explanation for this could be that Nairobi and Mombasa are both urban areas and information flows

more freely in those areas as compared to rural areas such as Vihiga County, where this study took place.

Table 15: Major sources of information on vasectomy

SOURCE	RESPONSES	PERCENTAGE
Radio	9	40.90
Television	4	18.18
Newspaper	5	22.73
Health Center	3	13.64
Friend	1	4.55
TOTAL	22	100.00

Of the respondents who reported to know about vasectomy, 58% heard about it from mass media, 23% from print media, 14% from health centers and 5% from friends. One respondent who heard about it from radio stated that:

“I remember once hearing people on radio mention vasectomy as a family planning method for men. However, not much was said about it. How can we know what it is about and how it works if details are not available? If it was a method for women I am sure it would have been discussed more!”

This finding is important because it tells us that mass media continues to be the most common source of family planning information and this resource should be utilized by providers to talk about and explain how it works as a permanent method. The range of family planning methods available to men at present is limited, and this inhibits men’s capacity to participate in fertility regulation and reproductive health programmes effectively. For example, studies in some African countries such as Kenya and Zimbabwe show that lack of adequate information and services on male methods such as vasectomy is a major hindrance to their use of family planning services (Wilkinson, 1989; Miller et al., 1991; Green, Cohen & Ghouayel, 1995; Kim, Marangwanda & Kols, 1996). To rectify this shortcoming, adequate and proper information must be disseminated through various forms of mass and print media in order to enhance use of male methods.

4.3.5 Use of vasectomy as a family planning method

Despite 15% of the respondents having heard about vasectomy, with little / inadequate or no access to information about it, not many men would be willing to use it as a family planning method.

Table 16: Perceived approval of vasectomy as a family planning method

IS VASECTOMY A GOOD METHOD?	RESPONDENTS	PERCENTAGE
YES	7	31.82
NO	15	68.18
TOTAL	22	100.00

Table 16 shows that only 7 out of 22 respondents (32%) who had heard of vasectomy thought it was a good family planning method while a majority 68% did not agree. A respondent who had one wife and eight children and who agreed that it could be a good method stated that:

“The good thing about it is that you will never worry about making your wife pregnant again. But I think it should only be done when both husband and wife are sure they do not want more children at all. No one should jump into it without understanding it fully. I would use it after my wife and I are sure we do not want any more.”

Another respondent who did not favor the procedure stated that:

“As far as I understand, vasectomy is not an African idea. It was introduced by the white people who want us to have only few children and finish us! In our community many children are a sign of wealth and people respect you. I do not understand why anyone would agree to get a vasectomy.”

During the study however, some respondents gave conflicting information regarding their vasectomy status as they kept circling the topic, therefore the number of those who may have undergone the procedure may somewhat be higher but it was not confirmed most likely due to fear of being stigmatized. This made it difficult to establish with certainty whether there were any men in the study area who had undergone vasectomy.

Studies show that one way to foster male involvement in family planning is to give couples more contraceptive choices through the promotion of male-oriented methods such as vasectomy. Vasectomy is a safe, simple and effective method that is relatively unknown and much unused throughout much of the world. Although sterilization is the most widely used contraceptive method worldwide, tubal ligation accounts for more than five times as many procedures as vasectomy. In 2002, vasectomy made up only 7% of all modern contraceptive use worldwide. And although its prevalence is low in most developing regions, it is especially low in Africa, where it rarely exceeds 0.1% (Wright et al., 2005).

Researchers have suggested that vasectomy is unacceptable to most African men and probably will long remain so (Caldwell & Caldwell, 2002). However, similar predictions made in the late 1980s about female sterilization have proved unfounded. It can therefore be concluded that the low use of vasectomy is not entirely because of men's resistance to the method, but also because of the failure of many health professionals to make information and services readily available and accessible.

4.3.6 Interest in vasectomy

Table 17: Respondents who would ever consider getting a vasectomy

RESPONSES	RESPONDENTS	PERCENTAGE OF RESPONDENTS
YES	17	11.33
NO	133	88.67
TOTAL	150	100.00

Table 17 shows that approximately 9 in every 10 men (89%) would not consider getting a vasectomy while only 11/5 would. On further inquiry by the researcher on why they gave the responses they did, one respondent who reported to be a father of six stated that:

“I have heard it cannot be undone and so it is a very serious thing to do. I would hate to regret in future if I wanted more children but could not have any. I would rather use other methods than have this done to me. ”

Another respondent who was a Muslim, with three wives and eight children stated that:

“This procedure seems complicated but also useful at the same time. I would need the advice of a professional because they know more about it and maybe later also consult my wives after thinking about it seriously. I would not want to make a bad decision due to lack of proper information.”

In a study conducted in 1992 by JHU/PCS, findings showed that 16% of men in Nairobi and Mombasa said they would consider having a vasectomy. Of the men who wanted more children, 37% said they would consider having a vasectomy later in life after they have had all the children they wanted. Lack of information, misunderstandings and rumors about the vasectomy process contributes to many men's reluctance to choose it as their ideal family planning method.

Despite the low number of men who have shown interest in undergoing a vasectomy, it is regarded as one of the most effective means of birth control and is offered free of charge in clinics such as MarieStopes, Kisumu. Dr. Charles Ochieng, one of the very few vasectomists in Kenya - who himself has undergone the procedure - mentions that the fear of what will happen if a man loses children through death or divorce is what hinders men from embracing this family planning method. While some of these concerns are valid, Dr. Ochieng wants the myths about the procedure dispelled in order to increase consumption. In 2009, he reported to have only conducted 6 vasectomies, which is quite low.

Although vasectomy is available in some hospitals in Kenya, the demand for it seems to be quite low. Emphasis on supply should be matched with equal, if not more emphasis on demand creation. There is need to create demand before the supply of vasectomy is increased and this can be done using mass media campaigns, using physicians as well as satisfied clients to address myths and misinformation associated with it. Highlighting the economic benefits of smaller sized families may also make vasectomy more attractive to men. For example, messages could emphasize a sterilized man's ability to be a good provider for his family and his satisfaction from being able to send all his children to school and give them a quality life.

In most areas of the world, vasectomies are a highly underutilized form of contraception. Overall, the number of female sterilizations performed is five times higher than the number of vasectomies performed. The rates of vasectomies are higher than the rates of female sterilization in only five countries in the world. These countries are Bhutan, Denmark, the Netherlands, New Zealand and Great Britain (Barone et al.,2009). The rates are relatively high in Oceania and North America, and very low in parts of Asia and nearly all of Africa. There are currently many barriers to vasectomy that stem from inadequate service delivery of vasectomy and from cultural and community beliefs. Strategies aimed to overcome these barriers must be introduced so that the vasectomy prevalence can continue to increase throughout the world.

In 8 countries worldwide, (Australia, Bhutan, Canada, the Netherlands, New Zealand, the Republic of Korea, Great Britain and the United States), the prevalence of vasectomy use exceeds 10%. New Zealand has the highest prevalence of vasectomy at 19.3%. It has been a widely used method of contraception since the 1970s. In the 1980s, it became more widely used than female sterilization. A survey conducted in the late 1990s in New Zealand found that 57% of men aged 40 to 49 had received vasectomies. Overall the prevalence of vasectomy is lower in developing countries. The use of vasectomy is particularly low in sub-Saharan Africa. Even though vasectomy services have been introduced in some sub-Saharan African countries such as Ghana, Kenya, Malawi, Rwanda and Tanzania, in the vast majority of sub-Saharan Africa the prevalence rarely exceed 0.1% and has remained relatively stable throughout the past decade. The two African countries with a slightly higher rate of vasectomy are Namibia and South Africa at 0.8% (Barone et al., 2009).

Kenya's long-term development plan, known as Vision 2030, recognizes that rapid population growth could severely derail progress in reaching its primary goal: To achieve a high quality of life for all Kenyans that is sustainable with available resources (NCPD, 2012). The National Council for Population and Development (NCPD), under the Ministry of Planning, National Development, and Vision 2030, initiated a series of consultations to achieve a population policy that would bolster this vision. Although Kenya has made great strides in increasing contraceptive coverage, from 27 percent in 1989 to 46 percent in 2009, concerns over worsening unemployment, food shortages, and a large youth population threaten Kenya's economic future. To assist in efforts meant to help the country achieve this goal, in March 2014, the council embarked on a study to evaluate male involvement in family planning and reproductive health.

This is an important factor for Kenya because it has been recognized by many development agencies that lack of male participation is one of the major causes for the rapid population growth in Kenya. Unless the population is managed, Kenya faces the risk of not meeting its 2030 developmental goals and with increasing population and diminishing resources; the living standards will be poor. According to the council's Director General (DG), Dr. Josephine Kibaru, family planning uptake by men in the country currently stands at 26 percent with Nyanza, Coast, Western and North Eastern regions having the lowest levels unlike Nairobi and Central having the highest rates of 70 percent. The survey has been prompted by reports that men had taken a back seat and left the role of family planning to women.

According to Dr. Kibaru, the survey which began in March 2014 is expected to draw answers from men as to why they shy away from family planning and reproductive health besides finding out what they would like done differently for them to be fully involved. Dr. Kibaru also added that once the three month survey is completed and the barriers to male involvement to family planning are identified, the government will be able to implement programmes and policies aimed at improving the current scenario (NCPD, 2014).

At the time that this study was completed in Vihiga County, the NCPD findings were not available yet but the findings are expected to ensure that the outcome will guide in implementing sustainable policies and programmes that will bring men on board on matters of family planning and reproductive health.

It can be said that one of the major reasons why vasectomy is highly unutilized among men is because of various service-delivery and cultural as well as community barriers. While the blame for underutilization has been placed on men, various studies have suggested that men would like to be more involved in the prevention of unintended pregnancies.

In conclusion therefore, various strategies should be implemented that aim to increase vasectomy use. Men should be the target of educational campaigns to increase acceptance of and knowledge surrounding vasectomy. Multimedia campaigns have been proven to increase vasectomy use in Brazil, Columbia and Guatemala. Information should be delivered to men through community talks, home visits, and the mass media to create awareness about vasectomy and its advantages as a modern male family planning method.

4.3.7 Male attitudes towards family planning

Earlier in this study, it was hypothesized that sources of information, knowledge and spousal discussions all played a role in the formation of attitudes towards family planning. To assess the general attitude of men towards family planning and participation in decision making, a series of statements was read to the respondents and rated using a five point opinion scale which resulted in the findings below.

Table 18: Perceived male attitudes towards family planning

NO	STATEMENTS	RESPONDENTS WHO (n=150)					TOTAL NUMBER OF RESPONDENTS
		STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	
1	The general use of family planning is important for a healthy family.	69 (46.0%)	13 (8.7%)	18 (12%)	17 (11.3%)	33 (22%)	150 (100.0%)
2	Male family planning methods are equally as effective as female methods.	31 (20.7%)	23 (15.3%)	9 (6.0%)	19 (12.7%)	68 (45.3%)	150 (100.0%)
3	Men should take up the responsibility of using family planning.	27 (18.0%)	13 (8.7%)	21 (14.0%)	19 (12.6%)	70 (46.7%)	150 (100.0%)
4	It is better for a woman to have tubal ligation than for a man to have a vasectomy.	84 (56.0%)	18 (12.0%)	9 (6.0%)	23 (15.3%)	16 (10.7%)	150 (100.0%)
5	Vasectomy is the same as castration.	106 (70.7%)	27 (18.0%)	8 (5.3%)	3 (2.0%)	6 (4.0%)	150 (100.0%)
6	A man who has many children has a higher social status than the one who has few.	89 (59.3%)	17 (11.4%)	0 (0.0%)	15 (10.0%)	29 (19.3%)	150 (100.0%)
TOTAL		406	111	65	96	222	900
CELL REPRESENTATIVENESS		45.1%	12.3%	7.2%	10.7%	24.6%	

Each statement above explored different aspects related to participation in family planning decision making which will be discussed in brief independently. Statement one showed that 82 respondents

(55%) held favorable attitudes towards the general use of family planning for healthier families, 12% (18 respondents) were uncertain while 33% did not favor this statement. This finding therefore could be taken to mean that men in this county still favor large families and would rather have those than few whom they can care for easily. It also shows unwillingness to use modern family planning methods.

Statement two explored the attitude of men towards male family planning methods as compared to female methods. Findings showed that only 36% (54 respondents) held favorable attitude towards male methods indicating they thought that they were just as effective as female methods but a majority 58% disagreed with this statement. The assumption which can be made here is that because female methods are well known and more popular than male ones, it becomes natural to assume that they are the best. Lack of adequate information about male methods can also be said to have influenced the responses indicated above.

When it came to taking up responsibility to use male family planning methods, only 40 respondents (27%) were in favor of this statement, 14% were uncertain while a majority 59% (89 respondents) held unfavorable attitudes towards this responsibility. From other findings in this study, it can be concluded that the attitude towards use of family planning by men is influenced by various cultural and social values which must be changed in order to enhance its use by men.

Statement four intended to measure how men felt about permanent male and female family planning methods. From the findings above, it can be concluded that majority of the respondents (68 %) had a favorable attitude towards women undergoing tubal ligation as compared to men undergoing vasectomy despite the permanency in both procedures being standard. Only 26% of the respondents did not favor this statement while 6% were uncertain about it. This can be assumed to be as a result of the knowledge that men have towards family planning. Female methods are more popular than male methods and because this community lacks sufficient knowledge on vasectomy, they support tubal ligation instead.

Statement five intended to determine the attitude of men towards vasectomy. Findings showed that 89% of the respondents revealed highly unfavorable attitudes towards it by agreeing that it is synonymous with castration. Only 6% had favorable attitudes while 5% were uncertain about it. Vasectomy is the presently the most advanced male family planning method which offers a permanent solution to birth control. The unfavorable attitude of men towards vasectomy can be said

to be influenced by lack of sufficient information, low levels of spousal discussion and traditional cultural and social values which this study further explores.

Lastly, it was found that 71% of the respondents showed favorable attitudes towards having many children as they believed it positively influenced their social status in the community while 29% did not agree with the same. With findings like this, it can be assumed that because majority of the respondents still favor having many children as a form of social and cultural security, their use of male family planning methods and participation in decision making will continue to be quite low. Traditionally, children hold an intrinsic value and it is believed that the more one has, the better their lives will be in old age.

In conclusion, besides the source of information, level of knowledge and spousal discussion which is thought to influence the use of male designed methods, men's attitudes also play an integral role in determining participation. It is also important to note that attitudes of males regarding family planning are deeply embedded in their roles as leaders of communities and their aspirations to survive in terms of lineage. When family planning goals are inconsistent with cultural values of a community, men tend to develop unfavorable attitudes towards family planning. This is why it is crucial that family planning providers consider a community's socio-cultural characteristics before designing programs that encourage them to use modern family planning methods.

It can also be argued that there is a relationship between attitudes and interest in family planning. With regard to this study, the attitude of men in this community towards family planning can be said to be mostly favorable depending on the specific aspect family planning seeks to address. A favorable attitude towards family planning is strongly associated with a desire for more knowledge and information, but not necessarily with interest in getting a method to use. Men with favorable attitudes are more likely to engage in family planning decision making than those who have unfavorable attitudes.

4.4 Male participation in family planning decision making

The third objective of this study intended to determine the participation of men in family planning decision making. It was hypothesized that adequate information about family planning, inter-spousal discussion and attitudes held towards family planning together come into play in influencing male participation in decision making. This section therefore seeks to investigate if this is accurate.

4.4.1 Going with wives to family planning clinics

To begin determining participation of men in decision making, the respondents were first asked whether they have ever gone to the clinics with their wives to seek these services.

Table 19: Attendance with wives

EVER GONE	RESPONDENTS	PERCENTAGE
YES	48	32.00
NO	102	68.00
TOTAL	150	100.00

Table 19 shows that majority of the respondents (68%) reported to have never gone together with their wives to visit health centers, while a minority 32% had gone. According to a study by KMET and Boston University (2009), it was found that men were reluctant to visit reproductive health clinics for advice on family planning because they associated such facilities as a ‘woman’s place’ and did not want to be seen mixing with women for fear of being labeled as henpecked or considered effeminate. The findings from that study coincide with the findings from this study because men in Vihiga County seemed to be repelled by the idea of going together for family planning counseling.

Table 20: Reasons for accompanying wives to health centers

REASONS	RESPONSES	PERCENTAGE OF RESPONDENTS
Responsibility	21	14.78
Pay the bill	78	54.93
To get FP together	25	17.61
To guard her	18	12.68
TOTAL	142	100.00

Table 20 shows that 55% of men reported they went along to pay the bill, while only 18% went with them to get family planning together. It also shows that 15% only felt it was the responsible thing to do while 13% went together to guard their wives. These findings indicate that men in this county

seem uninterested in receiving counseling and this affects their ability to make decisions on male methods to use because they failed to get the information needed.

Table 21: Reasons for not going with wives

REASONS	RESPONSES	PERCENTAGE OF RESPONDENTS
Perceived cultural barriers	62	55.86
Perceived religious barriers	33	29.73
It is Embarrassing	16	14.41
TOTAL	111	100.00

Table 21 shows majority of the respondents (56%) indicated the main reason for not go to the health centers with their wives because it was against their culture, 30% stated it was against religion while 14% sited embarrassment. One respondent who did not accompany his wife to the health center stated that:

“Although my religion does not permit the use of artificial family planning, periodic abstinence has not worked for us. Two of our children were unplanned and we do not wish to have more. My wife decided she will use family planning anyway because she had no other option. She goes to the clinic by herself.”

A doctor from Emuhaya District Hospital said the following:

“On a daily basis, we find many men outside the clinic gates just sitting. When we ask them if they need to see a doctor, many of them say they are waiting for their wives who came to receive family planning. When I ask them to come inside and have the discussions with the providers and their wives, they say it is not their place as men.”

In a study conducted in Zambia (Benkele, 2007), it was found that 42% of men did not accompany their wives to health centers because they felt it was not their role to be involved in reproductive issues. The study found that men felt more comfortable in fulfilling their social roles as providers than as what they perceived to be as caregivers, which is meant for women. It can therefore be concluded that men

in this county are held back by various social and cultural factors hindering their participation which the fourth objective will explore.

4.4.2 Participation in family planning discussions at health centers

Table 22: Men who have ever discussed family planning with health providers

EVER DISCUSSED	RESPONSES	PERCENTAGE OF RESPONDENTS
Yes	18	12.00
No	132	88.00
TOTAL	150	100.00

Findings from Table 22 show that approximately 8 in every 10 men (88%) reported to have never participated in family planning discussions with health providers at health centers. Only 12% reported to have ever been engaged. One respondent who reported to be cohabiting stated that:

“In our community, matters of child bearing and reproduction are not responsibilities of men. It is up to the woman to handle all that. Having talks on family planning with women and providers will not benefit men here. It is better left to the woman.”

A nurse at Hamisi sub district hospital who deals specifically with family planning issues state that:

“Men need to take up more responsibility and be more active in issues regarding family planning. It seems to be hard for them to talk to us and ask about family planning. Most men only bring their wives here but wait outside. They seem uninterested but there is need for them to become more involved at the discussion levels.”

Studies show that at least 200 million women worldwide want to use safe and effective family planning methods, but are unable to do so because they lack the support of their husbands (UNFPA, 2013). When men do not participate in family planning discussions, decision making can become a burden to women. This lack of participation at the discussion level is what has contributed to the unmet need for contraceptives in Kenya, which currently stands at 43%, because even as the heads

of the households, men are unable to make a decision to use male family planning methods due to lack of sufficient information.

4.4.3 Importance of involvement in family planning discussions

Table 23: Need to be involved in family planning discussions

NEED	RESPONSES	PERCENTAGE OF RESPONDENTS
YES	72	48.00
NO	78	52.00
TOTAL	150	100.00

Table 23 shows that a majority of the respondents (52%) felt that it was not important to be involved in family planning discussions while 48% thought it was important. One respondent who reported to have one wife and four children who reported not to see the importance stated that:

“When men are involved in these discussions, women start thinking they are our equals and even become rude and we cannot control them. They can even become promiscuous. With family planning you cannot know if a woman is badly behaved unless they get pregnant from other men other than their husbands. Discussing family planning with them might be seen a way to allow them to go with other men.”

In contrast to this, a similar study conducted in Hosanna town, Ethiopia, (Tularo et al., 2006) it was found that 66% of married men considered it necessary to be involved in family planning discussions with both their wives and health care providers. However, another study done in Gondor town, Ethiopia (Ismail, 1998) showed that only 23.9% of men agreed that it was important to be involved in talks on family planning. In conclusion therefore, it emerges that the importance of discussion and of family planning options is relative depending on the communities in question. Every community has their own values but the topic of sex is taboo in most of Africa and even married couples cannot openly discuss it. However, in modern times, the importance of involving males cannot be overlooked and policies need to be developed to encourage this if national and international developmental goals are to be met.

4.4.4 Responsibility for family planning decision making

Table 24: Family planning decision makers

DECISION MAKER	RESPONSES	PERCENTAGE OF RESPONDENTS
Wife Only	65	43.33
Husband Only	11	7.33
Joint Decision	18	12.01
Health care provider	56	37.33
TOTAL	150	100.00

Table 24 shows that 43% of the respondents stated that it was the responsibility of the wife alone to make decisions on whether the couple should use male or female family planning methods. The second most common response (37%) was that it was the decision of the health care provider at the clinic. Only 12% of the respondents supported a joint decision facilitated by intra-spousal communication, while a minority 7% stated that it was the decision of the man alone to decide on which method will be used by the couple. One respondent who had one wife and six children and supported decision making by the wife alone stated that:

“It is the woman who should make that decision because she is the one who experiences many problems from the time she finds out she is pregnant to the time she delivers the baby. She should take steps to space children according to her strength. If she wanted me to use condoms, I would think about it but maybe not agree. Men should not have to think about all those things as well.”

These findings on decision making responsibility were found to be consistent with those of a study undertaken in Malawi by APHRC (1997) which similarly found that it is mostly the women (87%) who were left with the responsibility of making family planning decisions on preferred methods. This can be attributed to the fact that most family planning programs target women as the primary recipients of this service and also because they knew more about it compared to men. However, when decision making is left to women alone, they are inclined to make a decision to use female designed methods because their husbands are opposed to using male methods. When this occurs, men do not contribute to the decision making process as well as the consumption of male designed methods.

However, despite the findings the reality on the ground reflects a different view. When women attend family planning counseling – even in the absence of their husbands – they are mostly given the options that are available to use for both themselves and their husbands. Upon being asked to make a decision, the reality is that many women will be seen stepping out to make a phone call or consult with their husbands outside the clinic then come back at tell the service provider of their decision. It is critical to note that the mere physical presence at the clinics does not necessarily mean that women make these decisions in autonomy. Many Kenyan men have an upper hand in this decision because of the patriarchal nature of most traditional societies. These actions therefore suggest that decision making is indeed a joint effort although men in this county did not admit to it probably for fear of being labeled as “hen-pecked” among their peers. This finding is therefore inconsistent with what actually happens in most cases.

More so, sometimes the decision to space and plan for children is not solely in the hands of the couple alone. In most rural societies, including in western Kenya, extended families are the norm. This means that issues regarding fertility are sometimes dictated by the grandparents and relatives of the couple who assist in determining family size as well. In conclusion therefore, it can be said the inconsistencies from the findings in this section compared to reality is caused by the male ego which men in this county are protecting in order to preserve their “manhood”.

4.4.5 The use of family planning in marriage

Table 25: Person responsible for family planning use in marriage

RESPONSIBLE PERSON	RESPONSES	PERCENTAGE OF RESPONDENTS
The woman	83	55.33
The man	21	14.00
Either man or woman	32	21.34
Neither	14	9.33
TOTAL	150	100.00

Table 25 shows that majority of the respondents (55%) stated that they perceived it as the responsibility of women to use family planning methods after a decision has been made. Only 14% of the respondents thought it was the responsibility of the man while 21% of the respondents thought that it was the responsibility of either the man or woman.

A 39 year old father of two children, who supported the use of family planning by either husband or wife, stated that:

“It is known by everyone that the Bible tells us that man and woman were placed on earth to have children. When God said we should fill the earth He knew why and what He was talking about. Couples who are truly religious should not use any family planning methods. If they have a baby, it is a gift from God. It is His will that we have as many children as possible.”

Another respondent offered a contrasting opinion and stated that:

“After they have discussed together and come to an agreement on who will begin using which method they can go ahead. Both of them should be ready to take up this responsibility though many men may be unwilling due to cultural and traditional constraints.”

In a similar study carried out by NCPD (1989), findings indicated that 64.6% of men stated that it was the responsibility of the woman to use family planning in marriage while only 36.4% felt that men should bear that responsibility. From the findings of this study in Vihiga County, it was found that even lesser respondents (55%) said it was the responsibility of the woman alone to use a family planning method.

Given that most societies are patriarchal, men do not feel the need to take responsibility for family planning because it is women who bear the burden of pregnancy and the social responsibility of raising them. Some men have also been known to intentionally avoid engaging in discussions about male methods because they want to resist the use of condoms, based on the argument that they reduce sensation and sexual pleasure (Nzioka, 2000).

More so, the fact that more than half of the respondents in this study indicated it was responsibility of the woman alone to use a female designed family planning method, shows low levels of interest for methods designed for men despite joint decisions being made by the couple.

4.4.6 Involvement of men in family planning programmes

Table 26: Interest in involvement in family planning programs

INTEREST	RESPONSES	PERCENTAGE OF RESPONDENTS
YES	127	84.67
NO	23	15.33
TOTAL	150	100.00

Table 26 shows that majority of the respondents (85%) expressed some form of interest to be more involved in family planning programs to enhance decision making on male methods while 15% did not. However, previous findings which showed low levels of participation in decision making and use of male methods, made it difficult to determine whether the interest reported in table 26 was superficial or genuine.

One respondent who had two children and expressed desire to be involved stated that:

“I think it is important to know what these programs have for both men and women. Sometimes our women may want to use family planning but because we do not show interest they do not use it and get pregnant at a bad time. This is what I think happened to my brothers’ wife and it led to her having to remove the pregnancy (termination of the pregnancy). She died in the process. Also it might encourage men to share this responsibility with women. ”

However, another respondent who stated disinterest said that:

“These are issues that belong to women (mambo ya wanawake) and men do not need to know too much about it. I might be the father of my children but I am not the one who has to give birth. I do not think it should be my concern.”

The statement above discloses that men think that family planning programmes only involve matters regarding reproduction and birth. It should however be made clear that apart from the immediate reproductive aspect, these programmes have long term socio-economic benefits for the whole family and that they seek to encourage the use of both male and female methods in order for these goals to be realized.

The desire to involve men more in family planning programs has been one of the major goals of family planning providers, both governmental and non-governmental (NCPD, 1989). It is apparent that some men exhibit interest but there exists no entry point for them to be more involved in these programs which will lead to an increase in the consumption of male designed methods. However, it is now mandatory that they be given as much priority as women, because both of them are, and can be consumers of this vital service (Ezeh, 1996).

This mandate to increase male involvement is further emphasized by the 1994 ICPD which, in brief, calls for an understanding of men's and women's joint responsibilities, so that they become equal partners in public and private life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour, which includes decision making and use of male designed methods to plan for their children as well as to prevent the spread of HIV/AIDS.

4.5 Socio-Cultural factors influencing family planning decision making

The fourth and final objective of this study was to identify the various-socio cultural factors that influenced male participation in family planning decision making. It is stated in our hypothesis that opposition to family planning is not naturally in built but is as a result of certain notions instilled in men through the socialization process which the study sought to determine.

Table 27: Social factors influencing male participation

FACTORS	RESPONSES	PERCENTAGE OF RESPONDENTS
Perceived health of the wife	123	21.61
Perceived health of the children	104	18.27
Perceived state of personal health	57	10.01
Fear of social stigma	137	24.10
Societal acceptance of male methods	148	26.01
TOTAL	569	100.00

Findings in Table 27 show that approximately 5 out of every 10 men (50%) cited that participation in family planning decision making was influenced by fear of social stigma and the social acceptance of male methods. This means that procedures such as vasectomy which are usually deemed unacceptable among men in Africa, would be one of the least used methods chosen by these respondents. This was followed by the perceived health of the wife at 22%, perceived health of the children at 18% and their own perceived state of health at 10%.

One respondent who mentioned that the health of his wife was most important said that:

“Women need sufficient time to nurse children and also rest to regain their strength after giving birth. If my wife was getting sick and weak due to too many births, I would decide to use artificial methods to save her life and that of my children.”

Another respondent said that:

“The use of family planning in our society is not acceptable to many men. Even when field educators visit our homes, they only talk to women and men are neglected. No one has approached men in a way that is acceptable to us, and there is fear of being stigmatized in this society if they are found engaging in ‘women’s activities’.”

From discussions held with a doctor from Emuhaya district hospital, the main reasons why men choose to use male family planning methods is mainly influenced by socio-economic factors. The doctor argued that the men who were confident enough to ask about the family planning methods available to them cited financial strain and poor health of their families as the main reasons.

From the excerpt above it is clear that men continue perceiving family planning as an activity for women only and this is why even joint decisions are usually inclined towards the use of female methods only. Male use of contraceptives is mainly addressed through the promotion of condoms while vasectomy is rarely heard of during these activities. More so, male clinics have not been developed in Africa yet this could be an avenue where men can have their reproductive health needs met without feeling stigmatized or embarrassed. Health care providers also need to make clear the distinctions between spacing and permanent methods for couples who have come to the end of desired facilities.

Table 28: Cultural factors influencing male participation

FACTORS	RESPONSES	PERCENTAGE OF RESPONDENTS
Religious Values	103	26.41
Number of wives	98	25.13
Number of Children	47	12.05
Sex of children	142	36.41
TOTAL	390	100.00

Table 28 shows that 36% of the respondents stated the most common cultural factor that would influence their decision to use male contraception would be the sex of the children born into the family. Religious values accounted for 26%, followed by number of wives (25%) and number of children (12%). One respondent whose main factor was the sex of children born into the family stated that:

“In this community, a marriage is not considered as fully sealed unless the couple is able to have at least one son. Sons ensure the family lineage continues and inherit land from their fathers. I know of many people who have even chased their wives because they have only had girls all in search for a boy.”

However, another respondent who was mostly influenced by the number of children he had stated:

“My wife and I only wanted to have four children when we got married. She got pregnant the fifth time by accident and we thought it would be the last, but again she got pregnant and this time with twins. We were both very stressed. She does not work and my whole family relies on me to take care of them. It was very tough but now we use condoms because she has bad reactions to the female injections.”

A similar study on family planning programs in India’s rural Bihar state indicated that improved access to services, expanded choice of available methods, and increased knowledge of family planning were important for the acceptance of male family planning methods. However, opposition from husbands and in-laws, and the desire for at least two sons were obstacles to the acceptance of family planning (Rudranand et al., 1995). Religious affiliation is also a major cultural factor affecting the use and acceptance of male contraception. For instance, the Catholic Church does not encourage the use of

modern artificial birth control methods, which strongly discourages men who follow this faith from allowing their partners and themselves to use any such available methods.

Table 29: Psychological factors influencing male participation

FACTORS	RESPONSES	PERCENTAGE OF RESPONDENTS
Perceived Side effects	137	35.77
Extra marital affairs	142	37.08
Interference of sexual pleasure	104	27.15
TOTAL	383	100.00

Table 29 shows that 37% of the respondents reported that the fear of their partners engaging in extra marital affairs influenced their decisions on whether to use male cotraception or not. The fear of side effects from modern family planning methods accounted for 36% while 27% were worried their sex lives would be affected. One respondent who was concerned about side effects said that:

“We hear a lot of stories about how it makes it hard to have children after using some methods for too long and in the event that she gets pregnant, the child could be born deformed or disabled. We cannot know which ones are true or not but it is enough to make me decide not to use any method with my wife.”

As indicated above, the most influential psychological factors that influence men are the percieved side effects, extra marital affairs and the interference of sexual pleasure. All these can also be concluded to be an outcome of the inadequate information on family planning that men receive. This directly influences their notions on family planning and affects both decision making and consumption of services.

Studies show that there exists widespread myths and misconceptions about family planning methods for men, especially about vasectomy. In a study by KMET (2009) among men in Kisumu about perceptions towards modern family planning methods, findings revealed that men thought that using condoms with your wife indicated demise of the relationship or existence of another sexual partner. They also had misconceptions about female methods as the study showed that they

said methods such as the IUD made women cold and unresponsive in bed. Vasectomy was the male method they greatly opposed because it is thought to render men useless and unable to have sex. Moreso, it is believed that men who undergo vasectomy lose their standing in society and are viewed as weak among other men because they are no longer able to sire children.

In a study carried out by Mbiti (1987) among the Luhya in Kakamega on the intrinsic value of children, findings showed that children were viewed as the central focus of society and the community's social, cultural, educational and economical futures. Having small families was seen to be a sign that the man and woman were cursed and that they did not wish to continue their lineage. It also meant that they would live in poverty because they had no children for social and economic security.

In conclusion, to enhance the consumption of male methods, it is important to first study different communities and find out what factors influence their uptake and find ways to address them without causing social disturbance. To initiate this, they must first be able to receive frequent and accurate information regarding the options available to them male participation in family planning decision making, religious, social and cultural barriers have to be overcome. In order to initiate this process, education must be paramount. Men who reside in rural areas must primarily be educated on modern family planning methods and the benefits of consuming these services. This will eventually liberate themselves from outdated values and cultural practices that hinder them from using male designed methods for family planning purposes.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives a brief summary of the main findings, conclusions on the study and recommendations made.

5.2 Summary

The overall purpose of this study was to assess male participation in family planning decision making, with a focus on the use of male methods. The study found that the major source of information for men was mass media (43%) and print media (32%). However, despite this, information was found to be inadequate and inaccurate which leaves men with more questions than answers making them shy from consuming methods designed for them.

The study also found that 49% of men had moderately favourable attitudes towards the use of family planning by couples if it was for the purpose of spacing births. However, 48% disagreed that using male methods was just as effective as using female methods to plan for children. When it came to the use of male methods by men in marriage, only 24% agreed that men should share this responsibility indicating unfavorable attitudes towards male specific methods.

On male participation in decision making and consumption of male contraception, of the 32% who reported to go to clinics with their wives, the main reason was to pay the bills (55%) and they never participated in counseling sessions together with their wives. It was also found that 88% of men did not discuss family planning with providers at the health center and this resulted in 43% of men leaving decision making mostly to the wife and 38% to the health care providers. More so, only 15% of men supported the use of male methods within marriage while a majority 55% said it was the responsibility of the woman. Despite the indication of low levels of participation in decision making regarding method choice, 85% reported to have interest in the programmes and were willing to learn more about methods available for them.

Lastly, in the quest to identify the socio-cultural factors that influenced male consumption of methods, it was found that 50% of respondents cited the fear of social stigma and acceptance as the main barrier. This was followed by health of the wife (22%), sex of the children born into the family (24%) while fear of extra marital affairs and side effects accounted for 37% and 36% of the barriers to consumption of methods respectively.

5.3 Conclusions

The study concluded that despite displaying high levels of knowledge on family planning methods available for both men and women, this did not result in high consumption of methods as would naturally be assumed, especially by men. To enhance the rate of consumption of male methods, accurate and adequate information should be disseminated mostly through audio-visual sources (radio and television) as they were found to be the most major sources of information for men in this County. Because attaining of information builds individual and communal knowledge which in turn leads to the formation of attitudes, service providers should strive to increase access to information which will eventually lead to an increase in consumption of male methods.

It is important to note that participation of men in family planning, does not only mean attending counseling sessions and supporting spouses in the use of methods, but also involves taking responsibility of use of male methods to encourage responsible fatherhood. This will assist in the reduction of cases of unsafe abortions caused by unintended pregnancies. One of these methods is to encourage the use of vasectomy among men who feel they already have enough children and other family planning methods are not as effective as they had hoped. It is the most advanced male family planning method that exists, but yet is the least consumed especially in Africa where its use only ranks at 0.1% compared to western countries where the method has been accepted by its people. Due to the many myths and fears that surround the procedure itself, it is not a method which many men would like to use. Promotion of male condom and vasectomy should be prioritized by program providers as well as service delivery agents to enhance consumption by all men.

Culture and community aspects influence the ability and willingness of men to use male family planning methods. In many traditional societies, men dictate whether their wives will use family planning or not and ironically they mostly do not believe that utilizing a method is their responsibility. As equal sexual and reproductive partners, men should accept to share this responsibility in order to ensure that their families receive a quality life with consideration to the resources available. More so, in order for nations to develop strong and healthy human resource, the use of condoms should be promoted because they act as a double barrier against unintended pregnancies and the spread of the HIV virus. Conclusively therefore, men should realize that their role in the use of male family planning methods is just as important as female methods and they should strive to be a part of this crucial endeavor.

5.4 Recommendations

Policy

- 1) There is need to review the national family planning policies to ensure male services are integrated into existing ones in order to increase male involvement in family planning and use of male methods.
- 2) There is need to develop policies that call for mandatory male attendance at family planning counseling sessions with their spouses in order to enhance joint deliberation on available methods to use, especially male methods.

Program

- 1) There is need to develop family planning programs to include male participation in reproductive health which should promote male methods as an alternative to female ones
- 2) There is need to establish male-only family planning clinics to address problems such as lack of privacy, convenience and confidentiality of men as they seek services.

Research

- 1) There is need to conduct more research on men and different aspects of family planning and come up with ways to increase their participation and consumption of services in various communities in Kenya.

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LIST OF APPENDICES

APPENDIX 1: QUESTIONNAIRE FOR MALE RESPONDENTS

MALE PARTICIPATION IN FAMILY PLANNING DECISION MAKING SURVEY

Serial number of questionnaire

|_|_|_|_|_|_|_|

Site number

|_|_|_|

CONSENT FORM

Hello Sir,

My name is Loreen Adagala, a student at the University Of Nairobi. I am conducting a study on male participation in family planning decision making in Vihiga County. I will now give you information on what the assessment is about. Afterwards, I will invite you to be a study participant. Once I have shared this information, you can decide whether or not you will participate in the study. Please feel free to stop me as we go through the information and I will take time to explain any queries or concerns you may have. If you have questions later, you can ask me or any member of my research team to respond to your concern or query.

May we proceed? ___Yes ___No

The overall purpose of the study is to establish the factors that influence the role and level of participation of men in family planning decision making. This area of study is important because for many centuries, family planning decision making has been a task mostly left to the woman and neglects the opinion of men in this crucial decision. This study aims to bring out a clear understanding of men and their opinions on family planning as well as their level of participation in decision making.

You've been selected randomly and we wish, with your permission, to interview you. Some of the questions asked, are of a sensitive nature, but please note that your name or any of your personal details will not be recorded in the questionnaire, and any details related to your privacy will be kept confidential and will not be disclosed to anyone without your knowledge or permission. Your participation in this survey is very important and we rely on you to provide us with accurate information that will help us to develop effective policies and strategies on how to involve men more in family planning decision making. There are no risks associated with your participation in this study. However, we feel that your participation will contribute greatly in knowing how best to address challenges faced in family planning among men in Kenya. Be assured that we want to learn from you and use all the information we collect to help address these challenges.

The interview will take approximately 75 minutes, but with your cooperation it can be done quickly.

May I have your permission to undertake this interview? Yes No

If you do not want to participate, please tell me why:

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

Name and signature of the interviewer that a verbal consent was obtained:

Name of interviewer

Signature of the interviewer

___/___/2013

Date (dd/mm/yyyy)

Date of interview: ___/___/2013
dd/ mm/ yyyy

Start of interview: ___/___
hr min

SECTION I

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

A. GENERAL INFORMATION			
NO.	QUESTIONS	ANSWERS	SKIP
1.	Marital status of the respondent	01 = Married 02 = Single 03 = Cohabiting __ __ 04 = Divorced 05 = Separated	
2.	Record age in years	Record number of years 99 = Don't know __ __	
3.	What is your religion?	01 = Protestant 02 = Catholic __ __ 03 = Muslim 04 = Other	
4.	What is your highest achieved education level?	00 = None 01 = Primary 02 = Secondary __ __ 03 = College/University 98 = No answer 99 = Don't Know	

5.	What is your occupation?	00 = None/Unemployed 01 = Farmer 02 = Teacher 03 = Make crafts _ _ 04 = Trader/sell goods 05 = Barber 06 = Manage a hotel or restaurant 07 = Casual Labourer 08 = Other (Specify) _____	
		98 = No answer 99 = Don't know	

SECTION II

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

B. FAMILY SIZE			
NO.	QUESTIONS	ANSWERS	SKIP
6.	When did you first get married?	Record number of years 98 = No answer 99 = Don't know _ _	
7.	Have you married again since then?	01 = Yes 02 = No _ _ 99 = No answer	If NO skip to 10
8.	If YES, how many more times?	Record number of times 99 = Don't know _ _	

9.	How many wives do you have today?	Record number of wives 99 = Don't know __ __	
10.	How many children do you have by your wife/wives?	Enter number for each 01 = Wife 1 __ __ 02 = Wife 2 __ __ 03 = Wife 3 __ __ 04 = Wife 4 __ __ 05 = Wife 5 __ __ Total __ __	
11.	How many boys do you have?	Record number 99 = Don't know __ __	
12.	How many girls do you have?	Record number 99 = Don't know __ __	
13.	(a) Have you ever lost any children? (b) If YES, how many? ----- ----- -----	01 = Yes 02 = No __ __ 98 = No answer	
14.	(a) Do you want more children? (b) If YES, how many? ----- ----- (c) Why do you want more children? ----- ----- -----	01 = Yes 02 = No __ __ 98 = No answer 99 = Don't know	

15.	(a) Do you prefer any gender to the other?	01 = Yes 02 = No _ _ _ 98 = No answer 99 = Don't know	If NO go to 19
16.	a) Which one do you prefer? ----- ----- ----- b) Why the preference? ----- ----- -----	01 = Male 02 = Female _ _ _ 98 = No answer 99 = Don't know	

SECTION III

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

C. KNOWLEDGE ON FAMILY PLANNING METHODS			
NO.	QUESTIONS	ANSWERS	SKIP
17.	Have you ever heard of any of these family planning methods? (a) Coil/IUD (b) Condom (c) Diaphragm (d) Female injections (e) Norplant (f) Periodic abstinence (g) Pill (h) Tubal ligation (i) Vasectomy (j) Withdrawal	01 = Yes 02 = No 98 = No answer 99 = Don't know _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	

18.	<p>What is your major source of information on family planning?</p>	<p>01 = Radio 02 = Television 03 = Newspaper 04 = Magazine 05 = Leaflet 06 = Poster 07 = Health centre __ __ 08 = Friend 09 = Neighbour Other (please state) -----</p>	
19.	<p>(a) Is the information you have adequate in assisting you at deciding which family planning methods to use?</p> <p>(b) If yes, why?</p> <p>(c) If no, why not?</p>	<p>01 = Yes 02 = No __ __ </p> <p>----- ----- ----- ----- ----- -----</p>	
20.	<p>(a) Have you ever used any of the methods stated in question 17 above?</p> <p>(b) If yes, with who?</p>	<p>01 = Yes 02 = No __ __ 98 = No answer 01 = Wife 02 = Girlfriend __ __ 03 = Other (please state) -----</p>	

21.	<p>Are you currently using any of these male family planning methods?</p> <p>a) Condoms b) Periodic abstinence c) Vasectomy d) Withdrawal</p>	01 = Yes 02 = No _ _ _ 98 = No answer	If NO go to 25
22.	<p>If yes, which one?</p>	01 = Condoms 02 = Periodic abstinence 03 = Vasectomy 04 = Withdrawal 98 = No answer _ _ _	
23.	<p>How long have you used this method?</p>	Record number of years 99 = Don't know _ _ _	
24.	<p>(a) Do you consider this method of family planning as effective?</p> <p>(b) Why is this?</p>	01 = Yes 02 = No _ _ _ ----- -----	
25.	<p>Are you aware if your wife/wives are using any female family planning methods?</p>	01 = Yes 02 = No _ _ _ 98 = No answer 99 = Don't know	
26.	<p>If yes, which one?</p>	01 = Coil/IUD 02 = Diaphragm 03 = Female injections 04 = Norplant 05 = Periodic abstinence 06 = Pill _ _ _ 07 = Tubal ligation	

SECTION IV

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

D. SPOUSAL COMMUNICATION ON FAMILY PLANNING			
NO.	QUESTIONS	ANSWERS	SKIP
27.	Have you and your wife/wives ever discussed family planning together?	01 = Yes 02 = No _ _ _ 	
28.	Have you and your wife ever discussed the number of children you would both like to have together?	01 = Yes 02 = No _ _ _ 	
29.	Have you and your wife ever discussed male methods of family planning together?	01 = Yes 02 = No _ _ _ 	If NO go to 38
30.	If yes, which ones?	01 = Condoms 02 = Withdrawal 03 = Periodic abstinence 04 = Vasectomy _ _ _ 98 = No answer	
31.	Have you and your wife ever discussed female methods of family planning before?	01 = Yes 02 = No _ _ _ 	
32.	If yes, which ones?	01 = Tubal ligation 02 = Female injections 03 = Norplant 04 = Pill _ _ _ 05 = Coil/IUD 06 = Diaphragm 07 = Periodic abstinence	

33.	(a) Do you think it is important for you as a husband to participate in family planning discussions?	01 = Yes 02 = No	_ _ _
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SECTION V

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

E. KNOWLEDGE OF MALE METHODS OF FAMILY PLANNING			
NO.	QUESTIONS	ANSWERS	SKIP
34.	Have you ever used any male method of family planning before?	01 = Yes 02 = No	If NO go to 41
35.	Which ones have you used?	01 = Condoms 02 = Withdrawal 03 = Vasectomy 98 = No answer	
36.	Have you ever heard of a vasectomy?	01 = Yes 02 = No	
37.	If yes, where did you hear about it from?	01 = Radio 02 = Television 03 = Newspaper 04 = Magazine 05 = Leaflet 06 = Poster 07 = Health centre 08 = Friend 09 = Neighbour	_ _ _

38.	From this source of information, were you convinced that vasectomy is good for family planning?	01 = Yes 02 = No _ _ 	
39.	(a) Is vasectomy an acceptable male method of family planning to you? (b) Is it an acceptable method to members of your community?	01 = Yes 02 = No _ _ 01 = Yes 02 = No _ _ 	
40.	Would you ever consider getting a vasectomy after you have had the desired number of children with your wives?	01 = Yes 02 = No _ _ 	If NO skip to 47
41.	If you ever decide to have a vasectomy, who would you consult first?	01 = Wife 02 = Religious leader 03 = A doctor 04 = A nurse 05 = A friend _ _ 06 = A vasectomised man 07 = Other (please state) -----	

SECTION VI

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

F. MALE INVOLVEMENT IN FAMILY PLANNING DECISION MAKING			
NO.	QUESTIONS	ANSWERS	SKIP
42.	Have you ever gone with your wife to the health centre?	01 = Yes 02 = No _ _ 	IF NO SKIP TO 45
43.	Why did you go with your wife to the health centre?	01 = It is responsible as a man 02 = To pay the bill 03 = To get family planning together 04 = To guard her _ _ 	
44.	Have you ever participated in family planning discussions with both your wife and health care provider?	01 = Yes 02 = No	
45.	Between a man and a woman who do you think should use family planning to avoid or delay a pregnancy?	01 = The woman 02 = The man 03 = Either man or woman 04 = Neither _ _ 98 = No answer 99 = Don't know	
46.	Why do you think so?	----- ----- -----	
47.	Whose responsibility should it be to make family planning decisions? Why?	01 = Wife only 02 = Husband only 03 = Joint decision _ _ 04 = Health care provider ----- -----	

48.	<p>(a) Do you think men should be more involved in family planning programs to enhance use of male methods?</p> <p>(b) If yes, why?</p> <p>(c) If no, why not?</p>	<p>01 = Yes</p> <p>02 = No <input type="checkbox"/> <input type="checkbox"/></p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p>	
49.	<p>(a) Have you ever been visited by a family planning service provider in your home?</p> <p>(b) Were you involved in discussions on family planning with them?</p> <p>(c) Do you think it is important to be involved?</p>	<p>01 = Yes</p> <p>02 = No <input type="checkbox"/> <input type="checkbox"/></p> <p>01 = Yes</p> <p>02 = No <input type="checkbox"/> <input type="checkbox"/></p> <p>01 = Yes</p> <p>01 = No <input type="checkbox"/> <input type="checkbox"/></p>	<p>If YES continue to (b) and (c)</p>

SECTION VII

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

G. SOCIAL AND CULTURAL FACTORS INFLUENCING MALE PARTICIPATION IN FAMILY PLANNING DECISION MAKING			
NO.	QUESTIONS	ANSWERS	SKIP
50.	Which of these factors would mostly influence your decision to use a male method with your wife?	01 = Social factors 02 = Cultural factors 03 = Religious factors 04 = Psychological factors 05 = Economic factors Other (please state) ----- -----	
51.	Which social factors would mostly influence decisions to use a male method to plan your family?	01 = Health of the wife 02 = Health of the children 03 = Your own health 04 = Fear of social stigma 05 = Social acceptance of modern family planning methods Other (please explain) ----- ----- -----	
52.	Which of these cultural values influences your decisions on using male methods?	01 = Religious values 02 = Number of wives 03 = Number of children 04 = Sex of the children Other (please explain) ----- ----- -----	

53.	<p>(a) Are economic factors important in determining participation in family planning decision making?</p> <p>(b) If yes, how?</p> <p>(c) If no, explain why not?</p>	<p>01 = Yes</p> <p>02 = No <input type="checkbox"/> <input type="checkbox"/></p> <p>-----</p> <p>-----</p> <p>-----</p>	
54.	<p>What are some psychological reasons that determine whether you will participate or not you will use male methods?</p>	<p>01 = Side effects</p> <p>02 = Fear of extra marital affairs</p> <p>03 = Interference of sexual pleasure <input type="checkbox"/> <input type="checkbox"/></p> <p>Others (please explain)-----</p> <p>-----</p> <p>-----</p>	

SECTION IX

(Note to interviewer: 98 = No answer provided, 99 = Don't know)

CIRCLE THE RESPONSE YOU AGREE WITH MOST

I. ATTITUDE TOWARDS FAMILY PLANNING						
NO	STATEMENTS	RESPONDENTS WHO				
		STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
55.	The general use of family planning methods is important for a healthy family.	1	2	3	4	5
56.	Male family planning methods are equally as effective as female methods.	1	2	3	4	5
57.	Men should take up the responsibility of using family planning.	1	2	3	4	5
58.	It is better for a woman to have tubal ligation than for a man to have a vasectomy.	1	2	3	4	5
59.	Vasectomy is the same as castration.	1	2	3	4	5
60.	A man who has many children has a higher social status than the one who has few.	1	2	3	4	5

APPENDIX 2: FOCUS GROUP DISCUSSION INTERVIEW GUIDE

FOGUS GROUP DISCUSSION INTERVIEW GUIDE ON MALE PARTICIPATION IN FAMILY PLANNING DECISION MAKING

A) GENERAL INFORMATION

1. Have you ever heard about family planning?
2. Where did you hear it from?
3. What did you hear about family planning?
4. Have you ever used family planning? If yes, which methods did you use? (male or female)
5. Is it common for couples to use family planning? Why?
6. Which are the most common family planning methods you use within your marriages?
7. Do you think it is important for you as a man to get family planning services?
8. What do you think is the right number of children to have?
9. Does the gender of your children determine use of family planning? If yes, how?
10. How important is your religion in your decision to use male designed methods to plan for your family?

B) FAMILY PLANNING SEEKING BEHAVIOUR

1. Have you ever sought male family planning services before? Why?
2. If yes, where did you go?
3. What encouraged you to go?
4. Have you and your wife ever gone to the clinic together to seek family planning counseling services? If yes, why?
5. If no, why don't you go together?
6. Are there occasions where you sought male family planning services without the knowledge of your spouse?
7. Which are the most acceptable methods for you as men to use as family planning and why?
8. Which are the least acceptable methods for you as men to use and why?
9. What are some of your major concerns about the use of male family planning methods?

C) DECISION MAKING BEHAVIOUR

1. Have you ever discussed family planning with your wife? If yes, did you mostly discuss male or female methods?
2. Who initiated the discussion? Why?
3. Do you think it is important for you and your wife to discuss family planning together?
4. What factors would encourage you to discuss male methods with your wife?
5. What factors would prevent you from discussing male methods with your wife?
6. Between you and your wife, who should make the decision to use family planning?
7. Between you and your wife, who should use family planning to avoid or delay pregnancy?

D) PARTICIPATION IN DECISION MAKING ON METHOD USE

1. Have you ever heard of a vasectomy?
2. What gave you heard about it?
3. Where did you hear about it from?
4. Do you think it is a good family planning method for you as men?
5. Do you know where to get a vasectomy if you decided to get one?
6. How long do you think the procedure to get a vasectomy takes?
7. Have you ever gone to a health facility to inquire about vasectomy?
8. Would you be willing to have a vasectomy if it was declared safe and made available to you as a family planning option?
9. What do you think would be your wife's reaction to you getting a vasectomy?
10. Would you be willing to discuss its possibility and use with your wife? If no, why not?

E) OBSTACLES TO DECISION MAKING

1. What major factors hinder you as men from participating in family planning decision making with your wives? (Probe for individual, cultural or social reasons)
2. What do you think should be done to increase male consumption of methods designed for them?

APPENDIX 3: KEY INFORMANT INTERVIEW GUIDE

KEY INFORMANT INTERVIEW GUIDE ON MALE PARTICIPATION IN FAMILY PLANNING DECISION MAKING

A) GENERAL INFORMATION

1. What is the general attitude among men on family planning in this area?
2. Who often takes on the responsibility to use family planning to avoid or delay pregnancy?
3. Which are the most common family planning methods that you know which many couples use? (probe for male and female)

B) OPINIONS ON FAMILY SIZE

1. In your opinion, what is the best number of children for couples in this area to have?
2. How often do you discuss your thoughts on family size with your clients?
3. With whom did you have this discussion? (Husbands, wives or both?)
4. Why was it important to you to talk about it?

C) FAMILY PLANNING SEEKING BEHAVIOUR

1. Do men and women seek family planning services together?
2. Do women often seek family planning services without their spouse?
3. Do men often seek family planning services without the knowledge of their spouse?
4. Which methods are most common for men to use?
5. How many men do you know who have ever inquired about a vasectomy?
6. Would you encourage men to take on responsibility of use of methods?

D) PARTICIPATION IN DECISION MAKING ON METHOD

1. Do men and women often seek family planning counseling together?
2. Do both men and women make joint decisions on the method they would like to use?
3. Should both men and women be involved in family planning decision making on preferred method?
4. How often do you get asked about vasectomy as a male family planning method?
5. How willing are men to have a vasectomy after they have the desired number of children?

E) OBSTACLES TO DECISION MAKING AMONG MEN

1. What factors hinder men from making decisions to use male methods?
2. What do you think can be done to increase use of male methods in this county?